ACT Government
Health

ANNUAL REPORT 2014–15

ACT Health acknowledges the Ngunnawal people as the traditional owners and custodians of the Canberra region and that the region is also an important meeting place and significant to other Aboriginal groups. We respect the Aboriginal and Torres Strait Islander people, their continuing culture, and the contribution they make to the Canberra region and the life of our city.

ACT Government Health Directorate

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Enquiries: Canberra 13ACT1 or 13 22 81 | Publication No 15/1124

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ARABIC	إذا إحتجت للمساعدة بالترجمة الشفوية،إتصل بالهاتف:
CHINESE	如果您需要口译员帮助，请拨电话：
CROATIAN	Ako trebate pomoć tumača telefonirajte:
DARI	اگر به کمک ترجمه شفاهی ضرورت دارید, به این شماره تیلفون کنید:
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LAO	ຕ້ອ ງການຄວາມຊ ່ວຍເຫ ລືອ ກ ່ ຽ ວ ກ ັ ບ ການແປ ພ າ ສ າ, ໃ ຫ ້ ໂ ທ ຣ ະ ສ ັ ບ ຫ
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PERSIAN	اگر به ترجمه شفاهی احتیاج دارید به این شماره تلفن کنید:
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HEALTH CARE INTERPRETERS 6205 3333
TRANSLATING AND INTERPRETING SERVICE
13 22 81
Canberra and District – 24 hours a day, seven days a week

CONTENTS

ABBREVIATIONS AND ACRONYMS

Abbreviation/ acronym	Meaning
AAQ	Ambient Air Quality
ACAT	Aged Care Assessment Team
ACHS	Australian Council on Healthcare Standards
ACS	Acute Coronary Syndrome
ACTAS	ACT Ambulance Service
ACTES	ACT Equipment Services
ACTPANS	ACT Physical Activity and Nutrition Survey
ACTPAS	ACT Patient Administration System
ACTPS	ACT Public Service
ACU	Australian Catholic University
ADS	Alcohol and Drug Services
AHA	Allied health assistant
AHWMC	Australian Health Workforce Ministerial Advisory Council
AIHW	Australian Institute of Health and Welfare
AMC	Alexander Maconochie Centre
AMHDS	Adult Mental Health Day Service
AMHRU	Adult Mental Health Rehabilitation Unit
AMHU	Adult Mental Health Unit
ANU	Australian National University
AQI	Air Quality Index
ARATA	Australian Rehabilitation and Assistive Technology Association
ASBA	Australian School-Based Apprentice
ASSAD	Australian Secondary School Alcohol and Drug Survey
ASU	Acute Surgical Unit
AUGP	Academic Unit of General Practice
BCHC	Belconnen Community Health Centre
BHRC	Brian Hennessy Rehabilitation Centre
BIS	BreastScreen Information System
CALD	Culturally and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Services
CARE	Call and Respond Early
CatCH	Continuity at the Canberra Hospital
CCDS	Cardiac Catheter Diagnostic Suite
CCU	Coronary Care Unit
CDNMs	Clinical Development Nurses and Midwives
CDS	Child Development Service
CH	Canberra Hospital
CHHS	Canberra Hospital and Health Services
CHWC	Centenary Hospital for Women and Children
CIT	Canberra Institute of Technology
CMTEDD	Chief Minister, Treasury and Economic Development Directorate
CNGF	Carbon Neutral Government Fund
CONCERT	Centre for Oncology Education and Research Translation
COSEI	Continuity of Services Essential Infrastructure
CRCC	Canberra Region Cancer Centre

Abbreviation/ acronym	Meaning
CRMEC	Canberra Region Medical Education Council
CRPMC	Canberra Region Prevocational Management Committee
CRT	Community Rehabilitation Team
CSD	Community Services Directorate
CT	Computed Tomography
CTS	Clinical Technology Services
CUP	Capital Upgrades Program
CVAD	Central venous access device
CWLS	Centralised Waitlist Service
DAPIS	Drugs and Poisons Information System
DARS	Driver Assessment and Rehabilitation Service
DCHP	Dementia Care in Hospital Program
DMFT	Decayed, Missing, or Filled Teeth
DNW	Did Not Wait
DORSS	Domiciliary Oxygen and Respiratory Support Scheme
DSS	Department of Social Services
DTP	Diphtheria, Tetanus, and Pertussis
EAR	Education Activity Register
ECEC	Early Childhood Education and Care
EIG	Evaluation Implementation Group
ELS	Equipment Loan Service
EPAU	Early Pregnancy Assessment Unit
ESD	Environmentally Sustainable Development
ESP	Enterprise Sustainability Platform
ETD	Education and Training Directorate
EVD	Ebola Virus Disease
FEIG	Food Environment Implementation Group
FRRG	Food Regulation Reference Group
FSP	Final Sketch Plan
FTE	Full-time Equivalent
GEHU	Gastroenterology and Hepatology Unit
GHS	General Health Survey
GP	General Practitioner
HAAS	Healthcare Access At Schools
HCCA	Health Care Consumers Association
HCW	Health Care Worker
HETI	Health Education and Training Institute
HIP	Health Infrastructure Program
HITH	Hospital in the Home
HPI	Health Planning and Infrastructure
HPV	Human Papilloma Virus
HSR	Health and Safety Representative
HTC	Haemophilia Treatment Centre
HWA	Health Workforce Australia
HWPC	Health Workforce Principal Committee
ICT	Information and communications technology
ICTN	Integrated Clinical Training Network

Abbreviation/ acronym	Meaning
ICU	Intensive Care Unit
ILC	Independent Living Centre
IM&ICT	Information management and information and communications technology
IMRT	Intensity Modulated Radiation Therapy
IPCU	Infection Prevention and Control Unit
KPI	Key Performance Indicator
LSA	Learning Support Assistant
LSVT	Lee Silverman Voice Treatment
MACH	Maternal and Child Health
MAPU	Medical Assessment and Planning Unit
MAU	Maternity Assessment Unit
MCHPU	Multicultural Health Policy Unit
MDT	Multidisciplinary team
MET	Medical Emergency Team
MEWS	Modified Early Warning Scores
MH&W	Mental Health and Wellbeing
MHAU	Mental Health Assessment Unit
MLA	Member of the Legislative Assembly
MND	Motor Neurone Disease
MSD	musculoskeletal disorder
MUD	Mandatory Update Day
NATA	National Association of Testing Authorities
NBCSP	National Bowel Cancer Screening Program
NBHF	Ngunnawal Bush Healing Farm
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NEPM	National Environmental Protection Measure
NHMRC	National Health and Medical Research Council
NHPA	National Hospital Performance Authority
NHRA	National Health Reform Agreement
NICU	Neonatal Intensive Care Unit
NPAPH	National Partnership Agreement on Population Health
NRT	Nicotine Replacement Therapy
NSQHSS	National Safety and Quality Health Service Standards
OCHO	Office of the Chief Health Officer
OPMHS	Older Persons Mental Health Service
PACS	Picture Archival and Communication System
PART	Professional Assault Response Training
PARTY	Prevent Alcohol and Risk-Related Trauma in Youth
PHD	Population Health Division
PHN	Primary Health Network
PIN	Provisional Improvement Notice
PIP	Performance Information Portal
PMI	Patient master index
PMP	People Manager Program

Abbreviation/ acronym	Meaning
PMS	Performance Monitoring Station
PPID	Positive patient identification
PRRAC	Palliative Radiotherapy Rapid Access Clinic
PSP	Preliminary Sketch Plan
PSSB	People Strategy and Services Branch
PV	photovoltaic
RACC	Rehabilitation, Aged and Community Care
RADAR	Rapid Assessment of the Deteriorating Aged at Risk
RAP	Reconciliation Action Plan
RCPA	Royal College of Pathologists of Australasia
RED	Respect, Equity and Diversity
RFA	Request for Admission
RMP	Resource Management Plan
RN	Registered Nurse
EN	Enrolled Nurse
RO	Reverse Osmosis
ROM	RADAR, Geriatric Outpatients and Memory Assessment
RTO	Registered Training Organisation
RWTS	Ride or Walk to School
S&D	Staging and Decanting
SAB	Staphylococcus Aureus Bacteraemia
SAGU	Sub-acute Geriatric Unit
SCN	Special Care Nursery
SEA	Special Employment Arrangements
SIRF	Service Innovation and Redesign Framework
SKIP	School Kids Intervention Program
SLA	Service Level Agreement
SLE	Simulated Learning Environment
SMHU	Secure Mental Health Unit
SNSWLHD	Southern NSW Local Health District
SPO	Student Placement Online
SRS	Stereotactic Radiosurgery
STEMI	ST segment elevation myocardial infarction
TCH	The Canberra Hospital
TCM	Trauma case management
TL	Team Leader
TROG	Tasman Radiation Oncology Group
TTCP	Transitional Therapy and Care Program
UCPH	University of Canberra Public Hospital
URTOT	Unplanned Return To the Operating Theatre
VMO	Visiting Medical Officer
VRV	Variable Air Volume
WHO	World Health Organisation
WHSMS	Work Health and Safety Management System
WiC	Walk-in Centre
WPS	Workplace Safety
YTD	year-to-date

GLOSSARY OF TECHNICAL TERMS

Term	Meaning
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.
Decant	To rehouse people while their buildings are being refurbished or rebuilt.
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 General Practitioners, 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.
Subacute	Intermediate care provided between acute care and community-based care. Subacute care includes services such as rehabilitation that can be provied 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 Canberra Hospital, Garran, and from community health centres.

Copies of the ACT Health 2014–15 Annual Report are also available online at: *www.health.act.gov.au/annual-report*

Information can also be accessed through the Health Directorate website at *www.health.act.gov.au*, Access Canberra website at *www.accesscanberra.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:

ACT Government Health Directorate
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 2014–15

Australian hospital statistics 2013–14, Australian Institute of Health and Welfare

Australia's health 2014, Australian Institute of Health and Welfare.

Websites referenced in this report

Name	Address
ACT Auditor-General's Office Performance Audit Report – Report No 5 of 2015 – Auditor – General's Report – Integrity of data in Health Directorate, Report 5	http://www.audit.act.gov.au/auditreports/reports2015/Report%20No%205%20of%202015%20Integrity%20of%20Data%20in%20the%20Health%20Directorate.pdf
ACT Auditor-General's Office Performance Audit Report – Report No 4 of 2014 – Auditor – General's Report – Gastroenterology and Hepatology Unit, Canberra Hospital, Report 4	http://www.parliament.act.gov.au/__data/assets/pdf_file/0008/603773/Report-No-4-of-2014-Gastroenterology-and-Hepatology-Unit,-Canberra-Hospital.pdf
ACT Auditor-General's Office Performance Audit Report – Report No 8 of 2013 – Management of funding for community services, Report No 8 of 2013	http://www.audit.act.gov.au/auditreports/reports2013/Report_08-2013_-_Management_of_Funding_for_Community_Services.pdf
ACT Health Air Quality Monitoring	http://www.health.act.gov.au/public-information/public-health/act-air-quality-monitoring
ACT Health Promotion Grants Program	http://www.health.act.gov.au/healthy-living/health-promotion-grants-program
Australian Secondary School Alcohol and Drug Survey (ASSAD)	http://www.health.act.gov.au/sites/default/files/Number%2060%20-%20Substance%20use%20and%20other%20health-related%20behaviours%20among%20ACT%20secondary%20students%20-%20results%20of%20the%202011%20ACT%20Secondary%20Students%20Alcohol%20and%20Drug%20Survey%20%28ASSAD%29.pdf
Cervical Screening Program	http://www.health.act.gov.au/healthy-living/cervical-screening
Childhood immunisation	http://www.health.act.gov.au/our-services/immunisation
Childhood immunisation	http://www.health.act.gov.au/our-services/immunisation
Corporate Plan	http://inhealth/PPR/Policy%20and%20Plans%20Register/Corporate%20Plan%202012-2017.pdf

Name	Address
Disease control measures	http://www.health.act.gov.au/public-information/public-health/communicable-diseases
Drugs and Poisons Information System	http://health.act.gov.au/public-information/businesses/pharmaceutical-services
Food regulation issues	http://www.health.act.gov.au/public-information/businesses/food-safety-regulation
Fresh Tastes: healthy food at school	http://www.health.act.gov.au/freshtastes
Future directions for tobacco reduction in the ACT 2013–2016	http://health.act.gov.au/sites/default/files/Future%20directions%20for%20tobacco%20reduction%20in%20the%20ACT%202013-2016.pdf
Good Habits for Life	http://act.gov.au/goodhabitsforlife
Good Habits for Life	http://act.gov.au/goodhabitsforlife
Health Act 1993	http://www.legislation.act.gov.au/a/1993-13/default.asp
Healthier Work Service	http://www.healthierwork.act.gov.au/
Healthy Food and Drink Choices Policy	http://www.health.act.gov.au/healthy-living/health-improvement
Healthy Food at Sport	http://www.health.act.gov.au/healthy-living/healthy-children-and-young-people/healthy-foodsport
Healthy Workers—ACT Health	http://www.health.act.gov.au/healthy-living/healthy-workers
It's Your Move	http://www.health.act.gov.au/healthy-living/healthy-children-and-young-people/its-your-move
Kids at Play (Active Play)	http://www.health.act.gov.au/healthy-living/kids-play
Licensing and Registrations	http://www.health.act.gov.au/public-information/businesses/licensing-and-registration
Measles	http://www.health.act.gov.au/research-publications/fact-sheets
Population Health Division	http://www.health.act.gov.au/healthy-living/population-health
Ride or Walk to School (RWTS)	http://www.health.act.gov.au/healthy-living/healthy-children-and-young-people/ride-or-walk-school
Select Committee on Estimates 2014–2015 – Inquiry into Appropriation Bill 2013-2014 and the Appropriation (Office of the Legislative Assembly) Bill 2014–2015, Report 1	http://www.parliament.act.gov.au/in-committees/select_committees/estimates-2014-2015/inquiry-into-appropriation-bill-2014-2015-and-the-appropriation-office-of-the-legislative-assembly-bill-2014-2015/reports
Select Committee on Health, Ageing, Community and Social Services – Inquiry into the sourcing and supply of dental prostheses and appliances to Australian dental practitioners from overseas, Report 4	http://www.parliament.act.gov.au/in-committees/standing_committees/Health,-Ageing,-Community-and-Social-Services/sourcing-and-supply-of-dental-appliances-and-related-products?inquiry=624642
Standing Committee on Health, Ageing, Community and Social services – Annual and Financial Reports 2013–14, Report 5	http://www.parliament.act.gov.au/in-committees/standing_committees/Health,-Ageing,-Community-and-Social-Services/annual-and-financial-reports-2013-2014/reports?inquiry=649333
Tobacco Control and Smoke-Free Environments	http://www.health.act.gov.au/public-information/public-health/tobacco-and-smoke-free
Towards Zero Growth: Healthy Weight Action Plan	http://www.health.act.gov.au/sites/default/files/Towards%20Zero%20Growth%20Healthy%20Weight%20Action%20Plan.pdf

SECTION A **Transmittal Certificate**

TRANSMITTAL CERTIFICATE

ACT Government
Health

Mr Simon Corbell 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 under the 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 information in the attached Annual Report, and information provided for whole of government reporting, is an honest and accurate account and that all material information on the operations of ACT Health has been included for the period 1 July 2014 to 30 June 2015.

I 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 4 months of the end of the financial year.

Yours sincerely

Nicole Feely
Director-General

29 September 2015

GPO Box 825 Canberra ACT 2601 | phone: 6205 0825 | www.act.gov.au

SECTION B Organisation Overview and Performance

AT A GLANCE

ACT HEALTH STAFF

2,884* Nurses

876* Doctors

1,201* Health Professionals

2,103* Other Essential Staff

* head count
Visiting Medical Officers (VMO's) not included

WALK-IN CENTRES

Walk-in Centre
32,980 attendances

- MINOR INJURIES
- COLDS & FLU
- CUTS & ABRASIONS
- MINOR ILLNESS
- BITES & STINGS

PROGRAMS IN SCHOOLS

52 schools participating in RIDE or WALK to school

42 schools participating in fresh TASTES healthy food at school

ANALYTICAL LAB

ACT Government Analytical Laboratory Samples Analysed 2014–15

118 coronial cases finalised

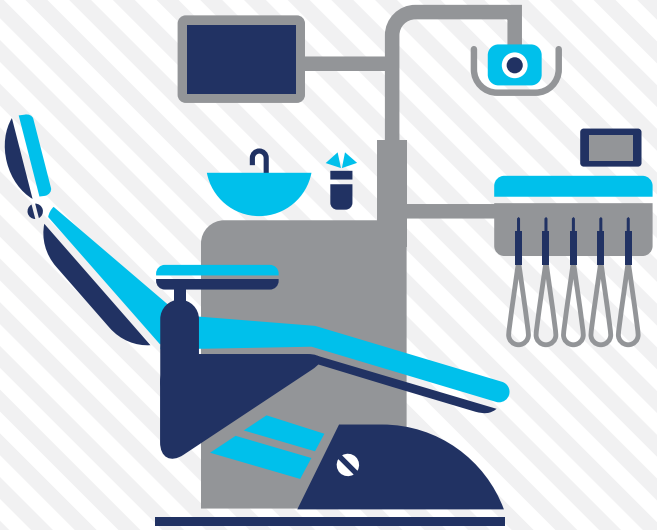
2,590 asbestos client samples

4,285 illicit drug samples

1,187 water samples

1,678 road traffic samples

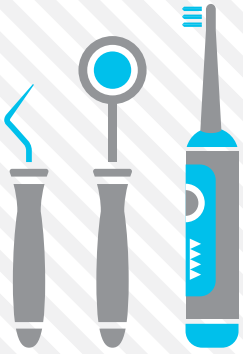
DENTAL



21,056
adult, child and youth clients attended

53,976
appointments

over
280,000
dental procedures



6,723
scale and cleans

20,462
fillings

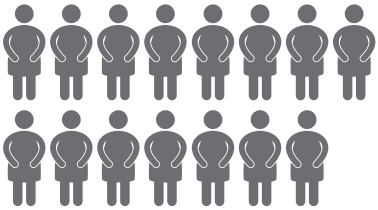
CANBERRA HOSPITAL

73,623
patients attended the Emergency Department
= 200+ per day
on average

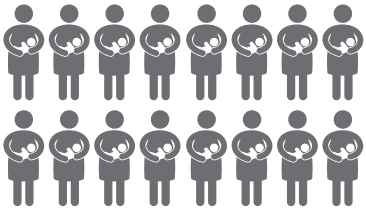
1,391
broken arms

Around
208
patients are discharged from hospital daily

425,455
pharmacy items dispensed



3,380
mums



had
3,430
babies

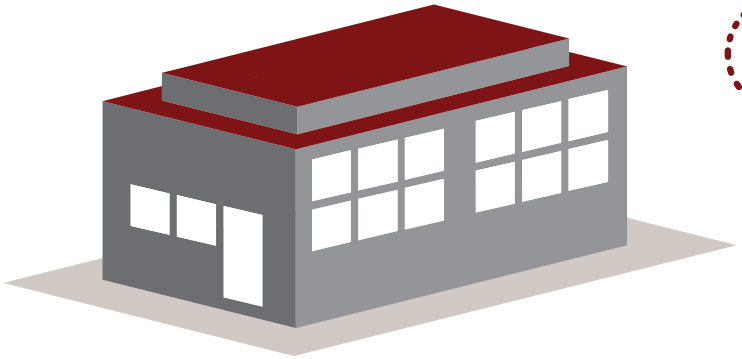
IMMUNISATION

Vaccines distributed to immunisation providers in the ACT **173,652**

Doses provided under the National Immunisation Program **167,451**

6,201 ACT Government funded vaccines

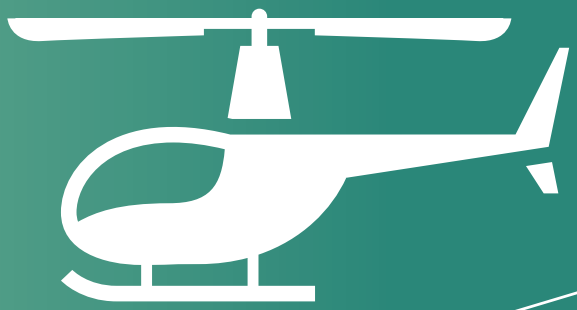
HEALTH PROTECTION



2,130 food safety inspections

RETRIEVAL SERVICE

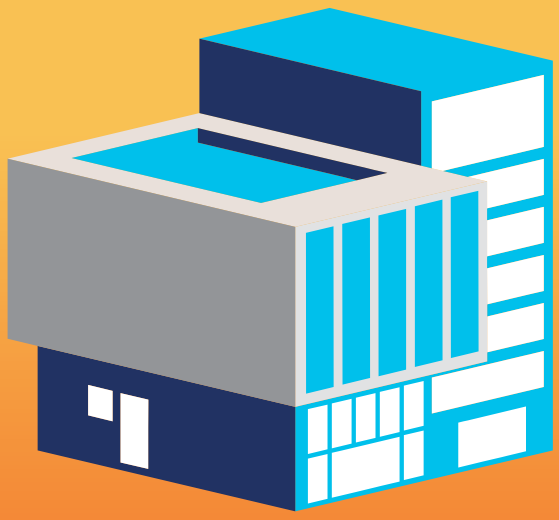
786 Capital Region Retrieval Service instances

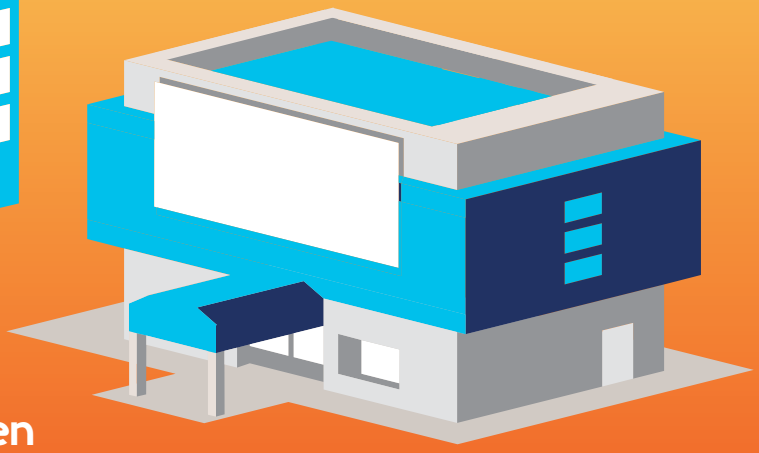


SECURITY

4,921 verbal interactions with consumers for smoking on TCH campus

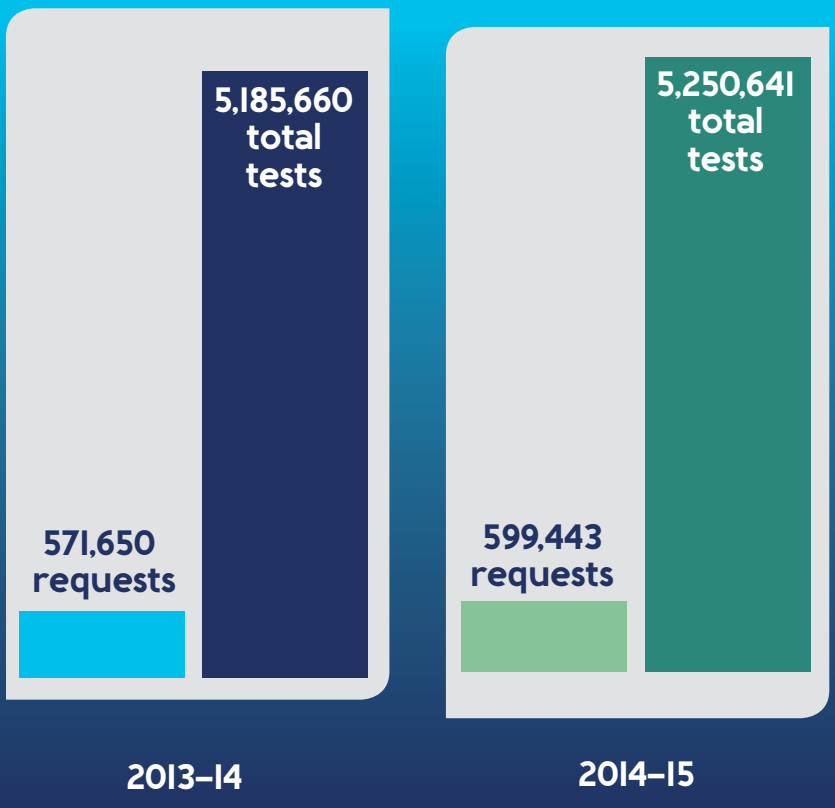
HEALTH INFRASTRUCTURE





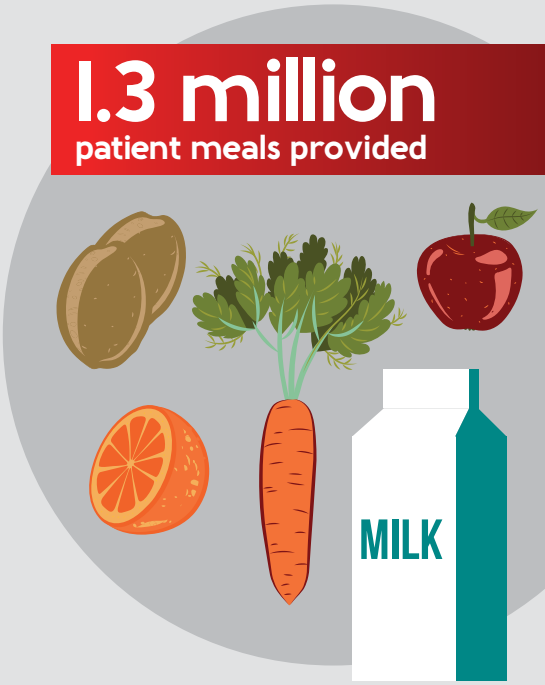
$909
million has been invested in the Health Infrastructure Program to date

PATHOLOGY



FOOD SERVICES

1.3 million
patient meals provided



12,800 kgs potatos
3,100 kgs carrots
4,200 kgs apples
6,400 kgs oranges
23,334 kgs chicken products
197,000 litres of milk
85,200 loaves of bread

B.I ORGANISATIONAL OVERVIEW

Vision, mission 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 often see people in our community at their most vulnerable. The way we interact with them is extremely important and directly influences their experience of care. Both compliments and complaints from our consumers are largely to do with our commitment to our values, as evidenced by our behaviour, which can be summarised as:

- **Care**: Go the extra distance in delivering services to our patients, clients and consumers. Be diligent, compassionate and conscientious in providing a safe and supportive environment for everyone. Be sensitive in managing information and ensuring an individual's privacy. Be attentive to the needs of others when listening and responding to feedback from staff, clinicians and consumers.
- **Excellence**: Be prepared for change and strive for continuous learning and quality improvements. Acknowledge and reward innovation in practice and outcomes. Develop and contribute to an environment where every member of the team is the right person for their job, and is empowered to perform to the highest possible standard.
- **Collaboration**: Actively communicate to achieve the best results by giving time, attention and effort to others. Respect and acknowledge everyone's input, skills and experience by working together and contributing to solutions. Share knowledge and resources willingly with your colleagues.
- **Integrity**: Be open, honest and trustworthy when communicating with others, and ensure correct information is provided in a timely way. Be accountable, reflective and open to feedback. Be true to yourself, your profession, consumers, colleagues and the government.

Role, functions and services

ACT Health aims to deliver better service:

- to our community on behalf of our Government
- to our Government to meet the needs of our community.

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.

The ACT Health Corporate Plan addresses the following challenges:

- meeting increasing demand for health services
- improving the health of vulnerable people
- improving the patient journey
- building and nurturing a sustainable health system
- ensuring that service planning and delivery is underpinned by ACT Health's Safety and Quality Framework.

ACT Health has already established the foundations to meet the challenges facing the health system by:

- redesigning the organisation and services
- redeveloping capital infrastructure under the umbrella of the Health Infrastructure Program (HIP).

Clients and stakeholders

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
- having robust safety and quality systems.

ACT Health works closely with other ACT Government agencies such as the:

- Community Services Directorate (CSD)
- Justice and Community Safety Directorate
- Chief Minister, Treasury and Economic Development Directorate.

This also includes emergency services providers, such as the ACT Ambulance Service and ACT Policing.

Formalised consultative arrangements exist with a range of agencies, such as:

- the Health Care Consumers Association (ACT)
- Medicare Local
- mental health, alcohol and drug, and other community service providers.

The tertiary and training sectors remain key partners in planning, developing and delivering healthcare services. Partnership arrangements with the Australian National University (ANU) Medical School, University of Canberra, Australian Catholic University (ACU) and Canberra Institute of Technology (CIT) are well established and serve to assure the future supply of skilled health professionals.

Organisational structure

The ACT Health Director-General leads the organisation in delivering its vision of 'Your Health—Our Priority'.

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

Canberra Hospital and Health Services (CHHS) is led by the Deputy Director-General, Canberra Hospital and Health Services and provides acute, subacute, primary and community-based health services to the ACT and surrounding region through its key service divisions. 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 Group is led by the Deputy Director-General, Strategy and Corporate. The role of the Strategy and Corporate Group is to provide corporate and strategic support to clinical service areas. The group:

- supports national health reforms and National Partnership Agreements
- develops strategies for attracting and retaining the health workforce
- maintains critical physical and technological infrastructure for the ACT's public hospitals and health services.

Health Planning and Infrastructure (HPI) Program is led by the Deputy Director-General, HPI, which is the single largest capital works project undertaken in the history of the ACT. This includes:

- 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
- directing and managing the directorate's Health Infrastructure Program (HIP), including health planning, coordination, management and implementation
- strategic accommodation
- the Capital Upgrades Program (CUP)
- the Arts in Health Program.

ACT Health's Population Health Group is led by the ACT Chief Health Officer/Deputy Director-General and provides a range of public and environmental health services, health protection services and health promotion services including:

- undertaking the core functions of prevention, assessment, policy development and assurance
- contributing to local and national policy, program delivery and protocols on population health issues.

The Chief Health Officer fulfils a range of statutory responsibilities and delegations as required by public health legislation.

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

During 2014–15, resources from the Quality and Safety Branch, excluding the Workplace Safety Unit, were realigned to Canberra Hospital and Health Services within the HealthCARE Improvement Unit. The Workplace Safety Unit continues to sit within the Strategy and Corporate Group. This was to ensure the effective oversight of progress to meet the requirements for patient safety and accreditation.

Organisational chart

** Simon Corbell MLA replaced Katy Gallagher MLA from 20/1/15. Nicole Feely replaced Dr Peggy Brown on 1/6/15. Kim Smith replaced Stephen Goggs on 20/5/15. Liesl Cantenera replaced Judi Childs on 2/2/15.*

Environment and the planning framework

To contribute to the broader ACT Government vision, ACT Health's vision is 'Your Health—Our Priority'. This vision is supported by a range of strategic plans that identify objectives for the organisation. There is recognition that the demand for health services is increasing every year. Expanding health technologies, consumer expectation and an increasing and ageing population all contribute to this demand.

The Corporate Plan articulates:

- key focus areas
- priorities for improvement
- key strategies for achieving the priorities
- achievements planned for the long term (five years).

In 2014–15, 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.

Summary of performance

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

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

Life expectancy at birth is:

- 85.0 years for females in the ACT, against a national average of 84.3 years
- 81.7 years for males, against a national average of 80.1 years.

This indicates the general health of the population and reflects on a range of issues other than providing health services, such as economic and environmental factors.

More information: For more information, see Strategic Objective 9: Management of Chronic Disease: Maintenance of the Highest Life Expectancy at Birth in Australia, page 44.

ACT Health saw 100 per cent of emergency dental clients within 24 hours and achieved lower than the national rate in the Decayed, Missing, or Filled Teeth (DMFT) index at ages six years and 12 years.

The DMFT index at six years in the ACT rate was 1.03, compared to the national rate of 2.13. At 12 years the ACT rate was 0.70, compared to the national rate of 1.05. This is the lowest of all jurisdictions.

More information: For more information, see: Strategic Objective 2: No Waiting for Access to Emergency Dental Health Services, page 40. Strategic Objective 16: Achieve Lower than the Australian Average in the Decayed, Missing, or Filled Teeth (DMFT) Index, page 46.

Preliminary results show that 11,875 people were removed from the ACT elective surgery waiting list in 2014–15.

More information: For more information, see Strategic Objective 1: Removals from Waiting List for Elective Surgery, page 37.

100 per cent of urgent, 95 per cent of semi-urgent and 99 per cent of non-urgent radiotherapy patients commenced treatment within standard timeframes. All three urgency categories reported better than target results in 2014–15.

More information: For more information, see Strategic Objective 3: Improving Timeliness of Access to Radiotherapy Services, page 40.

55 per cent of women in the target age group (50 to 69 years) had a breast screen in the 24 months before each counting period. This is slightly below the 2014–15 target of 60 per cent.

More information: For more information, see Strategic Objective 4: Improving the Breast Screen Participation Rate for Women aged 50 to 69 years, page 40.

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.

More information: For more information, see Strategic Objective 12: Government capital expenditure on healthcare infrastructure, page 45.

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.

More information: For more information, see Strategic Objective 13: Higher proportion of Government recurrent health funding expenditure on public health activities than the national average, page 82.

For the two-year participation rate in the Cervical Screening Program, the ACT achieved 57.9 per cent, which is a slight increase on the national average of 57.8 per cent and demonstrates the effectiveness of early intervention health messages.

More information: For more information, see Strategic Objective 15: Higher Participation Rate in the Cervical Screening Program than the National Average, page 46.

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.

More information: For more information, see Strategic Objective 5: Maintaining the waiting times for in hospital assessments by the Aged Care Assessment Team, page 41.

Public mental health services were effective in providing care to mental health clients, with only 6 per cent of clients returning to hospital within 28 days of discharge from an ACT public acute psychiatric unit following an acute episode of care. This is 4 per cent below the target of 10 per cent.

More information: For more information, see Strategic Objective 7: Maintaining Reduced Rates of Patient Return to an ACT Public Acute Psychiatric Inpatient Unit, page 42.

ACT public hospitals achieved an average bed occupancy rate of 85 per cent in 2014–15, an improvement on the 90 per cent reported for 2013–14.

More information: For more information, see the Strategic Objective 8: Reaching the Optimum Occupancy Rate for all Overnight Hospital Beds section, page 42.

In 2013–14, the ACT rate of admissions in persons aged 75 years and over with a fractured neck of femur was 6.7 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.

More information: For more information, see Strategic Objective 17: Reducing the Risk of Fractured Femurs in ACT Residents Aged Over 75 years, page 46.

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

More information: For more information, see Strategic Objective 11: Lower Prevalence of Diabetes than the National Average, page 44.

Overall, the ACT Aboriginal and Torres Strait Islander immunisation rate of 90.5 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.

More information: For more information, see Strategic Objective 14: Addressing Gaps in Aboriginal and Torres Strait Islander Immunisation Status, page 45.

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.

More information: For more information, see Strategic Objective 18: Reduction in the Youth Smoking Rate, page 46.

Our public hospitals continue to exceed national and local benchmarks for:

- hand hygiene rates
- hospital-acquired infection rates
- unplanned return to hospital within 28 days
- unplanned return to the operating theatre.

More information: For detailed information, see the ACT Local Hospital Network strategic objectives and indicators, page 47.

Outlook for 2015–16

Although there are many challenges in the year ahead, 2015–16 promises to be another year of growth and achievement for ACT Health.

The ACT Government continues to invest heavily in public healthcare to meet both present and future challenges. Health continues to be one of the ACT Government's biggest areas of investment, with a commitment of $1.42 billion in recurrent spending for health services for the people of the ACT and surrounding NSW in 2015–16.

More general inpatient beds and intensive care beds will be opened. This will be complemented by additional Hospital in the Home (HITH) places.

Outpatient services in cancer, women, youth and children and other outpatient clinics will continue to be expanded.

In addition, more support will be for available for:

- people affected by suicide
- mental health
- suicide prevention awareness and research.

The 2015–16, the ACT Budget provides $6.2 million (and $8.4 million in a full year) to significantly enhance mental health services. This funding is allocated to increase current services and provide new interventions to better meet client needs. All of the funding is directed at community-based service responses and is in line with the ACT Government's aim of ensuring that care is provided in the least invasive environment possible for any condition.

Along with this investment in mental health services, we will be continuing the work to transform other aspects of our services, through 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.

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

Under the HIP, work will commence on:

- the University of Canberra Public Hospital (UCPH) and the Secure Mental Health Unit (SMHU)
- the expansion of the Emergency Department at Canberra Hospital
- a range of staging and decanting projects.

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

Internal accountability

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.

Table 1 identifies the Senior Executives across the organisation.

Table I: Senior Executives

Senior Executive	Position
Dr Peggy Brown	Director-General 1 July 2014 – 30 May 2015
Nicole Feely	Director-General from 1 June 2015
Ian Thompson	Deputy Director-General, Canberra Hospital and Health Services
Dr Paul Kelly	Chief Health Officer, Population Health Division
Paul Carmody	Deputy Director-General, Health Infrastructure and Planning
Stephen Goggs	Deputy Director-General, Strategy & Corporate
Ron Foster	Chief Finance Officer
Dr Frank Van Haren	Director, DonateLife ACT
Liz Sharpe	Director, Strategic Projects
Dr Andrew Mitchell	Director, Territory-Wide Surgical Services
Judy Redmond	Chief Information Officer, E-health and Clinical Records Branch
Phil Ghirardello	Executive Director, Performance Information Branch
Jodie Skriveris	Executive Director, Canberra Region Medical Education Council
Rosemary Kennedy	Executive Director, Business and Infrastructure Branch
Ross O'Donoughue	Executive Director, Policy and Government Relations Branch
Judi Childs	Executive Director, People Strategy and Services Branch
Veronica Croome	ACT Chief Nurse
Prof Frank Bowden	Chief Medical Administrator
Karen Murphy	Chief Allied Health Officer
Prof Kirsty Douglas	Director, Academic Unit of General Practice and Professor of General Practice, ANU Medical School
Dr Marianne Bookallil	GP Advisor
Professor Nicholas Glasgow	Dean ANU Medical School
A/Prof Deborah Browne	Executive Director, HealthCARE Improvement Unit
Rosemary O'Donnell	Executive Director, Medicine
Katrina Bracher	Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
Prof Peter Collignon	Executive Director, Pathology
Linda Kohlhagen	Executive Director, Rehabilitation, Aged and Community Care
Barbara Reid	Executive Director, Surgery, Oral Health and Medical Imaging
Elizabeth Chatham	Executive Director, Women Youth and Children
Mark Dykgraaf	Executive Director, Critical Care
Adrian Scott	Executive Director, Acute Support Services
Denise Lamb	Executive Director, Cancer, Ambulatory and Community Health Support

Senior management committees and roles

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 cascades down from Tier 1 committees. Similarly, information and issues can be raised at the Tier 3 level and reported and managed up through the higher committee tiers.

Figure 2 shows the relationship between the Executive Council and other councils and committees.

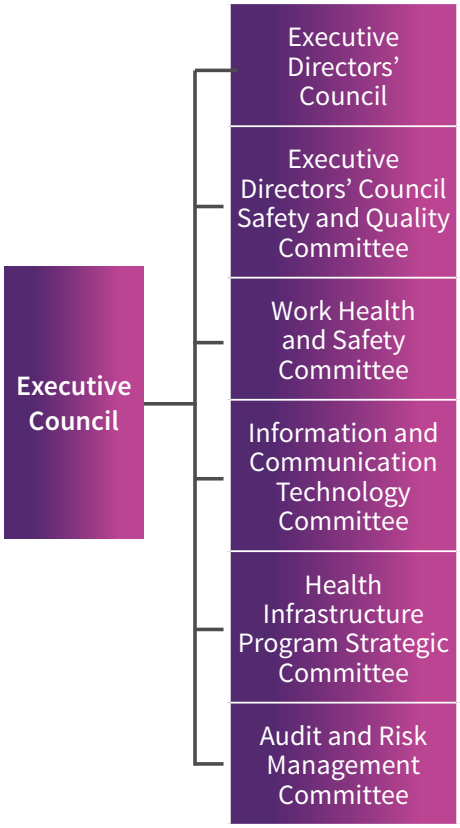


Figure 2: Relationship between the Executive Council and other councils and committees.

Executive Council

The overarching governance committee for ACT Health 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, where:

- one meeting focuses on finance, performance and other matters
- one meeting focuses on other business.

A number of subcommittees report to the Executive Council, each dealing with different areas of accountability across the directorate.

Executive Directors' Council

The Executive Directors' 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
- maximising operational effectiveness.

Executive Directors' Quality and Safety Committee

The Executive Directors' Quality and Safety 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. The committee:

- sets the strategic direction, priorities and objectives for safety and quality across the organisation
- oversees clinical practice improvement, quality improvement, accreditation, clinical governance matters (including sentinel events), consumer engagement and clinical policy.

Work Health and Safety Committee

The Work Health and Safety Committee:

- facilitates cooperation between ACT Health and staff to instigate, develop and carry out measures designed to ensure the health and safety of staff
- assists in developing standards, rules and procedures relating to health and safety that are to be complied with in the workplace
- provides work health and safety advice and recommendations on strategies, resource allocation and legislative arrangements
- addresses whole-of-agency work health and safety issues unable to be resolved at the division or branch level.

Information Communication and Technology Committee

The Information Communication and Technology Committee:

- oversees 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
- monitors lifecycle information and communications technology (ICT) asset management frameworks, strategies and policies and ensures these are consistent with best practice
- monitors portfolio IM&ICT risks
- monitors, reviews and manages ICT assets, services and delivery and financial performance and infrastructure risk across the Health Directorate
- ensures whole-of-ACT Government and Health Directorate IM&ICT policies and standards are implemented across the organisation
- prioritises IM&ICT initiatives
- evaluates proposed IM&ICT initiatives and submits business cases for all major IM&ICT projects to the Executive Council, for endorsement
- reviews and reports the status of ICT projects under development and, if required, recommends strategies to rectify significant variances of these.

Health Infrastructure Program Strategic Committee

The Health Infrastructure Program Strategic Committee is the chief decision-making body for the ACT Health Infrastructure Program (HIP). It is responsible for:

- providing advice
- monitoring progress
- monitoring risk in the HIP.

Audit and Risk Management Committee

The Audit and Risk Management Committee provides independent assurance, assistance and advice to the Director-General regarding:

- audit
- risk control and its framework
- external accountabilities and responsibilities
- appropriate internal controls.

Canberra Hospital and Health Services Overview

Canberra Hospital and Health Services is led by the Deputy Director-General. It provides acute, subacute, primary and community-based health services to the ACT and surrounding region through its key service divisions, which are:

- Division of Surgery, Oral Health and Imaging
- Division of Women, Youth and Children
- Division of Critical Care
- Division of Cancer, Ambulatory and Community Health Support
- Division of Rehabilitation, Aged and Community Care
- Division of Mental Health, Justice Health, Alcohol and Drug Services
- Division of Pathology
- Division of Medicine
- Division of Clinical Support Services
- The Office of the Chief Nurse
- The Office of the Chief Medical Administrator
- The Office of the Chief Allied Health Officer
- HealthCARE Improvement Division.

Achievements

The Acute Surgical Unit (ASU) commenced in April 2015 and is staffed and run by consultants at Canberra Hospital. The ASU admits patients who have been assessed as likely to require a surgical procedure and aims to maximise access to emergency theatre time for suitable patients. The ASU has access to a dedicated theatre list from Monday to Friday.

The Mobile Dental Clinic was launched in January 2015. The purpose-built truck is improving access to dental health services for Canberrans residing in aged care facilities. In the first six months it visited seven facilities, providing a range of preventative, restorative and denture services.

A new Cardiac Catheter Diagnostic Suite (CCDS) was installed in the Cardiology Department at Canberra Hospital in 2014. This has provided enhanced clinical services for our patients. The CCDS brings a new imaging performance, enabling the clinician to ultimately treat the patient faster, with more precision and with added confidence for enhanced patient outcomes. The CCDS is the first of its kind in the ACT.

An Adult Community Mental Health Model of Care redesign project delivered a preliminary Model of Care and high-level implementation plan. It is anticipated that this redesign will support community mental healthcare that is evidence-based, contemporary and better meets the needs of the expanding Canberra community.

The Community Nursing and Allied Health performance exceeded the 2014–15 targets for:

- number of nursing occasions of service, which was set at 82,000
- number of allied health regional services, which was set at 22,600.

This was achieved by:

- recruiting additional allied health and nursing positions, which expanded community-based services
- implementing changed models of care.

ACT Health undertook an extensive transformational policy redesign project, which reviewed over 1,800 policies across Canberra Hospital and Health Services. The project significantly reduced the number of policies housed on the ACT Health Policy Register and improved our evidence base to ensure clinical reliability.

The Respecting Patient Choices Program signed a two-year agreement with the Health Care Consumers Association (HCCA) to assist in increasing awareness of Advance Care Planning. It particularly focuses on:

- disadvantaged groups
- Aboriginal and Torres Strait Islander people
- Culturally and Linguistically Diverse (CALD) groups.

Extended visiting hours at Canberra Hospital were implemented after a successful trial. Visiting hours are now 6.00 am to 9.00 pm.

Outlook for 2015–16

The *Mental Health (Treatment and Care) Amendment Act 2014* will be implemented on March 2016. A training program is being developed to ensure that all staff are familiar with their responsibilities under the new Act.

A community mental health team will be established for the Gungahlin region. Currently, services are provided to this area as an extension from the Belconnen Mental Health Team.

The current community Adult Model of Care will be redesigned to ensure an improved integrated flow of patients from both inpatient and community settings—crisis, assertive outreach, clinic- and home-based care.

Enhancements to the Model of Care for both the Discharge Lounge and Medi-Hotel are planned. The aim is to improve access to the services and improve patient flow for patients being discharged from the hospital.

A breast screening clinic will open at the Belconnen Community Health Centre (BCHC) in the latter half of 2015. This will increase accessibility and ensure an increased capacity to accommodate the expansion of the target age group to target women aged 70–74 years.

ACT Pathology will introduce a pilot electronic ward ordering system that will improve the accuracy and timeliness of pathology orders.

The Dementia Care in Hospitals Program will be implemented. The program aims to raise awareness and support for more dementia-friendly and supportive environments in Canberra Hospital.

Canberra Hospital will also enhance patient care by developing an Acute Stroke Pathway. It is developing, in collaboration with the ACT Ambulance Service and Calvary Public Hospital, an evidence-based, widely-endorsed pathway for caring for acute stroke patients across the territory.

Strategy and Corporate Overview

The Strategy and Corporate Group:

- supports national health reforms and National Partnership Agreements
- develops strategies for attracting and retaining the health workforce
- maintains critical physical and technological infrastructure for the ACT's public hospitals and health services.

The Strategy and Corporate Division consists of seven branches:

- Policy and Government Relations
- Business and Infrastructure
- People, Strategy and Services
- Performance Information
- eHealth and Clinical Records
- Academic Unit of General Practice
- Canberra Region Medical Education Council (CRMEC).

Quality and Safety transferred to the Canberra Hospital and Health Services Division in 2013–14.

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 2014–15 is provided in an annexed report.

More information: Attachments, Annexed and subsumed public authority reports, Calvary Health Care, page 243.

Much of the work supported by Strategy and Corporate is discussed elsewhere in this report; however, other highlights for the division during this reporting period are discussed in this section.

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
- assisting with its phasing in for clients of ACT Health services
- workforce issues.

During 2014–15, ACT Health and contracted providers began transitioning clients and funding into the NDIS. ACT Health is working closely with the ACT Government NDIS Taskforce and the National Disability Insurance Agency (NDIA) to support clients and services through the transition period.

The commencement of the NDIS and the associated planning and implementation requirements are significant for the Division of Mental Health, Justice Health and Alcohol and Drug Services. An implementation plan has been developed to ensure:

- appropriate services are available for eligible people for the transition of care arrangements to the NDIS
- support those people who may not be eligible or who may have difficulties accessing these services.

Rehabilitation, Aged and Community Care (RACC) is a registered service provider to the NDIS. Procedures have been implemented to:

- identify NDIS clients at intake
- capture service delivery activity in the ACT Patient Administration System (ACTPAS)
- raise notional or actual claims to the NDIS for services delivered.

ACT Equipment Services (ACTES) is providing funding assistance to clients who are involved in the initial NDIS planning process. The funding aims to meet a client's ongoing needs until their planning process is completed.

The ACT NDIS trial will conclude with all eligible residents to be phased in by 2016. Nationally, preparation continues for the implementation of the full scheme.

ACTES will still be required to operate to provide funding assistance to NDIS ineligible clients, who are clients who:

- need items not covered by the NDIS
- are over the age of 65 years with lower incomes.

RACC will continue to strengthen systems for identifying potentially eligible clients, ascertaining whether they have an NDIS plan, and encouraging them to register with the NDIS.

RACC will continue to work collaboratively with:

- the NDIA to promote timely, appropriate and seamless service delivery to clients with disabilities
- the NDIA and other ACT Government directorates to contribute lessons learnt from the trial, promote inter-sectoral resolution of issues, and work towards the development of a full scheme.

In April 2014, the ACT Government announced that, due to the implementation of the NDIS, it would withdraw from providing:

- early intervention services in 2014
- therapy services by December 2016.

To provide continuity of service during the NDIS trial, a collaborative approach to service provision was undertaken from January 2015 as Stage 1 of the Child Development Service (CDS). This provided:

- therapy intervention for children not eligible or not yet phased for the NDIS, which continues to be provided by Therapy ACT
- early development groups for children not eligible for early intervention services funded by NDIS, which were run through child and family centres by Early Childhood Teachers funded by the Education and Training Directorate (ETD)
- co-locating at Therapy ACT Holder of Community Paediatricians (Health) and Early Intervention Psychologists (ETD) to provide developmental and health assessment.

The CDS proposes that current services be redesigned to achieve:

- streamlined access to allied health and medical assessment for children who are ACT residents and at risk of developmental delay
- referral to appropriate services including the NDIS
- a model of intervention and support for those children not eligible for the NDIS, including group programs and parent support.

Depending on the assessed need, this may include time limited, episodic interventions and/or referral to mainstream services, such as playgroups or parenting programs for children at risk of developmental delay and their parents.

ACT Health is working closely with the Community Services Directorate to progress this work.

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 named ED Live was developed during the reporting period and released to the public in July 2014. The website, the first 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 was developed in line with the Government's Open Data Strategy.

The Performance Information Portal (PIP) allows ACT Health users to:

- view real-time activity in many areas of the organisation
- access historical trends and activities in particular areas of its operations.

Further developments have been rolled out during 2014–15, including a theatre utilisation module and a bed management tool.

Centralised Waitlist Service

Performance Information Branch will build an improved elective surgery site for public viewing in 2016. The site intends to provide users with information on surgical waiting lists for differing specialist groups and the surgeons within each group. The site will allow users of public hospital elective surgery facilities to become more informed about potential waiting times, and assists them in making informed decisions about the doctors undertaking their care.

The site is being built in response to the Auditor-General's Report No. 1 of 2011: Waiting Lists for Elective Surgery and Medical Treatment report, which recommended establishing a single waiting list across the territory.

While the Centralised Waitlist Service (CWLS) is not a single wait list, it is the first stage in progressing to this concept. This continues to be progressed in 2015.

The main features of the CWLS are:

- All Request for Admission forms (RFAs) are received into the CWLS and patients are added to the elective surgery waiting list. All RFAs have previously been managed at individual hospital sites.
- Clinicians can specify a surgery location, or indicate if the procedure can be undertaken at either site.
- Patients will be added to the waitlist within the shortest waiting time possible.

Policy adherence is also more easily enforced with this model.

The CWLS is located at Gungahlin Community Health Centre. It is managed by the Territory-Wide Surgical Services Team and is staffed by administrative and nursing staff.

Additionally, work is underway to realign the delivery of surgical services in the territory. This will include:

- identifying ways to improve theatre utilisation
- managing the allocation of theatre sessions based on demand for particular specialty groups.

Implementing this strategy will greatly assist in more timely access to surgical services in the future.

Systems, technology and clinical records

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 from suppliers by more than 60 per cent. Electronic trading provides early shipping status from suppliers. Supply Services (in the Business and Infrastructure Branch) uses the information to advise internal customers of when goods can be expected to be delivered, thus enhancing the customer service experience.

The eHealth and Clinical Records Branch has overseen improvements to a range of existing ICT, including the following:

- enhancing the Clinical Portal to provide greater flexibility when viewing pathology results
- upgrading the Cardiobase system used within the Canberra Hospital Cardiology Unit
- expanding the renal information system to the Tuggeranong and Belconnen Dialysis clinics.

A pilot of an Electronic Medication Reconciliation solution has additionally been undertaken within the Canberra Hospital Geriatric Specialty.

The BreastScreen Information System was implemented in December 2014. This purpose-built system has been designed to:

- streamline administrative and clinical workflows
- support BreastScreen management and reporting processes.

An electronic task management system, known as the Medical Officer Notice board, was introduced in 2015 to assist nursing, midwifery and medical staff to manage tasks for inpatient wards. This has reduced reliance on the paging system and supports clearer, more consistent communication of tasks.

An improved clinical record search and registration solution, known as Active Search, has been developed and is being progressively rolled out across ACT Health. Active Search leverages the patient master index (PMI) to provide advanced searching tools that support fast, effective patient record searches and reduce duplicate record creation rates.

eHealth and Clinical Records has overseen a successful trial of a rapid access technology solution, which enables staff to log into shared computers within 4–6 seconds. This technology is available within Canberra Hospital Emergency Department and is being progressively rolled out to other clinical areas of Canberra Hospital.

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

E-learning continued to be used 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.

More information: For detailed information on further initiatives, see B.8 Human resources management, Learning and Development Programs, page 100.

The Clinical Record Service undertook a number of back-scanning and record archiving projects to digitise or track and file a range of decentralised paper records, including a range of Respiratory and Sleep Medicine, Psychology and Pain Management records. In total, 65,000 records or 250,000 pages were scanned and a further 16,000 inactive records were tracked and filed. A team of 11 temporary staff members were employed to carry out this work.

During the last six months the Clinical Coding Team has exceeded the coding Key Performance Indicator (KPI) of 90 per cent of records, averaging a 95 per cent completion rate without the assistance of external contract coders.

Future directions

eHealth and Clinical Records Branch is working towards implementing a range of initiatives, which support staff in delivering high-quality care to ACT Health consumers. The initiatives build on the solid e-health foundation that has been established over the past few years. The objectives that guide the initiatives include:

- improving availability and timeliness of information designed to support clinical decision-making at the point of care
- facilitating better collaboration
- supporting improved efficiencies across hospital and community-based health services.

Reviews and Planning

A significant review of the *Mental Health (Treatment and Care) Act 1994* was completed during the year. As a result, an extensive amendment bill was debated and passed by the ACT Legislative Assembly on 30 October 2014. An additional *Mental Health Transition and Minor Amendments Bill* was tabled in the Legislative Assembly on 4 June 2015. The combined amendments from these two bills will mean that the new *ACT Mental Health Act 2015* will become operational from March 2016.

In 2014–15, ACT Health chaired 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 contribute to the ACT Government's strategic priorities for improving the community's mental health and wellbeing and protecting vulnerable groups.

The framework will explicitly address self-harm and suicide prevention. The ACT 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 developed by December 2015.

A replacement for the ACT Mental Health Services Plan 2009–2014 will be developed by December 2015, 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's Corporate Plan 2012–17. The plan will contribute to ACT Health's strategic priorities of continuing to meet the growth in demand for mental health services.

A new Aboriginal and Torres Strait Islander Reconciliation Action Plan (RAP) is planned for release in August 2015.

Workforce Planning

ACT Health continues to grow as an organisation that provides health services to support the growing community of the ACT. Workforce planning is essential to guide the recruitment, retention and development of a very diverse clinical and non-clinical workforce. This approach helps to ensure that the right person, with the right skills is in the right place at the right time to provide the right services within budget.

Workforce planning, as a key pillar within the organisation, is needed to support the largest recurrent expense of the organisation, with approximately 80 per cent of recurrent funds being spent on workforce.

The ACT Health Workforce Plan 2013–2018 identified five focus areas:

- Health Workforce Reform
- Health Workforce Development
- Health Workforce Leadership
- Health Workforce Planning
- Health Workforce Policy.

To date, the organisation is tracking well against all focus areas.

Recruitment and retention strategies are being explored and implemented to ensure that we have a workforce into the future that has the skills and capability of providing health services of the highest standard.

The Australian Government funds the ACT Region Integrated Clinical Training Network (ICTN). The network is made up of the region's health and education sectors. The ICTN and its two programs—Simulated Learning Environment (SLE) and Clinical Supervision and Support Program (CSSP)—continue to be used in the region, and staff are:

- working towards a sustainable coordinated jurisdictional simulation learning program
- increasing capacity for all levels of clinical and student supervision in all health settings.

More information: For detailed information about human resources activities, see B.8 Human resources management, page 97.

Academic Unit of General Practice

The Academic Unit of General Practice (AUGP) is co-founded by the ACT Health Directorate and the ANU Medical School. Since its establishment in 1997, the AUGP has made extensive contributions to delivering:

- the ANU Medical School Program
- medical educational programs for junior medical officers, General Practitioner (GP) vocational trainees and practicing doctors.

The 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
- scholarship in teaching and learning.

The AUGP has led research, building from information gathered during the ACT Health Kindergarten Health Check.

In addition, the AUGP has contributed to policy development within the Australian Capital Territory (ACT) and wider Australian health service:

- through the work of the GP Advisor
- through the work of ICTN and Health Workforce Australia (HWA)
- through committee work
- by liaising with the ACT Medicare Local
- by communicating its research findings.

The AUGP and academics provide clinical services to:

- Winnunga Nimmityjah Aboriginal Health Service
- Companion House Refugee health service
- mainstream general practice in the ACT.

Senior members of the AUGP have pivotal roles with the:

- Royal College of General Practitioners (RACGP)
- ACT Medicare Local
- Australian Association of Academic Primary Care
- Confederation of Postgraduate Medical Education Councils.

Achievements

During 2014–15, AUGP's achievements included the following:

- ANU Medical School Program
- Healer's Art
- Prevocational GP Placement Program (PGPPP)
- Supervisor and Registrar Teaching
- GP Workforce Infrastructure Program
- Peter Sharp Scholarship
- Kindergarten Health Check Research
- Treating Adult Obesity in General Practice Research
- Refugee Health Research
- Integration in Primary Health Care Research
- Vertical Integration of GP Education Research.

Strategic partnerships are being developed with the Research School of Population Health at the ANU and ACT Medicare Local. Future research will build on primary healthcare health services research, with a particular focus on developing more systematic and reliable ways to articulate, measure and value the complex nature of primary care consultation. Research effort will continue in the areas of primary care in vulnerable populations, medical education and child health.

Canberra Region Medical Education Council (CRMEC)

The Canberra Region Medical Education Council (CRMEC) was established in December 2014 by the Minister for Health and took over the functions of the Canberra Region Prevocational Management Committee (CRPMC). The CRMEC has been accredited by the Australian Medical Council as an intern training accreditation authority for the next three years to March 2018. The CRMEC has a strong collaborative relationship with South Australian Medical Education and Training, the equivalent body in South Australia, and has strong consumer engagement and representation.

The CRMEC performs accreditation functions for the intern training and education program within the ACT and region for Canberra Hospital and Health Services, Calvary Hospital, Goulburn Hospital and Bega District Hospital.

Additionally, the CRMEC oversees the development and management of medical education standards, policies, processes and functions of the ACT and Region Prevocational Network.

In March 2015, the CRMEC, with the assistance of the South Australian Medical Education Training Unit, facilitated training of 13 accreditation surveyors, including members from the CRMEC and the Accreditation Committee:

- A/Prof Katrina Anderson
- Dr Rob Griffin
- Dr Diana Tracy
- Ms Fiona Tito Wheatland
- Ms Miffany Trenery
- Dr David Banfield
- Dr Estella Janz-Robinson
- Dr Cameron Maxwell
- Dr Yinan Zhang
- Dr Helmut Yu
- Dr Russell Thomas
- Dr Suhaila Fatima Kamrani
- Dr Glenn Verheul.

An accreditation of the Bega District Hospital was undertaken on 22 July 2015 in conjunction with Health Education and Training Institute (HETI). Future accreditation of the Calvary Hospital and Goulburn hospital intern training programs are planned to be undertaken over the next 12 months.

The CRMEC is committed to identifying, evaluating, monitoring and promoting medical education and training programs for junior medical officers and their educators, in conjunction with key stakeholders. The council's goal is to continue to develop partnerships nationally and locally with other Postgraduate Medical Councils and professional networks to ensure familiarity with the work of other jurisdictions and maintain collaborative working relationships.

Canberra Hospital Smoke-free Environment Implementation

In 2014–15, a comprehensive smoke-free implementation plan was developed, and included:

- an education campaign
- providing an increased range of Nicotine Replacement Therapy (NRT) for inpatients and staff
- removing the Designated Outdoor Smoking Areas on the campuses
- increasing staff training in smoking care
- increasing enforcement of the smoke-free environment.

Business and Infrastructure

Business and Infrastructure Branch is responsible for providing a range of infrastructure and strategic support services to all ACT Health acute and non-acute sites across the ACT. The value of assets under management was $886.129 million as at 30 June 2015, with property assets totalling 274,480 square metres. Activities span across several campuses including:

- the Canberra Hospital campus
- Calvary Hospital
- Community Health Centres
- Civic offices
- Curtin
- Holder
- Mitchell.

More information: For detailed information about asset management, see C.4 Asset management, page 207.

Achievements

ACT Health Business and Infrastructure undertook a Food Service 'Meal Service Quality Improvement Project' based on feedback from patients, consumer representatives and relatives following their hospital experience.

As part of the menu item review aspect of the project, Food Services coordinated input from a variety of stakeholders, to deliver a replacement menu, based on items and packaging with:

- ease of opening
- improved flavour
- the correct portion size
- improved presentation.

Stakeholders included the:

- ACT Rheumatoid Arthritis and Sjogrens Support Group
- ACT Health Aged Care Unit, Nutrition department and Speech Pathology department.

As a result Food Services introduced easy-opening breakfast cereal packs as part of the breakfast patient meal service and a range of easy-opening packaged items.

Other initiatives undertaken included an Improving Patient Meal Consumption Project to provide greater 'access' to meals. This project included introducing coloured tray mats to communicate to clinical staff that:

- a patient requires full assistance with their meal (red tray mat) or
- a patient requires their meal to be set up for self-feeding, i.e. inserting straws and opening packaging (green tray mat).

Following the trial of coloured tray mats within ward 11A, there has been a 22.9 per cent increase in lunch main meals consumed and a 19 per cent increase in the main dinner meals consumed. The tray mats have since been implemented into wards 11A, 11B, 5A and 5B.

Issues and challenges

ACT Health is one of the highest consumers of energy in the ACT Government due to the type of services delivered. Canberra Hospital delivers a critical 24-hour service to our community and is the ACT Government's largest user of energy, with 25 per cent of the territory's electricity being consumed at that site alone.

As an organisation, ACT Health faces increasing environmental challenges, some of which are yet to be experienced. These challenges include increased stakeholder pressure for a robust position on sustainability.

The organisation is required to achieve certain targets and meet numerous regulatory and policy measures, such as the:

- ACT Climate Change Strategy 2007–25
- Building Code of Australia
- ACT Government's target of zero net emissions by 2020.

Future directions

ACT Health is committed to whole-of-government sustainability initiatives that work towards achieving carbon neutrality by 2060. As a part of this commitment, a feasibility study was undertaken to support an application to the Carbon Neutral Government Loan Fund. The application to the fund was for the installation of 500kW solar photovoltaic (PV) system on the roof of the southern (multi-storey) car park at Canberra Hospital. This is estimated to reduce the hospital's energy consumption by about 721,000kW each year. The project also includes the rollout of LED lighting for many of the older buildings on the hospital campus. The application was submitted in May 2015.

More information: For detailed information about utilities usage and sustainability initiatives, see B.9 Ecologically sustainable development, page 111.

Workplace safety

Safety training remains a priority and continues to be provided for Health and Safety Representatives (HSRs), managers and new staff. The Work Health and Safety Managers and Investigation course assists managers to:

- implement relevant preventive and corrective safety controls
- continuously improve safety in the workplace.

ACT Health received accreditation in 2015 from WorkSafe ACT as a Registered Training Organisation (RTO) to provide tailored HSR training for our staff.

Population Health

The Population Health Division (PHD) has primary responsibility for managing population health issues within ACT Health. The division:

- undertakes the core functions of prevention, assessment, policy development and assurance
- contributes to local and national policy, program delivery and protocols on population health issues.

The PHD 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 also required to report biennially on the health of the ACT population on specific health-related topics, through the Chief Health Officer's Report.

The Health Improvement Branch has carriage of policy and program delivery in the areas of health promotion and preventive health. Current programs include:

- Kids at Play Active Play
- Good Habits for Life
- Fresh Tastes
- Ride or Walk to School (RWTS)
- Active Streets.

The Health Improvement Branch also collects, analyses and disseminates information on the health status and health-related behaviours of the ACT population. This information 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 relating to areas such as:

- food safety
- communicable disease control
- environmental health
- emergency management
- pharmaceutical products
- tobacco control
- analytical services.

The Office of the Chief Health Officer (OCHO) is responsible for:

- providing public health advice—both internally and externally to the division
- conducting high-level project and policy work on behalf of the Chief Health Officer.

Key policy priority areas for the OCHO include:

- obesity and injury prevention and reduction
- medicinal cannabis
- loose-fill asbestos
- organ and tissue donation
- gene technology
- the health effects of climate change.

Achievements

In February 2015, a team of 11 public health officers conducted food inspections during the three-day National Multicultural Festival, as part of a strategy to minimise public health risk from serious breaches of the *Food Act 2001*. Public health officers routinely look for issues that would give rise to unacceptable food safety risks including:

- inadequate temperature control
- poor hand washing facilities
- inappropriate food storage.

Over 290 inspections were conducted during the event. A number of food safety breaches were identified, resulting in five incidents of voluntary disposal of food.

The Good Habits for Life Program is a locally-developed behaviour change campaign, which targets families with young children, and encourages physical activity and healthy eating. Good Habits for Life was launched on 11 November 2014. Phase 2 was rolled out in May and June 2015 using innovative social media streams. The campaign website has received over 30,000 visits since its launch.

On 7 April 2015, ACT Health announced an Antenatal Pertussis Vaccination Program. Vaccinating pregnant women in the third trimester has been shown to be effective in preventing pertussis disease in newborn infants because protection is transferred from the mother to the unborn child. The ACT Government is funding the vaccine, which is to be administered at 28 weeks gestation or as soon as possible afterwards. The vaccine is available at general practices and hospital maternity units.

The ACT continued to achieve high childhood immunisation coverage in the general population. Coverage rates for children in all cohorts were consistently above the national average. In 2014–15, ACT childhood immunisation coverage rates remained above 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 (92.5 per cent, 93.1 per cent, 92.9 per cent and 92.9 per cent).

On 17 November 2014, the ACT Health Air Quality Monitoring website, which included an Air Quality Index (AQI) value to indicate the cleanliness of ACT air, was launched at the Health Protection Service. The AQI provides a number that allows easy comparison of different pollutants, locations and time periods. The website provides real-time air quality data from the three air quality monitoring stations operated by ACT Health.

Outlook for 2015–2016

The cessation of the National Partnership Agreement on Population Health (NPAPH) in the 2014–15 Federal Budget created significant funding shortfalls for health improvement services and programs. However, the ACT Government continued to support the majority of NPAPH-related programs for 2014–15 and provided additional support in the 2015–16 budget through its Healthier Lifestyles initiative.

PHD continues to progress work on improving controlled medicines regulation in the ACT. Consultation was undertaken in 2013 on a proposed model to remove the current Chief Health Officer approval requirement for prescribing controlled medicines. This was to be coupled with improved prescription monitoring by PHD using pharmacy data.

While the majority of stakeholders supported the proposal, some stakeholders have raised concerns that removing the current safeguards will put patients at risk. PHD is currently considering an alternative model to retain the approvals system for consideration by the Minister in 2015–16.

Health Improvement Branch will lead implementation of the Healthier Lifestyles initiative, focusing on:

- delivering health promotion services for children in schools
- reducing smoking in pregnancy
- continuing implementation of Good Habits for Life.

The Health Improvement Branch (HPI) is developing a new web platform to report on national and local health indicators and other population health priorities. The project aims to increase the availability of population health information for use in health policy and planning, research and by other stakeholders.

PHD will continue to progress work to address the potential public health issues associated with the sale and use of electronic cigarettes.

Health Planning and Infrastructure Overview

Health Planning and Infrastructure (HPI) 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
- directing and managing the directorate's Health Infrastructure Program (HIP), including health planning, coordination, management and implementation
- strategic accommodation
- the Capital Upgrades Program (CUP)
- the Arts in Health Program.

Achievements

Implementing the HIP was a strategic priority for 2014–15.

More information: For detailed information about the HIP, see B.1 Organisational overview, 2014–15 strategic priorities, Implementing the Health Infrastructure Program, page 31.

Following a review of the governance of the HIP undertaken in 2013–14, a revised HPI Group organisation structure was implemented in September 2014. This structure delineates roles and functions within Health Planning and Infrastructure and the HIP.

During 2014–15, HPI aligned planning activity for:

- the Corporate Plan 2012–2017
- the ACT Health Business Plan 2014–15
- the draft ACT and Southern NSW Local Health District Cancer Services Plan 2015–2020
- the ACT Lymphoedema Services Background Paper and Implementation Plan 2015–2018
- associated Lymphoedema Services Plan 2015–2018
- capital and facility planning in support of the HIP.

A review of the Calvary Master Plan Stage 1 commenced in March 2015, and was completed on 30 June 2015 for consideration by ACT Health, the Little Company of Mary and the ACT Government.

The Calvary Master Plan review will inform decisions about the future development of the Calvary Public Hospital campus. If the ACT Government agrees to progress to undertaking a full Master Plan study for the Calvary Public Hospital, Calvary staff and consumers will be involved in providing input to the process.

Projects delivered by HPI as part of the HIP in 2014–15 included:

- the Canberra Region Cancer Centre (CRCC)
- refurbishing Building 1 Level 5, Canberra Hospital
- providing 15 additional beds at Calvary Hospital
- upgrading external signage at Canberra Hospital.

The CRCC was a strategic priority for 2014–15.

More information: For detailed information about the CRCC, see B.1 Organisational overview, 2014–15 strategic priorities, Canberra Region Cancer Centre, page 31.

The Arts in Health Program includes developing and implementing briefs for art in new HIP projects. In 2014–15, this included procuring works for the:

- CRCC
- Centenary Hospital for Women and Children (CHWC)
- Isolation Ward, Intensive Care Unit
- Belconnen Community Health Centre (BCHC).

Planning is underway to procure art works for the Secure Mental Health Unit (SMHU) and the University of Canberra Public Hospital (UCPH).

The Arts in Health Program is supported by the Canberra Hospital Foundation.

Outlook for 2015–16

During 2015–16, the following plans are programmed to be released and implemented:

- the ACT and Southern NSW Local Health District Cancer Services Plan 2015–2020
- the ACT Lymphoedema Services Background Paper and Implementation Plan 2015–2018, and the associated Lymphoedema Services Plan 2015–2018.

A number of specialty-level clinical services plans are scheduled to be completed/reviewed in 2015–16, in collaboration with clinical networks, staff and consumers. These include:

- reviewing the Ambulatory Care Framework, Critical Care Plan and Mental Health Services Plan
- developing new plans for Child Health Services, Chronic Conditions, Cardiology and Surgical Services
- developing an ACT Child and Youth Health Services Plan that is supported by the National Child and Youth Health Strategic Framework, which is due for finalisation in 2015.

The Canberra Hospital Master Plan Study is scheduled to be completed in early 2016. The Canberra Hospital Master Plan Study will guide future planning and inform long-term investment in health infrastructure development on the Canberra Hospital campus.

Corporate and Operations Plans

ACT Health's efforts over the reporting year have been guided by:

- frameworks and strategies
- a range of whole-of-government strategic documents, including the Canberra Social Plan and the ACT Children's Plan.

This section discusses the ACT Health-specific frameworks and strategies.

ACT Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013–2018

The Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013–2018 seeks to increase the number of Aboriginal and Torres Strait Islander people employed in the health workforce.

Employing, recruiting and retaining Aboriginal and Torres Strait Islander people in the health workforce strengthens our ability to provide an effective, responsive and culturally safe health system, which is of mutual benefit to the community and our organisation.

ACT 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.

ACT Alcohol, Tobacco and Other Drug Strategy 2010–2014

The ACT Alcohol, Tobacco and Other Drug Strategy 2010–2014 aims to:

- improve the health and social wellbeing of individuals, consumers, families and carers, and the community in the ACT
- minimise the harm in our community from alcohol, tobacco and other drugs while recognising the individual needs of all citizens in the ACT
- develop evidence-informed policies and initiatives to ensure that issues associated with harmful alcohol, tobacco and other drug use are addressed in an effective way
- implement the Strategy Action Plan in a manner that respects, protects and promotes human rights.

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

ACT Breastfeeding Strategic Framework 2010–2015

The ACT Breastfeeding Strategic Framework 2010–2015 sets the context for protecting, promoting and supporting 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.

ACT Chronic Conditions Strategy 2013–2018

The ACT Chronic Conditions Strategy 2013–2018 provides overarching direction for chronic condition care and support in the ACT 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 Health Corporate Governance Statement, 2015

The ACT Health Corporate Governance Statement provides an overview of the organisation. It is a starting point for gaining further detailed information on organisational:

- structures
- roles and relationships
- policies and procedures
- accountability mechanisms.

ACT Health Corporate Plan 2012–2017

The Corporate Plan articulates:

- key focus areas
- priorities for improvement
- key strategies for achieving the priorities
- achievements planned for the long term (five years).

In 2014–15, ACT Health continued to measure its performance against these areas through key performance measures identified in:

- the ACT Public Health Service's quarterly performance reports
- 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.

ACT Health Food and Nutrition Strategic Framework 2012–2018

The ACT Health Food and Nutrition Strategic Framework: 2012–2018 has been developed to assist ACT Health staff to understand the key food and nutrition issues facing the population of the ACT and to take action to address these issues. The framework identifies:

- key food and nutrition issues affecting the ACT population
- strategic areas for action by ACT Health
- guiding principles to underpin the ACT Health's roles in food and nutrition.

The framework has a high-level strategic focus on issues and areas for action that affect the whole ACT population and vulnerable subgroups of the population. It focuses on promoting healthy eating in accordance with Australian Dietary Guidelines among the general population. The framework is also used to inform stakeholders and the community about ACT Health's roles in food and nutrition.

The framework is not intended to guide clinical practice in managing an individual's health conditions where specific dietary advice and intervention is required.

ACT Health Quality and Clinical Governance Framework 2015–2018

The ACT Health Quality and Clinical Governance Framework 2015–2018 articulates the clinical governance systems within ACT Health that support delivering high-quality safe services. In practice, good clinical governance focuses on creating an environment in which there is transparent responsibility and accountability for maintaining standards, allowing excellence in clinical care to flourish.

ACT Health 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 that will improve the safety and quality of ACT Health services.

ACT Health Sustainability Strategy 2010–2015

The Sustainability Strategy is designed to meet the challenges that climate change will have on the ACT. It provides a roadmap for collaborative action between:

- ACT Health and all stakeholders
- clients and staff, including other government departments.

The roadmap ensures that business and clinical services (including planning for the future) are linked with the strategy and incorporate actions and achievements to deliver the objective of a sustainable health system for the future.

ACT Health Physical Activity Strategic Framework 2010–2015

The ACT Health Physical Activity Strategic Framework seeks to address the growing need for a strategic approach to:

- improve physical activity outcomes at a population level
- guide the activities of ACT Health in this regard.

It proposes that promoting physical activity should be core business for the Health Directorate, given the strong evidence base demonstrating downstream health system benefits to be gained from improving physical activity levels.

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.

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
- address, as far as possible, mental health issues in community settings, working with and developing natural systems of support.

ACT Health Palliative Care Services Plan 2013–2017

The ACT Health Palliative Care Services Plan 2013–17 was released on 28 October 2013 by the then Chief Minister and Minister for Health, Ms Katy Gallagher, MLA. An ACT Palliative Care Clinical Network has been established to:

- implement the plan
- streamline and improve access to coordinated palliative care services
- facilitate communication and collaboration between specialist palliative care services, acute services, and community service providers.

The network has been designed to work flexibly across the various service delivery settings in the ACT and surrounding NSW region to provide a cohesive palliative care service.

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
- is appropriate to their needs.

The ACT Palliative Care Services Plan 2013–2017 provides strategic direction for developing palliative care in the ACT to best meet current and projected population needs.

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 healthcare sector in providing primary healthcare. Six-monthly reports outlining progress against the annual implementation plan are provided to the ACT Health Executive Council and primary health care stakeholders.

Improving Women's Access to Healthcare Services and Information: A Strategic Framework 2010–2015

The Strategic Framework: Improving Women's Access to Healthcare Services and Information is an overarching planning document. It outlines the long-term strategic directions and objectives and initiatives to be adopted by ACT Health for:

- enabling and enhancing women's access to and satisfaction with health care services
- providing clear information about health services.

The target group for this framework is females aged 12 years and over.

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 of ACT residents. 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
- increase collaboration among organisations providing suicide prevention and postvention services in the ACT.

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.

2014–15 strategic priorities

Strategic and operational initiatives pursued in 2014–15 included:

- continuing to meet the growth in demand for acute care, Emergency Department, critical care, cancer treatment, mental health, women's and children's services, outpatient services and community health centres through extra capacity and by redesigning care delivery systems
- continuing implementation of a comprehensive HIP to build a sustainable and modern health system to ensure safety, availability and viability of quality healthcare in the ACT for now and into the future
- continuing work to improve health and wellbeing within the Aboriginal and Torres Strait Islander community
- opening the CRCC
- opening the new Walk-in Centre (WiC) at Belconnen
- maintaining accreditation with international standards and other appropriate national bodies.

Meeting growth in demand

Overview

In 2014–15, ACT public hospitals had increased demand levels for:

- Emergency Department presentations
- inpatient admissions
- elective surgery
- births.

The Australian Institute of Health and Welfare (AIHW) reported that in 2013–14, ACT public hospitals provided an average of 1,030 beds. In 2014–15, ACT Health further boosted the bed capacity to a total of 1,068 available beds in ACT public hospitals. This is a 59 per cent increase on the 670 beds available in 2002–03.

As shown in Figure 3, in 2013–14, ACT public hospitals reported an average of 2.7 available beds per 1,000 populations, which is above the national average of 2.5. Furthermore, the ACT was the only jurisdiction to report continued growth from 2009–10 up to 2013–14. Average available beds per 1,000 population is reported as a crude rate based on the estimated resident population as at 30 June of the relevant year.

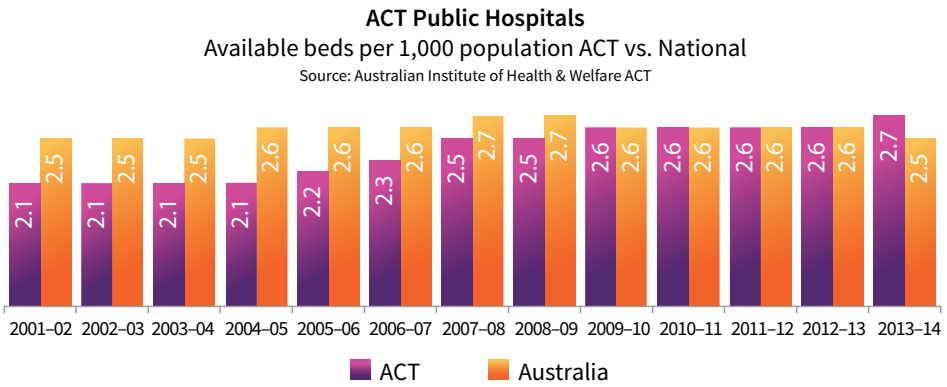


Figure 3: Available beds per 1,000 population, ACT and national comparison

The 2015–16 ACT Budget provides for an additional 18 beds to be opened across ACT public hospitals to meet the growing demand for our hospital services. The increase in bed capacity has been funded by increases to ACT Government health funding.

As shown in Figure 4, the estimated budget for this financial year (2014–15) was $1.4 billion, which was 171 per cent more than the $512 million provided for health services in 2002–03.

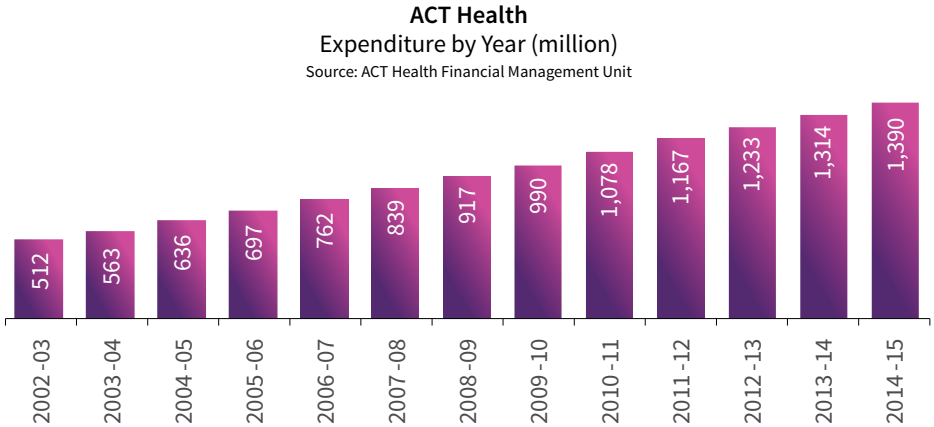


Figure 4: Expenditure by year

Births

In 2014–15, there was a total of 5,184 births at ACT public hospitals, an increase of 4 per cent when compared with the 4,999 births reported in 2013–14. As shown in Figure 5, the result for 2014–15:

- is the highest number of births within a single year for ACT Health
- represents a 26 per cent increase (over 1,060 additional births) in the number of ACT public hospital births since 2009–10.

In 2014–15, the number of births born by caesarean section equated to 29 per cent of all births, consistent with the result reported for 2013–14.

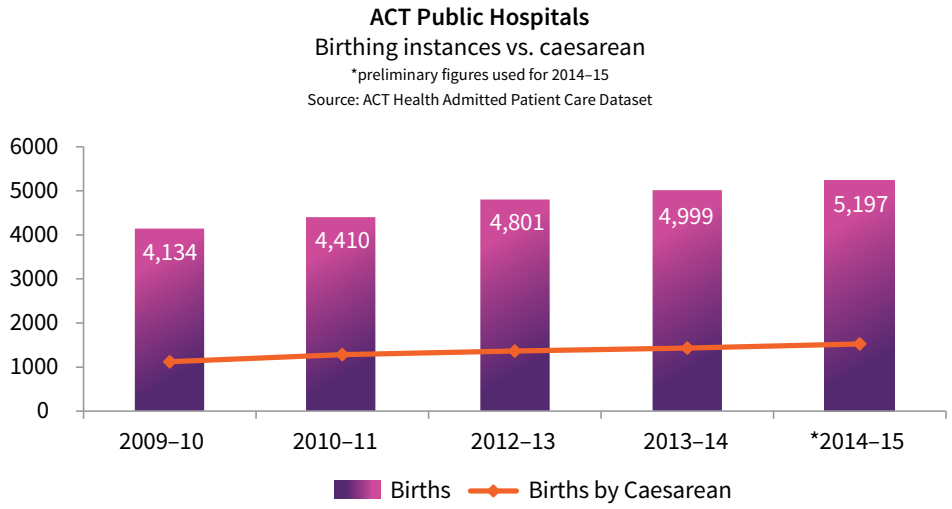


Figure 5: Birthing instances versus caesarean

Emergency Department presentations

As shown in Figure 6, in 2014–15, ACT public hospital Emergency Departments had 129,963 presentations, a 3 per cent increase when compared with 2013–14. This was the highest number of presentations recorded in a single year. The 129,963 result represents a 22 per cent increase in the number of presentations when compared with the figure reported in 2009–10 and a 6 per cent increase when compared to 2012–13 to 2013–14.

Admissions to hospital via the Emergency Department have increased, with 35,583 admissions (4 per cent increase) reported in 2014–15 compared to 34,221 recorded in 2013–14.

Despite the increase, ACT Health is committed to improving waiting times in the Emergency Departments.

More information: For detailed information on improving Emergency Department timeliness, see B.2 Performance analysis, ACT Local Hospital Network strategic objectives and indicators, Strategic Objective 2: Improved Emergency Department Timeliness, page 47.

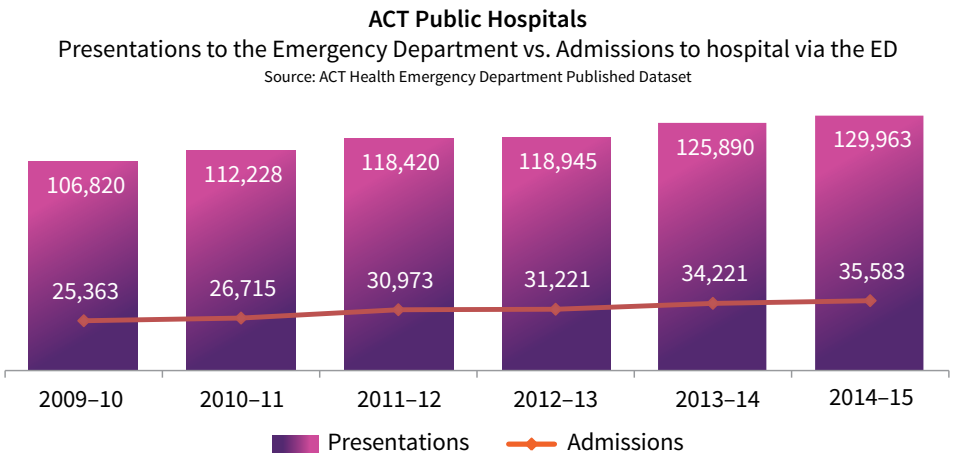


Figure 6: Presentation to the Emergency Department versus admissions for hospital; via the Emergency Department

Elective surgery

The demand for elective surgery and the number of additions to the elective surgery waiting list continues to increase. In 2014–15, 824 more people were added to the elective surgery waiting list than in 2013–14 (a 6 per cent increase). Despite the increase in demand, ACT public hospitals have ensured that patients can access elective surgery as quickly as possible, according to their urgency category.

More information: For detailed information on elective surgery, see: B.2 Performance analysis, Health Directorate strategic indicators, Strategic Objective 1: Removals from Waiting List for Elective Surgery, page 37; B.2 Performance analysis, ACT Local Hospital Network strategic objectives and indicators, Strategic Objective 1: Percentage of Elective Surgery Cases Admitted on Time by Clinical Urgency, page 47.

Implementing the Health Infrastructure Program

2014–15 marked the seventh year of the Health Infrastructure Program (HIP). The HIP continues to plan and construct new or refurbished infrastructure to provide enhanced services.

A range of projects within the HIP have been completed, others are ongoing and a number recently commenced. Aligned with planning, designing and constructing facilities is concurrent activity relating to:

- the workforce
- models of care
- service delivery
- technology.

This will ensure that the built environment assists clinicians to provide the best possible care.

The continued management and delivery of the HIP on time and on budget is a priority to ensure the following are not negatively impacted:

- quality of care and health outcomes
- access
- cost/efficiency
- workforce sustainability.

The following HIP projects are programmed to be completed in 2015–16:

- Calvary Car Park
- Building 15 demountable
- Building 1 Level 4 refurbishment
- Emergency Department Paediatric Stream
- internal signage and wayfinding at Canberra Hospital.

The following HIP projects are programmed to commence construction in 2015–16:

- the UCPH
- the Ngunnawal Bush Healing Farm (NBHF)
- the SMHU
- works under the Continuity Of Services – Essential Infrastructure project that support engineering and infrastructure at Canberra Hospital.

More information: For a detailed description of the progress of HIP works, and works undertaken as part of the Capital Upgrades Program (CUP), see C.3 Capital works, page 202.

Improving health and wellbeing within the Aboriginal and Torres Strait Islander community

Detailed information is provided in:

- B.2 Performance analysis, Strategic Objective 14: Addressing Gaps in Aboriginal and Torres Strait Islander Immunisation Status, page 45.
- B.2 Performance analysis, Output 1.6: Early Intervention and Prevention, page 78.

Canberra Region Cancer Centre

Services commenced in the Canberra Region Cancer Centre (CRCC) on 18 August 2014. The centre is designed to improve the integration and standard of care to people with cancer in the ACT and surrounding region by:

- being patient-centred
- bring together services and supports within a cohesive environment.

The new facility provides capacity for additional outpatient cancer services with increases in resources for:

- medical oncology
- haematology
- immunology.

Multidisciplinary clinics are also being provided.

The following clinics have been established within the CRCC:

- A Shared Care Model of Care for Early Breast Cancer, which provides a new nurse-led clinic and preparation of End of Treatment Summaries to assist in follow-up care.
- A Melanoma Clinic to assist in the multidisciplinary care of patients with this condition. This is especially important because many new treatment options, including immune therapies and targeted agents, are now available.
- A Palliative Care Outpatient Clinic, which is run by the Nurse Practitioner. This clinic has assisted in timely care and support for patients of the service.

A Volunteer Program was also established for the CRCC to extend engagement and support people accessing the centre and cancer wards. Volunteers are engaged to:

- assist with patient comfort measures
- provide support and company
- assist with way finding.

With the move into the CRCC, implementing a Rapid Assessment Clinic has been further developed in a dedicated area on level 4 of the building. This enables patients who are having current treatment or within three months of completing treatment to be reviewed, assessed and if required treated by an oncology nurse and doctor.

An initial review of the Rapid Assessment Clinic model has found that total time for review, rate of hospital admission and length of stay after admission were significantly shorter than when patients were required to present to the Emergency Department.

The Rapid Assessment Clinic has been complemented by the availability of a 24-hour dedicated Telephone Triage number for current and recent patients of the CRCC.

Walk-in Centres

The Walk-in Centre (WiC) is designed to help people get free, one-off treatment for minor illnesses and injuries. Presenting patients 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
- coughs and colds.

Australia's first public, nurse-led WiC was opened in May 2010 on the Canberra Hospital campus. From its opening in May 2010, until it relocated on 25 June 2014, 73,392 clients presented to the WiC, as shown in Figure 7 (page 33).

The WiC relocated to two sites during 2014:

- the Tuggeranong WiC opened on 26 June 2014
- the Belconnen WiC opened on 1 July 2014.

The WiCs continue to provide free access to health advice and treatment for minor injury and illness on a one-off basis.

As shown in Figure 8 (page 33), in 2014–15, the Tuggeranong WiC had 18,669 presentations and Belconnen recorded 14,311 people presenting for treatment.

In 2014–15, the combined total presentations to the two WiCs increased by 47 per cent, when compared to the 2013–14 presentations to Canberra Hospital WiC.

Figure 9 (page 33) shows the top 10 presenting conditions for treatment. The top 10 conditions treated have not changed significantly since last year. The common cold remains the main reason for presentations at the WiCs.

As shown in Table 2, in 2014–15, the median wait time to treatment in the WiCs was 13 minutes, where:

- Belconnen reported a median wait time of seven minutes
- Tuggeranong reported a median wait time of 19 minutes.

Table 2: Median wait times for WiCs

Location	Median wait time
Belconnen	7 minutes
Tuggeranong	19 minutes
Combined WiCs	13 minutes

Source: ACT Health Walk-In-Centre Database

As shown in Table 3, in 2014–15, Belconnen and Tuggeranong WiCs reported a combined rate of 1.1 per cent of patients not waiting for treatment. Belconnen WiC reported the lowest Did Not Wait (DNW) and Tuggeranong was 1.5 per cent.

Table 3: Percentage of patients who DNW for treatment at the Walk-In-Centres in 2014–15

Location	% of patients who DNW for treatment
Belconnen	0.6%
Tuggeranong	1.5%
Combined WiCs	1.1%

Source: ACT Health Walk-In-Centre Database

The WiC does not:

- provide ongoing care for patients
- treat people with chronic conditions
- treat children less than two years of age.

These patients are encouraged to seek treatment and advice from their GP or the Emergency Department.

The WiC does not provide the range of services that a GP can provide, including:

- comprehensive medical management
- referral to specialist services
- general health checks.

However, the nurses who work in the WiC have all completed additional training. The care they provide is guided by established clinical 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
- community health services
- pharmacists
- the WiCs.

New WiC software is currently under development. It will deliver an electronic client record that is integrated with other ACT Health applications. The introduction of the new software is progressing with an expected rollout in late 2015.

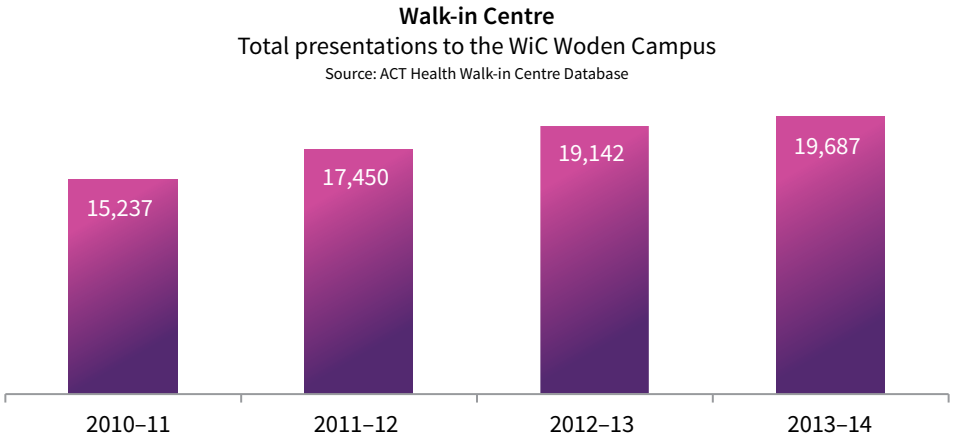


Figure 7: Total presentations to the Woden WiC

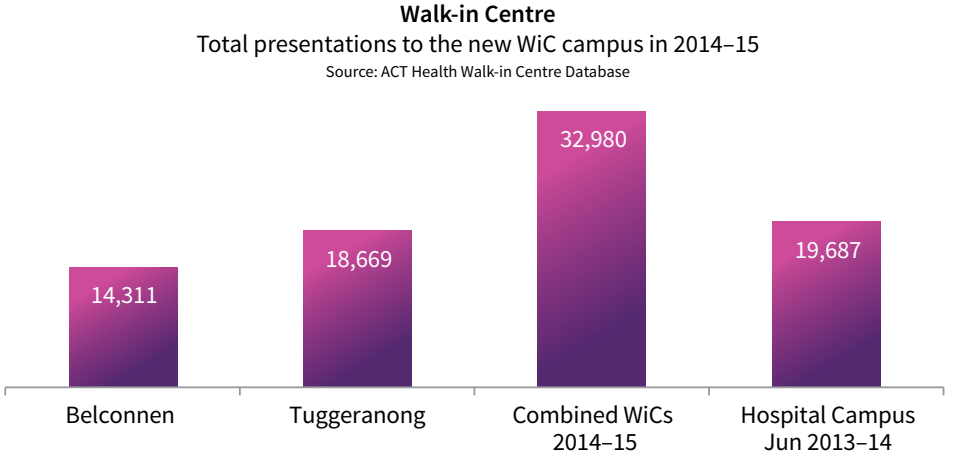


Figure 8: Total presentations to the new WiC campuses

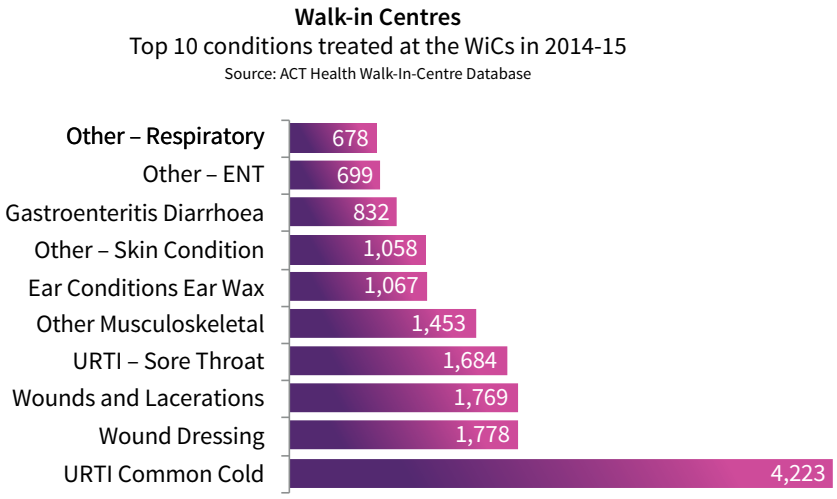


Figure 9: Top 10 conditions treated at the WiCs

Accreditation

In May 2015, ACT Health underwent a successful organisation-wide accreditation against the National Safety and Quality Health Service Standards. The Australian Commission on Safety and Quality in Health Care has awarded ACT Health full accreditation for the next three years.

Significant changes to the National Safety and Quality Health Service Standards in the next accreditation cycle will require ACT Health to review its current accreditation processes to meet the requirements of the revised standards.

ACT Pathology undergoes accreditation inspections by the National Association of Testing Authorities (NATA) and Royal College of Pathologists of Australasia (RCPA). The latest accreditation reassessment occurred in February and March 2015. This involved five NATA staffers and 16 technical assessors consisting of scientist and pathology specialists from other institutions. The result of this reassessment was the renewed accreditation of all of ACT Pathology laboratories.

The current three-year accreditation process will change to a four-year cycle with:

- a surveillance mid-term reassessment conducted during the second year (2017)
- online assessments conducted during the first and third years (2016 and 2018).

ACT Pathology also supports Canberra Hospital in their Australian Council on Healthcare Standards (ACHS) accreditation to the National Safety and Quality Health Service Standards.

In 2014, Rehabilitation, Aged and Community Care's (RACC's) Geriatric Medicine Training programme was successfully accredited for a period of five years, until 2019.

ACT Health is accredited with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) for the provision of for obstetrics and gynaecology training until October 2015.

B.2 PERFORMANCE ANALYSIS

Overview

ACT Health continually strives to provide a safe and high-quality health care system, and is continually implementing service improvements to increase safety for all patients. This section discusses our performance against the strategic objectives/ indicators specified in the ACT Budget Papers.

Due to the differing type and nature of services provided at each public hospital campus the targets for some indicators are different.

Table 4 provides an overview of ACT Health's performance against the specified strategic objectives/indicators.

Table 4: Performance analysis overview

Strategic objective/indicator	2014–15 performance comment	More information
Health Directorate		
Strategic Objective 1: Removals from Waiting List for Elective Surgery.	ACT public hospitals performed 11,875 elective surgery procedures, a 1% increase on the 11,780 reported for 2013–14.	Strategic Objective 1: Removals from Waiting List for Elective Surgery, page 37.
Strategic Objective 2: No Waiting for Access to Emergency Dental Health Services.	ACT public hospitals achieved this target throughout 2014–15.	Strategic Objective 2: No Waiting for Access to Emergency Dental Health Services, page 40.
Strategic Objective 3: Improving Timeliness of Access to Radiotherapy Services.	ACT public hospitals achieved or exceeded the targets.	Strategic Objective 3: Improving Timeliness of Access to Radiotherapy Services, page 40.
Strategic Objective 4: Improving the Breast Screen Participation Rate for Women aged 50 to 69 years.	The participation rate for women aged 50–69 years was 55%, which is below the target of 60%. The target for the total number of screens exceeded the participation target for women aged 70–74 years.	Strategic Objective 4: Improving the Breast Screen Participation Rate for Women aged 50 to 69 years, page 40.
Strategic Objective 5: Maintaining the waiting times for in hospital assessments by the Aged Care Assessment Team.	ACT hospitals met ACT Health requirements to respond to public hospital-based assessments within the target of two working days of acceptance of referral.	Strategic Objective 5: Maintaining the waiting times for in hospital assessments by the Aged Care Assessment Team, page 41.
Strategic Objective 6: Reducing the Usage of Seclusion in Mental Health Episodes.	ACT public hospitals reported a seclusion result of 5%, which is 2% above our local target.	Strategic Objective 6: Reducing the Usage of Seclusion in Mental Health Episodes, page 41.
Strategic Objective 7: Maintaining Reduced Rates of Patient Return to an ACT Public Acute Psychiatric Inpatient Unit.	ACT public hospitals achieved 6%, which met the <10% target.	Strategic Objective 7: Maintaining Reduced Rates of Patient Return to an ACT Public Acute Psychiatric Inpatient Unit, page 42.
Strategic Objective 8: Reaching the Optimum Occupancy Rate for all Overnight Hospital Beds.	ACT public hospitals reported a combined occupancy rate of 85 %, which is a 5 % improvement on the 90 % reported in 2013–14. This is a positive improvement as the demand for beds increased in 2014–15.	Strategic Objective 8: Reaching the Optimum Occupancy Rate for all Overnight Hospital Beds, page 42.
Strategic Objective 9: Management of Chronic Disease: Maintenance of the Highest Life Expectancy at Birth in Australia.	The ACT remains the jurisdiction with the highest life expectancy in Australia. Over the 10 year period from 2004 to 2013, life expectancy in the ACT increased by two years for males and 1.1 years for females.	Strategic Objective 9: Management of Chronic Disease: Maintenance of the Highest Life Expectancy at Birth in Australia, page 44.
Strategic Objective 10: Lower Prevalence of Circulatory Disease than the National Average.	The proportion of the ACT population diagnosed with some form of cardiovascular disease was 18.4%, which is slightly above the national rate of 16.9%.	Strategic Objective 10: Lower Prevalence of Circulatory Disease than the National Average, page 44.
Strategic Objective 11: Lower Prevalence of Diabetes than the National Average.	The prevalence of diabetes in the ACT is 3.8%, which is slightly above the national rate of 3.7%.	Strategic Objective 11: Lower Prevalence of Diabetes than the National Average, page 44.
Strategic Objective 12: Government capital expenditure on healthcare infrastructure.	The ACT exceeded the national rate of expenditure on infrastructure.	Strategic Objective 12: Government capital expenditure on healthcare infrastructure, page 45.

Strategic objective/indicator	2014–15 performance comment	More information
Health Directorate (continued)		
Strategic Objective 13: Higher proportion of Government recurrent health funding expenditure on public health activities than the national average.	The ACT exceeded the Australian average rate of recurrent health funding on public health activities as a strategy to reduce the long-term chronic disease burden.	Strategic Objective 13: Higher proportion of Government recurrent health funding expenditure on public health activities than the national average, page 45.
Strategic Objective 14: Addressing Gaps in Aboriginal and Torres Strait Islander Immunisation Status.	During 2014–15, vaccination coverage rates for Aboriginal and Torres Strait Islander children in the ACT within two of the three cohorts were the highest in Australia.	Strategic Objective 14: Addressing Gaps in Aboriginal and Torres Strait Islander Immunisation Status, page 45.
Strategic Objective 15: Higher Participation Rate in the Cervical Screening Program than the National Average.	The ACT participation rate for the target population exceeded the target.	Strategic Objective 15: Higher Participation Rate in the Cervical Screening Program than the National Average, page 46.
Strategic Objective 16: Achieve Lower than the Australian Average in the Decayed, Missing, or Filled Teeth (DMFT) Index.	The ACT rate for DMFT index was lower than the national average on the DMFT index.	Strategic Objective 16: Achieve Lower than the Australian Average in the Decayed, Missing, or Filled Teeth (DMFT) Index, page 46.
Strategic Objective 17: Reducing the Risk of Fractured Femurs in ACT Residents Aged Over 75 years.	In 2013–14, the ACT rate of admissions in persons aged 75 years and over with a fractured neck of femur was 6.7 per 1,000 persons in the ACT population.	Strategic Objective 17: Reducing the Risk of Fractured Femurs in ACT Residents Aged Over 75 years, page 46.
Strategic Objective 18: Reduction in the Youth Smoking Rate.	The proportion of ACT students reporting to be current smokers in 2011 is slightly lower than the national average of 6.7 %.	Strategic Objective 18: Reduction in the Youth Smoking Rate, page 46.
ACT Local Hospital Network		
Strategic Objective 1: Percentage of Elective Surgery Cases Admitted on Time by Clinical Urgency.	The demand for elective surgery and the number of additions to the elective surgery waiting list continued to increase in 2014–15, which has impacted the ability to meet the targets.	Strategic Objective 1: Percentage of Elective Surgery Cases Admitted on Time by Clinical Urgency, page 47.
Strategic Objective 2: Improved Emergency Department Timeliness.	See below.	Strategic Objective 2: Improved Emergency Department Timeliness, page 47.
Strategic Indicator 2.1: The proportion of Emergency Department presentations that are treated within clinically appropriate timeframes.	The 3 % increase in demand experienced in 2014–15 was a major reason for some performance indicators underachieving against targets.	Strategic Indicator 2.1, page 47.
Strategic Indicator 2.2: The proportion of Emergency Department presentations whose length of stay in the Emergency Department is four hours or less.	ACT public hospital Emergency Departments continued to improve the proportion of patients who presented to Emergency Departments who stayed less than four hours from their arrival to either admission or their departure home.	Strategic Indicator 2.2, page 49.
Strategic Objective 3: Maximising the Quality of Hospital Services.	See below.	Strategic Objective 3: Maximising the Quality of Hospital Services, page 50.
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.	Both Canberra Hospital and Calvary Public Hospital met the 2014–15 targets.	Strategic Indicator 3.1, page 50.
Strategic Indicator 3.2: The Proportion of People Separated from ACT Public Hospitals who are re-admitted to Hospital within 28 Days of their Separation due to Complications of their Condition (where the re-admission was unforeseen at the time of separation)	The results at Canberra Hospital and Calvary Public Hospital remained below the targets during 2014–15.	Strategic Indicator 3.2, page 51.
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.	The results are below the national benchmark of 2.00 cases per 10,000 bed days of care. Furthermore, recent national figures show both public hospitals remain below the national average for their respective hospital categories or peer groups.	Strategic Indicator 3.3, page 51.
Strategic Indicator 3.4: The Estimated Hand Hygiene Rate.	Canberra and Calvary public hospitals continued to improve on the national benchmark of 70 % during the most recent audit, which was undertaken in March 2015.	Strategic Indicator 3.4, page 52.

Health Directorate strategic indicators

Strategic Objective I: Removals from Waiting List for Elective Surgery

In order to improve access to elective surgery, the ACT Government has committed to an increase in the number of elective surgery operations provided in the territory, and to reduce the number of people waiting more than the clinically recommended times for that surgery.

Strategic Indicator I: The number of people removed from the ACT elective surgery waiting lists (This may include public patients treated in private hospitals)

	2014–15 target	2014–15 result
People removed from the ACT elective surgery waiting list for surgery	12,000	11,875*

*Preliminary figure – subject to change

Source: ACT Health Elective Surgery published data set–July 2015.

As shown in Figure 10, in 2014–15, ACT public hospitals performed 11,875 elective surgery procedures, a 1 per cent increase on the 11,780 reported for 2013–14. The result for 2014–15 is the highest number of elective surgeries performed within a single year.

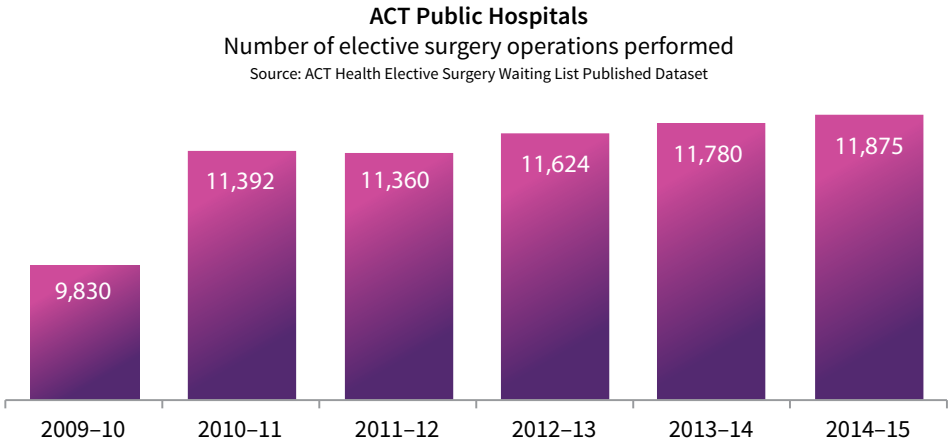


Figure 10: Number of elective surgeries performed

This is the fifth consecutive year that ACT Health has performed over 11,000 elective surgery procedures. Since 2002–03, when ACT Health provided a total of 7,661 elective surgery operations, there has been a 55 per cent increase in elective surgery activity, despite a 17 per cent increase in population since 2000–01.

As shown in Figure 11, ACT public hospitals recorded an increase in the number of patients waiting longer than the recommended timeframes for elective surgery in 2014–15, with 1,355 patients on the list at the end of June.

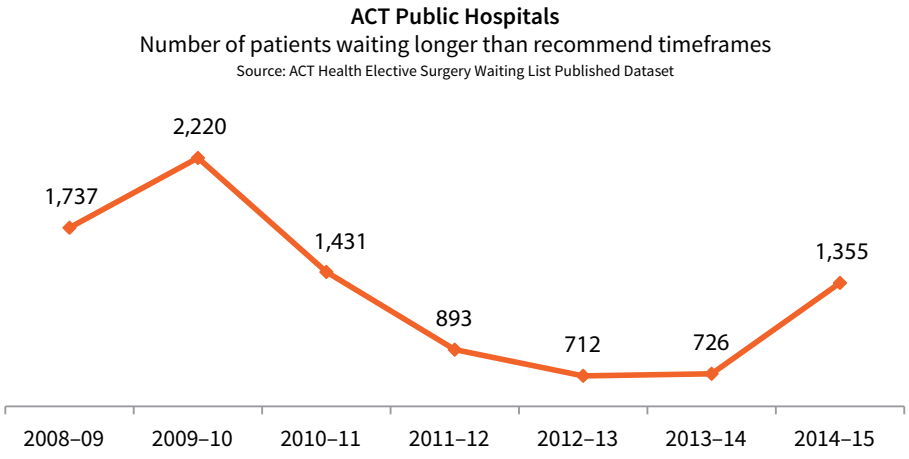


Figure 11: Number of patients waiting longer than recommended timeframes for elective surgery

Despite the increases, ACT Health has still reduced the number of overdue patients over the last few years. When comparing the 1,355 patients waiting longer than the recommended timeframes at the end of June 2015 with the 2,220 patients waiting in June 2010, there has been a 39 per cent decrease in long wait patients.

Initiatives have been implemented to address the increase in long wait patients, including:

- transferring some patients to the private sector, with no additional cost to the patient
- increasing some surgery in public hospitals, for example, ear nose and throat surgery
- improving partnerships with Southern NSW.

ACT Health is undertaking an in-depth analysis of elective surgery in the territory, with a focus on improving theatre utilisation and session allocation to more accurately reflect demand for specific specialty groups. We have built simulation models that predict the effect of changes to managing elective surgery. These findings will assist ACT Health in developing a surgical re-alignment strategy.

As shown in Figure 12, the median waiting time for access to elective surgery continues to improve, with a result of 45 days recorded for 2014–15, a decrease from 77 days four years ago. The ACT Health's result of 45 days is still above the 2013–14 national average of 36 days. This demonstrates the improvement that ACT Health has made over recent years. ACT Health has reduced its long waiting patients over the last few years, which has reduced the median wait time to the lowest since 2002–03.

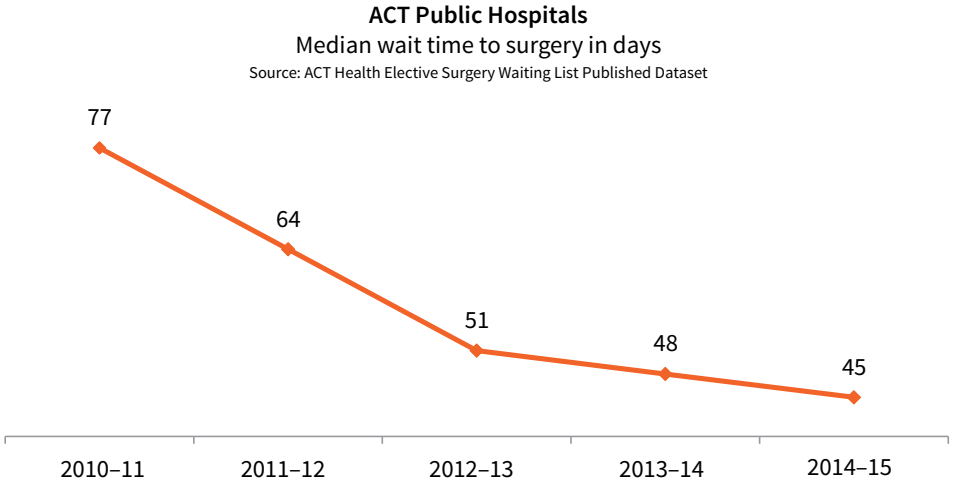


Figure 12: Median wait time for elective surgery in days

Hospital-Initiated Postponements (HIPs) measures how many patients have their elective surgery postponed. This performance indicator is useful for 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. As shown in Figure 13, in 2014–15, ACT public hospitals achieved a result of 7 per cent, which compares favourably to the 9 per cent reported for 2010–11.

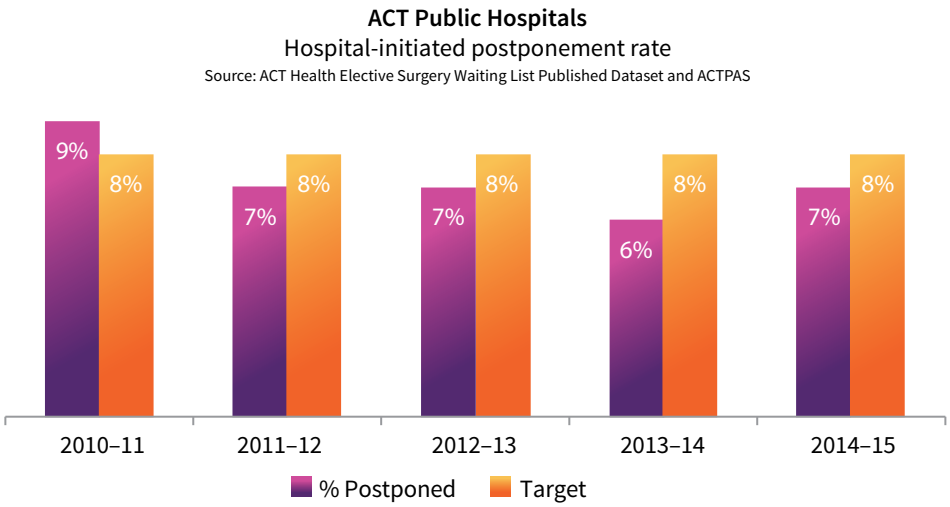


Figure 13: Hospital-Initiated Postponement rate

The ACT Health 2014–15 Annual Report presents some national elective surgery figures sourced from the National Hospital Performance Authority (NHPA). This information is reported by hospital peer group, which categories similar sized hospitals.

Table 5 shows comparisons between ACT public hospitals elective surgery timeliness by urgency category compared with other peer hospital groups.

It is widely recognised that there is inconsistency among jurisdictions within Australia in relation to the classifications of particular procedures and what urgency categories they should be. National agencies along with jurisdictions are working to better align with a national standard for categorisation of particular procedures, but until this work has been finalised caution should be exercised when considering comparability of these results.

Table 5: Proportion of patients admitted within their recommended timeframes for their awaited procedure (major metropolitan hospitals peer group)

Fin year	Canberra Hospital			Calvary Public Hospital			Peer group average		
	Urgency Category One (within 30 days)	Urgency Category Two (within 90 days)	Urgency Category Three (within 365 days)	Urgency Category One (within 30 days)	Urgency Category Two (within 90 days)	Urgency Category Three (within 365 days)	Urgency Category One (within 30 days)	Urgency Category Two (within 90 days)	Urgency Category Three (within 365 days)
2013–14	99%	72%	74%	97%	76%	94%	98%	79%	92%
2012–13	99%	64%	80%	97%	54%	95%	95%	76%	90%
2011–12	98%	50%	73%	97%	52%	92%	92%	76%	90%

Source: ACT Health Elective Surgery Waiting List Published Dataset and National Hospital Performance Authority (My Hospitals)

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: The percentage of assessed emergency clients seen within 24 hours

	2014–15 target	2014–15 result
Percentage of assessed emergency clients seen within 24 hours	100%	100%

Source: ACT Health Dental published data – June 2015

Strategic Objective 2, for Canberra Hospital and Health Services is to ensure that 100 per cent of eligible clients triaged as a dental emergency are seen within 24 hours of contact to the service. The ACT Dental Health Program has continued to achieve this target throughout 2014–15.

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: The percentage of cancer patients who commence radiotherapy treatment within standard time frames

Category	2014–15 target	2014–15 result
Emergency — treatment starts within 48 hours	100%	100%
Palliative — treatment starts within 2 weeks	90%	95%
Radical — treatment starts within 4 weeks	90%	99%

Source: ACT Health Radiation Oncology published data (CAS) – July 2015

For 2014–15, radiotherapy performance measures and targets were revised to be in line with the National Radiation Oncology Practice Standards.

Radiation Oncology is committed to commencing treatment for radiation therapy patients within the waiting time guidelines specified in Radiation Oncology Practice Standards. In 2014–15, the department achieved the following:

- Against a target of 90 per cent, 95 per cent of palliative patients received radiation therapy treatment within two weeks.
- Against a target of 90 per cent, 99 per cent of radical patients received radiation therapy treatment within four weeks.

In 2014–15, 95 per cent of all radiotherapy patients were seen within standard waiting timeframes.

Table 6 provides comparative figures since 2011–12.

Table 6: Comparative timeframes for percentage of cancer patients who commence radiotherapy treatment within standard time frames

July to June	2011–12	2012–13	2013–14	2014–15
Emergency: within 48 hours	100%	100%	100%	100%
Palliative: with 2 weeks	100%	100%	100%	95%
Radical: within 4 weeks	94%	98%	100%	99%

Source: ACT Health Radiation Therapy Dataset

Strategic Objective 4: Improving the Breast Screen Participation Rate for Women aged 50 to 69 years

Strategic Indicator 4: The proportion of women aged 50 to 69 years who had a breast screen in the 24 months prior to each counting period

	2014–15 target	2014–15 result
Proportion of women aged 50 to 69 who have a breast screen	60%	55%

Source: ACT Health BreastScreen published data (BIS) – July 2015

Despite ready availability of appointments, getting women to attend screening is proving challenging. A total of 15,566 breast screens were performed for ACT residents in 2014–15, compared with the 16,407 screening procedures reported for the same period in 2013–14.

The participation rate for women aged 50–69 years was 55 per cent.

BreastScreen ACT achieved the target for the total number of screens and exceeded the participation target for women aged 70–74 years.

To improve numbers, BreastScreen ACT has commenced an active recruitment campaign using multiple strategies, such as contacting lapsed attendees and sending letters to GPs to encourage women to have a breast screen.

More information: For detailed information, see BreastScreen Australia Program, page 117.

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

Strategic Indicator 5: Aged care assessment waiting time

	2014–15 target	2014–15 result
Mean waiting time in working days	2 days	2 days

Source: ACT Health Admitted Patient Care published data – July 2015

During 2014–15, the Aged Care Assessment Team (ACAT) continued to manage client referrals and assess clients in a timely manner. ACAT has met ACT Health requirements to respond to public hospital-based assessments within the target of two working days of acceptance of referral.

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

	2014–15 target	2014–15 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%	5%

Source: ACT Health Mental Health published data (MHAGIC) – July 2015

Mental Health, Justice Health, Alcohol and Drug Services is a national leader in reducing seclusion and restraint rates in mental health inpatient settings. During the 2015 National Seclusion and Restraint Forum the national rates of seclusion were a focus. Nationally, the highest rates of seclusion occur in adult mental health units.

As shown in Table 7, in 2014–15, the ACT seclusion result was 2 per cent above our local target of 3 per cent and an increase when compared to previous year's results.

Table 7: Change in seclusion results

ACT public hospitals – Mental Health Seclusion Rates		
2012–13	2013–14	2014–15
2%	2%	5%

Source: ACT Health Admitted Patient Care Published Dataset and MHAGIC Database

Reducing seclusion remains a high priority for the staff in the Adult Mental Health Unit. The higher rate of seclusion during 2014–15 was due to a very high level of clinical acuity in the Adult Mental Health Unit at Canberra Hospital in December 2014 and January 2015.

The weekly seclusion review meetings continue to occur. Implementing the Aggression and Violence clinical guidelines will provide further support to staff in the early identification and management of aggression and violence. A new training program for the Early Support and Intervention Team in the Adult Mental Health Unit (AMHU) with updated procedures and protocols will contribute to reducing episodes of seclusion.

Based on a former counting methodology, the target for the percentage of inpatients contacted within seven days post-discharge indicator was increased from 75 per cent in 2013–14 to 85 per cent in 2014–15. The ACT's result for this indicator in 2014–15 was 72 per cent.

The most recent national publication released by the Productivity Commission is the Report on Government Services (RoGS) 2015, which examines each jurisdiction's post-discharge follow-up performance for 2012–13. As shown in Figure 14, the national rate is 61 per cent. While the ACT's result of 72 per cent is below the target, it is the highest rate of patient follow-up seven days post-discharge in Australia.

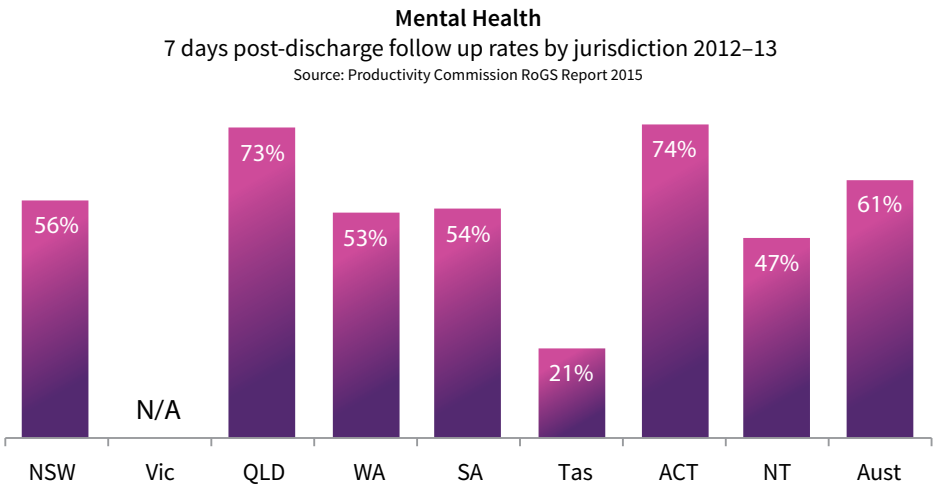


Figure 14: Mental health seven days post-discharge follow-up rates for 2012–13 by jurisdiction

The unplanned re-admission rate for 2014–15 has improved to 6 per cent when compared to 2013–14. It is known that community follow-up by mental health services, carer involvement and other community supports are key factors in reducing re-admissions within 28 days of an initial inpatient admission.

Table 8: ACT Public Hospitals 28 Day Re-admissions for Mental Health patients

Financial year	Percentage of ACT Public Hospitals 28 day re-admissions for mental health patients
2012–13	10%
2013–14	7%
2014–15	6%

Source: ACT Health Admitted Patient Care Published Dataset and MHAGIC Database

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

	2014–15 target	2014–15 result
Proportion of clients who return to hospital within 28 days of discharge from an ACT acute psychiatric mental health inpatient unit	<10%	6%

Source: ACT Health Mental Health published data (MHAGIC) – July 2015

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

	2014–15 target	2014–15 result
Mean percentage of overnight hospital beds in use	90%	85%

Source: ACT Health Admitted Patient Care published data – July 2015

As shown in Table 9, in 2014–5, ACT public hospitals reported a combined occupancy rate of 85 per cent, a 5 per cent improvement when compared to 90 per cent reported in 2013–14. This is a positive improvement as the demand for beds:

- increased in 2014–15
- is directly related to the additional beds that have been injected into ACT public hospitals.

Table 9: Mean percentage of overnight hospital beds in use

ACT public hospital	Mean percentage of overnight hospital beds in use
Canberra Hospital	88%
Calvary Public Hospital	78%
ACT Public Hospitals Combined Result	85%
2014–15 Target	90%

Source: ACT Health Admitted Patient Care Dataset

In 2014–15, there were a total of 100,785 inpatient episodes of care (separations) in ACT public hospitals. This consisted of:

- 53,457 same day patients
- 47,329 overnight patients who stayed one or more nights in hospital.

Overall, the number of separations increased by 4 per cent when compared with 96,969 separations reported for 2013–14.

ACT public hospitals provided 290,621 overnight hospital bed days of care in 2014–15, which is:

- a 3 per cent increase on the reported 2013–14 result of 280,939
- a 17 per cent increase on the reported 2009–10 result of 249,046.

Figure 15 shows the number of overnight bed days and overnight separations.

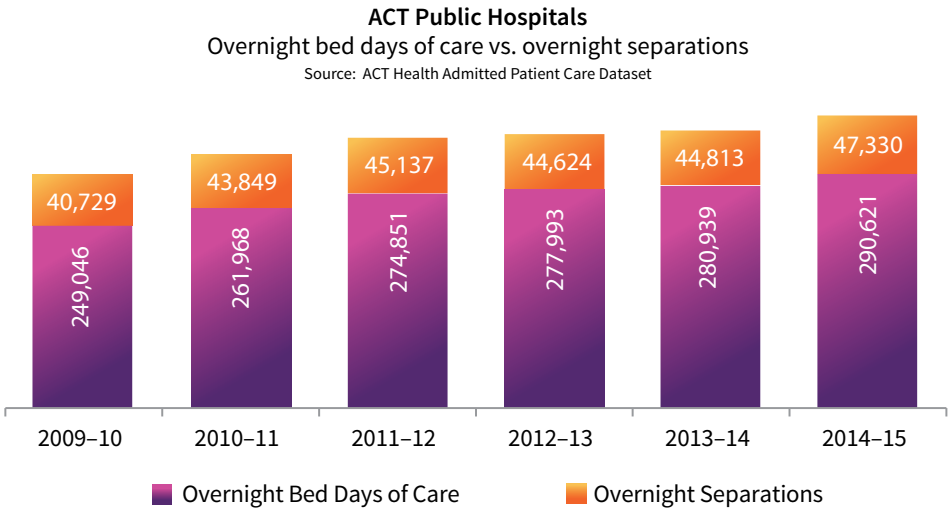


Figure 15: Overnight bed days of care versus overnight separations

As shown in Table 10, the average length of stay for overnight patients in ACT public hospitals in 2014–15 was 6.2 days. This is a slight reduction when compared to the 6.3 days reported for 2013–14. The result for 2014–15 is still above the 2013–14 national average of 5.5 days.

Table 10: Average length of stay in hospital for overnight patients

Year	Canberra Hospital	Calvary Public Hospital	ACT public hospitals	National average
2012–13	6.2 days	6.3 days	6.3 days	4.9 days
2013–14	6.3 days	6.3 days	6.3 days	5.5 days
2014–15	6.4 days	5.7 days	6.2 days	N/A

Source: ACT Health Admitted Patient Care Dataset and Australian Institute of Health & Welfare

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 over time. In 2007, a person was 17 per cent less like to die prematurely from a chronic disease than in 1997.

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 2013

	ACT rate (years)	National rate (years)
Females	85.0	84.3
Males	81.7	80.1

Source: ABS 2013, Deaths, Australia, 2013, cat. no. 3302.0, ABS, Canberra.

The ACT remains the jurisdiction with the highest life expectancy in Australia. Over the 10 year period from 2004 to 2013, life expectancy in the ACT increased by two years for males and 1.1 years for females.

Cancer and cardiovascular disease are the leading contributors to the total burden of disease in the ACT, contributing nearly half of the total disease burden.

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, however the population is still younger than the national average, having a median age of 34.9 years in 2014 compared with 37.3 years. 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, 2011–12

	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. A number of factors may have contributed to this, such as changed criteria for the diagnosis of diabetes, increased public awareness and an increase in the prevalence of risk factors such as obesity and sedentary behaviour. Prevalence rates may also increase in the short-term as a result of early intervention and detection campaigns. This would be a positive result as undiagnosed diabetes can have significant impacts on long-term health. The prevalence of diabetes in the ACT is similar to the national rate.

Strategic Indicator 11: Age standardised 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: 4364.0.55.001.

Strategic Objective I2: 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 I2: Capital consumption

Government capital expenditure as a proportion of government capital consumption expenditure by healthcare facilities, 2008–09 to 2010–11	ACT rate	National rate
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). This report is released every two years and presents historical data.

Strategic Objective I3: 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 I3: Proportion of Government recurrent health funding expenditure on public health activities

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 I4: 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's Aboriginal and Torres Strait Islander population has a lower rate of immunisation than the general population at 24–27 months. The rates of immunisation coverage for Aboriginal and Torres Strait Islander children at 12–15 months is equal to the general population and higher than the general population for children at 60–63 months. The ACT aims to increase immunisation coverage rates for all Aboriginal and Torres Strait Islander children through a targeted immunisation strategy.

Strategic Indicator I4: Immunisation Rates – ACT Aboriginal and Torres Strait Islander Population

Immunisation rates for vaccines in the national schedule for the ACT indigenous population:	2014–15 target	2014–15 result
12 to 15 months	≥90%	92.9%
24 to 27 months	≥90%	84.3%
60 to 63 months	≥90%	94.3%
All	≥90%	90.5%

During 2014–15, vaccination coverage rates for Aboriginal and Torres Strait Islander children in the ACT within two of the three cohorts were the highest in Australia. However, 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.

Strategic Objective I5: 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 continue to exceed the national average for this indicator.

Strategic Indicator I5: Two Year Participation Rate in the Cervical Screening Program

	ACT rate	National rate
Two year participation rate	57.9%	57.8%

Source: Cervical Screening in Australia 2013–14 (Published: Australian Institute of Health and Welfare, June 2015).

The Cervical Screening Program captures and reports data over a two-year period as recommended by the National Cervical Screening Program. The AIHW report, Cervical Screening in Australia 2013–2014, 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.

Strategic Objective I6: 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 be lower than the national average on the DMFT index.

Strategic Indicator I6: The Mean Number of Teeth with Dental Decay, Missing or Filled Teeth at Ages 6 and I2

	ACT rate	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 (Published: Australian Institute of Health and Welfare, 2013).

Strategic Objective I7: Reducing the Risk of Fractured Femurs in ACT Residents Aged Over 75 years

This indicator provides an indication of the success of public and community health initiatives to prevent hip fractures. In 2013–14, the ACT rate of admissions in persons aged 75 years and over with a fractured neck of femur was 6.7 per 1,000 persons in the ACT population.

Strategic Indicator I7: Reduction in the Rate of Broken Hips (Fractured Neck of Femur) for those aged over 75 years

	2013–14 result	Long-term target
Rate per 1,000 people	6.7	5.3

Source: ACT Health Admitted Patient Care data, 2013–14.

Strategic Objective I8: 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 represents a significant decline in current smoking from 20.5 per cent of students in 1999.

The proportion of ACT students reporting to be current smokers in 2011 is slightly lower than the national average of 6.7 per cent.

Strategic Indicator I8: Percentage of Persons Aged I2 to I7 Years Who Smoke Regularly

	2011 outcome	National rate
Percentage of persons aged 12 to17 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, The Cancer Council Victoria, December 2012.

ACT Local Hospital Network strategic objectives and indicators

Strategic Objectives and Indicators

The ACT Local Hospital Network (ACT LHN) consists of a networked system that includes the Canberra Hospital and Health Services, Calvary Public 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	2014–15 target	2014–15 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	100%	95%
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	78%	69%
Non-urgent – admission at some time in the future 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	91%	83%

Source: ACT Health Elective Surgery published data – July 2015

Strategic Objective 2: Improved Emergency Department Timeliness

Access to emergency care is a major priority for the ACT Government. ACT Health is committed to improving waiting times in the Emergency Departments and continues to provide services to the Canberra community while ongoing work into new initiatives and investments occurs.

Strategic Indicator 2.1

Strategic Indicator 2.1: The proportion of Emergency Department presentations that are treated within clinically appropriate timeframes

Triage category	2014–15 target	2014–15 result
One (resuscitation seen immediately)	100%	100%
Two (emergency seen within 10 minutes)	80%	78%
Three (urgent seen within 30 minutes)	75%	48%
Four (semi-urgent seen within 60 minutes)	70%	53%
Five (non-urgent seen within 120 minutes)	70%	86%
All Presentations	70%	59%

Source: ACT Health Emergency Department published data – July 2015

The 3 per cent increase in demand experienced in 2014–15 was a major reason for some performance indicators underachieving against targets. This was evident for Emergency Department timeliness, where ACT public hospitals recorded results below last year's overall timeliness figures.

Emergency Department timeliness measures how long patients wait to receive their care. In 2014–15, ACT public hospital Emergency Departments reported an overall timeliness result of 59 per cent, 2 per cent below the result reported in 2013–14.

Table 11 shows the percentage of patients seen on time by triage category in 2014–15. The 3 per cent increase in presentations experienced in 2014–15 affected on the ability to treat all patients within recommended timeframes. This led to longer waiting times for some lower acuity patients. The ACT met the target for triage category one and category two.

Table 11: Patients seen on time by triage category in 2014–15

Triage category	2014–15 target	ACT Public Hospitals combined 2014–15 results	Canberra Hospital 2014–15 results	Calvary Public Hospital 2014–15 results	National average 2013–14 results
Category 1 (resuscitation – seen immediately)	100%	100%	100%	100%	100%
Category 2 (emergency – seen within 10 minutes)	80%	78%	77%	81%	82%
Category 3 (urgent – seen within 30 minutes)	75%	48%	39%	59%	70%
Category 4 (semi-urgent – seen within 60 minutes)	70%	53%	43%	66%	75%
Category 5 (non-urgent – seen within 120 minutes)	70%	86%	80%	92%	92%
All presentations	70%	59%	51%	69%	75%

Source: ACT Health Emergency Department Published Dataset and Australian Institute of Health & Welfare

The AIHW notes in their Emergency Department Care 2013–14 report that the ACT had the highest growth rate of any jurisdiction in terms of presentations to the Emergency Departments in 2013–14. When simply comparing presentations, from 2012–13 to 2013–14, there was a 6 per cent increase in people seeking treatment in 12 months. This equates to an average of 345 people attending the public hospital Emergency Departments each day.

Table 12 provides a further breakdown of national comparative figures for the major metropolitan hospital peer group over recent financial years for percentage of presentations seen on time.

Table 12: Yearly comparison of patients seen on time by triage category

	Canberra Hospital					Calvary Public Hospital					Peer group average				
Fin Year	Triage 1	Triage 2	Triage 3	Triage 4	Triage 5	Triage 1	Triage 2	Triage 3	Triage 4	Triage 5	Triage 1	Triage 2	Triage 3	Triage 4	Triage 5
2013–14	99%	80%	42%	49%	81%	100%	89%	60%	67%	91%	100%	80%	66%	73%	91%
2012–13	100%	70%	34%	39%	74%	99%	82%	52%	54%	85%	100%	81%	64%	70%	89%
2011–12	100%	73%	43%	45%	78%	100%	81%	57%	51%	83%	100%	80%	62%	68%	88%
2010–11	99%	78%	38%	38%	70%	100%	78%	59%	58%	81%	100%	78%	61%	66%	86%

Source: ACT Health Emergency Department Published Dataset and National Hospital Performance Authority (My Hospitals)

Table 13 shows the median waiting times for patients to be seen from when they first present to an ACT public hospital Emergency Department to when treatment first commences.

Over the past two years ACT public hospitals have made improvements in the median waiting time to be seen, particularly for triage category three and four presentations.

Table 13: Waiting time between earliest event in episode and seen time

	Triage category					
Waiting time between earliest event in episode and seen time	Resuscitation – Immediate within seconds Median	Emergency <= 10 mins Median	Urgent <= 30 mins Median	Semi-urgent <= 60 mins Median	Non-Urgent <= 120 mins Median	Total Median
2014–15	0:00:00	0:05:00	0:33:00	0:55:00	0:42:00	0:37:00
2013–14	0:00:00	0:04:00	0:30:00	0:50:00	0:37:00	0:33:00
2012–13	0:00:00	0:06:00	0:41:00	1:08:00	0:50:00	0:44:00

Source: ACT Health Emergency Department Published Dataset

Strategic Indicator 2.2

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

	2014–15 target	2014–15 result
The proportion of Emergency Department presentations who either 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.	77%	63%

Source: ACT Health Emergency Department published data – July 2015

As shown in Table 14, in 2014–15, ACT public hospital Emergency Departments continued to improve the proportion of patients who presented to Emergency Departments who stayed less than four hours from their arrival to either admission or their departure home. The result was 63 per cent, which is a 1 per cent improvement when compared to 2013–14, and a 5 per cent improvement when compared with the 58 per cent reported for 2011–12.

Table 14: Four hour rule ACT vs. Australia

Financial year	ACT performance	National average
2014–15	63%	N/A
2013–14	62%	73%
2012–13	57%	67%
2011–12	58%	64%

Source: ACT Health Emergency Department Published Dataset and Australian Institute of Health & Welfare

As shown in Table 15, ACT public hospitals compare more favourably in this measure to the peer group average.

Table 15: Four hour rule ACT Public Hospitals against their peer group average

Financial year	Canberra Hospital	Calvary Public Hospital	Peer group average
2013–14	56%	69%	66%
2012–13	52%	64%	58%
2011–12	54%	63%	54%

Source: ACT Health Emergency Department Published Dataset and National Hospital Performance Authority (My Hospitals)

In 2014–15, the proportion of patients who Did Not Wait (DNW) for treatment was 5 per cent. This is comparable with the result reported for 2013–14 and better than the 10 per cent reported in 2010–11. The result for 2014–15 is under the ACT target, which is set at 10 per cent.

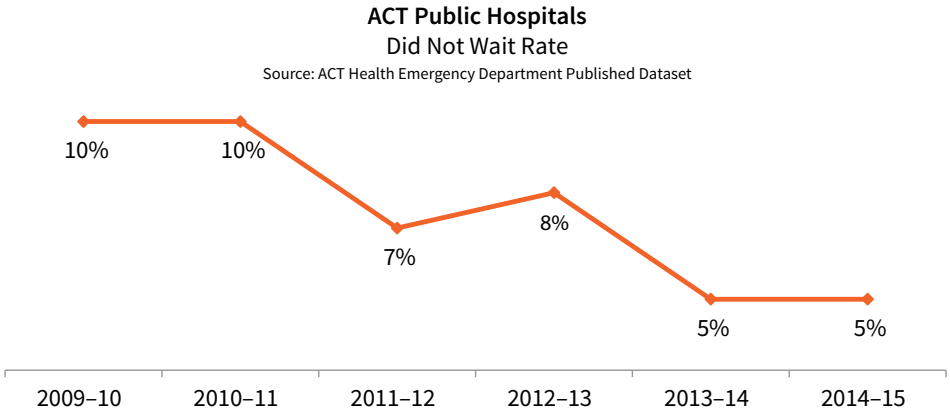


Figure 16: Did Not Wait for treatment rates

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 postoperative care.

Strategic Indicator 3.1

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

	2014–15 target	2014–15 result
Canberra Hospital	<1.0%	0.80%
Calvary Public Hospital	<0.5%	0.23%

Source: Data obtained by screening individual medical records of patients from ACTPAS reports against the ACHS definitions for these indicators.

As shown in Figure 17, in 2014–15, preliminary results suggest Calvary Public Hospital reported:

- positive results in the proportion of people who require an Unplanned Return To the Operating Theatre (URTOT) during their hospital stay when compared to 2013–14
- was below its target, which is set at 0.50 per cent.

Also as shown in Figure 17, preliminary figures suggest Canberra Hospital reported an increase in 2014–15 when compared to previous years. However, this result is below the target, which is set at 1 per cent. Canberra Hospital is a major teaching and referral hospital that manages more complex patients and higher levels of complications.

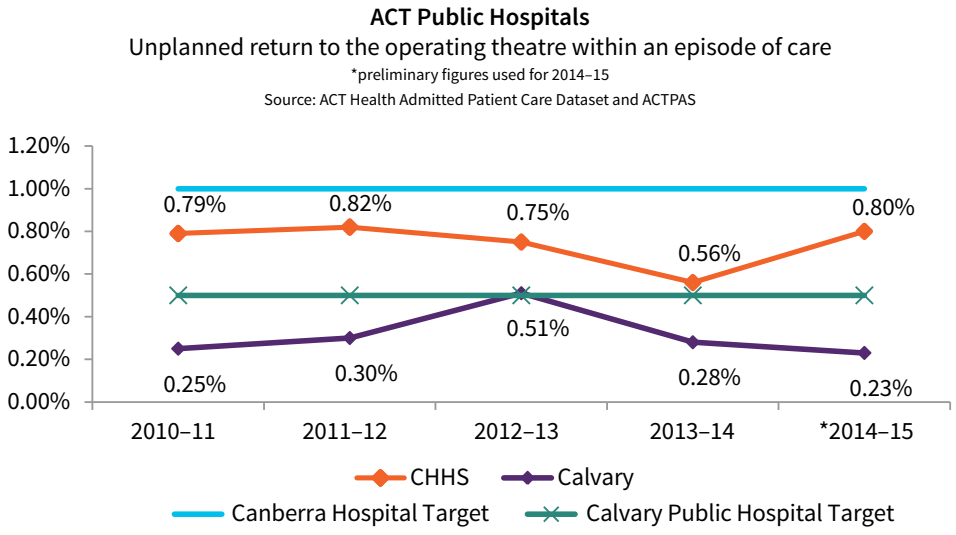


Figure 17: Unplanned return to the operating theatre within an episode of care

Strategic Indicator 3.2

Strategic Indicator 3.2: The Proportion of People Separated from ACT public hospitals who are re-admitted to Hospital within 28 Days of their Separation due to Complications of their Condition (where the re-admission was unforeseen at the time of separation)

This indicator highlights the effectiveness of hospital-based and community services in the ACT in the treatment of persons who receive hospital-based care.

	2014–15 target	2014–15 result
Canberra Hospital	<2.0%	1.21%
Calvary Public Hospital	<1.0%	0.53%

Source: Data obtained by screening individual medical records of patients from ACTPAS reports against the ACHS definitions for these indicators.

As shown in Figure 18, in 2014–15, preliminary figures suggest ACT public hospitals continue to report good results for the proportion of people who return to hospital within 28 days of discharge. The results at Canberra Hospital and Calvary Public Hospital remained below the targets during 2014–15.

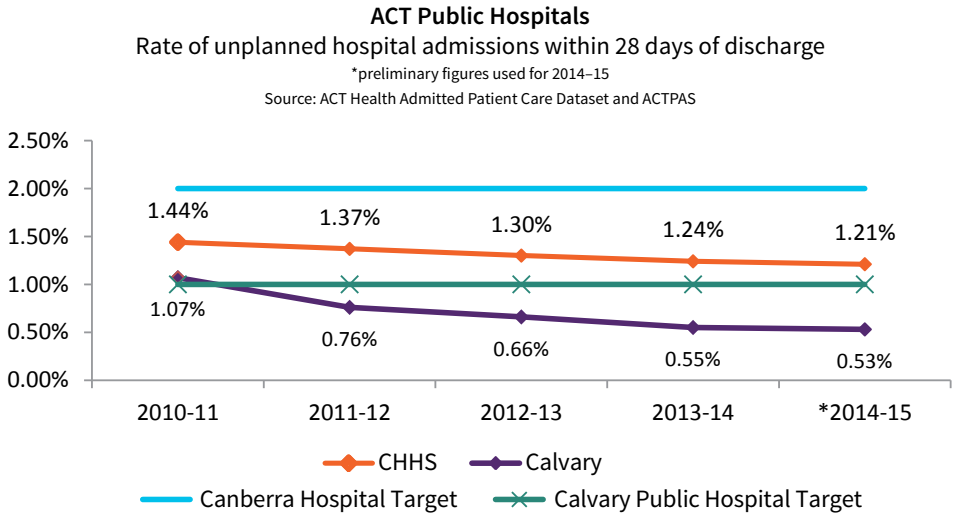


Figure 18: Rate of unplanned hospital admissions within 28 days of discharge

Strategic Indicator 3.3

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.

	2014–15 target	2014–15 result
Canberra Hospital	<2 per 10,000	1.00 per 10,000
Calvary Public Hospital	<2 per 10,000	0.32 per 10,000

Source: ACT Health Infection Control database

This indicator has changed based on the national quality and safety standards. It now measures the number of people admitted to hospitals per 10,000 occupied bed days who acquire a SAB infection during their hospital stay.

ACT Health infection control officers continue to develop and implement programs and processes to limit the transfer of infections within public hospitals. This includes providing communication and education programs for clinicians, patients, general staff and visitors. In addition, both ACT public hospitals maintain processes to minimise hospital-acquired infections during hospital stays.

As noted previously, the targets for each hospital are based on the types of services provided. As the major trauma hospital for the region, Canberra Hospital has higher SAB infection rates than Calvary Public Hospital.

As shown in Table 16, Canberra Hospital reported a positive SAB rate result of 1.00 cases per 10,000 bed days in 2014–15, which is an improvement on the 1.05 cases reported for 2013–14.

Table 16: Canberra Hospital vs. National SAB Rates Peer Group 1 (Major metropolitan hospital – principal referral centre)

Financial year	Canberra Hospital	National peer group average	Target
2014–15	1.00	N/A	2.00
2013–14	1.05	1.28	2.00
2012–13	1.55	1.35	2.00

Source: ACT Health Admitted Patient Care Dataset, ACTPAS and National Hospital Performance Authority (My Hospitals)

As shown in Table 17, Calvary Public Hospital reported a SAB rate of 0.32 cases per 10,000 bed days in 2014–15, compared with the 0.33 result recorded in 2013–14.

Calvary public hospital reported low results for SAB rates in 2013–14 compared to their peer hospitals in the major hospitals with fewer vulnerable patients category. Calvary public hospital reported a result of 0.33 cases per 10,000 patient bed days against the peer group average of 0.78 cases per 10,000 patient bed days.

Table 17: Calvary Public Hospital vs. National SAB Rates Peer Group 2 (Major metropolitan hospital – public acute group A hospitals)

Financial year	Calvary Public Hospital	National peer group average	Target
2014–15	0.32	N/A	2.00
2013–14	0.33	0.78	2.00
2012–13	0.32	0.91	2.00

Source: ACT Health Admitted Patient Care Dataset, ACTPAS and National Hospital Performance Authority (My Hospitals)

These results are below the national benchmark of 2.00 cases per 10,000 bed days of care. Furthermore, recent national figures illustrated in Table 16 and Table 17 show both public hospitals remain below the national average for their respective hospital categories or peer groups.

On 9 April 2015, the National Health Performance Authority (NHPA) released its latest report titled Healthcare-associated *Staphylococcus aureus* bloodstream infection in 2013–14.

The report highlighted that in 2013–14, major peer group hospitals with more vulnerable patients had an average result of 1.28 cases per 10,000 patient bed days. For that same period, Canberra Hospital reported a result of 1.05 cases per 10,000 patient bed days, which is:

- below the peer group average
- a decrease compared to the result reported for 2012–13 of 1.55 cases per 10,000 patient days.

Strategic Indicator 3.4

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 practiced in a specified audit period, by the total number of observed hand hygiene 'moments' in the same audit period.

	2014–15 target	2014–15 result
Canberra Hospital	70%	79%
Calvary Public Hospital	70%	77%

Source: Hand Hygiene Australia online database

As shown in Table 18, Canberra and Calvary public hospitals continued to improve on the national benchmark of 70 per cent during the most recent audit, which was undertaken in March 2015.

Table 18: Estimated hand hygiene rate

	Canberra Hospital	Calvary Public Hospital
National benchmark	70%	70%
2014 March audit	73%	82%
2014 June audit	74%	83%
2014 October audit	76%	73%
2015 March audit	79%	77%

Source: ACT Health Admitted Patient Care Dataset, ACTPAS and National Hospital Performance Authority (My Hospitals)

Health Directorate Outputs

Output I.I: Acute Services

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:

- strategies to meet performance targets for the Emergency Department, elective and emergency surgery
- continuing to increase the capacity of acute care services.

Overview

Acute services are provided by:

- the Division of Critical Care
- the Division of Medicine
- the Division of Pathology
- the Division of Surgery, Oral Health and Medical Imaging
- the Division of Women, Youth and Children.

Division of Critical Care

The Division of Critical Care is responsible for delivering acute and critical care and providing retrieval services. These are provided as inpatient and outpatient services at 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
- Intensive Care Unit (ICU)
- Access Unit
- Surgical Short Stay Unit
- Acute Surgical Unit (ASU)
- Discharge Lounge and Medi-Hotel
- Medical Assessment and Planning Unit (MAPU).

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 holds academic appointments at the ANU Medical School, and many research programs are in operation. Many members of the division's staff participate in developing national professional guidelines and quality initiatives.

Division of Pathology

Pathology is a medical specialty that examines disease processes and their cause. Services are provided in the acute setting at Canberra Hospital, Calvary Hospital, 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.

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. Due to the critical role of pathology testing in diagnosis and treatment, the objective and direction for pathology are intimately tied to the objectives and priorities of ACT Health's Corporate Plan.

Pathology works in close collaboration with many areas of the Health Directorate to provide access to accurate, timely results to assist in diagnosing, managing and monitoring patients.

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

- infection control
- public health outbreaks (Norovirus, Measles, Flu, Tuberculosis, Meningococcal, etc.)
- Emergency Department.

Pathology also performs testing for the ACT Breast Screening and Cervical Screening programs.

Division of Surgery, Oral Health and Medical Imaging

The Division of Surgery, Oral Health and Medical Imaging is responsible for delivering:

- inpatient and outpatient surgical and medical imaging services
- prevention and treatment dental health programs for children, targeted youth and adults of the ACT and surrounding region.

The division includes:

- Surgical Bookings and Pre-Admission Clinic
- Anaesthesia
- Pain Management Unit
- Operating Theatres
- Post-Anaesthetic Care Unit
- Day Surgery Unit and Admissions / Extended Day Surgery Unit
- Medical Imaging
- specialist surgical ward areas
- medical and nursing outpatient services
- Shock Trauma Service
- Trauma and Orthopaedic Research Unit
- the ACT Dental Health Program.

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 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
  - Canberra Midwifery Program (CMP)
  - Maternity Assessment Unit (MAU)
  - Early Pregnancy Assessment Unit (EPAU)
  - Fetal Medicine Unit (FMU)
- women's health, including:
  - health screening
  - gynaecology
  - programs targeting violence against women
  - the Women's Health Service, which prioritises women who experience barriers to accessing mainstream services
- neonatology, including:
  - the Neonatal Intensive Care Unit (NICU)
  - the Special Care Nursery (SCN)
  - specialist clinics
  - newborn hearing screening
  - the ACT Newborn Retrieval Service
- paediatrics, including:
  - inpatient care
  - specialist clinics
  - community paediatricians
- a genetics service
- the Maternal and Child Health (MACH) nursing service, including:
  - a universal home visit following birth
  - breastfeeding and parenting support
- immunisation and referral services that support children and their families with complex care needs, including:
  - the MACH Parenting Enhancement Program
  - the Asthma Nurse Educator Service
  - the Caring for Kids Program, which supports care in the home for children with complex needs
  - the Child at Risk Health Unit, which supports care for children affected by violence and abuse
  - Integrated Multi-agencies for Parents and Children Together Program, which coordinates care for woman with complex care needs who are pregnant and/or have young children
  - child protection training for clinicians
  - the 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, which provides hearing assessments to children and adults.

Performance against accountability indicators

The Dental Health Program has continued to achieve the mean waiting time target for clients on the dental services waiting list. This is now set at six months, which is a reduction of six months when compared to previous years. The Dental Health Program has improved on the target with clients on the waiting list having a year-to-date (YTD) mean waiting time of 4.15 months at the end of June 2015. In June 2014, the YTD mean waiting time was reported at 5.01 months and in June 2013 YTD, it was 11 months.

The National Partnership Agreement for dental Adult Waiting List Times has been extended by the Commonwealth until 30 June 2016. This initiative has enabled the ACT Restorative Waiting list to be reduced and achieve a lower than six month mean waiting time. The KPI to meet is set at six months. At the end of this initiative the ACT waiting time will need to be reviewed.

More information: For additional information, see C.6 Statement of performance, Output 1.1: Acute Services, page 223.

Emergency Department

The Emergency Department continues to face challenges associated with an increase in patients presenting for treatment in comparison to the 2013–14 financial year. Similarly, the ICU faces challenges with an increase in:

- patients requiring admission
- the acuity of patients requiring admission.

The increasing number of presentations to the Emergency Department will continue to impact on the demand in the Emergency Department. However, there is a whole-of-hospital focus on initiatives to enhance access to care at Canberra Hospital.

Emergency surgery

Canberra Hospital is the major tertiary and trauma referral centre for the ACT and surrounding NSW. This means that it needs to be equipped and able to manage high volumes of trauma and emergency cases that cannot be provided by other facilities.

The increasing demand for elective and emergency surgical procedures has continued into the 2014–15 period. ACT Health continues to change where and how surgery is delivered in the ACT, to ensure that patients are receiving their surgery in the right facility at the right time.

Elective surgery

From 2009–10 to 2013–14, ACT public hospitals made significant improvements in how quickly patients access their elective surgery and within the clinically recommended timeframes. These improvements have continued into 2014–15.

On 20 October 2014, the AIHW released their latest report on elective surgery waiting times performance over 2013–14. While the ACT's result of 48 days for 2013–14 is still above the national average of 36 days, in 2009–10, the ACT reported a median wait time to surgery of 73 days, which is not the highest national median wait time.

The Surgical Services Re-alignment Program is being led by the Performance Information Branch to provide short-, medium- and long-term planning for surgery across the territory and surrounding region. The main principle underpinning the re-alignment is to provide a regional approach to surgical services that achieve better patient outcomes and best utilise all available public hospital resources.

Acute Care services

The Acute Surgical Unit (ASU) commenced in April 2015 and is staffed and run by consultants at Canberra Hospital. The ASU admits patients who have been assessed as likely to require a surgical procedure and aims to maximise access to emergency theatre time for general surgery patients. The ASU has access to a dedicated theatre list from Monday to Friday.

Following on from the ICU extension, which was completed in October 2013, an additional two ICU beds opened in 2014–15. This has provided efficiencies in bed management because it allows patients to be isolated or positioned further away from other patients, as required.

The Capital Region Retrieval Service was successful in securing funding to purchase a road vehicle to improve patient care and road retrieval response times. The Capital Region Retrieval Service continues to see an increase in annual total activity (Missions and Consults) from 702 in 2013–14 to 786 in 2014–15.

The ACT Government funded Canberra's first Mobile Dental Clinic, which was launched in January 2015. The purpose-built truck is improving access to dental health services for Canberrans residing in aged care facilities. In the first six months it visited seven facilities, providing a range of preventative, restorative and denture services.

A dedicated nursing Trauma Case Management Service commenced within the Shock Trauma Service. Funding for the appointment of a Nurse Practitioner in the Shock Trauma Service has been confirmed. The goals of trauma case management (TCM) are to:

- provide well-coordinated care for patients and families
- ensure that satisfactory clinical outcomes are met.

In addition, the service aims to effectively manage patient length of stay and hospital resources by improving the integration and coordination of the activities of multiple sub specialties.

A new Cardiac Catheter Diagnostic Suite (CCDS) was installed in the Cardiology Department at Canberra Hospital in 2014. This has provided enhanced clinical services for our patients. The CCDS brings a new imaging performance, enabling the clinician to ultimately treat the patient faster, with more precision and with added confidence for enhanced patient outcomes. The CCDS is the first of its kind in the ACT. The high powered X-ray tube reduces the radiation dose to the patient (and operator) by up to 60 per cent when compared to conventional imaging equipment.

During 2014–15, Cardiology implemented an integrated database that provides clinicians with a seamless flow of information and data across both clinical and diagnostic services. This has improved communication between Canberra Hospital and Health Services (CHHS) specialists and GPs and improved patient care.

An additional two non-invasive cardiologists were appointed to support and improve echocardiography at Canberra Hospital. The appointments have significantly improved access and, as a result, there is no longer a wait time associated with the echocardiography service for inpatients.

The Canberra Hospital's Coronary Care Unit (CCU) opened at Woden Valley Hospital on 16 June 1975, under the direction of Dr David Coles and RN Judy Foskett. The CCU now has:

- nine cardiologists
- 35 CCU nursing staff
- 24-hour medical cover.

During 2014–15, it celebrated its 40th anniversary. The CCU has established and maintained a high-quality service for Canberra and the surrounding region.

Following the completion of renovations to the Gastroenterology and Hepatology Unit (GEHU) in 2014 and the allocation of an additional $300,000 in enhancement funding in 2014–15, overall patient flow and capacity has increased. This has allowed an additional 300 procedures to be completed, which assisted in reducing the waiting list and improved timely access to this service in the territory.

A dedicated 20-bed Gastroenterology and Hepatology Medical Inpatient Unit opened and accepted its first patients on 18 November 2014.

Hospital in the Home (HITH) has increased its capacity to deliver the service by increasing the number of Registrars who visit and treat patients within their own home. In addition, through the Capital Upgrades Program (CUP), enhancement funding is being used to expand the HITH service, which will increase the physical treatment space at Canberra Hospital. This upgrade will:

- allow patients to receive treatment from clinicians in a safe clinical space in a timely manner
- support the ongoing HITH service and improve overall patient satisfaction.

This work is due to be completed in September 2015.

In 2014–15 and into the beginning of 2015–16, the Northside Dialysis Unit will relocate 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
- longer opening hours, with plans to offer nocturnal dialysis.

This will make BCHC the first public nocturnal dialysis provider in Australia. In addition, dialysis services are also now offered in the refurbished Tuggeranong Community Health Centre, which commenced treating patients on 25 May 2015 and offers 12 dialysis stations.

The Division of Medicine's inpatient sleep laboratory provides opportunities to interpret complex sleep studies. Four additional clinical staff have recently been recruited. This has resulted in an increased ability to meet the demand for this service, improving access for patients and referring clinicians.

Canberra Hospital, as the only Level Three Tertiary hospital for the ACT and surrounding regions, accepts patients who cannot be accepted by non-tertiary facilities due to the patient's clinical indications. The dual demands of occupancy and acuity are impacting on Canberra Hospital's ability to provide tertiary-level care to women and their babies.

In response to the escalating demands for maternity services at the Centenary Hospital for Women and Children (CHWC), the Canberra Hospital has been working closely with Calvary Public Hospital and Queanbeyan Hospital to determine ways of better managing maternity services across the ACT and the surrounding region.

Early intervention and prevention

The Shock Trauma Service received a grant from the NRMA ACT Road Safety Trust to pilot the Prevent Alcohol and Risk-Related Trauma in Youth Program (PARTY Program), in response to an increasing trend in alcohol-associated harm and hospitalisation in the ACT. The program, targeted at high school students, involves the students:

- hearing talks from ambulance workers and trauma surgeons
- participating in tours of the hospital
- interacting with rehabilitation equipment
- meeting young trauma survivors.

The HAAS Program provides nurse-led care to students with additional healthcare needs while they attend ACT Government schools. The model includes a HAAS Registered Nurse (RN) who works with the family and others involved to develop a care plan for the student. The RN then trains the school Learning Support Assistant (LSA) in the specific healthcare tasks required to support that particular student. These are often the same tasks that are undertaken by family members or carers when the child is not at school.

Due to some concerns from the community, ACT Health in collaboration with the Education and Training Directorate (ETD), has reviewed the needs of children in specialist schools and has undertaken a consultation process regarding HAAS and the role of nurses in specialist schools. The consultation process involved Health, ETD, teachers, unions and parents. This work will be completed by August 2015.

Pathology

Demand for pathology requests increased in 2014–15. Table 19 shows the number of pathology requests received, the total number of tests performed and the percentage increase.

Table 19: Pathology requests

	2013–14	2014–15	% increase
Total requests	571,650	599,443	4.64%
Total tests	5,185,660	5,250,641	1.30%

Australian Council on Healthcare Standards (ACHS) Clinical Indicators demonstrate timeliness of reporting of results for selected Canberra Hospital Emergency Department tests. As shown in Table 20:

- the potassium result is regularly above target
- the haemoglobin result regularly meets target
- the coagulation result is below target, which reflects a definition issue that does not take into account the centrifugation time required in sample preparation.

Table 20: ACHS Clinical Indicators

Test	2013–14	ACHS target
Potassium (% results in <60 minutes)	89.6%	81.5%
Haemoglobin (% results in <40 minutes)	89.8%	89.5%
Coagulation testing (% results in <40 minutes)	62.0%	70.0%

ACT Pathology holds Royal College of Pathologists of Australasia (RCPA) accreditation for medical postgraduate pathology training in all of the major pathology specialisations. We work in collaboration with the University of Canberra, ANU and CIT to continue to develop and support the various scientific and technical courses required to support medical laboratory science.

ACT Pathology staff undertake continuing education by attending external conferences of national associations and industry workshops.

Pathology Division is a scientific discipline with research as a cornerstone. We participate in many research projects and many of our pathologists and scientists are actively involved in their own research or work collaboratively with others.

Members of the division (scientific and medical) continue to publish actively in peer-reviewed journals and participate in professional meetings and workshops both in Australia and overseas.

Telemedicine services

The Telemedicine network is now established across Southern NSW and the ACT and incorporates:

- 12 hospitals in Southern NSW
- the two ACT public hospitals
- the SouthCare rescue helicopter base at Hume.

Health Pathways

The Division of Medicine clinical units have been a major player in the rollout of Health Pathways. This was developed in collaboration with the ACT Medicare Local to articulate and publish pathways of care across the continuum, in collaboration with Canberra and regional GPs.

Health Pathways has been developed to increase the quality of referrals to specialist services and improve the wait time for patients accessing specialist care. The system provides evidence-based guidelines to manage patients within primary care and triggers for specialist referral, which are promulgated by the tertiary specialist service.

Health Pathways went live on 13 April 2015 and was launch by the Minister for Health, Simon Corbell Member of the Legislative Assembly (MLA), on 25 May 2015. There are currently 70 live pathways, including pathways for:

- Diabetes
- Sexual Assault
- Early Breast Cancer Follow-up
- Blood borne virus exposure
- Deep vein thrombosis
- Cardiology
- Chronic Obstructive Pulmonary Disease.

Many more pathways are currently under development, including those for mental health services and liver conditions.

Awards and presentations

The Family-Integrated Care Program Team from NICU/SCN won the Public Team Excellence Award for their consistent commitment to parental involvement in care. The project team is examining whether the Family-Integrated Care model improves the health and wellbeing of prematurely born babies.

More information: For detailed information, see Future directions, Models of care, page 60, in this section.

Future directions

Emergency Department

The HPI Branch commenced a $23 million project to deliver an expansion of the Emergency Department at Canberra Hospital, which includes delivering an integrated paediatric streaming function. The project incorporated a $5 million commitment from the Commonwealth.

The expansion and refurbishment will improve the Emergency Department's layout, creating efficiencies that are expected to reduce waiting times. The works will include more comfortable sub waiting areas for patients waiting for treatment and a dedicated waiting and triage area for paediatric patients.

Acute Care services

The Medical Imaging Department will transition to the Division of Critical Care in 2015–16, to allow closer alignment between the department and other key stakeholders.

During 2014–15, the Capital Region Retrieval Service faced challenges in recruiting staff to its 24-hour roster. As such, in 2015–16, it will focus on identifying innovative ways to recruit further staff.

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.

As part of the strategy, further work is also being undertaken to formalise the management of staffing allocation and patient flow across the four inpatient wards during the high activity period. The capacity to have an overflow area (Paediatric Surgical Area) for increased admission numbers during winter is one of the components in addressing staff allocation and improved patient flow for the Emergency Department.

Currently, CHHS does not have clinics specifically for pulmonary hypertension or dyspnoea and has identified this as an area of need. Work has recently started in collaboration with Cardiology, Rheumatology and Respiratory and Sleep sub specialties to develop these services. Further research is being undertaken with regard to best practice and next steps.

The Division of Medicine has faced challenges over 2014–15 in meeting demand across all sub specialties. However, plans are in place to address this and improve access to medical services for all our patients across the territory.

Over the next year, an emphasis will be placed on the care of acute medical admissions to CHHS. This will include admission models of prevention, streamlining the flow of patients to inpatient services and streamlining discharging patients to appropriate services in the community. The Internal Medicine Unit Directors meeting will facilitate collaboration across all physician-based specialties, regardless of divisional structure.

The Division of Medicine will:

- refine the Acute General Medicine model, incorporating the Medical Assessment and Planning Unit (MAPU)
- continue to 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
- 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
- participate in the CHHS-wide Optimising the Patient Experience project, which will see the Division of Medicine improve access to home oxygen for clinicians and their patients discharged home from an inpatient ward.

Work is currently being undertaken in collaboration with all physician-based units at Canberra Hospital and acute allied health services to establish a physician-led Medical Admissions Unit. This unit will coordinate care and admission for referred patients from the Emergency Department to the most appropriate clinical team. This will create a more streamlined process from presentation to admission, and improve the clinical care provided to our patients, including reducing the length of stay.

The Division of Medicine has identified areas of improvement in the care of patients with Acute Coronary Syndrome (ACS) across the territory, and the transfer of these patients between Calvary Hospital and Canberra Hospital. The Division of Medicine is working with Calvary Public Hospital to ensure that improvements are aligned with the:

- Australian Commission on Safety and Quality in Health Care national standards
- clinical benchmarks
- indicators for these patients.

In conjunction with the work being undertaken to improve care for patients with ACS, Cardiology is working to establish a specific Coronary Angiography Computed Tomography (CT) Service. This service will build on existing cardiology services, such as the Chest Pain Evaluation Unit, and will serve to identify underlying cardiac conditions.

Early intervention and prevention

As a result of the positive feedback of the PARTY Program, the Shock Trauma Service will seek an alternative source of funding for the program to allow it to continue and expand in 2015–16.

Pathology

Pathology is working collaboratively with Health IT to introduce an electronic ward ordering system that will improve completion of mandatory information required for pathology testing and legibility. This will improve the accuracy of request information and provide decision-making support information to the requesting doctor. A pilot is expected to be available early in 2016.

Pathology works closely with clinicians at Canberra Hospital to ensure accurate patient identification in specimen collection for pathology testing. To support this, the electronic ward ordering system will include a positive patient identification (PPID) component, which will reduce misidentification and mislabelling of specimens.

The major challenge for the Division of Pathology is facing 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 while maintaining a skilled workforce operating 24 hours a day.

The future will see a significant increase in technology usage, including both automation and new technologies. This will require a workforce that is well informed and able to adapt to changes in laboratory practice.

Telemedicine services

The Telemedicine service will expand into managing moderately ill patients, with possible integration into the Canberra Hospital access unit and Emergency Department Admitting Officer roles.

Models of care

Enhancements to the Model of Care for both the Discharge Lounge and Medi-Hotel are planned. The aim is to improve access to the services and improve patient flow for patients being discharged from the hospital.

ACT Health has completed the framework to introduce a model of patient care that will allow privately practising eligible midwives to admit their private patients to the CHWC for birthing services. This Model of Care will be operationalised by the Division of Women, Youth and Children.

In some models of care in NICUs, parents spend significant 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 SCN at 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. 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 length of time.

The nurse-to-patient ratio will not change. It is estimated that this study will commence at the end of July 2014 and will be completed in August 2015.

Health Pathways

The Division of Medicine identified that patient care and patient experience could be enhanced by developing a Back Pain Pathway. Back pain is a relatively common problem in the Australian community with implications for:

- work productivity
- mental health
- interpersonal relationships
- the overall health budget.

Early initial intervention using a multidisciplinary approach is effective in reducing long-term disability. The project aims to streamline the flow of patients through the Emergency Department who present with back pain, and then ensure that the patients receive the best possible care through an efficient use of CHHS resources. A working group has been established to lead this work, which will examine the inpatient and outpatient experience across all CHHS divisions and review resources within the community.

The Division of Medicine will also enhance patient care by developing an Acute Stroke Pathway. It is developing, in collaboration with the ACT Ambulance Service and Calvary Public Hospital, an evidence-based, widely-endorsed pathway for caring for acute stroke patients across the territory. The pathway will aim to result in:

- improved timeliness to first intervention
- decreased mortality
- lower rates of disability
- increased adherence to evidence-based guidelines for the management of acute stroke.

While caring for patients with ST segment elevation myocardial infarction (STEMI) and Non-STEMI (NSTEMI) patients, CHHS has identified a need to improve the transfer of care pathways. CHHS is working with Southern NSW Local Health District (SNSWLHD) to improve the transfer of STEMI patients to Canberra Hospital for care. CHHS and SNSWLHD are currently working to improve communication lines between Southern NSW hospitals and Canberra Hospital and the management of patient care.

A Service Innovation and Redesign Framework (SIRF) project is being undertaken to manage the demand and flow of patients within GEHU who require outpatient clinic visits and procedures. This project aims to improve flow, to create efficiencies and to improve utilisation of available resources.

As part of the redesign work, the Service Lead will review endoscopy pathways with a view to streamlining, including reviewing the provision of additional anaesthetics assisted lists for high risk patients. The project is due to be completed at the end of the second quarter in 2015–16.

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

The Health Directorate provides a range of Mental Health, Justice Health and Alcohol and Drug Services through:

- the public and community sectors in hospitals
- community health centres and other community settings
- adult and youth correctional facilities
- people's homes across the territory.

These services work to provide integrated and responsive care to a range of services, including:

- hospital-based specialist services
- therapeutic rehabilitation
- counselling
- supported accommodation services
- other community-based services.

The key priorities for Mental Health, Justice Health and Alcohol and Drug Services are ensuring that:

- people's health needs are met in a timely fashion
- care is integrated across hospital, community, and residential support services.

This means focusing on:

- ensuring timely access to emergency mental health care
- ensuring that public and community mental health services in the ACT provide people with appropriate assessment, treatment and care that result in improved mental health outcomes
- providing community- and hospital-based alcohol and drug services
- providing health assessments and care for people detained in corrective facilities.

Overview

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 delivers services at a number of locations, including:

- hospital inpatient and outpatient settings
- community health centres
- detention centres
- other community settings, including people's homes.

During 2014–15, a significant number of the recommendations from the Child and Adolescent Mental Health Services (CAMHS) Model of Care were implemented, including:

- establishing a Bimberi CAMHS liaison role
- establishing a child early intervention program
- addressing comorbidity through training
- enhanced and routine screening
- establishing and strengthening liaison and consultation pathways with youth alcohol and drug services
- providing secondary consultation.

The services provided by the division 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 and Torres Strait Islander Mental Health Services
Adult Mental Health Day Service
Brian Hennessy Rehabilitation Centre
Crisis Assessment and Treatment Team
Mental Health Comorbidity Clinician
Mental Health Service for People with Intellectual Disabilities
Mental Health Consultation Liaison—the Canberra Hospital (TCH) and Calvary Hospital
Mobile Intensive Treatment Team- North
Neuropsychology
Older Persons Mental Health Team

Justice Health Services
Forensic Mental Health Services
Justice Health Primary Health
Secure Mental Health Unit (in development)
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
Police and Court Diversion Services
Opioid Treatment Service
Withdrawal Services

The Mental Health, Justice Health and Alcohol and Drug Services workforce is facing a challenge associated with the increase in growth across the service. A workforce plan will oversee the development of a workforce strategy, planning and development framework.

Mental Health, Justice Health and Alcohol and Drug Services commenced the preparatory phase of the Workforce Development for the Secure Mental Health Unit (SMHU). A workforce development and recruitment plan has been developed, which includes staging staff recruitment in line with the commissioning/staging of beds. Training opportunities, such as scholarships, will be offered to staff to facilitate their development in the area of Forensic Mental Health.

Performance against accountability indicators

Against the accountability indicators, Mental Health, Justice Health and Alcohol and Drug Services have:

- Exceeded the target of 109,000 occasions of service within the Adult Mental Health Services Program by 4 per cent. This achievement is in response to the demand for services and improvements in staff resourcing to meet this demand.
- Achieved 100 per cent against the target of 65,000 occasions of services within CAMHS.
- Exceeded the target of 100,000 occasions of service within the ACT-Wide Mental Health Services Program by 6 per cent. This higher than expected level of activity was predominately achieved due to the high levels of contact with the Crisis Assessment and Treatment Team.
- Achieved 100 per cent of all detainees admitted to the Alexander Maconochie Centre (AMC) having a completed health assessment within 24 hours of detention.
- Achieved 94 per cent against the target of 100 per cent of all young people admitted to Bimberi Youth Justice Centre having a completed health assessment within 24 hours of detention. This was due to four health assessments not being undertaken within the 24 hour period where:
  - one was due to a potential security risk of the young person as advised by Bimberi management and was completed approximately 48 hours after admission
  - three were due to health staff not being advised of the admission of the three young people, and were completed at 24.5, 27 and 27.5 hours after admission.
- Exceeded the target of 105,000 occasions of service within the Justice Health Services Program by 9 per cent. This can be attributed to an increased demand related to an increased muster at the AMC.
- Achieved the target of 98 per cent of all new clients on pharmacotherapy treatment for opioid dependency having a completed management plan.
- Achieved 97 per cent against the target of 70,000 occasions of services within the Alcohol and Drug Services Program.

More information: For additional information, see C.6 Statement of performance, Output 1.2: Mental Health, Justice Health and Alcohol and Drug Services, page 225.

Emergency mental health care

A review of the Mental Health Assessment Unit (MHAU) Model of Care is underway. A workshop was held in April 2015 and provided an opportunity to review current governance arrangements and clinical pathways. Final sketch plans have been completed for the mental health space within the Emergency Department. The AMHU Model of Care was reviewed in the context of the Canberra Hospital Emergency Department expansion, which is due for completion in 2016. The new footprint will support both an emergency assessment and mental health short-stay functions.

Mental health services

An Adult Community Mental Health Model of Care redesign project delivered a preliminary Model of Care and high-level implementation plan. It is anticipated that this redesign will support community mental healthcare that is evidence-based, contemporary and better meets the needs of the expanding Canberra community.

An Adult Mental Health Rehabilitation Unit (AMHRU) and an interim Adult Mental Health Day Service (AMHDS) Model of Care were both developed and finalised as part of the overall Service Delivery Plan for the University of Canberra Public Hospital (UCPH). The purpose of a specialist AMHRU is to deliver effective recovery-based treatment and rehabilitation to people whose needs cannot be met by less intensive community-based adult mental health services.

An AMHDS began operating from the BCHC in July 2014. This is an interim measure until an enhanced AMHDS is commissioned in the UCPH. The AMHDS provides treatment for adults aged 18–65 years and offers:

- subacute 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
- extended treatment and recovery programs.

A plan was developed in August 2014, to transition the residents of the Brian Hennessy Rehabilitation Centre (BHRC). The aim is to establish individual plans for the people currently supported at BHRC to access appropriate accommodation, supports and services to enable them to successfully reside in the community in the future. Information sessions were held to inform key stakeholders, family, carers and peak bodies of the transitional arrangements and plan.

Alcohol and Drug Services

Alcohol and Drug Services (ADS) continue to implement the pharmacist-led Nicotine Replacement Clinic for clients of the Opioid Treatment Service and withdrawal services. Opportunistic smoking cessation interventions are provided to clients:

- accessing alcohol and drug services
- accessing the AMHU
- in the BHRC.

ADS are part of a national research project, Tackling Nicotine Together, through Newcastle University.

Justice Health Services

The Model of Care for the SMHU was finalised in May 2014 and the facility design finalised in 2015. Significant work has occurred on the workforce plan for the SMHU.

Forensic Mental Health Services provided training on mental health awareness and processes to the magistrates of the ACT Law Courts. It is planned that this initiative will be further expanded to other agencies, such as:

- the Office of the Director of Public Prosecutions
- Magistrates Associates
- Legal Aid services.

A streamlined induction process was established at the Bimberi Youth Justice Centre. A review of this change is ongoing and is being supported by extra staff supervision and training.

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.

Justice Health Services has commenced the 2015–2016 Young Persons in Custody Health Survey. The survey will run from February 2015 to February 2016. The results from 50 or more young people who participate will provide further information regarding the health, sexuality, education, employment, social circumstances, alcohol and other drugs exposure of the young people. This information will be used to inform future service provision.

Future directions

Mental Health, Justice Health and Alcohol and Drug Services will be undertaking work to boost a range of services in the areas of:

- emergency mental health care
- mental health services
- alcohol and drug services
- justice health Services.

Emergency mental health care

As part of redesigning the Adult Community Mental Health Model of Care, the Crisis Assessment and Treatment Team will be expanded. This will provide additional intensive in-home support for people experiencing acute mental health problems.

Mental health services

The *Mental Health (Treatment and Care) Amendment Bill 2014* will be implemented on March 2016. A training program is being developed to ensure that all staff is familiar with their responsibilities under the new Act.

A new initiative will be established within the CAMHS and in partnership with education that will provide:

- early identification and treatment of children presenting with emerging mental illnesses/disorders
- mental health consultation and in-reach into primary health services targeted at children.

To improve pathways of care for Canberra Hospital patients with mental illness, Mental Health, Justice Health and Alcohol and Drug Services will also collaborate with Critical Care Services at Canberra Hospital. Representatives from the Adult Mental Health Services and ACT-wide Mental Health Services programs will also meet regularly with Critical Care.

The current community Adult Model of Care will be redesigned to ensure an improved integrated flow of patients from both inpatient and community settings—crisis, assertive outreach, clinic and home-based care.

A community mental health team will be established for the Gungahlin region. Currently services are provided to this area as an extension from the Belconnen Mental Health Team.

Staff will be recruited to develop the therapeutic program, provide training, and develop policy and standards for the new 25-bed SMHU.

The existing Consultation and Liaison service for people admitted to the general wards of Canberra Hospital who have mental health-related issues will be expanded. This will enable the service to operate after hours seven days per week

A 20-bed, 24-hour supportive accommodation service will be established for people with significant chronic and severe mental health issues. This initiative is a collaborative partnership with the Community Services Directorate (CSD).

Mental Health, Justice Health and Alcohol and Drug Services will also provide intensive support to people with psycho geriatric conditions living in residential care, or transitioning from an acute inpatient unit. This will provide assertive clinical assessment and treatment for Older Persons Mental Health Service (OPMHS) consumers residing in residential aged care facilities. The aim is to circumvent an acute psychiatric inpatient admission, wherever possible. Additionally, the service will assist in gradually transitioning consumers from an inpatient admission back into the community. It is envisaged that this service will reduce demand on inpatient beds.

The AMHU has experienced challenges in the timely discharge of some patients. Primarily this is related to accessing appropriate housing options. Work is progressing to improve inter-agency relationships, particularly with ACT Housing, Disability ACT and the NDIA taskforce, to:

- ensure the needs of these people are appropriately met in the community
- reduce the impact on acute mental health inpatient beds.

Alcohol and Drug services

In terms of alcohol and drug services, Mental Health, Justice Health and Alcohol and Drug Services will enhance the Alcohol and Drug Service Consultation and Liaison services at Canberra Hospital. This includes expanding to a seven day per week service and introducing a nurse practitioner to enhance expertise within this service.

Specialist Drug Treatment Services will:

- expand the outreach specialist medical, counselling and case management services provided at community health centres
- complement the existing services provided at Canberra Hospital.

Justice Health Services

The primary health team within Justice Health Services will be expanded to enable the effective delivery of health services within the AMC. This incorporates the proposed expansion of beds at the AMC between 2015 and 2016.

Output 1.3: Public Health Services

The aim of Output 1.3 is to improve 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
- 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 measures to reduce the risk to the health of the public from communicable diseases, environmental hazards and the supply of medicines and poisons.

Overview

The Population Health Division (PHD) has primary responsibility for managing population health issues within ACT Health. The division undertakes the core functions of:

- prevention
- assessment
- policy development and assurance.

It also contributes to:

- local and national policy
- program delivery
- protocols on population health issues.

In 2014, PHD 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 an independent, external analysis and opinion on the effectiveness of the directorate's approach to emergency management
- make recommendations for improvement.

The review was conducted between May and June 2014. It included:

- analysis of legislation, plans and policy
- interviews with executives and managers who execute emergency management arrangements.

The ACT Health Executive Council considered the external review report in late 2014 and again in April 2015. Of the eight recommendations made in the report, the council:

- fully agreed to three
- partially agreed to two
- disagreed with the remaining recommendations.

The agreed recommendations relate to:

- reviewing and simplifying ACT Health's current suite of emergency plans, including the Health Emergency Plan
- clarifying identified triggers for internal escalation of emergency response
- providing a dedicated emergency exercise program and budget for the directorate
- renaming and clarifying the roles of the unit that provides core emergency management support to the Chief Health Officer and the broader directorate.

The PHD is now developing an implementation plan in line with the Executive Council's determinations and will report regularly to the council on implementation progress.

Performance against accountability indicators

On 27 November 2014, the *Food Amendment Bill* was passed by the Legislative Assembly. The bill introduced provisions to reduce red tape for food businesses and non-profit community organisations that sell food for fundraising purposes.

More information: Detailed information about the amendment is provided in the C.6 Statement of performance, Output 1.3: Public Health Services section, page 204.

From 1 January 2015, food businesses have had the option of registering under the *Food Act 2001* for up to three years, rather than annually. Food businesses that were required to notify their details to PHD are no longer required to do so, and the $57 fee previously charged to businesses for changing or updating their details has been abolished.

From 20 April 2015, eligible non-profit community organisations have been removed from the operation of the *Food Act 2001*, meaning there are no restrictions on the types of food they can sell as part of their fundraising activities. The changes have:

- reduced the regulatory burden on these organisations
- provided an incentive to sell more nutritious foods, such as salads, sandwiches and fruit, at community fundraising stalls.

In line with ACT Government regulatory reforms and reducing red tape, PHD began implementing multi-year licenses and registrations for businesses and individuals. The aim was for 20 per cent of all licenses and registrations to be multi-year by the end of the financial year. The Health Protection Service was able to progress this program earlier than anticipated and achieved 100 per cent compliance in this area.

More information: For additional information, see C.6 Statement of performance, Output 1.3: Public Health Services, page 204.

As part of a continuous review process, updated tobacco compliance testing procedures were introduced on 9 December 2014. The updated procedures clarify recruitment and training requirements, and streamline administrative processes. Compliance testing is an essential regulatory tool used across Australia to help reduce tobacco sales to young people.

Altering the ACT environment

On 8 December 2014, the ACT Health Air Quality Monitoring website was launched at the Health Protection Service. The website includes an Air Quality Index (AQI) value to indicate the cleanliness of ACT air; the lower the index, the better the quality of the air.

The AQI provides a number that allows easy comparison of different pollutants, locations and time periods. The website provides real-time air quality data from the three air quality monitoring stations operated by ACT Health, which are located at:

- Monash
- Civic
- Florey.

The stations at Monash and Florey monitor the following five pollutants:

- carbon monoxide
- nitrogen dioxide
- ozone
- particulate matter less than 10 microns (PM10)
- particulate matter less than 2.5 microns (PM2.5).

The air quality station at Civic monitors ozone, PM10 and PM2.5.

Interventions and mitigations

To provide a collaborative and transparent approach to food regulation issues, PHD has established a Food Regulation Reference Group (FRRG), which meets quarterly. The FRRG first met in September 2014. Members include representatives from:

- industry
- public health and consumer groups
- ACT Government stakeholders.

The PHD also drafted and coordinated input into the ACT Government Submission to the Standing Committee on Health, Ageing, Community and Social Services inquiry into the exposure draft of the *Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014* and related discussion paper.

The PHD also developed the ACT Government submission to the Senate Legal and Constitutional Affairs Legislation Committee inquiry into the Regulator of *Medicinal Cannabis Bill 2014*.

In February 2015, a team of 11 public health officers conducted food inspections during the three-day National Multicultural Festival as part of a strategy to minimise public health risk from serious breaches of the *Food Act 2001*. During inspections of food stalls, public health officers routinely look for issues (breaches) that would give rise to unacceptable food safety risks including:

- inadequate temperature control
- poor hand washing facilities
- inappropriate food storage.

Over 290 inspections were conducted during the event. A number of food safety breaches were identified, resulting in five incidents of voluntary disposal of food. No food was seized.

In May 2015, an extensive property clean-up was conducted under the *Public Health Act 1997* due to an insanitary condition. The property had an accumulation of food and other material in and around the house. The food was decaying, odorous, providing harbourage for vermin and impacting on neighbours. Due to the tendency for this occupant to relapse and difficulties in managing hoarding cases, PHD has begun developing a multi-agency model for handling hoarding cases.

On 7 May 2015, PHD hosted a forum for the staff of aged care facilities. The aim of the forum was to provide aged care facilities with information and advice for preventing and managing influenza and gastroenteritis outbreaks. It covered topics such as:

- the epidemiology of influenza and gastroenteritis in the ACT
- influenza vaccination
- outbreak management
- infection control.

Presenters at the forum included staff from PHD and Canberra Hospital. More than 20 representatives from facilities in the ACT attended the forum.

The Drugs and Poisons Information System (DAPIS) was successfully deployed in PHD in September 2014. DAPIS collects and records information about prescribing and supplying controlled medicine in the ACT. DAPIS enables pharmacies to submit electronic reports of controlled medicine supplies to PHD, which is used for monitoring purposes. All ACT pharmacies are now submitting their reports electronically to PHD every month (Phase 1). Phase 2 of the rollout will result in pharmacies reporting dispensing information in real-time. This is dependent on pharmacy software vendors making necessary updates to software. PHD is assisting software vendors in this regard.

The ACT Chief Health Officer served a Disciplinary Notice on an ACT practicing pharmacist for failing to record controlled medicines dealings as prescribed by regulation and demonstrating a lack of accountability for controlled medicines. The proposed disciplinary actions included:

- a formal reprimand
- cancellation of the pharmacist's authority to deal with controlled medicines
- cancellation of the pharmacist's Opioid Dependency Treatment Licence
- a copy of the final disciplinary Decision Notice being forwarded to the Pharmacy Board of Australia.

The final disciplinary action was reduced to a formal reprimand for the contraventions of the *Medicines, Poisons and Therapeutic Goods Act 2008*.

Health status evaluations and reports

The PHD undertook or published the following population health surveys and data collections in 2014–15:

- The ACT General Health Survey (GHS), which is a telephone computer-assisted technology household survey that collects information on a range of factors influencing health status.
- The ACT Secondary Students Alcohol and Drug Survey, (ASSAD), which is a classroom-based questionnaire collecting information on risk behaviours of ACT secondary school students, including alcohol, tobacco and illicit drug use.
- Finalised the collection of birth and death data from The ACT Registrar of Birth, Death and Marriage.

The division also:

- improved the completeness and timeliness of maternal and perinatal data and continued to report nationally against key indicators
- increased availability of public hospital data for data-linkage purposes
- through the NSW Cancer Institute, improved the quality and efficiency of ACT cancer registry data collection.

To inform the future strategy of the ACT Cancer Registry an independent review was undertaken by experts in the field. Key recommendations are being implemented to improve the relevance, timeliness and flexibility of the information collected and able to be reported for public health benefit.

The PHD continued to monitor, analyse and report on the health outcomes across the population through a variety of methods and formats including:

- Completing a proof of concept internet-based project to provide more timely access to population health data.
- Continuing capacity building to link different data sets through data-linkage with the Centre for Health Record Linkage in New South Wales. This provides an invaluable tool to better understand health challenges and outcomes across the ACT community. For example, ACT Health is collaborating on a project, using data-linkage to better understand the outcomes of cardiac care, with the aim of improving services.
- Continuing a partnership with the National Health and Medical Research Council's (NHMRC's) Australian Prevention Partnership Centre. The centre focuses on the primary prevention of chronic health conditions.
- Partnering with the ANU, after winning an Australian Research Council grant in 2012. This includes providing support for a PhD student research internship focused on dementia.

Health hazards and countermeasures

Exercise Melilla

On 26 March 2015, PHD conducted a functional one-day exercise, named Exercise Melilla. The exercise took eight weeks to plan and develop and aimed to validate the preparedness of the ACT Health sector to identify, transport and treat a suspected case of Ebola Virus Disease (EVD).

The scenario for Exercise Melilla involved:

- a role-player patient presenting at Calvary Hospital
- activating public health protocols by the Health Protection Service, Communicable Disease Control
- transporting the patient to Canberra Hospital via ACT Ambulance Service for reception and testing.

The exercise included approximately 60 participants across four sites, and was a timely and valuable opportunity to practice infectious disease response coordination.

Deregulation

As part of the ACT Government's ongoing commitment to reducing red tape, PHD assessed public health regulation to identify areas that may be deregulated without compromising public health. The division's historical data showed that the ACT's licensed boarding houses and hairdressing businesses had high rates of compliance with public health requirements. The risk to public health from licensed boarding houses and hairdressers was therefore considered minimal.

Based on this assessment the Minister for Health concluded that it should no longer be necessary for:

- boarding houses and hairdressing businesses to be declared public health risk activities or
- the occupation of hairdressing to be a declared public health risk procedure.

Accordingly, the Minister for Health determined that from 1 January 2015 licenses under the *ACT Public Health Act 1997* would no longer be required to operate a boarding house or a hairdressing business. The Health Protection Service has retained regulatory powers under the Public Health Act 1997 to address any condition that is, or may become, a public health risk or be offensive to community health standards. PHD will continue to investigate any public health complaints received from the community concerning practices at boarding houses and hairdressing businesses.

Measles

In 2014–15, eight cases of measles were notified in the ACT. All eight cases were in children that that had not been immunised. Four cases acquired their infections overseas. The remaining four cases were a family cluster with an unknown source of infection although likely acquired interstate.

An increase in overseas-acquired measles cases has been observed nationally in recent years, highlighting the importance of measles vaccination, especially prior to overseas travel.

In March 2014, Australia achieved measles-free status, as declared by the World Health Organisation (WHO). This means that Australia has:

- no local strain of measles circulating in the community
- well-performing surveillance systems to rapidly detect and respond to measles cases.

Achieving measles-free status does not mean the complete absence of the disease in Australia, but recognises that cases will continue to be imported by travellers from countries where the disease is prevalent. PHD investigates and implements disease control measures for each confirmed case of measles under national guidelines. Since the beginning of 2010, 32 cases of measles have been notified in the ACT.

Medicines Advisory Committee

The *Medicines, Poisons and Therapeutic Goods Regulation 2008* was amended on 23 October 2014 to increase the membership of the Medicines Advisory Committee from three to seven members. The Medicines Advisory Committee is an independent statutory committee that provides advice to the Chief Health Officer on complex matters relating to prescribing controlled medicine. The committee was expanded to allow a broader range of expertise and includes new pharmacist, pain or addiction specialist, GP and consumer positions.

Ebola Virus Disease

In April 2015, a multi-agency health response was required to investigate and manage a returned Health Care Worker (HCW) from Liberia who reported symptoms consistent with early Ebola Virus Disease (EVD). The HCW reported no known contact with Ebola cases and was considered as low risk for having acquired Ebola.

A multi-agency response was enacted by the:

- Population Health Division (PHD)
- Canberra Hospital and Health Services (CHHS)
- ACT Ambulance Service (ACTAS).

The HCW was transported to Canberra Hospital for treatment and testing. The HCW was subsequently confirmed negative for EVD and discharged to home quarantine.

Following the response the division implemented a detailed After Action Review plan to capture relevant response diagnostics from participating agencies. A multi-agency debrief with PHD, CHHS, ACTAS and CSD was conducted on 23 April 2015. Findings from the multi-agency debrief concluded that overall the multi-agency response had worked well. Diagnostics identified a number of strategic-level improvements that could be realised. The recommendations arising from the review to streamline and strengthen future EVD responses will be managed through the Health Emergency Management Sub Committee, which is chaired by the Chief Health Officer.

Future directions

Behavioural changes

As part of Future directions for tobacco reduction in the ACT 2013-2016, PHD will investigate options to further restrict places of tobacco use. This will include a community consultation on creating new smoke-free areas in the ACT, with the aim of reducing the exposure of the community to environmental tobacco smoke.

The PHD will also continue to work on improving the policy and legal framework that supports organ and tissue donation in the ACT. Amendments to arrangements related to organ and tissue donation aim to enhance efficiency and maximise clinical outcomes for organ recipients.

Interventions and mitigations

The division will continue to progress work to address the potential public health issues associated with the sale and use of electronic cigarettes.

Health status evaluations and reports

The PHD will continue to work towards enhancing knowledge of and raising awareness regarding the health risks associated with exposure to loose-fill asbestos.

Health hazards and countermeasures

PHD will continue to progress work on improvements to food regulation in the ACT, including its transparency. This work includes:

- improving stakeholder engagement
- further developing tools used by public health officers, for example guidelines, manuals and procedures
- improving information for food businesses and the public
- implementing a staff development program
- developing IT solutions to improve both data integrity and the efficiency and transparency of the food regulation system
- improving the effectiveness of food safety services.

PHD continues to progress work on improving controlled medicines regulation in the ACT. Consultation was undertaken in 2013 on a proposed model to remove the current Chief Health Officer approval requirement for prescribing controlled medicines. This was to be coupled with improved prescription monitoring by PHD using pharmacy data.

While the majority of stakeholders supported the proposal, some stakeholders have raised concerns that removing the current safeguards will put patients at risk. PHD is currently considering an alternative model to retain the approvals system for consideration by the Minister in 2015–16.

As various inquiries into matters related to the medicinal use of cannabis are finalised, additional issues will need to be considered and significant analytical policy work will continue.

Output 1.4: Cancer Services

The division of Cancer, Ambulatory and Community Health Support provides:

- Canberra Region Cancer Services inclusive of a comprehensive range of cancer screening, assessment, diagnostic and treatment services
- palliative care services
- administration support to Ambulatory and Community Health sites.

Services are provided in inpatient, outpatient and community settings.

The key strategic priorities for cancer care services are early detection and timely access to diagnostic and treatment services. These include:

- ensuring that population screening rates for breast and cervical cancer meet targets
- ensuring that the waiting time for access to essential services, such as radiotherapy, are consistent with agreed benchmarks
- 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.

The division is also responsible for providing administrative and clinical support services across Canberra Hospital and Health Services, including:

- intake
- referral management
- booking and scheduling
- clinic management
- nursing and allied health to Central Outpatients
- transcription services.

Overview

Services commenced in the Canberra Region Cancer Centre (CRCC) on 18 August 2014. The centre is designed to improve the integration and standard of care to people with cancer in the ACT and surrounding region. A Medical Oncology Nurse Practitioner position has been recruited. In 2015–16, this position will be integrated into the operations of the CRCC Rapid Assessment Clinic.

More information: Detailed information about the CRCC is provided in the Canberra Region Cancer Centre section, page 31.

Cancer Services provided 1,428 radiotherapy treatment courses for new and returning patients during 2014–15. This is a 4.4 per cent increase on the same period last year. New referrals increased by 5.9 per cent during 2014–15.

Cancer inpatient services increased with the opening of eight extra beds in ward 11C. This ward is designed to assist patients with their transition:

- between acute care services and the community prior to discharge
- during interstate transfers
- when having radiation treatment that require an inpatient bed
- from ward 14B to an awaiting a nursing home placement.

During 2014–15, the Centre for Personalised Immunology was established. Clinicians from the Department of Immunology worked in collaboration with the centre and a broader collaborative network of Australian and international clinicians and scientist.

Cancer Services also developed Cancer Psychosocial Service introduction postcards, which are designed to support access to and normalisation of psychosocial support for patients and families/carers following a cancer diagnosis.

Two DVDs were developed and launched in 2014–15 to assist people when they or someone they care for is experiencing cancer:

- one DVD was for patients requiring radiotherapy, outlining what to expect during treatment
- the second DVD was for health professionals to assist in end-of-life conversations.

The DVDs were developed with input from patients and carers. Funding sources included Dry July.

Performance against accountability indicators

BreastScreen ACT's access and uptake has continued to improve during 2014–15:

- 99 per cent of women wait less than 28 days for a screening appointment.
- For women requiring further investigation at an assessment clinic, 90 per cent were provided an appointment within 28 days from their initial breast screening appointment.
- 99.95 per cent of women with a normal result received a letter within 28 days.

Breast and cervical cancer screening

Achieving a 60 per cent participation rate in breast screening in the ACT remains a challenge for the BreastScreen Australia Program.

Despite efforts, breast screening participation for the 50–69 year old cohort in the ACT has remained steady at 55 per cent. Efforts to encourage GPs to refer women to the program will be a focus in the coming year.

More information: Detailed information is provided in the BreastScreen Australia Program section, page 71.

Essential services wait times

With the appointment of new specialists within Haematology the waitlist has been reduced from six months to triage category timeframes. This also provides the ability to continue to refine and improve the multidisciplinary approach to lymphoma care and clinics.

The Haemophilia Treatment Centre (HTC) has been established and provides information and educational material for patients of all ages and their family and carers.

Following receipt of a funding grant, the HTC has commenced an outreach program for:

- medical practitioners
- nursing staff
- paramedics
- local school teachers
- patients living in the rural NSW adjoining to ACT region and their families.

To date, two programs have been undertaken involving an education program and follow-up visits by the haemophilia care providers.

Both programs were very successful, increasing the attendee's knowledge of haemophilia and other bleeding disorders, and identifying the challenges that regional and rural families face.

BreastScreen Australia Program

From November 2014, BreastScreen ACT used Electoral Roll data and lapsed attendee reports to send breast screening invitation letters to women in the target age group (50–74 years). From November 2014 to 30 June 2015, BreastScreen ACT sent invitations to 10,370 women identified from the Electoral Roll.

The program also instigated:

- follow-up phone calls to lapsed attendees
- letters and education sessions to GPs
- community information sessions
- stalls at various conventions
- resource distribution.

Also in November 2014, BreastScreen ACT implemented the BreastScreen Information System (BIS). This is an electronic record keeping system, which is linked to the Picture Archival and Communication System (PACS). The implementation of the BIS aims to streamline administration and clinical processes, and better support the program's reporting requirements.

Within the reporting period, the Breast Cancer Treatment Group completed 15 years of breast cancer treatment data from the ACT and Southern NSW Region. This significant body of work will provide cancer services in the region with data on the treatment outcomes for women with breast cancer. The report is due for release in October 2015.

BreastScreen ACT was awarded a Reconciliation Recognition Certificate for work with the Aboriginal and Torres Strait Islander community in the ACT.

Administrative and clinical support

The Ambulatory Care Administration Model project saw significant progress in relation to standardisation of administration processes across CHHS. This included significant work to address problems with ambulatory care data reporting.

While the Ambulatory Care Administration Model has progressed in relation to standard processes, the required structural changes are still being implemented. The model's success is dependent on these changes in structure and governance, which will be fully implemented by the end of 2015.

A major restructure of ACTPAS clinics commenced in June 2015. This will enable improved data reporting for all ambulatory services and provide:

- a clinic hierarchy reflective of the current organisational structure
- allow for comprehensive territory and national reporting of non-admitted services
- allow for more comprehensive and flexible reporting at a local level to assist with service planning activities.

Transcription services resolved the backlog in transcribing, which was due to the significant increase in demand for outpatient services at Canberra Hospital. This was achieved by increasing the use of outsource providers. It has resulted in all specialities achieving receipt of letters for approval within the five day performance indicator.

Community Health Intake successfully incorporated the ACT Health Dental Program Intake. This provides a single point of intake for a wider range of community-based services. It resulted in call volumes increasing by 50 percent over the year compared to the previous year.

Oncology

The Medical Oncology Research Unit received a grant of $50,000 from the Monaro Committee for Cancer Research, to support its research program.

The Department of Medical Oncology continues to contribute to collaborative research with 16 clinical studies open to enrolment. In 2014–15, it:

- published 18 journal articles and four book chapters
- had an additional five papers accepted for publication
- contributed to 42 research abstracts presented at various local, national and international conferences.

ACT Health became a formal research partner of the Centre for Oncology Education and Research Translation (CONCERT), which is:

- a collaboration between cancer research groups within South Western Sydney, Illawarra Shoalhaven and the ACT Health districts
- funded by a grant from the Cancer Institute NSW.

The aim is to systematically and collaboratively study specific cancers in-depth and to develop new technologies and methods to improve treatments, quality of life and outcomes for patients with cancer.

Radiation Oncology has increased active participation in clinical trials. The department's strategic research directions align with national cooperative clinical trial research groups, such as the Trans Tasman Radiation Oncology Group (TROG). There are high levels of representation, engagement and contributions from all clinical groups within the department.

The Radiation Oncology Private Practice Trust Fund continues to support a significant number of research personnel within the department. This has had a positive effect in:

- progressing the research
- developing and implementing new technologies and making these available to patients
- implementing investigator-initiated projects, enabling the education and further specialisation of radiation oncology staff.

Awards and nominations

A number of awards and nominations were received during 2014–15:

- The Centre for Personalised Immunology was recently awarded a prestigious National Health and Medical Research Council (NHMRC) Centre of Research Excellence grant.
- The Palliative Radiotherapy Rapid Access Clinic (PRRAC) project team were finalists in the ACT Quality in Healthcare Awards in the category of Access and Efficiency.
- The 2014 Award for Allied Health Team Excellence was awarded to the Stereotactic Radiosurgery (SRS) team in recognition of outstanding commitment to the development, trial and implementation of a multidisciplinary SRS treatment service.
- The Palliative Care team were winners in the ACT Public Service Awards for Integrity, with recognition of how the team worked together to take responsibility and accountability for health support and care decisions and actions. All team members provide the upmost patient care with compassion, understanding, dignity and respect.

Future directions

During 2015–2016, Cancer Services will:

- continue the growth of translational research and clinical trials
- expand multidisciplinary team services, including a specific Myeloma multidisciplinary team (MDT) and clinic
- develop a sub specialty thrombosis, haemostasis and platelet service, which will be achieved with the appointment of an eighth staff specialist.

Models of Care for cancer services will continue to be developed, to enable improved quality of care while addressing the increasing demand for services

Survivorship Model of Care data is still being analysed to determine future directions that are important in providing this service.

Breast and cervical cancer screening

A breast screening clinic will open at the BCHC in the latter half of 2015. This will increase accessibility and ensure an increased capacity to accommodate the expansion of the target age group to target women aged 70–74 years.

Administrative and clinical support

When the Ambulatory Care Administration Model is fully implemented, the focus across CHHS will be to embed standardised processes and create sustainable systems, supported by appropriate technologies. Ultimately this will allow all processes across the continuum from referral to discharge to be better managed, including ambulatory care waiting list management.

While transcription services have dramatically improved over the past year, a review of the current model is needed. This review will consider a number of options to provide an efficient, timely, flexible and sustainable transcription service across CHHS.

An education package designed to increase awareness of haemophilia in Canberra Hospital and other health care providers is being developed.

Community Health Intake is planned to expand to provide a comprehensive intake service across CHHS over the coming year. This will assist in achieving a single point of intake for consumers of ACT Health services.

Radiation Oncology

Technology capabilities are a critical component of the Radiation Therapy service. Updated technology through the Radiation Oncology Major Equipment program provides efficiencies and improvements to radiation therapy services. Planned future replacement of end-of-life major equipment will provide further efficiencies and improve access to more targeted radiation therapy treatments, such as Intensity Modulated Radiation Therapy (IMRT).

The planned integration of the ARIA oncology information system with other ACT Health systems will support:

- increased efficiency
- streamlined processes
- establishing an electronic medical record.

Implementing new technologies enables improved treatments and outcomes for patients. However, the increasing complexity, planning and treatment time is resulting in an increase in demand for Radiation Oncologists, Radiation Therapists and Physics groups and presents ongoing challenges to ensure patients are treated within safe timelines.

Radiation Oncology will continue developing the following clinical projects:

- Expanding verification imaging capabilities, including developing a credentialing program.
- Developing respiratory gating, including:
  - 4D image acquisition, to improve tumour definition
  - deep inspiration breath hold techniques, to reduce the radiation dose to critical organs.
- Expanding the application of IMRT to include prostate cancer treatment.
- Expanding the use of ARIA, which is the oncology information management system.
- Developing scripting to automate radiotherapy treatment planning system processes and provide process efficiencies.
- Increasing access to IMRT in Radiation Oncology from the current 12 per cent of patients to the recommended 30 to 40 per cent, depending on clinical case mix.

Output 1.5: Rehabilitation, Aged and Community Care

The aim of Output 1.5 is to provide an integrated, effective and timely response to rehabilitation, aged care and community care services in inpatient, outpatient, Emergency Department, subacute and community-based settings.

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

- 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
- improving discharge planning to minimise the likelihood of re-admission or inadequate support for independent living, following completion of hospital care
- ensuring that hospitalised older persons wait an appropriate time for access to comprehensive assessment by the Aged Care Assessment Team (ACAT), which assist in their:
  - safe return home with appropriate support
  - accessing appropriately supported residential accommodation.

Overview

The Exercise Physiology Department commenced input into the School Kids Intervention Program (SKIP), which is a family-centred, multidisciplinary service within the Division of Women, Youth and Children for children aged 4–12 years who are overweight or obese. The program was developed based on the recommendations of the Obesity Service Redesign Project 2012. It has been developed with the aim to support a number of ACT Government's plans and strategies, including the:

- Children's Plan 2010–14
- Towards Zero Growth Healthy Weight Action Plan.

The program commenced in March 2015 and aims to improve the health and wellbeing of children and their families.

More information: For detailed information about SKIP, see Output 1.6: Early Intervention and Prevention, Programs Promoting healthy lifestyle choices, page 88.

The Veteran Liaison Service successfully hosted an ANZAC Day Service to commemorate the 100th Anniversary of the landing at Gallipoli. A representative of the Turkish Embassy attended the service.

The Veteran Liaison Service received a 'Love Award' from the Canberra Hospital Foundation to refurbish their lounge and kitchen area.

The RACC Psychology and Counselling service has been restructured to include new graduate and junior positions for clinical psychology and neuropsychology. They, along with the Speech Pathologists, have been responsible for introducing a Cognitive Remediation Program for patients both in hospital and in the community. The aim of this program is to increase and improve the cognitive re-training of patients.

Performance against accountability indicators

The Community Nursing and Allied Health performance exceeded the 2014–15 targets for:

- number of nursing occasions of service, which was set at 82,000
- number of allied health regional services, which was set at 22,600.

This was achieved by:

- recruiting additional allied health and nursing positions, which expanded community-based services
- implementing changed models of care.

More information: For additional information, see C.6 Statement of performance, Output 1.5: Rehabilitation, Aged and Community Care, page 231.

Rehabilitation

In May 2015, the Rehabilitation and Aged Care Outpatient Clinics relocated to larger premises. The new location in Building 3 of Canberra Hospital provides patients with a more relaxed environment, which assists both the clinician and patient during the assessment or consultative process.

Speech Therapy began using iPads in the inpatient wards (12B and RILU). The aim was to increase therapeutic communication time by introducing innovative activities. This activity has provided the following benefits:

- assisted when running small communication groups
- allows patients to practice independently between sessions
- has indirectly increased social communication between patients on the wards

- allows interactive language and speech practise using app technology
- can also be used to assist patients with cognitive communication difficulties in working on cognitive domains such as attention, memory and executive function.

Speech Pathology services use began using telehealth in MDT settings.

Aged care

Reduced access to residential aged care beds has continued to impact on the average length of stay. However, with the opening of new beds across the ACT (in July 2015) this may improve.

Community care

A number of community-based services have reported growth in demand.

Podiatry referrals have increased from by 11.23 per cent from 2013–14 to 2014–15. Physiotherapy referrals increased by 21.5 per cent over the same period.

Referrals for palliative care to the Community Care Nursing service are expected to rise in response to the increased need for primary palliative care services for the ACT community. This will place pressure on the existing capacity of Community Nursing, who will continue to work with Calvary Hospital Home-Based Palliative Care, who provides the specialist component of palliative care services.

The improved Community Nursing performance can be attributed to increased capacity of the service, with growth funding available to the City, Tuggeranong and Belconnen nursing teams. In addition, the foot clinics, which were previously attended by Community Nursing, are now provided by the Podiatry team.

An additional RN was recruited to the Self Management of Chronic Conditions Program in early 2014. This has resulted in increasing the number of chronic conditions group courses by 48 per cent.

The community-based allied health services have also grown, with the Community Podiatry, Nutrition and Physiotherapy teams expanding.

Physiotherapy Assistants review clinics have been implemented in our community team while Occupational Therapy assessment clinics have also been established at the Independent Living Centre (ILC). Our Community Nutrition team has commenced services to renal patients at Belconnen and Tuggeranong Community Health Centres.

The Community Rehabilitation Team (CRT) and Falls Assessment and Prevention Services have also expanded with introduction of additional:

- Occupational Therapists
- Physiotherapists
- Allied Health Assistants.

Dementia care

Canberra Hospital is one of four national hospitals selected to be a national partner with Ballarat Health Services, to implement and evaluate the Dementia Care in Hospital Program (DCHP). This program is funded by the Commonwealth Department of Social Services (DSS). It is an all of hospital education program aimed at improving hospital care of patients with cognitive impairment. ACT Health Human Research Ethics Committee approval is currently being sought. Alzheimer's Australia is a strong supporter of the project. Its representative and a representative of the Health Care Consumers Association (HCCA) will be involved in the project steering group.

Referrals to the Driver Assessment and Rehabilitation Service (DARS) have increased, especially for older drivers with dementia, which presents an ongoing challenge. An increase of approximately 100 referrals to this service has been recorded over the last two years.

Access to services

The Transitional Therapy and Care Program (TTCP) occupancy continues to increase, with an expected occupancy for 2014–15 of approximately 80 per cent. This has been achieved by altering the service model and improving the staffing profile.

Demand for our equipment services has also increased:

- As at 30 June 2015, the Domiciliary Oxygen and Respiratory Support Scheme (DORSS) were supporting 1,356 clients compared to 1,228 clients at 30 June 2014. This is an increase of 10 per cent.
- The Equipment Loan Service (ELS) provided 10,722 items of equipment to clients in the community to facilitate hospital discharges and aid rehabilitation. In 2013–14, 10,222 items were provided. This was an increase of 500 items.

As part of a joint initiative between CRT and the Palliative Care service from Calvary Hospital, the cross-service clinic model for clients with Motor Neurone Disease (MND) was reviewed. Changes were made to improve the continuity of care for clients attending and increase satisfaction of the team.

Video-teleconferencing was also introduced for clients with MND in regional NSW.

RACC continues to actively support student education. Health Workforce Authority (HWA) funding received in 2014–15 was used to provide four staff members with experience in clinical educator positions. This activity was undertaken as a part of a succession planning and retention strategy.

The Coordinator of Community Geriatric Service Rapid Assessment Deteriorating Aged at Risk (RADAR) Service, Geriatric Outpatients and Memory Assessment Service (ROM) commenced within the RACC team in January 2015. This has resulted in a more unified approach to the outpatient-based services provided by RADAR, Geriatric Outpatient Clinics and the Memory Assessment Service.

Hospitalised older persons

In September 2014, the Sub-acute Geriatric Unit (SAGU), ward 11B, was established in Canberra Hospital. This unit is staffed by an MDT and increased the inpatient bed capacity of Canberra Hospital by 18. These 18 beds comprise:

- 10 subacute geriatric beds
- eight beds for non-acute patients awaiting residential aged care placement.

This allowed eight inpatients residing at Goodwin Aged Care Service Monash to transfer back to Canberra Hospital.

The falls minimisation rooms in wards 11A and 11B were both highly praised by the surveyors in the May 2015 National Safety and Quality Health Service Standards (NSQHSS) survey.

Awards and presentations

A number of RACC staff received awards during 2014–15:

- Laura-Jayne Van Alphen was awarded the Allied Health Professional of the Year 2014.
- Kathryn Pettigrove was nominated for Early Career Excellence Award for 2014 and was awarded with a Recognition of Service.
- Jaspreet Singh was awarded the Allied Health Assistant of the Year 2014.
- The RACC Inpatient Leadership Team was nominated for a 2015 ACT Nursing and Midwifery Excellence Award.

A number of RACC staff gave notable presentations during 2014–15:

- The Physiotherapy Clinical Educator presented at the World Congress of Physical Therapy in Singapore on her PhD research findings on Stroke Rehabilitation.
- Dr Sarah Walker, Clinical Psychologist, presented at the 2014 Canberra Health Annual Research Meeting on her PhD findings concerning Driving Cessation in Later Life.
- Mr Yu-Lung Chan and Dr Harriet Downing presented at the 2014 Allied Health Symposium, The Brain That Trains Itself, outlining cognitive remediation and its application in a rehabilitation setting.
- The Exercise Physiology Department presented a research poster at the ACT Health Allied Health Symposium, demonstrating the value of implementing a behaviour change tool designed to assist patients in self managing their condition.
- Clinical Technology Services (CTS) presented a paper and a poster at the Australian Rehabilitation and Assistive Technology Association (ARATA) national conference held in Canberra in August 2014.

Future directions

The Australian Government continues to implement significant reforms of the aged care and disability sectors, which present challenges to the:

- operations and funding of RACC services
- communications to RACC clients, referrers and the community.

Rehabilitation

Growth funding received in the 2015–16 budget will be used to establish a new community-based rehabilitation service. This will increase collaboration with inpatient services and increase a seamless transition between services.

A cognitive remediation working group will be developed for patients who have had a stroke or have a traumatic brain injury.

Dementia care

The Dementia Care in Hospitals Program will be implemented from July 2015. The program aims to raise awareness of and support for more dementia-friendly and supportive environments in Canberra Hospital.

Wards 11A, 6A and 5A will be pilot wards for the program.

Access to services

From 1 July 2015, ACT ACAT will transition to the My Aged Care system. The transition period for ACT ACAT is from 1 July 2015 to 1 September 2015, when it is expected the ACAT will be fully operational within the My Aged Care portal.

My Aged Care will become the single mandatory gateway into aged care services, and will:

- implement a central client record
- implement a nationally consistent standardised screening and assessment process
- manage electronic referrals via the My Aged Care online portal
- strengthen consumer-directed care.

The planning process for moving outpatient clinics to Building 15 will include:

- determining whether reduced space will impact services
- determining if some clinics may be better placed in the Community Health Centres
- using the staging and decanting process to ensure a smooth transition into the new premises.

Occupational Therapy will continue to trial an alternative model of service delivery to ensure equity of service delivery to subacute and chronic neurological caseloads. The goal is to provide a timely, early intervention, interprofessional rehabilitation service to consumers.

RACC continues to be an active participant in a range of Health Infrastructure programs including the establishment of the UCPH. Planning continues for UCPH, which is scheduled for opening in early 2018.

During 2015–16, the Cognitive Remediation Program will be evaluated and quality improvements will be completed.

Lee Silverman Voice Treatment (LSVT) groups will be implemented. Management of the LSVT waiting list will improve, with an extra staff member being trained in the use of the LSVT companion.

In terms of models of care:

- Service development will continue to examine models of care, service provision and use of allied health assistant (AHA) roles in all clinical areas. For example, CRT is implementing a stream type model within the current Occupational Therapy staffing to provide a more responsive service across the main client groups of subacute and chronic neurological.
- The Model of Care of the Memory Assessment Service will be reviewed to identify methods for increasing patient flow in the Outpatient Clinic.

In terms of staffing:

- Active recruitment is progressively filling vacant specialist staff positions in Geriatric Medicine. This will reduce the excessive workload on existing staff and improve streamlining of services. All vacant positions are expected to be filled by end of 2015.
- Occupational Therapy has experienced staff shortages. While it is anticipated that there will continue to be several staff on temporary contracts in Occupational Therapy, all positions will be filled by August 2015.

The Electronic Medication Management System will be implemented across the RACC inpatient services in early 2016. It will improve medication management and reduce medication errors.

Discharge planning

Statistics indicate 100 patients in the 85 years and older age group will be sent home from the Emergency Department each month. However, approximately 70 per cent of those will return to the Emergency Department and be admitted to hospital. The ROM service is currently developing robust and efficient strategies to reduce hospital admission rates for these patients.

Output 1.6: Early Intervention and Prevention

The aim of Output 1.6 to improve 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 such as obesity and diabetes
- reducing risky health behaviours, such as smoking and alcohol consumption
- maintaining high levels of immunisation.

Overview

ACT Health undertakes initiatives that provide early intervention to, or prevent, health conditions that may result in major acute or chronic health care burdens on the community.

Early intervention is managed in many ways, including:

- screening programs, such as BreastScreen, Cervical Screening and Newborn Hearing Screening
- immunisation programs
- health promotion programs and initiatives
- behaviour-changing campaigns.

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.

Performance against accountability indicators

The ACT continued to achieve high childhood immunisation coverage in the general population. Coverage rates for children all three cohorts were consistently above the national average. The ACT achieved the highest coverage rate of all states and territories in all quarterly reports for children at 12 months of age.

In 2014–15, 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 (92.5 per cent, 93.1 per cent, 92.9 per cent and 92.9 per cent).

Well Women's Checks were provided to 40 per cent of women from Culturally and Linguistically Diverse (CALD) communities. This is in line with the target of 40 per cent, which is an increase in target from 30 per cent in 2013–14. In collaboration with the Health Improvement Branch, which oversees the Cervical Screening register, eligibility criteria for Well Women's Checks were reviewed to include:

- young women who had previously not initiated a cervical screening test
- women who have not been screened for over three years.

This is believed to be consistent with the eligibility criteria targeting vulnerable women.

93 per cent of children aged 0–4 years 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 90 per cent.

More information: For additional information, see C.6 Statement of performance, Output 1.6: Early Intervention and Prevention, page 231.

Promoting healthy lifestyle choices

The cessation of the National Partnership Agreement on Population Health (NPAPH) in the 2014–15 Federal Budget created significant funding shortfalls for health promotion programs. However, the ACT Government continued to support the majority of NPAPH-related programs for 2014–15 and has provided additional support in the 2015–16 budget through its Healthier Lifestyles initiative.

During 2014–15, Population Health Division continued to deliver initiatives aimed at improving the health of the population in a range of settings and population groups including children, families and workers.

Children

ACT Health delivers programs aimed at reducing the rates of overweight and obesity in children and young people aged 0–18 years.

The Kids at Play (Active Play) Program contributes to improved developmental outcomes for children aged three to five years in Early Childhood Education and Care (ECEC) services. Thirty-five ECEC services in Canberra participated in the program in July 2014.

Forty schools are involved in the Fresh Tastes: healthy food at school Program, which aims to improve student and teacher knowledge of and access to healthy food and drinks. Fresh Tastes provides curriculum support in:

- nutrition education
- growing food
- healthy cooking
- healthy food and drink options.

A number of businesses and community organisations partner and support the schools. Out of 50 school canteens assessed annually, over one-third showed a decrease in unhealthy food on their menus.

The Healthy Food at Sport Program aims to increase healthy food choices available to children and young people through sporting canteens. Fifty-two ACT primary schools are involved in the Ride or Walk to School (RWTS) Program, which aims to increase physical activity. The program is delivered by the Physical Activity Foundation through a Healthy Canberra Grant. It provides support for teacher professional development and workshops on:

- bikes and helmets
- self defence
- BMX riding.

ACT Health continues to work with cross-government partnerships with other directorates to develop an extension of RWTS named Active Streets to trial infrastructure improvements around schools and identify strategies to better engage parents.

The It's Your Move is a high school research intervention program conducted with Deakin University. It aims to increase physical activity and healthy eating and reduce unhealthy weight gain in young people aged 12–16 years. Numerous positive outcomes were demonstrated including improved student attitudes, knowledge and behaviours related to physical activity and nutrition. The rates of overweight and obesity in the target group decreased or remained stable over the study period. This program has informed the development of It's Your Move phase two involving nine ACT high schools.

Families

The Good Habits for Life Program is a locally-developed behaviour change campaign, which targets families with young children, and encourages physical activity and healthy eating. The campaign website has received over 30,000 visits since its launch in November 2014.

Workers

ACT Health delivers programs to promote and support healthy lifestyles within, and through, ACT workplaces.

The ACT Healthier Work Service has been developed by Health Improvement Branch and implemented with WorkSafe ACT. It supports ACT workplaces to implement staff health and wellbeing programs. Over 100 local businesses are engaged in the program and over 50 businesses across a range of sectors achieved Healthier Work recognition. From 2015–16 onwards the Healthier Work Service will be delivered through Access Canberra.

ACT Health runs 'my health', which is a comprehensive staff health and wellbeing program Healthy Workers | ACT Health for the ACT Health workforce of over 6,000 employees. As a part of the program, ACT Health introduced the Healthy Food and Drink Choices Policy to increase the range and number of healthy food and drink choices available to staff, volunteers and visitors at ACT Health facilities and events. As a result:

- drink vending machines are largely compliant with the policy
- 'junk food' advertising has been removed from Canberra Hospital lifts
- contracts for food outlets across ACT Health include a requirement to comply with the Policy.

Grants

The ACT Health Promotion Grants Program provided $1,838,730 in grants to a wide range of community-based organisations. The grants fund activities that help improve health outcomes and minimise the risk of developing chronic disease. The focus of grants funding has been on identified population health issues, including overweight and obesity, and smoking and alcohol-related harms.

Early intervention and prevention programs

BreastScreen ACT is part of a national population breast screening program that is aimed at reducing deaths from breast cancer through early detection.

More information: For detailed information about BreastScreen ACT, see the B.2 Performance analysis, Output 1.4: Cancer Services section, page 70.

During 2014–15, the ACT Cervical Screening Program:

- promoted an updated message of 'regular cervical screening test' to community groups using print media, at women's health events and through 98 per cent of general practices
- delivered a radio advertising campaign to promote screening to women from the Aboriginal and Torres Strait Islander community, and women from non-English speaking backgrounds, in 21 language groups.

As part of the Commonwealth-funded National Bowel Cancer Screening Program (NBCSP), endoscopy services are provided to patients. In 2014–15, CHHS operated a colonoscopy pathway to support NBCSP participants for those referred to the service.

The School Youth Health Nurse works with a preventative focus in high schools including activities associated with:

- early identification
- brief intervention
- harm minimisation.

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.

More information: For detailed information, see B.2 Performance analysis, Output 1.1: Acute Services Early intervention and prevention, page 57.

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. Work to increase awareness of this valuable service has seen demand grow by 60 per cent over 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
- introduce them to appropriate services as soon as possible.

More information: For detailed information, see B.2 Performance analysis, Output 1.1: Acute Services, Early intervention and prevention, page 57.

The results of the kindergarten health checks are now sent to the family's GP (if nominated on the consent form) for ongoing support.

The School Kids Intervention Program (SKIP) commenced as a pilot on March 2015. This program is for children 4–12 years who are overweight, either on the:

- 85% percentile or above with co-morbidities or
- 95% percentile without co-morbidities.

The program is family-oriented and incorporates multidisciplinary information, including

- nutrition
- paediatric (medical)
- psychology
- exercise physiology.

SKIP received 30 referrals in the three months since commencement.

The Dental Health Program collaborates with child and family centres to provide oral health information and support to families of young children. Key activities of this collaboration include:

- conducting outreach dental assessments
- facilitating dental appointments
- educating parents.

The First Smiles Program promotes early intervention for young children with a strong focus on early childhood caries and dental trauma prevention and management. Dental assessments and information sessions are delivered to children at:

- playgroups
- preschools
- community events, for example, Floriade.

ACT Health funded the ACT Medicare Local (now the Capital Health Network) to run a 12 month demonstration primary health care service aimed at disadvantaged ACT citizens attending the Early Morning Centre in the city. This commenced in June 2014 and continued throughout 2015.

Implementation of the ACT Primary Health Care Strategy 2011–2014 was completed in December 2014 with all 47 sub actions implemented or in progress. A new document to steer the direction of future primary health care-related activities in the ACT is being developed.

Immunisation rates

From the beginning of 2013, the Human Papilloma Virus (HPV) vaccine, Gardasil, was offered to boys and girls in Year 7. The catch-up program for male Year 9 students ceased in December 2014. The ACT remains above the national average in students receiving the full three-dose HPV vaccine. Preliminary data on the HPV vaccine administered through the school immunisation program indicates the following uptake rates for the 2014 calendar year:

- Year 7 students: 78%
- Year 9 boys: 66 %

Throughout the school year, the school-based immunisation program also provides students with booster doses of the:

- varicella (chickenpox) vaccine
- combined diphtheria, pertussis and tetanus vaccine.

During 2014–15, the Maternal and Child Health (MACH) Service delivered 11,838 early childhood immunisations.

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:

- maintaining or increasing vaccine coverage for Indigenous Australians
- maintaining or increasing coverage in agreed areas of low immunisation coverage
- maintaining or decreasing wastage and leakage
- 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 all three of the assessable benchmarks (benchmarks 1, 3 and 4).

More information: For information on the status of Aboriginal and Torres Strait Islander immunisation, see Strategic Objective 14: Addressing Gaps in Aboriginal and Torres Strait Islander Immunisation Status, page 45.

Implementing the ACT Immunisation Strategy 2012–2016 continued, with work targeted at maintaining ACT immunisation coverage rates and reaching vulnerable community members.

Changes to the National Immunisation Program continue to be implemented within the ACT. One new change in 2015 is the expansion of the program to include providing the influenza vaccine free for all Aboriginal and Torres Strait Islander children aged six months to five years.

In March 2015, the Australian Immunisation Handbook (10th Edition) was amended to recommend that the pertussis (whooping cough) vaccine be provided for women in their third trimester of pregnancy. In April 2015, ACT Health introduced a funded Antenatal Pertussis Vaccination Program aimed at protecting both mother and her newborn from whooping cough. Vaccines and promotional materials were delivered to all GPs and antenatal clinics as part of the program.

PHD undertook a quarterly mail-out to parents of children who were recorded in the Australian Childhood Immunisation Register as overdue for immunisation, either because:

- they have not been vaccinated or
- their vaccination has not been recorded on the register by their immunisation provider.

The letter advised parents or guardians that their child was overdue for immunisation, reminded them of the importance of vaccination and enabled any administered but unrecorded vaccinations to be entered onto the register.

In March 2015, PHD commenced sending reminders to parents for their child's upcoming four-year-old immunisation. In 2015–16, this will be expanded to include children due for their one-year and 18-months vaccinations.

Future directions

Promoting healthy lifestyle choices

ACT Health will continue to contribute strongly to implementing actions listed in the Towards Zero Growth: Healthy Weight Action Plan. The action plan is a crucial element of efforts aimed at reducing the burden of disease associated with overweight and obesity.

The PHD chairs the ACT Healthy Weight Initiative Food Environment Implementation Group (FEIG) and the Evaluation Implementation Group (EIG).

Under the auspices of the FEIG, additional drinking water fountains have been installed in public places to increase access to, and promote, drinking water.

The Minister for Heath accepted a report from the Heart Foundation ACT, which highlighted the extent of marketing of unhealthy food and beverages to children in the ACT. The EIG has made significant progress in:

- improving the collection of biometric data in General Practice
- collecting data in relation to the usage of ACT Government walking and cycling infrastructure.

Reducing risky behaviours

PHD will continue to focus on services and programs that prevent chronic disease and reduce related health care costs across the ACT community. The focus for 2015–16 will be on reducing lifestyle risk factors that lead to:

- overweight and obesity
- diseases such as cancer, diabetes and cardiovascular conditions.

The PHD will also focus on monitoring health trends and outcomes and making that data and evidence available in a timely and accessible fashion for decision-making.

Immunisation rates

PHD will continue to work with the Department of Health during 2015–16 to implement changes to the National Immunisation Program Schedule. A number of new vaccines are to be added to the schedule, including the Diphtheria, Tetanus, and Pertussis (DTP) booster for children aged 18 months, which will be added in October 2015.

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
- investigating immunisation promotion opportunities with the Aboriginal and Torres Strait Islander community.

B.3 SCRUTINY

Introduction

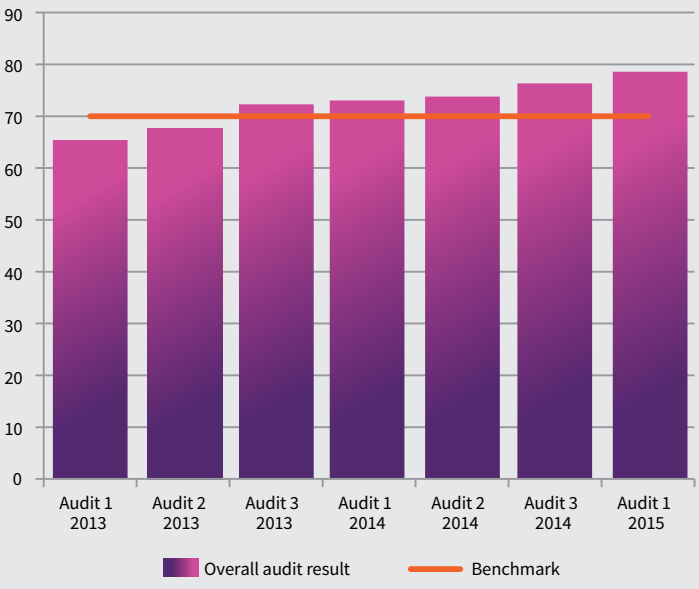
ACT Health responds to requests from ACT Legislative Assembly Committees, including reports automatically referred from the ACT Auditor-General's Office as required to assist with and ensure proper examination of matters.

ACT Health also responds to complaints that are referred from the ACT Ombudsman Office.

In 2014–15, ACT Health received no complaints 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.

Standing Committee on Health, Ageing, Community and Social Services – Annual and Financial Reports 2013–14

Reporting Entity	Standing Committee on Health, Ageing, Community and Social Services
Report Number	Report No 5. The report can be found at: http://www.parliament.act.gov.au/in-committees/standing_committees/Health,-Ageing,-Community-and-Social-Services/annual-and-financial-reports-2013-2014/reports?inquiry=649333
Report Title	Annual and Financial Reports 2013–14.
Government Response/ Submission Title	The Government Response is not due as at 30 June 2015.
Date Tabled/ Released	5 May 2015.
Recommendation Number and Summary of Recommendation	**Recommendation 10**: The Committee recommends that the ACT Government consider annual benchmarking for emergency department timeliness against peer group hospitals to provide a better indication of how the ACT is performing compared to similar hospitals. **Recommendation 12**: The Committee recommends that ACT Government consider establishing targets to measure how effectively diversion to other health care and human services management programs is working to reduce frequent re-presentations at emergency departments. **Recommendation 13**: The Committee recommends that ACT Government look to revise its information systems promptly in order to facilitate the recording and reporting of timeliness measures for non-elective surgery. **Recommendation 14**: The Committee recommends that the ACT Government undertake additional efforts to ensure that hospital staff comply with hand washing guidelines.

Reporting Entity	Standing Committee on Health, Ageing, Community and Social Services
Action	**Recommendation 10** – Agreed. • ACT Health will endeavour to incorporate national peer group hospital results into our annual report for benchmarking purposes. Currently, ACT Health does not have access to national datasets for the purpose of generating our own national comparative figures. As such, ACT relies on data that is made available to jurisdictions via national publications. • ACT Health currently sources national peer group results and individual hospitals performance results from federal bodies such as the Australian Institute of Health & Welfare (AIHW) and the National Hospital Performance Authority (NHPA) annual hospital publications retrospectivity. • As these national publications can often take some time before they are made available to jurisdictions, ACT Health cannot guarantee that the inclusion of the most recent national data into our annual report. • Nevertheless, ACT Health will incorporate historic publicised national results into our annual report as per data availability. **Recommendation 12** – Agreed in Principle. ACT Health is working with the ACT Primary Health Network (PHN) (formally ACT Medicare Local) to develop initiatives which are aimed at reducing pressure on Emergency Departments by providing better community based options. This initiative will initially focus on those with chronic conditions and those who present regularly at ED's. Further extension will be determined following an evaluation of the work with the ACT PHN. **Recommendation 13** – Agreed. This recommendation is currently a high priority for ACT Health. ACT Health currently working on ways to improve the capturing and reporting of non-elective surgery information to provide greater transparency in of this area. **Recommendation 14** – Agreed. ACT Health strives to achieve continuous improvements in all areas including compliance with hand hygiene requirements. Since 2010 the Hand Hygiene Program at Canberra Hospital and Health Services (CHHS) has been coordinated via the Infection Prevention and Control Unit (IPCU) at Canberra Hospital, and has involved a multi-factorial approach to hand hygiene compliance ranging through education, audit and feedback, promotional activities, equipment and supplies, and focused area or unit specific intervention, with specific examples listed below. During this time the Hand Hygiene program has not only expanded significantly across the health service, but has also resulted in a steady increase in hand hygiene compliance (see graph), although further improvement is required, especially among Medical Practitioners. Following each audit period the IPCU analyses the results according to the ward area, moment of hand hygiene and type of healthcare worker, to determine the areas to target with specific interventions prior to the next audit cycle. Whilst the IPCU has been essential in coordinating the program, the importance of individual ward areas and healthcare worker groups in leading and driving the program at a local level needs to be recognised. 

Reporting Entity	Standing Committee on Health, Ageing, Community and Social Services
Action (continued)	**Program**: • CHHS run the hand hygiene program as per the '5 moments' set out by Hand Hygiene Australia in conjunction with the Commission on Safety and Quality. • The program now takes in 21 wards/units across the service, leaving only three areas which will be on the program by the third and final round of 2015. • All staff undertake essential infection prevention and control training and to date for 2015 2500 staff have been trained in the '5 moments of Hand Hygiene' and infection control practices. This number includes doctors, nurses and allied health. • Round 1 of 2015 involved 18 units with a total of 6091 moments collected, with an overall rate of 78.7 per cent being achieved. • IPCU run auditor training monthly successful completion of which requires passing an exam to ensure the data collected is valid and accurate. • Each ward/unit collects their own moments and this has been an effective way to collect the data as it ensures staff owns the information within their unit. They also see and handle problems or issues and address them as they arise, which is a more effective way to learn. • In addition to the national hand hygiene program, ACT Health run an auditing process of which the hand hygiene snapshot is a part. The snapshot reflects the national program and allows auditing to take place in the community and the outpatient setting. • Alcohol hand rub is readily available across ACT Health to make it easy to perform hand hygiene. It is available at the entry to wards, point of use within wards and in all outpatient settings. **Interventions include**: • International Hand Hygiene Day (children from Woden Valley Childcare Centre helped to raise awareness); International infection control day in October (wear pink t-shirts and encourage wards to hold hand hygiene awareness days, e.g. 10A and women's and children often hold pink days); Infection control, 'Bug Busters' and hand hygiene newsletters are circulated every month; IPCU nurses provide on-the-spot positive and constructive feedback to staff from all disciplines. • Feedback from each audit period is provided to those wards/units that have been part of the Hand Hygiene program, including compliance rates and graphs to display. • Education and promotion is provided to wards/units that don't meet the national benchmark during an audit period. • The Infection Control have fun days to promote hand hygiene and good infection control practices, for example, an annual 'Bake off' with the theme of 'My Hospital Rules'. • 'No touch' hand hygiene stations are situated in all foyers and entry points across the ACT Health. • A DVD has been developed and is on a replay loop in the foyer (this DVD was based on Chesterfield Hospital in the UK). • Skin assessment service is provided by infection control to ensure staff who develop skin irritations are reviewed.
Status	In progress

Standing Committee on Health, Ageing, Community and Social Services – Inquiry into the sourcing and supply of dental prostheses and appliances to Australian dental practitioners from overseas

Reporting Entity	Standing Committee on Health, Ageing, Community and Social Services
Report Number	Report No 4. The report can be found at: http://www.parliament.act.gov.au/in-committees/standing_committees/Health,-Ageing,-Community-and-Social-Services/sourcing-and-supply-of-dental-appliances-and-related-products?inquiry=624642
Report Title	Inquiry into the sourcing and supply of dental prostheses and appliances to Australian dental practitioners from overseas.
Government Response/ Submission Title	Letters were sent to the Chair of the Dental Board of Australia, the Director of the Therapeutic Goods Australia and the Chair of the Standing Committee on Health, Ageing, Community and Social Services.
Date Tabled/Released	17 March 2015.
Recommendation Number and Summary of Recommendation	**Recommendation 1**: The Committee recommends that the ACT Government should request that the Therapeutic Goods Administration and the Dental Board of Australia consider amending the relevant regulations, codes and guidelines to require the details about the manufacturer of a custom-made dental device to be provided to the prescribing practitioner and the patient.
Action	Agreed. Correspondence was prepared and sent to the Chair of the Dental Board of Australia, the Director of the Therapeutic Goods Australia requesting they consider amending relevant regulations, codes and guidelines to require the details about the manufacture of a custom-made dental device to be provided to the prescribing practitioner and patient.
Status	Complete.

Standing Committee for Health, Ageing, Community and Social Services – Inquiry into the exposure draft of the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014

Reporting Entity	Standing Committee for Health, Ageing, Community and Social Services
Report Number	Not Applicable.
Report Title	Report pending release.
Government Response/ Submission Title	ACT Government Submission to the ACT Legislative Assembly Standing Committee on Health, Ageing, Community and Social Services Inquiry into the Exposure Draft of the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 and related discussion paper.
Date Tabled/Released	13 February 2015.
Recommendation Number and Summary of Recommendation	As at 30 June 2015, the inquiry was ongoing.
Action	Not Applicable.
Status	In progress.

Select Committee on Estimates 2014-2015 – Inquiry into Appropriation Bill 2013-2014 and the Appropriation (Office of the Legislative Assembly) Bill 2014–2015

Reporting Entity	Select Committee on Estimates 2014-2015
Report Number	Report No 1. The report can be found at: http://www.parliament.act.gov.au/in-committees/select_committees/estimates-2014-2015/inquiry-into-appropriation-bill-2014-2015-and-the-appropriation-office-of-the-legislative-assembly-bill-2014-2015/reports
Report Title	Inquiry into Appropriation Bill 2014–2015 and the Appropriation (Office of the Legislative Assembly) Bill 2014–2015.
Government Response/ Submission Title	Government Response to the Report of the Select Committee on Estimates 2014-2015 on the Inquiry into Appropriation Bill 2014–2015 and the Appropriation (Office of the Legislative Assembly) Bill 2014–2015.
Date Tabled/Released	5 August 2014.
Recommendation Number and Summary of Recommendation	**Recommendation 91**: The Committee recommends that the ACT Government collect, maintain and report annually on ACT school students' health and fitness. **Recommendation 92**: The Committee recommends that the ACT Government research and report on best practice programs to improve children's health and fitness outcomes in the ACT by the last sitting day of March 2015. **Recommendation 94**: The Committee recommends that where significant variations in the total cost or the government payment for outputs figures in the budget papers they should be accompanied by an explanatory note. **Recommendation 95**: The Committee recommends that the Minister for Health update the Legislative Assembly when the detailed working figures used by the Commonwealth to derive the revised NHRA funding arrangements in its 2014–15 Budget are made available. **Recommendation 96**: The Committee recommends that the Minister for Health update the Legislative Assembly half-yearly on the progress of updates to the Emergency Department Information System in response to Auditor-General's Report No.6 of 2012. **Recommendation 97**: The Committee recommends that the Minister for Health detail to the Legislative Assembly improvements made to the Gastroenterology and Hepatology Unit to improve administration and governance in response to Auditor-General's Report No. 4 of 2014. **Recommendation 98**: The Committee recommends that the Minister for Health detail to the Legislative Assembly how the issue of under reporting of incidents at the Canberra Hospital through the RiskMan system, as identified in Auditor-General's Report No. 4 of 2014, has been addressed. **Recommendation 99**: The Committee recommends that the Minister for Health detail to the Legislative Assembly the current scope, quantum and effectiveness of government funding for Aboriginal and Torres Strait Islander health services in the ACT. **Recommendation 100**: The Committee recommends that the Government take all possible steps to accurately evaluate the scope, cost and timetable of all capital works projects prior to commencement. **Recommendation 101**: The Committee recommends that the ACT Government increase adult education regarding sufficient activity for those adults already engaged in some level of sport or fitness activity. **Recommendation 102**: The Committee recommends that the ACT Government investigate the reintroduction of direct access to the ACT Equipment Loans Service for patients of private hospitals in the ACT. **Recommendation 103**: The Committee recommends that the Government specifically address suicide among older Canberrans in its forthcoming suicide prevention initiative. **Recommendation 104**: The Committee recommends that the ACT Government review the type of data collected by emergency response officers and hospital emergency room staff to better assist in dealing with alcohol-related injuries and incidents in the ACT and report to the Assembly by March 2015.

Reporting Entity	Select Committee on Estimates 2014-2015
Action	**Recommendation 91** – Noted. The ACT Government has a range of mechanisms through which it collects health data of ACT school students. ACT school student's health and fitness status is reported biennially in the Chief Health Officer's report. Annual statistics are available. The Education and Training Directorate is working in partnership across ACT Government agencies to develop and implement programs that enhance children's health and fitness. Action in schools is a high priority area within the Towards Zero Growth Health Weight Action Plan. Schools are already engaged with programs to improve the physical health of children such as the Walk and Ride to School Program, supporting schools canteens to provide healthy food choices and building physical activity into the school day. The Epidemiology Section of ACT Health collects and reports on the health and fitness status of primary and secondary school aged students in the ACT through several surveys including the ACT General Health Survey (GHS), the ACT Physical Activity and Nutrition Survey (ACTPANS), and the Australian Secondary Students' Alcohol and Drug Survey (ASSAD). The GHS is conducted annually, while the ASSAD and ACTPANS are conducted every three years. **Recommendation 92**– Not agreed. ACT Health routinely undertakes evaluation of its programs, many of which have historically been funded through the Healthy Children Initiative under the National Partnership Agreement on Preventive Health. The Commonwealth Government ceased this Agreement on 1 July 2014 and, accordingly, funding to the underlying programs has been cut. The ACT Government is currently looking at the impacts of this loss of funding. **Recommendation 94** – Agreed in principle. The Government will examine this proposal during the 2015–16 Budget process. **Recommendation 95** – Noted. The ACT has not yet received a formal response to its request for detail to explain the derivation of the figures in the 2013–14 and 2014–15 Budgets. **Recommendation 96** – Noted. There are only three outstanding issues in relation to the Auditor-General's report: • a single sign-on system that reduces the time for people to log-on to the system, as a means of eliminating the need for generic passwords; • adoption of new outcome measures for emergency department services; and • completion of relevant documentation for the system, in term of education, training, auditing and governance. Two of these required the implementation of the new version of the emergency department information system in order to complete the actions. The new system was implemented in late June 2014, and work is now underway to complete these actions. In relation to outcome measures, the ACT is leading a national effort to consider possible outcome measures. This process will be completed in late 2014. **Recommendation 97** – Agreed. Substantial work has been undertaken since the completion of the field work of the Auditor-General's office for this audit. ACT Health has introduced changes to improve processes for acceptance and registration of referrals and is focusing on increasing the Gastroenterology consultants' utilisation of IT systems to triage, in an effort to streamline referral processing and booking of patients into clinics. Enhancements to the electronic referral system have also been identified and are being developed, which will improve the Gastroenterology and Hepatology Unit's visibility of their demand, enabling better management of appointment requirements. **Recommendation 98** – Agreed. This will occur as part of the ACT Government's response to the Auditor-General's report. **Recommendation 99** – Noted. The ACT Government will consider reporting to the Legislative Assembly at an appropriate time. **Recommendation 100** – Agreed in principle. The Government notes the comments in the report in relation to the significant challenges associated with budgeting accurately for the timing of delivery of health related infrastructure. The CMTEDD has implemented The Capital Framework, designed to enhance the evaluation of the scope, cost and timing of capital works prior to any budget funding being allocated. **Recommendation 101** – Noted. Following the cessation of the National Partnership Agreement on Preventive Health from 1 July 2014, funding for programs under the Healthy Workers Initiative has been cut. The ACT Government is currently looking at the impacts of this. Funding from the Healthy Canberra Grants Program to the Heart Foundation will deliver the Live Lighter campaign, targeting adults, to increase awareness around obesity and promotion of increasing physical activity and healthier eating. **Recommendation 102** – Noted. The service is already available to patients discharged from private hospitals in the ACT.

Reporting Entity	Select Committee on Estimates 2014-2015
Action (continued)	**Recommendation 10**3 – Agreed. The document currently in development (the ACT Mental Health and Wellbeing (Suicide Prevention) Framework 2015–2025) is positioned at a strategic, Whole-of-Government and whole of community level. The document identifies high level goals to promote mental health and wellbeing and reduce suicide and self-harm across all age groups. Interventions for specific vulnerable groups, whether aged based, gender, ethnic groups, etc are not identified. Following the endorsement of the above Framework, each Directorate will develop a business plan or strategic policy to address the Framework objectives. It is within these documents that interventions targeted at specific groups will be contained. ACT Heath will develop a Mental Health Services Plan that will contain strategies targeted at various higher risk groups including older people at risk of suicide. **Recommendation 104** – Noted. While the Government is committed to improving data collection in relation to alcohol-related harms in other areas, the collection of additional information above current requirements in emergency situations is not supported at this time. It is important that health services, and especially ambulance paramedics and clinical staff in the hospital emergency departments, manage presentations based on clinical need and record the primary condition they are treating, not the apparent cause of the condition.
Status	Complete.

ACT Auditor-General's Office Performance Audit Report – Report No 5 of 2015 – Auditor-General's Report – Integrity of data in Health Directorate

Reporting Entity	ACT Auditor-General's Office Performance Audit Report
Report Number	Report No 5. The report can be found at: http://www.audit.act.gov.au/auditreports/reports2015/Report%20No%205%20of%202015%20Integrity%20of%20Data%20in%20the%20Health%20Directorate.pdf
Report Title	Auditor – General's Report – Integrity of data in Health Directorate.
Government Response/ Submission Title	Not applicable.
Date Tabled/Released	Released 19 June 2015.
Recommendation Number and Summary of Recommendation	As at 30 June 2015, the Committee was considering the report.
Action	Not applicable.
Status	In progress.

ACT Auditor-General's Office Performance Audit Report – Report No 4 of 2014 – Auditor-General's Report – Gastroenterology and Hepatology Unit, Canberra Hospital

Reporting Entity	ACT Auditor-General's Office Performance Audit Report
Report Number	Report No 4. The report can be found at: http://www.parliament.act.gov.au/__data/assets/pdf_file/0008/603773/Report-No-4-of-2014-Gastroenterology-and-Hepatology-Unit,-Canberra-Hospital.pdf
Report Title	Auditor–General's Report – Gastroenterology and Hepatology Unit, Canberra Hospital.
Government Response/ Submission Title	Not applicable.
Date Tabled/Released	
Recommendation Number and Summary of Recommendation	As at 30 June 2015, the Committee was considering the report.
Action	Not applicable.
Status	In progress.

ACT Auditor-General's Office Performance Audit Report – Report No 8 of 2013 – Management of funding for community services

Reporting Entity	ACT Auditor-General's Office Performance Audit Report
Report Number	Report No 8 of 2013. The report can be found at: http://www.audit.act.gov.au/auditreports/reports2013/Report_08-2013_-_Management_of_Funding_for_Community_Services.pdf
Report Title	Auditor-General's Report – Management of funding for community services.
Government Response/ Submission Title	Government Response – Auditor-General's Report No 8 of 2013 – Management of funding for community services.
Date Tabled/Released	Released 13 February 2015.
Recommendation Number and Summary of Recommendation	As at 30 June 2015, the Committee was considering the report.
Action	Not applicable.
Status	In progress.

B.4 RISK MANAGEMENT

Introduction/overview

ACT Health provides a high-quality service to our community, safe and effective care to our consumers and maintains a safe environment for patients, visitors and employees. To achieve this, ACT Health is committed to managing risks that may prevent us achieving our objectives.

Developing the Risk Management Plan

In line with ACT Government risk management protocols, the ACT Health Risk Management policy, framework and guidelines are maintained in full compliance with the International Standard for risk management, which is AS/NZS ISO 31000:2009. The documents provide clear governance arrangements, including responsibilities and measurable KPIs.

ACT Health is committed to establishing a risk culture that demonstrates the principles of risk management through:

- proactive, timely identification and reporting of actual and perceived risks by staff
- including risk in the planning, implementation and maintenance phases of all ACT Health systems, processes, policies and procedures.

Monitoring risks

Executive Risk Management forums and workshops are held regularly to review the directorate's organisational-level risks.

Identifying and responding to emerging risks

ACT Health's Executive Directors' Council is responsible for:

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

B.5 INTERNAL AUDIT

Overview

The ACT Government Internal Audit Framework provides guidance for all internal audit functions within the ACT Government. ACT Health's Internal Audit Charter and Internal Audit Policy and Procedures are based on this framework and guide the work performed by ACT Health's Internal Audit and Risk Management Branch.

Internal Audit Arrangements

ACT Health's Internal Audit and Risk Management Branch promotes and improves ACT Health's corporate governance by:

- conducting internal audits and investigations
- making recommendations for improvements.

In 2014–15, six internal audit assignments were completed. An ACT Health Internal Control Review was also completed.

Audit findings and recommendations are rated in line with ACT Health's Risk Management Guidelines. Throughout the year, the Manager, Internal Audit and Risk Management reported developments in implementing:

- the Strategic Internal Audit Program
- audit recommendations to the Executive Directors' Council and to the Audit and Risk Management Committee.

The committee is also informed of the implementation of recommendations made by the ACT Auditor-General's Office, where these apply to ACT Health.

Internal Audit Committee

ACT Health's *Audit and Risk Management Committee Charter* and *Terms of Reference* govern the operation of the Audit and Risk Management Committee, which provides:

- assurance to the Director-General on ACT Health's governance
- oversight in relation to risk management, internal systems and legislative compliance.

The committee consists of five members:

- an independent chair
- three Senior Executives from within ACT Health
- 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 2014–15. Attendances are set out in Table 21.

Table 21: Audit and Risk Management Committee meetings

Name of member	Position	Duration on the committee	Meetings attended
Mr Geoff Knuckey	Independent Chairperson	4 years	5
Mr Jeremy Chandler	External member and Deputy Chairperson	2.5 years	5
Mr Ian Thompson	Member	8.5 years	5
Ms Katrina Bracher	Member	2.1 years	5[1] *
Mr Stephen Goggs	Member	2.5 years	3[2]
Mr Kim Smith	Member	0.25 of a year	0[2]
Dr Peggy Brown	Observer	N/A	4[1] * + [3]
Ms Nicole Feely	Observer	N/A	1[3]
ACT Auditor-General's Office	Observer	N/A	5

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.

2 represents the same substantive position held by two different people. Stephen Goggs resigned on 15 May 2015.

3 represents the same substantive position held by two different people. Dr Peggy Brown resigned on 29 May 2015.

B.6 FRAUD PREVENTION

Introduction/overview

Under the provisions of section 13 of the Public *Sector Management Act 2006* the Director-General of each agency is required to ensure that threats to the integrity of the agency are addressed in a detailed fraud and prevention plan. To address this obligation ACT Health has:

- a Fraud and Corruption Policy
- a Fraud and Corruption Plan.

The Deputy Directors-General and Executive Directors are responsible for ensuring compliance with the policy and plan at all levels within their areas.

Risk assessments and fraud prevention strategies

Divisions of ACT Health undertake fraud risk assessments, in line with ACT Health Risk Management protocols. Mitigating controls are put in place to address fraud threats and risks. The ACT Health Senior Executive responsible for Business Integrity Risk:

- analyses trends and risk assessments for fraud and other integrity breaches
- provides biannual reports to the Audit and Risk Management Committee.

The one fraud matter reported in the 2013–14 Annual Report has been finalised. No fraud matters were reported in 2014–15.

Fraud control plans and fraud awareness training

Staff receive fraud control and prevention training during orientation and through an e-learning program titled Ethics, Integrity and Fraud Prevention.

Managers are provided with further fraud control and prevention information and training during managers' orientation programs.

This is supported by targeted information that alerts staff to the responsibilities and protocols intended to improve systems or mitigate identified fraud threats and risks.

B.7 WORK HEALTH AND SAFETY

Introduction/overview

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 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
- meet legislative compliance as far as is reasonably practicable.

WPS provides occupational medicine services across ACT Health to prevent potential infectious disease being transmitted to healthcare workers. These services include:

- pre-employment screening
- a vaccination program, including annual influenza vaccinations
- occupational risk exposure and follow-up management, counselling and advice
- cytotoxic screening
- monitoring safety devices
- health surveillance
- education.

WPS also provides a holistic early intervention physiotherapy service to staff who have sustained musculoskeletal injuries. This assists in:

- reducing time off work
- facilitating early return to work
- improving staff morale
- decreasing workers compensation claims.

A priority is educating staff to increase their awareness of safe work practices and ergonomic environments.

WPS has operational responsibility for the Riskman system. This allows ACT Health to configure the system to meet business needs, including

- providing support to stakeholders
- using the system to coordinate issues with the ACT Health's divisions and services.

The Riskman system currently consists of nine registers and associated extensions.

More information: For detailed information, see Riskman, page 148.

Workplace safety measures

During 2014–15, the WHSMS was reviewed and updated to reflect changes to:

- legislation
- regulations and codes of practice
- operational requirements
- processes.

WPS also developed an asbestos management plan, which has been implemented across the organisation.

Additional workplace safety measures undertaken during 2014–15 are discussed below.

Riskman

The electronic staff accident and incident reporting system (Riskman) is now in its sixth year of operation. This system continues to provide consistent reporting and enables ACT Health to quickly:

- identify and implement relevant controls
- report incident and trend data to management and workplace Health and Safety Representatives (HSRs).

The Riskman system continues to be developed to meet organisational needs both in clinical and non-clinical areas. Various registers and extensions were upgraded to:

- provide customised reports, indicator sets and body charts
- improve functionality.

Staff/management feedback has led to the development of a more user-friendly system, which allows higher quality reporting to management and committees. This will be fully implemented in 2016.

An Occupational Medicine Unit Riskman module has been developed to capture data for staff screening and immunisation, including annual influenza vaccinations and occupational risk exposures.

Safety training and auditing

Safety training remains a priority and continues to be provided for HSRs, managers and new staff. The Work Health and Safety Managers course and Investigation course assist managers to:

- implement relevant preventive and corrective safety controls
- continuously improve safety in the workplace.

ACT Health received accreditation in 2015 from WorkSafe ACT as a Registered Training Organisation (RTO) to provide tailored HSR training for our staff.

ACT Health has developed its own internal safety auditing tool in response to feedback from management and staff. This enables ACT Health to meet corporate and legislative requirements.

Work Health and Safety Act 2011 reporting

Incidents, accidents, investigations and notices in 2014–15 were as follows:

- 1,318 accident/incident reports were lodged during the 2014–15 financial year. This compares with 1,367 lodged during the preceding year. Of these reports, 151 resulted in lost time injury of one day or more, compared with 158 in 2013–14.
- 40 accidents/incidents relating to ACT Health staff were notified to ACT WorkSafe under section 35 of the *Work Health and Safety Act 2011*, compared to 54 in 2013–14.
- One Provisional Improvement Notice (PIN) was issued by an ACT Health HSR in 2014–15:
  - The PIN was issued on 25 July 2014.
  - The PIN was placed on the Adult Mental Health Unit (AMHU) by the AMHU's HSR. It related to concerns for staff safety related to staffing levels at the unit following a post occupancy evaluation.
  - The PIN was lifted on 31 October 2014, following negotiations with management.
- No notices of noncompliance were issued in 2014–15 in relation to the *Work Health and Safety Act 2011.*
- One prohibition notice was issued to ACT Health in February 2015 in relation to construction activity under Regulation 296 of the Workplace Health and Safety Regulation 2011. WorkSafe identified that a principal contractor had not been appointed for this construction activity.
- There were no workplace fatalities in 2014–15.

Health and Safety Representatives

At 30 June 2015 there were 268 elected Health and Safety Representatives (HSRs) within the Health Directorate.

Worker consultation arrangements

The ACT Health Tier 1 Work Health Safety Committee is the peak organisational body for work health and safety in ACT Health. It met four times during the year. This committee is chaired by the Director-General and includes management and workplace HSRs.

Tier 2 Health and Safety Committees are chaired by Executive Directors and represent major divisions and branches. Tier 2 committees meet quarterly (in administrative environments) and monthly (in clinical environments). These committees must include more HSRs than management representatives.

Tier 3 Health and Safety Committees represent localised work areas and bring together groups within similar locations/job types. Tier 3 committees meet monthly.

WPS Early Intervention Physiotherapy Program

The WPS Early Intervention Physiotherapy Program completed 579 workstation assessments during the 2014–15.

Workstation assessments may also be conducted to support an employee returning to work where a work or non-work injury has occurred.

Performance against Australian Work Health and Safety Strategy 2012–22 targets

Target I: A reduction of at least 30 per cent in the incidence rate of claims resulting in one or more weeks off work

Figure 19 and Table 22 shows the number of new claims per 1,000 employees that resulted in five or more days off work since 2012–13. Figure 19 also shows the baseline and targets for each financial year up to 2021–22.

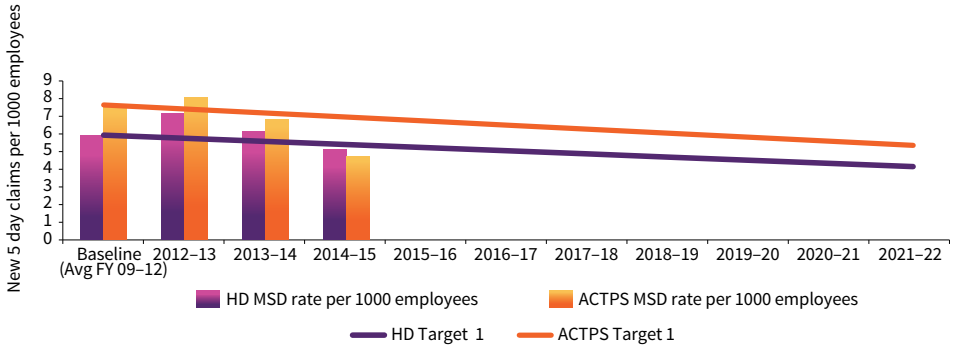


Figure 19: Incident rate of claims resulting in five days or more off work

Table 22: Incident rate of claims resulting in five days or more off work

Health	Baseline (Avg FY 09–12)	2012–13	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22
HD # new 5 day claims	67	87	81	70							
HD rate per 1000 employees	13.31	16.07	13.79	11.51							
HD Target 1	13.31	12.92	12.52	12.12	11.72	11.32	10.92	10.52	10.12	9.72	9.32
ACTPS # new 5 day claims	335.33	369	322	226							
ACTPS rate per 1000 employees	17.16	18.07	15.29	10.65							
ACTPS Target 1	17.16	16.64	16.13	15.61	15.10	14.59	14.07	13.56	13.04	12.53	12.01

In 2014–15, ACT Health continued to reduce the number of new claims that exceeded five days off work per 1,000 employees. This is due to early intervention strategies and proactive case management.

The 2014–15 figures are consistent with historical trends, and overall performance is very good against both the Health Directorate and ACT Public Service targets.

Target 2: A reduction of at least 30 per cent in the incidence rate of claims for musculoskeletal disorders resulting in one or more weeks off work

Figure 20 and Table 23 shows the number of new musculoskeletal disorders claims per 1,000 employees that resulted in five or more days off work since 2012–13. Figure 20 also shows the baseline and targets for each financial year up to 2021–22.

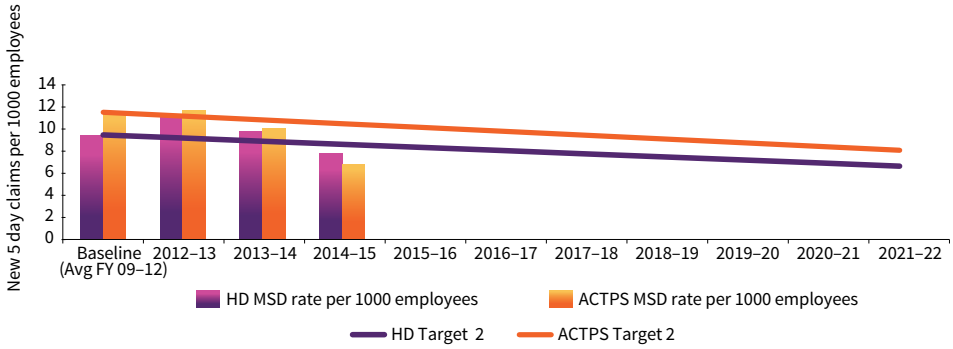


Figure 20: Incident rate of claims for musculoskeletal disorders resulting in five days off work

Table 23: Incident rate of claims for musculoskeletal disorders resulting in five days off work

Health	Baseline (Avg FY 09–12)	2012–13	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22
HD # new 5 day MSD claims	47.33	60	57	47							
HD MSD rate per 1000 employees	9.41	11.08	9.71	7.73							
HD Target 2	9.41	9.12	8.84	8.56	8.28	8.00	7.71	7.43	7.15	6.87	6.58
ACTPS # new 5 day MSD claims	224	238	210	142							
ACTPS MSD rate per 1000 employees	11.46	11.66	9.97	6.69							
ACTPS Target 2	11.46	11.12	10.77	10.43	10.09	9.74	9.40	9.06	8.71	8.37	8.02

In 2014–15, ACT Health reduced the incidence of musculoskeletal claims resulting in five days or more off work, continuing a trend from previous years and bringing the incidence rate below the target level. The overall trend in performance on these claims has been achieved with early intervention strategies and proactive case management.

B.8 HUMAN RESOURCES MANAGEMENT

Introduction/overview

ACT Health has a dispersed model for human resources management with many areas sharing responsibility for staff-related issues. Business units are responsible for deciding their workforce composition below the executive level. They make their own recruitment decisions and undertake day-to-day management duties. People Strategy and Services Branch (PSSB) assists business units with their human resources functions, especially in complex or difficult cases. The most common areas where this occurs are:

- where allegations of misconduct have been made
- team interventions are required to address specific workplace culture issues
- advice on public sector employment obligations is needed
- it is difficult to recruit staff with particular skills or qualifications.

PSSB is also responsible for whole of directorate and/or strategic human resources issues, such as:

- providing general clinical and leadership training
- conducting enterprise bargaining negotiations
- conducting high-level workforce planning and directorate-wide people policy.

The Chief Minister, Treasury and Economic Development Directorate (CMTEDD) provides whole-of-service human resources policy, strategy and programs. It:

- sets targets for Aboriginal and Torres Strait Islanders and People with Disability
- authorises the employment of executives
- provides transactional human resources services through its Shared Services centre.

All powers in relation to the appointment, engagement and employment of staff are exercised on delegation from the Head of Service or the Director-General of ACT Health.

Human resource management

The organisation's workforce profile reflects the increased health workforce that is required for the growing organisation, including:

- implementing new and extended services in the community sector of the ACT
- meeting ongoing service delivery growth within the hospital.

To ensure that the services provided by ACT Health reflect best practice in national/international services the models of care for clinical areas are regularly reviewed. ACT Health is engaged in the national health workforce committees, including the:

- Australian Health Workforce Ministerial Advisory Council (AHWMC)
- Health Workforce Principal Committee (HWPC).

This ensures that the organisation is aligned to the National Agenda for health workforce policy and planning.

Workforce planning

The aim of ACT Health workforce planning is to ensure that the right person, with the right skills is in the right place at the right time to provide the right services within budget.

Workforce planning guides the recruitment, retention and development of ACT Health's diverse clinical and non-clinical workforce. Workforce projections are developed using contemporary methodologies, and gap analysis provides a guide to the recruitment needs of the organisation. ACT Health's largest recurrent expense is the cost of employees, with approximately 80 per cent of recurrent funds being spent on workforce.

The ACT Health Workforce Plan 2013–2018 identifies the following five focus areas:

- Health Workforce Reform
- Health Workforce Development
- Health Workforce Leadership
- Health Workforce Planning
- Health Workforce Policy.

The organisation is tracking well against all focus areas, with demonstrated collaboration between strategic and operational areas of the organisation to implement and evaluate the changes.

The organisation is one of the largest employers in the ACT and we need to ensure that people with the right skill sets are recruited.

To keep ACT Health facilities and services operating efficiently and effectively we need:

- doctors, nurses and allied health personnel
- administrative, technical and support workers.

Using targeted recruitment strategies and collaborating with local tertiary education facilities to grow our own health workforce has been a successful approach.

The first biannual ACT Health Workforce Summit 'Leading workforce risk mitigation initiatives' was held on 12 March 2015. Executive Directors from across ACT Health discussed workforce planning as a tool for workforce leaders and attended a workshop focused on key challenges and risks.

The strategic management of the workforce was identified as one of the greatest challenges for workforce leaders for the next decade. The group found that ACT Health is required to:

- maximise the flexibility of the workforce
- minimise workforce risks
- constantly develop skills to remain abreast of ongoing changes, while retaining valuable skills.

The group then focused on identifying strategies to:

- mitigate the risks and support the workforce to deliver on required outcomes
- help the organisation overcome workforce challenges.

Retention strategies

Recruitment and retention strategies are being implemented to ensure that we have a workforce into the future with the organisational knowledge, skills and capability to provide health services of the highest standard.

ACT Health's exit rate was 7.1 per cent, which is less than the national average. Recommendations made in Exit Survey Reports indicate we need to increase the focus on working conditions and staff support measures, including:

- supporting flexible work arrangements
- strengthening the options for part-time or casual re-employment of retired and retiring staff members.

Learning and development opportunities are provided to staff in accordance with the Essential Education Policy. Continuing professional development opportunities for staff include:

- development of health professional networks across ACT Health
- discipline-specific professional development
- clinical supervision workshops for supervisors.

Workplace culture and engagement continue to be an area of priority for ACT Health, given the strong correlation with retention and overall performance. An effective internal consultancy service for managers/teams enabled effective analysis of workplace culture issues and targeted strategies, which took into account the unique factors of each team. In 2014–15, 48 teams from across the organisation received this targeted assistance, with good improvement outcomes.

ACT Health offers retired employees opportunities to re-enter the workforce in a part-time or casual capacity. Opportunities that allow early retired employees to return in roles that are less physically demanding have been explored.

ACT Health has been accepted into the 2014–15 Commonwealth Department of Employment Corporate Champions Program, which supports the development and implementation of strategies to retain workers aged 45 or over. A work plan has been approved for the rollout of the Corporate Champions program and implementation has commenced.

Employment strategies

ACT Health offers a range of competitive incentives to ensure it is a desirable place of employment for clinical and non-clinical professionals. Ongoing professional development to both cohorts of staff is offered through a range of avenues including:

- internal and external training
- targeted employment projects
- through the performance development plans.

ACT Health has worked strategically with the ANU and other approved higher education institutions to ensure medical students are provided with the relevant support to perform their duties while also undertaking further professional development or targeted placements for junior medical staff.

In June 2014, an Employment Inclusion Manager was permanently engaged to undertake initiatives and provide support and assistance within ACT Health to increase the number of employees that have a disability or are Aboriginal and/or Torres Strait Islander.

A large part of the inclusion work has focused on assisting, educating and developing staff and managers on the employment inclusion area for people with a disability and Aboriginal and Torres Strait Islander people. This has involved meeting with areas to discuss inclusion placements and then providing support for staff and management once a placement has been undertaken.

To increase staff awareness regarding employment inclusion, two separate monthly inclusion seminars have been conducted. The presentation topics included:

- Disability and Aboriginal and Torres Strait Employment and training ideas, benefits and opportunities
- the support and funding available to managers.

In April 2015, ACT Health began an Employment Inclusion partnership with Chief Minister Treasury and Economic Development Directorate (CMTEDD). The partnership will focus on the Disability and Aboriginal and Torres Strait Employment Inclusion initiatives to be undertaken to increase the number of inclusion staff across all directorates.

The ACT Health and CMTEDD partnership on inclusion employment initiatives commenced in 2015. As part of this, monthly ACT Health Inclusion Seminars and presentations have been opened up to all ACT Government directorates. In June 2015, the Head of Service invited representatives from the directorates to attend the inclusion seminar held on 30 June 2015. This invitation is one of the first steps to establishing a whole-of-ACT Government Inclusion Practitioners network.

A panel of Disability and Aboriginal and Torres Strait Islander employment providers was established through the Employment Inclusion Manager, which aims to:

- seek people who are available for work with ACT Health
- provide support, advice and possible funding towards workplace modifications, adjustments and support.

The Disability Employment Providers, through the Employment Inclusion Manager, also provide assistance, support, education and training to the supervisors and work colleagues in the workplace.

Aboriginal and Torres Strait Islander people

The ACT Health Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013–2018 (Workforce Action Plan) sits under the organisation's Workforce Plan 2013–2018 (Health Workforce Plan).

During 2014–15, the Reconciliation Action Plan (RAP) Committee was established. It consists of ACT Health representatives. The committee, in consultation with Reconciliation Australia and the ACT Elected Body and Community:

- reviewed the second RAP 2012–15
- created the new third ACT Health RAP for the period covering 2015–18.

Managers are encouraged to use the enterprise agreement's flexible working arrangements, where appropriate, to achieve a healthy balance between operational needs and work-life balance. Aboriginal and Torres Strait Islander employees are provided with details of their entitlements to attend culturally significant events.

People with a Disability

During 2014–15, the Disability Employment Action Plan Committee was established. It consists of representatives from across ACT Health and consulted with other ACT Government directorates, including the:

- ACT Human Rights Commission
- Australian Network on Disability
- Commonwealth Human Rights office.

The committee was responsible for the creating and establishing ACT Health's first Disability Employment Action Plan. The ACT Health Disability Employment Action Plan 2015-2018 was released in January 2015 and is registered with the Commonwealth Human Rights Office.

Apprenticeships

In the 2013-2014 period, ACT Health commenced its first inclusion Australian School-Based Apprentice (ASBA), which was for an Aboriginal and Torres Strait Islander Apprentice. During 2014–15, ACT Health increased this number to six Inclusion ASBAs, with three being Disability and three being Aboriginal and Torres Strait Islander.

The ASBA Program has been very successful and we will be working towards increasing these numbers in the upcoming financial year.

Traineeships

In 2015, ACT Health started an Employment Inclusion partnership with CMTEDD. It will focus on the Disability and Aboriginal and Torres Strait Islander Employment Inclusion initiatives to be undertaken to increase the number of inclusion staff across all directorates. This has included involving the:

- 2016 Graduate Program
- Aboriginal and Torres Strait Islander Traineeship, which commenced in August 2015.

Future traineeships will include a disability placement traineeship, cadetships and other development programs.

Learning and development programs

In 2014–15, participation in learning and development increased. This satisfied the quality improvements for health accreditation education requirements, as outlined in the National Safety and Quality Service Standards. This is reflected in an increase in e-learning completions, which doubled from the previous year. Some face-to-face programs now use a blended approach or were replaced by e-learning programs. This has provided a more flexible and cost effective delivery that meets the needs of the workforce.

ACT Health implements governance strategies to ensure the quality of education and training in ACT Health. Planned and integrated education is based on the annual learning needs analysis and identified organisational requirements.

ACT Health is a Registered Training Organisation (RTO), which provides a quality framework for delivery of training in line with the Standards for RTO 2015. 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). In 2014–15, 155 programs were recorded on the EAR.

The EAR ensures programs:

- are reviewed
- are evaluated
- are linked to evidence-based practice
- involve consumers
- are updated annually
- are appropriately authorised.

In 2014–15, key achievements included:

- establishing partnerships and networks across ACT Health to develop and implement the education required to achieve health accreditation and organisational priorities
- meeting education reporting requirements for the National Safety and Quality Health Service Standards (NSQHSS) accreditation
- increasing medical officer engagement with essential education
- successfully implementing a planned process to ensure Visiting Medical Officers (VMOs) meet essential education requirements.

Leadership and culture programs

The ACT Health Leadership Network is composed of approximately 100 employees who have been identified by the executive as leaders and potential leaders who could most benefit from, and contribute to, the network's objectives.

During the three workshops held in 2014, participants further developed their individual leadership skills. Activities included:

- presentations from guest speakers
- examining contemporary leadership research
- participating in network discussions.

The employees worked in small collaborative groups and formed constructive partnerships across the organisation.

Specific leadership programs were developed and delivered for Canberra Hospital and Health Services and for Strategy and Corporate. These programs involved over 120 staff (executives, senior and middle managers) participating in six to eight days of training in topics such as:

- leading through vision
- instilling accountability
- facilitating effective teamwork.

The People Manager Program (PMP) aims to develop knowledge and skills in people management, and is underpinned by ACT Health's values. The PMP is for clinicians and non-clinicians in frontline supervisor and middle management positions who have people management responsibilities. It consists of five half-day modules, which were in significant demand in 2014–15. Table 24 shows the attendance figures.

Table 24: Number of Attendances for each module in 2014–15

Module	Number of attendees
Module 1	153
Module 2	151
Module 3	161
Module 4	187
Module 5	151

The ACT Public Service (ACTPS) Performance Framework was supported by the development and delivery of information sessions for all staff and workshops for supervisors and managers. The workshops focused on the practical skills used in performance conversations and on providing feedback, including feedback on conduct and behaviour. There were 656 attendances at all staff information sessions and 545 attendances at supervisor/manager workshops.

Managers and staff were provided with training in managing and preventing bullying, harassment and discrimination. Since the program began in 2011, over 5,200 staff and managers have been trained, which represents over 75 per cent of the workforce. In 2014–15, the Respect@Work refresher training was attended by 172 staff.

The number of Respect, Equity and Diversity (RED) contact officers at 30 June 2015 was 106. RED contact officers include:

- nurses
- allied health professionals
- doctors
- administrative staff
- staff who work outside traditional business hours.

Education programs developed in partnership with consumers and consumer groups

In 2014–15, a key initiative was to introduce education programs for ACT Health staff to improve the patient experience by addressing the requirements of the NSQHSS, Standard 2-'Partnering with Consumers'. All education sessions were delivered to an interprofessional audience. Table 25 provides course details, including attendances.

Table 25: Consumer and consumer group partnered courses

Course	Attendance	Consumer involvement
Introduction to Patient Centred Care	363	Consumer stories were included in presentation
Patient Experience Program	302	Three consumers attended to evaluate program. Consumer stories were included in presentation
Involving Consumers in Quality Improvement Activities	30	Consumers were co-presenters
Patient Centred Care and Shared Decision Making	39	Consumer stories were included in presentation
Writing Consumer Publications elearning	88	Reviewed in April 2015 Two consumers provided feedback
Involving Consumers in Education Professional Development Session for Educators	14	Consumer stories were included in presentation

In early 2015, an audit of the EAR indicated that 47 per cent of education programs involve consumers in planning, delivery or evaluation of education provided to clinical staff.

The consumers in education working group are currently establishing a volunteer program to allow consumers to be involved in education. The working group is also developing:

- further training in partnership with consumer organisations
- developing guidelines for educators on how to involve consumers in education programs.

The ACT Health Cultural Competence program

This program aims to enhance ACT Health employee cultural awareness while working with Culturally and Linguistically Diverse (CALD) consumers and staff.

The content of the program meets the requirements of Standard 2 of the NSQHSS (2012) and item 1.1.6 of the ACT Health Business Plan 2013–2014. Cultural competence has also been recognised as a driving influence towards providing culturally competent care and services to our CALD consumers.

The two hour face-to-face program is being delivered as:

- a stand-alone session
- as a part of the Clinical Supervision Support Essentials Program
- as a part of the TAE40110 Certificate IV in Training and Assessment.

There were 93 participants at the face-to-face programs. A cultural competence e-learning program was developed in May 2015, which has been completed by 173 staff.

Safety training

A range of targeted health-specific manual tasks programs are provided to meet the safety requirements of various work groups in the clinical and administrative environment. High-risk workers complete annual refreshers.

In 2014–15, 3,511 staff and volunteers completed face-to-face training in manual tasks, an increase of 16 per cent from the previous year. In addition, training was provided to 1,047 tertiary students attending clinical placements. All staff are required to complete a general manual tasks e-learning program on commencement. There were 3,346 completions, a significant increase from the previous year.

Staff also have access to training to assist with managing challenging and aggressive behaviour from clients. The e-learning modules on Personal Aggression and Conflict Awareness were completed by 435 staff. The face-to-face, skills-based Predict, Assess and Respond to Challenging/Aggressive Behaviour (PART) Program or refresher was completed by 234 staff. In 2014–15, extra programs were provided for specialised areas in Mental Health, Justice Health, Alcohol and Drug Division and Health Centres.

Essential education and clinical education

Orientation

The aim of orientation is to ensure all new staff are:

- welcomed
- informed of legislative requirements
- conversant on how ACT Health contributes to the local community
- aware of requirements of their job role as a public servant
- aware of their obligation to complete essential education requirements.

In 2014–15, 12 orientation sessions were provided to a total of 1,184 staff and volunteers attending the ACT Health Orientation. An additional 728 staff were deemed to have completed requirements through recognition of prior learning, as approved by their Executive Director. An additional orientation program will be provided in January 2016, which will provide a total of 13 programs annually.

The Workplace Induction Pathway complements the ACT Health Corporate Orientation Program to ensure staff are orientated to their work area and adhere to the responsibilities of their role and work safety. In 2014–15, a total of 3,994 staff completed the Workplace Induction Pathway. An additional 93 staff were deemed to have completed requirements through recognition of prior learning as approved by their Executive Director.

Child protection

Three levels of child protection training are provided to ACT Health staff, depending on their role and the likelihood they will have contact with children and young people as part of their work.

In 2015, additional one hour ‘Q&A’ sessions commenced for the nursing staff at Canberra Hospital and the Health Service Emergency Department. These are facilitated by the child protection training team from the Division of Youth and Children and the Child Protection Liaison Officers. These sessions discuss child protection concerns with staff and provide further advice on reporting and child abuse matters.

ACT Health continues to maintain the partnership with the Community Services Directorate (CSD) in providing the ‘What About Me’ series of workshops for government and non-government organisations. The aim is to increase staff confidence in their ability to work with vulnerable children and families.

Table 26 lists the training courses and identifies the number of participants that attended each.

Table 26: Number of staff who attended child protection training

Child protection training	Participants trained
Level 1 classroom training	142
Level 2 classroom training	905
Level 3 classroom training	482
In-service	15
Level 3 refresher	273
Level 1 e-learning CHHS	1378
Level 2 e-learning CHHS	665
Level 1 e-learning Calvary Bruce	132
Level 2 e-learning Calvary Bruce	204
Level 1 e-learning Calvary John James	419
Level 1 e-learning Calvary John James	215
Total July 2014-June 2015	4668*

Source: ACT Health Capabiliti data

* Staff may attend more than one level of training, for example Level 1 and Level 3. The participant total reflects the number of attendees at education sessions. These figures include staff from ACT Health, Calvary Bruce and Calvary John James.

Life support programs

ACT Health provides life support training and assessment programs that align with:

- current National Safety and Quality Standards
- current Australian Resuscitation Council guidelines
- the ACT Health Essential Education Policy.

The courses provide staff with the knowledge and skills necessary to effectively manage resuscitation. Table 27 identifies the number of staff who received training in life support programs during 2014–15. It includes all staff trained not just those allocated this training as per the Essential Education Policy.

Table 27: Number of staff who attended life support courses

Life Support Courses	Attendance
Advanced Life Support One Day – 17 programs	147
Advanced Life Support Two Day – 2 programs	31
Advanced Life Support Refresher – 14 programs	154
Basic Life Support	4460
Basic Life Support Train the Trainer – 4 programs	75
Neonatal Advanced Life Support – 11 programs	177 Plus 45 from Calvary
Neonatal Advanced Life Support Refresher – e-learning plus assessment	120
Paediatric Life Support – 5 programs	90 Plus 26 from Calvary and five external participants

Mandatory Update Day

Mandatory Update Day (MUD) for Canberra Hospital and Health Services (CHHS) nurses and midwives provides nursing and midwifery staff with annual refresher training in essential or highly recommended education. It is an alternative to completing separate sessions on different days. In 2014–15, 23 programs were offered with 930 nurses and midwives attending.

Medication safety

In 2014–15, 420 nurses completed e-learning on medication calculations and 1,375 staff completed e-learning on medication legislation.

Human Rights Act training for managers

Education on the *Human Rights Act 2004* is provided through an e-learning program, which was developed in consultation with the ACT Human Rights Commission. This is essential education for policy writers and managers in ACT Health and is available for all staff to complete. In 2014–15, 364 staff completed the e-learning program.

COMPASS

The Early Recognition of the Deteriorating Patient Program (COMPASS) is designed for nurses, physiotherapists, doctors and undergraduates. It is delivered by the Early Recognition of the Deteriorating Patient team. Specific workshops and refreshers focus on adult, paediatric, maternity or neonatal patients, and aim to enable health professionals to recognise the deteriorating patient and initiate appropriate and timely interventions. In 2014–15:

- 36 workshops were held, which were attended by 474 participants
- 114 refresher sessions were held, which were attended by 1,431 participants.

An additional bimonthly Modified Early Warning Scores (MEWS)/Medical Emergency Team (MET) forum is also held with 173 participants attending for the year.

Call and Respond Early (CARE) Family Escalation program

This program for patient and family escalation provided 11, 90-minute in-services for 30 nursing staff. In addition a Skills Day for Potential Leaders program was conducted in collaboration with Organisational Development. This one-day program complements the Call and Respond Early (CARE) Patient and Family Escalation program to provide additional training in communication and conflict resolution skills. Five sessions were held, with 45 participants attending.

Invasive devices education programs

During 2014–15, the following invasive device education programs were conducted:

- **Peripheral Intravenous Cannulation Education**: Provided to Registered Nurses (RNs), Enrolled Nurses (ENs), midwives, medical officers and radiographers caring for patients requiring cannula access for their treatment. The theory is offered via a self-directed learning package and was completed by 31 staff. A two hour, face-to-face workshop to practice cannulation was attended by 117 staff. Clinical competencies are completed in the clinical setting.
- **Venepuncture and Blood Culture Collection**: This program offers education and clinical skills assessment for Venepuncture and Blood Culture Collection for RNs, ENs, midwives and medical officers. An e-learning program was completed by 231 staff and the practical workshop was completed by 68. Clinical competence assessment is completed in the clinical setting.

- **Central Venous Access Devices (CVADs)**: ACT Health offers education and clinical skills assessment for the care and maintenance of CVAD. This is provided to RNs, midwives and medical officers caring for patients requiring central venous access for their treatment. The theory is offered online as an e-learning program. In 2014–15, 422 staff completed this training. This is prerequisite for completing the clinical competency assessments carried out in the clinical setting. A three hour, face-to-face workshop is offered for those staff who wish to have additional education after completing the e-learning. In 2014–15, 37 staff attended this workshop.
- **Indwelling Urinary Catheter**: In 2014–15, 290 staff completed this e-learning program.

Newborn assessment

The purpose of the Newborn Assessment Workshop is to support the education of midwives, nurses and medical staff to develop the knowledge and clinical skills of newborn assessment. Four workshops were held in 2014–15, with 34 ACT Health and Calvary staff attending, of which 13 achieved competency.

Wound management

ACT Health provides e-learning on wound assessment and management, consisting of four modules. In 2014–15, 110 staff completed the modules. Monthly face-to-face sessions on wound management have been completed by 94 staff. The bimonthly Wound Management Day (6.5 hours) has been completed by 81 staff. Negative pressure dressing and fistula management workshops have been completed by 41 staff.

The Night Duty Continuing Education Program

The Night Duty Continuing Education sessions support educational opportunities for those staff working mostly at night who may otherwise have limited access to in-service education.

The Night Duty Continuing Education Program is conducted with two sessions per week, over 15 individual weeks in the calendar year. Sessions are repeated within the same week to allow different staff rotations equitable opportunity to attend. The program content is closely aligned to the National Safety and Quality Standards.

A total of 1,123 staff attended sessions in 2014–15.

Paediatric programs

During 2014–15, the following paediatric programs were offered:

- **Child and Adolescent Mental Health Program**: This three-day program is run in conjunction with the Child and Adolescent Mental Health Service. It provides health professionals with knowledge and management skills useful when caring for a child and young person with an acute mental-health problem. The course is run every 18 months. In 2015, 15 participants from paediatric and mental health areas completed the program.
- **Paediatric High Dependency Nursing Program**: This six module course is offered to RNs and focuses on caring for an acutely ill child/young person. In 2014, six paediatric RNs completed the course. In 2015, the course curriculum was revised to reflect feedback from 2014, incorporating a more practical approach to the teaching sessions. The 2015 program is currently running with 16 participants comprising:
  - six RNs from paediatrics
  - nine RNs from the Emergency Department
  - one RN from the Medical Imaging Department.
- **Paediatric Oncology Nursing Program**: This course is run annually in conjunction with the Sydney Children's Hospital Rural Outreach Service. It is targeted at RNs from both ACT Health and the Southern Children's Healthcare Network, and provides participants with information on treating and managing the acutely unwell paediatric oncology patient. In 2014, 14 participants attended the course. In 2015, the course is open to 25 participants from both ACT Health and the Southern Children's Healthcare Network.

Perioperative programs

In 2014–15, the following perioperative programs were offered:

- **The Perioperative Nursing Foundation Program**: This program was developed to attract and retain nurses within the Perioperative Unit and is delivered annually in line with ACT Health Transition to Practice Nursing Programs. In 2014, all seven graduate nurses participating in the program elected to continue to work in the perioperative area after they successfully completed their program. Four regional hospital participants also participated.

- **The Perioperative Team Leader (TL) Program:** This program was developed to attract and educate nurses to fulfil the role of team leader after hours. The increasing responsibilities of the perioperative TLs and the skills required to coordinate the clinical environment after hours are the driving forces behind creating a program specifically for team leading. Through the process of evaluation and organisational need, the program was changed to deliver a broader, team-orientated and collaborative approach, providing education modules encompassing all perioperative nursing specialties. Twelve nurses participated in 2014.

Allied health clinical education

In 2014–15, the number of designated clinical educators increased by two positions. These were established through Health Workforce Australia's (HWA'S) time-limited funding in psychology and physiotherapy (acute). There are now 14 allied health clinical educators providing clinical education and support for staff and students.

The annual Allied Health Symposium was held in March 2015, and 180 allied health staff attended from the ACT Public Service.

Recruitment, graduate and transition to practice programs

ACT Health recruits and conducts transition to practice programs for ENs, RNs and allied health graduates as a recruitment and retention strategy. These programs provide a high level of clinical and professional support, care, feedback and guidance during the transition year. Table 28 provides course details for transition to practice programs.

Table 28: Number of participants in transition to practice programs

Program	No. intakes 2014–15	No. participants
Enrolled nurse Transition to Practice Program	4	17
Registered nurse Transition to Practice Program	4	75

Table 29 provides course detailed for new graduate programs.

Table 29: Number of participants in new graduate programs

Program	No. participants	No disciplines represented
Allied Health New Graduate Program 2014–15 Includes six modules and runs twice a year	35	11
Interprofessional Graduate Program 2014–2015 Conducted 2-3 times per year	155	10

Re-entry Programs for Registered Nurses/Midwives and Overseas-qualified Nurse Programs

The ACT Health Re-entry (Refresher) and Overseas Registered Nurse/Midwife Programs provide educational support to RNs and midwives who have not worked in health care for up to 10 years. The overseas nurses program provides education and support for internationally qualified nurses who are residents in the ACT.

Once participants have successfully completed the program they are eligible to apply for employment with ACT Health. All programs require ACT regional residency as a criteria to apply and are accredited with the Nursing and Midwifery Board of Australia.

The new revised programs in 2015–16 will be developed in partnership with a tertiary provider.

Table 30 provides course details.

Table 30: Number of nurses/midwives and overseas-qualified nurses who have completed, currently enrolled and employed by ACT Health

	Completed	Currently enrolled	Employed by ACT Health
Registered Nurse re-entry	4	5	2
Midwifery refresher	3	0	1
Overseas qualified	4	3	4

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 are responsible for providing workplace:

- learning support and education
- competency assessment
- student clinical supervision.

These programs support compliance with NSQHSS Standard 1. The standard requires that:

- competency-based training is provided to clinical staff
- supervision is provided for individuals to fulfil their designated roles.

Table 31 provides course details.

Table 31: Educational programs provided in 2014–15

Program name	Program description	No. sessions and attendees
Teaching on the run	This program is provided by allied health clinical educators for staff who provide clinical teaching and student supervision.	7 sessions 102 attendees
Supervision for allied health	External clinical supervision training at intermediate/advanced level was conducted for allied health staff by the University of Sydney.	2 sessions 35 attendees
Supervision Allied Health Assistants	Supervision workshops to assist allied health assistants (AHA) and supervisors implement the AHA supervision framework.	3 sessions 39 attendees
Psychology supervision training	Implementation of Psychology Board of Australia approved supervision training to increase student placement capacity.	2 sessions 38 attendees
Clinical Educators Network	This education-focused network meets six times a year and involves clinical educators or primary supervisors from over 25 different allied health professions.	6 session 99 attendees
The Clinical Support and Supervision Program	This two-part program for any clinician who supports or works with new staff, graduates or undergraduate students in the clinical environment. The aim of the program is to provide training for professionals who fulfil a preceptorship or clinical supervision role with students and staff.	103 completed the e-learning 110 attended the one-day workshop
TAE40110 Certificate IV in Training and Assessment	In 2014–2015, the course was revised to offer it in modules so staff can choose to complete relevant units of competency and skills sets rather than the full course. Participants have up to 12 months to complete the modules.	64 enrolments 31 completions of qualification or competency units
Clinical Development Nurse/Midwife Professional Development Program	Clinical Development Nurses and Midwives (CDNMs) are employed by the clinical Divisions to provide workplace learning and support for nursing and midwifery staff.	11 sessions 123 participants
ACT Health Trainers and Educators Network	The Trainers and Educators Network is a forum to discuss best practice in learning and development and to share ideas and initiatives covering issues such as the training design, development and delivery, evaluation and assessment processes, and training management.	Four meetings with 46 staff attending

Scholarships to support further learning for allied health, nursing and midwifery

The Chief Allied Health Office supports ongoing learning and development through the Allied Health Postgraduate Scholarship Scheme. The scheme supports allied health professionals to undertake further learning at postgraduate level in either:

- clinical practice
- education and training
- research
- management and leadership.

In 2014–15, the Chief Allied Health Office supported 54 individual postgraduate scholarship payments.

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 ENs
- post-registration
- travel
- mental health
- clinical leadership and management.

Post-registration scholarships continue to support the greatest number of nurses and midwives, with a total of 173 recipients during the 2014 calendar year. This reflects growth of 24 per cent on the 2013 calendar year.

Funding support for between 50 and 100 per cent of course costs is provided. Recipients range from ENs undertaking a Bachelor of Nursing qualification (10 per cent) to RNs studying at graduate certificate/diploma level (49 per cent) and at Masters level (35 per cent).

Student support programs

Postgraduate certificates for ACT Health nurses and midwives

The following postgraduate certificates are offered to nurses and midwives in collaboration with the Australian Catholic University (ACU):

- Neonatal Nursing
- Child and Adolescent Health.

The ACU delivers an online component for two units, and educators in the ACT Health Staff Development Unit teach a curriculum approved by the 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 participating staff are well educated for local 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 pay fees for the ACT Health component.

Once postgraduate certificates are completed students have an option to continue and undertake a Masters degree in their speciality.

Table 32 provides course details.

Table 32: Postgraduate certificates

Course	June–December 2014	January–June 2015
Neonatal	Five students with four completing.	Four students with one completing in June.
Child and Adolescent Health (includes either acute paediatrics or a maternal and child health specialty)	Acute paediatrics: Eight students with five completing in December. Child Health: Five students with three completing in December.	Acute paediatrics: Six students with two completing in June. Child and Adolescent: Three students and one continuing online as the course has now ceased.
Masters, Neonatal	Two students continuing.	Four students continuing.

Tertiary students

The Student Clinical Placement Unit coordinates clinical placements for nursing, midwifery, medical and allied health students.

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 RNs 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 before commencing a clinical placement.

In 2014–15, 28,937 clinical placement days were provided to nursing and midwifery students. Night duty clinical placements continued for third year nursing students and again received positive feedback from the students, facilitators and clinicians.

In 2014–15, 10, 327 clinical placement days were provided to local, interstate and international students across the allied health disciplines and medicine.

Work experience in ACT Health for school students

ACT Health provides educational and practical healthcare work experience placements to ACT Year 10, 11 and 12 students in either clinical or non-clinical areas. Availability of placements is the decision of the senior manager of the area requested to provide the placement.

The ACT Health Orientation evaluation asks new staff commencing employment to identify if they were previously a work experience student in ACT Health. In November 2014, the Staff Development Unit began to audit orientation evaluations. Since November 2014, 52 new staff identified that they had previously been a school work experience student in ACT Health.

e-learning

Currently, 70 e-learning courses are available on the learning management system Capabiliti. The courses are available 24 hours a day, seven days a week.

During 2014–15, 17 new courses were implemented on Capabiliti. In addition, 15 courses are under development and review, and a further 14 courses were evaluated and redeveloped.

Table 33, Table 34 and Table 35 provide details.

Table 33: Courses developed and implemented in 2014–15

Courses developed and implemented in 2014–2015	
An introduction to Parkinson's Disease	Ketamine for Acute Pain Management
Aseptic Technique	Medical Officers Noticeboard
Clinical Support and Supervision Essentials	Medication legislation processes
CHARM Documentation Scanning and Importing	Performance Plan Record
COMPASS General Quiz	Performance Plan Review
Cultural Competency	Pressure Injuries
Haemostasis	Records Management
Indwelling Catheter	Screening and assessment of emotional Wellbeing
Intrathecal Epidural Morphine	

Table 34: Courses currently under development and review

Courses currently under development and review	
Aboriginal and Torres Strait Islander Awareness	Fire and Emergency
Basic Life Support	Human Rights Act 2011
Child Protection Level 1	Magnetic Resonance Imaging
Child Protection Level 2 – Refresher	Neonatal Resuscitation Update
Essential Finance	Theatre Etiquette
Falls Prevention	Security Awareness
Fluid and Electrolyte	Writing Consumer Publications
Finance Practicalities	

Table 35: Courses evaluated and redeveloped in 2014–15

Courses evaluated and redeveloped 2014–15	
ACT Work Health and Safety Act 2011	Medication Package for Orientation
Certificate IV Training and Assessment Module 4	Negligence and Documentation
CVAD Care and Maintenance	Neonatal Resuscitation
Donate Life Designated Officer Training	Personal Safety and Conflict Awareness Module 1
Essential Finance Module 1	Patient ID and Procedure Matching
Ethics, Integrity and Fraud	Privacy and Confidentiality
Infection Prevention and Control, Occupational Medicine and Waste Management	Tobacco Intervention

ACT Health total learning and development activity

Table 36 provides details of learning and development activity for face-to-face programs and completion of e-learning by division during 2014–15.

Table 36: Learning and development activity for face-to-face programs and completion of e-learning by division, 2014–15

Health division	No. of attendances	Hours	Salary	E-learning completed
Canberra Hospital and Health Services	51,950	102,374	4,043,237	37,272
Health Infrastructure and Planning	82	253	13,308	222
Office of the Director General	133	413	18,580	320
Population Health	304	1,524	80,306	554
Special Purpose Account	52	95	4,440	44
Strategy and Corporate	2,872	5,496	240,868	2,026
Other (non-staff on Capabiliti)	NA	NA	NA	984
Calvary*	61	NA	NA	NA
Total	55,454	110,155	$4,400,739	41,422

Notes:

*Calvary hours and salary costs are not available.

An additional 1895 participants attended face-to-face training during the year that do not have profiles on the LMS Capabiliti. Of these, 1163 were tertiary students.

An additional 967 staff were deemed to have completed requirements for some Essential Education programs by Recognition of Prior Learning approved by their Executive Directors.

Future learning and development key priorities

Future learning and development key priorities are:

- refining and enhancing leadership, management and supervision programs
- planning and implementing a framework for further engaging medical staff in essential education
- implementing a new Aboriginal and Torres Strait Islander Awareness e-learning program
- updating the Learning Management System, Capabiliti, and incorporating a new electronic version of the Education Activity Register (EAR) in the next 12 months
- updating education requirements for education on chemotherapy.

Demonstrated commitment to whole-of-government learning and development initiatives

Table 37 shows ACT Health's participation in whole-of-government learning and development initiatives and ACT Health staff provided with study assistance.

Table 37: ACT Health's participation in whole-of-government learning and development initiatives

Initiative	No. of participants 2014–2015
ACTPS Graduate Program	6
Activity	**No. of participants**
Studies Assistance	233
Shared Services Calendar of Training	215

Attraction and Retention Initiatives (ARIns)

Table 38 provides ARIns details.

Table 38: Attraction and Retention Initiatives

Description	No. of individual (A)	Number of group (B)	Total employees covered by group (C)	Total (A + C)
Number of ARIns at 30 June 2015	18	5	128	146
Number of SEAs that have become ARIns during period	24	5	0	24
Number of ARIns entered into during period	3	0	0	3
Number of ARIns terminated during period*	23	0	0	23
Number of ARIns for privately plated vehicles as at 30 June 2015	1	0	0	1

Notes:

* The number of ARIns terminated during the period depicts the number of staff who had the payment of an ARIn cease during the period due to resignation, or ineligibility for payment under a group SEA. It does not represent the number of ARIns terminating.

Table 39 provides classification and remuneration rates.

Table 39: Classification and remuneration rates

	Classification Range	Remuneration as at 30 June 2015
Individual and Group ARIns	DEN1/2, DEN3, DEN4	$54,402–$167,172
	HPO1-HPO6	$20,273–$162,920
	PAO3	$120,508
	SITA – SITB	$134,102–$136,229
	SOA, SOB, SOC	$88,550–$163,201

Notes:

This data does not take into account Special Employment Arrangements (SEA) for staff covered by the ACT Public Service Medical Practitioners Enterprise Agreement 2011–13. Staff under this agreement are still paid an SEA not an ARIn.

Our Workforce

Table 40 shows Full-time Equivalent (FTE) and headcount by division/branch.

Table 40: Ia. FTE and headcount by division/branch

Division/branch	FTE	Headcount
Canberra Hospital and Health Services	5,212.5	5,999
Health Infrastructure and Planning	47.7	49
Office of the Director-General	101.2	107
Population Health	158.9	173
Special Purpose Account	16.1	21
Strategy and Corporate	659.1	715
Total	6,195.4	7,064

Table 41 shows headcount by division/branch and employment type.

Table 41: Ib. Headcount by division/branch and employment type

Division/branch	Permanent	Temporary	Casual
Canberra Hospital and Health Services	4,335	1,363	301
Health Infrastructure and Planning	34	15	0
Office of the Director-General	93	14	0
Population Health	145	27	1
Special Purpose Account	6	13	2
Strategy and Corporate	587	80	48
Total	5,200	1,512	352

Table 42 shows FTE and headcount by gender.

Table 42: 2. FTE and headcount by gender

	Female	Male	Total
Full-Time Equivalent	4,591.1	1,604.3	6,195.4
Headcount	5,340	1,724	7,064
Percentage of workforce (based on headcount)	75.6%	24.4%	100.0%

Table 43 shows headcount by classification and gender.

Table 43: 3. Headcount by classification and gender

Classification groups	Female	Male	Total
Administrative Officers	788	187	975
Dental	16	6	22
Executive Officers	13	10	23
General Service Officers and Equivalent	198	297	495
Health Assistants	72	9	81
Health Professional Officers	883	243	1,126
Information Technology Officers	0	2	2
Legal Officers	0	1	1
Medical Officers	421	455	876
Nursing Staff	2,554	330	2,884
Professional Officers	10	6	16
Senior Officers	257	130	387
Teacher	1	0	1
Technical Officers	124	47	171
Trainees and Apprentices	3	1	4
Total	5,340	1,724	7,064

Table 44 shows headcount by employment category and gender.

Table 44: 4. Headcount by employment category and gender

Employment category	Female	Male	Total
Casual	258	94	352
Permanent Full-time	2440	975	3,415
Permanent Part-time	1,613	172	1,785
Temporary Full-time	778	433	1,211
Temporary Part-time	251	50	301
Total	5,340	1,724	7,064

Table 45 shows headcount by diversity group.

Table 45: 5. Headcount by diversity group

Diversity group	Headcount	Percentage of agency workforce
Aboriginal and Torres Strait Islander	79	1.1%
Culturally and Linguistically Diverse (CALD)	1,761	24.9%
People with disability	144	2.0%

Note: Employees may identify with more than one of the diversity groups.

Table 46 shows headcount by age group and gender.

Table 46: 6a. Headcount by age group and gender

Age group (years)	Female	Male	Total
Under 25	352	109	461
25-34	1,517	529	2,046
35-44	1,287	429	1,716
45-54	1,262	381	1,643
55 and over	922	276	1,198

Table 47 shows the average length of service by gender (headcount).

Table 47: 6b. Average length of service by gender (headcount)

	Female	Male	Total
Average years of service	7.6	6.4	7.3

Table 48 shows headcount by length of service, generation and gender.

Table 48: 6c. 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	2	2	165	49	347	147	813	348	1,327	546
2-4	2	0	119	34	309	111	482	181	912	326
4-6	2	1	136	36	262	96	292	74	692	207
6-8	2	0	151	54	221	79	182	30	556	163
8-10	4	0	117	36	199	57	86	13	406	106
10-12	3	1	126	36	151	56	46	7	326	100
12-14	0	0	125	34	116	33	20	2	261	69
14 plus	4	5	554	137	293	65	9	0	860	207

Note:

Pre-Baby Boomers cover the years prior to 1946. Baby Boomers cover the years from 1946 to 1964 inclusive. Generation X cover the years from 1965 to 1979 inclusive. Generation Y cover the years from 1980 onwards.

Table 49 shows recruitment and separation rates by division.

Table 49: 7 a. Recruitment and separation rates by division

Division	Recruitment rate	Separation rate
Canberra Hospital and Health Services	9.9%	7.0%
Health Infrastructure and Planning	12.0%	18.0%
Office of the Director-General	11.6%	9.3%
Population Health	8.4%	7.7%
Special Purpose Account, Canberra Hospital	22.2%	0.0%
Strategy and Corporate	8.0%	7.3%
Total	9.6%	7.1%

Table 50 shows recruitment and separation rates by classification group.

Table 50: 7b. Recruitment and separation rates by classification group

Classification group	Recruitment rate	Separation rate
Administrative Officers	13.5%	7.0%
Dental	16.3%	8.2%
Executive Officers	0.0%	0.0%
General Service Officers and Equivalent	4.7%	4.7%
Health Assistants	25.1%	11.6%
Health Professional Officers	13.9%	8.8%
Information Technology Officers	0.0%	0.0%
Legal Officers	0.0%	0.0%
Medical Officers	10.9%	4.7%
Nursing Staff	7.6%	7.1%
Professional Officers	0.0%	0.0%
School Leaders	0.0%	0.0%
Senior Officers	5.1%	6.6%
Teacher	0.0%	0.0%
Technical Officers	8.2%	6.0%
Trainees and Apprentices	41.3%	82.5%
Total	9.6%	7.1%

B.9 ECOLOGICALLY SUSTAINABLE DEVELOPMENT

Introduction/overview

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 2014 Chief Health Officer Report.
  Progress: The Chief Health Officer decided against including the 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 10 (ii)**: 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 (PMS) at Florey is fully operational and the ACT is now compliant with the AAQ NEPM.
- **Recommendation 10 (iii)**: Improve local air quality outdoors, through determining the feasibility, including costs, of mobile monitoring of appropriate ambient air quality NEPM standards at locations in and around Canberra.
  Progress: This recommendation is not supported. ACT Health has examined the feasibility of this recommendation and determined that it would be cost-prohibitive and the quality of obtained data would be insufficient for any meaningful evaluation or policy making.

ACT Health actively supports whole-of-government and continues to work towards embedding sustainability initiatives into the delivery of service to achieve the ACT Government's target of zero net emissions by 2020.

ACT Health has developed policies, programs and plans to promote Environmentally 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 actively participates in the ACT Government Carbon Neutral Government Implementation Committee and Buildings and Infrastructure Sub Committee.

In 2014–15, ACT Health's contribution to the Carbon Neutral Government Fund (CNGF) was calculated at $98,570. The contribution was made as part of Cabinet's decision to reallocate out-year GreenPower purchases, to allow energy efficiency projects to be implemented across ACT Government.

ACT Health commenced work to renew its Sustainability Strategy, Resource Management Plan (RMP) and Environmental Principles and Guidelines – Building and Infrastructure Projects documents. The Sustainability Strategy Action Plan is being rolled into the RMP.

ACT Health provided a supported framework for staff to set up Green Teams.

Energy

ACT Health began using the Enterprise Sustainability Platform (ESP) database to capture data for analysis and reporting purposes and to inform operational management of trends and potential energy usage reduction strategies.

A Sustainability Committee (the Health Planning and Infrastructure Sustainability Reference Group) has been established within ACT Health to review the energy efficiency and whole-of-life costing of building elements of all new builds. This aims to assist in reducing carbon emissions.

A feasibility study was undertaken to support an application to the CNGF to install solar photovoltaic (PV) panels on the roof of the southern multi-storey car park at Canberra Hospital, in conjunction with rolling out LED lighting to buildings on the hospital campus. The application to the CNGF was submitted in May 2015.

Initiatives incorporated into the various ACT Health new building projects, upgrades and improvements, aimed at reducing carbon emissions include:

- installing energy efficient lighting, including emergency lighting
- installing motion sensors for lighting in office areas
- installing energy efficient window glazing, including double glazing in some areas
- installing intelligent networked lighting controls
- using paints, glues and sealants with low Volatile Organic Compounds (VOC)
- replacing the old boiler system for heating and old chiller units with high efficiency Variable Air Volume (VRV) units (at Tuggeranong only)
- assessing the economy mode usage on damper air intake of air conditioning
- implementing a new Building IQ system and building analytical software to improve the use of utilities in Property Management and Maintenance
- analysing the ACTSmart Enterprise Sustainable Platform to help identify saving opportunities.

Water

The clinical and domestic services delivered by ACT Health rely heavily on water usage, including:

- patients showers
- theatre operations
- sterilising surgical equipment.

Efficient water initiatives incorporated into the various ACT Health new buildings, upgrades and improvements aimed at reducing water usage include:

- re-using Reverse Osmosis (RO) water from the renal process in the toilet facilities at identified community health centres
- installing flow restrictors on a range of plumbing fixtures, for example, showers, hand basins and toilets
- installing motion sensors where applicable, while considering infection control issues
- considering the water usage star rating when replacing old, broken or obsolete equipment, where practical
- replacing heating pipe work and associated works at Canberra Hospital, in accordance with the preventative maintenance schedule
- upgrading boilers at Canberra Hospital
- continuing restrictions on the use of potable (drinkable) water for outside watering at all ACT Health facilities
- deactivating all garden sprinklers and decommissioning fountains
- conducting metering analysis of water utilisation at Canberra Hospital and reporting on any anomalies
- continuing tank water usage for outdoor garden watering and external washing of facilities, buildings and pavements, where tanks are installed
- analysing the ACTSmart Enterprise Sustainable Platform to help identify saving opportunities.

Waste

ACT Health is deploying the ACTSmart Recycling Program across both acute and non-acute sites. In 2015, the ACTSmart Online Recycling Training was made available to staff. It provides education and guidance on the impacts and outcomes the program can deliver at health sites to improve resource recovery and reduce waste.

ACT Health, the Auditor's Office and Community Services Directorate, all located at 11 Moore Street, submitted a nomination in the Corporate category of the ACTSmart Awards 2015. The three directorates applied a collaborative approach to implementing sustainable waste management within the building, including separating:

- organic waste
- mixed-recyclables
- land-fill.

The application was not successful this year.

Transport

ACT Health currently has three electric vehicles in its fleet. We continue to explore opportunities to include additional electric vehicles and additional charge stations at key ACT Health facilities to support these vehicles. The total fleet is 321 vehicles.

ACT Health assesses replacement vehicles for efficiencies, both fuel and greenhouse gas emissions, when vehicle replacement occurs.

Staff are encouraged to use active travel (walk, bus or bike) for trips less than four kilometres instead of using motor vehicles.

Fuel usages decreased during the 2014–15 financial year.

More information: For more information, see Table 51, page 133.

ACT Health continues to encourage staff car pooling and has designated car parks spaces at Canberra Hospital for those staff who participate in this option.

Sustainable development performance

Table 51: ACT Health operational consumption of resources

Indicator as at 30 June	Unit	Previous FY (2013–14)	Current FY (2014–15)	Percentage Change
Agency staff and area				
Agency staff	FTE	5,979.9	6,195.4	3.59%
Agency staff	Headcount	6,797	7,064	3.93%
Workplace floor area	Area (m^2)	259,504	274,480	5.77%
Stationary energy usage				
Electricity use	Kilowatt hours	31,978,303[1]	36,399,242[2]	13.82%
Renewable electricity use	Kilowatt hours	N/a	N/a[3]	-
Natural gas use	Megajoules	110,109,684	109,252,309	-0.77%
Transport fuel usage				
Total number of vehicles	Number	321	321[4]	0%
Total kilometres travelled	Kilometres	3,882,625	3,755,211	-3.28%
Fuel use – Petrol	Kilolitres	221	199	-9.95%
Fuel use – Diesel	Kilolitres	126	128	1.58%
Fuel use – Liquid Petroleum Gas (LPG)	Kilolitres	-	-	-
Fuel use – Compressed Natural Gas (CNG)	Kilolitres	-	-	-
Water usage				
Water use	Kilolitres	220,317.3	214,267.5[5]	-2.75%
Resource efficiency and waste				
Reams of paper purchased	Reams	48,781	49,487[6]	1.44%
Recycled content of paper purchased	Percentage	3.76	21.6	474.47%
Waste to landfill	Litres	21,282,888	23,758,168[7]	11.63%
Co-mingled material recycled	Litres	4,120,160	5,682,435	37.92%
Paper and Cardboard recycled (incl. secure paper)	Litres	976,396	1,117,613[8]	14.50%
Organic material recycled	Litres	4,910[9]	7,262[10]	47.9%
Greenhouse gas emissions				
Emissions from stationary energy use	Tonnes CO2-e	40,958	36,199[11]	-11.62%
Emissions from transport	Tonnes CO2-e	936.15	879.12	-6.09%
Total emissions	Tonnes CO2-e	41,894.15	37,078.12	-11.49%

1 Canberra Hospital meter readings in the first five months of 2013–14 reading 4,680,842kWh, or 35 per cent, less than reported in 2012–13 due to electrical meter irregularity.

2 The increase in energy usage for 2014–15 is associated with activity and infrastructure growth across all of ACT Health, for example the Canberra Region Cancer Centre and Walk in Centres at Belconnen and Tuggeranong becoming operational.

3 Not being reported at Directorate level, only reported at Whole-of-Government level.

4 Figure for 2014–15 is inclusive of two electric vehicles.

5 Reduction due to completion of building construction at acute and non-acute sites plus introduction of water efficient measures, such as fittings and newer plant.

6 Figure reflects an increase of paper reams purchased associated with increased headcount/activity growth across all of Health.

7 2014–15 waste to landfill litres reflects an increase of 2,475,280 litres (11.63 per cent) when compared to 2013–14 due to increased activity and infrastructure growth.

8 In 2014–15, ACT Health increased paper and cardboard recycling by 141,217 litres (or 14.50 per cent) when compared to 2013–14.

9 Replaces incorrect 2013–14 figure of 8,012 litres (calculation error), which was to represent 11 Moore St outputs only, 4,910 litres includes eight months data for 1 Moore Street and 12 months data for 11 Moore Street.

10 7,262 litres for 2014–15 includes 12 months data for 1 Moore Street and 11 Moore Street.

11 ACT Health reduced its overall emissions across all scopes in 2014–15 against a 5.77 per cent increase in workplace floor area.

SECTION C Financial Management Reporting

C.I FINANCIAL MANAGEMENT DISCUSSION & ANALYSIS FOR THE HEALTH DIRECTORATE FOR THE FINANCIAL YEAR ENDED 30 JUNE 2015

General Overview

Operations and Principal Activities

The Directorate 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 healthcare; 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.

The Directorate continues to strengthen clinical governance of its processes, and strives to be accountable to both the government and the community.

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

Changes in Administrative Structure

On 15 December 2014, Administrative Arrangements 2014 (No 2) (Notifiable Instrument NI2014-654) came into effect. This instrument transferred the Public Health Protection and Regulation function from the Health Directorate to the Chief Minister, Treasury and Economic Development Directorate as part of the establishment of Access Canberra.

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;
- 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; and
- a significant investment in clinical systems and recording systems.

The above risks are monitored regularly throughout the year.

Financial Performance

The following financial information is based on audited financial statements for 2013–14 and 2014–15, and the budget and forward estimates contained in the 2015–16 Health Directorate Budget Statements.

Total Net Cost of Services

	Actual 2013–14 $m	Budget 2014–15 $m	Actual 2014–15 $m	Budget 2015–16 $m	Forward Estimate 2016–17 $m	Forward Estimate 2017–18 $m	Forward Estimate 2018–19 $m
Total Expenditure	1,115.9	1,188.7	1,195.3	1,253.7	1,320.4	1,346.5	1,412.5
Total Own Source Revenue	849.2	886.8	898.1	942.7	986.0	1,008.4	1,037.8
Net Cost of Services	266.7	301.9	297.2	311.0	334.4	338.1	374.7

Comparison to Budgeted Net Cost of Services

The Directorate's net cost of services for 2014–15 of $297.2 million was $4.7 million or 1.5 per cent lower than the 2014–15 budget.

A combination of factors resulted in higher than budgeted own source revenue ($11.3 million). The main higher revenue variations are:

- Other Gains ($5.5 million) – due to the derecognition of lease liabilities (receiving a gain in revenue from no longer recording a lease pay out amount to own the vehicle) due to the change in lease type for motor vehicles which has been reclassified from finance leases to operating leases. This revenue is offset by an expense amount in 'Other Expenses' of $5.3 million for the derecognition of the motor vehicle asset (an expense from no longer recording the vehicle as ACT Health's asset);
- User Charges ACT Government ($3.2 million) – largely due to receiving additional revenue from the ACT Local Hospital Network Directorate; and
- User Charges Non-ACT Government ($3.2 million) – largely due to more inpatient fees as a result of an increase in compensable and private patients and revenue related to Department of Veterans Affairs patients that was not accounted for until 2014–15.

This higher than budgeted own source revenue was partially offset by higher than budgeted expenses ($6.6 million). The main higher expense variations are:

- Depreciation and Amortisation ($8.2 million) – due to the demolition of Building 15 at Canberra Hospital ($5.4 million) earlier than it's original useful life and higher computer amortisation costs ($8.0 million) for completed software projects that became operational during 2014–15, partially offset by delays in the completion of capital works projects that have been moved out to 2015-16 and 2016-17;
- Employee Expenses ($7.7 million) – largely due to an increase in the rate used to estimate the present value of long service leave from 103.5% to 104.2% ($2.9 million) and annual leave consumption being lower than anticipated ($3.3 million). An increase in overtime costs and penalties account for the remaining balance;
- Supplies and Services ($4.1 million) – largely due to charges for Blood Products ($8.9 million) classified as supplies and services but in the budget allocated to Other Expenses. Partially offset by:
  - cost savings in medical and surgical supplies ($1.3 million);
  - cost savings in staff development ($1.4 million);
  - lower domestic services charges ($1.2 million); and
  - utilities charges being lower than anticipated ($1.0 million).

The higher than budgeted expenses were partially offset by lower than budgeted Grants and Purchased Services ($14.5 million) expense. The 2014–15 Budget for Grants and Purchased Services was higher than required and has been adjusted down in the 2015–16 Budget.

Comparison to 2013–14 Net Cost of Services

There was an 11.4 per cent increase in net cost of services or $30.5 million more when compared to the 2013–14 actual cost of $266.7 million.

This increase in net cost of services was due to higher expenses ($79.4 million). The main increases in expenses are:

- Employee Expenses ($36.7 million) – largely due to:
  - the impact of collective agreement pay rises;
  - an increase in the rate used to estimate the present value of long service leave from 103.5% to 104.2%;
  - the impact of pay rises on employee leave;
  - leave earned exceeding leave taken; and
  - an increase in the overall workforce to cover growth in services;
- Depreciation and Amortisation ($14.1 million) – the increase is largely due to:
  - higher amortisation for computer software projects that became operational in 2014–15 ($8.0 million); and
  - The demolition of Building 15 at Canberra Hospital in 2014–15 earlier than its original useful life;
- Supplies and Services ($13.2 million) – increased costs for:
  - medical and surgical supplies ($4.5 million) due to inflation and growth in acute services, mental health services and cancer services;
  - increased computer costs ($2.8 million);
  - higher pharmaceuticals costs ($2.4 million) mainly due to inflation and an increase in the use of high cost drugs;
  - higher cleaning and water and sewerage costs ($1.5 million) for the full year effect of the opening of new buildings; and
  - ageing assets increasing repairs and maintenance costs ($1.2 million);
- Other Expenses ($6.4 million) – largely due to the derecognition of motor vehicle assets ($5.3 million) following a change of lease type from finance to operating leases;
- Grants and Purchased Services ($5.7 million) – largely due to providing a dedicated hip and knee joint replacement program at Calvary John James Hospital which increased elective surgery payments by $3.6 million and an increase in payments to Calvary Public Hospital ($1.0 million) mainly for inflation and growth in services; and
- Superannuation ($4.6 million) – largely due to pay rises under collective agreements and an increase in the number of employees.

Total expenditure was partially offset by reduced expenditure for Cost of Goods Sold ($1.0 million) due to a lower volume of goods being sold to private hospitals.

Total Own Source Revenue increased by $48.9 million largely due to higher:

- ACT Government User Charges ($42.6 million) largely due to indexation and growth in patient activity; and
- Other Gains ($5.7 million) largely from the derecognition of lease liability for motor vehicles due to a change from finance leases to operating leases.

Future Trends

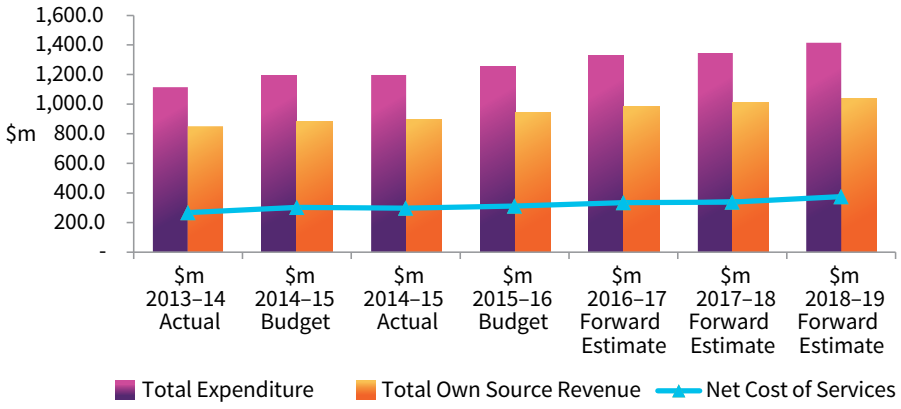


Figure 1: Net Cost of Services

Net cost of services is planned to increase steadily over the future years consistent with funding provided in the 2015–16 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.

Total Expenditure

Components of Expenditure

Figure 2 below indicates the components of the Directorate's expenses for 2014–15 with the largest components of expense being employee expenses which represents 53.8 per cent or $643.1 million, supplies and services which represents 27.1 per cent or $323.9 million, and superannuation, which represents 6.8 per cent or $81.0 million.

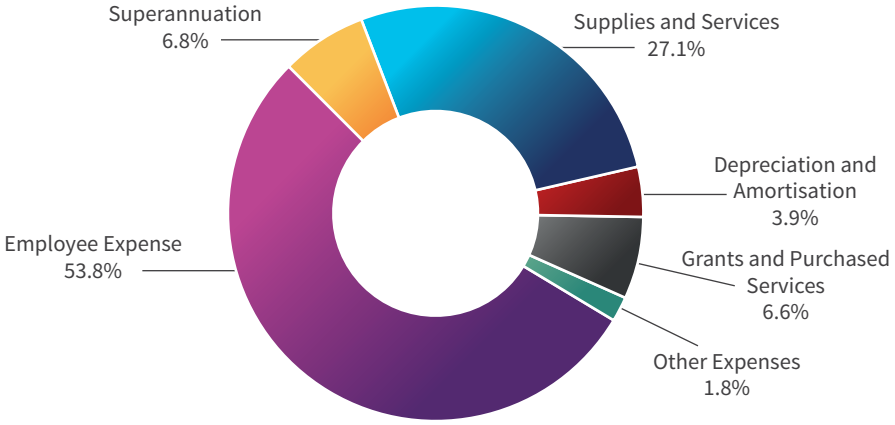


Figure 2: Components of Expenditure

Comparison to Budget

Total expenses of $1,195.3 million were $6.6 million, or 0.6 per cent higher than the original 2014–15 budget of $1,188.7 million.

This increase was predominantly due to higher:

- Depreciation and Amortisation ($8.2 million) – due to the demolition of Building 15 at Canberra Hospital ($5.4 million) earlier than its original useful life and higher amortisation costs for completed computer software projects that became operational during 2014–15 ($8.0 million), offset by delays in the completion of capital works projects that have been moved out to 2015–16 and 2016–17;
- Employee Expenses ($7.7 million) – largely due to an increase in the rate used to estimate the present value of long service leave from 103.5% to 104.2% ($2.9 million) and annual leave consumption being lower than anticipated ($3.3 million). An increase in staff numbers, increased overtime costs and penalties account for the balance;
- Supplies and Services ($4.1 million) – largely due to:
  - the use of visiting medical officers (VMO's) to backfill staff specialist vacancies and staff specialists on extended leave ($3.1 million);
  - increased amounts of assets purchased under the capitalisation threshold of $5,000 ($1.7 million); and
  - the hiring of non-contract staff ($1.9 million);
  - These higher supplies and services were partially offset by:
    - cost savings in medical and surgical supplies ($1.3 million);
    - cost savings in staff development ($1.4 million);
    - lower domestic services charges ($1.2 million); and
    - utilities charges being lower than anticipated ($1.0 million); and
- Superannuation ($1.4 million) – largely due to;
  - pay rise 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 ($14.5 million) expense. The 2014–15 Budget for Grants and Purchased Services was higher than required and has been adjusted down in the 2015–16 Budget.

Comparison to 2013–14 Actual Expenses

Total expenses were ($79.4 million) or 7.1 per cent higher than the 2013–14 actual result. The increase was predominantly due to higher:

- Employee Expenses ($36.7 million) – largely due to:
  - the impact of collective agreement pay rises;
  - an increase in the rate used to estimate the present value of long service leave from 103.5% to 104.2%;
  - the impact of pay rises on employee leave;
  - leave earned exceeding leave taken; and
  - an increase in the overall workforce to cover growth in services;
- Depreciation and Amortisation ($14.1 million) – the increase is due to:
  - higher amortisation for computer software projects that became operational in 2014–15 ($8.0 million); and
  - The demolition of Building 15 at Canberra Hospital in 2014–15 before the end of its original useful life ($5.4 million);
- Supplies and Services ($13.2 million) – the main variations are due to increased:
  - clinical expenses/medical surgical supplies ($4.5 million) – mainly due to inflation and growth in patient activity;
  - computer expenses ($4.5 million) – due to a combination of factors, including inflation, increase in staff numbers and support costs for projects that became operational during the year;
  - pharmaceuticals ($2.4 million) – mainly due to inflation and an increase in the use of high cost drugs;
  - domestic services, food and utilities ($1.5 million) – mainly due to higher cleaning and water and sewerage costs for the full year effect of the opening of new buildings;
  - repairs and maintenance ($1.2 million) – as a result of preventative and reactive repairs on ageing assets and an increase in maintenance costs for new buildings; and
  - the higher supplies and services were partially offset by lower visiting medical officers (VMO's) ($1.8 million) – as a result of higher expenses in 2013–14 that included costs for services provided in 2012–13 that had previously not been accounted for;
- Other Expenses ($6.4 million) – due to:
  - the derecognition of motor vehicle assets ($5.3 million) following a change of lease type from finance to operating leases;
  - the write off of audio visual communication equipment ($1.8 million) that was bought for hospitals throughout Southern New South Wales; and
  - the higher other expenses were offset by a reduction in legal settlements ($1.1 million);
- Grants and Purchased Services ($5.7 million) – largely due to providing a dedicated hip and knee joint replacement program at Calvary John James which increased elective surgery payments by $3.6 million, an increase in payments to Calvary Public Hospital ($1.0 million) which was largely related to inflation and growth and the balance relates to inflation on contracts with non-government organisations; and
- Superannuation ($4.6 million) – as a result of an increase in:
  - the number of employees;
  - pay rises under collective agreements;
  - increase in notional superannuation rates; and
  - a slower decline in the number of employees leaving the higher cost CSS, PSS and PSSap schemes than had been anticipated.

The increased expenses were partially offset by lower Cost of Goods Sold ($1.0 million) – due to a lower volume of goods being sold to private hospitals.

Future Trends

Expenses are budgeted to increase steadily across the forward years to account for inflation 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 2015, the Directorate received 85.4 per cent of its total own source revenue ($3.2 million) from ACT Government user charges.

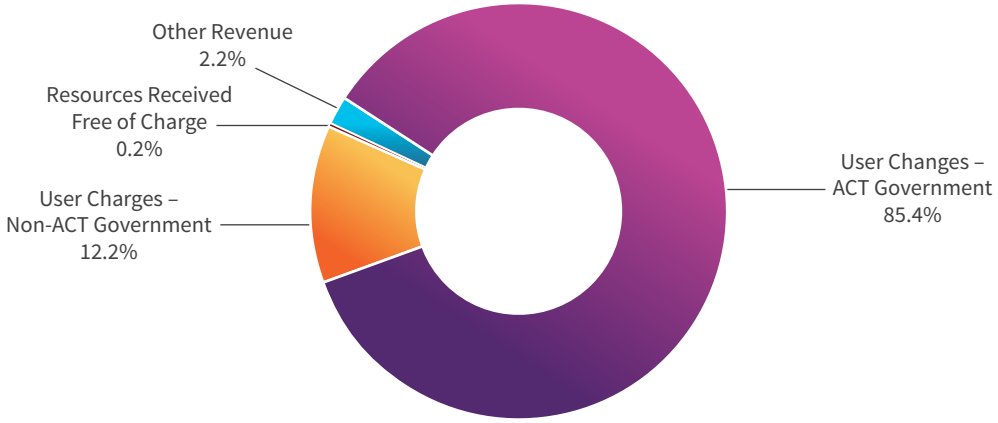


Figure 3 – Components of Own Source Revenue

Comparison to Budget

Own source revenue for the year ending 30 June 2015 was $898.1 million, which was $11.3 million or 1.3 per cent higher than the 2014–15 budget of $886.8 million.

This favourable variance is due to higher:

- Other Gains ($5.5 million) – due to the derecognition of lease liabilities from the change in lease type for motor vehicles which moved from finance leases to operating leases;
- User Charges ACT Government ($3.2 million) – due to receiving additional revenue from the ACT Local Hospital Network Directorate; and
- User Charges Non-ACT Government ($3.2 million) – largely due to increased inpatient fees from an increase in compensable and private patients and prior year revenues related to Department of Veterans Affairs patients.

Comparison to 2013–14 Actual Revenue

Own source revenue was $48.9 million or 5.8 per cent higher than the 2013–14 actual result of $849.2 million.

The increase compared to last financial year is due to:

- ACT Government User Charges ($42.6 million) largely due to inflation and growth in patient activity;
- Other Gains ($5.7 million) – mainly due to the derecognition of lease liabilities (receiving a gain in revenue from no longer recording a lease payout amount to own the vehicle) due to the change in lease type for motor vehicles which has been reclassified from finance leases to operating leases; and
- Non-ACT Government User Charges ($1.6 million) – largely due to an increase in inpatient fees as a result of increases in compensable and private patients as well as prior year revenues related to the Department of Veterans Affairs patients.

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 2015–16 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 2015, the Directorate held 74.6 per cent of its assets in property, plant and equipment.

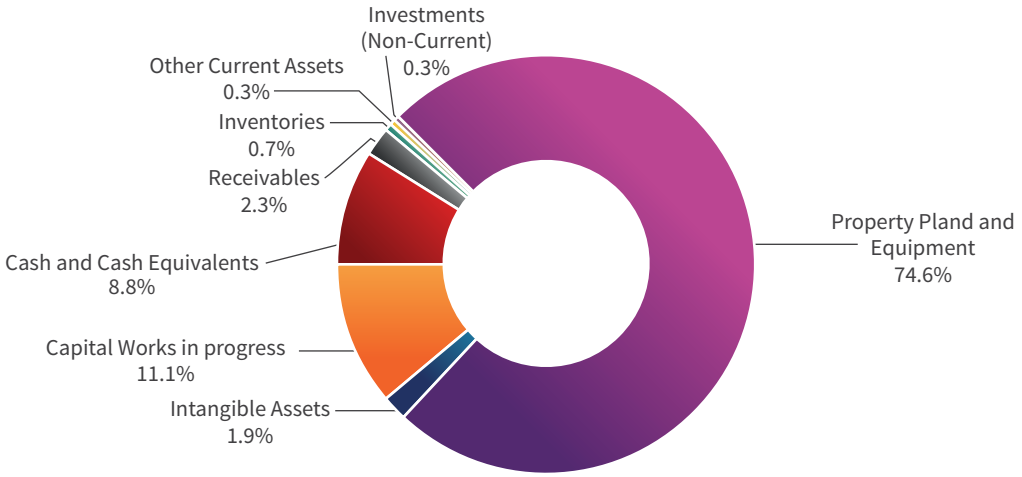


Figure 4 – Total Assets as at 30 June 2015

Comparison to Budget

The total asset position as at 30 June 2015 is $1,188.4 million, $118.8 million lower than the 2014–15 budget of $1,307.2 million.

The variance reflects the timing associated with the acquisition and completion of various assets over the 2014–15 financial year resulting in lower:

- Property, Plant and Equipment ($129.2 million) – largely due to delays with current capital works projects from lengthy contract negotiations, procurement delays and extensions, delays in hospital road works as a result of the installation of a new demountable building, and a flow on effect of delays between projects;
- Receivables ($46.2 million) – largely due to the budget including a large amount for cross border revenue which has since been received;
- Intangible Assets ($7.8 million) – largely due to delays with computer software projects; and
- Capital Works in Progress ($1.5 million) – due to the deferral of capital works from 2014–15 into future years, partially offset by the deferral of 2013–14 capital works projects into 2014–15.

Partially offset by higher:

- Cash and Cash Equivalents ($63.0 million) – largely due to payment of the 27th pay happening on 1 July 2015 rather than 30 June 2015 and continued delay in the medical officers enterprise bargaining agreement.

Comparison to 2013–14 Actual

The Directorate's total asset position is $29.6 million higher than the 2013–14 actual result of $1,158.8 million, largely due to increases in:

- Property, Plant and Equipment ($27.0 million) – largely due to completed building capital works projects; and
- Intangible Assets ($15.7 million) – due to completed computer software packages; and
- Receivables ($3.8 million) – the increase mainly relates to reimbursements of Directorate doctors seconded to Calvary Hospital and accrued revenue for chargeable patients fees.

The above increases were partially offset by a reduction in:

- Capital Works in Progress ($16.0 million) – as a result of completed computer software works moving to intangible assets and completed building works moving to property, plant and equipment; and
- Cash and Cash Equivalents ($2.2 million) – The reduction in cash relates to the return of $27 million surplus cash to the ACT Government, this is offset by cash held by the Directorate for a 27th pay that occurs in 2015–16, outstanding pay rise back pay for medical officers and deferred expenditure.

Total Liabilities

Components of Total Liabilities

Figure 5 below indicates that the majority of the Directorate's liabilities relate to employee benefits 81.3 per cent and payables 18.1 per cent.

Figure 5 – Total Liabilities as at 30 June 2015

Comparison to Budget

The Directorate's liabilities for the year ended 30 June 2015, of $300.1 million, is $1.9 million lower than the 2014–15 budget of $302.0 million.

This was largely due to higher:

- Employee Benefits ($41.2 million) – largely due to the impact of pay rises on leave provisions, increases in the rates used to estimate the present value of long service leave from 103.5% to 104.2% and annual leave from 100.9% to 101.0%.

Offset by lower:

- Payables ($33.9 million) – largely due to the budget including a large amount for unpaid capital works invoices which was reduced in 2014–15;
- Finance Leases ($6.9 million) – this relates to motor vehicle finance leases and on 23 April 2015 there was a change in contract at the Whole-of-Government level to move these to operating leases leaving a nil actual figure; and
- Other Liabilities ($2.3 million) – largely due to the budget including a large amount for revenue received in advance which was based on actual figures from 2012–13.

Comparison to 2013–14 Actual

Total liabilities of $300.1 million are $27.3 million higher than the actual results as at 30 June 2014 of $272.8 million. This is due to increases in:

- Employee Benefits ($22.0 million) – largely due to the impact of pay rises on leave provisions, accrued pay rise amounts for medical officers, increases in the rates used to estimate the present value of long service leave from 103.5% to 104.2% and annual leave from 100.9% to 101.0%;
- Payables ($11.6 million) – the increase includes capital works accruals ($7.0 million), visiting medical officer accruals ($2.0 million) and pharmaceutical accruals ($2.0 million); and

The above increases were partially offset by a decrease in:

- Finance Leases ($6.2 million) – this relates to motor vehicle finance leases and on 23 April 2015 there was a change in contract lease type from finance to operating leases.

Attachment A – Comparison of net cost of services to budget 2014–15

Description	Original Budget $'000	Plus AAO Transfers $'000	Total Funding $'000	Less Actual $'000	Variance to be Explained $'000	Variance to be Explained %
Expenses						
Employee Expense and Superannuation	715,062	(382)	714,680	724,154	9,474	1.3%
Supplies and Services	319,790	-	319,790	323,871	4,081	1.3%
Depreciation and Amortisation	38,395	-	38,395	46,586	8,191	21.3%
Purchased Services	92,810	-	92,810	78,343	(14,467)	-15.6%
Other Expenses	11,758	-	11,758	13,084	1,326	11.3%
Cost of Goods Sold	10,934	-	10,934	9,295	(1,639)	-15.0%
Total Expenses	**1,188,749**	**(382)**	**1,188,367**	**1,195,333**	**6,966**	**0.6%**
Own Source Revenue						
User Charges	863,162	-	863,162	866,105	2,943	0.3%
Interest	278	-	278	70	(208)	-74.8%
Resources Received Free of Charge	792	-	792	1,470	678	85.6%
Gains	1,574	-	1,574	7,080	5,506	349.8%
Other Revenue	16,722	-	16,722	19,857	3,135	18.7%
Grants from the Commonwealth	4,245	-	4,245	3,503	(742)	-17.5%
Total Own Source Revenue	**886,773**	**-**	**886,773**	**898,085**	**11,312**	**1.3%**
Total Net Cost of Services	**301,976**	**(382)**	**301,594**	**297,248**	**(4,346)**	**-1.4%**

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 16.0 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 2015 was $8.0 million, which is $0.9 million lower than the budget figure of $8.9 million due to reprofiling of capital works into 2015–16 for the completion of building refurbishment for clinical services and the electrical substation and savings returned from a prior year capital upgrade.

Total Territorial income for 2014–15 of $8.0 million is $2.2 million higher than the 2013–14 income of $5.8 million. The main contributor to this increase is:

- Payment for Expenses on Behalf of the Territory ($2.1 million) – this is due to capital works paid to Calvary Public Hospital.

Total Expenses

Figure 7 below indicates that 84.1 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 15.9 per cent being the transfer, to Government, of regulatory licence fees.

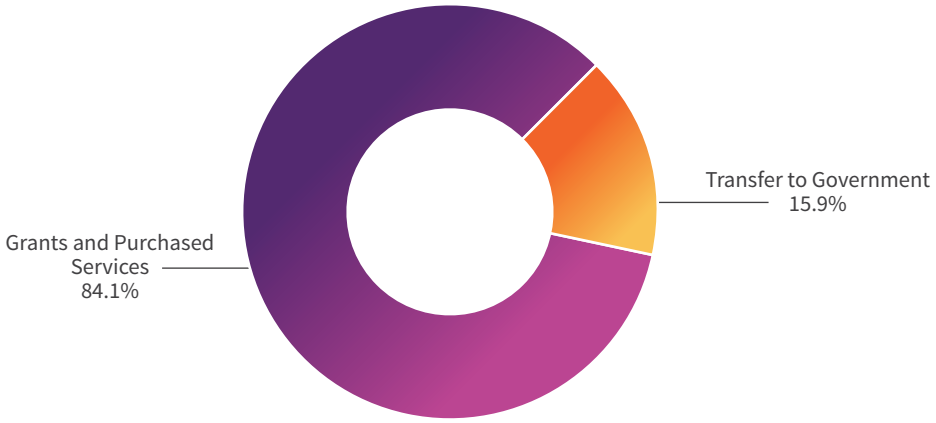


Figure 7 – Sources of Territorial Expenses

Total expenses were $8.0 million, which was $0.9 million lower than the budget of $8.9 million due to lower regulatory licence fees received.

Total expenses were $2.2 million higher than the 2013–14 total of $5.7 million. This is due to capital works paid to Calvary Public Hospital.

C.2 HEALTH DIRECTORATE FINANCIAL STATEMENTS

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

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 2015 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 statement of appropriation.

Responsibility for the financial statements

The Director-General 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.

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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 2015:

(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 2015 and results of its operations and cash flows for the year then ended.

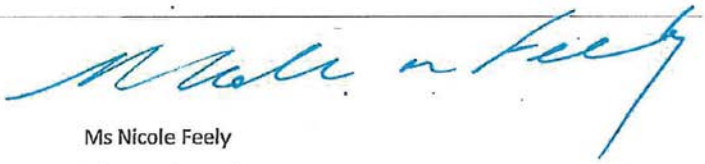
The audit opinion should be read in conjunction with other information disclosed in this report.

Dr Maxine Cooper
Auditor-General
14 September 2015

Health Directorate
Financial Statements
For the Year Ended 30 June 2015

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 2015 and the financial position of the Directorate on that date.



Ms Nicole Feely

Director-General

Health Directorate

24 July 2015

Health Directorate
Financial Statements
For the Year Ended 30 June 2015

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 2015 and the financial position of the Directorate on that date.

Mr Ron Foster

Chief Finance Officer

Health Directorate

24 July 2015

Health Directorate
Operating Statement
For the Year Ended 30 June 2015

	Note No.	Actual 2015 $'000	Original Budget 2015 $'000	Actual 2014 $'000
Income				
Revenue				
Government Payment for Outputs	4	252,617	257,615	229,062
User Charges – ACT Government	5	760,594	757,356	718,016
User Charges – Non-ACT Government	5	109,014	105,806	107,377
Interest	6	70	100	97
Distribution from Investments with the Territory Banking Account	7	97	178	98
Resources Received Free of Charge	8	1,471	792	1,618
Other Revenue	9	19,760	20,967	20,628
Total Revenue		**1,143,623**	**1,142,814**	**1,076,896**
Gains				
Gains on Investments	10	12	-	4
Other Gains	11	7,068	1,574	1,394
Total Gains		**7,080**	**1,574**	**1,398**
Total Income		**1,150,703**	**1,144,388**	**1,078,294**
Expenses				
Employee Expenses	12	643,111	635,448	606,380
Superannuation Expenses	13	81,043	79,614	76,443
Supplies and Services	14	323,871	319,790	310,676
Depreciation and Amortisation	15	46,586	38,395	32,483
Grants and Purchased Services	16	78,343	92,810	72,677
Borrowing Costs	17	305	401	551
Cost of Goods Sold	18	9,295	10,934	10,339
Other Expenses	19	12,779	11,357	6,390
Total Expenses		**1,195,333**	**1,188,749**	**1,115,939**
Operating (Deficit)		**(44,630)**	**(44,361)**	**(37,645)**
Other Comprehensive Income				
Items that will not be reclassified subsequently to profit or loss				
(Decrease) in Asset Revaluation Surplus	37	(90)	-	(14,489)
Total Comprehensive (Deficit)		**(44,720)**	**(44,361)**	**(52,134)**

The above Operating Statement should be read in conjunction with the accompanying notes. The Directorate has only 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
For the Year Ended 30 June 2015

	Note No.	Actual 2015 $'000	Original Budget 2015 $'000	Actual 2014 $'000
Current Assets				
Cash and Cash Equivalents	23	105,069	42,075	107,256
Investments		-	3,011	-
Receivables	24	27,232	73,236	23,458
Inventories	25	8,655	8,513	7,806
Assets Held for Sale	26	-	34	29
Other Assets	31	3,939	4,172	3,391
Total Current Assets		**144,895**	**131,041**	**141,940**
Non-Current Assets				
Receivables	24	-	200	-
Investments	27	3,027	-	3,015
Property, Plant and Equipment	28	886,129	1,015,328	859,100
Intangible Assets	29	22,583	30,411	6,933
Capital Works in Progress	30	131,756	130,259	147,783
Total Non-Current Assets		**1,043,495**	**1,176,198**	**1,016,831**
Total Assets		**1,188,390**	**1,307,239**	**1,158,771**
Current Liabilities				
Payables	32	54,269	88,172	42,647
Finance Leases	33	-	2,515	2,156
Employee Benefits	34	229,506	187,149	208,007
Other Liabilities	36	370	2,624	523
Total Current Liabilities		**284,145**	**280,460**	**253,333**
Non-Current Liabilities				
Finance Leases	33	-	4,362	4,042
Employee Benefits	34	14,529	15,692	14,044
Other	35	1,418	1,503	1,375
Total Non-Current Liabilities		**15,947**	**21,557**	**19,461**
Total Liabilities		**300,092**	**302,017**	**272,794**
Net Assets		**888,298**	**1,005,222**	**885,977**
Equity				
Accumulated Funds		758,870	861,215	756,459
Asset Revaluation Surplus	37	129,428	144,007	129,518
Total Equity		**888,298**	**1,005,222**	**885,977**

The above Balance Sheet should be read in conjunction with the accompanying notes. The Directorate has only 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 2015

	Note No.	Accumulated Funds Actual 2015 $'000	Asset Revaluation Surplus Actual 2015 $'000	Total Equity Actual 2015 $'000	Original Budget 2015 $'000
Balance at 1 July 2014		**756,459**	**129,518**	**885,977**	**917,332**
Comprehensive Income					
Operating (Deficit)		(44,630)	-	(44,630)	(44,361)
(Decrease) in the Asset Revaluation Surplus	37	-	(90)	(90)	-
Total Comprehensive (Deficit)		**(44,630)**	**(90)**	**(44,720)**	**(44,361)**
Transactions Involving Owners Affecting Accumulated Funds					
Capital Injections		74,041	-	74,041	132,251
Capital (Distributions)		(27,000)	-	(27,000)	-
Total Transactions Involving Owners Affecting Accumulated Funds		**47,041**	**-**	**47,041**	**132,251**
Balance at 30 June 2015		**758,870**	**129,428**	**888,298**	**1,005,222**

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

	Note No.	Accumulated Funds Actual 2014 $'000	Asset Revaluation Surplus Actual 2014 $'000	Total Equity Actual 2014 $'000	Original Budget 2014 $'000
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.

Health Directorate
Cash Flow Statement
For the Year Ended 30 June 2015

	Note No.	Actual 2015 $'000	Original Budget 2015 $'000	Actual 2014 $'000
Cash Flows from Operating Activities				
Receipts				
Government Payment for Outputs		252,617	257,615	229,062
User Charges – ACT Government		760,881	755,973	778,083
User Charges – Non-ACT Government		105,233	106,947	148,228
Grants Received from the Commonwealth		4,805	4,245	4,110
Interest Received		70	100	97
Distribution from Investments with the Territory Banking Account		104	178	106
Goods and Services Tax Input Tax Credits from the Australian Taxation Office		39,346	49,100	44,129
Goods and Services Tax Collected from Customers		4,590	4,300	6,164
Other		15,573	18,296	16,002
Total Receipts from Operating Activities		**1,183,219**	**1,196,754**	**1,225,982**
Payments				
Employee		621,323	637,897	575,760
Superannuation		80,761	81,675	75,847
Supplies and Services		318,270	320,619	321,786
Grants and Purchased Services		78,343	92,810	73,679
Goods and Services Tax Paid to Suppliers		43,826	54,400	50,321
Borrowing Costs		305	401	351
Other		13,237	21,432	20,082
Total Payments from Operating Activities		**1,156,065**	**1,209,234**	**1,117,825**
Net Cash Inflows/ (Outflows) from Operating Activities	**42**	**27,154**	**(12,480)**	**108,157**
Cash Flows from Investing Activities				
Receipts				
Proceeds from Sale of Property, Plant and Equipment		1,131	-	1,566
Total Receipts from Investing Activities		**1,131**	**-**	**1,566**
Payments				
Payments for Property, Plant and Equipment		8,915	8,809	38,948
Payments for Capital Works		66,894	132,251	88,893
Total Payment from Investing Activities		**75,809**	**141,060**	**127,841**
Net Cash (Outflows) from Investing Activities		**(74,678)**	**(141,060)**	**(126,275)**

Health Directorate
Cash Flow Statement (continued)
For the Year Ended 30 June 2015

	Note No.	Actual 2015 $'000	Original Budget 2015 $'000	Actual 2014 $'000
Cash Flows from Financing Activities				
Receipts				
Capital Injections		74,041	132,251	118,142
Total Receipts from Financing Activities		**74,041**	**132,251**	**118,142**
Payments				
Repayment of Finance Leases		1,703	1,452	2,330
Capital Distributions		27,00	-	-
Total Payment from Financing Activities		**28,703**	**1,452**	**2,330**
Net Cash Inflows from Financing Activities		**45,338**	**130,799**	**115,812**
Net (Decrease)/ Increase in Cash and Cash Equivalents		**(2,187)**	**(22,741)**	**97,694**
Cash and Cash Equivalents at the Beginning of the Reporting Period		107,256	64,816	9,562
Cash and Cash Equivalents at the End of the Reporting Period	**42**	**105,069**	**42,075**	**107,256**

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

Health Directorate
Financial Statements
For the Year Ended 30 June 2015

	Original Budget 2015 $'000	Total Appropriated 2015 $'000	Appropriation Drawn 2015 $'000	Appropriation Drawn 2014 $'000
Controlled				
Government Payment for Outputs	257,615	261,103	252,617	229,062
Capital Injections	132,251	147,703	74,041	118,142
Total Controlled Appropriation	**389,866**	**408,806**	**326,658**	**347,204**

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 due to Enterprise Bargaining Agreement funding for pay rises ($2.924 million) and revised Commonwealth funding for the Breastscreen Australia ($0.521 million) and Essential Vaccines ($0.425 million) National Partnership Agreements offset by the transfer of the Public Health Protection and Regulation Function ($0.382 million) in December 2014 to the Chief Minister, Treasury and Economic Development Directorate.

Capital Injections

The difference between the Original Budget and Total Appropriated in 2014–15 is due to the transfer of appropriation ($15.452) million from 2013–14. The transfer ensures the balance of the appropriation for each capital project is available to complete the approved work.

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 funding to align revenue with the latest planned timing of delivery of services; and
- a reduction in appropriation drawdown by the Directorate to offset additional funding received from the ACT Local Hospital Network Directorate associated with Commonwealth funding for the 'Public Hospital System – Additional Funding National Partnership Agreement' ($4.373 million).

Capital Injections

The difference between the Total Appropriated and Appropriation Drawn in 2014–15 is due to the deferral of capital works projects from 2014–15 to 2015–16 and 2016–17. The major deferrals from 2014–15 into future years are:

- $10.2 million moved out of this financial year for the Calvary Car Park due to delays in excavation works as a result of large volumes of unexpected unsuitable material found on site;
- $9.6 million moved out of this financial year due to postponement of works on Hospital Road at the Canberra Hospital as a result of road closures associated with Building 15 demountable installation;
- $8.0 million moved out of this financial year for the E-Health ICT project due to lengthy delays in contract negotiations in relation to the Electronic Medication Management and Clinical Records Information System Replacement Projects; and
- $7.4 million moved out of this financial year from the clinical services redevelopment – phase 3 project due to delays with procurement of generators and a flow on effect of delays with other construction works.

HEALTH DIRECTORATE CONTROLLED NOTE INDEX FOR THE YEAR ENDED 30 JUNE 2015

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

Note I. Objectives of the Health Directorate

Operations and Principal Activities

The Directorate 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 healthcare; 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.

The Directorate continues to strengthen clinical governance of its processes, and strives to be accountable to both the government and the community.

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

Note 2. Summary of Significant Accounting Policies

(a) Basis of Preparation

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 Health Directorate's (the Directorate) 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.

As at 30 June 2015, the Directorate's current liabilities ($284.1 million) exceed current assets ($144.9 million) by $139.2 million. However, this is not considered to be a liquidity risk as its cash needs are funded through appropriation from the ACT Government on a cash-needs basis. This is consistent with the Whole-of-Government cash management regime, which requires excess cash balances to be held centrally rather than within individual 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 assets held for sale, 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.

Note 2. Summary of Significant Accounting Policies (Continued)

(a) Basis of Preparation (Continued)

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.

(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 preparation 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 2015 together with the financial position of the Directorate as at 30 June 2015.

(d) Comparative Figures

Budget Figures

To facilitate a comparison with Budget Papers, as required by the *Financial Management Act 1996*, budget information for 2014–15 has been presented in the financial statements. Budget numbers in the financial statements are the original budget numbers that appear in the Budget Papers.

Note 2. Summary of Significant Accounting Policies (Continued)

(d) Comparative Figures (Continued)

Prior Year Comparatives

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

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

(e) Rounding

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

(f) Revenue Recognition

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

Government Payment for Outputs and Payment for Expenses on Behalf of the Territory

Government Payment for Outputs and Payment for Expenses 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.

ACT Government User Charges

The Directorate receives funding from the Local Hospital Network Directorate (LHN). The funding received from the LHN by the Health Directorate is based on the historical costs of the Directorate adjusted for growth in services provided and inflation. Funding from the LHN is recognised as revenue when the Directorate gains control over the funding. Control over LHN funding is obtained upon the receipt of cash.

Service Revenue

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

Inventory Sales

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

Note 2. Summary of Significant Accounting Policies (Continued)

(f) Revenue Recognition (Continued)

Amounts Received for Highly Specialised Drugs

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

Inpatient Fees

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 is 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 are 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.

Note 2. Summary of Significant Accounting Policies (Continued)

(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. This is because these asset classes are measured at fair value and have an Asset Revaluation Surplus attached to them. 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.

(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.

(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.

Note 2. Summary of Significant Accounting Policies (Continued)

(n) Receivables (Continued)

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

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

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

The amount of the allowance is the difference between the asset's carrying amount and the present value of the estimated future cash flows, discounted at the original effective interest rate. Cash flows relating to shortterm 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 is 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 is initially recorded at cost. Cost includes the purchase price, directly attributable costs and the estimated cost of dismantling and removing the item (where, upon acquisition, there is a present obligation to remove the item).

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

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

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

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

Property, plant and equipment is valued using the cost or revaluation model of valuation. Land, buildings and leasehold improvements are measured at fair value. 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 comprise 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 subject to systematic depreciation/amortisation 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 subject to depreciation/amortisation 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.

Note 2. Summary of Significant Accounting Policies (Continued)

(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.

(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.

Motor Vehicle Leasing Arrangements 2014–15

Changes were made to the whole-of-government motor vehicle leasing arrangements with SG Fleet as a result of which all such leases were classified as operating leases rather than finance leases from 23 April 2015. The leased vehicles held as Property, Plant and Equipment (under the previous finance lease arrangement with SG Fleet) were derecognised and the associated loss on the derecognition of the leased vehicle assets reflected under Other Expenses (refer to Note 19: Other Expenses). The corresponding finance lease liability (current and non-current) was also derecognised and the associated gain from the derecognition of the liability reflected under Other Gains (refer to Note 11: Other Gains). Accordingly, gross amounts for the loss on the derecognition of the leased vehicles and the gain on the derecognition of the finance lease liability have been reported separately rather than on a net basis, in these financial statements.

Note 2. Summary of Significant Accounting Policies (Continued)

(x) Employee Benefits

Employee benefits include:

- Short-term employee benefits such as wages and salaries, annual leave loading, and applicable on-costs, 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;
- Other long-term benefits such as long service leave and annual leave; and
- Termination benefits.

Oncosts 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 2014–15 the rate used to estimate the present value of future payments for annual leave is 101.0% (100.9% in 2013–14).

In 2014–15, the rate used to estimate the present value of future payments for long service leave is 104.2% (103.5% in 2013–14).

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 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(ad): 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.

Note 2. Summary of Significant Accounting Policies (Continued)

(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 total Territory superannuation liability for the CSS, PSS, and Comsuper is recognised in the Chief Minister, Treasury and Economic Development Directorate's Superannuation Provision Account and the external schemes recognise the superannuation liability for the PSSAP and other schemes respectively. This superannuation liability is not recognised at individual agency level.

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.

(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 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 44: Third Party Monies.

Note 2. Summary of Significant Accounting Policies (Continued)

(ac) Budgetary Reporting

Explanations of major variances between the 2014–15 original budget and the 30 June 2015 actual results are discussed in Notes 45 (Controlled) and 59 (Territorial): Budgetary Reporting.

The definition of 'major variances' is provided in Note 2(ad): Significant Accounting Judgements and Estimates – Budgetary Reporting.

Original budget refers to the original budgeted financial statements presented to the Legislative Assembly in a form that is consistent with the Directorate's annual financial statements. The 2014–15 budget numbers have not been audited.

Budgetary reporting is disclosed for both controlled and territorial financial statements with the exception of Statement of Changes in Equity as relevant line items are included in other financial statements.

(ad) Significant Accounting Judgements and Estimates

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

a) *Fair Value of Assets:* the Directorate has made a significant 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 oncosts will become payable. Further information on this estimate is provided in Note 2 (x): Employee Benefits.

c) *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.

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

Note 2. Summary of Significant Accounting Policies (Continued)

(ad) Significant Accounting Judgements and Estimates (Continued)

e) *Budgetary Reporting:* Significant judgements have been applied in determining what variances are considered as 'major variances' requiring explanations in Notes 45 (Controlled) and 59 (Territorial): Budgetary Reporting. Variances are considered to be major variances if both of the following criteria are met:

- The line item is a significant line item: the line item actual amount accounts for more than 10% of the relevant associated category (Income, Expenses and Equity totals) or sub-element (e.g. Current Liabilities and Receipts from Operating Activities totals) of the financial statements; and
- The variances (original budget to actual) are greater than plus (+) or minus (-) 10% for the budget for the financial statement line item.

  Further information on this is provided in Note 2(ac): Budgetary Reporting.

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

The following new and revised accounting standards and interpretations have been issued by the Australian Accounting Standards Board but do not apply to the current reporting period. These standards and interpretations are applicable to future reporting periods. The Directorate does not intend to adopt these standards and interpretations early. Where applicable, these Australian Accounting Standards will be adopted from their application date.

- AASB 9 Financial Instruments (December 2014) (application date 1 January 2018);

This standard supersedes AASB 139 Financial Instruments: Recognition and Measurement. The main impact of AASB 9 is that it will change the classification, measurement and disclosure of financial assets. No material financial impact on the Directorate is expected.

- AASB 15 Revenue from Contracts with Customers (application date 1 January 2017);

AASB 15 is the new standard for revenue recognition. It establishes a comprehensive framework for determining whether, how much and when revenue is recognised. It replaces AASB 111 Construction Contracts and AASB 118 Revenue. The Directorate has assessed the impact of this standard and has identified there could be a potential impact on the timing of the recognition of revenue for user charges. This impact is not expected to be material.

Note 3. Change in Accounting Policy and Accounting Estimates, and Correction of 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 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.

	2015 $'000	2014 $'000
Revenue from the ACT Government		
Government Payment for Outputs [a]	252,617	229,062
Total Government Payment for Outputs	**252,617**	**229,062**

a. The increase relates to funding for growth in services, salary increases and indexation for non labour expenses.

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.

	2015 $'000	2014 $'000
User Charges – ACT Government		
Local Hospital Network Funding [a]	760,262	717,273
Service Revenue [b]	332	743
Total User Charges – ACT Government	**760,594**	**718,016**
User Charges – Non-ACT Government		
Service Revenue [c]	12,422	11,032
Amounts Received for Highly Specialised Drugs [d]	16,102	17,602
Cross Border (Interstate) Health Revenue [e]	-	4,726
Inpatient Fees [f]	36,906	31,677
Facilities Fees[g]	26,590	24,382
Non-inpatient Fees	1,056	866
Inventory Sales[h]	12,285	13,279
Accommodation and Meals	3,653	3,813
Total User Charges – Non-ACT Government	**109,014**	**107,377**
Total User Charges	**869,608**	**825,393**

Note 5. User Charges (Continued)

a. The increase mainly relates to inflation, growth in services provided and additional activities now covered under the National Health Reform.

b. The decrease is largely the result of $0.4m revenue for aero-medical services that was shown as revenue from Justice and Community Safety Directorate in 2013–14 and is now paid by ACT & South East NSW Aero Medical Services LTD and is shown as 'User Charges non-ACT Government' revenue.

c. The increase is mainly due to $0.4m revenue for aero-medical services that was shown as revenue from Justice and Community Safety Directorate in 2013–14 and is now paid by ACT & South East NSW Aero Medical Services LTD and is shown as 'User Charges non-ACT Government', increased revenue from sterilising services provided to other hospitals, increases in pathology services and an increase in commercial space rentals.

d. 2013–14 included revenue that related to 2012–13 that had not previously been recognised.

e. 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 relate to prior year activity confirmed through an annual acquittal process with the New South Wales Ministry of Health.

f. The increase is largely attributable to an increase in compensable and private patients and prior year revenues related to Department of Veterans Affairs patients that had not previously been recognised.

g. The increase mainly relates to increased private patient activities in Pathology, Oncology and Medical Imaging specialities.

h. This is mainly due to a fall in volume of consumables sold to the private hospitals.

Note 6. Interest

	2015 $'000	2014 $'000
Revenue from Non-ACT Government Entities		
Interest Revenue	70	97
Total Interest Revenue from Non-ACT Government Entities	**70**	**97**
Total Interest Revenue	**70**	**97**
Total interest revenue from financial assets not at fair value through profit and loss.	70	97

Note 7. Distribution from Investments with the Territory Banking Account

	2015 $'000	2014 $'000
Revenue from ACT Government Entities		
Distribution from Investments with the Territory Banking Account	97	98
Total Distribution from Investment with the Territory Banking Account	**97**	**98**

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.

	2015 $'000	2014 $'000
Revenue from ACT Government Entities		
Legal Services [a]	1,359	1,479
Other Resources Received Free of Charge [b]	112	139
Total Resources Received Free of Charge	**1,471**	**1,618**

a. The decrease is due to requests for legal advice reducing from 116 in 2013–14 to 111 in 2014–15.

b. The decrease is due to reduced instances of 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.

	2015 $'000	2014 $'000
Revenue from Non-ACT Government Entities		
Grants [a]	16,493	18,184
Other [b]	3,267	2,444
Total Other Revenue from Non-ACT Government Entities	**19,760**	**20,628**
Total Other Revenue	**19,760**	**20,628**

a. The reduction mainly relates to special purpose grants for medical research which fluctuate from year to year.

b. The increase mainly relates to insurance claims revenue in relation to spoilage of pharmacy stock, receipt of prior year worker's compensation claims and reimbursement of prior year expenses.

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

	2015 $'000	2014 $'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	3,479	1,610
Contributions recognised in previous years which were not expended in the current financial year	7,653	8,167
Total amount of unexpended contributions as at balance date	**11,132**	**9,777**

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Note 10. Gains on Investments

	2015 $'000	2014 $'000
Revenue from ACT Government Entities		
Unrealised Gains on Investments [a]	12	4
Total Gains on Investments	**12**	**4**

a. The rate of investment return for 2014–15 was higher than that for the previous 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.

	2015 $'000	2014 $'000
Gains from the Sale of Assets	82	85
Assets Transferred from Other Entities [a]	485	-
Donations [b]	1,032	1,309
Gain from De-recognition of Finance Lease Liability[c]	5,469	-
Total Other Gains	**7,068**	**1,394**

a. In 2014–15 land was transferred to the Directorate from ACT Property Group for the purpose of building a Secure Mental Health Facility in Symonston.

b. The reduction in donations is a result of one-off amounts received in 2013–14 that were for the Centenary Hospital for Women and Children.

c. The gain from de-recognition of lease vehicles liabilities is in accordance with the whole-of-government vehicle leasing arrangements, which took effect on 23 April 2015. The net impact of the gross loss of $5.29 million on the derecognition of the leased vehicles (refer to Note 19: Other Expenses) and the gross gain of $5.47 million on the derecognition of the finance lease liability was a net gain of $0.18 million. Also refer to Note 2(w): Summary of Significant Accounting Polices – leases.

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

	2015 $'000	2014 $'000
Contribution Analysis – Donations		
Contributions which have conditions of expenditure still required to be met:		
Contributions recognised as revenues during current year for which expenditure in manner specified had not occurred as at balance date	427	918
Contributions recognised in previous years which were not expended in the current financial year	2,730	2,975
Total amount of unexpended contributions as at balance date	**3,157**	**3,893**

Note 12. Employee Expenses

	2015 $'000	2014 $'000
Wages and Salaries [a]	582,352	549,176
Annual Leave Expense [b]	16,523	14,905
Long Service Leave Expense [c]	14,054	11,876
Workers' Compensation Insurance Premium	20,457	20,355
Termination Payment Expense	718	2,066
Other Employee Benefits and On-Costs [d]	9,007	8,002
Total Employee Expenses	**643,111**	**606,380**

	No.	No.
Average full-time equivalent staff levels during the year were:	6,092	5,873

a. The increase in Wages and Salaries mainly relates to pay rises under collective agreements and increases in staff numbers related to growth in services in acute services, mental health, community health centres, the Centenary Hospital for Women and Children, the Canberra Region Cancer Centre, community nursing, emergency department, and outpatient and imaging services.

b. The increase is mainly due to the impact of collective agreement pay rises, an increase in staff numbers related to growth in services provided to patients and the growth in liability due to leave earned exceeding leave taken.

c. 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 103.5% to 104.2% and the effect of pay rises under the collective agreements.

d. The increase is mainly due to an increase in the number of staff on paid maternity leave and increased recruitment agency costs.

Note 13. Superannuation Expenses

	2015 $'000	2014 $'000
Superannuation Contributions to the Territory Banking Account	38,040	38,526
Productivity Benefit	4,976	5,066
Superannuation Payment to ComSuper (for the PSSAP)	3,460	3,467
Superannuation to External Providers [a]	34,567	29,384
Total Superannuation Expenses	**81,043**	**76,443**

a. The increase is due to pay rises under collective agreements and that most additional employees are members of superannuation schemes managed by external providers

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Note 14. Supplies and Services

	2015 $'000	2014 $'000
Audit Expenses	454	459
Blood Products	8,856	8,494
Clinical Expenses/Medical Surgical Supplies[a]	64,034	59,487
Communications[b]	3,617	4,171
Computer Expenses[c]	38,281	33,742
Contractors and Consultants	7,578	7,229
Domestic Services, Food and Utilities[d]	33,509	32,025
General Administration	18,194	17,516
Hire and Rental Charges	4,216	4,279
Insurance	30,993	31,181
Minor Capital[e]	4,054	3,341
Non-Contract Services[f]	4,718	5,130
Operating Lease Rental Payments[g]	7,170	6,415
Pharmaceuticals[h]	37,834	35,476
Printing and Stationery	2,529	2,566
Property and Rental Expenses[i]	2,305	2,717
Public Relations[j]	686	898
Publications	1,348	1,299
Repairs and Maintenance[k]	17,023	15,851
Staff Development and Recruitment	6,973	6,682
Travel and Accommodation	1,013	1,152
Vehicle Expenses[l]	1,207	1,490
Visiting Medical Officers[m]	27,279	29,076
Total Supplies and Services	**323,871**	**310,676**

a. The increase in clinical expenses/medical surgical supplies is mainly due to inflation and growth in patient activity in acute care services, mental health, community health centres, the Centenary Hospital for Women and Children, the Canberra Region Cancer Centre, community nursing, emergency department, and outpatient and imaging services.

b. The decrease in communications charges is due to lower postage costs from fewer mail outs and reduced landline charges due to savings through a new whole-of-government contract.

c. The increase in computer expenses is due to a combination of factors, including inflation, increase in staff numbers, support costs for projects that became operational during the year such as the Digital Mammography, Calvary PAS Integration and Clinical Portal Suites software packages and $1.5m expenses relating to a prior year which was accounted for as a prepayment instead of being expensed in that year.

d. The increase in domestic services, food and utilities is for water and sewerage rates and cleaning services from a full year effect of new buildings beginning operation. These new buildings are the Belconnen Community Health Centre, the Centenary Hospital for Women and Children, the Canberra Region Cancer Centre and the expanded Tuggeranong Community Health Centre.

e. The increase in minor capital is due to a rise in the purchase of furniture and fittings, and medical and surgical assets under the capitalisable threshold of $5,000.

f. The reduction in non-contract services is due to lower use of registered nurses from external labour providers.

g. The increase in operating lease rental payments is a result of changing motor vehicle leases from finance leases to operating leases from 23 April 2015.

h. The increase in pharmaceuticals is due to inflation and an increase in the use of high cost drugs.

i. The reduction in property and rental is due to the cessation of renting office space at Swanson Plaza in Belconnen and the cessation of renting additional office space for staff while construction work was in progress.

j. The reduction in public relations is due to cost savings for promotional activities including refreshments and displays/events.

k. The increase in repairs and maintenance is due to the need for repairs on ageing assets and inflation.

l. The reduction in vehicle expenses is due to the change in motor vehicle lease type from finance leases to operating leases with these costs now reflected as operating lease rental payments, as well as lower fuel charges in 2014–15.

m. 2013–14 included $1.1 million relating to services from 2012-13 and in 2014–15 several visiting medical officers were replaced by salaried specialists.

Note 15. Depreciation and Amortisation

	2015 $'000	2014 $'000
Depreciation		
Buildings [a]	22,665	15,096
Plant and Equipment	10,643	10,763
Leasehold Improvements [b]	3,088	1,783
Total Depreciation	**36,396**	**27,642**
Amortisation		
Intangible Assets [c]	10,190	4,841
Total Amortisation	**10,190**	**4,841**
Total Depreciation and Amortisation	**46,586**	**32,483**

a. The increase mainly relates to accelerated depreciation for building 15 at the Canberra Hospital which has been demolished. There is also the full year effect of depreciation for new buildings that were completed in 2013–14 which are the Centenary Hospital for Women and Children, the Belconnen Community Health Centre, the Tuggeranong Community Health Centre, the Canberra Region Cancer Centre, and the Canberra Hospital emergency department intensive care unit expansion.

b. The increase relates to works at North Curtin offices which is leased by the Directorate.

c. The increase is a result of finalised computer software projects which became new assets in 2014–15. These computer software packages are Canberra Hospital eProcurement, Single Sign On/Rapid Access, Canberra Hospital Priority Systems, My Shift eRostering, Renal Dialysis System, Clinical Portal Suites, Order Entry, Identity and Access Management, Radiology Information System Upgrade, Digital Mammography and Calvary Patient Administration System Integration.

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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.

	2015 $'000	2014 $'000
Grants		
Grants	2,161	2,509
Total Grants	**2,161**	**2,509**
Purchased Services		
Calvary Hospital[a]	4,086	3,121
Non-Government Organisations	64,387	63,544
Cross Border Health Costs	24	32
Other[b]	7,685	3,471
Total Purchased Services	**76,182**	**70,168**
Total Grants and Purchased Services	**78,343**	**72,677**

a. The increase in funding to Calvary Public Hospital is largely related to inflation and growth in service provision.

b. The increase relates to a dedicated hip and knee joint replacement program in 2014–15 at Calvary John James Hospital for elective surgery patients in which a total of 355 procedures were performed.

Note 17. Borrowing Costs

Borrowing costs are finance charges in respect of finance leases for the Directorate's fleet of vehicles and clinical equipment. Due to a change in the Whole-of-Government vehicle leasing arrangements with SG Fleet, from 23 April 2015 all such leases for the Directorate will be classified as operating leases (whose costs appear in supplies and services) rather than finance leases. There will be no borrowing costs in respect of the Directorate's fleet of vehicles in the next financial year.

	2015 $'000	2014 $'000
Finance Charges	262	351
Finance Cost on Make Good [a]	43	200
Total Borrowing Costs	**305**	**551**

a. In 2013–14 there was a catch up of the discounting for make good provision to cover multiple years which increased the expenditure in that year.

Note 18. Cost of Goods Sold

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

	2015 $'000	2014 $'000
Cost of Goods Sold [a]	9,295	10,339
Total Cost of Goods Sold	**9,295**	**10,339**

a. The decrease is due to a reduction in medical supplies purchased by private hospitals.

Note 19. Other Expenses

	2015 $'000	2014 $'000
Miscellaneous Expenses [a]	3,302	1,004
Legal Settlements [b]	1,935	2,999
Waivers, Impairment Losses and Write-offs (see Note 20)	2,244	2,338
Loss on Sale of Assets	12	49
Loss on De-recognition of Motor Vehicle Under a Finance Lease[c]	5,286	-
Total Other Expenses	**12,779**	**6,390**

a. The increase relates to the write off of audio visual equipment that was bought for the Telehealth project for use throughout Southern New South Wales and for the return of grant money to Health Workforce Australia that related to clinical training subsidies.

b. 2013–14 included medical negligence legal claims settled in 2013–14 due to the civil blitz arrangements introduced by the ACT Courts resulting in better case management of older claims and court ordered mediations.

c. The loss on de-recognition of motor vehicle under a finance lease is in accordance with the whole-of-government vehicle leasing arrangements, which took effect on 23 April 2015. The net impact of the gross loss of $5.29 million on the derecognition of the leased vehicles and the gross gain of $5.47 million on the derecognition of the finance lease liability (refer to Note 11: Other Gains) was a net gain of $0.18 million. Also refer to Note 2(w): Summary of Significant Accounting Polices – leases.

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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.

	2015		2014	
	No.	$'000	No.	$'000
Waivers				
Waivers	-	-	-	-
Total Waivers	**-**	**-**	**-**	**-**
Impairment Losses				
Impairment Loss from Receivables				
Trade Receivables [a]	194	431	178	653
Total Impairment Loss from Receivables	**194**	**431**	**178**	**653**
Impairment Loss from Property, Plant and Equipment				
Plant and Equipment [b]	19	217	61	530
Total Impairment Losses from Property, Plant and Equipment	**19**	**217**	**61**	**530**
Total Impairment Losses	**213**	**648**	**239**	**1,183**
Write-Offs				
Irrecoverable Debts [c]	2,742	1,596	2,469	1,155
Total Write-Offs	**2,742**	**1,596**	**2,469**	**1,155**
Total Waivers, Impairment Losses and Write-Offs	**2,955**	**2,244**	**2,708**	**2,338**

a. This decrease is largely attributable to a reduction of Medicare ineligible patient debts that have been impaired following assessment of receivables in 2014–15.

b. 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.

c. The increase mainly relates to an increase in write offs of debts for Medicare ineligible patients.

Note 21. Auditor's Remuneration

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

	2015	2014
	$'000	$'000
Audit Services		
Audit Fees Paid or Payable to the ACT Audit Office	223	208
Total Audit Services	**223**	**208**

No other services were provided by the ACT Audit 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 3.10% (3.45% in 2014). These funds are able to be withdrawn upon request.

	2015 $'000	2014 $'000
Cash on Hand	44	44
Cash at Bank	105,025	107,212
Total Cash and Cash Equivalents	**105,069**	**107,256**

Note 24. Receivables

	2015 $'000	2014 $'000
Current Receivables		
Trade Receivables	1,103	1,203
Trade Receivables – Patient Fees	8,359	8,447
	9,462	**9,650**
Less: Allowance for Impairment Losses	(2,781)	(2,591)
	6,681	**7,059**
Other Trade Receivables [a]	11,311	8,863
Less: Allowance for Impairment Losses	(450)	(209)
	10,861	**8,654**
Net GST Receivable	3,622	3,718
Accrued Revenue [b]	6,068	4,027
Total Current Receivables	**27,232**	**23,458**
Total Receivables	**27,232**	**23,458**

a. The increase mainly relates to an increase in receivables from Calvary Health Care for cost reimbursements of Directorate doctors seconded to Calvary Hospital.

b. The increase mainly relates to an increase in accrued revenue for chargeable patient fees due to an increase in patient numbers.

Note 24. Receivables (Continued)

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
2015					
Not Impaired					
Receivables [a]	21,050	1,811	782	3,589	27,232
Impaired					
Receivables	-	-	-	3,232	3,232
2014					
Not Impaired					
Receivables	18,442	2,087	553	2,376	23,458
Impaired					
Receivables	-	-	-	2,800	2,800

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 the Directorate.

	2015 $'000	2014 $'000
Reconciliation of the Allowance for Impairment Losses		
Allowance for Impairment Losses at the Beginning of the Reporting Period	2,800	2,146
Additional Allowance and Impairment Losses Recognised	431	654
Reduction in Allowance	-	-
Allowance for Impairment Losses at the End of the Reporting Period	**3,231**	**2,800**
Classification of ACT Government/Non-ACT Government Receivables		
Receivables from ACT Government Entities		
Net Trade Receivables	61	59
Net Other Trade Receivables	98	112
Accrued Revenue	-	7
Net Goods and Services Tax Receivable	50	52
Total Receivables from ACT Government Entities	**209**	**230**
Receivables from Non-ACT Government Entities		
Net Trade Receivables	6,170	7,000
Net Other Trade Receivables	11,213	8,542
Net Goods and Services Tax Receivable	3,572	3,666
Accrued Revenue	6,068	4,020
Total Receivables from Non-ACT Government Entities	**27,023**	**23,228**
Total Receivables	**27,232**	**23,458**

Note 25. Inventories

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

	2015 $'000	2014 $'000
Current Inventory		
Purchased Items – Cost [a]	8,655	7,806
Total Current Inventory	**8,655**	**7,806**
Total Inventory	**8,655**	**7,806**

a. The increase mainly relates to pharmaceuticals. Pharmacy has commenced carrying several new highly specialised high cost drugs including, a new medication for Hep C (simeprevir) and new antiretrovirals. Inflation and an increase in stock holdings to cater for higher turnover and higher acuity of patients also have contributed to this increase.

Note 26. Assets Held for Sale

Due to a change in the Whole-of-Government vehicle leasing arrangements with SG Fleet, from 23 April 2015 all such leases for the Directorate will be classified as operating leases rather than finance leases. As such there are no vehicles classified as plant and equipment held for sale as at 30 June 2015.

	2015 $'000	2014 $'000
Plant and Equipment Held for Sale	-	29
Total Assets Held for Sale	**-**	**29**

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 2015 are as follows:

	Classification According to Fair Value Hierarchy			
2015	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Assets Held for Sale at Fair Value				
Plant and Equipment	-	-	-	-
	-	**-**	**-**	**-**

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			
2014	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
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 current and previous reporting 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.

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Note 27. Investments

Non-Current Investments	2015 $'000	2014 $'000
Investments with the Territory Banking Account – Cash Enhanced Fund at Fair Value	3,027	3,015
Total Non-Current Investments	**3,027**	**3,015**
Total Investments	**3,027**	**3,015**

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.

	2015 $'000	2014 $'000
Land and Buildings		
Land at Fair Value	40,645	40,250
Total Land Assets	**40,645**	**40,250**
Buildings at Fair Value	815,234	771,290
Less: Accumulated Depreciation	(16,416)	-
Total Written Down Value of Buildings	**798,818**	**771,290**
Total Land and Written Down Value of Buildings	**839,463**	**811,540**
Leasehold Improvements		
Leasehold Improvements at Fair Value	6,527	4,811
Less: Accumulated Depreciation	(3,088)	-
Total Written Down Value of Leasehold Improvements	**3,439**	**4,811**
Plant and Equipment		
Plant and Equipment at Cost	110,130	107,993
Less: Accumulated Depreciation	(66,464)	(64,714)
Less: Accumulated Impairment Losses	(439)	(530)
Total Written Down Value of Plant and Equipment	**43,227**	**42,749**
Total Written Down Value of Property, Plant and Equipment	**886,129**	**859,100**

Assets Under a Finance Lease

Due to a change in Whole-of-Government vehicle leasing arrangements with SG Fleet, from 23 April 2015 vehicle leases for the Directorate are now classified as operating leases.

Carrying Amount of Assets Under a Finance Lease		
Plant and Equipment Under a Finance Lease	-	8,271
Accumulated Depreciation of Plant and Equipment under a Finance Lease	-	(2,307)
Total Written Down Value of Assets Under a Finance Lease	**-**	**5,964**

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 2014–15.

	Land $'000	Buildings $'000	Leasehold Improvements $'000	Plant and Equipment $'000	Total $'000
Carrying Amount at 1 July 2014	40,250	771,290	4,811	42,749	859,100
Additions	485	50,193	1,716	17,172	69,566
Revaluation (Decrement)	(90)	-	-	-	(90)
Assets Classified as Held for Sale	-	-	-	-	-
Disposals	-	-	-	(6,999)	(6,999)
Depreciation	-	(22,665)	(3,088)	(10,643)	(36,396)
Depreciation Write Back for Asset Disposals	-	-	-	6,143	6,143
Impairment Losses Recognised in the Operating (Deficit)	-	-	-	(217)	(217)
Reversal of Impairment Losses Recognised in the Operating (Deficit)	-	-	-	308	308
Other Movements	-	-	-	(5,286)	(5,286)
Carrying Amount at 30 June 2015	**40,645**	**798,818**	**3,439**	**43,227**	**886,129**

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**

Valuation of Non-Current Assets

Certified practicing registered valuers AON Risk 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:

i) Mr Geoff Pyman FAPI, MRICS – Certified Practising Valuer

ii) Mr Michael Farley – Certified Practising Valuer

The next valuation will be undertaken during 2016–17.

Note 28. Property, Plant and Equipment (Continued)

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 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 2014–15 are as follows:

Classification According to Fair Value Hierarchy 2015	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Property, Plant and Equipment at Fair Value				
Land	-	-	40,645	40,645
Buildings	-	2,845	795,973	798,818
Leasehold Improvements	-	-	3,439	3,439
	-	**2,845**	**840,057**	**842,902**

Details of the Directorate's property, plant and equipment at fair value and information about the Fair Value Hierarchy as at 30 June 2014 is as follows:

Classification According to Fair Value Hierarchy 2014	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**

Transfers between Categories

There have been no transfers between Levels 1, 2 and 3 during the current and previous 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.

Note 28. Property, Plant and Equipment (Continued)

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.

Note 28. Property, Plant and Equipment (Continued)

Fair Value measurements using significant unobservable inputs (Level 3) 2015	Land $'000	Buildings $'000	Leasehold Improvements $'000
Fair Value at beginning of the reporting period	40,250	768,445	4,811
Additions	485	50,193	1,716
Revaluation increments/(decrements) recognised in Other Comprehensive Income	(90)	-	-
Depreciation	-	(22,665)	(3,088)
Fair Value at end of the reporting period	**40,645**	**795,973**	**3,439**

2014	Land $'000	Buildings $'000	Leasehold Improvements $'000
Fair Value at beginning of the reporting period	36,827	620,486	6,629
Additions	360	180,549	275
Revaluation increments/(decrements) recognised in Other Comprehensive Income	3,063	(17,494)	(310)
Depreciation	-	(15,096)	(1,783)
Fair Value at end of the reporting period	**40,250**	**768,445**	**4,811**

Note 28. Property, Plant and Equipment (Continued)

Information about significant unobservable inputs (Level 3) in fair value measurements

Item	Fair Value as at 30 June 2015 $000	Fair Value as at 30 June 2014 $000	Significant Unobservable Inputs	Range of Unobservable Inputs (Weighted Average) 2015	Range of Unobservable Inputs (Weighted Average) 2014	Relationship of Unobservable Inputs to Fair Value
Valuation Technique: Market Approach						
Land	40,645	40,250	Selection of land with similar approximate utility and permissible usage	$0.40 – $1,200 per m^2	$0.40 – $1,200 per m^2	Higher value of comparable land increases values
Valuation Technique: Depreciated Replacement Cost						
Buildings	795,973	768,445	Consumed physical, functional and economic obsolescence	0% – 92%	0% – 92%	Greater consumption of obsolescence reduces values
Leasehold Improvements	3,439	4,811	Consumed physical, functional and economic obsolescence	29% – 88%	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'.

	2015 $'000	2014 $'000
Computer Software		
Internally Generated Software		
Computer Software at Cost [a]	65,797	39,957
Less: Accumulated Amortisation [b]	(43,214)	(33,024)
Total Internally Generated Software	**22,583**	**6,933**
Total Computer Software	**22,583**	**6,933**
Total Intangible Assets	**22,583**	**6,933**

a. The increase is due to completed internally generated software projects including TCH eProcurement, Single Sign On/Rapid Access, TCH Priority Systems, My Shift eRostering, Renal Dialysis System, Clinical Portal Suites, Order Entry, Identity and Access Management, Radiology Information System Upgrade, Digital Mammography and Calvary Patient Administration System Integration.

b. The increase directly relates to amortisation cost for the new software applications listed above.

Note 29. Intangible Assets (Continued)

Reconciliation of Intangible Assets

The following table shows the movement of internally generated Intangible Assets from the beginning to the end of 2014–15. There was no externally purchased software during this period.

	Internally Generated Software $'000	Total $'000
Carrying Amount at 1 July 2014	6,933	6,933
Additions	25,840	25,840
Amortisation	(10,190)	(10,190)
Carrying Amount at 30 June 2015	**22,583**	**22,583**

Reconciliation of Intangible Assets

The following table shows the movement of internally generated Intangible Assets from the beginning to the end of 2013–14. There was no externally purchased software during this period.

	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**

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 2014–15, include hospital buildings, community health centres and computer software.

	2015 $'000	2014 $'000
Building Works in Progress [a]	82,785	79,626
Plant and Equipment Works in Progress [b]	227	2,186
Computer Software Works in Progress [c]	48,687	65,914
Other Works in Progress	57	57
Total Capital Works in Progress	**131,756**	**147,783**

a. The increase in building works in progress is a result of ongoing capital projects. These include the Calvary Public Hospital Car Park, the Secure Mental Health Unit, the University of Canberra Public Hospital, the Canberra Hospital Emergency Department expansion, various works throughout the Canberra Hospital campus and other capital upgrade projects.

b. The decrease in plant and equipment works in progress is due to the completion of the 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 decrease in computer software works in progress is due to the implementation of several computer software projects including TCH eProcurement, Single Sign On/Rapid Access, TCH Priority Systems, My Shift eRostering, Renal Dialysis System, Clinical Portal Suites, Order Entry, Identity and Access Management, Radiology Information System Upgrade, Digital Mammography and Calvary Patient Administration System Integration.

Note 30. Capital Works in Progress (Continued)

Reconciliation of Capital Works in Progress

The following table shows the movement of Capital Works in Progress during 2014–15.

	Buildings Works in Progress $'000	Plant and Equipment Works in Progress $'000	Computer Software Works in Progress $'000	Other Works in Progress $'000	Total $'000
Carrying Amount at 1 July 2014	79,626	2,186	65,914	57	147,783
Additions	55,434	8,163	8,613	-	72,210
Capital Works Expensed	(366)	(1,800)	-	-	(2,166)
Capital Works in Progress Completed and Transferred to Property, Plant and Equipment	(51,909)	(8,322)	(25,840)		(86,071)
Carrying Amount at 30 June 2015	**82,785**	**227**	**48,687**	**57**	**131,756**

Reconciliation of Capital Works in Progress

The following table shows the movement of Capital Works in Progress during 2013–14.

	Buildings Works in Progress $'000	Plant and Equipment Works in Progress $'000	Computer Software Works in Progress $'000	Other Works in Progress $'000	Total $'000
Carrying Amount at 1 July 2013	186,265	915	54,398	57	241,635
Additions	77,742	1,271	12,472	-	91,485
Capital Works Expensed	(711)	-	(956)	-	(1,667)
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**	**65,914**	**57**	**147,783**

Note 31. Other Assets

	2015 $'000	2014 $'000
Current Other Assets		
Prepayments [a]	3,939	3,391
Total Current Other Assets	**3,939**	**3,391**
Total Other Assets	**3,939**	**3,391**

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

	2015 $'000	2014 $'000
Current Payables		
Trade Payables	3,633	4,099
Other Payables	24	19
Accrued Expenses [a]	50,612	38,529
Total Current Payables	**54,269**	**42,647**
Total Payables	**54,269**	**42,647**

a. The increase is mainly due to an increase in accrued capital works expenses ($7.0 million), increases in accruals for visiting medical officers cost ($2.0 million) and Pharmaceuticals costs ($2.0 million).

	2015 $'000	2014 $'000
Payables are aged as followed		
Not Overdue	53,016	41,371
Overdue for Less than 30 Days	1,165	767
Overdue for 30 to 60 Days	10	337
Overdue for More than 60 Days	78	172
Total Payables	**54,269**	**42,647**
Classification of ACT Government/Non-ACT Government Payables		
Payables with ACT Government Entities		
Trade Payables	-	-
Accrued Expenses	3,607	8,563
Total Payables with ACT Government Entities	**3,607**	**8,563**
Payables with Non-ACT Government Entities		
Trade Payables	3,633	4,099
Other Payables	24	19
Accrued Expenses	47,005	29,966
Total Payables with Non-ACT Government Entities	**50,662**	**34,084**
Total Payables	**54,269**	**42,647**

Note 33. Finance Leases

Due to a change in the Whole-of-Government vehicle leasing arrangements with SG Fleet, from 23 April 2015 all such leases for the Health Directorate are classified as operating leases rather than finance leases.

	2015 $'000	2014 $'000
Current Finance Leases		
Secured		
Finance Leases	-	2,156
Total Current Finance Leases	**-**	**2,156**
Non-Current Finance Leases		
Secured		
Finance Leases	-	4,042
Total Non-Current Finance Leases	**-**	**4,042**
Total Finance Leases	**-**	**6,198**

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.

	2015 $'000	2014 $'000
Finance lease commitments are payable as follows:		
Within one year	-	2,437
Later than one year but not later than five years	-	4,199
Minimum Lease Payments	**-**	**6,636**
Less: Future Finance Lease Charges	-	(438)
Amount Recognised as a Liability	**-**	**6,198**
Add: Lease incentive involved with non-cancellable operating lease	-	-
Total Present Value of Minimum Lease Payments	**-**	**6,198**
The present value of the minimum lease payments are as follows:		
Within one year	-	2,437
Later than one year but not later than five years	-	3,761
Total Present Value of Minimum Lease Payments	**-**	**6,198**
Classification on the Balance Sheet		
Finance Leases		
Current Finance Leases	-	2,156
Non-Current Finance Leases	-	4,042
Total Finance Leases	**-**	**6,198**

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Note 34. Employee Benefits

	2015 $'000	2014 $'000
Current Employee Benefits		
Annual Leave [a]	97,797	90,413
Long Service Leave [b]	97,218	86,752
Accrued Salaries [c]	34,281	30,599
Other Benefits	210	243
Total Current Employee Benefits	**229,506**	**208,007**
Non-Current Employee Benefits		
Long Service Leave [d]	14,529	14,044
Total Non-Current Employee Benefits	**14,529**	**14,044**
Total Employee Benefits	**244,035**	**222,051**

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 from 103.5% to 104.2% also contributed to this variance.

c. The increase is due to pay rises accrued for Medical staff whose collective agreements have not been finalised and the cost of an additional day's pay accrued in 2015 compared to 2014 which were partially offset by pay rises accrued in 2014 that were settled in 2015.

d. The increase is mainly due to an increase in the rate used to estimate the present value of future long service leave payments from 103.5% to 104.2%.

Estimate of when Leave is Payable	2015 $'000	2014 $'000
Estimated Amount Payable within 12 months		
Annual Leave	54,021	50,646
Long Service Leave	7,312	7,420
Accrued Salaries	34,281	30,599
Other Benefits	210	243
Total Employee Benefits Payable within 12 months	**95,824**	**88,908**
Estimated Amount Payable after 12 months		
Annual Leave	43,776	39,767
Long Service Leave	104,435	93,376
Total Employee Benefits Payable after 12 months	**148,211**	**133,143**
Total Employee Benefits	**244,035**	**222,051**

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.

	2015 $'000	2014 $'000
Non-Current Other Provisions		
Provision for Make Good at the beginning of the Reporting Period [a]	1,375	1,503
Increase in Provision due to unwinding of discount [b]	43	200
Make good charges incurred	-	(76)
Decrease due to revaluation	-	(252)
Total Other Provisions	**1,418**	**1,375**

a. The reduction relates to a terminated lease at Swanson Plaza Belconnen and Level 5, 1 Moore Street Civic.

b. In 2013–14 there was a catch up of the discounting for make good provision to cover multiple years which increased the expenditure in that year.

Note 36. Other Liabilities

	2015 $'000	2014 $'000
Current Other Liabilities		
Revenue Received in Advance	370	523
Total Current Other Liabilities	**370**	**523**
Total Other Liabilities	**370**	**523**

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.

	2015 $'000	2014 $'000
Balance at the Beginning of the Reporting Period	129,518	144,007
(Decrement)/Increment in Land due to Revaluation	(90)	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	**(90)**	**(14,489)**
Balance at the End of the Reporting Period	**129,428**	**129,518**

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

Note 38. Restructure of Administrative Arrangements

Restructure of Administrative Arrangements 2014-2015

On 15 December 2014, Administrative Arrangements 2014 (No 2) (Notifiable Instrument NI2014-654) came into effect. This instrument transferred the Public Health Protection and Regulation function from the Health Directorate to the Chief Minister, Treasury and Economic Development Directorate as part of the establishment of Access Canberra.

The following table shows the income and expense items associated with this transfer of function.

	Amounts Relating to Function when held by Chief Minister, Treasury and Economic Development $'000	Amounts Relating to Function when held by Health Directorate $'000	Total 2015 $'000
Revenue			
Government Payment for Outputs	382	324	706
Total Revenue	**382**	**324**	**706**
Expenses			
Employee Expenses	16	305	321
Superannuation Expenses	1	19	20
Grants and Purchased Services	365	–	365
Total Expenses	**382**	**324**	**706**

Note 39. 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'.

Note 39. Financial Instruments (Continued)

Credit Risk (Continued)

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 ACT Government, Commonwealth Government and insurance companies for compensable patients. 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 source of cash to pay these obligations is user charges revenue from the ACT 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.

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.

Note 39. Financial Instruments (Continued)

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 2015 $'000	Fair Value Amount 2015 $'000	Carrying Amount 2014 $'000	Fair Value Amount 2014 $'000
Financial Assets				
Cash and Cash Equivalents	105,069	105,069	107,256	107,256
Receivables	23,610	23,610	19,740	19,740
Investment with the Territory Banking Account	3,027	3,027	3,015	3,015
Total Financial Assets	**131,706**	**131,706**	**130,011**	**130,011**
Financial Liabilities				
Payables	54,269	54,269	42,647	42,647
Finance Leases	-	-	6,198	6,198
Total Financial Liabilities	**54,269**	**54,269**	**48,845**	**48,845**

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.

	Classification According to Fair Value Hierarchy			
2015	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Financial Assets				
Investment with the Territory Banking Account – Cash Enhanced Fund	-	3,027	-	3,027
Total Financial Assets	**-**	**3,027**	**-**	**3,027**

	Classification According to Fair Value Hierarchy			
2014	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 current and previous reporting period.

Note 39. 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 2015. 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.

	Note No.	Weighted Average Interest Rate	Fixed Interest Maturing In:					
			Floating Interest	1 Year or Less	Over 1 Year to 5 Years	Over 5 Years	Non-Interest Bearing	Total
			$'000	$'000	$'000	$'000	$'000	$'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	23		-	-	-	-	105,069	105,069
Receivables	24		-	-	-	-	23,610	23,610
Investments with the Territory Banking Account	27	3.10%	3,027	-	-	-	-	3,027
Total Financial Assets			**3,027**	**-**	**-**	**-**	**128,679**	**131,706**
Financial Liabilities								
Payables	32		-	-	-	-	54,269	54,269
Finance Leases	33		-	-	-	-	-	-
Total Financial Liabilities			**-**	**-**	**-**	**-**	**54,269**	**54,269**
Net Financial Assets / (Liabilities)			**3,027**	**-**	**-**	**-**	**74,410**	**77,437**

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.

	Note No.	Weighted Average Interest Rate	Fixed Interest Maturing In:					
			Floating Interest	1 Year or Less	Over 1 Year to 5 Years	Over 5 Years	Non-Interest Bearing	Total
			$'000	$'000	$'000	$'000	$'000	$'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**

Note 39. Financial Instruments (Continued)

Carrying Amount of Each Category of Financial Asset and Financial Liability	2015 $'000	2014 $'000
Financial Assets		
Loans and Receivables Measured at Amortised Cost	23,610	19,740
Financial Assets at Fair Value through the Profit and Loss Designated upon Initial Recognition	3,027	3,015
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	54,269	48,845
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	97	98

Note 40. Commitments

Capital Commitments

Capital commitments, contracted at reporting date, include the Secure Mental Health Unit, the Canberra Hospital Redevelopment, University of Canberra Public Hospital, 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, 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.

	2015 $'000	2014 $'000
Capital Commitments – Property, Plant and Equipment		
Payable:		
Within One Year [a]	179,753	102,335
Later than one year but not later than five years	61,455	77,637
Total Capital Commitments – Property, Plant and Equipment	**241,208**	**179,972**
Total Capital Commitments	**241,208**	**179,972**

a. The increase is due to capital works that will be continuing for 2015-16 including the Canberra Hospital Emergency Department expansion, Secure Mental Health Unit, University of Canberra Public Hospital, Calvary Public Hospital Car Park, Ngunnawal Bush Healing Farm and various other works around the Canberra Hospital and Health Services campus.

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.

	2015 $'000	2014 $'000
Non-Cancellable operating commitments are committed as follows:		
Within one year [a]	6,940	8,343
Later than one year but not later than five years	22,779	22,911
Later than five years	249	422
Total Operating Lease Commitments	**29,968**	**31,676**

Note 40. Commitments (Continued)

Other Commitments

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

	2015 $'000	2014 $'000
Non-cancellable other commitments are payable as follows:		
Within one year	49,993	55,615
Later than one year but not later than five years [b]	110	38,829
Total Other Commitments	**50,103**	**94,444**

Operating Lease Commitments – Motor Vehicle

Due to a change in the Whole-of-Government car leasing arrangements with SG Fleet on 23 April 2015, all such leases for the Directorate are now classified as operating leases rather than finance leases from 23 April 2015. As a result of this change there are no prior year comparable figures.

	2015 $'000	2014 $'000
Non-cancellable other commitments are payable as follows:		
Within one year	2,471	-
Later than one year but not later than five years	2,200	-
Total Operating Lease Commitments – Motor Vehicle	**4,671**	**-**

a. The reduction in operating commitments is due to the property lease for 11 Moore Street expiring on 31 October 2015 and a reduction in the commitment for computer asset leases.

b. The reduction is due to the majority of current contracts with non-government organisations for provision of services expiring in June 2016.

Note 41. Contingent Liabilities and Contingent Assets

Contingent Liabilities

The Directorate is subject to 137 legal actions (2014 - 115 actions). The Directorate's maximum exposure under the ACT Insurance Authority insurance policy is estimated at $6,150,000 (2014 - $5,490,000), which has not been provided for in the accounts.

There were no contingent assets as at 30 June 2015.

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

Note 42. 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		
	2015 $'000	2014 $'000
Cash and Cash Equivalents Disclosed in the Balance Sheet	105,069	107,256
Cash and Cash Equivalents at the End of the Reporting Period as Recorded in the Cash Flow Statement	**105,069**	**107,256**
(b) Reconciliation of Net Cash Inflows/(Outflows) from Operating Activities to the Operating (Deficit)		
Operating (Deficit)	(44,630)	(37,645)
Add/(Less) Non-Cash Items		
Depreciation of Property, Plant and Equipment	36,396	27,642
Amortisation of Intangibles	10,190	4,841
Bad and Doubtful Debts	2,026	1,808
Asset Book Value Written Down	837	16
Impairment Loss of Non-Current Assets	217	530
Assets transferred from Other ACT Government Entities	(485)	-
Add/(Less) Items Classified as Investing or Financing		
Unrealised Gain on Investments	(12)	(4)
Gain from Derecognition of Finance Lease Liability	(5,469)	-
Loss on Derecognition of Motor Vehicles under a Finance Lease	5,286	-
Cash Before Changes in Operating Assets and Liabilities	**4,356**	**(2,812)**
Changes in Operating Assets and Liabilities		
(Increase)/Decrease in Receivables	(3,774)	102,415
(Increase)/Decrease in Inventories	(849)	306
(Increase) in Other Assets	(548)	(716)
Increase/(Decrease) in Payables	6,095	(18,407)
Increase in Other Provisions	22,027	29,071
(Decrease) in Other Liabilities	(154)	(1,701)
Net Changes in Operating Assets and Liabilities	**22,797**	**110,969**
Net Cashflows from Operating Activities	**27,154**	**108,157**

(c) Non-Cash Financing and Investing Activities

Due to a change in the whole-of-Government vehicle leasing arrangements with SG Fleet, from 23 April 2015 all such leases for the Health Directorate are classified as operating leases rather than finance leases.

	2015 $'000	2014 $'000
Acquisition of Motor Vehicles by Means of Finance Lease	1,703	2,322

Note 43. Events Occurring After Balance Date

There were no events occurring after the balance date, which would affect the financial statements as at 30 June 2015, or in the future reporting periods.

Note 44. Third Party Monies

The Directorate held funds in trust relating to the activities of the Health Directorate Human Research Ethics Committee.

	2015 $'000	2014 $'000
Human Research Ethics Committee Account		
Balance at the Beginning of the Reporting Period	517	563
Cash Receipts	855	1,077
Cash Payments	(880)	(1,123)
Balance at the End of the Reporting Period	**492**	**517**

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

	2015 $'000	2014 $'000
Mental Health Account		
Balance at the Beginning of the Reporting Period	33	36
Cash Receipts	111	322
Cash Payments	(101)	(325)
Balance at the End of the Reporting Period	**43**	**33**

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

	2015 $'000	2014 $'000
Private Practice Fund		
Balance at the Beginning of the Reporting Period	26,497	24,836
Cash Receipts	27,672	23,835
Cash Payments	(25,659)	(22,174)
Balance at the End of the Reporting Period	**28,510**	**26,497**

Note 45. Budgetary Reporting – Explanations of Major Variances Between Actual Amounts and Original Budget Amounts

The following are brief explanations of major line item variances between budget estimates and actual outcomes. Variances are considered to be major variances if both of the following criteria are met:

a) The line item is a significant line item: the line item actual amount accounts for more than 10% of the relevant associated category (Income, Expenses and Equity totals) or sub-element (e.g. Current Liabilities and Receipts from Operating Activities totals) of the financial statements; and

b) The variances (original budget to actual) are greater than plus (+) or minus (-) 10% of the budget for the financial statement line item.

Operating Statement Line Items	Actual 2014–15 $'000	Original Budget [1] 2014–15 $'000	Variance $'000	Variance %	Variance Explanation
Grants and Purchased Services	78,343	92,810	(14,467)	(15.59)	Lower than budgeted Grants and Purchased Services is mainly due to work being performed within the Directorate instead of being paid to external organisations.

1 Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period (2014–15 Budget Statements). These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

Note 45. Budgetary Reporting – Explanations of Major Variances Between Actual Amounts and Original Budget Amounts (Continued)

Balance Sheet Line Items	Actual 2014–15 $'000	Original Budget [1] 2014–15 $'000	Variance $'000	Variance %	Variance Explanation
Cash and Cash Equivalents	105,069	42,075	62,994	149.7	Higher than anticipated cash and cash equivalent is largely the result of: • higher opening balance of $42 million due to early settlement of cross border receivables in 2013–14; • higher net cash flow from operating activities of $40 million; • higher capital injection than capital works expenses due to timing delay $7m; • partially offset by the return of surplus cash of $27 million to the ACT Government.
Receivables – Current	27,232	73,236	(46,004)	(62.8)	Lower receivable balance is mainly due to early settlement of cross border receivables.
Property, Plant and Equipment	886,129	1,015,328	(129,199)	(12.7)	This is due to the deferral of capital works projects from 2014–15 to 2015–16 and 2016–17. The major deferrals from 2014–15 into future years are: • $10.2 million moved out of this financial year for the Calvary Car Park due to delays in excavation works; • $9.6 million moved out of this financial year from postponement of Hospital Road works due to road closures associated with Building 15 demountable installation; • $8.0 million moved out of this financial year for the E-Health ICT project due to lengthy delays in contract negotiations which delayed Electronic Medication Management & Clinical Records Information System Replacement Projects; and • $7.4 million moved out of this financial year from the clinical services redevelopment – phase 3 project due to delays with procurement of generators.
Payables – Current	54,269	88,172	(33,903)	(38.5)	Current payables were lower largely due to early settlement of cross border health costs and capital works invoices.
Finance Leases – Current	-	2,515	(2,515)	(100.0)	Finance leases are nil due to a change in leasing arrangements at a whole-of-government level. Motor vehicles are now classified as operating leases.
Employee Benefits – Current	229,506	187,149	42,357	22.6	Employee benefits are higher mainly due to accrued pay rises for Medical Officers, impacts of change in present value discounting factors, impact of higher than budgeted pay rise rates.
Finance Leases – Non Current	-	4,362	(4,362)	(100.0)	Finance leases are nil due to a change in leasing arrangements at a whole-of-government level. Motor vehicles are now classified as operating leases.
Accumulated Funds	758,870	861,215	(102,345)	(11.9)	Accumulated funds are lower mainly due to lower than budgeted capital injection of $58 million and $27 million of surplus cash returned to ACT Government.
Asset Revaluation Surplus	129,428	144,007	(14,579)	(10.1)	The accumulated revaluation surplus is lower mainly due to lower than anticipated asset values when the buildings were revalued in 2013–14.
Statement of Changes in Equity					
These line items are covered in other financial statements					

1 Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period (2014–15 Budget Statements). These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

Note 45. Budgetary Reporting – Explanations of Major Variances Between Actual Amounts and Original Budget Amounts (Continued)

Cash Flow Statement Line Items	Actual 2014–15 $'000	Original Budget [1] 2014–15 $'000	Variance $'000	Variance %	Variance Explanation
Goods and Services Tax Input Tax Credits from the Australian Taxation Office	39,346	49,100	(9,754)	(19.9)	This is mainly due to timing of the GST refund from the Australian Tax Office
Goods and Services Tax Paid to Suppliers	43,826	54,400	(10,574)	(19.4)	The reduction is mainly due to lower capital works invoices paid.
Payments for Capital Works	66,894	132,251	(65,357)	(49.4)	This is due to delays in some capital projects and timing of payment of capital works invoices.
Capital Injections	74,041	132,251	(58,210)	(44.0)	This is due to the deferral of capital works projects from 2014–15 to 2015–16 and 2016–17. The major deferrals from 2014–15 into future years are: • $10.2 million moved out of this financial year for the Calvary Car Park due to delays in excavation works; • $9.6 million moved out of this financial year from postponement of Hospital Road works due to road closures associated with Building 15 demountable installation; • $8.0 million moved out of this financial year for the E-Health ICT project due to lengthy delays in contract negotiations which Electronic Medication Management & Clinical Record Information System Replacement Projects; and • $7.4 million moved out of this financial year from the clinical services redevelopment – phase 3 project due to delays with procurement of generators.
Cash and Cash Equivalents at the Beginning of the Reporting Period	107,256	64,816	42,440	65.5	Higher than anticipated cash and cash equivalent is largely the result of: • higher opening balance of $42 million due to early settlement of cross border receivables in 2013–14; • higher than budgeted net cashflow from operating activities of $40 million; and • timing of capital expenses $10 million; partially offset by the return of surplus cash of $27 million to the ACT Government.

1 Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period (2014–15 Budget Statements). These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

HEALTH DIRECTORATE
TERRITORIAL FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2015

Health Directorate
Statement of Income and Expenses on Behalf of the Territory
For the Year Ended 30 June 2015

	Note No.	Actual 2015 $'000	Original Budget 2015 $'000	Actual 2014 $'000
Income				
Revenue				
Payments for Expenses on Behalf of the Territory	47	6,684	7,619	4,615
Fees	48	1,268	1,275	1,136
Total Revenue		**7,952**	**8,894**	**5,751**
Total Income		**7,952**	**8,894**	**5,751**
Expenses				
Grants and Purchased Services	49	6,684	7,619	4,615
Transfer to Government	50	1,267	1,275	1,133
Total Expenses		**7,951**	**8,894**	**5,748**
Total Comprehensive Surplus		**1**	**-**	**3**

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

Health Directorate
Statements of Assets and Liabilities on behalf of the Territory
For the Year Ended 30 June 2015

	Note No.	Actual 2015 $'000	Original Budget 2015 $'000	Actual 2014 $'000
Current Assets				
Cash and Cash Equivalents	51	242	295	268
Receivables	52	112	5	35
Total Current Assets		**354**	**300**	**303**
Total Assets		**354**	**300**	**303**
Non-Current Liabilities				
Advance from the Territory Banking Account	53	350	300	300
Total Liabilities		**350**	**300**	**300**
Net Assets		**4**	**-**	**3**
Equity				
Accumulated Funds		4	-	3
Total Equity		**4**	**-**	**3**

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

Health Directorate
Statement of Changes in Equity on Behalf of the Territory
For the Year Ended 30 June 2015

	Accumulated Funds Actual 2015 $'000	Total Equity Actual 2015 $'000	Original Budget 2015 $'000
Balance at 1 July 2014	3	3	-
Comprehensive Income			
Operating Surplus	1	1	-
Total Comprehensive Income	**1**	**1**	**-**
Balance at 30 June 2015	**4**	**4**	**-**

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

	Accumulated Funds Actual 2014 $'000	Total Equity Actual 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.

Health Directorate
Cash Flow Statement on Behalf of the Territory
For the Year Ended 30 June 2015

	Note No.	Actual 2015 $'000	Original Budget 2015 $'000	Actual 2014 $'000
Cash Flows from Operating Activities				
Receipts				
Cash from the ACT Government for Expenses on Behalf of the Territory		6,684	7,619	4,615
Fees		1,268	1,275	1,136
Other Receipts		704	763	467
Total Receipts from Operating Activities		**8,656**	**9,657**	**6,218**
Payments				
Grants and Purchased Services		6,635	7,619	4,615
Transfer of Territory Receipts to the ACT Government		1,267	1,275	1,133
Other		780	763	497
Total Payments from Operating Activities		**8,682**	**9,657**	**6,245**
Net Cash (Outflows) from Operating Activities	**54**	**(26)**	**-**	**(27)**
Net (Decrease) in Cash		(26)	-	(27)
Cash and Cash Equivalents at the Beginning of the Reporting Period		268	295	295
Cash and Cash Equivalents at the End of the Reporting Period	**54**	**242**	**295**	**268**

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 2015

	Original Budget 2015 $'000	Total Appropriated 2015 $'000	Appropriation Drawn 2015 $'000	Appropriation Drawn 2014 $'000
Territorial				
Expenses on Behalf of the Territory	7,619	6,684	6,684	4,615
Total Territorial Appropriation	**7,619**	**6,684**	**6,684**	**4,615**

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.

Variances between 'Original Budget' and 'Total Appropriated'

The difference between the Original Budget and Total Appropriated is due to the transfer of appropriation from 2014–15 to 2015–16 relating to:

- capital works for building works at Calvary Public Hospital for clinical services;
- the electrical substation; and
- savings returned from a prior year capital upgrade.

HEALTH DIRECTORATE TERRITORIAL NOTE INDEX FOR THE YEAR ENDED 30 JUNE 2015

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

Note 46. 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 47. 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 49: Grants and Purchased Services – Territorial)

	2015 $'000	2014 $'000
Payment for Expenses on Behalf of the Territory [a]	6,684	4,615
Total Payment for Expenses on Behalf of the Territory	**6,684**	**4,615**

a. The increase is due to capital works paid to Calvary Public Hospital for an electrical substation, refurbishment and fit out for 15 new beds in various wards and the refurbishment of clinical spaces.

Note 48. Fees – Territorial

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

	2015 $'000	2014 $'000
Fees		
Fees for Regulatory Services [a]	1,268	1,136
Total Fees	**1,268**	**1,136**

a. The increase is mainly due to inflation, growth in licence numbers and the introduction of licences for pharmacies.

Note 49. Grants and Purchased Services – Territorial

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

	2015 $'000	2014 $'000
Capital Grants to External Parties – Calvary Public Hospital [a]	6,684	4,615
Total Grants and Purchased Services	**6,684**	**4,615**

a. This is due to capital works paid to Calvary Public Hospital for an electrical substation, refurbishment and fit out for 15 new beds in various wards and the refurbishment of clinical space.

Note 50. 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.

	2015 $'000	2014 $'000
Transfers to the Territory Banking Account	1,267	1,133
Total Transfer to Government	**1,267**	**1,133**

Note 51. 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.

	2015 $'000	2014 $'000
Cash at Bank	242	268
Total Cash and Cash Equivalents	**242**	**268**

Note 52. Receivables – Territorial

	2015 $'000	2014 $'000
Current Receivables		
Net Goods and Services Tax Receivable	112	35
Less: Allowance for Impairment Losses	-	-
Total Current Receivables	**112**	**35**
Total Non-Current Receivables	**-**	**-**
Total Receivables	**112**	**35**

		Overdue			
Ageing of Receivables	**Not Overdue $'000**	**Less than 30 Days $'000**	**30 to 60 Days $'000**	**Greater than 60 Days $'000**	**Total $'000**
2015					
Not Impaired Receivables	112	-	-	-	112
Impaired Receivables	-	-	-	-	-
2014					
Not Impaired Receivables	35	-	-	-	35
Impaired Receivables	-	-	-	-	-

Classification of ACT Government/Non-ACT Government Receivables	2015 $'000	2014 $'000
Receivables with Non-ACT Government Entities		
Net Goods and Services Tax Receivable	112	35
Total Receivables with Non-ACT Government Entities	**112**	**35**
Total Receivables	**112**	**35**

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

Note 53. Advance from the Territory Banking Account – Territorial

	2015 $'000	2014 $'000
Advance from the Territory Banking Account	350	300
Total Advance from the Territory Banking Account	**350**	**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 Public Hospital attracts GST, which is not appropriated.

Note 54. 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

	2015 $'000	2014 $'000
Total Cash Disclosed on the Statement of Assets and Liabilities on Behalf of the Territory	242	268
Cash at the End of the Reporting Period as Recorded in the Cash Flow Statement on Behalf of the Territory	**242**	**268**

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

	2015 $'000	2014 $'000
Operating Surplus	1	3
Cash Before Changes in Operating Assets and Liabilities	**1**	**3**
Changes in Operating Assets and Liabilities		
(Increase) in Receivables	(77)	(30)
Increase in Advance from the Territory Banking Account	50	-
Net Changes in Operating Assets and Liabilities	**(27)**	**(30)**
Net Cash (Outflows) from Operating Activities	**(26)**	**(27)**

Note 55. 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 46: 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.

Note 55. Financial Instruments – Territorial (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 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.

Fair Value of Financial Assets and Liabilities

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

	Carrying Amount 2015 $'000	Fair Value 2015 $'000	Carrying Amount 2014 $'000	Fair Value 2014 $'000
Financial Assets				
Cash and Cash Equivalents	242	242	268	268
Total Financial Assets	**242**	**242**	**268**	**268**
Financial Liabilities				
Advance from the Territory Banking Account	350	350	300	300
Total Financial Liabilities	**350**	**350**	**300**	**300**
	(108)	**(108)**	**(32)**	**(32)**

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

Note 55. Financial Instruments – Territorial (Continued)

The following table sets out the Directorate's maturity analysis for financial assets and liabilities as well as the exposure to interest rates, including the weighted average interest rates by maturity period as at 30 June 2015. 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.

	Note No.	Weighted Average Interest Rate	Floating Interest Rate $'000	Fixed Interest Maturing In: 1 Year or Less $'000	Over 1 Year to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	51		-	-	-	-	242	242
Total Financial Assets			**-**	**-**	**-**	**-**	**242**	**242**
Financial Liabilities								
Advance from the Territory Banking Account	53		-	-	-	-	350	350
Total Financial Liabilities			**-**	**-**	**-**	**-**	**350**	**350**
Net Financial Assets / (Liabilities)			**-**	**-**	**-**	**-**	**(108)**	**(108)**

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 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.

	Note No.	Weighted Average Interest Rate	Floating Interest Rate $'000	Fixed Interest Maturing In: 1 Year or Less $'000	Over 1 Year to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	51		-	-	-	-	268	268
Total Financial Assets			**-**	**-**	**-**	**-**	**268**	**268**
Financial Liabilities								
Advance from the Territory Banking Account	53		-	-	-	-	300	300
Total Financial Liabilities			**-**	**-**	**-**	**-**	**300**	**300**
Net Financial (Liabilities)			**-**	**-**	**-**	**-**	**(32)**	**(32)**

Note 55. Financial Instruments – Territorial (Continued)

Carrying Amount of Each Class of Financial Asset and Financial Liability	2015 $'000	2014 $'000
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	350	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 56. Commitments – Territorial

Capital Commitments

Capital commitments at reporting date that have not been recognised as liabilities are as follows:

	2015 $'000	2014 $'000
Capital Grant Commitments		
Within One Year	1,076	784
Total Capital Commitments	**1,076**	**784**

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

Note 57. Contingent Liabilities and Contingent Assets – Territorial

There were no contingent liabilities or contingent assets as at 30 June 2015, (Nil at 30 June 2014).

There were no indemnities as at 30 June 2015, (Nil at 30 June 2014).

Note 58. 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 2015, or in the future reporting periods.

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

Note 59. Budgetary Reporting – Territorial – Explanations of Major Variances Between Actual Amounts and Original Budget Amounts

The following are brief explanations of major line item variances between budget estimates and actual outcomes. Variances are considered to be major variances if both of the following criteria are met:

a) The line item is a significant line item: the line item actual amount accounts for more than 10% of the relevant associated category (Income, Expenses and Equity totals) or sub-element (e.g. Current Liabilities and Receipts from Operating Activities totals) of the financial statements; and

b) The variances (original budget to actual) are greater than plus (+) or minus (-) 10% of the budget for the financial statement line item.

Statement of Income and Expenses on Behalf of The Territory Line Items	Actual 2014–15 $'000	Original Budget [1] 2014–15 $'000	Variance $'000	Variance %	Variance Explanation
Payments for Expenses on Behalf of the Territory	6,684	7,619	(935)	(12.3)	Payments for expenses on behalf of the Territory are lower than budget mainly due to delays in current year capital works and savings achieved in prior year capital upgrades.
Grants and Purchased Services	6,684	7,619	(935)	(12.3)	Grants and purchased services are lower than budget mainly due to delays in current year capital works and savings achieved in prior year capital upgrades.

Statement of Assets and Liabilities on Behalf of The Territory Line Items	Actual 2014–15 $'000	Original Budget [1] 2014–15 $'000	Variance $'000	Variance %	Variance Explanation
Cash and Cash Equivalents	242	295	(53)	(18.0)	Cash and cash equivalents are lower than budget mainly due to timing delay in receiving Goods and Services Tax refund from Australian Taxation Office.
Receivables	112	5	107	2,140.0	Receivables are higher than budget mainly due to timing of Goods and Services Tax refund from Australian Taxation Office.
Advance from the Territory Banking Account	350	300	50	16.7	Advance from the Territory Banking Account is higher than budget due to additional cash requirement to fund an increase in Goods and Services Tax cash outlay due to increased capital funding transferred to Calvary Hospital, which attracts GST.
Statement of Changes in Equity					
These line items are covered in other financial statements					

1 Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period (2014–15 Budget Statements). These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

Cash Flow Statement on Behalf of the Territory had no major variances.

C.3 CAPITAL WORKS

Introduction/overview

Capital works in ACT Health occur under the leadership of the Health Planning and Infrastructure (HPI) Group.

Health Planning and Infrastructure is responsible for delivering the:

- HIP, which is a significant investment in future health services for the ACT community and surrounding region
- Strategic Accommodation and the Capital Upgrades Program (CUP).

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. 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 seventh year of the HIP.

The CUP is funded annually. It aims to maintain and improve the existing infrastructure supporting the directorate. Work priorities are determined for 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.

Completed projects

Projects completed in 2014–15 under the HIP were as follows:

- **Canberra Region Cancer Centre (CRCC)**: Officially opened on 6 August 2014, with clinical services commencing on 18 August 2014.
- **Staging and Decanting**: Building 1 Level 5, Canberra Hospital refurbishment works were completed and handed over to ACT Health on 28 July 2014. Operations commenced on 2 September 2014 with the relocation of the Orthopaedic Ward 11B from Building 3 Level 2.
- **Calvary Hospital—15 additional beds**: A Territory Grant provided for an additional 15 beds at Calvary Hospital. The beds opened in March 2015.
- **Continuity of Services Essential Infrastructure (COSEI)**: Upgrading external signage at Canberra Hospital.
- **Upgrading Southern Generator on Canberra Hospital campus**: Completed March 2015.
- **Upgrading kitchen switchboards at Canberra Hospital**: Completed June 2015.

Works in progress

Works in progress under the HIP at 30 June 2015 are:

- **Refurbishment of Building 1, Level 4 at Canberra Hospital (part of staging and decanting)**: Converting the former paediatric ward into an aged care unit and rehabilitation ward to allow for the decanting of wards 11A and 11B from Building 3 to Building 1. This is programmed for completion in November 2015, and operational in February 2016.
- **Emergency Department and Paediatric Streaming Expansion**: This project will deliver an additional:
  - nine acute beds for patients with severe conditions
  - three beds or cubicles for patients with less severe problems
  - three beds in the Emergency Medical Unit, which provides care for short-term patients

- two paediatric treatment spaces
- two resuscitation bays
- new Mental Health Assessment Unit (MHAU) with two more beds
- three ambulance bays
- dedicated treatment space for Clinical Forensic Medicine.

This will take the total of the number of treatment areas in the Emergency Department from 54 to 75. Works commenced on 4 May 2015 and will not interfere with the day-to-day operations of the Emergency Department. The work is scheduled to be completed in late 2016. The project is co-funded with a contribution from the Commonwealth Government.

- **Calvary car park**: The new Calvary car park will provide 704 parking spaces in a structured car park over five levels. This will result in a net increase of approximately 515 spaces on the Calvary Hospital campus. The Head Contractor, ADCO Pty Ltd, was appointed in September 2014. Construction commenced in September 2014 and is due to be completed in late 2015.
- **Staging and Decanting (S&D) Bundle Package at Canberra Hospital**: This project is funded through three appropriations:
  - S&D – Moving to our Future (Phase 2)
  - S&D – Continuity of Service (Phase 1)
  - Canberra Hospital Redevelopment (Phase 3).

  A number of sub projects are progressing concurrently, including:

  - **Building 1 Level 4**: Design activities completed with asbestos-containing materials removed and early construction commence.
  - **Building 1, Level 8**: Design works placed on hold pending decision of Budget Cabinet for funding of eight additional beds.
  - **Building 1 Levels 9 and 10**: Completed design activities.
  - **Design works**: Completed to allow office areas to relocate staff from Building 3, including Level 2 Building 23, and Building 20.
  - **Head Contractor selection**: A Head Contractor was selected in May 2014 to plan, design, construct, commission and relocate all functions, to enable the complete decanting of Building 3 by 30 June 2016. To accommodate clinical and office space, the old Psychiatric Services Unit (Building 15) has been demolished A new modular building has been designed and is under construction.

    The demolition of the old Building 15 was completed in December 2014. Construction activities for the new building commenced in February 2015, with the new Building 15 due for completion in September 2015.
- **Adult Secure Mental Health Unit (SMHU)**: Richard Crookes Constructions was appointed as Head Contractor to complete the Final Sketch Plan (FSP) design and construction of the 25-bed facility. FSP was completed in May 2015. Early site works have commenced, with main construction works of the facility programmed to commence in July 2015.
- **University of Canberra Public Hospital (UCPH)**: This will provide 140 inpatient beds and 75 day places. Key services will include:
  - general and adult mental health rehabilitation and identified aged care services provided in inpatient units
  - admitted day services
  - outpatient services.

  The reference design, on which public consultation was sought, reflects the Preliminary Sketch Plan (PSP), which is used to inform the current tender process for the Head Contractor. Car parking for the UCPH site is currently subject to Budget Cabinet consideration.
- **Ngunnawal Bush Healing Farm (NBHF)**: The project met some significant milestones in 2014–15:
  - The Development Application was 'called in', with conditions, by the Minister for Planning on 5 October 2014.
  - Bridge strengthening works were completed in January 2015.
  - A traditional smoking ceremony was held at 'Miowera', site of the NBHF, in March 2015.
  - St Hilliers Pty Ltd was awarded the contract for site remediation and construction in April 2015.
  - Site remediation works commenced in May 2015 and as at 30 June 2015, are ongoing with construction programmed to commence in July 2015 for completion in late 2016.

- **Canberra Hospital—Continuity of Services Essential Infrastructure (COSEI)**: Stage 1, design of the main works package and the lump-sum delivery of a fire booster works package, was completed in July 2014. The external signage and wayfinding package was completed in early 2015. Internal signage and wayfinding will be updated and installed in late 2015. Stage 2 includes constructing, upgrading and/or enhancing a range of in-ground engineering services works package, including completing ring mains infrastructure works undertaken in recent years. This will enable development on the southern and northern ends of the Canberra Hospital campus. Stage 2 is programmed to commence in August 2015.
- **Canberra Hospital Essential Works – Infrastructure and Engineering**: The project will upgrade lifts, fire, mechanical and electrical services across a number of Canberra Hospital buildings. The proposed works will address compliance and replacement requirements for plant and equipment within the hospital.

Capital works tables

Table 52 shows the ACT Health Capital Works table.

Table 52: ACT Health Capital Works

Project	Proposed or actual completion date	Original project value $'000	Revised project value $'000	Prior year expenditure $'000	Current year (2014–15) expenditure $'000	Total expenditure to date $'000
New Works						
Calvary Public Hospital – Car park	Feb-16	16,872	16,872	0	6,077	6,077
Health Infrastructure Program – Project Management continuation	Jun-16	27,706	27,706	0	8,258	8,258
Secure Mental Health Unit	Sep-16	43,491	43,491	0	1,941	1,941
Canberra Hospital – Essential Infrastructure and Engineering Works	Feb-17	5,640	5,640	0	66	66
Canberra Hospital Redevelopment	Jun-16	21,241	21,241	0	0	0
Capital Upgrade Program Services						
Building Upgrades	Oct-15	710	710	0	341	341
Electrical/Fire/Safety Upgrades	Oct-15	700	700	0	312	312
Mechanical System Upgrades	Aug-15	715	715	0	196	196
Patient and medical Facility Upgrades	Sep-15	692	692	0	455	455
Upgrade of Medical and Administrative Offices	Sep-15	530	530	0	79	79
Workplace Improvements	Sep-15	595	595	0	230	230
Building Upgrades	Oct-15	705	705	183	274	457
Medical Facilities Upgrades	Nov-15	660	660	298	86	384
Facilities Improvements to Laboratory and Outpatients Area	Aug-15	890	890	10	379	389
Heating, Ventilation and Air Conditioning System Upgrades	Aug-15	375	375	86	171	257
Upgrade of Medical and Administrative Offices	Aug-15	646	646	163	275	438
Building Upgrades to address condition report findings including works to bathrooms, plumbing and other works	Aug-15	580	580	424	121	545
Works in Progress						
University of Canberra Public Hospital (Design)	Jun-16	8,252	8,252	13	601	614
Continuity of Health Services Plan – Essential Infrastructure (less previously completed Territorial works)	Jul-16	16,517	16,517	234	2,120	2,354
Clinical Services and Inpatient Unit Design and Infrastructure Expansion	Sep-16	40,780	40,780	752	4,526	5,278
Staging and Decanting – Moving to our Future	Jul-16	22,300	20,880	4,753	8,370	13,123
Staging, Decanting and Continuity of Services	Jun-16	19,430	18,430	10,524	6,358	16,882
Clinical Services Redevelopment – Phase 3	Jun-16	25,700	17,790	7,725	1,183	8,908
Aboriginal Torres Strait Islander Residential Alcohol and other Drug Rehabilitation Facility	Jun-16	6,883	11,731	2,243	5	2,248
Clinical Services Redevelopment – Phase 2	Jan-16	15,000	8,850	7,993	20	8,013
Provision for Project Definition Planning	Jan-16	63,800	58,040	56,572	558	57,130
Major Building Plant Replacement and Upgrade	Mar-16	5,292	5,292	3,222	322	3,544
An E-Healthy Future	Dec-16	90,185	90,185	54,315	7,857	62,172

Project	Proposed or actual completion date	Original project value $'000	Revised project value $'000	Prior year expenditure $'000	Current year (2014–15) expenditure $'000	Total expenditure to date $'000
Physically but not financially completed						
Integrated Cancer Centre – Phase 2	Jul-14	15,102	20,412	19,656	675	20,331
Tuggeranong Health Centre – Stage 2	Mar-14	14,000	14,000	13,673	198	13,871
Enhanced Community Health Centre – Belconnen	Sep-13	51,344	51,344	50,569	666	51,235
Women and Children's Hospital	Nov-13	90,000	113,517*	111,997	1,466	113,463
Electrical/Fire/Safety Upgrades	Jun-15	570	570	435	113	548
Replacement of CT Scanner at the Canberra Hospital	Sep-13	2,893	2,893	2,455	50	2,505
Completed Projects – physically and financially complete						
Calvary Hospital Car Park (Design)	Dec-14	1,300	1,300	431	869	1,300
Belconnen and Tuggeranong Walk-in Centres	Jun-14	951	951	951	-10	941
Adult Secure Mental Health Unit (Finalising Design)	Jun-15	2,000	2,000	512	1,488	2,000
Health Infrastructure Program – Project Management	Oct-14	19,319	19,319	15,490	3,829	19,319
Enhanced Community Centre Back up Power	Mar-14	3,540	1,342	1,342	0	1,342
Linear Accelerator Procurement and Replacement	Mar-15	18,700	17,250	16,523	727	17,250
HIP Change Management and Communication Support	Dec-14	4,117	4,117	3,754	325	4,079
Northside Hospital Specification and Documentation	Jun-15	4,000	4,000	1,868	2,132	4,000
National Health Reform	Sep-13	15,098	10,088	10,061	27	10,088
Mental Health Young Persons Unit	N/A	775	142	121	21	142
Adult Acute Mental Health Inpatient Unit	Mar-12	23,630	28,480	28,480	0	28,480
New Gungahlin Health Centre	Aug-12	18,000	17,540	17,540	0	17,540
New Multistorey Car Park TCH	Jun-11	29,000	42,720	42,196	524	42,720
Fire/Safety/Security Upgrades to address outcomes of fire reports, improve access control to plant rooms, upgrade flooring and other works	Jun-14	352	352	337	15	352
Mechanical Systems Upgrades to Building Plant and Equipment at the Canberra Hospital and other Health Facilities	Dec-13	580	580	563	17	580
Ambulatory Care Improvements at the Canberra Hospital including the Respiratory Medicine and Gastroenterology Areas	Oct-14	680	680	541	139	680
Augmentation of Medical and Administrative Offices to meet Organisational Change and Growth	Jun-15	420	420	291	129	420
Clinical Equipment for Calvary Hospital	Jun-15	3,500	3,500	3,341	159	3,500
Mobile Dental Clinic	Jun-15	600	575	91	484	575
Identity and Access Management	Jan-15	3,100	2,540	3,030	-490	2,540
Digital Mammography	Dec-14	5,715	5,715	5,080	635	5,715
Neonatal Intensive Care Unit – Video Streaming Services	Jun-15	200	200	126	74	200

* Revised project value includes $937,000 in donation revenue from external sources.

Table 53 shows the Territorial Capital Works table.

Table 53: Capital Works Table – Territorial

Project	Proposed or actual completion date	Original project value $'000	Revised project value $'000	Prior year expenditure $'000	Current year (2014–15) expenditure $'000	Total expenditure to date $'000
New Works						
Calvary Public Hospital – Car park (Grant component)	Nov-15	2,208	2,208	0	431	431
The Canberra Hospital Redevelopment (Grant component)	Dec-15	3,022	3,022	0	151	151
Capital Upgrade Program Services						
Fire Safety System Upgrade	Jul-15	200	200	80	94	174
Physically but not financially completed						
Calvary Public Hospital – Refurbishments for more beds (Grant component)	Jul-15	1,605	1,605	0	1,144	1,144
Completed Projects – physically and financially complete						
Floor Finishes Phase 2	Jun-15	200	200	0	200	200
Primary/Secondary Loop Phase 2	Jun-15	395	395	0	395	395
Public toilet Upgrade	Jun-15	189	189	0	189	189
Building Management System Upgrade	Jul-14	100	100	90	10	100
Installation of a Primary-Secondary Loop for the Environmental Cooling System to meet the needs of a Growing Hospital and Reduce Energy Costs	Feb-15	200	200	48	152	200
Residential Accommodation Refurbishment – Calvary	Aug-14	310	148	148	0	148

Reconciliation schedule

Table 54 shows the ACT Health Reconciliation schedule, capital works and capital injection.

Table 54: ACT Health 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	104,783	10,086	-1,093	-58,758	-1,061	53,957
ICT Capital Injections	18,500	3,305	0	-8,000	-1,853	11,952
Other Capital Injections	8,968	2,060	0	-894	-2,002	8,132
Total Departmental	132,251	15,451	-1,093	-67,652	-4,916	74,041
Total Territorial	7,619	0	-162	773	0	6,684

C.4 ASSET MANAGEMENT

Introduction/overview

At 30 June 2015, ACT Health managed assets with a total written down value of $886.129 million.

Assets managed

ACT Health managed assets included those listed in Table 55.

Table 55: ACT Health-managed assets

Asset	Value
Built property assets	$798.818M
Land	$40.645M
Plant and equipment	$43.227M
Leased plant and equipment	$0M
Leasehold improvements	$3.439M

The estimated replacement value of building assets was $1,100.325 million, as advised through the June 2014 asset revaluation by AON Valuation Services. The next revaluation is due in June 2017.

Table 56 lists ACT Health's property assets.

Table 56: ACT Health's property assets

Canberra Hospital (CH) Campus	Area m²	Health facilities	Area m²
CH Building 1—Tower Block	37,560	Belconnen Health Centre	3,800
CH Building 2—Reception/ Administration	5,950	Belconnen Community Health Centre	11,160
CH Building 3—Oncology/Aged Care/ Rehabilitation	17,390	Dickson Health Centre	490
CH Building 3—Radiation Oncology	1,650	Gungahlin Health Centre	2,608
CH Building 4—ANU Medical School	4,115	Phillip Health Centre	3,676
CH Building 5—Staff Training/ Accommodation	8,230	Tuggeranong Community Health Centre	6,760
CH Building 6—/Offices	4,710	Bruce—Arcadia House	467
CH Building 7—Alcohol and Drug	1,260	Bruce—Brian Hennessy House	3,719
CH Building 8—Pain Management	660	Health Protection Services—Holder	1,600
CH Building 9—Accommodation	740	Monash—Health Protection Service Air Monitoring Station	18
CH Building 10—Pathology	10,250	Lanyon Family Care Centre	194
CH Building 11—Centenary Hospital for Women and Children	19,200	Ngunnawal Family Care Centre	215
CH Building 12—Diagnostic and Treatment (including Emergency Department/ Intensive Care Unit)	19,510	Weston—Independent Living Centre	1,143
CH Building 13—Helipad Northern Car Park	7,980	Barton—Clare Holland House	1,600
CH Building 19—Canberra Region Cancer Centre	7,980	Curtin—QEII Family Centre	1,120
CH Building 22—Information Management	243	Kambah—Step Up Step Down Unit	279
CH Building 23—Redevelopment Unit Offices	1,810	Fadden—Karralika	534
CH Building 24—Health Administration Offices	1,332	Florey – Health Protection Service Air Monitoring Station	18
CH Building 25— Adult Mental Health Unit	5,436	Isabella Plains—Karralika	1,400
CH Building 26—Southern Car Park	53,000	O'Connor—Mental Illness Fellowship	200
Gaunt Place Building 1—Dialysis Unit	871	Rivett—Burrangiri Respite Care Centre	1,054
Gaunt Place Building 2—RILU	688	Watson Hostel	2,431
Gaunt Place Buildings 3, 4, 5, 6 (Health Offices)	668	Paddy's River—Miowera	206
Yamba Drive Car Park (Phillip Block 7, Section 1)	NA	Duffy—Cancer Patient Accommodation	319
		Student Accommodation—Phillip (3 units)	276
		Student Accommodation—Belconnen (2 units)	220
		Student Accommodation—Garran (1 unit)	117

Assets added to the asset register

During 2014–2015, the following assets were added to the agency's asset register:

- Land–Block 16 Section 40 Symonston for the Secure Mental Health Unit
- Land–Block 12 Section 53 Garran for the Secure Mental Health Unit.

Assets removed from the asset register

During 2014–2015, the following assets were removed from the agency's asset register.

- CH Building 15–Demolished to make way for new demountable building.

Properties not being utilised by ACT Health

On 30 June 2015, the agency had one property that was not being utilised, or had been identified as potentially surplus. This was the Belconnen Health Centre, which is to be transferred to Property Group.

Assets maintenance and upgrade

Capital upgrade works were undertaken at properties throughout ACT Health's portfolio in 2014–15. Works completed in the reporting year included:

- Canberra Hospital–Building 6, Level 2 refurbishment
- Canberra Hospital–Installation of pigeon barriers to Building 10
- Canberra Hospital–Building 1, Level 7 minor refurbishment works
- Canberra Hospital–Building 1, Level 6 bathroom upgrade
- Canberra Hospital–Building 5 kitchen upgrade
- Canberra Hospital–Building 10 lift controller upgrade
- Canberra Hospital–Property Management and Maintenance Office refurbishment
- Canberra Hospital–endoscopy refurbishment
- Brian Hennessy Rehabilitation Centre–bathroom and kitchen upgrades
- Clare Holland House–fire safety upgrade
- Phillip Community Health Centre–roof upgrade.

More information: For details of the capital works program, see the C.3 Capital works section, page 183.

Property, plant and equipment are maintained to a high standard to meet health requirements. Expenditure on repairs and maintenance, excluding salaries, was $17.023 million. This represents 1.41% per cent of the replacement value.

Building audits

Twenty-three 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 7,064 staff, of whom 1,219 occupy office-style accommodation in the sites listed in Table 6. The average utilisation rate is 14.5 square metres (m^2) per employee. Total office-style accommodation occupied is 17,623m^2.

Table 57 provides office accommodation details.

Table 57: Office accommodation

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	150	1,954	13.0
Civic	11 Moore Street Level 2 & 3	Leased	158	2,290	14.5
Civic	12 Moore Street Level 1*	Leased	43	447	10.4
Curtin	Carruthers Street	Leased	162	3,187	19.7
Garran	TCH Building 2	Owned	63	793	12.6
Garran	TCH Building 6	Owned	219	3,051	13.9
Garran	TCH Building 12 Medical Records	Owned	65	613	9.4
Garran	TCH Building 22	Leased	24	243	10.1
Garran	TCH Building 23	Owned	137	1,810	13.2
Garran	TCH Building 24	Owned	69	1,332	19.3
Holder	Health Protection Services	Owned	81	1,163	14.4
Phillip	Callam Offices	Leased	48	740	15.4

A further 5,845 staff are employed in non-office environments within the Health Directorate's acute and non-acute facilities. Due to the clinical nature of these workplaces, the average area per employee is not applicable.

C.5 GOVERNMENT CONTRACTING

Procurement principles and processes

In 2014–15, ACT Health exercised all procurement activities in accordance with the ACT Government tender thresholds and complied with procurement policies and procedures as stated in the *Government Procurement Act 2001* and the *Government Procurement Regulation 2007*.

To ensure compliance with ACT Government procurement legislation, ACT Health:

- sought advice on government procurement policies and procedures from the Shared Services Procurement and Capital Works Team
- notified Procurement and Capital Works of all procurements over $25,000 undertaken by ACT Health
- appropriately referred procurements requiring single, restrictive or open tender procurement processes to Procurement and Capital Works
- referred all procurements requiring Government Procurement Board consideration and/or approval to Procurement and Capital Works.

In accordance with procurement legislation, ACT Health afforded the highest standard of probity and ethical behaviour towards prospective tenderers. Such 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. These procurement methodologies are justified under the following circumstances:

- The procurement needs to be compatible (both hardware and software) with existing medical equipment within the clinical setting.
- Clinical units are seeking to standardise medical equipment with existing equipment. This mitigation strategy reduces the risk of human error when delivering clinical practice because equipment is familiar due to established equipment operating procedures.
- A limited number of providers possess the specialised medical knowledge and/or expertise to fulfil the agency's requirements.
- Timing may preclude public tenders being called in situations that could result in 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 NSW Department of Commerce Standing Offer Agreements for restricted select procurement. Through open tender, NSW has a selected a panel of preferred suppliers/providers from which a procurement is made.

To use the buying power of the NSW Government, ACT Health frequently asks panel suppliers to offer NSW Department of Commerce pricing on tenders. This strategy:

- increases the likelihood of better value for money to the Territory in comparison to a stand-alone open tender
- creates a more efficient procurement process.

Social procurement is considered wherever possible. However, due to the specialised nature of its operations, ACT Health is not always able to consider using social enterprise. ACT Health did not undertake any social procurement in 2014–15.

An ACT Health Procurement Package was introduced in September 2010 as a tool to educate ACT Health staff of their responsibilities for the proper expenditure of public monies in accordance with the Act. ACT Health requires its staff to seek quotations in accordance with the tender thresholds as stated in the regulations.

To further support the correct procurement processes, ACT Health has developed an e-learning package for staff use. This training program assists staff to develop their skills in undertaking procurement and provides procedural guidance on procurement activities. This tool is available through the Capabiliti training management system.

Open procurement processes include consideration of local suppliers.

External sources of labour and services

In 2014–15, ACT Health executed contracts with a range of suppliers for the provision of goods, services and works with a value of $25,000 or more. 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 executed by ACT Health for goods, services and works for the reporting period.

Goods, Services and Works

Table 58: Goods, Services and Works

Contract Title	Panel contract	Procurement methodology	Social procurement	Procurement type	Exemption from quotation and tender threshold requirements	Contractor name	Contract amount	Execution date	Expiry date	Small to Medium Enterprise (SME)
Purchase Orders from Beckman Coulter	No	Quotations	No	Goods	No	Beckman Coulter Australia Pty Ltd	$103,713.47	02/07/2014	02/07/2015	Yes
Purchase Orders from Abbott Diagnostics	No	Quotations	No	Goods	No	Abbott Diagnostic Division	$51,753.47	04/07/2014	04/07/2015	No
Purchase Orders from Ausco Trust Trading As Lightning Industries/ Lightning Mobility	No	Quotations	No	Goods	No	Ausco Trust Trading As Lightning Industries/ Lightning Mobility	$53,925.30	11/07/2014	11/07/2015	No
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	ACT Disability & Aged Carer Advocacy Service Inc	$118,139.00	15/07/2014	30/06/2016	Yes
Purchase Orders from Nexa Group Pty Ltd	No	Quotations	No	Goods	No	Nexa Group Pty Ltd	$66,825.00	16/07/2014	16/07/2015	No
Leasing of Haematology Analysers, Consumables and Associated Services	No	Public	No	Services (non-consultancy)	No	Beckman Coulter Australia Pty Ltd	$3,900,000.00	17/07/2014	17/07/2019	No
Purchase Orders from Gambro Australia	No	Quotations	No	Goods	No	Gambro Australia	$31,220.99	17/07/2014	17/07/2015	No
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Post and Antenatal Depression Support and Information Inc	$398,343.00	18/07/2014	30/06/2016	Yes
Purchase Orders from Abbott Diagnostics	No	Quotations	No	Goods	No	Abbott Diagnostic Division	$27,622.99	18/07/2014	18/07/2015	No
Elective Joint Replacement Program	No	Single Select	No	Services (non-consultancy)	Yes	Calvary Private Health Care Canberra Limited trading as Calvary John James Hospital	$15,000,000.00	21/07/2014	21/07/2017	No
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Grow	$174,735.00	21/07/2014	30/06/2016	Yes
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Duo Services Australia Ltd	$347,992.00	22/07/2014	30/06/2016	Yes
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Mental Illness Education ACT Incorporated	$507,360.00	22/07/2014	30/06/2016	Yes
Purchase Orders from Werfen Australia Limited	No	Quotations	No	Goods	No	Werfen Australia Limited	$50,950.46	22/07/2014	22/07/2015	No
Purchase Orders from B Braun Australia	No	Quotations	No	Goods	No	B Braun Australia Pty Ltd	$89,535.66	23/07/2014	23/07/2015	No
Purchase Orders from Roche Diagnostics	No	Quotations	No	Goods	No	Roche Diagnostics Australia Pty Ltd	$43,670.59	23/07/2014	23/07/2015	No
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Carers ACT Incorporated	$392,644.00	24/07/2014	30/06/2016	Yes

Contract Title	Panel contract	Procurement methodology	Social procurement	Procurement type	Exemption from quotation and tender threshold requirements	Contractor name	Contract amount	Execution date	Expiry date	Small to Medium Enterprise (SME)
Purchase Orders from Siemens Ltd	No	Quotations	No	Goods	No	Siemens Ltd	$821,011.04	28/07/2014	28/07/2015	No
Purchase Orders from Diagnostic Solutions	No	Quotations	No	Goods	No	Diagnostic Solutions	$54,995.95	28/07/2014	28/07/2015	No
Purchase Orders from Kestral Computing Pty Ltd	No	Quotations	No	Goods	No	Kestral Computing Pty Ltd	$43,560.00	29/07/2014	29/07/2015	No
Purchase Orders from Star Office Design	No	Quotations	No	Goods	No	Star Office Design	$42,407.20	30/07/2014	30/07/2015	No
Purchase Orders from Capital Medical Supplies	No	Quotations	No	Goods	No	Capital Medical Supplies	$90,907.20	31/07/2014	31/07/2015	No
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Society of St. Vincent De Paul Pty Ltd	$759,954.00	01/08/2014	30/06/2016	Yes
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Community Connections Incorporated	$152,843.00	01/08/2014	30/06/2016	Yes
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Oz Help Foundation Ltd	$647,613.00	01/08/2014	30/06/2016	Yes
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Volunteering ACT Incorporated	$188,048.00	04/08/2014	30/06/2016	Yes
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	ACT Mental Health Consumer Network Inc	$330,084.00	05/08/2014	30/06/2016	Yes
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Inanna Incorporated	$929,596.00	06/08/2014	30/06/2016	Yes
Purchase Orders from Siemens	No	Quotations	No	Goods	No	Siemens Ltd	$46,200.00	06/08/2014	06/08/2015	Yes
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Anglicare NSW South NSW West and ACT	$112,553.00	07/08/2014	30/06/2016	Yes
Purchase Orders from Philips Home Healthcare Solutions	No	Quotations	No	Goods	No	Philips Home Healthcare Solutions	$55,778.28	07/08/2014	07/08/2015	No
University of Canberra Public Hospital – Design Services Contract	No	Public	No	Consultancy	No	Newpolis Pty Ltd t/a Lyons	$1,247,945.00	08/08/2014	19/12/2014	No
Purchase Orders from Werfen Australia	No	Quotations	No	Goods	No	Werfen Australia Pty Limited	$46,035.00	08/08/2014	08/08/2015	No
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	A Gender Agenda Inc	$158,209.00	11/08/2014	30/06/2016	Yes
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Richmond Fellowship ACT Inc	$1,363,454.00	11/08/2014	30/06/2016	Yes
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Roman Catholic Church for the Archdiocese of Canberra and Goulburn as Trustees for Catholic Care	$2,892,843.00	11/08/2014	30/06/2016	Yes
Purchase Orders from Agilient	No	Quotations	No	Consultancy	No	Agilient Pty Limited	$39,873.28	11/08/2014	11/08/2015	No

Contract Title	Panel contract	Procurement methodology	Social procurement	Procurement type	Exemption from quotation and tender threshold requirements	Contractor name	Contract amount	Execution date	Expiry date	Small to Medium Enterprise (SME)
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Belconnen Community Service Inc	$975,502.00	12/08/2014	30/06/2016	Yes
Strategic Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Mental Health Community Coalition of the ACT	$584,309.00	12/08/2014	30/06/2016	Yes
Purchase Orders from Waters Australia	No	Quotations	No	Goods	No	Waters Australia Pty Ltd	$31,295.00	13/08/2014	13/08/2015	No
Purchase Orders from Varian Medical Systems	No	Quotations	No	Goods	No	Varian Medical Systems Australia	$132,987.43	13/08/2014	13/08/2015	No
Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Woden Community Service Incorporated	$806,882.00	18/08/2014	30/06/2016	Yes
Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Mental Health Foundation (ACT) Inc	$1,285,452.00	20/08/2014	30/06/2016	Yes
Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Mental Illness Fellowship Victoria	$2,918,142.00	01/09/2014	30/06/2016	No
Telephonic Coaching Services for the Secondary Prevention of Chronic Disease in the Territory	No	Public	No	Community-Based Services	No	Bupa Health Dialog Pty Ltd	$748,888.00	01/09/2014	31/08/2017	No
Purchase Orders from Workspace Commercial Furniture	No	Quotations	No	Goods	No	Workspace Commercial Furniture Pty Ltd	$30,232.40	01/09/2014	01/09/2015	Yes
Purchase Orders from Roche Diagnostics	No	Quotations	No	Services (non-consultancy)	No	Roche Diagnostics Australia Pty Ltd	$36,545.08	01/09/2014	01/09/2015	Yes
Sub-Sector Plan 2013–2016	No	Single Select	No	Community-Based Services	Yes	Barnardos Australia	$118,110.00	02/09/2014	30/06/2016	Yes
Pathology Laboratory Information Systems – Software Licensing, Support, Enhancement and Associated Services	No	Single Select	No	Services (non-consultancy)	Yes	Kestral Computing Pty Ltd	$2,202,635.00	02/09/2014	28/02/2019	Yes
Calvary Hospital Carpark Design and Construction	No	Public	No	Consultancy	No	ADCO Constructions Pty Ltd	$14,835,455.00	03/09/2014	24/07/2016	No
Purchase Orders from Stygron Systems	No	Quotations	No	Services (non-consultancy)	No	Stygron Systems Pty Ltd	$39,358.00	04/09/2014	04/09/2015	Yes
Purchase Orders from MKM Health	No	Quotations	No	Goods	No	MKM Health Pty Ltd	$47,740.00	10/09/2014	10/09/2015	Yes
Purchase Orders from Roche Diagnostics	No	Quotations	No	Services (non-consultancy)	No	Roche Diagnostics Australia Pty Ltd	$1,155,154.00	10/09/2014	10/09/2015	Yes
Purchase Orders from Shaw Building Group	No	Quotations	No	Services (non-consultancy)	No	Shaw Building Group Pty Ltd	$159,013.58	12/09/2014	12/09/2015	Yes
Purchase Orders from SAS Water Solutions	No	Quotations	No	Goods	No	SAS Water Solutions Pty Ltd	$52,868.20	16/09/2014	16/09/2015	Yes
Purchase Orders from Mainpac	No	Quotations	No	Goods	No	Mainpac Pty Ltd	$28,457.00	19/09/2014	19/09/2015	Yes
The Canberra Hospital Building 25 Remedial Landscape Works	No	Select	No	Works	No	Brindabella Contractors Pty Ltd	$114,114.00	19/09/2014	24/10/2016	Yes
Purchase Orders from Mobility Matters	No	Quotations	No	Goods	No	Mobility Matters Pty Ltd	$49,176.01	24/09/2014	24/09/2015	Yes

Contract Title	Panel contract	Procurement methodology	Social procurement	Procurement type	Exemption from quotation and tender threshold requirements	Contractor name	Contract amount	Execution date	Expiry date	Small to Medium Enterprise (SME)
Purchase Orders from Rollex Group	No	Quotations	No	Goods	No	Rollex Group Australia (2009) Pty Ltd	$38,483.61	25/09/2014	25/09/2015	No
Secure Mental Health Unit	No	Public	No	Works	No	Richard Crookes Constructions Pty. Limited	$38,110,253.50	30/09/2014	16/08/2016	No
ACT Patient Administration System (ACTPAS) & Emergency Department Information System (EDIS)	No	Single Select	No	Services (non-consultancy)	Yes	CSC Australia Pty Ltd	$4,393,774.00	03/10/2014	15/09/2019	No
Panel for Private Contracting of Elective Surgery in the ACT	Yes	Single Select	No	Services (non-consultancy)	Yes	Canberra Private Hospital Pty Limited	$2,000,000.00	07/10/2014	25/12/2015	Yes
Purchase Orders from Carefusion	No	Quotations	No	Goods	No	Carefusion Australia 316 Pty Ltd	$227,686.80	13/10/2014	13/10/2015	Yes
Panel Agreement for the Supply of Drug Eluting Coronary Stents	Yes	Public	No	Goods	No	Abbott Australasia Pty Ltd Boston Scientific Pty Ltd Medtronic Australasia Pty Ltd	$2,550,000.00	13/10/2014	13/10/2016	No
Purchase Orders from Stygron Systems	No	Quotations	No	Services (non-consultancy)	No	Stygron Systems Pty Ltd	$38,060.00	16/10/2014	16/10/2015	Yes
Aboriginal and Torres Strait Islander Drug and Alcohol Rehabilitation Facility; Ngunnawal Bush Healing Farm (NBHF) – Bridge Strengthening Works	No	Select	No	Works	No	Hawkins Civil Pty Ltd	$91,248.30	31/10/2014	01/12/2015	No
Provision Of Advance Care Planning In The ACT Community	No	Public	No	Services (non-consultancy)	No	Health Care Consumers Association of the ACT Incorporated	$175,643.00	24/11/2014	23/11/2017	Yes
ACT Health Capital Upgrade Projects – External Project Director	No	Single Select	No	Consultancy	Yes	Aurora Projects Pty Limited	$108,372.00	01/12/2014	30/04/2015	Yes
Provision of Relief Courier Services for ACT Pathology	No	Select	No	Services (non-consultancy)	Yes	Adecco Australia Pty Ltd	$450,000.00	17/12/2014	17/12/2017	No
Queue Flow Management Solution – Software and Associated Equipment Implementation and Support	No	Public	No	Services (non-consultancy)	No	NEXA Group Pty Ltd	$431,331.10	22/12/2014	21/12/2017	No
Provision of Eight (8) Endoscopic Surgical Towers & Associated Operating Equipment	No	Public	No	Goods	No	Karl Storz Endoscopy Australia Pty Ltd	$901,058.40	23/12/2014	27/03/2015	No
Technical Advisory Panel for Security	Yes	Select	No	Consultancy	Yes	Johnson, Willis Grant trading as Willis G Johnson	$67,450.00	12/01/2015	15/03/2016	Yes
Provision of Project Director Services for the Health Infrastructure Program	No	Public	No	Consultancy	No	Capital Works Consulting Pty Ltd	$385,000.00	12/01/2015	31/12/2015	Yes

Contract Title	Panel contract	Procurement methodology	Social procurement	Procurement type	Exemption from quotation and tender threshold requirements	Contractor name	Contract amount	Execution date	Expiry date	Small to Medium Enterprise (SME)
Technical Advisory Panel for FFE Specialist and Relocation Specialist	Yes	Select	No	Consultancy	Yes	Cameron Advisory Pty Ltd	Nil	15/01/2015	15/03/2016	Yes
Adult Step Up/Step Down Outreach Program – Transitional Intensive Recovery Outreach Support – (TIROS)	No	Public	No	Community-Based Services	No	Woden Community Service Incorporated	$800,000.00	22/01/2015	30/06/2016	Yes
Haemodialysis Services, Equipment, Consumables, and Other Support and Maintenance Services	No	Public	No	Services (non-consultancy)	No	Gambro Pty Ltd	$42,717,771.50	03/02/2015	02/02/2022	No
Technical Advisory Panel for ICT Health	Yes	Select	No	Consultancy	No	Cogility Pty Ltd	$142,759.00	05/02/2015	20/04/2016	Yes
Provision of Evaluation of the ACT Secondary Students Alcohol and Drug Survey	No	Quotations	No	Services (non-consultancy)	No	University Of Melbourne	$29,539.40	05/02/2015	05/02/2016	No
PICS Maintenance and Support Services FY 14–15	No	Quotations	No	Services (non-consultancy)	No	Stygron Systems Pty Ltd	$41,019.00	06/02/2015	06/02/2016	No
Thermo 5014I Beta Attenuation PM-2.5 Monitor	No	Single Select	No	Goods	Yes	Lear Siegler Australasia Pty Ltd	$29,715.40	02/03/2015	02/03/2016	No
Preventative Maintenance Plan for Agilent Technologies Brand Equipment	No	Quotations	No	Services (non-consultancy)	No	Agilent Technologies	$42,924.38	04/03/2015	04/03/2016	No
Bone Mineral Densitomerty Hologic DXA System	No	Single Select	No	Goods	Yes	Hologic (Australia) Pty Ltd	$90,717.00	04/03/2015	04/03/2016	No
Commercial Advisor Services for Completion of Uni of Canberra Hospital Car Park	No	Single Select	No	Consultancy	Yes	KPMG	$82,500.00	19/03/2015	19/03/2016	No
Technical Advisory Panel for Post Occupancy Evaluation and Health Infrastructure	Yes	Select	No	Consultancy	No	Cogent Business Solutions Pty Ltd	$38,280.00	23/03/2015	15/03/2016	Yes
Technical Advisory Panel for Electrical Building Services	Yes	Select	No	Consultancy	No	Techsafe Australia Pty. Ltd.	$200,000.00	24/03/2015	15/03/2016	Yes
Business Case for Phase 1 of the Redevelopment of Canberra Hospital (Building's 2 & 3)	No	Single Select	No	Consultancy	Yes	KPMG	$192,500.00	24/03/2015	27/01/2016	No
C1422 Implant PRC Line – CP920 With Hybrid Mode	No	Quotations	No	Goods	No	Cochlear Limited	$26,520.00	24/03/2015	24/03/2016	No
Epatslide Yellow Lightweight Slippery Sally with Heat Sealed Edges	No	Quotations	No	Goods	No	Haines Medical Aust Pty Ltd	$32,521.23	24/03/2015	24/03/2016	No
C1422 Implant PRC Line – CP910 Processing Unit	No	Quotations	No	Goods	No	Cochlear Limited	$25,070.00	24/03/2015	24/03/2016	No
Supply and Installation of Blinds	No	Select	No	Goods	No	Watson Blinds and Awnings Pty Ltd	$186,708.50	25/03/2015	25/03/2016	No

Contract Title	Panel contract	Procurement methodology	Social procurement	Procurement type	Exemption from quotation and tender threshold requirements	Contractor name	Contract amount	Execution date	Expiry date	Small to Medium Enterprise (SME)
Provision of Consumable Products for Interventional Cardiac Angiography	Yes	Public	No	Goods	No	Abbott Australasia Pty Ltd Bio-Excel (Australia) Pty Ltd Biotronik Australia Pty Limited Boston Scientific Pty Ltd Medtronic Australasia Pty Ltd Terumo Australia Pty Limited	$5,540,000.00	30/03/2015	28/02/2017	No
Ngunnawal Bush Healing Farm Additional Hazardous Materials Investigations	No	Select	No	Consultancy	No	Robson Environmental Pty Ltd	$50,401.00	18/05/2015	20/06/2015	No
ACT Membership of Centre for Health Record Linkage	No	Single Select	No	Services (non-consultancy)	Yes	Health Administration Corporation	$165,000.00	02/06/2015	30/06/2016	No
Provision of Evaluation of the Australian Secondary Students Alcohol and Drug Survey	No	Single Select	No	Services (non-consultancy)	No	University of Melbourne	$29,539.40	03/06/2015	03/02/2016	No
Provision of survey services for ACT Year 6 Physical Activity and Nutrition Survey 2015 (ACTPANS 2015)	No	Quotations	No	Services (non-consultancy)	No	McNair Ingenuity Research Pty Ltd	$52,140.00	17/06/2015	31/12/2015	Yes
Ngunnawal Bush Healing Farm Additional Hazardous Materials Investigations	No	Select	No	Consultancy	No	Robson Environmental Pty Ltd	$50,401.00	18/05/2015	20/06/2015	No
ACT Membership of Centre for Health Record Linkage	No	Single Select	No	Services (non-consultancy)	Yes	Health Administration Corporation	$165,000.00	02/06/2015	30/06/2016	No
Provision of Evaluation of the Australian Secondary Students Alcohol and Drug Survey	No	Single Select	No	Services (non-consultancy)	No	University of Melbourne	$29,539.40	03/06/2015	03/02/2016	No
Provision of survey services for ACT Year 6 Physical Activity and Nutrition Survey 2015 (ACTPANS 2015)	No	Quotations	No	Services (non-consultancy)	No	McNair Ingenuity Research Pty Ltd	$52,140.00	17/06/2015	31/12/2015	Yes

Visiting Medical Officers

Table 59 provides Visiting Medical Officer (VMO) details.

Table 59: Visiting Medical Officers

Title	Surname	First name	Specialty	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	$148,591.15
Dr	Albekaa	Safi	ENT Surgery	VMO	02-Nov-14	01-Nov-17	$77,788.81
Dr	Al-Sameraaii	Ahmad	Urology	VMO	01-Jun-13	31-May-16	$368,501.51
Dr	Ashman	Bryan	Orthopaedic Surgery	VMO	01-Sep-12	31-Aug-15	$428,670.32
Dr	Aubin	Phil	Orthopaedic Surgery	VMO	11-Feb-14	10-Feb-17	$143,148.98
Dr	Auzins	Edwin	General Dentistry (OMFS)	VMO	02-Jul-15	01-Jul-16	$69,251.94
Dr	Bassett	Mark	Gastroenterology	VMO	25-Nov-09	25-Nov-16	$33,456.47
Dr	Bissaker	Peter	Cardiac Surgery	VMO	01-Aug-08	01-Aug-15	$541,864.09
Dr	Bradshaw	Stephen	Vascular Surgery	VMO	02-Aug-14	01-Aug-17	$201,411.82
Dr	Brady	Marc	General Dentistry (OMFS)	VMO	31-Oct-13	30-Oct-14	$51,908.26
Dr	Burke	Bill	Thoracic Medicine	VMO	02-Oct-13	01-Oct-14	$42,013.95
Dr	Burns	Alexander	Orthopaedic Surgery	VMO	02-Jun-15	01-Jun-18	$234,530.08
Dr	Carney	Gavin (Gavin M Carney Pty Ltd)	Renal Medicine	VMO	24-Aug-10	01-Nov-14	$57,457.54
Dr	Chapman	Peter	ENT Surgery	VMO	02-Oct-14	01-Oct-17	$82,405.31
Dr	Chong	Guan (Dr Guan Chong Pty Ltd)	General Surgery	VMO	02-Jul-12	01-Jul-15	$347,444.00
Dr	Corbett	Michael	Gastroenterology	VMO	07-Feb-15	06-Feb-18	$70,871.51
Dr	Crawshaw	Ian	Paediatrics	VMO	01-Oct-07	30-Sep-14	$115,338.45
Dr	Damiani	Maurizio	Orthopaedic Surgery	VMO	07-Jul-13	06-Jul-16	$325,999.44
Dr	Davies	Stephen	Anaesthesia	VMO	02-Mar-15	01-Mar-18	$47,436.26
Dr	Davis	Ian	General Surgery	VMO	02-Sep-14	01-Sep-17	$190,420.62
Dr	Drummond	Catherine	Dermatology	VMO	01-Nov-14	31-Oct-17	$67,791.40
Dr	Duke	David	Cardiac Anaesthesia	VMO	22-Jan-15	21-Jan-18	$236,404.68
Dr	Edwards	Joanne	Paediatrics	VMO	22-Aug-13	21-Aug-16	$160,260.95
Dr	Ellingham	John	Cardiac Anaesthesia	VMO	29-Nov-09	29-Nov-16	$326,990.70
Dr	Fahey	Caroline	Anaesthesia	VMO	02-Sep-14	01-Sep-17	$40,540.89
Dr	Findlay	Michael	Plastic Surgery	VMO	12-Jun-14	11-Jun-15	$121,801.78
Dr	Fletcher	Victoria	Anaesthesia	VMO	11-Feb-15	10-Feb-18	$304,924.67
Dr	Freckmann	Mary-Louise	Clinical Genetics	VMO	01-Jul-15	30-Jun-18	$92,567.74
Dr	French	James	Anaesthesia	VMO	02-Sep-12	01-Sep-15	$257,722.76
Dr	Fuller	John	Neurosurgery	VMO	02-Aug-13	01-Sep-16	$152,586.09
Dr	Gantner	Dashiell	Intensive Care	VMO	17-Nov-14	16-Nov-15	$46,847.49
Dr	Gemmell-Smith	Nicholas	Anaesthesia	VMO	02-Jun-15	01-Jun-18	$54,412.75
Dr	Gibson	Graeme	Anaesthesia	VMO	30-Jun-14	29-Jun-15	$103,490.63
Dr	Gillmore	Colin	Anaesthesia	VMO	01-Feb-15	31-Jan-18	$77,417.95
Dr	Gross	Michael	Orthopaedic Surgery	VMO	10-Aug-13	09-Aug-16	$221,865.73
Dr	Gupta	Anil	Radiology	VMO	30-Mar-15	29-Mar-16	$191,134.03
Dr	Hamid	Celine	Paediatric Surgery	VMO	23-Mar-15	22-Mar-18	$182,433.54
Dr	Hardman	David	Vascular Surgery	VMO	01-Jul-08	01-Jul-15	$405,416.80
Dr	Hayes	Deborah	Cardiology (Paediatrics)	VMO	02-Mar-15	01-Mar-18	$42,470.27
Dr	Hehir	Andrew	Anaesthesia	VMO	28-Jan-15	27-Jan-18	$334,460.20
Dr	Jeans	Phil	General Surgery	VMO	12-Aug-12	11-Aug-15	$226,802.05
Dr	Kaye	Graham	Gastroenterology	VMO	31-Aug-14	30-Aug-17	$204,036.75
Dr	Khoo	Kenneth	Rheumatology (TCH) General Medicine & Rheumatology (CHC)	VMO	01-May-15	30-Apr-18	$71,468.35
Dr	Klar	Brendan	Orthopaedic Surgery	VMO	02-Aug-12	01-Aug-15	$164,676.20
Dr	Kulisiewicz	Gawel	Orthopaedic Surgery	VMO	07-Aug-09	07-Aug-16	$406,721.62
Dr	Kwan	Bernard	Anaesthesia	VMO	02-Sep-14	01-Sep-17	$73,862.83
Dr	Kwon	Jason	Anaesthesia	VMO	05-Dec-11	04-Dec-14	$324,158.58

Title	Surname	First name	Specialty	Description of contract	Date contract commences	Date contract expires	Total amount (exclusive of GST)
Dr	Lah	Frank	Anaesthesia	VMO	31-Jul-14	31-Jul-17	$135,760.25
Dr	Lang	Robert	Anaesthesia	VMO	20-May-15	25-Jan-16	$208,674.65
Dr	Lau	Yeong-Joe	Orthopaedic Surgery	VMO	20-Feb-14	19-Feb-15	$82,580.07
Dr	Lee	Elaine	Anaesthesia	VMO	11-Oct-12	10-Oct-15	$492,514.95
Dr	Lee	Tack-Tsiew	ENT Surgery	VMO	02-Jun-15	01-Jun-18	$103,634.67
Dr	Leerdam	Carolyn	Paediatric Medicine	VMO	02-Feb-15	01-Feb-18	$93,601.70
Dr	Lim	James	General Surgery	VMO	30-Nov-13	29-Nov-16	$132,673.37
Dr	Lu	Don Bunnag	Anaesthesia	VMO	02-Dec-14	01-Dec-17	$34,485.43
Dr	Major	Jennifer	Anaesthesia	VMO	03-Nov-14	02-Nov-15	$41,383.30
Dr	Makeham	Timothy	ENT Surgery	VMO	14-Feb-14	13-Feb-17	$105,421.30
Dr	Malecky	George	Paediatric Surgery	VMO	01-Nov-14	31-Oct-17	$647,696.95
Dr	Malhotra	Ram	Neurology	VMO	01-Apr-14	31-Mar-17	$64,212.75
Dr	Marshall	Natalie	Anaesthesia	VMO	01-Aug-14	31-Jul-17	$485,480.40
Dr	McDonald	Tim	Paediatrics	VMO	02-Aug-14	01-Aug-17	$381,373.74
Dr	McInerney	Carmel	Anaesthesia	VMO	02-Jun-15	01-Jun-18	$98,185.75
Dr	McCredie	Simon	Urology	VMO	02-Jul-13	01-Jul-16	$190,867.53
Dr	Meares	Nicola	Anaesthesia	VMO	31-May-13	30-May-16	$45,028.10
Dr	Miller	Andrew	Dermatology	VMO	30-Nov-13	29-Nov-16	$63,316.97
Dr	Morrissey	Phillip (P Morrissey Pty Ltd)	Anaesthesia	VMO	02-Nov-13	01-Nov-16	$144,916.04
Dr	Mosse	Charles	General Surgery	VMO	01-Dec-13	30-Nov-16	$199,366.55
Dr	Muggeridge	Catherine	Anaesthesia	VMO	25-Aug-14	24-Aug-17	$47,252.07
Dr	Mulcahy	Maurice	Urology	VMO	02-May-13	01-May-16	$1,155,929.64
Dr	Natale	Michael	Retrieval	VMO	06-Dec-14	05-Jun-15	$60,884.69
Dr	Neilson	Wendell	Vascular Surgery	VMO	01-Jul-13	30-Jun-16	$798,307.02
Dr	O'Connor	Simon	Cardiology	VMO	01-Oct-14	30-Sep-17	$353,159.01
Dr	OKera	Salim	Ophthalmology	VMO	12-Apr-10	12-Apr-17	$96,752.15
Dr	Peady	Clifford	Anaesthesia	VMO	02-Aug-14	01-Aug-17	$238,787.50
Dr	Peake	Ross	Anaesthesia	VMO	23-Jul-13	22-Jul-16	$101,138.91
Dr	Pham	Tuan	ENT Surgery	VMO	02-Jun-13	01-Jun-16	$369,926.65
Dr	Ponniah	Senthan	Anaesthesia	VMO	24-Jan-14	23-Jan-17	$106,568.07
Dr	Powell	Suzanna	Paediatric Medicine	VMO	01-Jun-08	31-May-15	$71,433.66
Dr	Quah	Yeow Leng (Valerie)	Anaesthesia	VMO	17-Jan-14	16-Jan-17	$115,107.90
Dr	Rangiah	David	General Surgery	VMO	02-Feb-15	01-Feb-18	$184,170.76
Dr	Robson	Stephen	O&G	VMO	01-Aug-14	31-Jul-17	$129,133.03
Dr	Rosier	Michael	Paediatric Medicine	VMO	02-Aug-14	01-Aug-17	$111,930.02
Dr	Sathasivam	Sivapirabu	Plastic Surgery	VMO	29-Jul-14	28-Jul-15	$504,746.60
Dr	Seppi	Viktoriya	Emergency	VMO	27-Aug-14	26-Aug-15	$116,748.26
Dr	Simpson	Erroll	Paediatric Surgery	VMO	01-Nov-14	31-Oct-17	$299,002.05
Dr	Smith	Paul	Orthopaedic Surgery	VMO	02-Feb-14	01-Feb-17	$249,446.35
Dr	Smith	Damian	Orthopaedic Surgery	VMO	02-Jul-15	01-Jul-18	$338,825.20
Dr	Smith	Joseph	Orthopaedic Surgery	VMO	01-Aug-14	31-Jul-15	$428,765.76
Dr	Speldewinde	Geoffrey	Anaesthesia	VMO	02-Nov-14	01-Nov-17	$32,971.30
Dr	Stone	Hilton	ENT Surgery	VMO	01-Feb-14	31-Jan-17	$112,241.65
Dr	Storey	Desmond	General Dentistry	VMO	30-Nov-13	29-Nov-16	$36,108.55
Dr	Stuart-Harris	Robin	Medical Oncology	VMO	01-June-08	31-May-15	$115,017.17
Dr	Tharion	John	Thoracic Surgery	VMO	02-Aug-12	01-Aug-15	$362,848.53
Dr	Thomson	Andrew	Gastroenterology	VMO	02-Oct-14	01-Oct-17	$404,212.11

Title	Surname	First name	Specialty	Description of contract	Date contract commences	Date contract expires	Total amount (exclusive of GST)
1.2 Mental Health, Justice Health and Alcohol and Drug Services							
Dr	Adesanya	Adesina	Psychiatry	VMO	01-Sep-14	31-Aug-15	$341,516.41
Dr	Bromley	Jennifer	General Practice (Corrections Health Program)	VMO	07-Feb-14	06-Feb-17	$47,641.25
Dr	Eldridge	James Neil	General Practice (Corrections Health Program & Clinical Forensics ACT)	VMO	23-Dec-13	01-Feb-17	$256,455.81
Dr	Manoharan	Jayaseelen	Psychiatry	VMO	19-May-15	18-May-16	$150,936.52
Dr	Owen	Cathy	Psychiatry	VMO	01-Jan-15	31-Dec-16	$122,068.25
Dr	Paull	Annita	Psychiatry	VMO	06-Jan-15	05-Jan-16	$162,942.11
Dr	Thomson	Graeme	General Practice (Corrections Health Program & Clinical Forensics ACT)	VMO	06-Jan-14	13-Jan-17	$175,010.69
Dr	Kasinathan	John	Psychiatry	VMO	02-Jul-15	02-Jul-17	$365,385.94
1.4 Cancer Services							
Drs	Applied Imaging Pty Ltd	Elizabeth Lim & Nigel Hunter	Radiology – BreastScreen	VMOs	01-Sep-08	01-Sep-15	$125,227.24
Dr	Bell	Susanne	Radiology – BreastScreen	VMO	11-Nov-14	10-Nov-17	$129,901.46
Dr	Chen	Suet Wan	Radiology – BreastScreen	VMO	01-Nov-14	31-Oct-17	$92,590.89
Dr	Cranney	Brendan	Radiology – BreastScreen	VMO	02-Jul-14	01-Jul-17	$39,776.89

C.6 STATEMENT OF PERFORMANCE

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

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 2015 has been reviewed.

Responsibility for the statement of performance

The Director-General is responsible for the preparation and fair presentation of the statement of performance of the Directorate 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.

As disclosed in the statement of performance, in accordance with the *Financial Management (Statement of Performance Scrutiny) Guidelines 2011*, the Government Payment for Outputs and Total Cost information included in the statement of performance has not been reviewed.

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 2015, 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
10 September 2015

Health Directorate
Statement of Performance
For the Year Ended 30 June 2015

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 2015 and also fairly reflects the judgements exercised in preparing it.

Nicole Feely
Director-General
Health Directorate
17 August 2015

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:

- strategies to meet performance targets for the emergency department, elective and emergency surgery;
- continuing to increase the capacity of acute care services.

	Original Target 2014–15	Actual Result 2014–15	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000s)	751,424	759,283	1%	Total Cost was higher than anticipated in the budget. This relates to depreciation for new information technology systems not included in the budget and the derecognition of motor vehicle assets when a change was made at the Whole-of-Government level to the lease type from finance to operating leases. These higher costs were offset by deferral of expenditure into 2015–16 for the Health Infrastructure Program.	
Government Payment for Outputs (GPO) ($000s)	100,469	96,284	-4%	GPO was lower than anticipated in the budget. The lower revenue relates mainly to the return of 'Public Hospital System – Additional Funding' as a saving to the ACT Government.	
Accountability Indicators					
a. Admitted – National Weighted Activity Units {14}	72,058	70,031	-3%	Admitted activity was lower than anticipated in the budget. The original target included 3,100 National Weighted Activity Units that relate to 1.1.d.	1
b. Non-Admitted – National Weighted Activity Units {14}	26,966	27,103	1%		2
c. Emergency Services – National Weighted Activity Units {14}	9,720	9,697	-		3

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

Explanation of Measures

1. Admitted services delivered at Canberra Hospital and Health Services, including those provided to cancer patients or rehabilitation patients, but excluding admitted mental health and subacute services. Activity is measured in National Weighted Activity Units {14} as defined by the Independent Hospital Pricing Authority's National Efficient Price Determination 2014–15.
2. Services provided to clients who were not admitted into hospital. Activity is measured in National Weighted Activity Units {14} as defined by the Independent Hospital Pricing Authority's National Efficient Price Determination 2014–15.
3. Services provided to clients in the Emergency Department of Canberra Hospital and Health Services. Activity is measured in National Weighted Activity Units {14} as defined by the Independent Hospital Pricing Authority's National Efficient Price Determination 2014–15.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office in accordance with the *Financial Management (Statement of Performance Scrutiny) Guidelines 2011*.

Output Class I: Health and Community Care (Continued)

Output I.I Acute Services (Continued)

	Original Target 2014–15	Actual Result 2014–15	% Variance from Original Target	Explanation of Material Variances	Notes
d. Acute Admitted Mental Health Services – National Weighted Activity Units {14}	841	3,905	364%	Acute Admitted Mental Health Services was higher than anticipated in the budget. The calculation used in setting the original target excluded approximately 3,100 NWAUs. They were included in the 1.1.a target.	4
e. Sub Acute Services – National Weighted Activity Units {14}	3,942	4,632	18%	Sub Acute Services activity was higher than anticipated in the budget. The higher activity is due to longer patient length of stay.	5
f. Calvary Services – National Weighted Activity Units (out of scope)	1,567	1,383	-12%	Calvary Services activity was lower than anticipated in the budget. The lower activity is due to a decline in Department of Veterans' Affairs activity.	6
g. Mean waiting time for clients on the dental services waiting list	6 Months	4 Months	-33%	Mean waiting time for dental services was lower than anticipated in the budget. This was due to increased funding from the Commonwealth for the 'Treating More Public Dental Patients' National Partnership Agreement. The Dental Health Program has been able to maintain shorter waiting times by referring extra clients to private dental services and employing additional clinical staff.	7
h. 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%	-		

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

Explanation of Measures

4. Acute Admitted Mental Health Services delivered at Canberra Hospital and Health Services. Activity is measured in National Weighted Activity Units {14} as defined by the Independent Hospital Pricing Authority's National Efficient Price Determination 2014–15.
5. Sub Acute Services delivered at Canberra Hospital and Health Services. Activity is measured in National Weighted Activity Units {14} as defined by the Independent Hospital Pricing Authority's National Efficient Price Determination 2014–15.
6. All patient activity for Calvary Public Hospital that does not meet the Independent Hospital Pricing Authority's criteria for inclusion on the 'General List of In-Scope Public Hospital Services'. Activity is measured in National Weighted Activity Units {14} as defined by the Independent Hospital Pricing Authority's National Efficient Price Determination 2014–15.
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.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office in accordance with the *Financial Management (Statement of Performance Scrutiny) Guidelines 2011*.

Output Class 1: Health and Community Care (Continued)

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

Description

The Health Directorate provides a range of Mental Health, Justice Health and Alcohol and Drug Services through the public and community sectors in hospitals, community health centres and other community settings, adult and youth correctional facilities and people's homes across the Territory. These services work to provide integrated and responsive care to a range of services, including hospital based specialist services, and therapeutic rehabilitation, counselling, supported accommodation services and other community based services.

The key strategic priorities for Mental Health, Justice Health and Alcohol and Drug Services are ensuring that people's 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
- ensuring that public and community mental health services in the ACT provide people with appropriate assessment, treatment and care that results in improved mental health outcomes
- providing community and hospital based alcohol and drug services
- providing health assessments and care for people detained in corrective facilities.

	Original Target 2014–15	Actual Result 2014–15	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000s)	126,378	129,675	3%	Total Cost was higher than anticipated in the budget. The higher expenses relate to higher levels of depreciation and the derecognition of motor vehicle assets when a change was made at the Whole-of-Government level to the lease type from finance to operating leases.	
Government Payment for Outputs (GPO) ($000s)	47,102	47,637	1%		
Accountability Indicators					
a. Adult mental health program community service contacts	109,000	113,610	4%		8
b. Children and youth mental health program community service contacts	65,000	64,933	-		9
c. ACT wide mental health program community service contacts	100,000	106,251	6%	ACT wide mental health community service contacts was higher than anticipated in the budget. This is mostly attributable to higher activity by the Crisis Assessment and Treatment Team.	10

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

Explanation of Measures

8. Mental Health ACT Adult community occasions of services (Age group 18–64).
9. Mental Health ACT Children and Adolescents community occasions of service (Age group 0–17).
10. ACT wide mental health program community services contacts 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.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office in accordance with the Financial Management (Statement of Performance Scrutiny) Guidelines 2011.

Output Class 1: Health and Community Care (Continued)

Output 1.2 Mental Health, Justice Health and Alcohol and Drug Services (Continued)

	Original Target 2014–15	Actual Result 2014–15	% Variance from Original Target	Explanation of Material Variances	Notes
d. Proportion of detainees at the Alexander Maconochie Centre with a completed health assessment within 24 hours of detention	100%	100%	-		11
e. Proportion of detainees in the Bimberi Youth Detention Centre with a completed health assessment within 24 hours of detention	100%	94%	-6%	During 2014–15, four health assessments were not undertaken within the 24 hour period. One was due to a potential security risk for staff as advised by Bimberi management. The assessment was completed approximately 48 hours after admission. The other three did not occur within 24 hours as health staff were not advised of their admission. The health assessments were completed at 24.5, 27 and 27.5 hours after admission.	11
f. Justice Health Services community contacts	105,000	114,860	9%	Justice Health Services community contacts was higher than anticipated in the budget. The higher activity reflects the increased number of detainees at the Alexander Maconochie Centre.	12
g. Percentage of current clients on opioid treatment with management plans	98%	99%	1%		13
h. Alcohol and Drug Services Community contacts	70,000	68,051	-3%		14

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

Explanation of Measures

11. Percentage of detainees at Alexander Maconochie Centre and Bimberi 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.

12. Community contacts are occasions of service with or about the client resulting in a dated entry in the clinical file. Contacts include both direct and indirect clinical contact, reported for all community mental health service units in the Justice Health program.

13. On presentation for opioid replacement treatment, a management plan is developed. This indicator represents the percentage of clients with management plans.

14. Direct occasions of service with a client (appointment, contact or dose).

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office in accordance with the *Financial Management (Statement of Performance Scrutiny) Guidelines 2011*.

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 2014–15	Actual Result 2014–15	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000s)	32,387	31,748	-2%		
Government Payment for Outputs (GPO) ($000s)	26,148	25,215	-4%	GPO was lower than anticipated in the budget. The lower revenue relates to the deferral of Health Program Grant funding to 2015–16 and the transfer of functions to Access Canberra.	
Accountability Indicators					
a. Samples analysed	8,500	11,918	40%	Samples analysed was higher than anticipated in the budget. The higher number of samples was due to increased food, water and oral fluid samples and a significant increase in illicit drug samples submitted for analysis.	15
b. Compliance of licensable, registrable and non licensable activities at the time of inspection	85%	77%	-9%	The compliance rates recorded primarily related to regulated food business. The non compliance is a continuation of previous downward trends in food safety compliance. ACT Health is examining further industry engagement and education along with appropriate regulation to improve compliance rates.	16
c. Response time to environmental health hazards, communicable disease hazards relating to measles and meningococcal infections and food poisoning outbreaks is less than 24 hours	100%	100%	-		17

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

Explanation of Measures

15. Number of samples analysed during the period by the ACT Government Analytical Laboratory.
16. 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*.
17. 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.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office in accordance with the *Financial Management (Statement of Performance Scrutiny) Guidelines 2011*.

Output Class I: Health and Community Care (Continued)

Output I.3 Public Health Services (Continued)

	Original Target 2014–15	Actual Result 2014–15	% Variance from Original Target	Explanation of Material Variances	Notes
d. Legalisation amendments to allow for deregulation of temporary non-profit community organisations (TNPCOs) that sell food	1	1	-		18
e. Percentage of Health Protection Service's regulated businesses/ activities who have access to Multi-year licenses/ registrations	20%	100%	400%	All Health Protection Service's regulated business/ activities have access to multi-year licenses/ registrations.	19

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

Explanation of Measures

18. Relates to legislative amendments to the *Food Act 2001*.

19. Relates to activities regulated under the: *Public Health Act 1997*; *Food Act 2001*; *Medicines, Poisons and Therapeutic Goods Act 2008*; and *Radiation Protection Act 2008*.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office in accordance with the *Financial Management (Statement of Performance Scrutiny) Guidelines 2011*.

Output Class I: Health and Community Care (Continued)

Output I.4 Cancer Services

Description

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

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

	Original Target 2014–15	Actual Result 2014–15	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000s)	73,599	73,816	-		
Government Payment for Outputs (GPO) ($000s)	8,097	8,089	-		
Accountability Indicators					
a. Total breast screens	15,500	15,559	-		20
b. Number of breast screens for women aged 50 to 69	12,950	11,687	-10%	Overall screening numbers were impacted by the introduction of the new BreastScreen Information System (BIS) in December 2014. The service commenced sending reminder letters to lapsed attendees and invitation letters to women on the electoral roll to improve participation rates.	21
c. Percentage of women who receive results of screen within 28 days	100%	100%	-		22
d. Percentage of screened patients who are assessed within 28 days	90%	90%	-		23

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

Explanation of Measures

20. Total number of women screened in the period.

21. Number of women aged between 50 to 69 years screened in the period.

22. 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.

23. The percentage of women requiring assessment who wait 28 days or less from their breast screen appointment to their assessment appointment.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office in accordance with the *Financial Management (Statement of Performance Scrutiny) Guidelines 2011*.

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 an appropriate 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 healthcare needs of the community.

	Original Target 2014–15	Actual Result 2014–15	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000s)	128,319	122,979	-4%	Total Cost was lower than anticipated in the budget. The lower expenses relates to identification of more services as early intervention and prevention (output 1.6) and underspends related to delayed opening of beds and difficulties in recruitment of staff.	
Government Payment for Outputs (GPO) ($000s)	44,490	44,995	1%		
Accountability Indicators					
a. Number of nursing (domiciliary and clinic based) occasions of service	82,000	85,220	4%		24
b. Number of allied health regional services (occasions of service)	22,600	26,628	18%	Allied Health Services was higher than anticipated in the budget.	25

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

Explanation of Measures

24. 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.

25. 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.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office in accordance with the *Financial Management (Statement of Performance Scrutiny) Guidelines 2011*.

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 2014–15	Actual Result 2014–15	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000s)	76,642	77,832	2%	Total Cost was higher than anticipated in the budget. The higher expenses relates to identification of more services as early intervention and prevention (output 1.6). These were offset by deferral of Commonwealth funding to 2015–16.	
Government Payment for Outputs (GPO) ($000s)	31,309	30,397	-3%	GPO was lower than anticipated in the budget. The lower revenue relates to the deferral of Commonwealth funding to 2015–16.	
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%		26
b. Proportion of clients attending 'Well Women's Check' within the Women's Health Service that are from culturally and linguistically diverse communities	40%	41%	3%		27
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	90%	93%	3%		28

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

Explanation of Measures

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

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

28. 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.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office in accordance with the *Financial Management (Statement of Performance Scrutiny) Guidelines 2011*.

SECTION D Notices of Noncompliance

D.I DANGEROUS SUBSTANCES

In 2014–15, ACT Health received no notices of noncompliance under section 200 of the *Dangerous Substances Act 2004.*

D.2 MEDICINES, POISONS AND THERAPEUTIC GOODS

In 2014–15, ACT Health received no notices of noncompliance under section 177 of the *Medicines, Poisons and Therapeutic Goods Act 2008.*

F.1 MENTAL HEALTH

See Attachments, Annexed and subsumed public authority reports, Chief Psychiatrist, page 246.

F.2 TOBACCO COMPLIANCE TESTING

No tobacco compliance tests were carried out during the 2014–15 financial year. As a result, no contraventions to section 14 (supply of smoking product to under 18-year-olds) were detected and no action was taken.

ATTACHMENTS

ACT CARE COORDINATOR

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 coordinating the provision of treatment, care and support to people with a mental dysfunction, in accordance with Community Care Orders (CCOs) made by the ACT Civil and Administrative Tribunal (ACAT). The Executive Officer for the ACT Care Coordinator is located within the Public Advocate of the ACT.

During the period 1 July 2014 to 30 June 2015, a total of 15 people were subject to a CCO, comprising nine men and six women. New CCOs were issued for 10 people during the reporting period.

For the 15 people subject to CCOs, two were referred by the courts and the remaining 13 were referred by clinical services. The CCOs were issued for the following reasons:

- dementia: seven people
- neurological disorder other than dementia: three people
- intellectual disability and acquired brain injury (ABI): four people
- personality disorder: one person.

Table 1 shows the ages of people subject to a CCO.

Table I: CCOs by age

Age	Number
≤18	0
19-29	1
30-39	2
40-49	1
50-59	3
60-69	1
70-79	3
80+	4
Total	15

As at 30 June 2015, five people continue to be subject to a CCO. Three of these orders are newly made and two orders have been reviewed and renewed.

Linda Kohlhagen
ACT Care Coordinator
16 September 2015

CALVARY HEALTH CARE LTD ANNUAL REPORT 2014–15

Calvary Health Care Bruce (Calvary) delivers public health and hospital services from its Bruce campus and from Clare Holland House in Barton.

Calvary's services are available to any person in need. The services deliver highly professional and quality clinical care, providing comfort and healing to ACT residents and people from surrounding communities.

Calvary Health Care Bruce provides services on behalf of the ACT Government. The principles of this partnership are described in the Calvary Network Agreement; funding and services are negotiated annually and formalised in the Calvary Performance Plan.

Calvary Health Care Bruce is a fully accredited health service comprising 275 beds across the Bruce and Barton campuses. The modern facilities are recognised for contemporary and multidisciplinary team-based care, which is provided by a dedicated, well prepared and highly professional workforce. At both campuses the natural environment contributes to holistic healing.

Calvary Health Care Bruce is Canberra's second major public hospital and provider of health service. It works in partnership with other acute care, primary care and community-based services. These partnerships are documented formally in the ACT Clinical Services and Network Services Plans. They are underpinned and made effective by clinicians at all levels and in all services being committed to every patient receiving the most appropriate care at the appropriate time in the appropriate setting.

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 good reputation in the Canberra community for the services it provides and the care it delivers. It is well understood in the local community that people of all faiths, and people without a professed faith, enjoy equal access to Calvary's services and that all faith rituals and cultural practices are respected and accommodated.

Services provided by Calvary Health Care Bruce 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
- the Hospital in the Home service.

Calvary Health Care Bruce is a teaching hospital associated with the Australian Catholic University, the Australian National University (ANU) 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 specialist palliative care service
- palliative care outpatients clinics
- a community-based domiciliary palliative care service.

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 2014–15, Calvary delivered:

- 56,321 Emergency Department presentations
- 5,255 elective surgery procedures
- 1,615 emergency surgery procedures
- 1,833 births
- 26,498 cost weights total activity.

During 2014–15, Calvary continued enhancing services and facilities at the Bruce campus and at Clare Holland House. This occurred through:

- refining patient flow processes
- improving discharge planning
- following up patients after complex treatment

- expanding the Calvary Hospital in the Home program and other service modalities designed to reduce or avoid inpatient admissions where other service options can provide a safe and less disruptive patient experience
- refining efficient and rapid admission of patients from the Emergency Department to a surgical or medical inpatient setting
- maintaining a 24-hour emergency surgery capability
- enhancing the parallel operation in Maternity Services where the midwifery care model and the more traditional maternity model of care continue in parallel
- embedding the efficient operations of the Rapid Assessment and Planning Unit, Medical Assessment and Planning Unit and Stroke Service Unit, which were established in 2013–14
- increasing the services in specialist outpatient clinics
- improving liaison and placement services for patients transitioning to Aged Care and Retirement residential situations
- enhancing palliative care services to those in residential aged care settings, and providing support for staff in these settings in support of quality end of life care.

Facility enhancements in the reporting period included:

- continuing the program of replacing floor coverings in public and clinical areas in accordance with environmental hygiene and infection-control best practice
- continuing refurbishment of patient rooms in Medical and Surgical Units to:
  - heighten infection-control measures
  - increase patient and staff safety
  - improve the amenity of patient rooms and public areas
- refurbishing public toilets in the Xavier and Marian buildings
- increasing general medical and surgical and intensive care unit (ICU) bed capacity.

These enhancements were completed with negligible disruption to clinical services and minimal effects on patient and visitor amenity.

Calvary would like to highlight the partnership of our facilities team, our diverse group of contractors, and the guidance of Barmco Mana Partnership in the ongoing process of accommodating new and contemporary clinical services within the existing footprint of buildings on the Calvary Health Care Bruce campus. The principles and philosophies of this partnership embody our value of stewardship.

Multistorey car park construction

Construction commenced on the 700+ space multistorey car park at the Calvary Health Care Bruce campus in late 2014. This project will be completed in late 2015.

The car park is funded by the ACT Government and is the foundation for future growth and expansion of services at Calvary. It has been recognised for some time that the available parking on the Calvary Bruce campus was:

- inadequate for existing activity levels
- an impediment to growing Calvary's capacity to meet the health and hospital needs of the expanding populations of North Canberra, Gungahlin and Molonglo.

This barrier will effectively be removed; the commissioning the multistorey car park will enable construction of a new stand-alone Calvary Private Hospital to commence in late 2015.

Issues and challenges

As with all Australian public health and hospital services, Calvary Health Care Bruce shares the challenge of meeting the growing needs of the community in an environment where state and territory governments, and the Commonwealth Government, endeavour to contain growing health costs.

The concurrent factors of longer life expectancy, an ageing population, improved management of chronic conditions, and the consistent emergence of new and expensive health practices and technology, represent a challenge at both network and individual facility levels.

Calvary is wholly committed to working with ACT Health to address these challenges.

Calvary remains committed to ensuring the community and patients and their carers know that in their time of need services will be available and delivered with respect and compassion by a highly trained and committed workforce and that the quality of care will never be compromised.

Future directions

The ACT Government Health Infrastructure Program (HIP) and the Bruce Precinct Master Plan are the basis for extensive consultation focused on the future of Calvary in its own right, and its role as a network provider as ACT public health services continue to expand.

The general expansion of the public hospital capacity at Calvary Bruce has been foreshadowed and will be assisted by:

- relocating Calvary Private Hospital from the sixth floor of the Xavier Building later in this decade
- transferring rehabilitation services to the new subacute hospital at the University of Canberra.

While infrastructure growth and service enhancement are significant and enduring, a key aspect of Calvary's future direction is ongoing community engagement and expanding and refining the processes that strengthen the contribution of community providers and hospital-based services to patient centred care.

Consumer engagement is a performance measure in contemporary health services; but it also critical to improving the patient experience and enhancing patient satisfaction. Calvary aims to continually explore ways to ensure that each of the almost 65,000 recipients each year experiences an individually fulfilling episode of care that provides the best possible health outcomes.

Calvary strives to make every member of the Calvary workforce more aware and more accountable about consumer and carer engagement and involvement in care planning.

CHIEF PSYCHIATRIST ANNUAL REPORT 2014–15

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:

- statistics in relation to people who have a mental illness during the year
- details of any arrangements with New South Wales (NSW) during the year in relation to people who have a mental illness.

Emergency apprehension

Table 1 shows the number of emergency apprehensions in 2014–15 by initiator.

Table 1: Emergency apprehension

Initiator	Number of emergency apprehensions
Police officer	723
Mental health officer	158
Medical practitioner	139
Total	1,020

Emergency detention

Table 2 shows the number of emergency detention notifications issued in 2014–15 in comparison to previous years. Applications for an 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).

Table 2: Emergency detention

Year	Number of emergency detentions
July 2011–June 2012	614
July 2012–June 2013	689
July 2013–June 2014	594
July 2014–June 2015	698

Outcome of those detained

Table 3 shows the outcomes for those detained in 2014–15 in comparison to previous years.

Table 3: Outcome of those detained

Year	Revocation of 72-hour detention and/or 72-hour detention being allowed to lapse	Applications for extension of involuntary detention
July 2011–June 2012	389	225
July 2012–June 2013	363	326
July 2013–June 2014	295	299
July 2014–June 2015	387	311

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. Table 4 shows PTO and Community Care Order (CCO) restriction order statistics for 2014–15 in comparison to previous years.

Table 4: Psychiatric treatment orders

Year	PTOs granted by the Tribunal	PTOs revoked	Breach of PTO	Tribunal restriction orders were all in relation to CCOs
July 2011–June 2012	864	148	76	5
July 2012–June 2013	924	127	82	16
July 2013–June 2014	890	167	80	15
July 2014–June 2015	921	156	90	14

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 the removal of an individual to Canberra Hospital for the purposes of an emergency assessment to determine whether immediate treatment and care are required. Table 5 provides statistics for other matters in 2014–15 in comparison to previous years.

Table 5: Other matters

Year	Application for ECT authorised	Application for emergency ECT authorised	Transfers to/from NSW	Court ordered removal for assessment—s309 of the Crimes Act 1900
July 2011–June 2012	16	1	10	54
July 2012–June 2013	13	1	8	40
July 2013–June 2014	7	0	9	44
July 2014–June 2015	10	1	12	63

Key points arising

The following trends in key areas of activity related to the Office of the Chief Psychiatrist are noteworthy.

In 2014–15, 1,020 people were apprehended and brought to Canberra Hospital for assessment. This is an increase of 5 per cent from the previous year, when it was 968.

Emergency detention revocations have increased from 295 to 387, a 31 per cent increase from the previous year. This reflects continuing efforts to move to least restrictive care at an early opportunity if at all possible.

Applications to extend involuntary detention by up to seven days increased by 4 per cent, 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 1,224 hearings throughout the year and granted 921 PTOs. This is an increase of 3 per cent from 2013–14. On application by a consultant psychiatrist, or of its own motion, ACAT revoked 156 orders, compared to 167 in the previous reporting period.

Ten ECT applications were authorised, which is a marginal increase from the previous year. Two applications for emergency ECT tribunal were made, however only one was authorised.

Twelve cross-border agreements were made between the ACT and NSW. The ACT accepted four transfers from NSW, and eight transfers were made to NSW facilities. One transfer was also made to the ACT from a Queensland facility and two transfers were made to Victorian facilities.

Breaches of PTOs increased from 80 in 2013–2014 to 90 in 2014–15. This amounts to an increase of 9 per cent from 2013–14. Fifty-nine people were brought to the Mental Health Assessment Unit for medication or assessment purposes, and 22 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 63 referrals for assessment pursuant to section 309 of the *Crimes Act 1900*, a significant increase of 43 per cent from the previous year. Of these, 37 people required admission to the Adult Mental Health Unit for assessment purposes, with 26 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.

With the pending implementation of the new *Mental Health Act 2014*, a Mental Health Act Strategic Implementation Group has been formed. Implementation 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. The new Act will begin on 12 November 2015.

Dr Peter Norrie
Chief Psychiatrist

HUMAN RESEARCH ETHICS COMMITTEE ANNUAL REPORT 2014–15

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)*, which is jointly developed by the:

- National Health and Medical Research Council (NHMRC)
- Australian Research Council
- Australian Vice-Chancellors' Committee.

During 2014–15, HREC has been an active contributor to the NHMRC consultation process on developing national reforms in research ethics administration.

The Research Ethics and Governance Senior Manager, August Marchesi, has continued to represent HREC and ACT Health on the Jurisdictional Working Group that is managing the National Mutual Acceptance (NMA) of ethical and scientific review for multi-centre clinical trials.

The Clinical Trials Subcommittee (CTSC) and the Social Research Subcommittee (SRSC) have continued to provide HREC with expert advice on the merit and integrity of research proposals. The Low Risk Subcommittee (LRSC) reviews and takes decisions on more than two-thirds of all proposals received.

HREC and its subcommittees draw on the expertise available in:

- ACT Health
- the wider ACT research community
- more broadly, the ACT community.

In June 2015 the HREC comprised:

- 11 external members external
- eight internal ACT Health members.

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 the Secretariat staff, August Marchesi, Matthew Wafer and Gillian Fox, for their tireless work in keeping the ACT Health HREC and its processes operating at the highest standards.

Louise Morauta PSM PhD
Chair

Membership of the Human Research Ethics committee

Table 1 identifies membership of the HREC.

Table 1: HREC membership

Name of member	Position
Dr Louise Morauta	Chair
A/Professor Peter Hickman	Deputy Chair (until July 2014) Current Researcher (Chemical Pathology) (from August 2014 until June 2015)
A/Professor Frank van Haren	Deputy Chair (from August 2014) Current Researcher (Intensive Care) (until July 2014)
Professor Walter Abhayaratna	Current researcher (Cardiology)
Ms Kimberley Baillie	Lawyer member (alternate)
Ms Margaret Blood	Lay member
Professor Doug Boer	Member providing professional care
Dr Bianca Calabria	Current researcher (Aboriginal and Torres Strait islander health) (from April 2015)
Professor Paul Craft	Current researcher (Oncology) (from August 2014)
A/Professor Marian Currie	Current researcher (Nursing and midwifery) (until Feb 2015)
Professor Geoff Farrell	Current researcher (Hepatology)
Rev Doug Hutchinson	Member providing pastoral care
Ms Julie Kussy	Registered nurse (until March 2015)
Dr David Larkin	Current researcher (Nursing and midwifery) (from March 2015)
Dr Ray Lovett	Current researcher (Aboriginal and Torres Strait islander health) (until March 2015)
Professor Imogen Mitchell	Current researcher (Intensive care) (from January 2015)
Mr John Morrissey	Lawyer member (alternate)
Dr Anna Olsen	Current researcher (Social Science) (from August 2014)
Dr Louise Stone	Current researcher (Social Science) (from May 2015)
A/Professor Dipti Talaulikar	Current researcher (Haematology)
Ms Lyn Todd	Pharmacist
Mr Luke Williamson	Lay member

Meetings of the Ethics Committee and its subcommittees

The committee met 11 times from 1 July 2014 to 30 June 2015. Meetings are held monthly. Subcommittee meeting details are as follows:

- The Clinical Trials Subcommittee (CTSC), under the chairmanship of Professor Walter Abhayaratna, met nine times during the year. In each instance recommendations were made to the subsequent HREC meeting.
- The Social Research Subcommittee (SRSC), under the chairmanship of Dr Jason Mazonov, met 10 times during the year. Again, in each instance recommendations were made to the subsequent HREC meeting.
- The Low Risk Subcommittee (LRSC), under the chairmanship of Dr Louise Morauta, met 24 times during the year. The LRSC meets on a fortnightly cycle to enable a faster decision-making process for projects 'in which the only foreseeable risk for participants is one of discomfort' (NHMRC National Statement, p 16).

Key points arising

Key developments during the 2014–15 year were:

- Achieving a three-year recertification by the NHMRC to maintain the HRECs status as one of only 20 per cent of committees certified for single ethical and scientific review of multi-centre health and medical research projects.
- Signing agreements with the University of Canberra and Australian National University HRECs for streamlined ethical review processes between institutions.
- Adding a third member to the Secretariat team, which is fully funded from HREC fee-for-service activities.
- Introducing a new system of compliance monitoring to improve compliance with HREC and NHMRC requirements.
- Exploring information technology solutions with the New South Wales (NSW) Ministry of Health to enable the ACT HREC to join the NMA and reduce duplication of ethical and scientific review across the public sector.

RADIATION COUNCIL ANNUAL REPORT 2013–14

Chair's review

It is my pleasure to present the Annual Report of the Radiation Council (the Council) for 2014–15.

In early 2015, Council member Pamela Brown announced her resignation from the Council. I would like to take this opportunity to thank Ms Brown for her service to the Council, and wish her well in her future endeavours. I would also like to welcome Fiona Jolly who is joining the Council as the appointed member of the public.

The Council has had a productive year, continuing to issue licenses, register radiation sources and consider issues that may affect the ACT community with regards to radiation safety and protection.

From 31 December 2014, the operation of commercial solariums in the ACT was prohibited following an amendment to the Radiation Protection Regulation 2007. The ban was introduced in line with similar changes across a majority of Australian jurisdictions, with an aim of reducing the incidence of melanoma, particularly in young people. The ban has been successfully implemented, with all previously registered tanning units removed from commercial premises as of 1 January 2015. No tanning units are registered in the ACT, and no person holds a licence to possess or operate a commercial solarium.

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 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 Council is specified in section 65 of the *Radiation Protection Act 2006*. Seven members are currently appointed to the Council, as shown in Table 1.

Table 1: Council members

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
Fiona Jolly	Incoming member	30 November 2016
Pamela Brown	Outgoing member	Retired from Council

Council meetings 2014–2015

The Council meets approximately every six weeks and met nine times during 2014–2015. Meetings were held in:

- July, August, September, November and December of 2014
- February, March, April and June of 2015.

Regulatory standards

The Council refers to a number of standards, codes of practice, safety guides, and recommendations when:

- considering matters relating to radiation protection
- issuing licences and approving registrations under the *Radiation Protection Act 2006*.

This includes documents in the Australian Radiation Protection and Nuclear Safety Agency (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 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.

Council activities

Approvals and decisions

Licences

The Council issued 194 new licences during the 2014–15 year, while 169 licences were not renewed. Overall this represents a 2.2% increase (25 licences) bringing the total number of licence holders in the ACT to 1,142.

Registrations

The Council registered 58 new radiation sources during the 2014–15 year, while 41 sources were decommissioned or transferred interstate. Overall this represents a 2.8% increase (17 sources) bringing the total number of registered radiation sources in the ACT to 602.

Radiation incidents

Eight radiation incidents were reported to the Council during the year and underwent further investigation, as explained in Table 2.

Table 2: Radiation incidents

Incident type	No. incidents	Details
Radiotherapy	3	One* incident involved equipment malfunction (safety interlock). One incident involved equipment malfunction (system calibration and correction). One incident involved a higher than normal result on a personal monitoring device.
Diagnostic Radiology	4	One incident involved the potential to deliver a diagnostic procedure other than prescribed. Two* incidents involved a higher than normal result on a personal monitoring device. One incident involved medical equipment malfunction.
Nuclear Medicine	1	One * incident, which involved a diagnostic procedure other than prescribed.

Following investigation, four of these incidents (marked with an asterisk *) were reported to ARPANSA for inclusion on the Australian Radiation Incident Register. In line with the ACT Health Risk Management Guidelines, the four incidents reported to ARPANSA were considered to be of minor consequence.

The remaining four incidents were deemed insignificant. The areas involved undertook reviews of 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 2014–2015.

Contact details

All correspondence should be addressed to:

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Radiation Council
C/- Health Protection Service
Locked Bag 5005
WESTON CREEK ACT 2611

Phone: (02) 6205-1700
Email: hps@act.gov.au
Website: *www.health.act.gov.au\radiationsafety*

Elizabeth Croft
Chair
3 July 2015

ACT LOCAL HOSPITAL NETWORK DIRECTORATE

Management Discussion and Analysis for the ACT Local Hospital Network Directorate For the Year Ended 30 June 2015

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 ways 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 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.

Risk Management

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

Actual public hospital activity (inpatient and outpatient services) delivered by entities in the ACT Local Hospital Network is lower than the budgeted activity resulting in a reduction of funding from the Commonwealth Government.

The Commonwealth Government will fund 45 per cent of the growth in public hospital activity from 2015–16 and the ACT Government and the Directorate will agree on the process for managing fluctuation in activity and costs from 2015–16.

The above risk is monitored regularly throughout the year.

Financial Performance

The following financial information is based on audited financial statements for 2013–14 and 2014–15, and the forward estimates contained in the 2015-16 Health Directorate and ACT LHN Budget Statements.

Total Net Cost of Services

	Actual 2013–14 $m	Budget 2014–15 $m	Actual 2014–15 $m	Budget 2015–16 $m	Forward Estimate 2016-17 $m	Forward Estimate 2017-18 $m	Forward Estimate 2018-19 $m
Total Expenses	915.4	957.1	966.0	1,019.6	1,070.3	1,109.4	1,142.7
Total Own Source Revenue	377.2	355.3	402.9	414.5	438.8	459.8	473.2
Total Net Cost of Services	538.2	601.8	563.1	605.1	631.5	649.6	669.5

Comparison to Budget

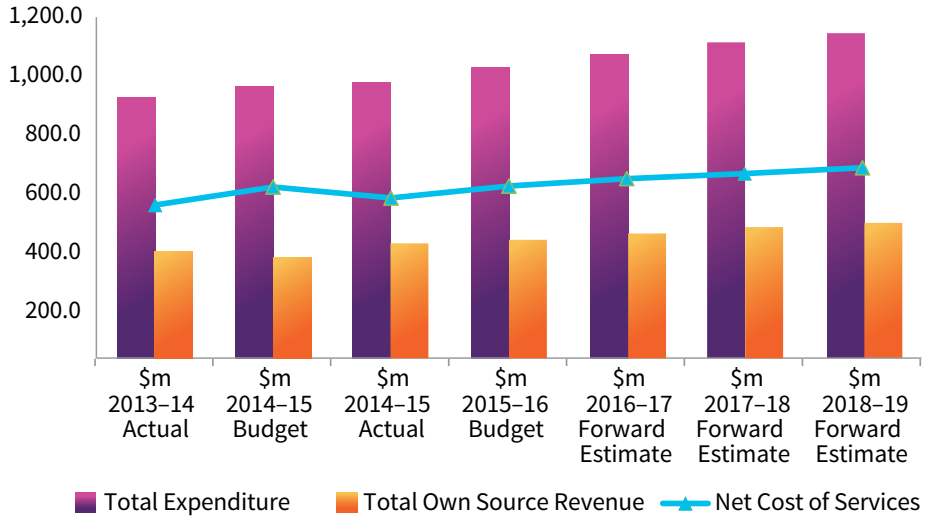
The Directorate's net cost of services for 2014–15 of $563.1 million was $38.7 million or 6.4 per cent lower than the 2014–15 budget (refer to Attachment A). This was mainly due to higher activity based funding and cross border revenue due to increased patient numbers compared to the estimate used in the budget.

Comparison to 2013–14 Actual Expenses

There was an increase of $24.9 million or 4.6% compared to the 2013–14 net cost of service of $538.2 million. This is due to higher expenses of $50.4 million from growth in public hospital activity, including acute services, mental health services and cancer services and an increase in the price paid for these services. Higher expenses are partially offset by an increase in own source revenue of $25.7 million from Commonwealth grant funding for growth in services and an increase in the price paid for these services.

Future Trends

Figure 1: Net Cost of Services



As shown above in Figure 1, net cost of services is expected to increase across the forward years.

Total Expenditure

Components of Expenditure

Figure 2 below shows that for the financial year ended 30 June 2015, 99.4 per cent of total expenditure ($966.0 million) relates to grants and purchased services.

Figure 2 – Components of Expenditure

Comparison to Budget

Total expenses of $966.0 million was $8.9 million, or 0.9 per cent higher than the original 2014–15 budget of $957.1 million.

Comparison to 2013–14 Actual Expenses

Total expenses were $50.6 million or 5.5 per cent higher than the 2013–14 actual result. This was due to growth in public hospital activity, including acute services, mental health services and cancer services, and inflation.

Future Trends

Expenses are budgeted to steadily increase across the forward estimate years.

Total Revenue

Components of Revenue

Figure 3 below indicates that for the financial year ended 30 June 2015, the Directorate received 58.4 per cent of its total revenue of $970.1 million from Government Payment for Outputs ($567.3 million), 9.5 per cent from Cross Border User Charges ($91.9 million), with the remaining 32.1 per cent made up of Grants from the Commonwealth ($311.0 million).

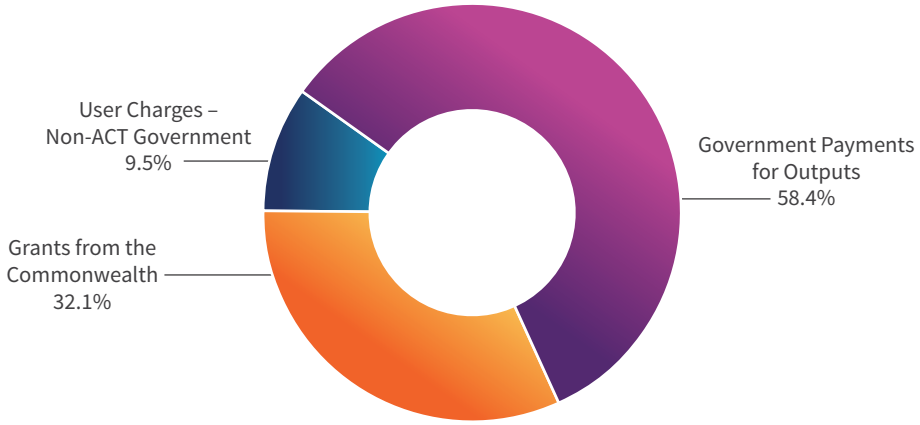


Figure 3 – Components of Own Source Revenue

Comparison to Budget

Own source revenue for the year ending 30 June 2015 was $402.9 million, which was $47.6 million or 13.4 per cent higher than the 2014–15 budget of $355.3 million. The higher own source revenue is due to higher activity based funding and cross border revenue from higher patient numbers than estimated in the budget.

Comparison to 2013–14 Actual Income

Own source revenue was $25.7 million or 6.8 per cent higher than the 2013–14 result of $377.2 million. The increase is mainly due to an increase in the price paid for services and growth in public hospital activity including acute services, mental health services and cancer services funded through the National Health Reform Agreement.

Future Trends

Total own source revenue is expected to increase steadily.

Financial Position

Total Assets

Components of Total Assets

Figure 4 below indicates that, as at 30 June 2015, the Directorate held total assets of $17.6 million with 72.1 per cent of its assets in receivables and 27.9 per cent in cash and cash equivalents.

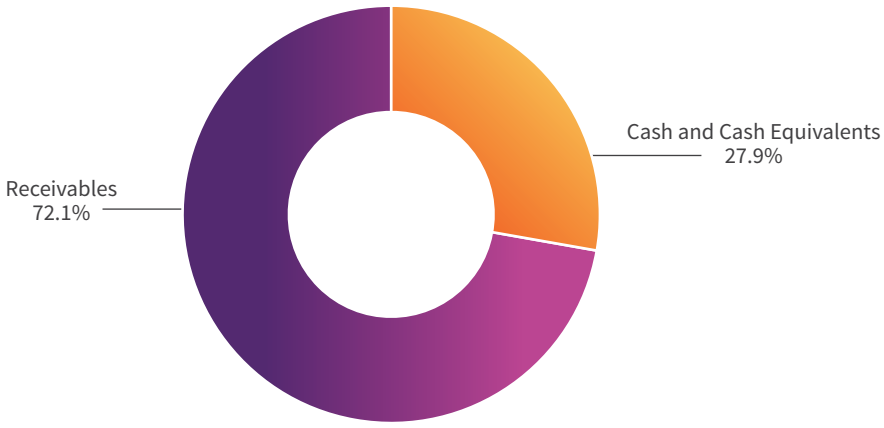


Figure 4 – Total Assets as at 30 June 2015

Comparison to Budget

The total asset position as at 30 June 2015 is $17.6 million, which exceeds the 2014–15 budget of $16.7 million by $0.9 million.

The variance reflects an increase in:

- Receivables ($11.5 million) – which relates to the cross border receivables from other jurisdictions for the treatment of their residents in ACT hospitals and a refund of GST from the Australian Taxation Office; offset by a decrease in
- Cash and Cash Equivalents ($10.6 million) – relates to the return of surplus cash to the ACT Government ($20.0 million) offset by the receipt of prior year cross border receivables from the New South Wales Ministry of Health.

Comparison to 2013–14 Actual

The Directorate's total asset position is $18.6 million lower than the 2013–14 actual result of $36.2 million. This is mainly due to the return of surplus cash to the ACT Government ($20.0 million) offset by the receipt of prior year cross border receivables from the New South Wales Ministry of Health.

Total Liabilities

Components of Total Liabilities

100.0 per cent of the Directorate's liabilities relates to payables.

Comparison to Budget

The Directorate's liabilities as at 30 June 2015 was $6.6 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 that were not anticipated in the budget.

Comparison to 2013–14 Actual

Total liabilities were $2.7 million lower than the actual results as at 30 June 2014 of $9.3 million.

The lower level of payables in 2014–15 is due to higher level of provisional payments made by the Directorate to the New South Wales Ministry of Health for cross border health services, which has resulted in a lesser amount owed at year end.

Net Assets

The Directorate's net assets as at 30 June 2015 were $5.7 million lower than the $16.7 million budgeted. This is mainly due to payables owed for cross border services not included in the budget.

Attachment A – Comparison of net cost of services to budget 2014–15

Description	Original Budget $'000	Plus AAO Transfers $'000	Total Funding $'000	Less Actual $'000	Variance to be Explained $'000	%
Expenses						
Purchased Services	936,600	-	936,600	960,497	(23,897)	-2.6%
Other Expenses	14,853	-	14,853	-	14,853	100.0%
Transfer Expenses	5,601	-	5,601	5,542	59	1.1%
Total Expenses	**957,054**	**-**	**957,054**	**966,039**	**(8,985)**	**-0.9%**
Own Source Revenue						
User Charges	84,249	-	84,249	91,906	(7,657)	-9.1%
Grants from Commonwealth	271,080	-	271,080	310,958	(39,878)	-14.7%
Total Own Source Revenue	**355,329**	**-**	**355,329**	**402,864**	**(47,535)**	**-13.4%**
Total Net Cost of Services	**601,725**	**-**	**601,725**	**563,175**	**38,550**	**6.4%**

ACT Audit Office

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 2015 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.

Level 4, 11 Moore Street Canberra City ACT 2601 PO Box 275 Civic Square ACT 2608
T 02 6207 0833 F 02 6207 0826 E actauditorgeneral@act.gov.au W www.audit.act.gov.au

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 2015:

(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 2015 and the results of its operations and cash flows for the year then ended.

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

M. Cooper

Dr Maxine Cooper
Auditor-General
14 September 2015

ACT Local Hospital Network Directorate
Financial Statements
For the Year Ended 30 June 2015

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 2015 and the financial position of the Directorate on that date.

Ms Nicole Feely

Director-General

ACT Local Hospital Network Directorate

27 July 2015

ACT Local Hospital Network Directorate
Financial Statements
For the Year Ended 30 June 2015

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 2015 and the financial position of the Directorate on that date.

Mr Ron Foster

Chief Finance Officer

ACT Local Hospital Network Directorate

24 July 2015

ACT LOCAL HOSPITAL NETWORK DIRECTORATE CONTROLLED FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2015

ACT Local Hospital Network Directorate
Operating Statement
For the Year Ended 30 June 2015

	Note No.	Actual 2015 $'000	Original Budget 2015 $'000	Actual 2014 $'000
Income				
Revenue				
Government Payment for Outputs	3	567,279	601,725	550,054
User Charges – Non-ACT Government	4	91,906	84,249	101,992
Grants from the Commonwealth	5	310,958	271,080	275,181
Total Revenue		**970,143**	**957,054**	**927,227**
Total Income		**970,143**	**957,054**	**927,227**
Expenses				
Grants and Purchased Services	6	960,497	936,600	910,084
Other Expenses		-	14,853	-
Transfer Expenses	7	5,542	5,601	5,316
Total Expenses		**966,039**	**957,054**	**915,400**
Operating Surplus		**4,104**	**-**	**11,827**
Total Comprehensive Income		**4,104**	**-**	**11,827**

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.

ACT Local Hospital Network Directorate
Balance Sheet
As at 30 June 2015

	Note No.	Actual 2015 $'000	Original Budget 2015 $'000	Actual 2014 $'000
Current Assets				
Cash and Cash Equivalents	11	4,902	15,502	12,277
Receivables	12	12,650	1,177	23,827
Other Assets	13	-	-	79
Total Current Assets		**17,552**	**16,679**	**36,183**
Total Assets		**17,552**	**16,679**	**36,183**
Current Liabilities				
Payables	14	6,605	-	9,340
Total Current Liabilities		**6,605**	**-**	**9,340**
Total Liabilities		**6,605**	**-**	**9,340**
Net Assets		**10,947**	**16,679**	**26,843**
Equity				
Accumulated Funds		10,947	16,679	26,843
Total Equity		**10,947**	**16,679**	**26,843**

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 2015

	Accumulated Funds Actual 2015 $'000	Total Equity Actual 2015 $'000	Original Budget 2015 $'000
Balance at 1 July 2014	26,843	26,843	16,679
Comprehensive Income			
Operating Surplus	4,104	4,104	-
Total Comprehensive Income	**4,104**	**4,104**	**-**
Transactions Involving Owners Affecting Accumulated Funds			
Capital (Distributions)	(20,000)	(20,000)	-
Total Transactions Involving Owners Affecting Accumulated Funds	**(20,000)**	**(20,000)**	**-**
Balance at 30 June 2015	**10,947**	**10,947**	**16,679**

	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.

ACT Local Hospital Network Directorate
Cash Flow Statement
For the Year Ended 30 June 2015

	Note No.	Actual 2015 $'000	Original Budget 2015 $'000	Actual 2014 $'000
Cash Flows from Operating Activities				
Receipts				
Government Payment for Outputs		567,279	601,725	550,054
User Charges		103,152	84,249	162,730
Grants Received from Commonwealth		310,958	271,080	275,181
Goods and Services Tax Input Tax Credits from the Australian Taxation Office		18,681	18,623	18,634
Total Receipts from Operating Activities		**1,000,070**	**975,677**	**1,006,599**
Payments				
Grants and Purchased Services		968,697	942,201	972,608
Goods and Services Tax Paid to Suppliers		18,748	-	18,721
Other		-	33,476	-
Payments to the Health Directorate		-	-	5,316
Total Payments from Operating Activities		**987,445**	**975,677**	**996,645**
Net Cash Inflows from Operating Activities	19	**12,625**	**-**	**9,954**
Cash Flows from Investing Activities				
Receipts				
Capital (Distributions)		(20,000)	-	-
Total Receipts from Investing Activities		**(20,000)**	**-**	**-**
Net Cash (Outflows) from Investing Activities		**(20,000)**	**-**	**-**
Net (Decrease)/Increase in Cash and Cash Equivalents		(7,375)	-	9,954
Cash and Cash Equivalents at the Beginning of the Reporting Period		12,277	15,502	2,323
Cash and Cash Equivalents at the End of the Reporting Period		**4,902**	**15,502**	**12,277**

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 2015

	Original Budget 2015 $'000	Total Appropriated 2015 $'000	Appropriation Drawn 2015 $'000	Appropriation Drawn 2014 $'000
Controlled				
Government Payment for Outputs	601,725	606,098	567,279	550,054
Total Controlled Appropriation	**601,725**	**606,098**	**567,279**	**550,054**

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 funding from the Commonwealth for the 'Public Hospital System – Additional Funding National Partnership Agreement' ($4.4 million).

Variances between 'Total Appropriated' and 'Appropriation Drawn'

Government Payment for Outputs

The difference between the Total Appropriated and the Appropriation Drawn relates to appropriation not required following increases in Commonwealth funding for inpatient and outpatient activity above original estimates and higher than budgeted cross border revenue from the New South Wales Ministry of Health and final acquittal of the 2012–13 cross border activity.

ACT LOCAL HOSPITAL NETWORK DIRECTORATE CONTROLLED NOTE INDEX

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

Note 1. Objectives of The ACT Local Hospital Network Directorate

Operations and Principal Activities

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 ways 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 from the Commonwealth and ACT Governments, and block funding for teaching, training and research. 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 Preparation

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 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 2015 together with the financial position of the Directorate as at 30 June 2015.

(d) Comparative Figures

Budget Figures

To facilitate a comparison with Budget Papers, as required by the *Financial Management Act 1996*, budget information for 2014-2015 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 price payable for the service. The price payable for services 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 are accounted for in the year of settlement.

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

Note 2. Summary of Significant Accounting Policies (Continued)

(f) Revenue Recognition (Continued)

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 2014–15 the ACT has a Cross Border Agreement in place with the New South Wales Ministry of Health.

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 interstate residents treated in ACT public hospitals.

Activity based funding (ABF) refers to a national system for funding public hospital services using national classifications, national price weights and a national efficient price (NEP). It is predicated on the Independent Hospital Pricing Authority (IHPA) pricing model which has set weights and pricing adjustments based on patient characteristics, that together give rise to a total payment amount for a hospital patient service. ABF covers all admitted, non admitted and emergency department services that meet the IHPA criteria for inclusion on the 'General List of In Scope Public Hospital Services'.

For 2014–15, ABF was paid at a rate of 45% of the NEP for activity above last year's baseline, with base activity payment paid at last year's rate plus price indexation.

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.

Commonwealth Grants is calculated and paid using estimates. The estimate is based on expected number of patients treated during the year. Further information on the basis of the estimate is provided in Note 2(O): Significant Accounting Judgements and Estimates.

Commonwealth Grants are recognised as revenues upon the receipt of cash.

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 Writeoffs**.**

(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.

Note 2. Summary of Significant Accounting Policies (Continued)

(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.

(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 2014–15. Under the National Health Reform Agreement, States and Territories are required to pay for Cross Border activity using the price payable for services. The price payable for services 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 loss is 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 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.

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

Note 2. Summary of Significant Accounting Policies (Continued)

(m) 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.

(n) Budgetary Reporting

Explanations of major variances between the 2014–15 original budget and the 30 June 2015 actual results are discussed in Note 21: Budgetary Reporting.

The definition of 'major variances' is provided in Note 2(o): Significant Accounting Judgements and Estimates – Budgetary Reporting.

Original budget refers to the original budgeted financial statements presented to the Legislative Assembly in a form that is consistent with the Directorate's annual financial statements. The 2014–15 budget numbers have not been audited.

Budgetary reporting is disclosed for controlled financial statements with the exception of Statement of Changes in Equity as relevant line items are included in other financial statements.

(o) 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 price determined by the Independent Hospital Pricing Authority. Interstate patient numbers for the current year is an estimation based on actual patient numbers for the nine months to 30 April 2015. 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.

Commonwealth Grants: is an estimation based on the expected number of patients converted into a National Weighted Activity Unit and paid at the price determined by the Independent Hospital Pricing Authority. Actual National Weighted Activity Units is settled following an acquittal process undertaken in the following financial year and variations to the revenue recognised are accounted for in the year of settlement.

Budgetary Reporting: Significant judgements have been applied in determining what variances are considered as 'major variances' requiring explanations in Note 21: Budgetary Reporting. Variances are considered to be major variances if both of the following criteria are met:

- The line item is a significant line item: the line item actual amount accounts for more than 10% of the relevant associated category (Income, Expenses and Equity totals) or sub-element (e.g. Current Liabilities and Receipts from Operating Activities totals) of the financial statements; and
- The variances (original budget to actual) are greater than plus (+) or minus (-) 10% of the budget for the financial statement line item.

Further information on this is provided in Note 2(n): Budgetary Reporting.

Note 2. Summary of Significant Accounting Policies (Continued)

(p) 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.

- AASB 9 Financial Instruments (December 2014) (application date 1 January 2018);

This standard supersedes AASB 139 Financial Instruments: Recognition and Measurement. The main impact of AASB 9 is that it will change the classification, measurement and disclosure of the financial assets. No material financial impact on the Directorate is expected.

- AASB 15 Revenue from Contracts with Customers (application date 1 January 2017);

AASB 15 is the new standard for revenue recognition. It establishes a comprehensive framework for determining whether, how much and when revenue is recognised. It replaces AASB 111 Construction Contracts and AASB 118 Revenue. No material financial impact on the Directorate is expected as the Directorate's current revenue recognition is already in line with the requirement of this standard.

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.

	2015 $'000	2014 $'000
Revenue from the ACT Government		
Government Payment for Outputs [a]	567,279	550,054
Total Government Payment for Outputs	**567,279**	**550,054**

a. The increase is due to growth in services in acute services, mental health, community health centres, the Centenary Hospital for Women and Children, the Canberra Region Cancer Centre, community nursing, the emergency department, and outpatient and imaging 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.

	2015 $'000	2014 $'000
User Charges – Non-ACT Government		
Cross Border (Interstate) Health Revenue [a]	91,906	101,992
Total User Charges – Non-ACT Government	**91,906**	**101,992**

a. 2013–14 included additional one-off revenue relating to prior year acquittals for cross border activity from several jurisdictions.

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

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.

	2015 $'000	2014 $'000
Grants from the Commonwealth		
Grants [a]	310,958	275,181
Total Grants from the Commonwealth	**310,958**	**275,181**

a. The increase is mainly due to an increase in the price paid for services 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 States and the Northern Territory for cross border patient services.

	2015 $'000	2014 $'000
Purchased Services		
Payments to Service Providers		
– Canberra Hospital and Health Services [a]	754,745	711,956
– Calvary Public Hospital [a]	178,557	167,133
– Clare Holland House	5,114	4,870
– Queen Elizabeth II Hospital	2,534	2,482
Cross Border (Interstate) Health Costs [b]	19,547	23,643
Total Grants and Purchased Services	**960,497**	**910,084**

a. The increase is mainly due to an increase in the price paid for services and growth in public hospital services.

b. The decrease is mainly due to the finalisation of prior year acquittals for several jurisdictions during 2013–14 which resulted in recognising additional expense in 2013–14.

Note 7. Transfer Expenses

Transfer Expenses relate to the on-passing of the Commonwealth's contribution to public health funding to the Health Directorate.

	2015 $'000	2014 $'000
Transfer Expenses	5,542	5,316
Total Transfer Expenses	**5,542**	**5,316**

Note 8. Auditor's Remuneration

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

	2015 $'000	2014 $'000
Audit Services		
Audit Fees Paid or Payable to the ACT Audit Office	45	44
Total Audit Services	**45**	**44**

No other services were provided by the ACT Audit Office.

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 2014–15 (nil, 2013–14).

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 2014–15 (nil, 2013–14).

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.

	2015 $'000	2014 $'000
Cash at Bank [a]	4,902	12,277
Total Cash and Cash Equivalents	**4,902**	**12,277**

a. The decrease is due to the return of surplus cash to the ACT Government ($20.0 million) offset by the receipt of prior year cross border receivables from the New South Wales Ministry of Health.

Note 12. Receivables

	2015 $'000	2014 $'000
Current Receivables		
Accrued Revenue [a]	11,318	22,563
Net GST Receivable	1,332	1,264
Total Current Receivables	**12,650**	**23,827**
Total Receivables	**12,650**	**23,827**

a. The reduction is mainly due to increased provisional payments from the New South Wales Ministry of Health for cross border health services in 2014–15 resulting in lower level outstanding debt.

		Overdue			
Ageing of Receivables	Not Overdue $'000	Less than 30 Days $'000	30 to 60 Days $'000	Greater than 60 Days $'000	Total $'000
2015					
Not Impaired Receivables [a]	12,650	-	-	-	12,650
Impaired Receivables	-	-	-	-	-
2014					
Not Impaired Receivables	23,827	-	-	-	23,827
Impaired Receivables	-	-	-	-	-

a. This mainly relates to cross border receivables for admitted and non-admitted patient services provided to residents of the States and the Northern 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.

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

Note 12. Receivables (Continued)

	2015 $'000	2014 $'000
Classification of ACT Government/Non-ACT Government Receivables		
Receivables from Non-ACT Government Entities		
Other Receivables	11,318	22,563
Net Goods and Services Tax Receivables	1,332	1,264
Total Receivables from Non-ACT Government Entities	**12,650**	**23,827**
Total Receivables	**12,650**	**23,827**

Note 13. Other Assets

	2015 $'000	2014 $'000
Current Other Assets		
Prepayments	-	79
Total Current Other Assets	**-**	**79**
Total Other Assets	**-**	**79**

Note 14. Payables

	2015 $'000	2014 $'000
Current Payables		
Accrued Expenses [a]	6,605	9,340
Total Current Payables	**6,605**	**9,340**
Total Payables	**6,605**	**9,340**

	2015 $'000	2014 $'000
Payables are aged as followed		
Not Overdue	6,605	9,340
Overdue for Less than 30 Days	-	-
Overdue for 30 to 60 Days	-	-
Overdue for More than 60 Days	-	-
Total Payables	**6,605**	**9,340**

Classification of ACT Government/Non-ACT Government Payables		
Payables with ACT Government Entities		
Accrued Expenses	-	-
Total Payables with ACT Government Entities	**-**	**-**
Payables with Non-ACT Government Entities		
Accrued Expenses [a]	6,605	9,340
Total Payables with Non-ACT Government Entities	**6,605**	**9,340**
Total Payables	**6,605**	**9,340**

a. This is accrued cross border expenses owed to the States and the Northern Territory for health services provided to residents of the ACT in the States and the Northern Territory. The reduction reflects higher level provisional payments made by the Directorate to the New South Wales Ministry of Health during 2014–15 which has resulted in a lesser amount owed at year end.

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.

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 and at year end the Directorate holds no investments.

The Directorate's receivables mainly consist of amounts owed from the New South Wales Ministry of Health and the Department of Health and Human Services in Victoria. As the New South Wales and Victorian Governments both have 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 and Department of Health and Human Services in Victoria is managed by having an agreement in place providing required activity data in a timely manner.

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 and Grants from the Commonwealth. Appropriation is paid on a fortnightly basis and the Commonwealth Grants on a monthly 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.

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

Note 15. Financial Instruments (Continued)

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 2015 $'000	Fair Value 2015 $'000	Carrying Amount 2014 $'000	Fair Value 2014 $'000
Financial Assets				
Cash and Cash Equivalents	4,902	4,902	12,277	12,277
Receivables	11,318	11,318	22,563	22,563
Total Financial Assets	**16,220**	**16,220**	**34,840**	**34,840**
Financial Liabilities				
Payables	6,605	6,605	9,340	9,340
Total Financial Liabilities	**6,605**	**6,605**	**9,340**	**9,340**

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 2015. 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		-	-	-	-	4,902	4,902
Receivables	12		-	-	-	-	11,318	11,318
Total Financial Assets			**-**	**-**	**-**	**-**	**16,220**	**16,220**
Financial Liabilities								
Payables	14		-	-	-	-	6,605	6,605
Total Financial Liabilities			**-**	**-**	**-**	**-**	**6,605**	**6,605**
Net Financial Assets			**-**	**-**	**-**	**-**	**9,615**	**9,615**

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.

	Note No.	Weighted Average Interest Rate	Fixed Interest Maturing In:					
			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**

Carrying Amount of Each Category of Financial Asset and Financial Liability	2015 $'000	2014 $'000
Financial Assets		
Loans and Receivables Measured at Amortised Cost	11,318	22,563
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	6,605	9,340

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 2015 (nil, 30 June 2014)

Note 17. Contingent Liabilities and Contingent Assets

There were no contingent liabilities or contingent assets as at 30 June 2015 (nil, 30 June 2014).

There were no indemnities as at 30 June 2015 (nil, 30 June 2014).

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 2015, or in future reporting periods.

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

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	2015 $'000	2014 $'000
The Cash and Cash Equivalents Recorded in the Balance Sheet	4,902	12,277
Cash and Cash Equivalents at the End of the Reporting Period as Recorded in the Cash Flow Statement	**4,902**	**12,277**

(b) Reconciliation of Net Cash Outflows from Operating Activities to the Operating Surplus/ (Deficit)	2015 $'000	2014 $'000
Operating Surplus	4,104	11,827
Cash Before Changes in Operating Assets and Liabilities	**4,104**	**11,827**
Changes in Operating Assets and Liabilities		
Decrease in Receivables	11,177	60,650
Decrease/(Increase) in Other Assets	79	(79)
(Decrease) in Payables	(2,735)	(62,444)
Net Changes in Operating Assets and Liabilities	**8,521**	**(1,873)**
Net Cash Inflows from Operating Activities	**12,625**	**9,954**

Note 20. Service Concession Asset

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

Note 21. Budgetary Reporting – Explanations of Major Variances Between Actual Amounts and Original Budget Amounts

The following are brief explanations of major line item variances between budget estimates and actual outcomes. Variances are considered to be major variances if both of the following criteria are met:

a) The line item is a significant line item: the line item actual amount accounts for more than 10% of the relevant associated category (Income, Expenses and Equity totals) or sub-element (e.g. Current Liabilities and Receipts from Operating Activities totals) of the financial statements; and

b) The variances (original budget to actual) are greater than plus (+) or minus (-) 10% of the budget for the financial statement line item.

Operating Statement Line Items	Actual 2014–15 $'000	Original Budget [1] 2014–15 $'000	Variance $'000	Variance %	Variance Explanation
Grants from the Commonwealth	310,958	271,080	39,878	14.7	Higher than budgeted Grants from the Commonwealth is due to higher levels of activity for public hospital services funded through the National Health Reform Agreement than estimated in the budget.

1 Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period (2014–15 Budget Statements). These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

Balance Sheet Line Items	Actual 2014–15 $'000	Original Budget [1] 2014–15 $'000	Variance $'000	Variance %	Variance Explanation
Cash and Cash Equivalents	4,902	15,502	(10,600)	(68.4)	Lower than budgeted Cash and Cash Equivalents is largely due to the return of $20 million surplus cash to the ACT Government and lower opening balance of $3 million which are partially offset by higher cashflow from operating activities due to timing of payable and receivables $13 million.
Receivables	12,650	1,177	11,473	974.8	Higher than budgeted Receivables is due to timing of acquittal of cross border health services provided to the residents of other jurisdictions.
Payables	6,605	-	6,605	100.0	Higher than budgeted Payables is due to timing of acquittals of cross border health services provided to residents of other jurisdictions.
Accumulated Funds	10,947	16,679	(5,732)	(34.4)	Lower than budgeted Accumulated Funds is largely due to the return of $20 million surplus cash to the ACT Government offset by $4 million in operating surplus, the receipt of prior year cross border payments and the recognition of current year cross border receivables and payables.
Statement of Changes in Equity					
These line items are covered in other financial statements					

1 Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period (2014–15 Budget Statements). These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

Health Directorate
Notes to and Forming Part of the Financial Statements
For the Year Ended 30 June 2015

Cash Flow Statement Line Items	Actual 2014–15 $'000	Original Budget [1] 2014–15 $'000	Variance $'000	Variance %	Variance Explanation
User Charges	103,152	84,249	18,903	22.4	Higher than budgeted User Charges is mainly due to higher cross border revenue due to higher number of interstate patients treated at the ACT Hospitals than estimated in the budget.
Grants Received from Commonwealth	310,958	271,080	39,878	14.7	Higher than budgeted Grants Received from Commonwealth is mainly due to higher public hospital activity than estimated in the budget.
Capital (Distributions)	(20,000)	-	(20,000)	(100.0)	This relates to the return of surplus cash to the ACT Government resulting from prior year operating surpluses.

1 Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period (2014–15 Budget Statements). These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

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 2015 has been reviewed.

Responsibility for the statement of performance

The Director-General is responsible for the preparation and fair presentation of the statement of performance of the Directorate 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.

As disclosed in the statement of performance, in accordance with the *Financial Management (Statement of Performance Scrutiny) Guidelines 2011*, the Government Payment for Outputs and Total Cost information included in the statement of performance has not been reviewed.

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 2015, 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
10 September 2015

ACT Local Hospital Network Directorate
Statement of Performance
For the Year Ended 30 June 2015

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 2015 and also fairly reflects the judgements exercised in preparing it.

Nicole Feely
Director-General
ACT Local Hospital Network Directorate
17 August 2015

Output Class I: 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 2014–15	Actual Result 2014–15	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	957,054	966,039	1%		
Government Payment for Outputs (GPO) ($000's)	601,725	567,279	-6%	GPO revenue was lower than anticipated in the budget. This was due to increased Commonwealth and Cross Border revenue due to revised forecasts for revenue from the Commonwealth for activity based funding and from other jurisdictions for Cross Border activity. As such less GPO was drawndown.	
Accountability Indicators					
a. Admitted Services – NWAU {14}	86,324	87,169	1%		1,2
b. Non-Admitted Services – NWAU {14}	10,272	17,711	72%	Activity was higher than anticipated in the budget. The target published in the ACT Budget was based on an estimate provided to the National Health Funding Body in March 2014 that was revised in May 2014 to around 17,000 based on more up to date information.	1,3
c. Emergency Services – NWAU {14}	15,929	15,727	-1%		1
d. Acute Mental Health Services – NWAU {14}	4,778	6,248	31%	Activity was higher than target due to greater demand than anticipated in the budget.	1, 4
e. Sub Acute Services – NWAU {14}	6,360	6,940	9%	Activity was higher than anticipated in the budget. This was due to longer patient length of stay.	1
f. Total in scope – NWAU {14}	123,663	133,795	8%	Activity was higher than anticipated in the budget. This is largely explained by the variance arising for non-admitted patient services (Indicator 1b).	1
g. Percentage of mental health clients with outcome measures completed	>65%	<65%	-100%	64% of mental health clients had outcome measures completed.	5
h. Proportion of mental health clients contacted by a Health Directorate community facility within 7 days post discharge from inpatient services	85%	72%	-15%	The proportion of mental health clients contacted by Health Directorate was lower than anticipated in the budget. In setting the target, the number of mental health inpatient episodes was thought to be smaller. Changes in data collection methodology and system integration have resulted in better capturing of clients with an inpatient episode.	6

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

Explanation of Measures

1. 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 {14} as defined by the Independent Hospital Pricing Authority's National Efficient Price Determination 2014–15. These measures combine the results for Canberra Hospital and Calvary Public Hospital for services that meet the Independent Hospital Pricing Authority's criteria for inclusion on the 'General List of In-Scope Public Hospital Services'.
2. Excludes mental health and sub-acute services.
3. Excludes community mental health services.
4. Acute admitted mental health services only.
5. 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.
6. 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.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office in accordance with the *Financial Management (Statement of Performance Scrutiny) Guidelines 2011*.

APPENDIX A COMPLIANCE STATEMENT

The ACT Health Annual Report 2014–15 must comply with the 2015 Annual Report Directions (the Directions). The Directions are found at the ACT Legislation Register:

http://www.legislation.act.gov.au/ni/annual/2015.asp

The Compliance Statement indicates the subsections, under the five Parts of the Directions, that are applicable to ACT Health and the location of information that satisfies these requirements:

Part I Directions Overview

The requirements under Part 1 of the 2015 Directions relate to the purpose, timing and distribution, and records keeping of annual reports. The ACT Health Annual Report 2014–15 complies with all subsections of Part 1 under the Directions.

In compliance with section 13 Feedback, Part 1 of the Directions, contact details for ACT Health are provided within the ACT Health Annual Report 2014–15 to provide readers with the opportunity to provide feedback.

Part 2 Agency Annual Report Requirements

The requirements within Part 2 of the Directions are mandatory for all agencies and ACT Health complies with all subsections. The information that satisfies the requirements of Part 2 is found in the ACT Health Annual Report 2014–15 as follows:

Part 3 Reporting By Exception

ACT Health has the following information to report by exception under Part 3 of the Directions for the 2014–15 reporting period:

Part 4 Agency-specific Annual Report Requirements

The following subsections of Part 4 of the 2015 Directions are applicable to ACT Health and can be found within the ACT Health Annual Report 2014–15:

Part 5 Whole-of-Government Annual Reporting

All subsections of Part 5 of the Directions apply to ACT Health. Consistent with the Directions, the information satisfying these requirements is reported in the one place for all ACT Public Service Directorates.

ACT Public Service Directorate annual reports are found at the following web address:

http://www.cmd.act.gov.au/open_government/report/annual_reports

APPENDIX B INDEX

Page number conventions: 't' refers to tables, 'f' refers to figures.

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