ANNUAL REPORT 2012–13

ACT Government Health Directorate

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

General enquiries: 132 281
Annual report contact: 02 6205 0837
Fax: 02 6207 5775

Web: ***www.health.act.gov.au***
Email: ***HealthACT@act.gov.au***

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Transmittal Certificate

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

Dear Minister

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

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

I hereby certify that the attached Annual Report is an honest and accurate account and that all material information on the operations of the ACT Health during the period 1 July 2012 to 30 June 2013 has been included and that it complies with the Chief Minister's Annual Report Directions.

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

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

Yours sincerely

Dr Peggy Brown MBBS (Hons) FRANZCP
Director-General

13 September 2013

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

Aids to access

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

Abbreviations and acronyms

Abbreviation	Meaning
AACB	Australian Association of Clinical Biochemists
ABF	Activity-based funding
ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team ACT Civil and Administrative Tribunal
ACHS	Australian Council on Healthcare Standards
ACP	Advanced care planning
ACTES	ACT Equipment Scheme
ACTGS	ACT Government Solicitor
ACTPS	ACT Public Service
ACTPAS	ACT Patient Administration System
ACU	Australian Catholic University
AGAR	Australian Group on Antimicrobial Resistance
AHA	Allied Health Assistant
AIDS	Acquired Immune Deficiency Syndrome
AIHW	Australian Institute of Health and Welfare
AMAP	Aboriginal Midwifery Access Program
AMC	Alexander Maconochie Centre
AMHU	Adult Mental Health Unit
ANU	Australian National University
APTSRH	Antenatal care, pre-pregnancy and teenage sexual and reproductive health
ARM	Admitting Registrar for Medicine
ARPANSA	Australian Radiation Protection and Nuclear Safety Agency
ASSAD	Australian Secondary School Alcohol and Drug survey
ATODA	Alcohol, Tobacco and Other Drug Association ACT
AVA	Australian Veterinary Association
AVBC	Australasian Veterinary Boards Council
AWA	Australian Workplace Agreement
AWOL	Absence Without Leave
BCHC	Belconnen Community Health Centre
BFHI	Baby-Friendly Health Initiative
BHRC	Brian Hennessy Rehabilitation Centre
CAA	Council of Ambulance Authorities
CALD	Culturally and Linguistically Diverse
CAHMA	Canberra Alliance for Harm Minimisation
CAMHS	Child and Adolescent Mental Health Service
CARE	Care and Response Escalation Call and Respond Early
CaTCH Program	Continuity at the Canberra Hospital
CCCS	Community Care Common Standards
CCL	Cardiac Catheter Laboratory
CDM	Chronic Disease Management
CDMR	Chronic Disease Management Register
CEO	Chief Executive Officer
CHF	Chronic heart failure
CHO	Chief Health Officer
CFACT	Clinical Forensics ACT
CFET	Consumer Feedback and Engagement Team
CFMS	Clinical Forensic Medical Services
CFR	Community Funding Round
CHF	Chronic heart failure
CHC ACT	Calvary Health Care ACT
CH&HS	Canberra Hospital & Health Services
CHWC	Centenary Hospital for Women and Children
CIT	Canberra Institute of Technology
CMP	Canberra Midwifery Program
CO2e	Equivalent carbon dioxide
COAG	Council of Australian Governments
COPD	Chronic Obstructive Pulmonary Disease
CPCHS	Community Paediatric and Child Health Service
CPD	Continuing Professional Development
CPOE	Computerised Physician Order Entry
CPSU	Community and Public Sector Union
CRCS	Capital Region Cancer Service
CSS	Commonwealth Superannuation Scheme
CSTD	Closed system transfer devices
CT	Computerised Tomography
CTSC	Clinical Trials Subcommittee
DA	Development application
DDG	Deputy Director-General
DG	Director-General
DHP	Dental Health Program
DMFT	Decayed, missing or filled teeth

DVA	Department of Veterans' Affairs
ECCHO	Effective Communication in Clinical Handover
ECT	Electro-convulsive therapy
ED	Emergency Department
EDIS	Emergency Department Information System
EDSU	Extended Day Surgery Unit
EEG	Electro-encephalogram
EH	Environmental Health team
EISGP	Education Infrastructure Support Grant Payment
EMM	Electronic medication management
EN	Enrolled Nurse
ESA	ACT Emergency Services Agency
FAMSAC	Forensic and Medical Sexual Assault Care
FMA	Financial Management Act 1996
FOI	Freedom of Information
FTE	Full-time equivalent
GAAP	Generally Accepted Accounting Principles
GHICS	Get Healthy Information and Coaching Service®
GM	Genetically modified
GP	General practitioner/general practice
GPADS	GP Aged Day Service
GPO	Government Payments for Outputs/ General Post Office
GPWWG	GP Workforce Working Group
GST	Goods and Services Tax
HAAS	Healthcare Access at School
HACC	Home and Community Care
HCCA	Health Care Consumers' Association of the ACT
HCI	Healthy Communities Initiative
HCV	Hepatitis C virus
HIP	Health Infrastructure Program
HITH	Hospital in the Home
HIV	Human Immunodeficiency Virus
HPS	Health Protection Service
HRC	ACT Human Rights Commission
HSU	Health Services Union
HPV	Human papillomavirus
HREC	Human Research Ethics Committee
HWA	Health Workforce Australia
IBLCE	International Board of Lactation Consultant Examiners
ICU	Intensive care unit
IM&IT	Information management and information technology
IMPACT	Integrated Multi-agencies for Parents and Children Together
ipatCH	Paediatrcis high dependency unit
IRCTN	Integrated Regional Clinical Training Network
ISS	ISS Health Services
JACSD	Justice and Community Services Directorate
LHN	Local hospital network
LSTS	Loan Scheme for Tertiary Study
MACH	Maternal and Child Health
MAPU	Medical Assessment and Planning Unit
MET	Medical Emergency Team
MEWS	Modified Early Warning Score
MHAGIC	Mental Health Assessment Generation and Information Collection
MHCPI	Mental Health Community Policing Initiative
MOU	Memorandum of understanding
NATA	National Association of Testing Authorities
NEAT	National Emergency Access Target
NEST	National Elective Surgery Target
NETS	Newborn Emergency Transport Service
NEWS	Neonatal Early Warning Score
NGO	Non-government organisation
NHMRC	National Health & Medical Research Council
NHRA	National Health Reform Agreement
NICU	Neonatal Intensive Care Unit
NIMC	National Inpatient Medication Chart
NIP	National Immunisation Program
NPAPH	National Partnership Agreement on Preventive Health
NPDI	National Perinatal Depression Initiative
NRVR	national recognition of veterinary registration
NSFATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health
NSQHSS	National Safety and Quality Health Service Standards
OCHO	Office of the Chief Health Officer
OCYFS	Office of Child, Youth and Family Services
OH&S	Occupational health and safety
OMATSIA	Office of Aboriginal and Torres Strait Islander Affairs
OPG	Orthopantomograph
OPMHIU	Older Persons Mental Health Inpatient Unit
ORE	Occupational risk exposure
OSCAR	Online System for Comprehensive Activity Reporting
PANDSI	Pre- and Ante-Natal Depression Support and Information Service
PART	Predict, Assess and Respond to Challenging/ Aggressive Behaviour
PatCH	Paediatrics at the Canberra Hospital
PBS	Pharmaceutical Benefits Scheme

PCEHR	Personally Controlled Electronic Health Record
PCHR	Personal Child Health Record
PET	Positron Emission Tomography
PH&CDS	Primary Health and Chronic Disease Strategy Committee
PHD	Population Health Division
PIN	Provisional improvement notice
PMHCS	Perinatal Mental Health Consultation Service
PND	Perinatal depression
P&O	Prosthetics and Orthotics
PPEI	Promotion, prevention and early intervention
PPID	Positive patient identification
PPM	privately practising midwife
PRRAC	Palliative Radiotherapy Rapid Access Clinic
PRSC	Practitioner Regulation Subcommittee
PSS	Public Sector Superannuation Scheme Pharmaceutical Service Section People Strategy and Services
PSSAP	Public Sector Superannuation Scheme Accumulation Plan
PSSB	People Strategy and Services Branch
PSU	Psychiatric Services Unit
PTO	Psychiatric treatment order
QSU	Quality and Safety Unit
RACC	Rehabilitation, Aged and Community Care
RADAR	Rapid Assessment of the Deteriorating and At-Risk
RCD	Residual current device
RCPA	Royal College of Pathologists of Australasia
RED	Respect, Equity, Diversity
RILU	Rehabilitation Independent Living Unit
ROGS	Review of Government Service
RPC	Respecting patient choices
RRC	Rapid Response Committee
SEA	Special Employment Arrangement
SHAHRD	ACT Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases
SHFPACT	Sexual Health and Family Planning ACT
SHOUT	Self Help Organisations United Together
SLE	Simulated Learning Environment
SOG	Strategic Oversight Group
SOP	Standard operating procedure
SPIEWG	ACT Suicide Prevention Implementation and Evaluation Working Group
SRG	Survey Resource Group
SRRM	Seclusion and restraint review meetings
SRS	Stereotactic radiosurgery Social Research Subcommittee
STI	Sexually transmissible infection
TAMS	Territory and Municipal Services Directorate
TCH	(the) Canberra Hospital
TIA	Transient ischaemic attack
TIS	Translating and Interpreting Service
TRIM	Total Records Information Management
TTCP	Transitional Therapy and Care Program
UNSW	University of New South Wales
VMO	Visiting medical officer
VTE	Venous thromboembolism
WHA	Women's Health Australasia
WHO	World Health Organization
WHS	Women's Health Service
WiC	Walk-in Centre
WHOS	We Help Ourselves
WIL	Workplace Integrated Learning
WYC	Women, Youth & Children Division
YPN	Young Professionals' Network

Glossary of technical terms

Term	Definition
Access Improvement Program	A major change program initiated in early 2005 aimed at redesigning the way we provide health services by focusing on patient journeys through our health system.
Acute care	An episode of acute care for an admitted patient is one in which the principal clinical intent is to provide short-term hospital admission focused on the treatment of emergency conditions or the conduct of an elective procedure.
Ambulatory care	Care provided in a non-inpatient setting such as outpatients, home-based care, office-based care or community health centre-based care.
Benchmarking	The process of assessing the performance of an organisation of entity within an organisation by comparing it to the performance of a similar entity, a national average, or the best performing entity within the same field in order to assess performance and determine opportunities for improvement.
Community-based organisations	Not-for-profit organisations within the community that have specialist skills in the management of certain health issues. These organisations provide services such as health services for disadvantaged young people, drug and alcohol rehabilitation, Aboriginal and Torres Strait Islander health services and supported accommodation for people with mental illness.
Cost weight	A cost weight is a form of measurement for the use of health services that provides an indication of the relative resource use. It provides an indication as to the complexity of an admission or an occasion of service.
Decant	To rehouse people while their buildings are being refurbished or rebuilt.
Hepatitis C	Hepatitis is inflammation of the liver. Hepatitis C is a viral form that is transferred by blood-to-blood contact.
Length of stay	The number of days (or part thereof) that each admitted patient stays in hospital. Patients who are admitted and discharged on the same day have a length of stay of one day.
Patient-centred care	Refocusing the delivery of health care around the needs of the patient rather than other stakeholders such as providers.
Patient journey	A patient's experience of travelling or moving through the health system at pre-hospital to hospital and to community care.
Primary healthcare service	Primary healthcare services are those which focus on first contact health services provided predominantly by GPs, but also by practice nurses, primary/ community health care nurses, early childhood nurses and community pharmacists, allied health professionals and other health workers such as multicultural health workers and Indigenous health workers, health education/ promotion and community development workers.
Public health officers	Public health officers provide a range of services to the community, including communicable disease control, pharmaceutical services, environmental health and scientific services, and have certain powers enshrined in legislation.
Occasion of service	A measure of services provided to patients—usually used in the outpatient or community health setting.
Sub-acute	Intermediate care provided between acute care and community-based care. Sub-acute care includes services such as rehabilitation that can be provided in a less invasive environment than an acute hospital environment.
Tertiary services	Tertiary services are generally those provided in a complex, highly specialised hospital environment.

Other sources of information

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

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

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

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Fax:	(02) 6207 5775
Web:	***www.health.act.gov.au***
Email:	***HealthACT@act.gov.au***

Additional publications relating to health status and health services in the ACT are:
ACT Chief Health Officer's Report 2012
ACT Human Rights Commission Annual Report 2012–13
Australian hospital statistics 2011–12, Australian Institute of Health and Welfare
Australia's health 2012, Australian Institute of Health and Welfare

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* As in previous years, the Care Coordinator annual report has been published as part of the *Public Advocate of the ACT Annual Report 2012–13*, by arrangement with the Chief Minister and Treasury Directorate.

** A national Medical Radiation Scientists Board was established for the entire year of 2012–13. Therefore, an ACT-based board annual report is no longer produced.

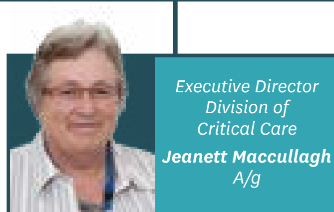
SECTION A

PERFORMANCE AND FINANCIAL MANAGEMENT REPORTING

Organisational chart

Professional Leadership, Research & Education

Operational Support



Performance Summary

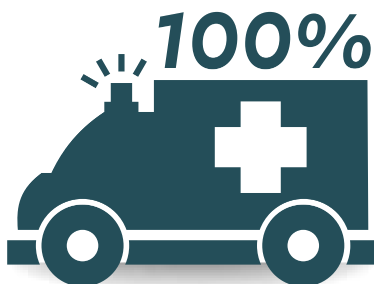
4,854
Births in ACT Public Hospitals

We are fully accredited for the next four years

28 Marked Achievements

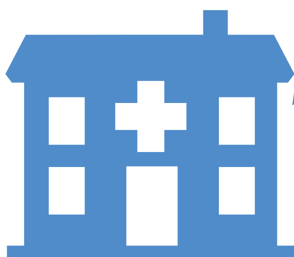
18 Extensive Achievements

1 Outstanding Achievement



100% of **category one** emergency patients seen *immediately*

8,322
Samples analysed by the ACT Government Analytical Laboratory



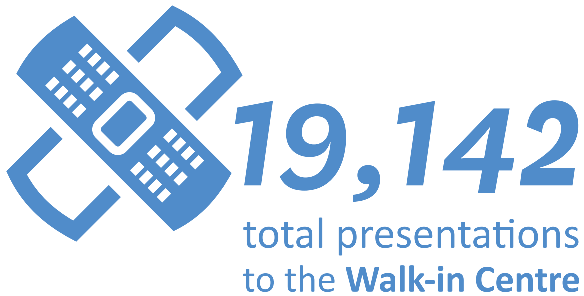
100% ***urgent and semi-urgent***
cancer treatments provided on time

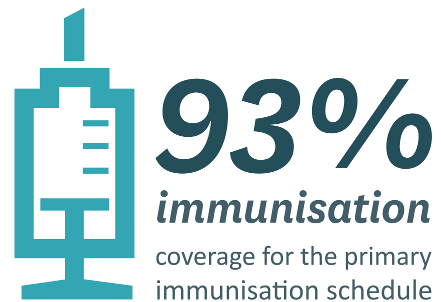
ACT Public Hospitals

410,785 outpatient services

11,579 elective surgery procedures

118,969 presentations to emergency





A.1 The organisation

Vision and values

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

Our values are:

- Care
- Excellence
- Collaboration
- Integrity.

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

The *ACT Health Directorate Corporate Plan 2012–17* guides ACT Health business units in achieving the overarching organisational vision in line with its corporate values.

The plan builds on existing and new plans under development, while providing an organisational framework against which to prioritise our efforts over the next five years.

We aim to deliver better service to our government to meet the needs of community, and to our community on behalf of our government.

Objectives

The *ACT Health Directorate Corporate Plan 2012–17* has four key areas of focus, which inform all business plans and performance agreements within the organisation.

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 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.

ACT Health continues to strengthen clinical governance of its processes, and strives to be accountable to both the government and the community.

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.

Organisational structure

The organisational chart on pages 2 and 3 provides an overview of the structure of the Health Directorate on 30 June 2013.

ACT Health's Director-General guides the organisation in delivering its vision. ACT Health's two major divisions are led by Deputy Directors-General who report to the Director-General.

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

Strategy and Corporate employs a smaller number of staff who provide infrastructure, policy guidance, funding and strategic planning support to clinical service areas, while planning for ACT Health's future workforce and health service needs.

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

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

ACT Health, other agencies and external stakeholders

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

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

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

A.2 and A.3 Overview and highlights 2012–13

ACT Health faced a challenging year in 2012–13, but rose to the challenge and performed well against its key strategic objectives.

In 2012–13, ACT Health exceeded its target for the number of people removed from the elective surgery waiting list—the highest on record for the ACT—and continues to reduce the amount of patients waiting longer than clinically recommended timeframes.

ACT Public hospitals met the need for cancer treatment services in all three major triage categories: urgent, semi-urgent and non-urgent.

The ACT Government's investment in the public health system bettered the national rate of government investment in 2012–13.

The ACT also fared well in the management of chronic disease, with rates of life expectancy at birth for men and women in the ACT exceeding the national average. ACT residents have the highest life expectancy of any Australian jurisdiction.

However, the higher proportion of the ACT population diagnosed with some form of circulatory disease when compared with the national average is tangible evidence that the ACT population is ageing faster than that of other jurisdictions, with the median age of the ACT population increasing 6.4 years since 1985 to 34.5 years in 2011.

Moreover, improved early intervention has increased detection of diabetes in the ACT. Experts estimate that only half of those with diabetes are actually aware of their condition.

The ACT met the national response timeframe for in-hospital assessments by the Aged Care Assessment Team, indicating the team's responsiveness in assessing the needs of clients.

Our mental health services were particularly effective at minimising the need for seclusion, reflected in a significant reduction in the use of seclusion during inpatient mental health episodes.

Moreover, mental health consumers and carers were represented on all Mental Health committees, which monitor the delivery and planning of our mental health services.

We also achieved our target of less that 10 per cent of mental health clients returning to hospital within 28 days of discharge from an ACT public mental health unit, which is very heartening.

We performed well in minimising the incidence of vaccine-preventable diseases among the ACT's population of Aboriginal and Torres Strait Islander people, with an overall immunisation rate of 88 per cent for children aged between 12 and 63 months, against a target of 90 per cent, thereby lessening the disparity with non-Indigenous Australians.

The high quality of service that Canberrans receive at our ACT public hospitals was reflected in the quality of theatre and post-operative care, the effective treatment of people who receive hospital-based care by our hospital-based and community services, and the low number of people admitted to hospital who acquired a bacteraemial infection (bacteria in the blood) during their stay.

The ACT exceeded the national average for its participation rate in the Cervical Screening Program.

ACT public hospital emergency departments continued to treat patients requiring urgent treatment within national timeframes, while dealing with increased demand.

Breastscreen ACT has a number of initiatives underway to raise awareness of its screening service, particularly within the target group of women aged 50 to 69, to lift the proportion of women in the target age group who have breastscreens.

The ACT had the lowest jurisdictional rate for the mean number of teeth with dental decay, missing or filled teeth among children at ages 6 and 12, showing the effectiveness of our prevention, early intervention and treatment services. Moreover, ACT Health met its target percentage for the number of dental emergency clients seen within 24 hours.

We didn't achieve our long-term target for reducing the rate of broken hips (fractured neck of femur) in older persons. However, only small numbers of patients are included in the calculations, and small changes can result in significant fluctuations in the result.

The ACT has seen a continued decline in the rate of 12–17-year-olds who smoke regularly, which is significantly lower than the national rate.

This year we also completed the ACT Health Workforce Plan 2013–2018 and the ACT Health Aboriginal Workforce Action Plan 2013–2018 and implemented Health Workforce Australia (HWA) initiatives to support national health workforce reforms.

An independent evaluation report confirmed the Walk-In Centre (WiC) model for the treatment of people with minor illness or injuries to be a safe and effective means of providing primary healthcare services, while highlighting that it improved access to free, extended hours primary health care services.

In 2012–13, we opened Stage One of the new Centenary Hospital for Women and Children—one of the Health Infrastructure Program's major new capital works, which features state-of-the-art equipment and facilities. The Gungahlin Community Health Centre also opened, providing a range of services to those in the north of Canberra.

The Radiation Oncology Department commenced operation of a fourth linear accelerator, which was timely in light of increased demand for radiotherapy treatment services.

We improved our Prosthetics and Orthotics Service by implementing a triage clinic to better manage the needs of clients, resulting in a significant fall in the non-urgent waiting time.

ACT Health, through the Australian Council on Healthcare Standards, met all reaccreditation criteria—with 28 marked achievements, 18 extensive achievements and one outstanding achievement—to retain its full accreditation status for another four years.

Projections suggest that life expectancy will continue to increase over the coming years, with cancer, mental disorders and cardiovascular disease the leading contributors to the total burden of disease, contributing nearly half of the total disease burden.

A number of staff changes at Canberra Hospital and Health Services occurred during the year. Mr Lee Martin, Deputy Director-General, resigned to return to the United Kingdom, as did Ms Susan Aitkenhead, Executive Director of Nursing and Midwifery. Dr Jo Burnand, Executive Director of Medical Services, also resigned. We thank them for their contributions and wish them well for their future careers.

ACT Health also mourned the loss of three senior medical staff in 2012. Dr Damian McMahon, Professor Marjan Klijakovic and Dr Toni Medcalf (Peadon) all passed away, cutting short lives that were dedicated to delivering better health to the ACT community.

A.4 Outlook for 2013–14

The 2013–14 reporting period promises to be another year of tremendous growth for ACT Health, as it delivers key pieces of infrastructure under the Health Infrastructure Program and further consolidates its response to the National Health Reform Agenda, including the National Elective Surgery Target and National Emergency Access Target.

The ACT Government continues to invest heavily in health to meet both present and future challenges. Health continues to be one of the ACT Government's biggest areas of spending, with annual investment of $1.3 billion to transform our health system.

In the coming year, we are committed to further improvements to elective surgery services, further reductions in waiting times, expansion of the Emergency Department and Intensive Care Unit at Canberra Hospital, and rapid assessment services at Calvary.

We will complete the planning and commence forward design of the new University of Canberra Public Hospital.

More beds will be opened at Canberra Hospital, Calvary Public Hospital and the Centenary Hospital for Women and Children, and there will be increased staffing at the Canberra Hospital Emergency Department.

ACT Health will deliver an additional 31 inpatient beds across Canberra and Calvary Public Hospitals, as well as six Hospital in the Home places.

Additional staffing and resources at Canberra Hospital will help us better manage patient movement through and out of the emergency department, and we will also establish an eight-bed rapid assessment unit at Calvary Public Hospital.

We will also establish an Obesity Management Service to improve the health of patients with severe obesity through coordinated intervention and prevention services.

A mobile dental clinic will help people who cannot access a dentist surgery, and we will expand outreach services for cancer sufferers.

We will increase mental health services provided through non-government organisations and community health programs, and expand our community health centres and nurse-led walk-in centres.

Services will be relocated to the new Belconnen Community Health Centre in Canberra's north, and an expanded and refurbished Tuggeranong Community Health Centre will reopen in Canberra's south.

Finally, in the first half of the 2013–14 financial year, we will officially open Stage 2 of the Centenary Hospital for Women and Children, and the Canberra Region Cancer Centre.

These are two of the most significant pieces of health infrastructure to have ever been delivered in the ACT, and are an important legacy for Canberra and the surrounding region of this centenary year.

A.5 Management discussion and analysis

Management discussion and analysis for the Health Directorate for the financial year ended 30 June 2013

General overview

Operations and principal activities

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

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

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

Changes in administrative structure

The Directorate did not gain or lose any functions in the 2012–13 financial year.

There was however, a change to funding arrangements. The ACT is a signatory to the National Health Reform Agreement, which changed the way hospitals are funded nationally. As a consequence, the ACT Government created a new Local Hospital Network (LHN) Directorate for receiving funding for both activity-based services and block-funded services from a national pool of funds that was contributed to by Commonwealth, States and Territories. The changed funding arrangement meant that the Health Directorate is no longer funded by the Government directly for hospital services.

The ACT Local Hospital Network Directorate purchases hospital services from the following ACT public hospitals:

- the Canberra Hospital
- Calvary Public Hospital
- Clare Holland House, and
- Queen Elizabeth II Family Centre.

Risk management

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

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

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

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

The above risks are monitored regularly throughout the year.

Financial performance

The following financial information is based on audited financial statements for 2011–12 and 2012–13, and the forward estimates contained in the 2013–14 Budget Paper Number 4.

Total net cost of services

	Actual 2011–12 $m	Budget 2012–13 $m	Actual 2012–13 $m	Forward Estimate 2013–14 $m	Forward Estimate 2014–15 $m	Forward Estimate 2015–16 $m
Total Expenses	1,177.8	1,063.3	1,083.8	1,109.7	1,174.0	1,252.7
Total Own Source Revenue	255.9	666.8	679.9	840.7	890.3	950.8
Net Cost of Services	**921.9**	**396.5**	**403.9**	**269.0**	**283.7**	**301.9**

Comparison to budget

The Directorate's net cost of services for 2012–13 of $403.9 million was $7.4 million or 1.9 per cent higher than the 2012–13 budget.

This reflects a combination of factors that resulted in higher than budgeted expenses ($20.5 million). The main variations are:

- depreciation and amortisation ($17.1 million)—due to accelerated depreciation for the old Women and Children's Hospital, Tuggeranong Community Health Centre, Level 5 Building 1 at the Canberra Hospital and the old Psychiatric Services Unit as a result of extensive refurbishment works
- grants and purchased services ($6.0 million)—due to higher payments to Calvary Public Hospital for cost pressures and emergency department refurbishment works, and
- salary and superannuation expenses ($6.4 million)—due to the difference between the long service leave discount rate of 92 per cent used in budget calculations and the actual rate of 101.3 per cent, and a slower than anticipated decline in the number of employees leaving the higher cost CSS, PSS and PSSAP superannuation schemes.

The higher than budgeted expenses were offset by lower than budgeted expenses for:

- cost of goods sold ($4.9 million)—as a result of ACT private hospitals purchasing some medical and surgical supplies directly from suppliers, and
- other expenses ($4.1 million)—due to this expense category including the budget for blood products and the actual expense being reported in the supplies and services expense category.

These expenses were offset by a combination of higher than budgeted own source revenue ($13.0 million). The main variations for higher than budgeted revenue are:

- non-ACT Government user charges ($12.4 million)—following acquittal of prior year cross border activity
- other revenue ($2.7 million)—for grants received from Health Workforce Australia and prior year reimbursements such as workers' compensation, and
- gains ($0.9 million)—mainly from increased general donations.

The higher than budgeted own source revenue was offset by lower than budgeted revenue for:

- ACT Government user charges ($3.2 million)—mainly due to reduced funding from the ACT Local Hospital Network Directorate in line with a reduction in the Commonwealth specific purpose funding based on population adjustments.

Comparison to 2011–12 actual expenses

Total net cost of services was $518.0 million or 56.2 per cent lower than the 2011–12 actual cost. This is due to decreased expenses ($94.0 million), mainly comprising lower:

- grants and purchased services ($164.6 million)—from Calvary Public Hospital payments that are now being paid through the ACT Local Hospital Network Directorate.

This was offset by increased expenses for:

- salary and superannuation expenses ($34.8 million)—as a result of a larger workforce and pay increases in line with enterprise agreements
- depreciation and amortisation ($24.1 million)—due to accelerated depreciation for the old Women and Children's Hospital, the Tuggeranong Community Health Centre, Level 5 Building 1 at the Canberra Hospital and the old Psychiatric Services Unit having extensive refurbishments works and the Commissioning of the new Gungahlin Community Health Centre and the Centenary Hospital for Women and Children, and
- supplies and services ($15.9 million)—from increased computer costs for additional ICT project staff, increases in floor space for the Health Directorate which results in higher cleaning/utilities costs, the introduction of the carbon tax levy, running costs associated with a new patient transport vehicle, including wages for a Paramedic team, and an increase in the demand for high-cost blood products.

Increased own source revenue ($423.9 million) also contributed to the lower net cost of services. The main contributors to this reduction are:

- ACT Government user charges ($542.7 million)—as a result of the changes to how payments are received from the ACT and Commonwealth Governments and this has a direct correlation with the reduced Government Payment for Outputs, which is $540.0 million lower than in 2011–12, and
- gains ($1.2 million)—from increased general donations and the profit from sale of a larger number of motor vehicles.

These were offset by reduced:

- non-ACT Government user charges ($115.9 million)—from a change in funding arrangements for interstate residents, and
- other revenue ($4.1 million)—as a result of receiving a large one-off grant from Health Workforce Australia in 2011–12 for the purchase of student accommodation properties and training equipment.

Future trends

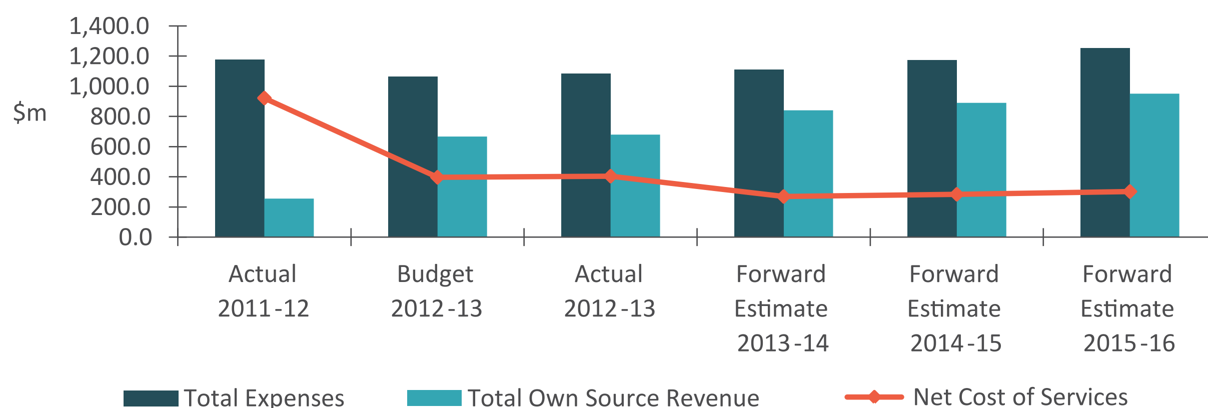


Figure 1: Net cost of services

The reason for net cost of services decreasing in 2013–14 is that this year is the first whole year that the change in funding from Government appropriation to own source revenue as a result of implementing the National Health Reform Agreement from 2012–13 is in operation. Net cost of services is then planned to increase slightly over the following years.

Total expenditure

Components of expenditure

Figure 2 below indicates the components of the Directorate's expenses for 2012–13, with the largest components of expense being employee expenses (excluding superannuation), which represents 51.3 per cent or $556.5 million, supplies and services which represents 27.8 per cent or $301.3 million and grants and purchased services, which represents 7.7 per cent or $82.9 million.

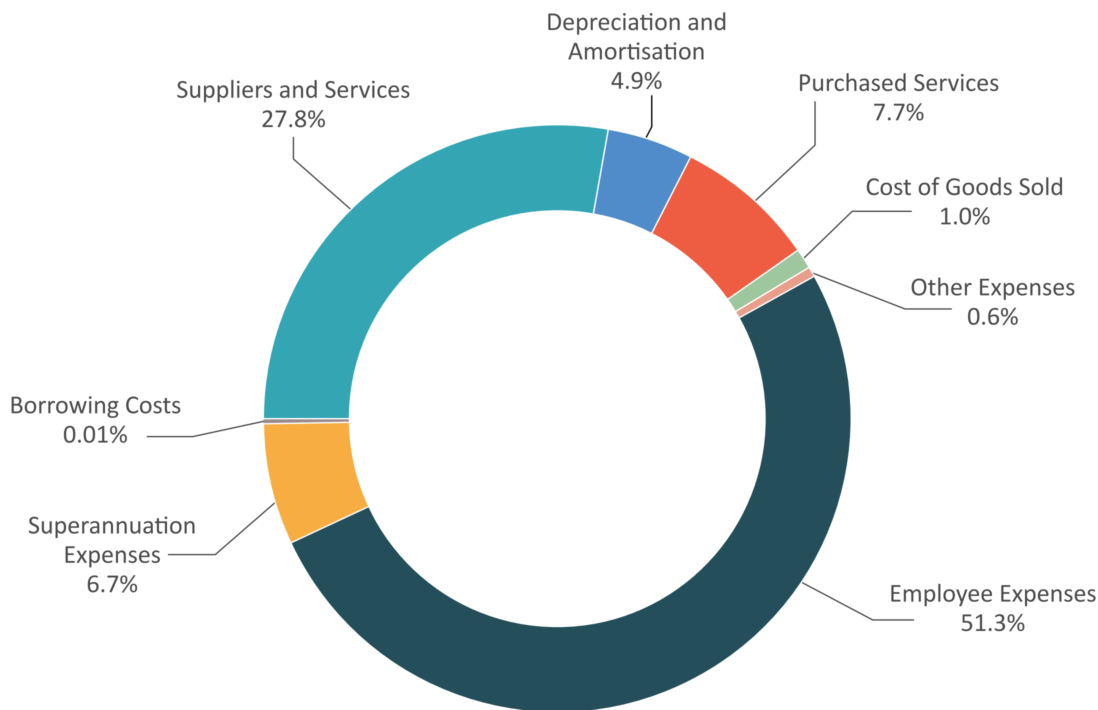


Figure 2: Components of expenditure

Comparison to budget

Total expenses of $1,083.8 million were $20.5 million or 1.9 per cent, higher than the original 2012–13 budget of $1,063.3 million.

This increase was predominantly due to higher:

- depreciation and amortisation ($17.1 million)—due to accelerated depreciation for the old Women and Children's Hospital, Tuggeranong Community Health Centre, Level 5 Building 1 at the Canberra Hospital, and the old Psychiatric Services Unit as a result of significant refurbishment works
- grants and purchased services ($6.0 million)—mainly due to higher payments to Calvary Public Hospital associated with cost pressures and refurbishment of the emergency department at Calvary Public Hospital
- employee expenses (excluding superannuation) ($3.2 million)—mainly due to the difference between the long service leave discount rate of 92 per cent used in budget calculations and the actual rate of 101.3 per cent, and
- superannuation ($3.2 million)—mainly due to 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:

- cost of goods sold ($4.9 million)—due to lower than anticipated supplies bought through the Directorate by private hospitals, who are now purchasing some items directly from suppliers, and
- other expenses ($4.1 million)—mainly relating to blood products, which is budgeted against other expenses but with the actuals being reflected against supplies and services, which are partially offset by higher miscellaneous expenses, higher legal settlements and higher impairment losses.

Comparison to 2011–12 actual expenses

Total expenses were ($94.0 million) or 8.0 per cent lower than the 2011–12 actual result. The decrease reflects a combination of factors:

- lower grants and purchased services ($164.6 million)—due to payments made to Calvary Public Hospital now being paid by the ACT Local Hospital Network Directorate.

The lower expenses were partially offset by higher:

- employee expenses (excluding superannuation) ($28.6 million)—due to a greater increase in the overall workforce to cover growth in services in critical care, acute care, women and children's hospital, adult mental health, aged care and rehabilitation and cancer and pay increases in line with associated enterprise agreements
- depreciation and amortisation ($24.1 million)—mainly resulting from accelerated depreciation for the old Women and Children's Hospital, Tuggeranong Community Health Centre, Level 5 Building 1 at the Canberra Hospital, and the old Psychiatric Services Unit due to extensive refurbishment works. The commissioning of the Gungahlin Community Health Centre and the new Centenary Hospital for Women and Children also increased depreciation costs
- supplies and services ($15.9 million)—the variations being largely due to increased:
  - computer expenses—which is a combination of price escalation, increase in staff numbers, and support costs for projects that became operational in 2013. These projects include a Digital Wireless Network at TCH Campus, Digital Intensive Care Unit CIS System, E-Referral & Discharge Summary and Clinical Systems Project
  - domestic services/food/utilities—as a result of cleaning contract price increases, increases in floor space for new facilities and the carbon tax levy
  - running costs from the purchase of a new patient transport vehicle, including wages for paramedics, and demand for high cost blood products
- superannuation ($6.2 million)—as a result of a larger workforce, 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.

Future trends

Expenses are budgeted to increase steadily across the forward years to account for price escalation and growth in services.

Total own source revenue

Components of own source revenue

Figure 3 below indicates that for the financial year ended 30 June 2013, the Directorate received 80.3 per cent of its total own source revenue of $543.6 million from ACT Government user charges.

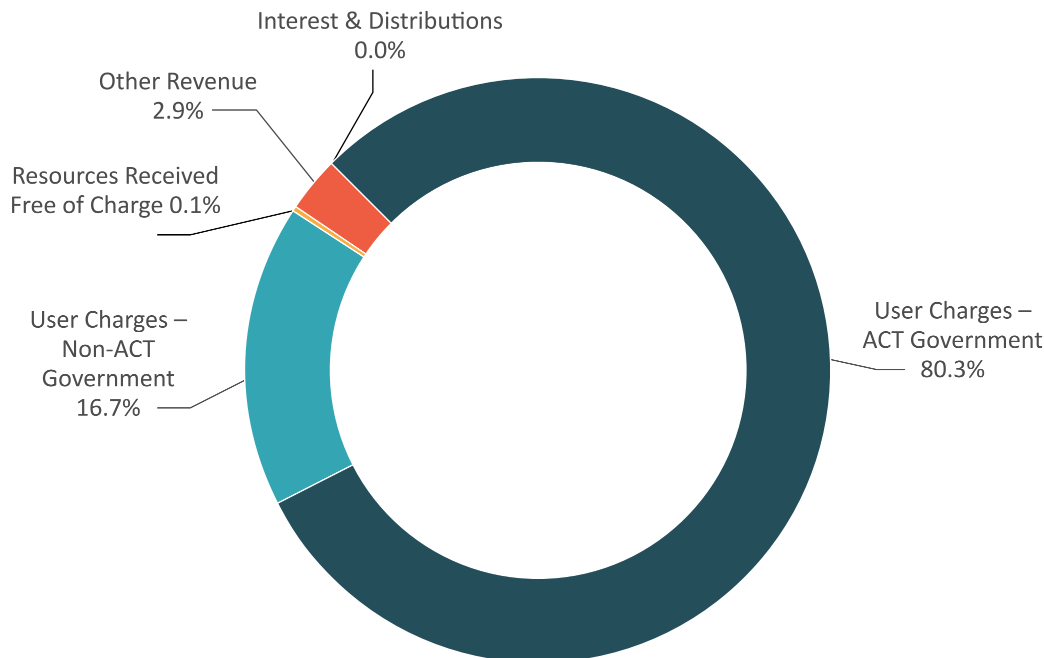


Figure 3: Components of own source revenue

Comparison to budget

Own source revenue for the year ending 30 June 2013 was $677.5 million, which was $12.2 million or 1.8 per cent higher than the 2012–13 budget of $665.3 million.

This favourable variance is due to higher:

- user charges—non-ACT Government ($12.4 million)—due to the accrual of cross border revenue related to prior years' activity for residents of New South Wales
- other revenue ($2.7 million)—mainly relating to Health Workforce Australia grants and additional prior year expenditure reimbursement for workers' compensation claims, and
- gains ($0.9 million)—due to increased general donations and profit from the sale of motor vehicles.

The higher revenue was offset by lower than budgeted:

- ACT Government user charges ($3.2 million) – mainly due to reduced funding from the ACT Local Hospital Network Directorate in line with a reduction in the Commonwealth specific purpose funds based on population adjustments.

Comparison to 2011–12 actual income

Own source revenue was $423.9 million or 165.7 per cent higher than the 2011–12 actual result of $254.7 million.

The result reflects an increase in:

- ACT Government user charges ($542.7 million)—due to a change in the way payments are received from the ACT and Commonwealth Governments, and has a direct correlation with Government Payments for Outputs, which is $540.0 million lower than the actual 2011–12 result, and

- gains ($1.2 million)—due to increased general donations and profit from the sale of motor vehicles, which due to the cyclic nature of motor vehicle leases more cars were due to be sold in 2012–13.

This was partially offset by a reduction in:

- non-ACT Government user charges ($115.9 million)—mainly due to the changed funding arrangements for the treatment of interstate patients in ACT hospitals following the implementation of the National Health Reform Agreement (these revenues are now collected through the ACT Local Hospital Network Directorate), and
- other revenue ($4.1 million)—due to the receipt, in 2011–12, of a large one-off grant from Health Workforce Australia for training and education of the health workforce in the ACT and surrounding regions, including purchase of student accommodation and training equipment.

Future trends

Total own source revenue is expected to increase by $160.9 million in 2013–14, mainly due to the first full year of changed funding arrangements following the implementation of the National Health Reform Agreement, under which the funding for hospital services, which was previously paid as Government Payment for Outputs, will now be paid as user charges by the new ACT Local Hospital Network Directorate. It will then trend upwards steadily across the two forward years.

Financial position

Total assets

Components of total assets

Figure 4 below indicates that, for the financial year ended 30 June 2013, the Directorate held 63.8 per cent of its assets in property, plant and equipment.

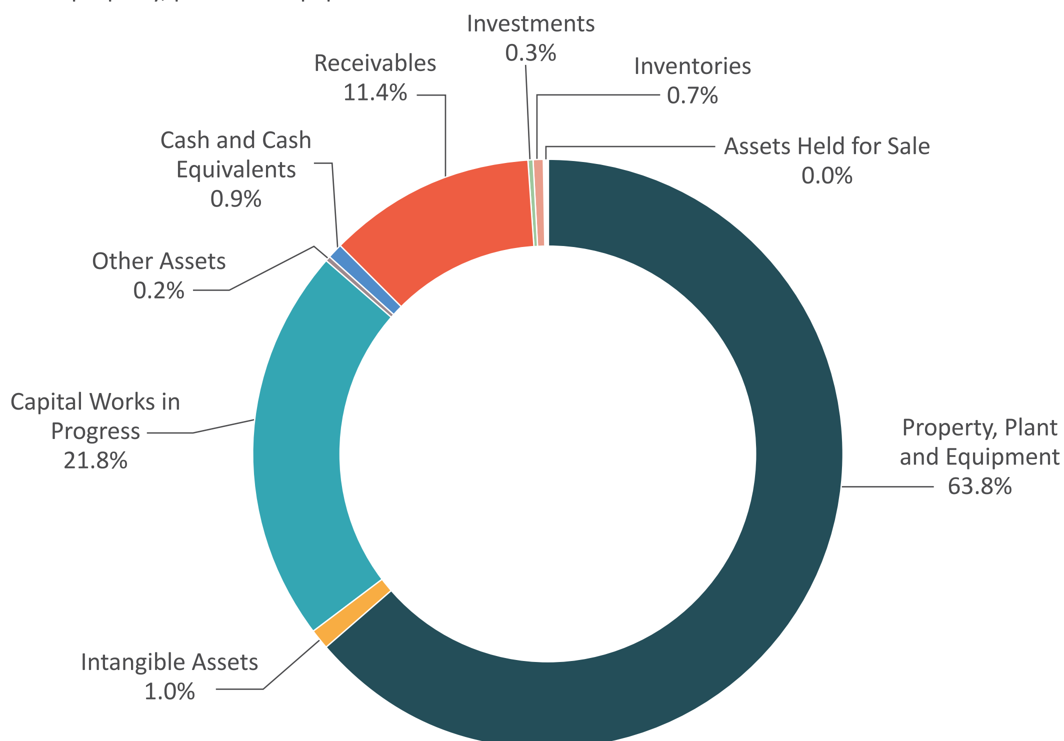


Figure 4: Total assets as at 30 June 2013

Comparison to budget

The total asset position as at 30 June 2013 is $1,110.9 million, $74.6 million lower than the 2012–13 budget of $1,185.5 million.

The variance reflects the timing associated with the acquisition and completion of various assets over the 2012–13 financial year including:

- intangibles ($22.2 million)—mainly due to delays with ICT projects such as e-Health and Identity Access Management
- capital works in progress ($59.7 million)—due to the deferral of capital works projects from 2012–13 into future years as a result of prolonged lease negotiations for decant space, procurement delays due to structural and manufacturing issues, and operational commissioning delays, and
- property, plant and equipment ($77.4 million)—mainly due to delays with commissioning of the Belconnen Community Health Centre and accelerated depreciation for buildings undergoing extensive refurbishment work.

This was partially offset by higher:

- receivables ($76.5 million)—due largely to payments owing from the ACT Local Hospital Network Directorate, which relies on payments from the New South Wales Ministry of Health to then pay the Health Directorate, and
- cash and cash equivalents ($8.0 million)—mainly due to funding for ICT capital projects and grants received from Health Workforce Australia.

Comparison to 2011–12 actual

The Directorate's total asset position is $114.7 million higher than the 2011–12 actual result of $996.2 million, largely due to increases in:

- property, plant and equipment including assets held for sale ($80.2 million)—mainly due to completed new building capital works projects, including the Centenary Hospital for Women and Children, the Gungahlin Community Health Centre and the Cancer Patient Accommodation property
- receivables ($68.6 million)—due largely to cross border revenue not yet received from the New South Wales Ministry of Health, and
- capital works in progress ($23.4 million)—as a result of works progressing on the new facilities, including the Community Health Centres in Belconnen, Tuggeranong and Gungahlin, the Canberra Region Cancer Centre, the Centenary Hospital for Women and Children, for Clinical Services Redevelopment, the Canberra Hospital Emergency Department Intensive Care Unit, e-Health, Digital Mammography, Identity Access Management and various capital upgrades.

The above increases were partially offset by a reduction in:

- cash and cash equivalents ($59.8 million)—due to an increase in receivables associated with the timing of cross border payments by the New South Wales Ministry of Health.

Total liabilities

Components of total liabilities

Figure 5 below indicates that the majority of the Directorate's liabilities relate to employee benefits 66.3 per cent and payables 30.2 per cent.

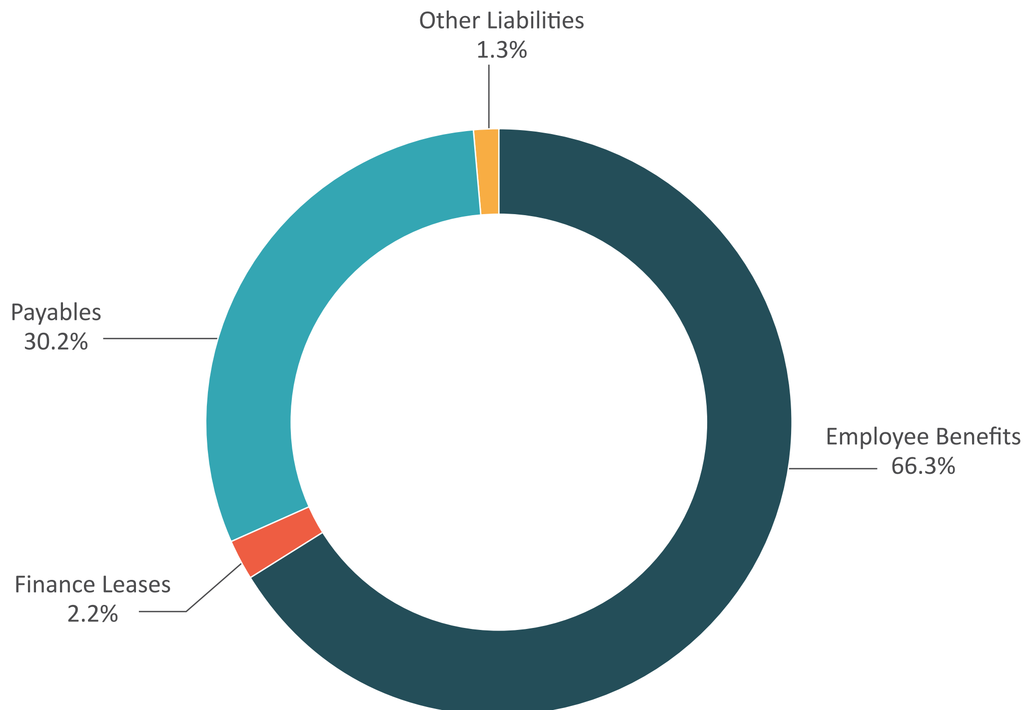


Figure 5: Total liabilities as at 30 June 2013

Comparison to budget

The Directorate's liabilities for the year ended 30 June 2013, of $291.0 million, were $43.7 million higher than the 2012–13 budget of $247.3 million.

This was largely due to higher:

- payables ($31.2 million)—mainly due to invoices for capital works projects being received late in June, and
- employee benefits ($15.5 million)—mainly due to the long service leave discount rate changing from 92 per cent to 101.3 per cent shortly after the original budget was set.

This was offset by lower:

- other liabilities ($3.2 million)—other liabilities mainly relates to revenue received in advance. Most of the grants and donations received during the year were brought to account as revenue earned even though conditions attached to those were not yet fulfilled. The variance is due to budget assumptions not being in line with the type of actual revenue received.

Comparison to 2011–12 actual

Total liabilities were $24.5 million higher than the actual results as at 30 June 2012 of $266.5 million.

This was due to increases in:

- employee benefits ($13.7 million)—mainly due to the impact of collective agreement pay rises and an increase in staff numbers for growth in services and the growth in liability due to leave consumption not in line with leave earned
- payables ($7.8 million)—due to receipt of invoices for contractual capital works to be paid to Shared Services Procurement being received late in June 2013
- other liabilities ($1.6 million)—mainly due to payment in advance for services provided to the Department of Veterans' Affairs, and
- finance leases ($1.4 million)—due to the cyclic nature of the motor vehicles, which are generally on a three year lease. In 2012–13 the Health Directorate acquired 185 new motor vehicle leases and disposed of 164 old motor vehicle finance leases.

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 59.5 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).

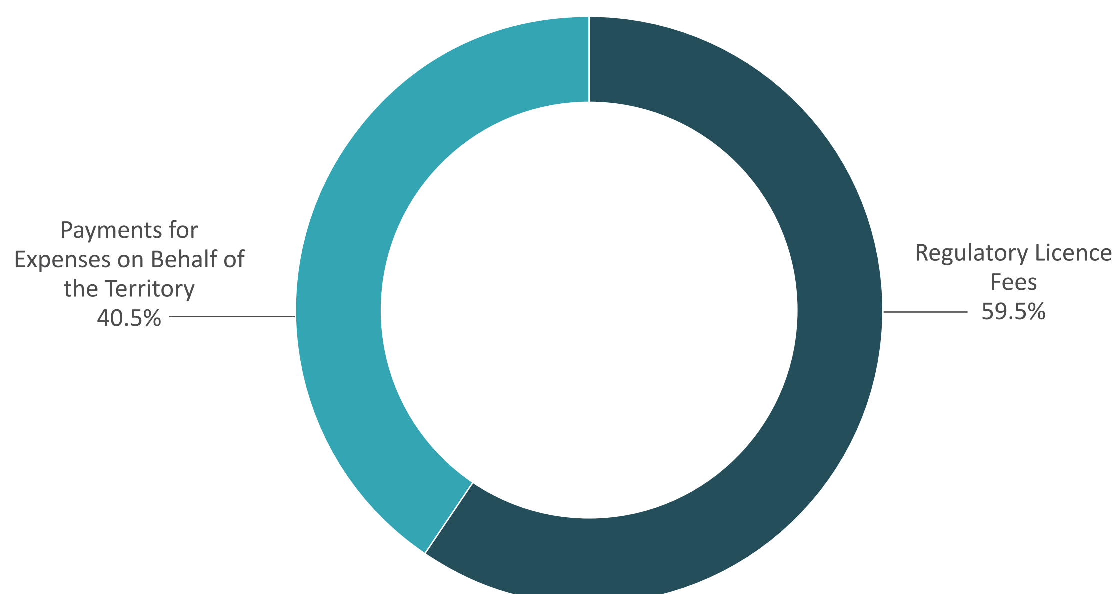


Figure 6: Sources of Territorial revenue

Total Territorial income for the year ending 30 June 2013 was $1.8 million, which was $0.4 million higher than the budget figure of $1.4 million. The variance was due to higher regulatory licence fees revenue ($0.4 million).

Total Territorial income for 2012–13, of $1.8 million was consistent with the 2011–12 income of $1.8 million.

Total expenses

Figure 7 below indicates that 40.6 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 59.4 per cent being the transfer, to Government, of regulatory licence fees.

Figure 7: Sources of Territorial expenses

Total expenses were $1.8 million, which was $0.4 million higher than the budget of $1.4 million due to higher regulatory licence fees received.

Total expenses were $0.3 million higher than for the same period last year of $1.5 million.

Other disclosures

Audit qualification/matters of emphasis

In September 2013, the Auditor-General completed the financial audit of the Directorate and provided an opinion. The Auditor-General's opinion of the Directorate's financial statements concluded that the statements were prepared in accordance with the *Financial Management Act 1996* and fairly represented the financial performance of the Directorate for the year ended 30 June 2013.

Attachment A—Comparison of net cost of services to budget 2012–13

Description	Original Budget $'000	Plus AAO Transfers $'000	Total Funding $'000	Less Actual $'000	Variance to be Explained $'000	%
Expenses						
Employee and Superannuation	622,396	–	622,396	628,781	–6,385	–1.03
Supplies and Services	301,234	–	301,234	301,333	–99	–0.03
Depreciation and Amortisation	35,882	–	35,882	53,014	–17,132	–47.75
Purchased Services	76,920	–	76,920	82,888	–5,968	–7.76
Other Expenses	11,461	–	11,461	7,299	4,162	36.32
Cost of Goods Sold	15,394	–	15,394	10,475	4,919	31.96
Total Expenses	**1,063,287**	**–**	**1,063,287**	**1,083,790**	**–20,503**	**–1.93**
Own Source Revenue						
User Charges	647,533	–	647,533	656,783	–9,250	–1.43
Interest	278	–	278	250	28	9.96
Resources Free of Charge	758	–	758	1,010	–252	–33.30
Gains	1,524	–	1,524	2,377	–853	–56.00
Other Revenue	16,746	–	16,746	19,425	–2,679	–16.00
Total Own Source Revenue	**666,839**	**–**	**666,839**	**679,845**	**–13,007**	**–1.95**
Total Net Cost of Services	**396,448**	**–**	**396,448**	**403,945**	**–7,497**	**–1.89**

A.6 Financial Report

ACT AUDITOR-GENERAL'S OFFICE

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 2013 have been audited. These comprise the following financial statements and accompanying notes:

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

Responsibility for the financial statements

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

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

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

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

Level 4, 11 Moore Street, Canberra City, ACT 2601 | PO Box 275, Civic Square, ACT 2608
Telephone: 02 6207 0833 | Facsimile: 02 6207 0826 | Email: actauditorgeneral@act.gov.au

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

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

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

Electronic presentation of the audited financial statements

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

Independence

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

Audit opinion

In my opinion, the financial statements of the Directorate for the year ended 30 June 2013:

(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 2013 and the results of its operations and cash flows for the year then ended.

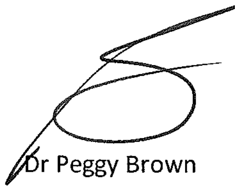
This audit opinion should be read in conjunction with the other information disclosed in this report.

Dr Maxine Cooper
Auditor-General
12 September 2013

Health Directorate
Financial Statements
For the Year Ended 30 June 2013

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 2013 and the financial position of the Directorate on that date.



Dr Peggy Brown

Director-General

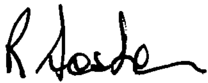
Health Directorate

12 September 2013

Health Directorate
Financial Statements
For the Year Ended 30 June 2013

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 2013 and the financial position of the Directorate on that date.



Mr Ron Foster

Chief Finance Officer

Health Directorate

11 September 2013

Health Directorate Controlled Financial Statements For the Year Ended 30 June 2013

Health Directorate Operating Statement For the Year Ended 30 June 2013

	Note No.	Actual 2013 $'000	Original Budget 2013 $'000	Actual 2012 $'000
Income				
Revenue				
Government Payment for Outputs	4	364,256	365,860	904,281
User Charges – ACT Government	5	543,569	546,730	825
User Charges – Non-ACT Government	5	113,214	100,803	229,102
Interest	6	106	278	97
Distribution from Investments with the Territory Banking Account	7	144	–	157
Resources Received Free of Charge	8	1,010	758	954
Other Revenue	9	19,425	16,746	23,542
Total Revenue		**1,041,724**	**1,031,175**	**1,158,958**
Gains				
Gains on Investments	10	21	–	–
Other Gains	11	2,356	1,524	1,185
Total Gains		**2,377**	**1,524**	**1,185**
Total Income		**1,044,101**	**1,032,699**	**1,160,143**
Expenses				
Employee Expenses	12	556,505	553,280	527,932
Superannuation Expenses	13	72,276	69,116	66,067
Supplies and Services	14	301,333	301,234	285,428
Depreciation and Amortisation	15	53,014	35,882	28,929
Grants and Purchased Services	16	82,888	76,920	247,512
Borrowing Costs	17	375	401	415
Cost of Goods Sold	18	10,475	15,394	13,359
Other Expenses	19	6,924	11,060	8,120
Total Expenses		**1,083,790**	**1,063,287**	**1,177,762**
Operating (Deficit)		**(39,689)**	**(30,588)**	**(17,619)**
Other Comprehensive (Deficit)				
Items that will not be reclassified subsequently to profit or loss				
(Decrease) in the Asset Revaluation Surplus	37	–	–	(994)
Total Comprehensive (Deficit)		**(39,689)**	**(30,588)**	**(18,613)**

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

Health Directorate Balance Sheet As at 30 June 2013

	Note No.	Actual 2013 $'000	Original Budget 2013 $'000	Actual 2012 $'000
Current Assets				
Cash and Cash Equivalents	23	9,562	1,522	69,379
Receivables	24	126,339	47,572	57,730
Inventories	25	8,113	8,066	7,553
Assets Held for Sale	26	34	127	169
Other Assets	31	2,675	2,516	2,515
Total Current Assets		**146,723**	**59,803**	**137,347**
Non-Current Assets				
Receivables	24	–	2,235	–
Investments	27	3,011	3,000	2,990
Property, Plant and Equipment	28	707,919	785,281	627,749
Intangible Assets	29	11,636	33,872	9,870
Capital Works in Progress	30	241,636	301,294	218,235
Total Non-Current Assets		**964,202**	**1,125,682**	**858,844**
Total Assets		**1,110,925**	**1,185,485**	**996,190**
Current Liabilities				
Payables	32	87,773	56,597	79,960
Finance Leases	33	2,315	3,099	3,288
Employee Benefits	34	180,522	159,114	164,307
Other Liabilities	36	2,224	5,462	656
Total Current Liabilities		**272,834**	**224,272**	**248,211**
Non-Current Liabilities				
Finance Leases	33	4,162	3,099	1,802
Employee Benefits	34	12,457	18,392	14,984
Other Provisions	35	1,503	1,503	1,503
Total Non-Current Liabilities		**18,122**	**22,994**	**18,289**
Total Liabilities		**290,956**	**247,266**	**266,500**
Net Assets		**819,969**	**938,219**	**729,690**
Equity				
Accumulated Funds		675,962	793,218	585,683
Asset Revaluation Surplus	37	144,007	145,001	144,007
Total Equity		**819,969**	**938,219**	**729,690**

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

Health Directorate Statement of Changes in Equity For the Year Ended 30 June 2013

	Note No.	Accumulated Funds Actual 2013 $'000	Asset Revaluation Surplus Actual 2013 $'000	Total Equity Actual 2013 $'000	Original Budget 2013 $'000
Balance at the Beginning of the Reporting Period		585,683	144,007	729,690	730,925
Comprehensive Income					
Operating (Deficit)		(39,689)	–	(39,689)	(30,588)
Increase/(Decrease) in the Asset Revaluation Surplus	37	–	–	–	–
Total Comprehensive (Deficit)		**(39,689)**	**–**	**(39,689)**	**(30,588)**
Transactions Involving Owners Affecting Accumulated Funds					
Capital Injections		129,968	–	129,968	237,882
Total Transactions Involving Owners Affecting Accumulated Funds		**129,968**	**–**	**129,968**	**237,882**
Balance at the End of the Reporting Period		**675,962**	**144,007**	**819,969**	**938,219**

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

	Note No.	Accumulated Funds Actual 2012 $'000	Asset Revaluation Surplus Actual 2012 $'000	Total Equity Actual 2012 $'000
Balance at the Beginning of the Reporting Period		440,499	145,001	585,500
Comprehensive Income				
Operating (Deficit)		(17,619)	–	(17,619)
(Decrease) in the Asset Revaluation Surplus	37	–	(994)	(994)
Total Comprehensive (Deficit)		**(17,619)**	**(994)**	**(18,613)**
Transactions Involving Owners Affecting Accumulated Funds				
Capital Injections		162,803	–	162,803
Total Transactions Involving Owners Affecting Accumulated Funds		**162,803**	**–**	**162,803**
Balance at the End of the Reporting Period		**585,683**	**144,007**	**729,690**

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 2013

	Note No.	Actual 2013 $'000	Original Budget 2013 $'000	Actual 2012 $'000
Cash Flows from Operating Activities				
Receipts				
Government Payment for Outputs		364,256	365,860	904,170
User Charges – ACT Government		483,564	–	822
User Charges – Non-ACT Government		112,659	647,487	215,328
Interest Received		106	278	97
Distribution from Investments with the Territory Banking Account		145	–	151
Goods and Services Tax Input Tax Credits from the Australian Taxation Office		48,063	–	59,616
Goods and Services Tax Collected from Customers		5,952	–	5,028
Other		19,183	104,670	19,882
Total Receipts from Operating Activities		**1,033,928**	**1,118,295**	**1,205,094**
Payments				
Employee		542,570	551,238	497,483
Superannuation		72,068	69,116	65,740
Supplies and Services		296,813	296,432	254,897
Grants and Purchased Services		80,159	76,920	243,608
Goods and Services Tax Paid to Suppliers		53,131	–	63,973
Borrowing Costs		375	401	415
Other		30,344	112,660	25,789
Total Payments from Operating Activities		**1,075,460**	**1,106,767**	**1,151,905**
Net Cash (Outflows)/Inflows from Operating Activities	**41**	**(41,532)**	**11,528**	**53,189**
Cash Flows from Investing Activities				
Receipts				
Proceeds from Sale of Property, Plant and Equipment		2,438	–	1,397
Total Receipts from Investing Activities		**2,438**	**–**	**1,397**
Payments				
Purchase of Property, Plant and Equipment		128,584	247,996	64,548
Payments for Capital Works		18,200	–	111,634
Total Payments from Investing Activities		**146,784**	**247,996**	**176,182**
Net Cash (Outflows) from Investing Activities		**(144,346)**	**(247,996)**	**(174,785)**

Health Directorate Cash Flow Statement
For the Year ended 30 June 2013 (Continued)

	Note No.	Actual 2013 $'000	Original Budget 2013 $'000	Actual 2012 $'000
Cash Flows from Financing Activities				
Receipts				
Capital Injections		129,968	237,882	162,803
Total Receipts from Financing Activities		**129,968**	**237,882**	**162,803**
Payments				
Repayment of Finance Leases		3,907	1,452	2,426
Total Payments from Financing Activities		**3,907**	**1,452**	**2,426**
Net Cash Inflows from Financing Activities		**126,061**	**236,430**	**160,377**
Net (Decrease)/Increase in Cash and Cash Equivalents		**(59,817)**	**(38)**	**38,781**
Cash and Cash Equivalents at the Beginning of the Reporting Period		69,379	1,560	30,598
Cash and Cash Equivalents at the End of the Reporting Period	**41**	**9,562**	**1,522**	**69,379**

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

Health Directorate Controlled Statement of Appropriation For the Year Ended 30 June 2013

	Original Budget 2013 $'000	Total Appropriated 2013 $'000	Appropriation Drawn 2013 $'000	Appropriation Drawn 2012 $'000
Controlled				
Government Payment for Outputs	365,860	377,387	364,256	904,170
Capital Injections	237,882	255,318	129,968	162,803
Total Controlled Appropriation	**603,742**	**632,705**	**494,224**	**1,066,973**

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 is due to the re-appropriation in 2012–13 of unspent Commonwealth Government funding from 2011–12 and increased Commonwealth Government funding for programs including Essential Vaccines, Long Stay Older Patients and Preventable Health.

Capital Injections

The difference between the Original Budget and Total Appropriated in 2012–13 is due to the Section 16b capital injection reconciliation instrument of $17.436m from 2011–12. The Section 16b instrument is used to move the balance of capital injection from the end of one year into the following financial year.

Variances between 'Total Appropriated' and 'Appropriated Drawn'

Government Payment for Outputs

The difference between the Total Appropriated and Appropriated Drawn is due to the movement of funding from 2012–13 into 2013–14 mainly due to delays in the National Health Reform and Preventable Health programs. The deferrals in part relate to delays in refurbishment work before facilities could become operational.

Capital Injections

The difference between the Total Appropriated and Appropriation Drawn in 2012–13 is due to the deferral of capital works projects from 2012–13 to 2013–14 and 2014–15. The main reasons for the deferral of capital works projects from 2012–13 into future years was prolonged lease negotiations for vacant space to be used as temporary accommodation, procurement delays due to structural and manufacturing issues, development application approval delays, delays in appointment of principal consultants, and operational commissioning delays.

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Note 1. Objectives of the Health Directorate

Operations and Principal Activities

The Health Directorate (the Directorate) aims to achieve good health for all residents of the Territory by planning for and providing quality community based health services, hospital and extended care services, managing public health risks and promoting health and early care interventions. (The ACT Local Hospital Network Directorate became responsible for purchasing public hospital services from July 2012.)

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

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

Note 2. Summary of Significant Accounting Policies

(a) Basis of Accounting

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

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

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

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

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

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

As at 30 June 2013, the Directorate's current assets are insufficient to meet its current liabilities, but this is not considered a liquidity risk as its operations 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.

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

The Directorate is an individual reporting entity.

Note 2. *Summary of Significant Accounting Policies (Continued)*

(b) Controlled and Territorial Items

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

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

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

(c) The Reporting Period

These financial statements state the financial performance, changes in equity and cash flows of the Directorate for the year ending 30 June 2013 together with the financial position of the Directorate as at 30 June 2013.

(d) Comparative Figures

Budget Figures

To facilitate a comparison with Budget Papers, as required by the *Financial Management Act 1996*, budget information for 2012–2013 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.

Note 2. Summary of Significant Accounting Policies (Continued)

(f) Revenue Recognition

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

Cross Border (Interstate) Health Revenue

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

Service Revenue

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

Inventory Sales

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

Amounts Received for Highly Specialised Drugs

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

Inpatient Fees

For the hospital treatment of chargeable patients, inpatient fees are recognised as revenue when the services have been provided.

Revenue related to hospital services provided to the Department of Veterans' Affairs patients is recognised when the number of patients and complexities of the treatments provided can be measured reliably and the contract price for such services are agreed with the Department of Veterans' Affairs. Actual patient numbers and services are settled following an acquittal process undertaken in subsequent years and variations to the revenue recognised is accounted for in the year of settlement with the Department of Veterans' Affairs.

Facilities Fees

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

Distribution

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

Note 2. Summary of Significant Accounting Policies (Continued)

(f) Revenue Recognition (Continued)

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.

(g) Revenue Received in Advance

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

(h) Resources Received and Provided Free of Charge

Resources received free of charge are recorded as a revenue and expense in the Operating Statement at fair value. The revenue is separately disclosed under resources received free of charge, with the expense being recorded in the line item to which it relates. Goods and services received free of charge from ACT Government agencies are recorded as resources received free of charge, 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.

(i) Repairs and Maintenance

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

(j) Borrowing Costs

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

(k) Waivers of Debt

Debts that are waived during the year under Section 131 of the *Financial Management Act 1996* are expensed during the year in which the right to payment was waived. Further details of waivers are disclosed at Note 20: Waivers, Impairment Losses and Write-offs.

Note 2. Summary of Significant Accounting Policies (Continued)

(l) Current and Non-Current Items

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

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

(m) Impairment of Assets

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

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

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

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

(n) Cash and Cash Equivalents

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

Note 2. Summary of Significant Accounting Policies (Continued)

(o) Receivables

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

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

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

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

(p) Investments

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

(q) Inventories

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

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

Note 2. Summary of Significant Accounting Policies (Continued)

(r) Assets Held for Sale

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

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

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

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

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

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

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

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

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

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

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

The Directorate measures its plant and equipment at cost.

Note 2. Summary of Significant Accounting Policies (Continued)

(u) Intangible Assets

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

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

Internally generated software is recognised when it meets the general recognition criteria outlined above and where it also meets the specific recognition criteria relating to internally developed intangible assets.

Capitalised software has a finite useful life. Software is amortised on a straight-line basis over its useful life, over a period not exceeding 5 years.

Intangible Assets are measured at cost.

(v) Depreciation and Amortisation of Non-Current Assets

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

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

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

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

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

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

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)

(w) Payables

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

Payables include Trade Payables, Accrued Expenses and Other Payables.

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

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

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

(x) Leases

The Directorate has entered into finance leases and operating leases.

Finance Leases

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

Operating Leases

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

Note 2. *Summary of Significant Accounting Policies (Continued)*

(y) Employee Benefits

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

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

Annual and long service leave including applicable on-costs that do not fall due within the next 12 months are measured at the present value of estimated future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given to the future wage and salary levels, experience of employee departures and periods of service. At each reporting period, the present value of future payments are estimated using market yields on Commonwealth Government bonds with terms to maturity that match, as closely as possible, the estimated future cash flows. In 2012–13, the rate used to estimate the present value of these future payments is 101.3% (106.6% in 2011–12).

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

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

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

Note 2. Summary of Significant Accounting Policies (Continued)

(z) Superannuation

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

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

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

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

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

(aa) Equity Contributed by the ACT Government

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

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

(ab) Insurance

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

(ac) Third Party Monies

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

Accordingly, third party transactions are excluded from the Directorate's financial statements. Details of third party monies are shown at Note 43: Third Party Monies.

Note 2. *Summary of Significant Accounting Policies (Continued)*

(ad) Significant Accounting Judgements and Estimates

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

a. *Fair Value of Assets*: the Directorate has made a significant judgement regarding the fair value of its assets. Land and Leasehold Improvements have been recorded at market value of similar properties as determined by an independent valuer. Buildings 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 employee benefits requires a consideration of the future wages and salary levels, experience of employee departures and periods of service. The estimate also includes an assessment of the probability that employees will meet the minimum service period required to qualify for long service leave and that on-costs will become payable. Further information on this estimate is provided in Note 2 (y): Employee Benefits and Note 3: Change in Accounting Policy and Accounting Estimates, and Correction of a Prior Period Error.

c. *Cross Border (Interstate) Health Revenue*: the cross border revenue in the Health Directorate relates to activity prior to 2012–13 and it is based on cost weighted separations and an agreed price. Actual patient numbers and services are settled following an acquittal process undertaken in subsequent years and variations to the revenue recognised are accounted for in the year of settlement with the States and Northern Territory. The Health Directorate has accounted for patient activity that has been agreed with the New South Wales Ministry of Health. There is currently three years of final acquittals for patient activity that have not been finalised due to a lengthy process of data review (In August 2013 the 2009–10 and 2010–11 financial year acquittal processes were finalised and paid by the New South Wales Ministry of Health).

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

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

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

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

Note 2. Summary of Significant Accounting Policies (Continued)

(ae) Impact of Accounting Standards Issued but Yet to be Applied

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

- AASB 9 Financial Instruments (application date 1 January 2015);
- AASB 13 Fair Value Measurement (application date 1 January 2013);
- AASB 119 Employee Benefits (application date 1 January 2013);
- AASB 1055 Budgetary Reporting (application date 1 July 2014);
- AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Interpretations 2, 5, 10, 12, 19 & 127] (application date 1 January 2015);
- AASB 2011-7 Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards [AASB 1, 2, 3, 5, 7, 9, 2009–11, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 139, 1023 & 1038 and Interpretations 5, 9, 16 & 17] (application date 1 January 2013 for for-profit entities and 1 January 2014 for not-for-profit entities);
- AASB 2011-8 Amendments to Australian Accounting Standards arising from AASB 13 [AASB 1, 2, 3, 4, 5, 7, 9, 2009–11, 101, 107, 112, 118, 119, 120, 121, 128, 131, 132, 133, 134, 136, 138, 139, 140, 141, 1004, 1023 &1038 and Interpretations 2, 4, 12, 13, 14, 17, 19, 131 & 132] (application date 1 January 2013);
- AASB 2011–10 Amendments to Australian Accounting Standards arising from AASB 119 (September 2011) [AASB 1, 8, 101, 124, 134, 1049 & 2011-8 and Interpretation 14]] (application date 1 January 2013);
- AASB 2012-2 Amendments to Australian Accounting Standards – Disclosures – Offsetting Financial Assets and Financial Liabilities [AASB 7 & 132] (application date 1 January 2013);
- AASB 2012-3 Amendments to Australian Accounting Standards – Offsetting Financial Assets and Financial Liabilities [AASB 132] (application date 1 January 2014);
- AASB 2012-5 Amendments to Australian Accounting Standards arising from Annual Improvements 2009–2011 Cycle [AASB 1, 1010, 116, 132 & 134 and Interpretation 2] (application date 1 January 2013);
- AASB 2012-6 Amendments to Australian Accounting Standards – Mandatory Effective Date AASB 9 and Transition Disclosures [AASB 9, 2009–11, 2010-7 & 2011-8] (application date 1 January 2013);
- AASB 2012–10 Amendments to Australian Accounting Standards – Transition Guidance and Other Amendments [AASB 1, 5, 7, 8, 10, 11, 12, 13, 101, 102, 108, 112, 118, 119, 127, 128, 132, 133, 134, 137, 1023, 1038, 1039, 1049 & 2011-7 and Interpretation 12] (application date 1 January 2013); and
- AASB 2013-3 Amendments to AASB 136 – Recoverable Amount Disclosures for Non–Financial Assets (application date 1 January 2014).

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

Change in Accounting Policy

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

Change in Accounting Estimates

Revision of the Estimation of Employee Benefit Liability

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

Last financial year the present value rate was 106.6%, however, due to a change in the Government bond rate that rate is now 101.3%. As such the estimate of the long service leave liability has changed. This change has resulted in a decrease to the estimate of the long service leave liability and expense in the current reporting period of $4,597,538.

Revision of Depreciation Charge

As a result of the Health Infrastructure Program, some Directorate buildings are being partially demolished and reconstructed and some are planned to undergo significant refurbishment work. As no future economic benefits will be derived from the part of the asset from the date of demolition or start of refurbishment, this would constitute a de-recognition of that component of the asset. Therefore, depreciation was accelerated for those asset components. For further details see Note 15: Depreciation and Amortisation.

Correction of a Prior Period Error

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

Note 4. Government Payment for Outputs

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

	2013 $'000	2012 $'000
Revenue from the ACT Government		
Government Payment for Outputs[a]	364,256	904,281
Total Government Payment for Outputs	**364,256**	**904,281**

a. The decrease in Government Payment for Outputs was due to the commencement of a new funding arrangement under the National Health Reform Agreement. Under the new arrangement the Directorate no longer receives Government Payment for Outputs for most public hospital services. Government Payment for Outputs for public hospital services are provided to the ACT Local Hospital Network Directorate.

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.

	2013 $'000	2012 $'000
User Charges – ACT Government		
Local Hospital Network Funding[a]	542,759	–
Service Revenue	810	825
Total User Charges – ACT Government	**543,569**	**825**
User Charges – Non-ACT Government		
Service Revenue[b]	13,069	13,751
Amounts Received for Highly Specialised Drugs[c]	15,639	16,423
Cross Border (Interstate) Health Revenue[d]	13,445	129,580
Inpatient Fees[e]	29,893	25,678
Facilities Fees[f]	23,846	22,929
Non-inpatient Fees	780	766
Inventory Sales[g]	12,864	16,501
Accommodation and Meals	3,678	3,474
Total User Charges – Non-ACT Government	**113,214**	**229,102**
Total User Charges	**656,783**	**229,927**

a. This revenue is due to the changed funding arrangements following the implementation of the National Health Reform Agreement from 1 July 2012. This revenue relates to the receipt of funding from the ACT Local Hospital Network Directorate for public hospital services provided by Canberra Hospital and Health Services.

b. The decrease is mainly attributable to a reduction in the number of private patients requiring implanted prostheses.

c. This is mainly due to usage of highly specialised drugs being lower than in the previous year.

d. The decrease is due to the changed funding arrangements for the treatment of interstate patients in ACT hospitals following the implementation of National Health Reform Agreement. This revenue is now collected by the ACT Local Health Network Directorate.

e. The increase mainly relates to revenue received for prior year activity for Department of Veterans' Affairs (DVA) patients following the acquittals of 2010–11 and 2011–12 financial years.

f. The increase is attributable to the full year operation of the Positron Emission Tomography (PET)/Computerised Tomography (CT) service which commenced operation during 2012.

g. The reduction is due to reduced demand from the private sector for the supply of medical and surgical supplies.

Note 6. Interest

	2013 $'000	2012 $'000
Revenue from Non-ACT Government Entities		
Interest Revenue	106	97
Total Interest Revenue from Non-ACT Government Entities	**106**	**97**
Total Interest Revenue	**106**	**97**
Total interest revenue from financial assets not at fair value through profit and loss	106	97

Note 7. Distribution from Investments with the Territory Banking Account

	2013 $'000	2012 $'000
Revenue from ACT Government Entities		
Distribution from Investments with the Territory Banking Account	144	157
Total Distribution from Investments with the Territory Banking Account	**144**	**157**

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.

	2013 $'000	2012 $'000
Revenue from within ACT Government		
Legal Services	1,010	954
Total Resources Received Free of Charge	**1,010**	**954**

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.

	2013 $'000	2012 $'000
Revenue from Non-ACT Government Entities		
Grants[a]	19,425	23,542
Total Revenue from Non-ACT Government Entities	**19,425**	**23,542**
Total Other Revenue	**19,425**	**23,542**
Contribution Analysis		
Contributions which have conditions of expenditure still required to be met		
Grants	583	546

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

a. The decrease is due to the receipt, in 2011–12, of a large one-off grant from Health Workforce Australia for training and education of the health workforce in ACT and surrounding regions, including purchase of student accommodation and training equipment.

Note 10. Gains on Investments

	2013 $'000	2012 $'000
Revenue from ACT Government Entities		
Unrealised Gains on Investments	21	–
Total Gains on Investments	**21**	**–**

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.

	2013 $'000	2012 $'000
Gains from the Sale of Assets[a]	331	206
Donations[b]	2,025	979
Total Other Gains	**2,356**	**1,185**
Contribution Analysis		
Contributions which have conditions of expenditure still required to be met		
Donations	594	282

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

a. This mainly relates to the disposal of motor vehicles that were on a finance lease which matured during the year. The increase is mainly due to a higher number of leases that matured than in 2012.

b. The increase is mainly attributable to increases in special purpose donations as well as donations from the public.

Note 12. Employee Expenses

	2013 $'000	2012 $'000
Wages and Salaries[a]	507,914	473,758
Annual Leave Expenses[b]	14,253	11,633
Long Service Leave Expenses[c]	8,253	16,297
Worker Compensation Insurance Premium[d]	18,361	17,407
Termination Payments[e]	778	1,314
Other Employee Benefits and On-Costs[f]	6,946	7,523
Total Employee Expenses	**556,505**	**527,932**
	No.	**No.**
Average full-time equivalent staff levels during the year were:	5,415	5,296

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

b. The increase in Annual Leave largely relates to the impact of payrises and an increase in staff numbers in 2013.

c. The decrease in Long Service Leave is mainly due to a reduction in the rate used to estimate the present value of Long Service Leave payments from 106.6% to 101.3%.

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

e. The decrease reflects a lower number of redundancies in 2013.

f. The decrease is mainly due to lower recruitment agency fees than in previous year due to changed recruitment practice.

Note 13. Superannuation Expenses

	2013 $'000	2012 $'000
Superannuation Contributions to the Territory Banking Account[a]	39,024	35,961
Productivity Benefit[b]	5,011	5,286
Superannuation Payment to Comsuper (for the PSSAP)	3,525	3,433
Superannuation to External Providers[c]	24,716	21,387
Total Superannuation Expenses	**72,276**	**66,067**

a. The increase is due to an increase in the rate for the Public Sector Superannuation Scheme (PSS) from 17.8% in 2012 to 19.7% in 2013. This was partially offset by a reduction in the rate for the Commonwealth Superannuation Scheme (CSS) from 19.7% in 2012 to 18.5% in 2013.

b. The decrease is due to declining number of members in the CSS and PSS.

c. The increase is due to pay rises and that most new starters are members of superannuation schemes managed by external providers.

Note 14. Supplies and Services

	2013 $'000	2012 $'000
Audit Expenses[a]	504	601
Blood Products[b]	9,344	7,922
Clinical Expenses/Medical Surgical Supplies[c]	57,436	55,875
Communications	3,690	3,835
Computer Expenses[d]	32,007	26,871
Contractors and Consultants[e]	5,535	6,061
Domestic Services, Food and Utilities[f]	31,762	27,513
General Administration[g]	17,959	15,570
Hire and Rental Charges	4,065	3,918
Insurance[h]	28,550	29,190
Minor Capital[i]	4,303	3,265
Non-Contract Services[j]	8,074	7,301
Operating Lease Rental Payments	6,459	6,175
Pharmaceuticals[k]	36,863	38,020
Printing and Stationery	2,253	2,219
Property and Rental Expenses[l]	3,009	2,548
Public Relations[m]	667	1,011
Publications	1,191	1,110
Repairs and Maintenance[n]	13,227	12,094
Staff Development and Recruitment[o]	6,277	5,773
Travel and Accommodation	1,178	1,308
Vehicle Expenses	1,554	1,638
Visiting Medical Officers	25,426	25,610
Total Supplies and Services	**301,333**	**285,428**

Note 14. Supplies and Services (Continued)

a. The decrease is due to a one-off audit of emergency department data conducted in 2012.
b. The increase is mainly attributable to price escalation and an increase in demand for high cost blood products.
c. The increase is mainly attributable to price escalation.
d. The increase is due to a combination of factors, including price escalation, increase in staff numbers and support costs for projects that became operational in 2013. They include Digital Wireless Network at the Canberra Hospital campus, Digital Intensive Care Unit Clinical Information System, E-Referral & Discharge Summary and Clinical Systems Project.
e. The decrease is mainly attributable to a reduction in the use of consultants in line with a targeted savings plan.
f. The increase is mainly attributable to cleaning contract price increases, increases in floor space and new facilities and the carbon tax levy.
g. The increase is mainly due to a combination of factors, including payments to ACT Emergency Services for operating an ambulance, increased cost of freight, payment to the Australian National University (ANU) for the maintenance of the medical research animal house that was re-located to the ANU campus and price escalation for Service Level Agreement charges paid to Shared Services.
h. The decrease in the insurance premium reflects a reduction following an actuarial assessment of the future cost of claims. The key element being a downward revision to the number of assumed small claim settlements for the 2012–13 insurance year.
i. The increase is mainly due to the quantity of medical equipment purchases that fell below the asset capitalisation threshold of $5,000.
j. The increase is mainly due to higher usage of agency nursing and agency dental staff to cover vacancies, which were partially offset by a reduction in the use of agency medical staff. Agency staff refers to temporary staff sourced at short notice from external labour providers.
k. The decrease is mainly due to a combination of factors, including a reduction in the usage of highly specialised (s100) drugs, price decreases for some drugs and a reduction in the usage of some expensive drugs.
l. This increase mainly relates to increases in temporary rental accommodation for new medical staff.
m. The decrease is mainly due to a reduction in use of promotional materials.
n. This is mainly attributable to increased expenditure on preventative and reactive maintenance of ageing infrastructure and an increase in breakdown repairs for medical equipment.
o. The increase mainly relates to training expenses and study reimbursements.

Note 15. Depreciation and Amortisation

	2013 $'000	2012 $'000
Depreciation		
Buildings[a]	35,854	12,034
Plant and Equipment	10,952	11,291
Leasehold Improvements[b]	1,754	1,078
Total Depreciation	**48,560**	**24,403**
Amortisation		
Intangible Assets	4,454	4,526
Total Amortisation	**4,454**	**4,526**
Total Depreciation and Amortisation	**53,014**	**28,929**

Change in Depreciation Due to De-recognition of Components of Buildings

Depreciation was accelerated to de-recognise part of the original Women and Children's Hospital and Tuggeranong Health Centre which were partially demolished for reconstruction and The Canberra Hospital Psychiatric Unit building and The Canberra Hospital Tower Block level 5 which are planned to undergo significant refurbishment work. As a result depreciation expenses increased by $22.1 million in the current accounting period.

a. The increase mainly relates to accelerating the depreciation for the original Women and Children's Hospital ($16.1 million) and Tuggeranong Health Centre ($1.4 million) which were partially demolished for reconstruction and for the Canberra Hospital Psychiatric Unit building ($1.9 million) and the Canberra Hospital Tower Block level 5 ($2.7 million) which are planned to undergo significant refurbishment work. The addition of new buildings, namely the Centenary Hospital for Women and Children, Gungahlin Community Health Centre and Cancer Patient Accommodation property in Duffy have also contributed to this increase.
b. The increase is mainly due to additional leasehold improvements at Village Creek Centre and 1 Moore Street.

Note 16. Grants and Purchased Services

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

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

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

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

Cross Border Health Costs relates to 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.

	2013 $'000	2012 $'000
Grants		
Grants	2,637	2,709
Total Grants	**2,637**	**2,709**
Purchased Services		
Calvary Hospital[a]	14,708	151,855
Non-Government Organisations[b]	59,436	71,515
Cross Border Health Costs[c]	2,788	16,675
Other[d]	3,319	4,758
Total Purchased Services	**80,251**	**244,803**
Total Grants and Purchased Services	**82,888**	**247,512**

a. The decrease in Purchased Services from Calvary Hospital is due to the commencement of the National Health Reform Agreement. Public hospital activities that meet the funding criteria of the Independent Hospital Pricing Authority are now purchased through the ACT Local Hospital Network Directorate.

b. The decrease is due to the changed funding arrangement for over 65 year olds and the Home and Community Care Program which are now being directly funded by the Commonwealth Government, offset by indexation, growth in mental health services and elective surgery procedures delivered by the non-government sector.

c. The decrease is due to cross border hospital services being purchased in 2012–13 by the ACT Local Hospital Network Directorate rather than the Health Directorate. The 2013 amount is due to the finalisation of prior year acquittals.

d. The decrease is due to a reduced level of elective surgery procedures purchased from private providers.

Note 17. Borrowing Costs

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

	2013 $'000	2012 $'000
Finance Charges	375	415
Total Borrowing Costs	**375**	**415**

Note 18. Cost of Goods Sold

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

	2013 $'000	2012 $'000
Cost of Goods Sold[a]	10,475	13,359
Total Cost of Goods Sold	**10,475**	**13,359**

a. The decrease is due to reduced demand for supplies from the private sector.

Note 19. Other Expenses

	2013 $'000	2012 $'000
Miscellaneous Expenses[a]	2,219	1,327
Legal Settlements	2,374	2,427
Waivers, Impairment Losses and Write-offs (see Note 20)[b]	2,292	2,764
Loss on Sale of Assets[c]	38	136
Assets Donated to Third Parties[d]	–	1,466
Total Other Expenses	**6,923**	**8,120**

a. The increase mainly relates to the expensing of feasibility and design costs of the Skills Development Centre Project.
b. The decrease mainly relates to a reduction in the amount of debt written off and debts assessed as impaired.
c. This relates to the sale of motor vehicles on finance lease that matured during the year. The reduction reflects a better market price for second hand cars.
d. 2012 relates to transfer of ownership of Intensive Care Unit equipment to Calvary Public Hospital.

Note 20. *Waivers, Impairment Losses and Write-Offs*

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

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

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

	No.	2013 $'000	No.	2012 $'000
Waivers				
Waivers[a]	1	14	-	-
Total Waivers	**1**	**14**	**-**	**-**
Impairment Losses				
Impairment Loss from Receivables				
Trade Receivables[b]	92	395	29	640
Total Impairment Loss from Receivables	**92**	**395**	**29**	**640**
Impairment Loss from Property, Plant and Equipment				
Plant and Equipment[c]	156	1,121	8	613
Total Impairment Loss from Property, Plant and Equipment	**156**	**1,121**	**8**	**613**
Total Impairment Losses	**248**	**1,516**	**37**	**1,253**
Write-Offs				
Irrecoverable Debts[d]	1,949	762	2,045	1,511
Total Write-Offs	**1,949**	**762**	**2,045**	**1,511**
Total Waivers, Impairment Losses and Write-Offs	**2,198**	**2,292**	**2,082**	**2,764**

a. The increase is due to the Treasurer's decision, in 2013, to grant a debtor a 50 per cent waiver of debt owed for hospital treatment on compassionate grounds.

b. This is largely attributable to lower levels of ineligible (those not covered by Medicare) and compensable patients' debts, that are impaired.

c. The increase is mainly attributable to medical and surgical equipment that has been assessed as not operating efficiently, or is under repair or cannot be located within the campus.

d. The decrease mainly relates to lower number of high value write-offs in 2013.

Note 21. Auditor’s Remuneration

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

	2013 $’000	2012 $’000
Audit Services		
Audit Fees Paid to the ACT Auditor-General’s Office	225	227
Total Audit Fees	**225**	**227**

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

Note 22. Act of Grace Payments

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

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

Note 23. Cash and Cash Equivalents

The Directorate holds a number of bank accounts. In 2013, as part of the Whole-of-Government banking arrangements, the Directorate transitioned banking services from the Commonwealth Bank to Westpac Banking Corporation. As part of these arrangements, the Directorate received interest at the rate of 3.44% (4.87% in 2012). These funds are able to be withdrawn upon request.

	2013 $’000	2012 $’000
Cash on Hand	46	47
Cash at Bank[a]	9,516	69,332
Total Cash and Cash Equivalents	**9,562**	**69,379**

a. The decrease in cash at bank is mainly due to the 2012 balance being unusually high due to the levels of payables associated with cash drawn down from Treasury and the timing of the payment of capital works invoices.

Note 24. Receivables

	2013 $'000	2012 $'000
Current Receivables		
Trade Receivables[a]	9,519	8,705
Less: Allowance for Impairment Losses	(1,668)	(1,697)
	7,851	**7,008**
Other Trade Receivables[b]	74,767	13,910
Less: Allowance for Impairment Losses	(478)	(538)
	74,289	**13,372**
Net GST Receivable	4,035	4,572
	4,035	**4,572**
Accrued Revenue[c]	4,254	6,349
Accrued Revenue – Cross Border[d]	35,910	26,429
	40,164	**32,778**
Total Current Receivables	**126,339**	**57,730**
Total Non-Current Receivables	**–**	**–**
Total Receivables	**126,339**	**57,730**

a. The increase mainly relates to private patients fees and an increase in debtors for consumables sold to private hospitals.

b. The increase mainly relates to receivable from the ACT Local Hospital Network Directorate for the provision of hospital services under the new funding arrangement, an increase in receivable for Calvary Health Care for seconded medical staff reimbursements, and for reimbursement for residential care services by the Community Services Directorate.

c. The decrease mainly relates to prior year acquittals, settled during the year with the Department of Veterans' Affairs for hospital care provided to veterans.

d. The increase mainly reflects adjustments for prior year activity not yet paid by the New South Wales Ministry of Health.

Note 24. Receivables (Continued)

Ageing of Receivables	Not Overdue $'000	Past Due Less Than 30 days[f] $'000	Past Due 30 to 60 days[f] $'000	Past Due Greater Than 60 days[f] $'000	Total $'000
2013					
Not Impaired					
Receivables[e]	77,647	3,503	1,486	7,793	90,429
Cross Border[g]	35,910	–	–	–	35,910
Impaired					
Receivables	–	–	–	2,146	2,146
2012					
Not Impaired					
Receivables	24,811	1,269	561	4,660	31,301
Cross Border	26,429	–	–	–	26,429
Impaired					
Receivables	–	–	–	2,235	2,235
Receivables are written-off during the year in which they are considered to become uncollectible.					

e. 'Not Overdue' component of Receivables largely consist of accrued revenues for Department of Veterans' Affairs patients which are not due until an acquittal process in subsequent years, Goods and Services Input Tax receivable from the Australian Taxation Office and private patient fees accrued in June.
'Past Due – 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 Canberra Hospital.

f. The increase in the overdue amounts in 2013 is largely attributable to payments due from Calvary Health Care.

g. Cross Border receivables is funding due from the New South Wales Ministry of Health for admitted and non-admitted patient services provided to residents of New South Wales. 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. In August 2013 the New South Wales Ministry of Health finalised and paid in full the 2009-10 and 2010-11 acquittals ($27.7 million).

Note 24. Receivables (Continued)

	2013 $'000	2012 $'000
Reconciliation of the Allowance for Impairment Losses		
Allowance for Impairment Losses at the Beginning of the Reporting Period	2,235	1,601
Additional Allowance and Impairment Losses Recognised	395	640
Reduction in Allowance	(484)	–
Reduction in Allowance Resulting from a Write-Back against the Receivables	–	(6)
Allowance for Impairment Losses at the End of the Reporting Period	**2,146**	**2,235**
Classification of ACT Government/Non-ACT Government Receivables		
Receivables with ACT Government Agencies		
Net Trade Receivables	67	42
Net Other Trade Receivables	60,349	1,677
Accrued Revenue	16	17
Net Goods and Services Tax Receivable	52	–
Total Receivables with Other ACT Government Agencies	**60,484**	**1,736**
Receivables with Non-ACT Government Entities		
Net Trade Receivables	7,784	6,966
Net Other Trade Receivables	49,850	11,695
Net Goods and Services Tax Receivables	3,983	4,572
Accrued Revenue	4,238	32,761
Total Receivables with Non-ACT Government Entities	**65,855**	**55,994**
Total Receivables	**126,339**	**57,730**

Note 25. Inventories

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

	2013 $'000	2012 $'000
Current Inventory		
Purchased Items – Cost	8,113	7,553
Total Current Inventory	**8,113**	**7,553**
Total Inventory	**8,113**	**7,553**

Note 26. Assets Held for Sale

The Directorate has 2 motor vehicles which have been returned to the Fleet Manager and are expected to be sold in July 2013. The residual and all lease payments have been paid. As such these vehicles have been classified as plant and equipment held for sale.

	2013 $'000	2012 $'000
Plant and Equipment held for Sale[a]	34	169
Total Assets Held for Sale	**34**	**169**

a. The decrease is due to the lower number of vehicles held for sale (two in 2013 compared to ten in 2012).

Note 27. Investments

	2013 $'000	2012 $'000
Non-Current Investments		
Investments with the Territory Banking Account – Fixed Interest Portfolio at Fair Value	3,011	2,990
Total Non-Current Investments	**3,011**	**2,990**
Total Investments	**3,011**	**2,990**

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.

	2013 $'000	2012 $'000
Land and Buildings		
Land at Fair Value	36,827	36,820
Total Land Assets	**36,827**	**36,820**
Buildings at Fair Value[a]	669,366	551,154
Less: Accumulated Depreciation	(48,881)	(13,027)
Total Written Down Value of Buildings	**620,485**	**538,127**
Total Land and Written Down Value of Buildings	**657,312**	**574,947**
Leasehold Improvements		
Leasehold Improvements at Fair Value	9,761	9,244
Less: Accumulated Depreciation	(3,132)	(1,378)
Total Written Down Value of Leasehold Improvements	**6,629**	**7,866**
Plant and Equipment		
Plant and Equipment at Cost	104,271	96,314
Less: Accumulated Depreciation	(59,172)	(50,765)
Less: Accumulated Impairment Losses	(1,121)	(613)
Total Written Down Value of Plant and Equipment	**43,978**	**44,936**
Total Written Down Value of Property, Plant and Equipment	**707,919**	**627,749**
Assets Under a Finance Lease		
Assets under a finance lease are included in the asset class to which they relate in the above disclosure.		
Assets under a finance lease are also required to be separately disclosed as outlined below.		
Carrying Amount of Assets Under a Finance Lease		
Plant and Equipment Under a Finance Lease	8,775	7,538
Accummulated Depreciation of Plant and Equipment under a Finance Lease	(2,130)	(2,485)
Total Written Down Value of Assets Under a Finance Lease	**6,645**	**5,053**

a. The increase mainly relates to completed new building capital works projects including the Centenary Hospital for Women and Children ($90.0 million), the Gungahlin Community Health Centre ($18.7 million) and the Cancer Patient Accommodation property ($1.4 million).

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 2012–13.

	Land $'000	Buildings $'000	Leasehold Improvements $'000	Plant and Equipment $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	36,820	538,127	7,866	44,936	627,749
Additions	7	118,213	517	13,162	131,899
Assets Classified as Held for Sale	–	–	–	(34)	(34)
Disposals	–	–	–	(4,561)	(4,561)
Depreciation	–	(35,854)	(1,754)	(10,952)	(48,560)
Depreciation Write Back for Asset Disposals	–	–	–	1,934	1,934
Impairment Losses Recognised in the Operating (Deficit)	–	–	–	(1,121)	(1,121)
Reversal of Impairment Losses Recognised in the Operating (Deficit)	–	–	–	613	613
Carrying Amount at the End of the Reporting Period	**36,827**	**620,486**	**6,629**	**43,978**	**707,919**

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

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

Valuation of Non-Current Assets

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

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

The next valuation will be undertaken during 2013–14.

Note 29. Intangible Assets

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

	2013 $'000	2012 $'000
Computer Software		
Internally Generated Software		
Computer Software at Cost[a]	39,819	33,599
Less: Accumulated Amortisation	(28,183)	(23,729)
Total Internally Generated Software	**11,636**	**9,870**
Total Computer Software	**11,636**	**9,870**
Total Intangible Assets	**11,636**	**9,870**

a. The increase is due to additional software purchases for the Intensive Care Unit Metavision System, Integrated Patient Meal System, Health Services Directory and enhancements to the ACT Patient Administration System.

Reconciliation of Intangible Assets

The following table shows the movement of each class of Intangible Asset distinguishing between internally generated and externally purchased intangibles from the beginning to the end of 2012–13.

	Internally Generated Software $'000	Externally Purchased Software $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	9,870	–	9,870
Additions	6,220	–	6,220
Amortisation	(4,454)	–	(4,454)
Carrying Amount at the End of the Reporting Period	**11,636**	**–**	**11,636**

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

	Internally Generated Software $'000	Externally Purchased Software $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	12,827	–	12,827
Additions	1,545	–	1,545
Amortisation	(4,526)	–	(4,526)
Other Charges	24	–	24
Carrying Amount at the End of the Reporting Period	**9,870**	**–**	**9,870**

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, include hospital buildings, community health centres and computer software.

	2013 $'000	2012 $'000
Building Works in Progress[a]	186,265	177,252
Plant and Equipment Works in Progress[b]	915	154
Computer Software Works in Progress[c]	54,398	40,641
Other Works in Progress	58	188
Total Capital Works in Progress	**241,636**	**218,235**

a. The increase in building works in progress is mainly for works carried out on the Community Health Centres in Belconnen and Tuggeranong, the Canberra Region Cancer Centre, the Centenary Hospital for Women and Children, for Clinical Services Redevelopment, the Canberra Hospital Emergency Department Intensive Care Unit, and various capital upgrade projects.

b. The increase in plant and equipment works in progress is due to the commencement 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 critically ill patients.

c. The increase in computer software works in progress is mainly for the e-Health project which is providing the information technology and communication systems needed to support the Health Infrastructure Program and National E-Health Program, the Identity Access Management project which is providing a system that automates and manages identity and access to information, and the Digital Mammography project which is changing the breast screening system from analogue (hard copy) to digital (soft copy).

Reconciliation of Capital Works in Progress

The following table shows the movement of Capital Works in Progress during 2012-2013.

	Building Works in Progress $'000	Plant and Equipment Works in Progress $'000	Computer Software Works in Progress $'000	Other Works in Progress $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	**177,252**	**154**	**40,641**	**188**	**218,235**
Additions	128,826	887	19,911	28	149,651
Capital Works in Progress Completed and Transferred to Property, Plant and Equipment and Intangible Assets	(118,715)	(121)	(6,154)	(28)	(125,018)
Capital Works Expensed	(1,098)	(5)	–	(130)	(1,232)
Carrying Amount at the End of the Reporting Period	**186,265**	**915**	**54,398**	**58**	**241,636**

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 2011-2012.

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

Note 31. Other Assets

	2013 $'000	2012 $'000
Current Other Assets		
Prepayments	2,675	2,515
Total Current Other Assets	**2,675**	**2,515**
Total Other Assets	**2,675**	**2,515**

Note 32. Payables

	2013 $'000	2012 $'000
Current Payables		
Trade Payables[a]	17,351	11,280
Other Payables	19	62
Accrued Expenses	70,403	68,203
GST Payable	–	415
Total Current Payables	**87,773**	**79,960**
Total Payables	**87,773**	**79,960**

a. The increase in current Trade Payables for 2012–13 is due to receipt of invoices for capital works to be paid to Shared Services Procurement late in June 2013.

	2013 $'000	2012 $'000
Payables are aged as follows:		
Not Overdue	78,388	79,404
Overdue for Less than 30 Days[b]	8,926	482
Overdue for 30 to 60 Days[c]	435	45
Overdue for More than 60 Days[c]	24	29
Total Payables	**87,773**	**79,960**
Classification of ACT Government/Non-ACT Government Payables		
Payables with ACT Government Entities		
Trade Payables	9,449	3,966
Accrued Expenses	34,760	39,541
Total Payables with ACT Government Entities	**44,209**	**43,507**
Payables with Non-ACT Government Entities		
Trade Payables	7,902	7,714
Other Payables	19	62
Accrued Expenses	35,643	28,677
Total Payables with Non-ACT Government Entities	**43,564**	**36,453**
Total Payables	**87,773**	**79,960**

b. This mainly relates to Shared Services Procurement invoices for progress payment of capital works. These payments were delayed to ensure adequate cash availability for non-ACT Government suppliers.

c. The delay is mainly due to disputed invoices.

Note 33. Finance Leases

The Directorate has 351 finance leases, which have been taken up as a finance lease liability and an asset under a finance lease. These leases are for motor vehicles. The interest rate implicit in these leases vary from 4.35% to 7.99% and the terms vary from 1 year to 5 years. These leases allow for extensions, but have no terms of renewal or purchase options and escalation clauses.

	2013 $'000	2012 $'000
Current Finance Leases		
Secured		
Finance Leases	2,315	3,288
Total Current Finance Leases	**2,315**	**3,288**
Non-Current Finance Leases		
Secured		
Finance Leases[a]	4,162	1,802
Total Non-Current Finance Leases	**4,162**	**1,802**
Total Finance Leases	**6,477**	**5,090**

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.

a. The increase in non-current finance leases is due to the cyclic nature of the motor vehicles which are generally on a 3 year lease. In 2012–13 Health Directorate acquired 185 new motor vehicle leases and disposed of 164 old motor vehicle finance leases which results in a larger non-current balance.

	2013 $'000	2012 $'000
Finance lease commitments are payable as follows:		
Within one year	2,613	3,513
Later than one year but not later than five years	4,412	1,905
Minimum Lease Payments	**7,025**	**5,418**
Less: Future Finance Lease Charges	(548)	(328)
Amount Recognised as a Liability	**6,477**	**5,090**
Add: Lease incentive involved with non-cancellable operating lease	–	–
Total Present Value of Minimum Lease Payments	**6,477**	**5,090**
The present value of the minimum lease payments are as follows:		
Within one year	2,613	3,288
Later than one year but not later than five years	3,864	1,802
Total Present Value of Minimum Lease Payments	**6,477**	**5,090**
Classification on the Balance Sheet		
Finance Leases		
Current Finance Leases	2,315	3,288
Non-Current Finance Leases	4,162	1,802
Total Finance Leases	**6,477**	**5,090**

Note 34. Employee Benefits

	2013 $'000	2012 $'000
Current Employee Benefits		
Annual Leave[a]	83,716	76,428
Long Service Leave[b]	79,538	71,762
Accrued Salaries[c]	17,025	15,688
Other Benefits	243	429
Total Current Employee Benefits	**180,522**	**164,307**
Non-Current Employee Benefits		
Long Service Leave[d]	12,457	14,984
Total Non-Current Employee Benefits	**12,457**	**14,984**
Total Employee Benefits	**192,979**	**179,292**

a. The increase is mainly due to the impact of collective agreement pay rises and an increase in staff numbers for growth in services and the growth in liability due to leave consumption not in line with leave earned.

b. The increase is mainly due to the impact of collective agreement pay rises and an increase in staff numbers for growth in services and the growth in liability due to leave consumption not in line with leave earned, which was partially offset by the impact of a reduction in the rate used to estimate the present value of long service leave payments from 106.6% to 101.3%.

c. The increase is due to an additional day's pay accrued in 2013 compared to 2012.

d. The reduction in non-current long service leave liabilities is mainly due to a reduction in the rate used to estimate the present value of long service leave payments from 106.6% to 101.3%.

Estimate of when Leave is Payable		
Estimated Amount Payable within 12 months		
Annual Leave	83,715	76,428
Long Service Leave	6,107	7,223
Accrued Salaries	17,026	15,688
Other Benefits	243	429
Total Employee Benefits Payable within 12 months	**107,091**	**99,768**
Estimated Amount Payable after 12 months		
Long Service Leave	85,888	79,524
Total Employee Benefits Payable after 12 months	**85,888**	**79,524**
Total Employee Benefits	**192,979**	**179,292**

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.

	2013 $'000	2012 $'000
Non-Current Other Provisions		
Provision for Make Good	1,503	1,503
Total Other Provisions	**1,503**	**1,503**

Note 36. Other Liabilities

	2013 $'000	2012 $'000
Current Other Liabilities		
Revenue Received in Advance[a]	2,224	656
Total Current Other Liabilities	**2,224**	**656**
Total Other Liabilities	**2,224**	**656**

a. The increase is mainly due to payment in advance for services provided to the Department of Veterans' Affairs.

Note 37. Equity

Asset Revaluation Surplus

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

	2013 $'000	2012 $'000
Balance at the Beginning of the Reporting Period	**144,007**	**145,001**
Increment in Land due to Revaluation	–	–
Decrement in Land due to Disposal	–	–
Increment in Buildings due to Revaluation	–	–
Decrement in Buildings due to Impairment Loss	–	–
Other Decrements	–	(994)
Total (Decrease) in the Asset Revaluation Surplus	**–**	**(994)**
Balance at the End of the Reporting Period	**144,007**	**144,007**

Note 38. Financial Instruments

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

Interest Rate Risk

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

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

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

A sensitivity analysis has not been undertaken as it is considered that the Directorate's exposure to this risk is insignificant and would have an insignificant impact on its 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. In 2012–13 as part of the Whole-of-Government banking arrangements, the Directorate transitioned banking services from the Commonwealth Bank to Westpac Banking Corporation. Both of these banks hold a AA- issuer credit rating with Standard and Poors.

Credit risk is managed by the Directorate for investments by only investing surplus funds with the Territory Banking Account, which has appropriate investment criteria for the external fund manager engaged to manage the Territory's surplus funds.

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

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

Note 38. Financial Instruments (Continued)

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

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

Price Risk

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

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

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

Fair Value of Financial Assets and Liabilities

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

	Carrying Amount 2013 $'000	Fair Value 2013 $'000	Carrying Amount 2012 $'000	Fair Value 2012 $'000
Financial Assets				
Cash and Cash Equivalents	9,562	9,562	69,379	69,379
Receivables	122,304	122,304	53,158	53,158
Investment with the Territory Banking Account	3,011	3,011	2,990	2,990
Total Financial Assets	**134,877**	**134,877**	**125,527**	**125,527**
Financial Liabilities				
Payables	87,773	87,773	79,960	79,960
Finance Leases	6,477	6,477	5,090	5,090
Total Financial Liabilities	**94,250**	**94,250**	**85,050**	**85,050**

Note 38. Financial Instruments (Continued)

Fair Value Hierarchy

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

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

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

2013				
	Classification According to Fair Value Hierarchy			
	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Financial Assets				
Investment with the Territory Banking Account – Fixed Interest Portfolio Account		3,011	–	3,011
	–	**3,011**	**–**	**3,011**
Transfer Between Categories				
There have been no transfers of financial assets or liabilities between Level 1 and Level 2 during the reporting period.				

2012				
	Classification According to Fair Value Hierarchy			
	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Financial Assets				
Investment with the Territory Banking Account – Fixed Interest Portfolio Account	–	2,990	–	2,990
	–	**2,990**	**–**	**2,990**
Transfer Between Categories				
There have been no transfers of financial assets or liabilities between Level 1 and Level 2 during the reporting period.				

Note 38. Financial Instruments (Continued)

The following table sets out the Directorate's maturity analysis for financial assets and liabilities as well as the exposure to interest rates, including weighted average interest rates by maturity period as at 30 June 2013. All financial assets and liabilities which have a floating interest rate or are non-interest bearing will mature in 1 year or less. All amounts appearing in the following maturity analysis are shown on an undiscounted cash flow basis.

				Fixed Interest Maturing in:				
	Note No.	Weighted Average Interest Rate	Floating Interest Rate $'000	1 Year or Less $'000	Over 1 to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	23	3.44%	9,516	–	–	–	46	9,562
Receivables	24		–	–	–	–	122,304	122,304
Investments with the Territory Banking Account	27		–	–	–	–	3,011	3,011
Total Financial Assets			**9,516**	**–**	**–**	**–**	**125,361**	**134,877**
Financial Liabilities								
Payables	32		–	–	–	–	87,773	87,773
Finance Leases	33	7.99%	–	2,613	4,412	–	–	7,025
Total Financial Liabilities			**–**	**2,613**	**4,412**	**–**	**87,773**	**94,798**
Net Financial Assets/ (Liabilities)			**9,516**	**(2,613)**	**(4,412)**	**–**	**37,588**	**40,079**

Note 38. Financial Instruments (Continued)

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

				Fixed Interest Maturing In:				
	Note No.	Weighted Average Interest Rate	Floating Interest Rate $'000	1 Year or Less $'000	Over 1 to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	23	4.87%	69,332	–	–	–	47	69,379
Receivables	24		–	–	–	–	53,158	53,158
Investments with the Territory Banking Account	27		–	–	–	–	2,990	2,990
Total Financial Assets			**69,332**	**–**	**–**	**–**	**56,195**	**125,527**
Financial Liabilities								
Payables	32		–	–	–	–	79,960	79,960
Finance Leases	33	7.18%	–	3,513	1,905	–	–	5,418
Total Financial Liabilities			**–**	**3,513**	**1,905**	**–**	**79,960**	**85,378**
Net Financial Assets/ (Liabilities)			**69,332**	**(3,513)**	**(1,905)**	**–**	**(23,765)**	**40,148**

	2013 $'000	2012 $'000
Carrying Amount of Each Specified Category of Financial Asset and Financial Liability		
Financial Assets		
Loans and Receivables Measured at Amortised Cost	122,304	53,158
Financial Assets at Fair Value through the Profit and Loss Designated upon Initial Recognition	3,011	2,990
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	94,250	85,050
Gains on Each Category of Financial Asset and Financial Liability		
Gains on Financial Assets		
Loans and Receivables Measured at Amortised Cost	–	–
Financial Assets at Fair Value through the Profit and Loss Designated upon Initial Recognition	144	157
Gains on Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	–	–

Note 39. Commitments

Capital Commitments

Capital commitments contracted at reporting date include Health Centres in Belconnen, Tuggeranong and Gungahlin, the Canberra Region Cancer Centre, the Centenary Hospital for Women and Children, the University of Canberra Public Hospital, the Emergency Department Intensive Care Unit Expansion, Adult Secure Mental Health Unit, Clinical Services and Inpatient Unit Design and Infrastructure Expansion, An e-Healthy Future, Central Sterilising Service, Walk-In Centres for Belconnen and Tuggeranong, and other minor new works construction projects. These have not been recognised as liabilities.

Capital Commitments – Property, Plant and Equipment	2013 $'000	2012 $'000
Payable:		
Within one year	191,154	238,628
Later than one year but not later than five years	121,860	169,273
Total Capital Commitments – Property, Plant and Equipment[a]	**313,014**	**407,901**
Total Capital Commitments	**313,014**	**407,901**

a. The decrease is a result of less capital works funding appropriated in 2013.

Operating Lease Commitments

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

Non-cancellable operating lease commitments are payable as follows:	2013 $'000	2012 $'000
Within one year	7,830	7,290
Later than one year but not later than five years	16,974	21,135
Total Operating Lease Commitments	**24,804**	**28,425**

Other Commitments

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

Non-cancellable other commitments are payable as follows:	2013 $'000	2012 $'000
Within one year	49,497	49,295
Later than one year but not later than five years[b]	53,060	36,855
Total Other Commitments	**102,557**	**86,150**

b. The increase in other commitments later than one year but not greater than five years is due to the cyclic nature of contracting with Non-Government Organisations with most contracts running for three years. Approximately 40 per cent of contracts were entered into in 2013 extending the commitment period.

Finance Lease Commitments

Finance lease commitments are disclosed in Note 33: Finance Leases.

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

Note 40. Contingent Liabilities

Contingent Liabilities

The Directorate is currently defending 123 actions (2012 – 142 actions). These actions have an estimated net liability of $5,190,000 (2012 – $5,530,000), which has not been provided for in the accounts. The estimated liability has been calculated net of the amounts covered under the Directorate's insurance policy. The reduction in the estimated net liability is due to the ACT Insurance Authority's acceptance, in 2012, of one previously declined high cost insurance claim.

There were no contingent assets as at 30 June 2013.

Note 41. Cash Flow Reconciliation

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

	2013 $'000	2012 $'000
Cash and Cash Equivalents Recorded in the Balance Sheet	9,562	69,379
Total Cash and Cash Equivalents at the end of the reporting period as recorded in the Cash Flow Statement	**9,562**	**69,379**

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

	2013 $'000	2012 $'000
Operating (Deficit)	(39,688)	(17,619)
Add/(Less) Non-Cash Items		
Depreciation of Property, Plant and Equipment	48,560	24,403
Amortisation of Intangibles	4,454	4,526
Bad and Doubtful Debts	1,171	2,151
Asset Book Value Written Down	509	1,871
Impairment Loss of Non-Current Assets	1,121	613
Add/(Less) Items Classified as Investing or Financing		
Net Gain on Disposal of Assets	–	(75)
Unrealised Gain on Investments	(21)	(10)
Cash Before Changes in Operating Assets and Liabilities	**16,106**	**15,859**
Changes in Operating Assets and Liabilities		
(Increase) in Receivables	(68,609)	(9,127)
(Increase)/Decrease in Inventories	(559)	313
(Increase) in Other Assets	(160)	(101)
(Decrease)/Increase in Payables	(3,565)	22,715
Increase in Provisions	13,686	28,136
Increase/(Decrease) in Other Liabilities	1,569	(4,606)
Net Changes in Operating Assets and Liabilities	**(57,638)**	**37,330**
Net Cash (Outflows)/Inflows from Operating Activities	**(41,532)**	**53,189**

c. Non-Cash Financing and Investing Activities

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

	2013 $'000	2012 $'000
Acquisition of Motor Vehicles by Means of Finance Lease[a]	3,908	1,235

a. The increase in finance leases is due to the cyclic nature of the motor vehicle leases which are mostly on a three year lease. In 2013, 185 new vehicles were acquired compared to 104 in 2012.

Note 42. Events Occurring After Balance Date

There were no events occurring after the balance date, which would affect the financial statements as at 30 June 2013, or in the future reporting periods.

Note 43. Third Party Monies

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

	2013 $'000	2012 $'000
Registration Boards and Ethics Committee Trust Account		
Balance at the Beginning of the Reporting Period	529	438
Cash Receipts	900	1,079
Cash Payments	(866)	(988)
Balance at the End of the Reporting Period	**563**	**529**

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

	2013 $'000	2012 $'000
Mental Health Trust Account		
Balance at the Beginning of the Reporting Period	27	22
Cash Receipts	108	127
Cash Payments	(99)	(122)
Balance at the End of the Reporting Period	**36**	**27**

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

	2013 $'000	2012 $'000
Private Practice Hospital Account		
Balance at the Beginning of the Reporting Period	23,267	21,702
Cash Receipts	24,973	18,954
Cash Payments	(23,404)	(17,389)
Balance at the End of the Reporting Period	**24,836**	**23,267**

Health Directorate Statement of Income and Expenses on Behalf of the Territory For the Year Ended 30 June 2013

	Note No.	Actual 2013 $'000	Original Budget 2013 $'000	Actual 2012 $'000
Income				
Revenue				
Payments for Expenses on Behalf of the Territory	45	746	746	986
Fees	46	1,094	693	794
Total Revenue		**1,840**	**1,439**	**1,780**
Total Income		**1,840**	**1,439**	**1,780**
Expenses				
Grants and Purchased Services	47	746	746	727
Transfer to the ACT Government	48	1,094	693	794
Total Expenses		**1,840**	**1,439**	**1,521**
Operating Surplus		**–**	**–**	**259**
Total Comprehensive Surplus		**–**	**–**	**259**

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

Health Directorate Statement of Assets and Liabilities on behalf of the Territory As at 30 June 2013

	Note No.	Actual 2013 $'000	Original Budget 2013 $'000	Actual 2012 $'000
Current Assets				
Cash and Cash Equivalents	49	295	294	300
Receivables	50	5	6	–
Total Current Assets		**300**	**300**	**300**
Total Assets		**300**	**300**	**300**
Non-Current Liabilities				
Advance from the Territory Banking Account	51	300	300	300
Total Liabilities		**300**	**300**	**300**
Net Assets		**–**	**–**	**–**
Equity				
Accumulated Surplus/(Deficits)		–	–	–
Total Equity		**–**	**–**	**–**

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 2013

	Accumulated Funds 2013 $'000	Total Equity 2013 $'000	Original Budget 2013 $'000
Balance at the Beginning of the Reporting Period	–	–	–
Comprehensive Income			
Operating (Deficit)	–	–	–
Total Comprehensive Income	**–**	**–**	**–**
Transactions Involving Owners Affecting Accumulated Funds			
Total Transactions Involving Owners Affecting Accumulated Funds	–	–	–
Balance at the End of the Reporting Period	**–**	**–**	**–**

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

	Accumulated (Deficits)/ Funds 2012 $'000	Total Equity 2012 $'000
Balance at the Beginning of the Reporting Period	(259)	(259)
Comprehensive Income		
Operating Surplus	259	259
Total Comprehensive Income	**259**	**259**
Balance at the End of the Reporting Period	**–**	**–**

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

Health Directorate Cash Flow Statement on Behalf of the Territory For the Year Ended 30 June 2013

	Note No.	Actual 2013 $'000	Original Budget 2013 $'000	Actual 2012 $'000
Cash Flows from Operating Activities				
Receipts				
Cash from the ACT Government for Expenses on Behalf of the Territory		746	746	986
Fees		1,094	693	794
Other Receipts		69	75	78
Total Receipts from Operating Activities		**1,909**	**1,514**	**1,858**
Payments				
Grants and Purchased Services		746	746	727
Transfer of Territory Receipts to the ACT Government		1,094	693	794
Other		74	75	73
Total Payments from Operating Activities		**1,914**	**1,514**	**1,594**
Net Cash (Outflows)/Inflows From Operating Activities		**(5)**	**–**	**264**
Net (Decrease)/Increase in Cash	52	(5)	–	264
Cash and Cash Equivalents at the Beginning of the Reporting Period		300	294	36
Cash and Cash Equivalents at the End of the Reporting Period	**52**	**295**	**294**	**300**

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 2013

	Original Budget 2013 $'000	Total Appropriated 2013 $'000	Appropriation Drawn 2013 $'000	Appropriation Drawn 2012 $'000
Territorial				
Expenses on Behalf of the Territory	746	746	746	986
Total Territorial Appropriation	**746**	**746**	**746**	**986**

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

Column Heading Explanations

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

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

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

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

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Note 44. Summary of Significant Accounting Policies – Territorial

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

Note 45. Payment for Expenses on Behalf of the Territory – Territorial

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

(See Note 47 Grants and Purchased Services – Territorial)

	2013 $'000	2012 $'000
Payment for Expenses on Behalf of the Territory[a]	746	986
Total Payment for Expenses on Behalf of the Territory	**746**	**986**

a. This relates to capital upgrades at Calvary Hospital. The decrease reflects that the payment in 2012 included some of the 2011 capital upgrades funding.

Note 46. Fees – Territorial

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

	2013 $'000	2012 $'000
Fees		
Fees for Regulatory Services[a]	1,094	794
Total Fees	**1,094**	**794**

a. The increase is mainly due to price escalation increases, growth in licence numbers and the introduction of licences for pharmacies.

Note 47. Grants and Purchased Services – Territorial

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

	2013 $'000	2012 $'000
Capital Grants to External Parties - Calvary Hospital[a]	746	727
Total Grants and Purchased Services	**746**	**727**

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

Note 48. Transfer to Government – Territorial

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

	2013 $'000	2012 $'000
Transfer to the Territory Banking Account	1,094	794
Total Transfer to the ACT Government	**1,094**	**794**

Note 49. Cash and Cash Equivalents – Territorial

The Directorate holds one Territorial bank account. In 2012–13, as part of the Whole-of-Government banking arrangements, the Directorate transitioned banking services from the Commonwealth Bank to Westpac Banking Corporation. Interest is not earned on cash at bank held in the Territorial Bank Account.

	2013 $'000	2012 $'000
Cash at Bank	295	300
Total Cash and Cash Equivalents	**295**	**300**

Note 50. Receivables – Territorial

	2013 $'000	2012 $'000
Current Receivables		
Goods and Services Tax Receivable	5	–
Less: Allowance for Doubtful Debts	–	–
Total Current Receivables	**5**	**–**
Total Non-Current Receivables	–	–
Total Receivables	**5**	**–**

Ageing of Receivables	Not Overdue $'000	Past Due Less than 30 days $'000	Past Due 30 to 60 days $'000	Past Due Greater than 60 days $'000	Total $'000
2013					
Not Impaired Receivables	5	–	–	–	5
Impaired Receivables	–	–	–	–	–
2012					
Not Impaired Receivables	–	–	–	–	–
Impaired Receivables	–	–	–	–	–

Classification of ACT Government/Non-ACT Government Receivables	2013 $'000	2012 $'000
Receivables with Non-ACT Government Entities		
Net Goods and Services Tax Receivable	5	-
Total Receivables with Non-ACT Government Entities	**5**	**-**
Total Receivables	**5**	**-**

Note 51. Advance from Territory Banking Account – Territorial

	2013 $'000	2012 $'000
Advance from Territory Banking Account	300	300
Total Advance from Territory Banking Account	**300**	**300**

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

Note 52. Cash Flow Reconciliation – Territorial

a. Reconciliation of Cash at the end of 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.

	2013 $'000	2012 $'000
Total Cash Disclosed on the Statement of Assets and Liabilities on Behalf of the Territory	295	300
Cash at the End of the Reporting Period as Recorded in the Cash Flow Statement on Behalf of the Territory	**295**	**300**

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

	2013 $'000	2012 $'000
Operating Surplus	–	259
Cash Before Changes in Operating Assets and Liabilities	**–**	**259**
Changes in Operating Assets and Liabilities		
(Increase)/Decrease in Receivables	(5)	5
Net Changes in Operating Assets and Liabilities	**(5)**	**5**
Net Cash (Outflows)/Inflows from Operating Activities	**(5)**	**264**

Note 53. Financial Instruments – Territorial

Details of the significant policies and methods adopted, including the criteria for recognition, the basis of measurement, and the basis on which income and expenses are recognised, with respect to each class of financial asset and financial liability are disclosed in Note 44: Summary of Significant Accounting Policies – Territorial.

Interest Rate Risk

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

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

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

Note 53. 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.

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. In 2012–13 as part of the Whole-of-Government banking arrangements, the Directorate transitioned banking services from the Commonwealth Bank to Westpac Banking Corporation. Both of these banks hold 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 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 2013 $'000	Fair Value 2013 $'000	Carrying Amount 2012 $'000	Fair Value 2012 $'000
Financial Assets				
Cash and Cash Equivalents	295	295	300	300
Receivables	5	5	–	–
Total Financial Assets	**300**	**300**	**300**	**300**
Financial Liabilities				
Advance from Territory Banking Account	300	300	300	300
Total Financial Liabilities	**300**	**300**	**300**	**300**
Net Financial (Liabilities)	**–**	**–**	**–**	**–**

Note 53. 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 2013. All financial assets and liabilities, excluding Advance from the Territory Banking Account which are non-interest bearing will mature in 1 year or less. All amounts appearing in the following maturity analysis are shown on an undiscounted cash flow basis.

				Fixed Interest Maturing In:				
	Note No.	Weighted Average Interest Rate	Floating Interest Rate $'000	1 Year or Less $'000	Over 1 to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	49		–	–	–	–	295	295
Total Financial Assets			**–**	**–**	**–**	**–**	**295**	**295**
Financial Liabilities								
Advance from Territory Banking Account	51		–	–	–	–	300	300
Total Financial Liabilities			**–**	**–**	**–**	**–**	**300**	**300**
Net Financial (Liabilities)			**–**	**–**	**–**	**–**	**(5)**	**(5)**

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

			Fixed Interest Maturing In:				
	Note No.	Floating Interest Rate $'000	1 Year or Less $'000	Over 1 to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments							
Financial Assets							
Cash and Cash Equivalents	49	–	–	–	–	300	300
Total Financial Assets		**–**	**–**	**–**	**–**	**300**	**300**
Financial Liabilities							
Advance from Territory Banking Account	51	–	–	–	–	300	300
Total Financial Liabilities		**–**	**–**	**–**	**–**	**300**	**300**
Net Financial Assets/ (Liabilities)		**–**	**–**	**–**	**–**	**–**	**–**

Note 53. Financial Instruments – Territorial (Continued)

	2013 $'000	2012 $'000
Carrying Amount of Each Class of Financial Asset and Financial Liability		
Financial Assets		
Loans and Receivables Measured at Amortised Cost	5	–
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	300	300

Fair Value Hierarchy

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

Note 54. Commitments – Territorial

Capital Commitments

Capital commitments at reporting date that have not been recognised as liabilities are as follows:

	2013 $'000	2012 $'000
Capital Grant Commitments		
Within one year	4,615	746
Later than one year but not later than five years	–	–
Total Capital Commitments	**4,615**	**746**
All amounts shown in the commitment note are exclusive of Goods and Services Tax (GST).		

Note 55. Contingent Liabilities and Contingent Assets – Territorial

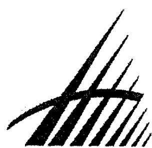
There were no contingent liabilities or contingent assets as at 30 June 2013, (Nil at 30 June 2012).

There were no indemnities as at 30 June 2013, (Nil at 30 June 2012).

Note 56. Events Occurring After Balance Date – Territorial

There were no events occurring after the balance date, which would affect the financial statements as at 30 June 2013, or in the future reporting periods.

A.7 Statement of Performance



ACT AUDITOR-GENERAL'S OFFICE

REPORT OF FACTUAL FINDINGS

HEALTH DIRECTORATE

To the Members of the ACT Legislative Assembly

Report on the statement of performance

The statement of performance of the Health Directorate (the Directorate) for the year ended 30 June 2013 has been reviewed.

Responsibility for the statement of performance

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

The auditor's responsibility

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

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

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

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

Level 4, 11 Moore Street, Canberra City, ACT 2601 | PO Box 275, Civic Square, ACT 2608
Telephone: 02 6207 0833 | Facsimile: 02 6207 0826 | Email: actauditorgeneral@act.gov.au

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

Electronic presentation of the statement of performance

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

Independence

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

Review opinion

Based on the review procedures, no matters have come to my attention which indicate that the results of the accountability indicators, reported in the statement of performance of the Directorate for the year ended 30 June 2013, are not fairly presented in accordance with the *Financial Management Act 1996*.

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

Dr Maxine Cooper
Auditor General
16 September 2013

Health Directorate
Statement of Performance
For the Year Ended 30 June 2013

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 2013 and also fairly reflects the judgements exercised in preparing it.

Dr Peggy Brown
Director-General
Health Directorate
13 September 2013

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 focussing on:

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

	Original Target 2012–13	Actual Result 2012–13	% Variance from Original Target	Explanation of Material Variances	Notes
Total cost ($000's)	659,657	682,977	4%	The higher than expected total cost relates mostly to accelerated depreciation for the old Women's and Children's Hospital and tower block level 5 at Canberra Hospital. These facilities are undergoing significant redevelopment.	
Government payment for outputs (GPO) ($000's)	137,678	134,615	(2%)		
Accountability Indicators Patient activity					
a. Cost weighted patient separations	63,541	66,184	4%	The growth in acute cost weighted separations in 2012–13 was largely due to increased levels of elective surgery and maternity services. The increase in maternity was due to high birth rates experienced in 2012–13.	1

Notes

1. Cost weighted separations for all Canberra Hospital episodes, excluding those reported elsewhere (Mental Health, Cancer Services and Aged Care and Rehabilitation Service) and unqualified neonates (well babies, who are counted as part of their mother's admission). Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of the activity performed.

Output Class 1: Health and Community Care (Continued)

Output 1.1 Acute Services (Continued)

	Original Target 2012–13	Actual Result 2012–13	% Variance from Original Target	Explanation of Material Variances	Notes
b. Non-admitted occasions of service	268,434	282,192	5%	There has been a higher than expected demand for outpatient services at the Canberra Hospital. Growth has occurred in all areas, although it is most notable in Medical Imaging and Pathology.	2
c. Percentage of category one elective surgery patients who receive surgery within 30 days of listing	97%	99%	2%		3
d. Number of allied health care services provided for acute care patients in ACT public hospitals	101,400	107,485	6%	There has been a higher than expected demand for these services.	4
e. Mean waiting time for clients on the dental services waiting list	12 Months	12 Months	–		5
f. Percentage of the Women's Health Service Intake Officer's clients who receive an intake and assessment service within 14 working days of their initial referral	100%	100%	–		6

Notes

2. Non-admitted patient services provided at the Canberra Hospital, excluding those services provided by Mental Health, Cancer Services and the Aged Care and Rehabilitation Service.
3. Category one patients are those assessed by the treating medical officer as the highest priority for elective surgery requiring surgery within 30 days of being listed on the elective surgery waiting list. In line with national definitions, the 30-day recommended waiting time for category one patients commences from when the hospital accepts the patient's 'request for admission' from the treating medical officer and is placed on the hospital's elective surgery waiting list. The time does not start from the date a patient is initially assessed by the treating medical officer as the Directorate cannot control the time taken by the treating medical officer to submit complete documentation to the hospital to place them on the elective surgery waiting list.
4. The number of allied health services to inpatients within the Canberra Hospital.
5. Client mean waiting time is defined as the mean waiting period between when a client is placed on the adult dental central waiting list and the receipt of treatment provided by a public dentist.
6. This accountibility indicator provides an indication of the availability of services.

Output Class 1: Health and Community Care (Continued)

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

Description

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

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

This means focussing on:

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

	Original Target 2012–13	Actual Result 2012–13	% Variance from Original Target	Explanation of Material Variances	Notes
Total cost ($000's)	117,504	114,338	(3%)	The variance relates to staff vacancies and a delayed opening of a planned older persons step-up step-down sub-acute service. The underspend was offset by increased expenditure for accelerated depreciation of the old Psychiatric Services Unit that will be converted to accommodate other services.	
Government payment for outputs (GPO) ($000's)	54,432	54,432	–		
Accountability Indicators					
a. Cost weighted separations	3,004	3,098	3%		7
b. Admitted patient separations	830	950	14%	The variance is due to increased demand for services at the Adult Mental Health Unit (AMHU).	8
c. Adult services (18 – 64 years)	185,000	203,689	10%	The variance is attributable to continued growth in demand for adult services.	9
d. Children and youth services (0 – 17 years)	52,000	48,455	(7%)	Staff vacancies early in the reporting period impacted on the level of activity.	10
e. Older persons' services (65+ years)	17,000	14,974	(12%)	The variance is mainly due to the unavailability of staff.	11

Notes

7. Cost weighted separations for mental health relate to the Adult Mental Health Unit at Canberra Hospital and Health Services and Alcohol and Drug Services. Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of activity performed.
8. Raw separations from the Adult Mental Health Unit. Raw separations count the number of inpatient hospital episodes discharged in the reference period.
9. Mental Health ACT Adult community occasions of service (Age group 18 – 64).
10. Mental Health ACT Children and Adolescents community occasions of service (Age group 0 – 17).
11. Mental Health ACT older person's community occasions of service (Age group 65+).

Output Class 1: Health and Community Care (Continued)

Output 1.2 Mental Health, Justice Health and Alcohol and Drug Services (Continued)

	Original Target 2012–13	Actual Result 2012–13	% Variance from Original Target	Explanation of Material Variances	Notes
f. Older persons' services bed days	4,928	5,174	5%	The variance is due to increased demand for this service.	12
g. Supported accommodation bed occupancy rate	95%	97%	2%		13
h. Proportion of clients contacted by a Health Directorate community facility during the 7 days post discharge from the inpatient services	75%	90%	20%	Follow-up contact post discharge was above target and this was due to the work undertaken by mental health workers who assist in the transition of patients from inpatient units back into the community.	14
i. Percentage of clients with outcome measures completed	65%	58%	(11%)	The target was based on a different method of calculation. By applying the method of calculation used in setting the target, the result would have been 65%	15
j. Proportion of offenders and detainees at the Alexander Maconochie Centre with a completed health assessment within 24 hours of detention	100%	100%	–		16
k. Proportion of offenders and detainees in Bimberi Youth Detention Centre with a completed health assessment within 24 hours of detention	100%	93%	(7%)	A total of 7 young people were not assessed within 24 hours of detention. Six young people were still assessed however due to attending court breached the 24 hour target by less than two hours. One young person refused a health assessment.	16
l. Percentage of current clients on opioid treatment with management plans	98%	99%	1%		17

Notes

12. The actual number of Occupied Bed Days at the Calvary Public Hospital older persons' mental health inpatient unit.
13. Actual occupancy expressed as a percentage of the total supported accommodation places provided by the following Community Service providers: Richmond Fellowship, Centacare, ACT Mental Health Foundation and Inanna.
14. The proportion of clients admitted to a mental health inpatient unit and contacted by Mental Health ACT Community Services during the 7 days post discharge from the mental health inpatient unit (not all inpatients are referred to Mental Health ACT community mental health but may be seen by their general practitioner or private psychiatrist).
15. Percentage of Mental Health ACT registered clients with mandatory outcome measures completed each three months and for each inpatient episode. The purpose of measuring clinical outcomes is to see whether consumers of public mental health services are getting better as a result of the services they receive.
16. Percentage of detainees inducted into Bimberi and Alexander Maconochie Centre who are assessed within 24 hours of arrival at the facility. In respect of Bimberi, young detainees who are detained for a period of less than 24 hours will be excluded from this indicator.
17. On presentation for opioid replacement treatment, a management plan is developed. This indicator represents the percentage of clients with management plans.

Output Class 1: Health and Community Care (Continued)

Output 1.3 Public Health Services

Description

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

	Original Target 2012–13	Actual Result 2012–13	% Variance from Original Target	Explanation of Material Variances	Notes
Total cost ($000's)	40,952	41,338	1%		
Government payment for outputs (GPO) ($000's)	37,417	37,417	–		
Accountability Indicators					
a. Samples analysed	7,600	8,322	10%	The variance is due to an increase in samples received to test for asbestos.	18
b. Compliance of licensable, registrable and non licensable activities at the time of inspection	85%	76%	(11%)	The compliance rates recorded primarily relate to regulated food business. The non-compliance is a continuation of previous trends in food safety compliance, which is attributed to routine inspections, complaint based inspections and re-inspections of non compliant premises.	19
c. Response time to environmental health hazards, communicable disease hazards relating to measles and meningococcal infections and food poisoning outbreaks is less than 24 hours	100%	100%	–		20

Notes

18. Number of samples analysed during the period by the ACT Government Analytical Laboratory.
19. Percentage of inspected premises found to be in compliance with relevant legislation, licence, or registration. The data is drawn from records of inspection carried out under provisions of all ACT Health administered legislation. The relevant Acts are: *Food Act 2001*, *Public Health Act 1997*, *Radiation Protection Act 2006* and *Medicines, Poisons and Therapeutic Goods Act 2008*.
20. Response time is defined as the elapsed time between notification and commencement of investigation. The reported percentage is derived from the combined data sets across the three classes of quick response categories: environmental health hazards, communicable disease control hazards and food poisoning outbreaks.

Output Class 1: Health and Community Care (Continued)

Output 1.4 Cancer Services

Description

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

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

	Original Target 2012–13	Actual Result 2012–13	% Variance from Original Target	Explanation of Material Variances	Notes
Total cost ($000's)	64,866	66,698	3%		
Government payment for outputs (GPO) ($000's)	15,205	15,252	–		
Accountability Indicators Patient activity					
a. Cost weighted admitted patient separations	4,142	4,154	–		21
b. Non-admitted occasions of service	59,260	65,462	10%	Demand remains high for outpatient cancer services. Significant growth has occured in all areas although it is most notable in Medical Oncology and Immunology. The increased activity was managed by permanent appointments during the financial year in both these areas.	22

Notes:

21. Inpatient cost weighted activity for patients of the Capital Region Cancer Service at Canberra Hospital. Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of activity performed.
22. Medical oncology (including chemotherapy), radiation oncology, immunology and haematology outpatient services at Canberra Hospital.

Output Class 1: Health and Community Care (Continued)

Output 1.4 Cancer Services (Continued)

	Original Target 2012–13	Actual Result 2012–13	% Variance from Original Target	Explanation of Material Variances	Notes
Breast Screening					
c. Total breast screens	14,907	14,017	(6%)	Appointments at BreastScreen ACT are readily available, however the service is experiencing difficulty in filling them. There are a number of initiatives underway to encourage ACT women to participate in the BreastScreen ACT program including contacting lapsed attendees and advising General Practitioners that there are appointments available. Use of electoral roll data for direct invitation for women in the target age group to participate in the program is currently being established.	23
d. Number of breast screens for women aged 50 to 69	12,552	11,385	(9%)	Appointments at BreastScreens ACT are readily available, however the service is experiencing difficulty in filling them. There are a number of initiatives underway to encourage ACT women aged 50–69 to participate in the BreastScreen ACT program including contacting lapsed attendees and advising General Practitioners that there are appointments available. Use of electoral roll data for direct invitation for women in this target group to participate in the program is currently being established.	24
e. Percentage of women who receive results of screen within 28 days	100%	100%	–		25
f. Percentage of screened who are assessed within 28 days	90%	94%	4%	The wait time to assessment has improved significantly, primarily as a result of modified work practices resulting from a redesign project and also due to increased capacity. In addition, a reduction in time taken to read images by radiologists has enabled women to be recalled for assessment sooner.	26

Notes:

23. Total number of women screened in the period.
24. Number of women aged between 50 to 69 years screened in the period. This age group is the target population for the breast screen program.
25. The percentage of women with a 'normal' result who receive notice of this outcome within 28 days of their screening appointment. Consistent with national 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.
26. The percentage of women requiring assessment who wait 28 days or less from their breast screen appointment to their assessment appointment.

Output Class 1: Health and Community Care (Continued)

Output 1.5 Rehabilitation, Aged and Community Care

Description

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

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

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

	Original Target 2012–13	Actual Result 2012–13	% Variance from Original Target	Explanation of Material Variances	Notes
Total cost ($000's)	101,815	100,891	(1%)		
Government payment for outputs (GPO) ($000's)	69,160	69,020	–		
Accountability Indicators Patient activity					
a. Cost weighted admitted patient separations	3,541	3,511	(1%)		27
b. Non-admitted occasions of service	2,230	1,485	(33%)	The below target result is due to a change which now excludes Geriatrics home visit activity (undertaken by the RADAR Team), which is now counted as community health service rather than as a non-admitted occasions of service. The below target result is also due to one registrar position being vacant in Rehabilitation Medicine for the larger part of the third quarter of 2012–13 due to an unexpected resignation.	28

Notes

27. Inpatient cost weighted activity for patients of the Aged Care and Rehabilitation Service at Canberra Hospital. Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of activity performed.
28. Geriatric and rehabilitation outpatient services.

Output Class 1: Health and Community Care (Continued)

Output 1.5 Rehabilitation, Aged and Community Care (Continued)

	Original Target 2012–13	Actual Result 2012–13	% Variance from Original Target	Explanation of Material Variances	Notes
c. Sub-acute service—episodes of care	1,384	1,289	(7%)	The variance is due to a large number of nursing home type patients waiting for an aged care placement, which has reduced the unit's capacity to manage additional sub-acute services. The unit has also experienced a delay in the recruitment of an additional medical specialist in rehabilitation medicine.	29
d. Sub-acute service—occupied bed days	13,349	11,572	(13%)	The variance is due to a large number of nursing home type patients waiting for an aged care placement, which has reduced the unit's capacity to manage additional sub-acute services. The unit has also experienced a delay in the recruitment of an additional medical specialist in rehabilitation medicine.	30
e. Number of people assessed in falls clinics	420	448	7%	The variance is a result of the increased use of awareness and promotional materials. These include representation at the Seniors Week Expo, April Falls month, engagement with the Healthcare Consumers Group and ACT Medicare Local, media advertisements and monthly newsletters.	31
f. Number of nursing (domiciliary and clinic based) occasions of service	80,000	83,962	5%	The variance is due to increased complexity and acuity of patients.	32
g. Number of allied health regional services (occasions of service)	22,000	21,740	(1%)		33

Notes

29. The total number of persons separated from the sub-acute service at Canberra Hospital.
30. Total number of occupied bed days used for persons separated from the sub-acute service at Canberra Hospital.
31. Data for the Falls Clinic is taken from 'Integrated Health Care Partnership Central Regional Team'. The 'Integrated Health Care Partnership Assessors' contacts have been excluded as this relates to 'non-clinic time' intervention by staff member.
32. All occasions of service provided to community patients by Continuing Care Nurses in the following settings: home visits; ambulatory care clinics; foot care clinics; continence clinics; wound clinics; and stoma clinics.
33. All occasions of service provided to community patients by Continuing Care Allied Health Professionals and Technical Officers for Physiotherapy, Occupational Therapy, Social Work, Podiatry and Nutrition.

Output Class 1: Health and Community Care (Continued)

Output 1.6 Early Intervention and Prevention

Description

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

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

	Original Target 2012–13	Actual Result 2012–13	% Variance from Original Target	Explanation of Material Variances	Notes
Total cost ($000's)	78,493	77,546	(1%)		
Government payment for outputs (GPO) ($000's)	51,968	53,520	3%		
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%		34
b. Proportion of clients attending 'Well Women's Check' within the Women's Health Service that are from culturally and linguistically diverse communities	30%	40%	33%	The favourable outcome is due to targeted promotion of services in culturally and linguistically diverse communities and services offered in outreach locations.	35
c. Proportion of children aged 0–14 who are entering substitute and kinship care within the ACT who attend to the Child at Risk Health Unit for a health and wellbeing screen	80%	96%	20%	The positive variance reflects improved referral rates from Office of Child, Youth and Family Services.	36

Notes

34. Percentage of 12 month old children who have been fully immunised in accordance with the Australian Childhood Immunisation Register.
35. This indicator measures the percentage of women who are from culturally and linguistically diverse communities accessing a 'Well Women's Check'.
36. This indicator measures the percentage of children aged 0–14 placed in out of home care (substitute or kinship care) who have received a health and wellbeing screen. The Health Directorate is reliant on referrals from the Community Services Directorate in order to provide these services.

A.8 Strategic indicators

Health Directorate strategic indicators

Strategic objectives and indicators

The government's overarching health policy, *Your health—our priority,* identifies the following priorities:

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

Some strategic indicators which were reported in 2011–12 have been deleted from the 2012–13 set of strategic indicators. The strategic indicators relating to emergency department access block were deleted, as they are no longer consistent with national reporting or reporting under the national health reforms. The strategic indicators relating to discharge planning have also been deleted, as they are not reflective of wider discharge planning services.

Strategic objective 1: Removals from waiting list for elective surgery

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

Strategic indicator 1: Number of people removed from waiting list

	2012–13 target	2012–13 result
People removed from the ACT elective surgery waiting list	11,000	11,579

In order to improve access to elective surgery, the Commonwealth and state and territory governments have entered into a partnership to significantly increase the number of elective surgery operations provided in our public hospitals each year and reduce the number of people waiting more than clinically recommended times for that surgery. As part of this program, the Commonwealth and the ACT governments have committed funds to specifically increase access to surgery from 2009–10 to 2012–13.

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

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

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

	2012–13 target	2012–13 result
Percentage of emergency clients seen within 24 hours	100%	100%

Strategic objective 3: Reaching the optimum occupancy rate for acute adult overnight hospital beds

Strategic indicator 3: The mean percentage of adult overnight acute medical and surgical beds in use

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

	2012–13 target	2012–13 result
Percentage of adult overnight acute medical and surgical beds in use	85%	93%[1]

1. There has been an increase in the number of non-same day bed days, which has impacted on the bed occupancy rate.

Strategic objective 4: Access to radiotherapy services

Strategic indicator 4: Percentage of radiotherapy patients who commence treatment within standard time frames

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

Category	2012–13 target	2012–13 result
Urgent—treatment starts within 48 hours	100%	100%
Semi-urgent—treatment starts within 4 weeks	95%	100%
Non-urgent—treatment starts within 6 weeks	95%	98%

Strategic objective 5: Government capital expenditure on healthcare infrastructure

Strategic indicator 5: Capital consumption

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

Government1 capital expenditure as a proportion of government2 capital consumption expenditure by healthcare facilities, 2007–08 to 2009–10	ACT rate	National rate
2007–08	1.89	1.51
2008–09	2.76	1.90
2009–10	2.67	1.57

Source: Health Expenditure Australia 2009–10 (Australian Institute of Health and Welfare).
Excludes local government.
Expenditure on publicly owned healthcare facilities.

Strategic objective 6: Management of chronic disease

Strategic indicator 6: Maintenance of the highest life expectancy at birth in Australia

Maintenance of the highest life expectancy at birth in Australia	ACT rate	National rate
Females	84.8	84.2
Males	81.0	79.7

Source: ABS 2012, Deaths, Australia, 2011, cat. no. 3302.0, ABS, Canberra.

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

Strategic objective 7: Lower than national average prevalence of circulatory disease

Strategic indicator 7: The proportion of the ACT population with some form of circulatory disease

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

Source: Australian Health Survey: First Results, 2011–12, cat. no: 4364.0.55.001, ABS, Canberra.

Population projections suggest that the ACT population is ageing faster than that of other jurisdictions. The median age of the ACT population (34.5 years in 2011) has increased 6.4 years since 1985. While people of all ages can present with chronic disease, the ageing of the population and its longer lifespan mean that chronic diseases will place major demands on the health system for workforce and financial resources.

Strategic objective 8: Lower than national average prevalence of diabetes

Strategic indicator 8: The proportion of the ACT population diagnosed with some form of diabetes

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

Source: Australian Health Survey: First Results, 2011–12, cat. no: 4364.0.55.001, ABS, Canberra.

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

Strategic objective 9: Higher than national average proportion of government recurrent health funding expenditure on public health activities

Strategic indicator 9: Proportion of government recurrent health funding expenditure on public health activities

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 better the Australian average.

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 10: Maintaining the waiting times for in-hospital assessments by the Aged Care Assessment Team

Strategic indicator 10: The mean waiting time in working days between the request for, and provision of, assessment by the Aged Care Assessment Team (ACAT) for patients in public hospitals

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

	2012–13 target	2012–13 result
Mean waiting time in working days	2 days	2.5 days[1]

1. The ACT Aged Care Assessment Team (ACAT) was unable to meet the indicator target due to increased public and private hospital referrals and ongoing issues with unexpected staff unavailability. To improve performance on this indicator, ACAT is attempting to recruit additional casual backfill assessors to deal with the increased levels of referrals. The result is still within the national response timeframe.

Strategic objective 11: Providing comprehensive services for mental health and reducing the usage of seclusion

Strategic indicator 11: The proportion of clients with episodes of seclusion of public mental health in the ACT who are subject to seclusion during an inpatient episode

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

	2012–13 target	2012–13 result
Proportion of clients of public mental health services in the ACT subject to seclusion during an inpatient episode	<3%	1.5%

ACT Health is leading an innovative piece of research into seclusion reduction practices in the mental health inpatient unit at the Canberra Hospital. The findings of the research, which concluded in April 2012, show the importance of consumer involvement in the grass roots of decision making, the importance of the consumer experience when implementing change and how understanding consumers' past traumatic experiences provides for informed care and can improve outcomes for mental health consumers, leading to a more compassionate and therapeutic relationship between consumers and staff. The research was done in collaboration with consumer representatives and clinical staff through weekly Seclusion and Restraint Review Meetings (SRRM) and has led to a huge reduction in the use of seclusion at that unit.

Strategic objective 12: Maintaining consumer and carer participation on relevant mental health committees

Strategic indicator 12: The proportion of mental health ACT committees in which consumers and carers are represented

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

	2012–13 target	2012–13 result
Proportion of mental health services committees with consumer and carer representation	100%	100%

Strategic objective 13: Patients return rate to an ACT public mental health inpatient unit lower than national average

Strategic indicator 13: The proportion of clients who return to hospital within 28 days of discharge from an ACT public mental health inpatient unit

	2012–13 target	2012–13 result
Proportion of clients who return to hospital within 28 days of discharge from an ACT public mental health inpatient unit	<10%	9.8%

Source: Report on Government Services, 2013.

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

Strategic indicator 14: Immunisation rates—ACT Indigenous population

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

Immunisation rates for vaccines in the national schedule for the ACT Indigenous population:	2012–13 target	2012–13[1] result
12 to 15 months	≥90%	81.5
24 to 27 months	≥90%	91.6
60 to 63 months	≥90%	91.0
All	≥90%	88.0

Source: Productivity Commission's Review of Government Service (ROGS).

1. The very low numbers of Aboriginal and Torres Strait Islander children in the Territory means that the ACT Aboriginal and Torres Strait Islander coverage data should be read with caution. Given the small population, small changes can result in significant rate fluctuations.

Strategic objective 15: Maximising the quality of hospital services

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

Strategic indicator 15.1: 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

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

	2012–13 target	2012–13 result
Canberra Hospital	<1.0%	0.75%[1]
Calvary Public Hospital	0.5%	0.05%

1. The Canberra Hospital target is based on similar rates for peer hospitals—based on Australian Council on Healthcare Standards (ACHS).

Strategic indicator 15.2: The proportion of people separated from ACT public hospitals who are readmitted to hospital within 28 days of their separation due to complications of their condition (where the readmission was unforeseen at the time of separation)

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

	2012–13 target	2012–13 result
Canberra Hospital	<2.0%	1.30%
Calvary Public Hospital	1.0%	0.6%

Strategic indicator 15.3: The number of people admitted to hospitals per 10,000 occupied bed days who acquire a bacteraemial infection during their stay

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

	2012–13 target	2012–13 result
Canberra Hospital	< 7 per 10,000	6.7 per 10,000
Calvary Public Hospital	< 3 per 10,000	1.3 per 10,000

Strategic objective 16: High participation rate in the Cervical Screening Program

Strategic indicator 16: Two-year participation rate in the Cervical Screening Program.

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

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

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

Strategic objective 17: Improved Emergency Department timeliness

Strategic indicator 17: The proportion of Emergency Department presentations that are treated within clinically appropriate timeframes

	2012–13 target	2012–13 result
One (resuscitation, seen immediately)	100%	100%
Two (emergency, seen within 10 mins)	80%	74%
Three (urgent, seen within 30 mins)	75%	43%
Four (semi-urgent, seen within 60 mins)	70%	46%
Five (non-urgent, seen within 120 mins)	70%	79%
All presentations	70%	51%

Strategic objective 18: Improved breast screen participation rate for women aged 50 to 69 years

Strategic indicator 18: The proportion of women in the target age group (50 to 69 years) who have a breast screen in the 24 months prior to each counting period

	2012–13 target	2012–13 result
Proportion of women aged 50 to 69	60%	56%[1]

1. Breast Screen ACT has readily available appointments but is experiencing difficulty filling them. A number of initiatives are underway to raise the awareness and profile of the service, particularly within the target group of women aged 50 to 69.

Strategic objective 19: Achieve lower than the Australian average in the Decayed, Missing, or Filled Teeth (DMFT) Index

Strategic indicator 19: The mean number of teeth with dental decay, missing or filled teeth at ages 6 and 12

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

	Dental health—Decay, missing or filled teeth (DMFT)	ACT rate[1]	National rate
a	DMFT Index at 6 years	1.16	2.31
b	DMFT Index at 12 years	0.71	1.11

Source: Child Dental Health Survey, 2008 (published: Australian Institute of Health and Welfare, 2012).

1. Lowest of all jurisdictions.

Strategic objective 20: Reducing the risk of fractured femurs in ACT residents aged over 75 years

Strategic indicator 20: Reduction in the rate of broken hips (fractured neck of femur)

This provides an indication of the success of public and community health initiatives to prevent hip fractures. In 2011–12, the ACT rate of admissions in persons aged 75 years and over with a fractured neck of femur was 6.6 per 1,000 ACT population. This is slightly higher than the previous rate of 5.3 in 2010–11; however, the difference is not statistically significant. This is within the long-term target and follows the generally decreasing trend since 2001–02.

	2011–12 outcome	Long-term target
Rate per 1,000 people	6.6	5.3

The low numbers of patients included in this calculation means that the rate of broken hips in older persons should be read with caution. Given the small numbers, small changes can result in significant rate fluctuations.

Strategic objective 21: Reduction in the youth smoking rate

Strategic indicator 21: Percentage of persons aged 12 to 17 years who smoke regularly

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

	2011 outcome	National rate	Long-term target
Percentage of persons aged 12–17 who are current smokers	5.8%	6.7%	5%

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.

A.9 Analysis of Agency Performance

Strategy and Corporate overview

The branches within the directorate's Strategy and Corporate division undertake work in diverse arenas which cross all areas of ACT Health. These range across support for National Health Reforms and National Partnership Agreements, strategies for attraction and retention of the health workforce, and development and maintenance of critical physical and technological infrastructure for our hospitals and health services.

Highlights for this reporting period for Strategy and Corporate, which may not appear elsewhere in this report, are set out below.

Professional leadership

Pending finalisation of a review of the 2011 restructure, interim arrangements were put into place following the departure of previous incumbents of senior clinical leadership positions. ACT Health took the opportunity to amalgamate the Principal Medical Advisor role with that of the Executive Director, Medical Services, and the Chief Nurse role with that of the Executive Director, Nursing and Midwifery.

eHealth

The eHealth and Clinical Records Branch administers the ICT strategy within ACT Health and is responsible for the implementation of the technologies to support the $90 million ACT Health *Your health—Our priority* program of work entitled 'Health-e Futures'. In addition to the projects within Health-e Futures, managed under the three areas of Clinical Systems, Support Systems, and Digital Health Infrastructure, the branch was responsible for successful completion of the first public hospital connection to the national Personally Controlled Electronic Health Health Record (PCEHR) during the reporting period. Healthcare consumers who are admitted to the Canberra Hospital can now elect to have their discharge summary sent to their national eHealth record. With the ACT being the first jurisdiction to submit discharge summaries to the national eHealth record system, and ACT Health being the second healthcare organisation to achieve this milestone, ACT Health is leading the way for healthcare organisations across the country.

Locally, the rollout of the ACT Patient Administration System (ACTPAS) to the Calvary Hospital in 2012 laid the foundation for introduction at Calvary of a variety of proven clinical systems used by ACT Health. The use of common systems enhances the networking of services across the territory for the benefit of patients and clinicians alike. The Concerto Clinical Portal is one example. Designed to provide a single point of access for clinical information, the portal enables staff from both the Canberra Hospital and Calvary Hospital to view episode information, allergies, alerts, radiology and pathology results, and discharge summaries created within it. This will greatly improve access to timely information to assist with clinical decisions.

Similarly, Metavision, the Intensive Care Clinical Information System at the Canberra Hospital, enables staff to manage all clinical documentation electronically, integrates with the clinical modalities and provides them with a complete view of patient health information at the point of care. This recently implemented application at Calvary Hospital now provides a shared view of care for the Intensive Care Staff Specialists treating the patients.

Infrastructure

In addition to the completion of a number of major capital development projects (see section C.14 Capital works), branches across the directorate collaborated to deliver a variety of other projects for the benefit of consumers of our health services.

Duffy House

In October 2011, a house in Duffy was purchased to provide a home-away-from-home environment for regional cancer outpatients and their carers during treatment at Canberra Hospital, less than 10 kilometres away. The Australian Government provided $1.8 million for the property's purchase, extensive renovations, special furniture and equipment, landscaping and fit-out of the facility, which was opened to its first residents on 6 September 2012.

Youth Mental Health Step-Up, Step-Down residential service

In late 2012, a house in Kambah was purchased with funding support from the Council of Australian Governments (COAG) National Partnership Agreement on Improving Public Hospital Services to provide a Youth (18–25-year-olds) Mental Health Step-Up, Step-Down residential accommodation service. The service, which opened on 6 March 2013, operates under a partnership arrangement between the ACT Health clinical mental health service and the community mental health service provider, the Mental Illness Fellowship of Victoria. The six-bed residence offers 24-hour support seven days per week and provides additional clinical and psychosocial support for young people who either require transition between an acute admission to hospital and their home, or have a deteriorating mental illness and require treatment and support of a type that cannot readily be provided at home but which does not require a hospital admission. The service completes the continuum of sub-acute mental health care between the two existing step-up step-down services currently operating for the 13–17-year-old and 26–64-year-old age groups.

MyMeal

In the Business and Infrastructure branch, the Food Services section introduced MyMeal—a fully integrated food service management system to improve the quality and efficiency of ordering and delivery of meals to patients within the Canberra Hospital, thereby enhancing the patient's journey. The MyMeal system underpins Canberra Hospital's ability to order safe and nutritious meals and deliver them to the right patient at the right time, as well as assisting with the management of the 1.3 million patient, client and cafeteria meals produced by Food Services annually.

Local Health Network performance

In 2011, COAG agreed to the National Health Reform Agreement (NHRA) to address changing and growing health care needs, nationally and for the ACT. The agreement provided for substantial increases in Commonwealth funding for the ACT. Key components of the reforms were the establishment of Local Hospital Networks (LHNs), comprising small groups of public hospitals with a geographic or functional connection, and a National Health Funding Body to administer payments for hospital services between the Commonwealth and participating states and territories.

In March 2011 the ACT Legislative Assembly passed amendments to the *Health Act 1993* that provided for the establishment of the ACT LHN and a skill-based ACT LHN Council. In February 2013 the Assembly passed complementary legislation establishing the banking and financial infrastructure that enables funds to be made payable to the ACT by the Administrator of the National Health Funding Pool.

The ACT LHN consists of a networked system of service contracts between ACT Health and Canberra Hospital, Calvary Public Hospital, Clare Holland House and the Queen Elizabeth II Family Centre.

Throughout the reporting period, ACT Health's Performance and Information Branch and Policy and Government Relations Branch have continued to refine data analysis and reporting capability to support these new arrangements, as evidenced by quarterly reports provided to the ACT LHN Council.

The ACT Local Hospital Network Directorate financial and performance statements are provided as an annexure to this annual report at page 314.

Workforce

It was particularly pleasing during the reporting period to have finalised the ACT Health Workforce Plan 2013–18 and the Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013–2018.

The former forges local linkages with national initiatives by describing local workforce issues and actions under the rubric of the domains identified in Health Workforce Australia's National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015.

The latter responds directly to the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011–2015* and the *ACT Public Service Employment Strategy for Aboriginal and Torres Strait Islander People—Building a culturally diverse workforce 2010*.

Refinement and updating of our Learning and Development Framework and the Essential Education Policy has also strengthened the support provided to our workforce.

Canberra Hospital and Health Services overview

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

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

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

Significant achievements for CHHS over the past year include the completion of the new Centenary Hospital for Women and Children. Patients were moved into the new hospital in August 2012 and it was a significant milestone to move patients from the old area to the new area without incident. The move included moving babies from within the Neonatal Intensive Care Unit. This move was a carefully planned and considered process, which included communication strategies to ensure that the safety of the patients and staff was upheld as the highest priority.

The new Centenary Hospital for Women and Children features state-of-the-art equipment and infrastructure and is an impressive building, delivering high-level care to women, children and adolescents.

As part of the National Elective Surgery Targets (NEST), the ACT was required to remove 11,000 people from the surgical waiting list. The Canberra Hospital component of this target was 6,300 removals. The Canberra Hospital exceeded this target by delivering 6,464 removals from the list. This contributed to the ACT meeting the NEST targets. A report released by the Australian Institute of Health and Welfare shows that the ACT was the only jurisdiction to meet all three components of the national elective surgery targets. In addition, the Canberra Hospital is currently admitting 81 per cent of patients for surgery within standard waiting times. This is a 10 per cent improvement on the same period last year.

Activity throughout the Canberra Hospital has increased over the past year, which has increased pressure on both inpatient and outpatient areas. The Canberra Hospital Emergency Department had a total of 65,815 presentations over the 2012–13 financial year, an increase on the previous year. A number of initiatives have been put in place to help manage increasing levels of activity within the emergency department and across the hospital.

These include:

- ‘front loading’—whereby patients can be assessed and treated by a doctor more rapidly
- expansion of the Canberra Hospital Discharge Lounge, which enables patients to leave the inpatient wards earlier, which in turn opens up inpatient beds quicker, allowing for increased access
- purchasing beds at Monash Goodwin Village for sub-acute patients with an extended length of stay. This enables acute beds to be made available for patients who need to be in an acute setting.

Managing increased demand requires a whole-of-hospital approach. The hospital frequently operates at capacity and regularly deals with increases in activity. Work will continue over the next financial year to initiate a number of hospital-wide changes that will further improve patient flow.

Canberra Hospital and Health Services also opened the new Gungahlin Community Health Centre in September 2012. This progressive development provides a range of services to residents who live in or near Gungahlin. The centre offers access to community nursing, allied health services, including physiotherapy and podiatry, dental surgeries for children and youth, and a range of services for women and children including a women’s health nurse and nutrition clinic. The centre incorporates many environmentally sustainable design principles, such as energy-efficient lighting systems, fresh-air ventilation, air-cooled chillers (rather than water-cooled ones), cyclist facilities, and stormwater retention tanks beneath the surface-level car park, which capture water for irrigating the landscaped areas.

Another significant achievement for CHHS was our progress in reducing the public dental waiting list. In 2012–13 the federal Government allocated $345.9 million over three years to reduce the public dental waiting list across Australia. The funding has increased workforce capacity and increased utilisation of the private sector to reduce public dental waiting lists. At 30 June 2013, there were 165 people waiting for non-urgent restorative dental services, compared with 2,310 clients on the waiting list at 30 June 2012. At 30 June 2013, 2,447 clients were removed from the restorative waiting list, compared with 1,856 at 30 June 2012. This is an increase in clients being removed of 591 in 12 months—a significant achievement.

Canberra Hospital and Health Services is also under new leadership, following the appointment of Mr Ian Thompson in August 2012.

Output 1.1 Acute Services

Output description

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

This means focusing on:

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

Both Canberra Hospital and Calvary Public Hospital are part of the ACT Local Hospital Network. Section A9 reflects acute services delivered by the ACT Local Hospital Network.

Increasing the capacity of the ACT Public Health Services

More beds to manage increasing demand for hospital services

The Australian Institute of Health and Welfare (AIHW) reported that in 2011–12, ACT public hospitals provided an average of 939 beds. In 2012–13, an additional 47 beds were introduced, providing an estimated capacity of 986 beds.

The ACT Government has proposed funding for another 39 inpatient beds in 2013–14, including:

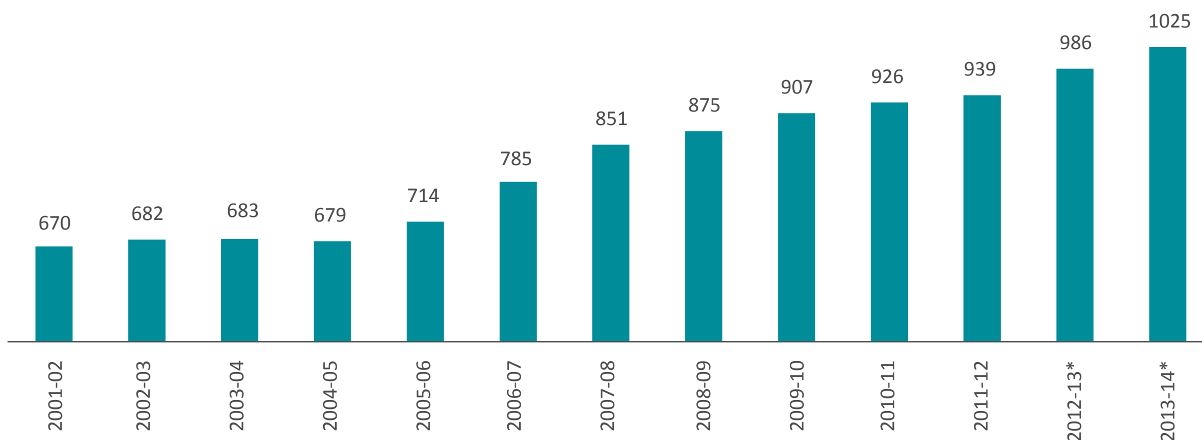
- 16 general inpatient beds at Canberra Hospital
- 15 general inpatient beds at Calvary Public Hospital
- an 8-bed Rapid Assessment and Planning Unit to be established at Calvary Public Hospital.

This equates to an extra 355 beds since 2001–02.

In addition there has been a considerable expansion to the Hospital in the Home service, with the addition of 15 bed equivalents in 2012–13.

ACT public hospitals

Bed capacity by year



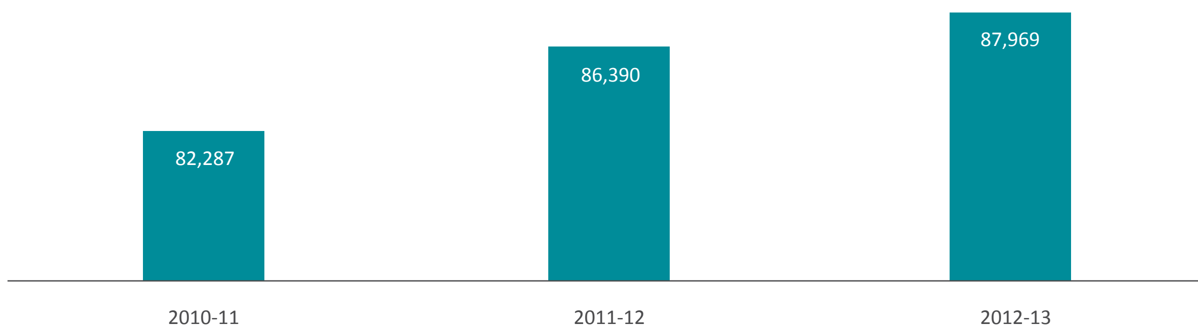
* 2012–13 and 2013–14 figures provides estimated impact of Government investment in additional capacity.
Source: Australian Hospital Statistics, AIHW, 2012–02 to 2011–2012 publications.

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

In 2012–13, the ACT's public hospitals provided 87,969 cost-weighted separations within Acute Care Services (which includes general hospital services and private hospital contracted patients but excludes hospital services provided by Mental Health ACT, the Capital Region Cancer Service and the Aged Care and Rehabilitation Service). This represents a 2 per cent increase in cost-weighted separations in 2012–13 compared with 2011–12.

ACT public hospitals

Inpatient Admitted Patient CWS
(Round 14 National DRG 6.0X)

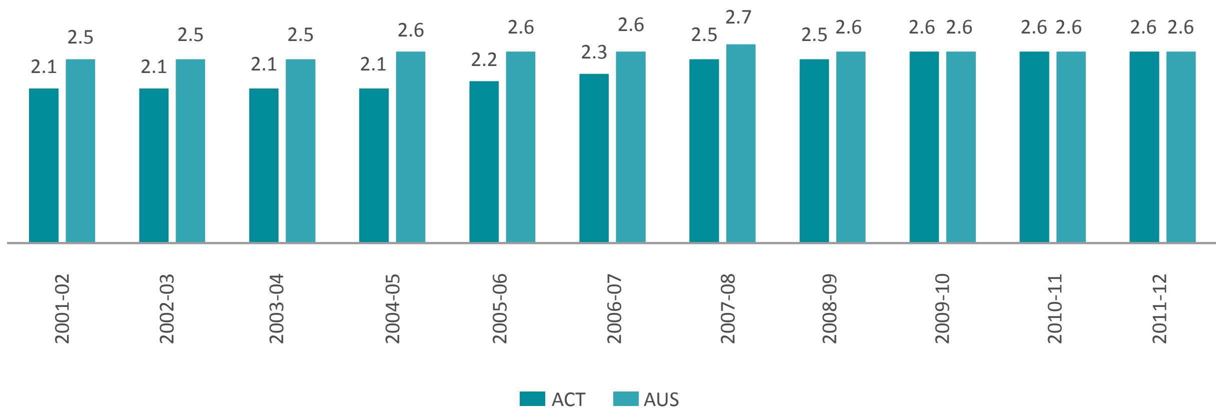


Source: Admitted patient care data set

In 2012–13, ACT's public hospitals provided over 277,988 overnight hospital bed days of care, 1 per cent up on the total of 274,851 in 2011–12. The *Australian Hospital Statistics Report* for 2011–12 issued by the AIHW in April 2013 showed that the ACT had achieved the national average in providing public hospital bed availability for the third time in the almost 21 years of reporting by the AIHW. ACT Health reached 2.6 public hospital beds per 1000 people—which is on par with the Australian national average.

ACT public hospitals

Available beds per 1,000 population ACT vs national

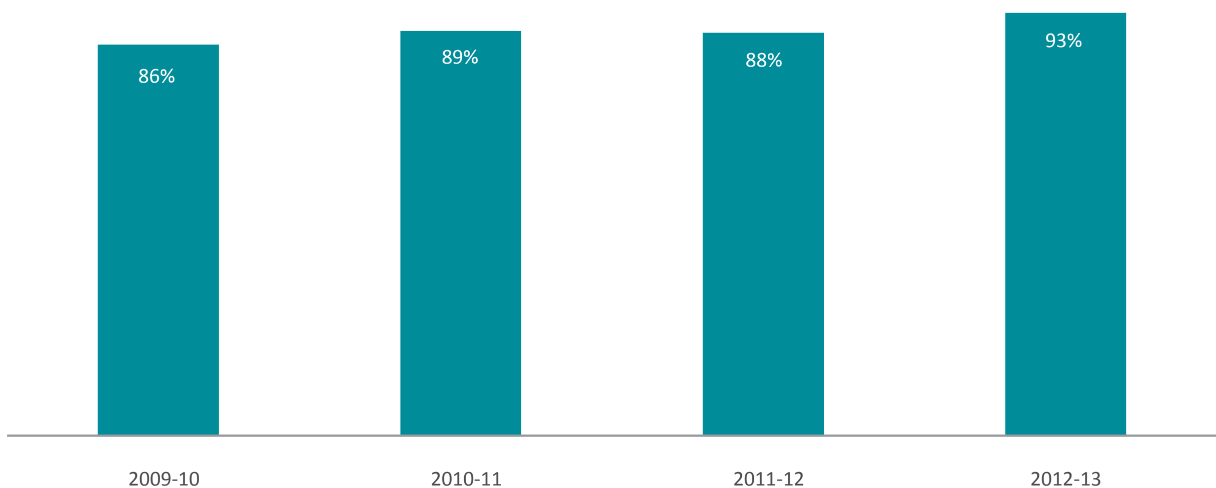


The bed occupancy rate for overnight adult medical and surgical beds in 2012–13 was 93 per cent. The Australian Government's long-term target is to maintain bed occupancy levels at around 85 per cent, which is considered the best level for best patient outcomes and to achieve maximum efficiency. However, with increasing pressure on ACT public hospitals each year, the target for this indicator in 2013–14 has been revised to 90 per cent. This will allow for the necessary infrastructure and process improvement to take effect which will make for more realistic transition for ACT public hospitals to achieve the 85 per cent in coming years.

The additional 39 beds funded in the 2013–14 budget should assist in reducing bed occupancy rates towards the 90 per cent target.

ACT public hospitals

Bed occupancy rate

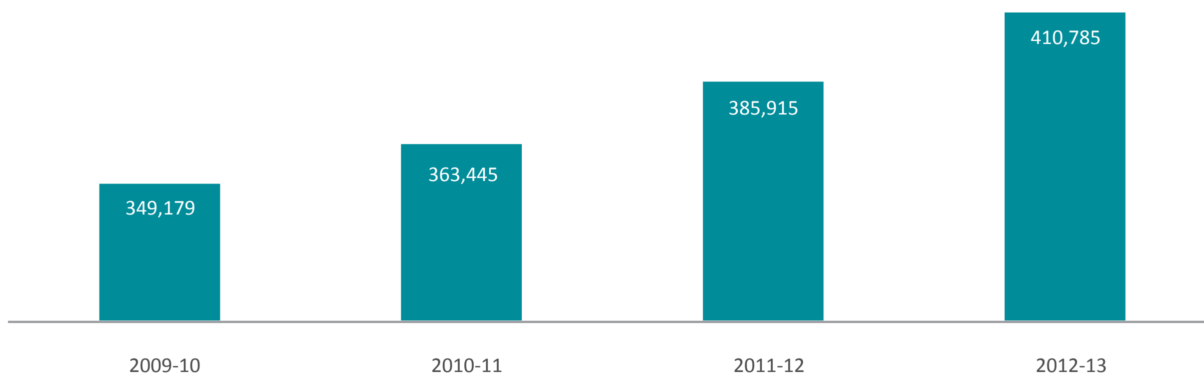


Outpatient Services redesign has been developed and implemented over the past two years, with the principal objectives being to review current business processes within the outpatient service and implement changes to improve efficiency, and to support access to services for consumers.

Over recent years, there have been significant increases in the demand for non-admitted outpatient services. In 2012–13, Outpatient Services experienced a 6 per cent growth in outpatient occasions of service compared with 2011–12. However, since 2009–10, demand for these services has grown by 18 per cent at both Canberra and Calvary hospitals. In response to this growth, resources have been committed to improve the function and processes of Outpatient Services.

ACT public hospitals

Non-admitted occasions of service



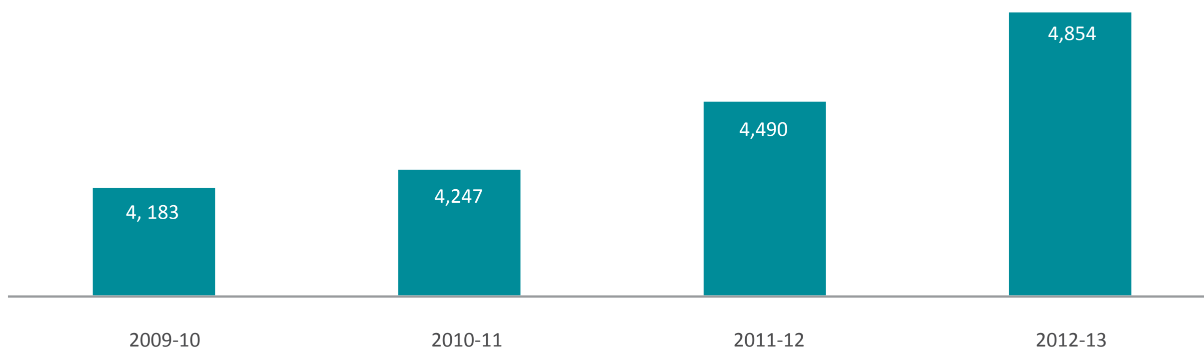
Source: Outpatient dataset

Births

ACT public hospitals have accommodated record numbers of births in 2012–13, with 4,854 births at Canberra and Calvary Hospitals, an 8 per cent increase on the 2011–12 result. The result of 4,854 births in 2012–13 also represents a 70 per cent growth (almost 2,000 additional births) in the number of ACT public hospital births since 2001–02.

ACT public hospitals

Births by year

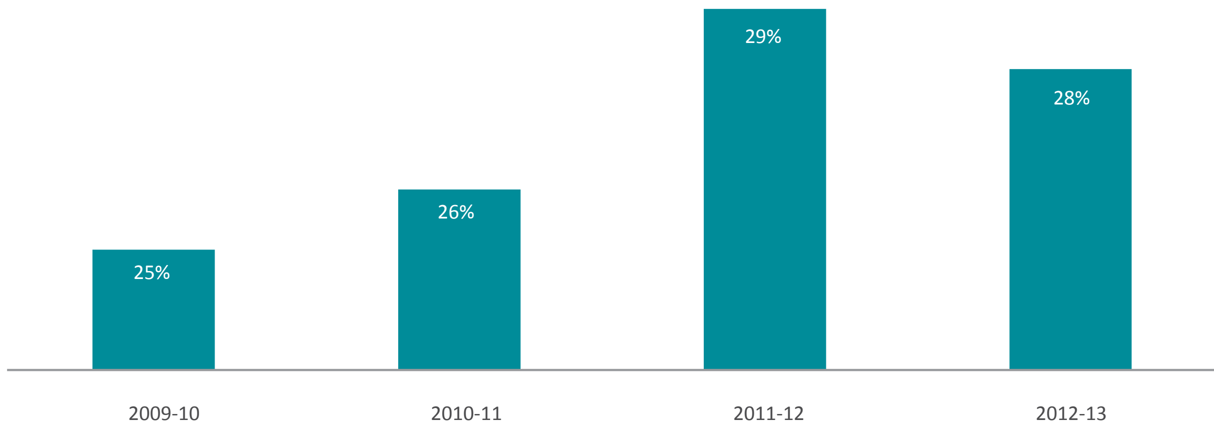


Source: Admitted patient care dataset

The number of births born by Caesarean section has reduced to 28 per cent of all births during 2012–13, down from the 29 per cent reported in 2011–12.

ACT public hospitals

Proportion of births that required a caesarean procedure



Source: Admitted patient care dataset

However, Caesarean rates have been steadily rising since 2001— both in the ACT and nationally. The ACT rate of 26 per cent in 2010–11 was lower than most recent national figures published by the AIHW, for 2007–08. ACT public hospitals continue to have a low Caesarean rate compared to benchmarking hospitals. The main strategy is to move towards further implementation of the 'continuity of maternity model of care' which has proven improved clinical outcomes for woman—such as reduced rate of Caesareans.

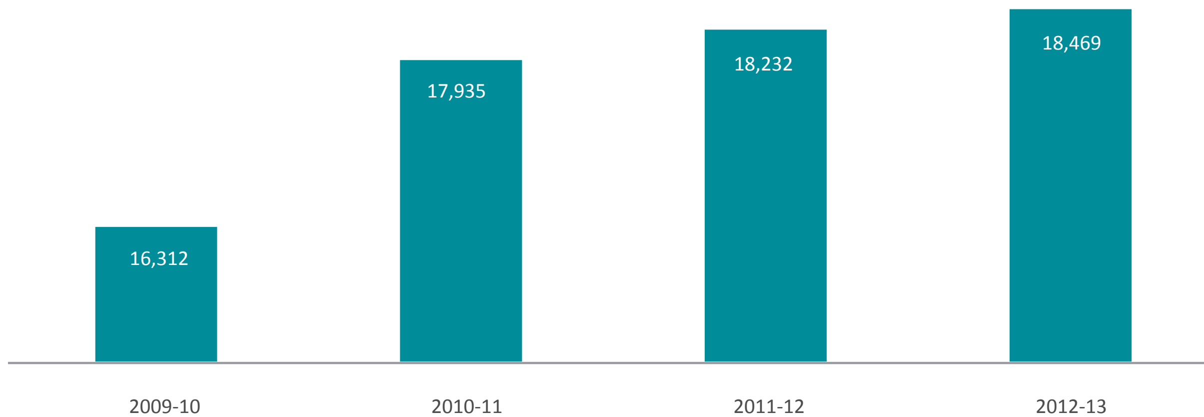
The ACT Government has also provided an additional $2 million in 2010–11 and $1.5 million in 2011–12 to enhance obstetric and gynaecological services and neonatal services. The Continuity at the Canberra Hospital (CatCH) Program began in 2011 as a second continuity-of-care model at the Canberra Hospital. In 2012–13, a Community Midwifery Program (CMP) at Calvary Public Hospital will be established to further enhance obstetric services at Calvary.

Operations in ACT public hospitals

Over the past three years, the number of surgical operations performed at ACT Health public hospitals has jumped by 13 per cent, from 16,312 in 2009–10 to 18,469 in 2012–13. Around 30 per cent of the emergency and elective surgical operations are performed on people from New South Wales.

ACT Public Hospitals

Total surgical operations performed (elective and emergency surgery)



Source: Admitted patient dataset

Access to elective surgery

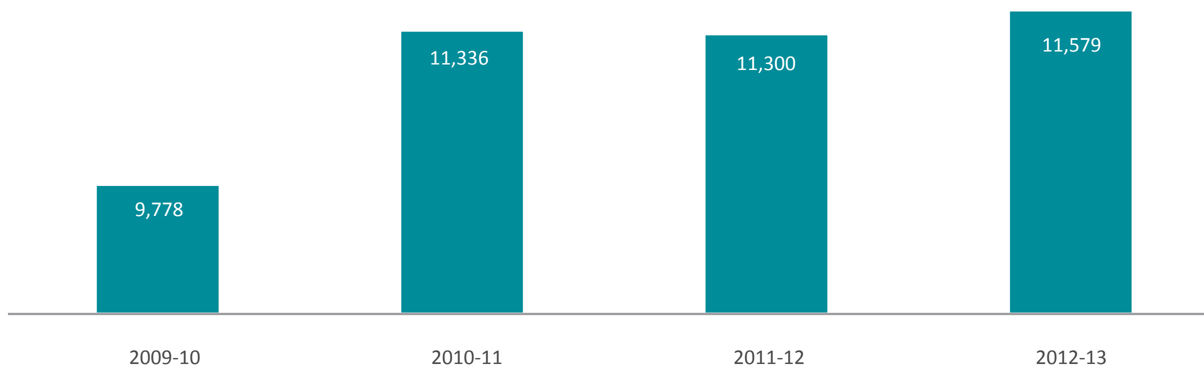
ACT public hospitals provided 11,579 elective surgery procedures in 2012–13. This is the highest number in a year of patients accessing elective surgery in the ACT. This is also the third consecutive year that ACT Health has provided for over 11,000 elective surgery procedures. The 2012–13 result of 11,579 is an 18 per cent increase over the figure of 9,778 in 2009–10.

This achievement was aided through utilising the private sector, and was part of the strategy to maintain the high level of throughput for elective surgery in the ACT—particularly in the specialties of ear, nose and throat surgery, urology surgery and orthopaedic surgery.

In 2010–11, approximately 171 patients accessed elective surgery under these arrangements. An additional 366 people accessed elective surgery under this agreement in 2011–12 and over 2012–13 a further 191 patients had elective surgery which makes a total of 761 patients since this initiative was first established.

ACT Public Hospitals

Number of elective surgery operations performed



Source: Elective surgery waiting list dataset

In addition to the work contracted by the private sector, the ACT Government and Southern New South Wales Local Health District have commenced utilisation of Queanbeyan Hospital to provide elective surgery capacity purchased by the ACT. In 2012–13, a total of 69 patients accessed elective surgery at Queanbeyan Hospital, covering urological and gynaecological procedures.

As a result of the increased access to elective surgery, the number of people waiting to access elective surgery has reduced to 3,943 people on the waiting list at 30 June 2013. This is a 1 per cent reduction compared with the same period last year, and a 26 per cent decrease compared with 2009–10.

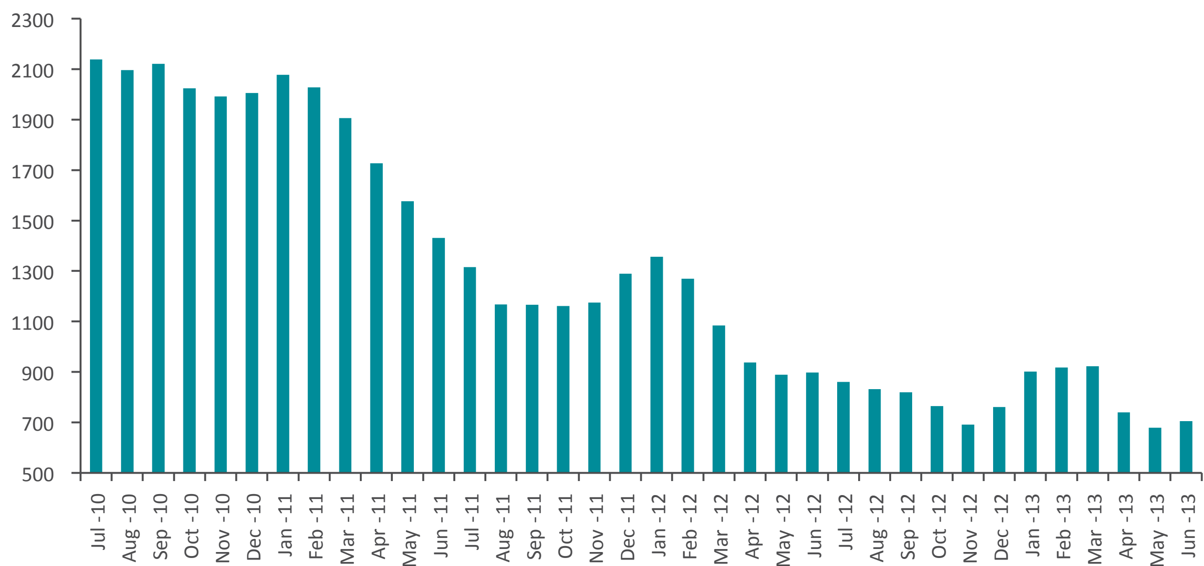
The increased access to elective surgery has also meant that the number of people waiting beyond the clinically recommended timeframes for their surgery has seen significant reductions, with a total of 705 patients waiting at 30 June 2013. This has resulted in a 21 per cent reduction in the number of overdue patients in just 12 months, and a 68 per cent reduction on the 2,220 reported for June 2010. While the result of 705 is pleasing, it is still too high. ACT Health's commitment to improving access to elective surgery will result in this number reducing in future reports.

The ACT Government will provide over $12 million over the next four years to meet the growing demand for surgical services in ACT public hospitals.

Number of people waiting against standard recommended waiting times by clinical urgency

ACT Public Hospitals

Reducing the number of patients waiting too long for elective surgery



Source: ACT elective surgerypublished dataset June 2013

Median waiting time to surgery for ACT public hospitals

ACT Health reports the median waiting time to access elective surgery. This ensures that any improvement or deterioration in the way the directorate manages the elective surgery waiting list is evident, so it can adjust management to improve access as required. The result of 51 days reported for 2012–13 is a vast improvement on the 77 days reported in 2010–11, which is evidence that this approach is paying off.

Urgency category	2009–10	2010–11	2011–12	2012–13
Category one	13 days	15 days	14 days	14 days
Category two	106 days	103 days	89 days	72 days
Category three	200 days	225 days	198 days	171 days
Median wait time all categories	73 days	77 days	64 days	51 days

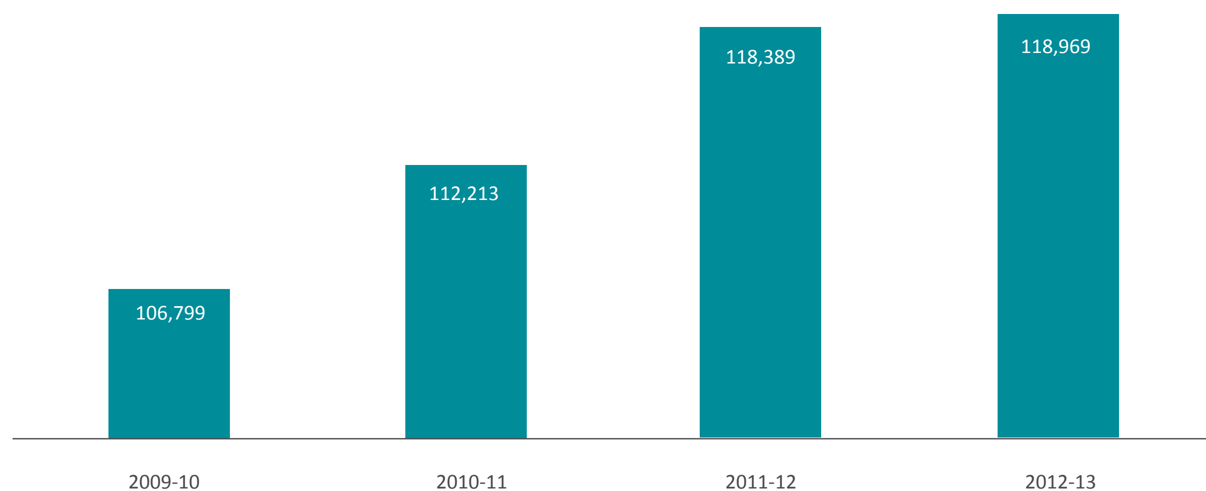
Access to acute services

ACT Health is committed to improving waiting times in ACT Health emergency department (ED) services and is working towards meeting the National Emergency Access Targets (NEAT).

In 2012–13, ACT Public Hospital EDs saw 118,969 presentations, an increase of 580 presentations, compared to 2011–12, and an 18 per cent increase compared with the same period four years ago. Admissions to hospital via the ED have also grown, with 31,206 admissions reported for 2012–13 compared to the 31,064 recorded in 2011–12.

ACT Public Hospitals

All presentations to the Emergency Department



Source: Emergency Department published dataset June 2013

Waiting times for emergency treatment

ACT public hospital EDs did not meet national targets for timely access to emergency care in three of the five triage categories. Presentations within triage categories one and five are currently meeting national targets.

Targets were not reached for triage category two, three or four presentations. While there has been growth in the number of presentations to the EDs, there has been a 12 per cent decrease in non-urgent category five presentations. This reflects a significant increase in higher acuity presentations and increasing pressure on ED resources and can restrict the ability to see and treat lower acuity presentations in a timely manner.

Triage category	2012–13 Target	2012–13 Result
One (resuscitation – seen immediately)	100%	100%
Two (emergency – seen within 10 mins)	80%	74%
Three (urgent – seen within 30 mins)	75%	43%
Four (semi – urgent – seen within 60 mins)	70%	46%
Five (non-urgent – seen within 120 mins)	70%	79%
All presentations	70%	51%

ACT Health ED staff are currently reviewing their processes, and working with their colleagues throughout the hospitals, to find ways of eliminate barriers that delay quick access to services and improve patient flow through the EDs.

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

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

The 2012–13 budget provides for an additional $12.7 million over the next four years to meet the growing demand for emergency care, including:

- an additional six treatment spaces at Calvary
- capital works at Canberra Hospital to expand the ED by six beds and to change the physical layout of the ED
- four cardiac assessment beds to provide rapid assessment for care for people who present to the ED with chest pain and associated cardiac issues
- an additional 47 inpatient beds across both public hospitals, which will allow for improved access to inpatient beds for patients in the ED.

The ACT Government has also committed additional funding from 2013–14 to provide for:

- expansion of Canberra Hospital’s Emergency Medicine Unit
- increasing the number of ED physicians at both Canberra Hospital and Calvary Public Hospital
- the establishment of a Rapid Assessment Unit at Calvary Public Hospital
- an additional 170 beds to the ACT public hospital system.

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

Australia's first Walk-in-Centre

The Walk-in-Centre (WiC), located on the campus of the Canberra Hospital at Garran, provides free treatment for people with minor illnesses or injuries. The WiC has been funded by the ACT and Australian governments.

The WiC is designed to help people get fast, free, one-off treatment for minor illnesses and injuries. The people of Canberra are able to see a specialist nurse for advice, assessment and treatment for conditions such as cuts and bruises, minor infections, strains, sprains, skin complaints, and coughs and colds.

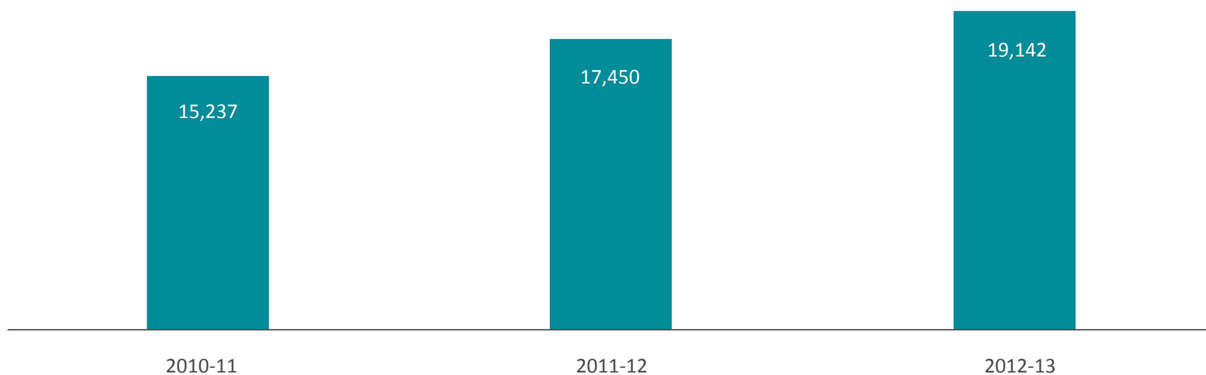
In 2011–12 an independent evaluation report confirmed the WiC model to be a safe and effective means of providing primary health care services. The report also highlighted the improved access to free, extended hours primary health care services.

ACT Health currently operates one WiC located on the campus of the Canberra Hospital. In 2012, the ACT Government made an election commitment to double the current budget for the WiC and expand the nurse-led WiCs to the community location in Belconnen and Tuggeranong. It is proposed that the two WiCs be located within the new Community Health Centres at Belconnen and Tuggeranong.

Work on the WiC within the Tuggeranong Health Centre refurbishment will occur in 2014.

Walk-in Centre

Total Presentations to the WiC



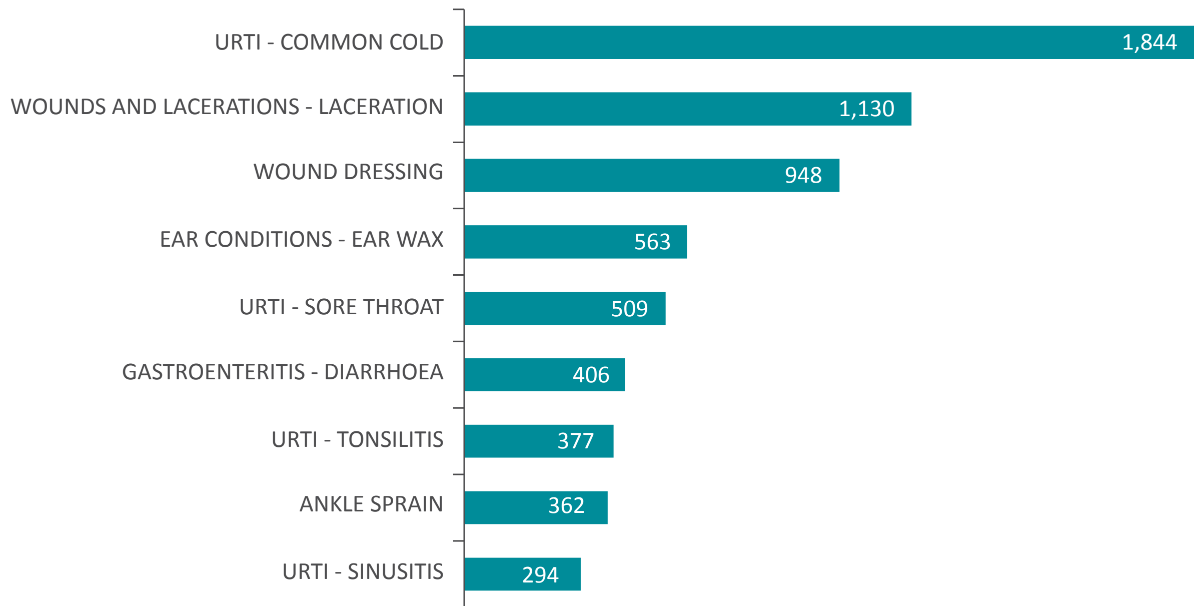
Source: WiC published dataset

Presentations to the WiC increased by 10 per cent in 2012–13 compared with 2011–12. This increase reflects the value that the service provides to the community.

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

Walk-in Centre

Top 10 conditions treated at the WiC

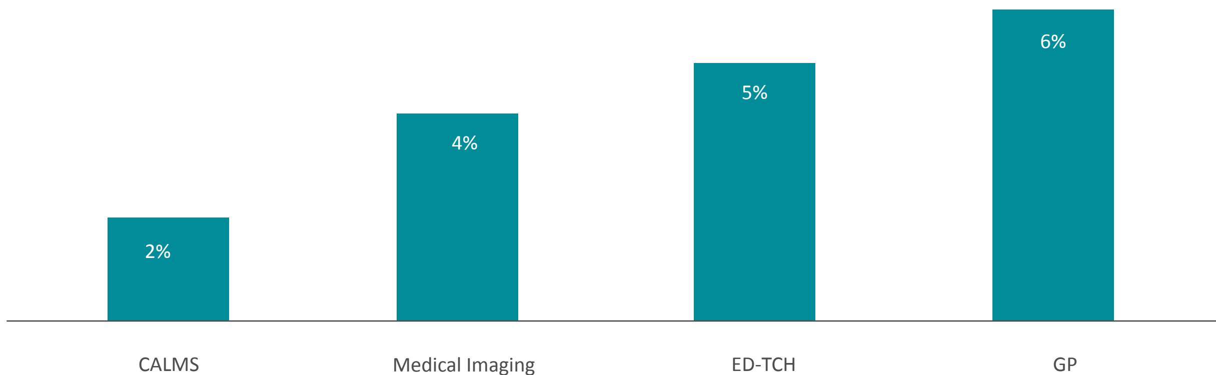


Note: URTI in above table is upper respiratory tract infection.

If necessary, people are redirected to more appropriate services, such as their GP or the ED. Of the 19,142 presentations in 2012–13, a total of 13,665 had a completed treatment episode by the nurse. A total of 6 per cent of patients assessed were subsequently redirected to their GP (compared with 18 per cent two years ago) and 5 per cent were told to present to the Canberra Hospital ED (on par with 2011–12).

Walk-in Centre

Patient redirections following assessment by nurse



Source: WiC published dataset

Note: CALMS in above table reflects Canberra After-hours Locum Medical Service. ED-TCH in above table reflects Emergency Department and Canberra Hospital. GP in above table reflects general practitioner.

The WiC does not provide ongoing care for patients and will not treat people with chronic conditions or children less than two years of age. These patients should seek treatment and advice from their GP or the ED.

The WiC is not designed to provide the range of services that a GP can provide, including comprehensive medical management, referral to specialist services or general health checks. The nurses who work in the WiC have all completed additional training and the care they provide is guided by established protocols that have been endorsed by the appropriate clinical approvals processes. A visit report is sent to the patient's general practitioner with consent.

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

The operation of the WiC was evaluated externally after its first year of operation. ACT Health is responding to aspects of the WiC review that will enhance its efficiency, such as staffing profile and hours of operation, as well as effectiveness of service delivery. Patient attendances have increased consistently since the WiC opened and consumer feedback remains positive.

National Partnership Agreement on Improving Public Hospital Services

The Commonwealth will deliver an additional $67 million to the ACT under the National Partnership Agreement on Improving Public Hospital Services for ED, elective surgery and sub-acute services. This agreement commenced on 1 January 2012.

National Emergency Access Targets

The main objective of National Emergency Access Targets (NEAT) is that 90 per cent of all patients presenting to a public hospital ED will be admitted, transferred or discharged within four hours. The targets will be staged in increments over the next 4 years to achieve the final target of 90 per cent. The first target was to be achieved by December 2012, with the target set at 64 per cent.

In the 2012 calendar year (January 2012 to December 2012), ACT public hospitals reported 57 per cent of all patients had a length of stay less than four hours. This was 7 per cent below the target of 64 per cent. National reports on jurisdictional performance against NEAT targets showed that Western Australia was the only jurisdiction to meet their 2012 target.

In the calendar year to end June 2013 (January 2013 to June 2013), ACT public hospitals have seen some improvement in NEAT performance, with a result of 58 per cent, against a target for the end of 2013 of 65 per cent. ACT Health expects further improvements in the future with:

- increased investment in infrastructure, including an additional 170 beds over the next four years
- physical redesigns of ED.

At the same time, both public hospitals are undergoing continual redesign and process improvement initiatives to improve the way patients move into, through and out of the EDs.

National Elective Surgery Targets

There are three components to the National Elective Surgery Targets (NEST). These are aimed at ensuring timely access to surgery whilst reducing the number of patients waiting beyond clinically recommended timeframes. The final targets for all components of the NEST are to be met by December 2016; the first set of targets was to be achieved by December 2012.

In the 2012 calendar year (January 2012 to December 2012) ACT Health was successful in meeting all three components of the NEST. On 27 February 2013, the AIHW released its first annual report on jurisdictional performance against emergency access and elective surgery targets. The report shows that the ACT was the only jurisdiction to successfully meet all three components of the NEST.

Part 1 of the NEST refers to the proportion of patients who access their elective surgery procedure within clinically recommended timeframes. In the calendar year to June 2013 (January 2013 to June 2013), ACT public hospitals achieved the required targets for category one and three patients accessing their surgery on time. Category two patients did not meet the target reporting a result of 57 per cent of category two patients accessing surgery on time against a target of 66 per cent. Recent monthly results have seen an improvement, and work is ongoing to improve this result for future months.

Part 2A of the NEST is based on the requirement to reduce the average overdue waiting times for each category of patients so that there are no overdue patients by the conclusion of the agreement. In the calendar year to end June 2013 (January 2013 to June 2013), ACT public hospitals were on track to meet the required targets for urgency category one, two and three patients.

Part 2B of the NEST is related to the removal of the top 10 per cent of longest waiting patients on the elective surgery waiting list. The Australian Government has issued ACT Health with the 2013 cohort of long-wait patients to have their surgery in 2013. In the calendar year to end June 2013 (January 2013 to June 2013), ACT public hospitals removed 76 per cent of the longest waiting patients from the list established at 31 December 2012, and remained on track to meet the end of 2013 target.

Sub-acute care reform

The sub-acute component is aimed at improving patient health outcomes, functional capacity and quality of life by increasing access to sub-acute care services including rehabilitation, palliative care, sub-acute mental health and geriatric evaluation and management, and psycho-geriatric services in both hospitals and the community.

The ACT was required to build capacity for 11 sub-acute bed equivalents before 1 July 2012. Due to a lack of appropriate tender applications in relation to the ACT's sub-acute projects, the ACT added 6.9 bed equivalents to the system at the end of June 2012.

However, to facilitate the process, ACT Health established a National Health Reform Steering Committee. This committee has worked on alternative models to attract additional service providers, as well as contingency plans in relation to this project. Over the 12 months of 2012–13, the planning into growth for sub-acute care services has paid off. The ACT has now delivered over 22 sub-acute bed equivalents into the system, above the June 2013 target of 16 bed equivalents. There is no financial reward or penalty associated with this target.

Division of Critical Care

The Division of Critical Care was formed following the restructure of ACT Health in February 2011. The division is responsible for the delivery of acute and critical care and retrieval services. These are provided as inpatient and outpatient services at the Canberra Hospital, with a strong emphasis on accessible and timely care, delivered to a high standard of safety and quality. This is underpinned by the division's commitments to research and training. The division includes the Retrieval Service (both road and air), Emergency Department (ED), Intensive Care Unit (ICU), Access Unit, Surgical Short Stay Unit, Medical Assessment and Planning Unit (MAPU), and Surgical Assessment and Planning Unit.

Achievements

- ED nursing introduced a Mentor Matrix in 2012 to ensure that all nursing staff have support for feedback, goal setting and recognition of achievements. Since its implementation, there has been 100% per cent compliance with learning and achievement plans.
- The Medical Education Team collaborated in a cross-border learning initiative to develop and introduce an education website (***www.canberraemergency.com.au***). This is available to all ED nursing, medical and allied health staff and has quickly become an excellent communication and education tool.
- ED Nursing Education Team arranged for Queanbeyan Emergency Staff to attend triage and resuscitation training workshops at Canberra Hospital.
- In September 2012, four additional ED treatment spaces were created. These are used to treat ambulatory patients with non-complex problems. The additional beds support the capacity requirements for the ED to provide quality, safe care and assist with meeting activity targets.
- The Optimal Capacity Escalation Plan was introduced to manage the unpredictable nature of the ED clinical volume and acuity through the implementation of efficient changes in bed management processes to maintain patient safety, including the forecasting of clinical workloads to assist in predicting future requirements for inpatient beds.
- A targeted education plan saw a significant improvement in the compliance rate with police blood testing requirements.

- The ED, in conjunction with Rehabilitation, Aged and Community Care, ran a Delirium Project to screen all patients older than 85 years presenting to the ED. The project achieved a greater understanding of the treatment of patients with a delirium diagnosis within an extremely busy ED and has improved the working relationship between the two departments.
- In November 2012, an additional two high-dependency beds were commissioned in the Intensive Care Unit. These have increased available capacity to 24 beds, expanding the ability of the Intensive Care Unit to optimally accept and treat 12 intensive care and eight high-dependency patients at any given time.
- A territory-wide approach to clinical leadership training for nursing and medical staff, with multiple leadership training opportunities, was implemented.
- A cascading mentorship structure was implemented in ICU to ensure all nursing staff participate in regular performance and feedback discussions, goal setting and recognition of achievements.
- The Medical Emergency Team (MET), in collaboration with the Deteriorating Patient Team, won the Quality Award for Care and Response Escalation (CARE) for patient safety and was a national finalist in the National Lead Clinicians Group Awards for Excellence in Innovative Implementation of Clinical Guidelines in 2013.
- A Volunteer Program was successfully introduced into the ICU waiting room to improve communication, support for families and orientation to the environment.
- On completion of her PhD, the Clinical Director of the ICU, Associate Professor Imogen Mitchell, received a Harkness Scholarship for Health and Policy Practice at Johns Hopkins Hospital in the United States.
- Associate Professor Frank Van Haren was appointed State Medical Director, DonateLife.
- Ms Jenny Rochow, ICU Nurse Unit Manager, received the Defence Reserves Support Council Employer Support Award.
- The relocation of the Discharge Lounge to level 2 of Building 1 has provided additional capacity, improved access to support services such as Pharmacy and made pick-up easier for relatives and transport services.
- The Access Unit received an Australia Day Team Achievement Award for the commitment and ability of staff to strive for excellence in service delivery in our health service system.

Issues and challenges

- While the National Emergency Access Targets remain a challenge, senior ED staff continue to develop initiatives directed at internal departmental issues, with a view to achieving triage targets for all categories and streamlining the discharge pathway.
- ED and ICU continue to experience challenges associated with the increasing numbers of unplanned admissions after hours.
- MET is working with the Staff Development Unit to implement a more comprehensive advanced life support training program to meet the learning needs of multiple tiers of staff and provide opportunities to meet the demands of concurrent MET calls.

Future directions

- The Division of Critical Care is working collaboratively with all hospital divisions to develop an ACT Health Winter Bed Strategy for the safety and isolation of patients during the flu season.
- The Division of Critical Care is working collaboratively with the Division of Women, Youth and Children to develop the Paediatric Short Stay Unit to enable paediatric patients to be admitted more quickly.
- Six new beds opened in the Medical Assessment and Planning Unit (MAPU) in September 2012 have been allocated to provide capacity for the Medical Short Stay Ward (MSS). This initiative is directed at expediting the flow of patients with an undifferentiated medical condition from the ED to an inpatient area for further assessment and management, leading to improved patient care and safety, and efficiencies of service.
- The Division of Critical Care is working collaboratively with the Division of Medicine to develop the MSS model and undertaking ongoing work to provide timely admission for patients.
- The ACT Government has committed funds to establish a dedicated Paediatric Stream for children in the Canberra Hospital ED to provide an overall increase in treatment spaces.

- A large Infection Control Quality Improvement Project in collaboration with the Infection Control Team is under way to reduce rates of infection in the ICU. A monthly scorecard, hand hygiene audits, environmental improvements and a comprehensive education strategy form part of the project to improve patient outcomes by reducing the transmission of infections between patients.
- An eight-bedroom MediHostel at the Canberra Hospital is on track to become operational in 2013. The MediHostel will provide high-quality, non-ward, hotel-style accommodation with nursing supervision to eligible consumers prior to or following their episode of acute care.
- In 2013, the Access Unit has expanded operational hours to provide seven-day cover, until 11 pm. The extended hours have enhanced service delivery, continuity, coordination and monitoring through a centralised point of contact for all patient flow activity.
- The Access Unit After-Hours Hospital Management Service was the beneficiary of a 2013 Practice Development Scholarship Award, which will provide resources for a review of its services. It is envisaged that the review will identify opportunities aimed at making resource efficiencies and implementing quality improvement initiatives.
- The University of Technology Sydney has engaged in a partnership project with ACT Health Ward 7B to undertake a study titled 'Effective clinical handover communication: improving patient safety, experiences and outcomes'. This innovative study project is due for completion in 2014 and aims to improve the safety of clinical handover practices, thereby reducing the number of adverse events.

Division of Medicine

The Division of Medicine provides a wide range of adult medicine services to the Canberra community in inpatient, outpatient and outreach settings. It also provides chronic disease management, infection control and pharmacy services. A strong emphasis is placed on accessible, timely and integrated care delivered to a high standard of safety and quality.

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

Many units of the division work actively with community groups, other services and the private sector to improve the care of patients across the whole health system. Consumer representatives play a crucial role on our internal advisory committees.

In the coming year, the division's services will expand to include more inpatient beds and an increase in Hospital in the Home provision. We will continue to develop innovative ways to provide the care that people need and ensure our patients have access to leading edge medical treatment. Over the next year, an emphasis will be placed on the care of acute medical admissions to Canberra Hospital and Health Services, including models of prevention of admission and the streamlining of discharge to appropriate services in the community with the further development of the Acute General Medicine Service.

Achievements

Endocrinology and Diabetes services

In 2012–13, the ACT Health Diabetes Service made progress in restructuring and expanding its service to meet existing needs and the expected growth in service requirements due to increasing diabetes prevalence. The restructure was directed at improving the quality and efficiency of care to children, youth, pregnant women and adults in the ambulatory and acute care settings. The restructure included the following:

- establishing the ACT Health Diabetes Service Clinical Advisory to provide strategic direction and clinical governance
- establishing clinical teams in each of the service areas
- increasing the focus and development of clinical services to adolescents and young adults with diabetes
- addressing deficiencies in service levels for people with diabetes on the north side of the ACT.

The expansion of the ACT Health Diabetes Service involved the recruitment of three new part-time endocrinologists and a part-time social worker. At the Canberra Hospital, the Diabetes Service was enhanced by the opening of two new specialist medical consulting rooms and a second podiatry room.

A northside ACT Diabetes Service Working Group (including consumer representation) was established to inform the development of an enhanced collaborative approach to diabetes prevention and care across all health care sectors for the community living on the north side of the ACT.

The ACT Health Diabetes Service commenced clinical services at the Gungahlin Community Health Centre in November 2012. Services for women are being strengthened on the northside with the establishment of a new clinic for women with gestational diabetes.

The ACT Health Diabetes Service increased its support to the Winnunga Aboriginal Health Service with the establishment of an endocrinologist clinic at Winnunga to support the existing nursing, nutrition and podiatry diabetes service.

A Service Funding Agreement was established with the ACT Medicare Local for the Diabetes Link Project to improve the collaborative links between the primary care sector and the ACT Health Diabetes Service and foster a best practice care approach for all people with diabetes in the ACT. A project coordinator for the Diabetes Link Project was identified and will commence in mid-2013.

Cardiology Services

Procurement is underway for the purchase of a replacement state-of-the-art cardiac catheter laboratory. In addition, approval has been granted to purchase two echocardiography machines and the tender process is currently underway. The first stage of the integrated IT system has just been rolled out. This stage will provide an improved archiving process and ultimately a more secure reporting of echocardiography and better access to echocardiography results. This is the first step in a major upgrade. The recruitment process for a cardiologist specialising in echocardiography is underway to support this growing service. This is a key position that will assist with the upgrade of Canberra Hospital's echocardiography services.

The Cardiology Department commenced the Chest Pain Evaluation Unit in April 2013. A large portion of patients attending the Emergency Department (ED) present with chest pain. Patients that are identified as requiring access to the Cardiac Catheter Laboratory for intervention are processed directly to the Cardiac Catheter Laboratory (CCL); however, those not requiring the CCL are transferred out of the ED in a more timely way. This process will allow for concentrated management and facilitation of investigation of these patients and therefore decrease times in ED.

Renal Services

The Renal Electronic Medical Record project is now operational and its use has steadily increased in all areas of the service. This project has improved renal service delivery by reducing duplication of data entry and improving communication between geographical sites and integration with other Health Directorate applications. Having a holistic view of patient data across the Renal Service allows for quality improvement in patient outcomes and will assist in further clinical research. The Renal Electronic Medical Record was launched in 2012 and has been rolled out to all dialysis units in the ACT and southern New South Wales.

A renal network covering the ACT and Southern New South Wales Local Health District was established. Under this agreement, the Renal Service is providing governance to all dialysis centres in the Southern New South Wales Local Health District, including those in Queanbeyan, Goulburn, Moruya and Bega. The Renal Service is providing outreach clinics to Goulburn, Moruya, Batemans Bay, Bega and Cooma and overseeing quality assurance across the area.

A further achievement for renal services in 2012–13 was the completion of the self-care training facility at Gaunt Place and the Weston Self-Care Unit, established for those patients who are unable to dialyse at home.

Chronic Disease Management

Chronic Disease Management (CDM) is a multidisciplinary team within the Division of Medicine of Canberra Hospital and Health Services. CDM focuses on improving the management of patients with chronic disease, particularly chronic obstructive pulmonary disease (COPD), chronic heart failure (CHF), Parkinson's Disease and obesity.

Achievements for 2012–13 include the following:

- Due to increased service demand, a new approach to managing patients in the Care Coordination Service was implemented, leading to significantly increased productivity.
- The Chronic Disease Management Register (CDMR) was used to support research projects and generate multiple patient identification reports. In collaboration with the ACT Medicare Local, a pilot study was developed to test joint care planning between the Chronic Care Program of the CDMU and the primary health care sector.
- There was an increased uptake of advanced care planning (ACP) in the Chronic Care Program, with around half of case coordination patients having an ACP by June 2013.

Neurology services

The number of admissions to the Stroke Unit continues to rise each year, but this year the rise was offset by the creation of a Transient Ischaemic Attack (TIA) clinic, which allowed appropriate urgent neurology patients to be seen on an outpatient basis.

In addition to the TIA clinics, there was an expansion of capacity to meet demand for neurology outpatients, with increased registrar input into clinics.

With the appointment of a third neurophysiology technician, the waiting time for an electro-encephalogram (EEG) was reduced in the past year, from eight months to less than a month.

Clinical Forensic Medical Services

Clinical Forensic Medical Services (CFMS) is the overarching service combining two services, Forensic and Medical Sexual Assault Care (FAMSAC), funded under ACT Health, and Clinical Forensics ACT (CFACT), funded under a tendered contractual arrangement between ACT Health and the Australian Federal Police (AFP).

CFMS continued to expand CFACT services, meeting increased demand in response to AFP requirements. This included: the successful introduction of a seven-day-a-week nursing service to triage and attend consultations within scope of practice; increased medical expert reporting requirements for the ACT Coroner's Office; and complex reporting to police requesting medical information and toxicology reports in relation to driving under the influence. Adding to this was a recently signed agreement with New South Wales allowing CFMS to provide medical forensic services to the New South Wales Police in the Monaro Local Area Command.

FAMSAC continued to provide care to victims of sexual assault in the ACT and surrounding New South Wales. FAMSAC also offers a service for injury documentation for victims of domestic violence. CFMS nursing staff commenced a service in 2013 to provide a weekly clinic within the drug and alcohol service for the purpose of blood-borne virus screening.

Pharmacy Services

A key indicator for pharmacy is the waiting time for discharge prescription processing. In 2012–13 the average wait time from receipt of the medication order to distribution of the medication order was less than 45 minutes. A significant recognition in allied health was attributed to the Pharmacy Department. Jessica Parker was the recipient of the 2012 Allied Health Award for Excellence and won the 2012 Allied Health Professional of the Year award.

Closed System Transfer Devices (CSTD) were fully implemented in chemotherapy production, enhancing safety for staff in the pharmacy and on the wards.

A number of medication safety initiatives and continuous quality improvement activities were undertaken, including:

- The Australian Commission on Safety and Quality in Healthcare recommended a pilot of a venous thromboembolism (VTE) prophylaxis section in the National Inpatient Medication Chart (NIMC). This pilot provided strong support for the inclusion of a VTE prophylaxis section in the NIMC, a major enhancement to patient safety.
- A drug library was introduced to the new B. Braun Smart Infusion Pumps, which ensures that all intravenous drugs are administered in the safest possible manner.

- The Director of the Pharmacy Department was the joint clinical lead for the Medication Safety Standard of the National Safety and Quality Health Service Standards and oversaw work to meet national standards for medication safety.

The Pharmacy Department of the Canberra Hospital participated in a national pharmaceutical spending benchmarking exercise. Despite being a small jurisdiction, the ACT has excellent purchasing processes, ensuring that resources are maximised.

Gastroenterology and hepatology

The Gastroenterology and Hepatology Unit at Canberra Hospital provides services to patients in the ACT and surrounding region in all areas of gastrointestinal diseases, with particular focus on inflammatory bowel diseases, gastrointestinal cancer, chronic hepatitis, chronic liver disease and gastrointestinal endoscopy. The unit has well-developed multidisciplinary teams, including consultant medical staff, senior registrars and nursing staff with special expertise.

In 2012–13, the unit commissioned a third endoscopy room and commissioned new technology, the Transient Elastography (FibroScan), to assist in the detection and staging of liver disease and to reduce reliance on liver biopsies. In 2012–13, additional medical, nursing and administrative staff were appointed on receipt of budget enhancement for the unit.

In 2012–13, staff of the unit performed 4,832 endoscopy procedures (elective and acute), the highest number of endoscopies ever recorded and an increase of 9.4 per cent from last year. There were 7,040 outpatient attendances, an increase of 9.8 per cent over 2011–12. The unit provided many other services, including inpatient care and day-only admissions. It also provided services and information sessions in the community and at the Alexander Maconochie Centre.

Hospital in the Home

In 2012–13, funding for Hospital in the Home (HITH) was increased. This was used to recruit nursing staff, including a nurse dedicated to identifying and assessing potential referrals in a timely manner. New arrangements were put in place whereby GPs can directly contact the HITH Registrar about a patient they are seeing in their rooms before sending them into HITH for assessment for admission, without patients needing to attend the Emergency Department.

Respiratory and Sleep Service

The Respiratory and Sleep Service is available to patients in the ACT and surrounding areas of New South Wales, with an occasional referral from Victoria. It provides care in all areas of respiratory and sleep medicine—and in particular supports the Tuberculosis Service of the ACT and surrounding New South Wales—including asthma, COPD (chronic obstructive pulmonary disease), interstitial lung disease and cystic fibrosis.

The Respiratory and Sleep Service supports the management of lung cancer and in particular has special weekly urgent clinics set aside. In addition, the service conducts joint meetings with thoracic surgeons, medical staff and radiation oncologists to facilitate the management of lung cancers. These meetings are held weekly.

The services provided have increased over the past few years and will continue to do so, particularly in relation to consultations for both inpatients, outpatients and bronchoscopies.

General/Acute Medicine

Work commenced in 2011–12 to develop a model for a general/acute medicine service as part of a redesign exercise. Funding in 2012–13 was utilised to implement an acute general medicine model with the advent of the Medical Short Stay (MSS) Unit. This service facilitates early identification and management of patients who are identified as requiring admission to medicine beds in the hospital from the Emergency Department. It is staffed by nursing and medical staff to better manage patients with multiple complex conditions who present to the hospital for care.

Issues and challenges

Issues and challenges for the Division of Medicine include:

- further integrating services across the Territory, such as the Stroke Unit, Renal Services and Cardiology Services, including Chronic Disease Management
- meeting patient demand for endoscopy
- facilitating prevention of hospital admission and promoting seamless discharge.

Future directions

Endocrinology and Diabetes services

Services will be represented on the northside with the opening of the Belconnen Community Health Centre in 2013. The Diabetes Service will be further enhanced on the northside with the establishment of a new Vision Screening Program.

In 2013–14, programs to enhance engagement between ACT Health Diabetes Service and primary care services will be developed with assistance from the ACT Medicare Local, and improved referral patterns, joint professional education and staff development programs will be established.

The ACT Health Diabetes Service has established collaboration with ACT health units involved in the care of patients with acute diabetes-related foot complications. A multidisciplinary high-risk foot collaboration clinic will commence in July 2013 at the Canberra Hospital.

ACT Health is working towards the establishment of a Public Obesity Management Service and is improving clinical data collection in relation to weight and height. In 2013–14, this service will work closely with general practitioners and community organisations, as well as other specialist services that care for these people. These hospital-based services include Diabetes, Cardiology, Respiratory and Chronic Care programs.

Neurology services

The development of a Stroke Network, inclusive of a Stroke Unit, planned for Calvary Health Care will greatly contribute to the management of these patients across the Territory.

Pharmacy

The Pharmacy Business Plan for 2013–14 aims to build on past successes and address upcoming challenges—namely:

- to improve clinical pharmacy services, such as the establishment of specialised pharmacist positions, the creation of a ward-based technician service and an increase in the number of clinical pharmacists
- to provide further education for the pharmacy workforce, such as TAFE certificate training for technicians and the internal People Manager Program for all senior staff.

Gastroenterology and Hepatology

Waiting lists for both endoscopy and outpatient services continue to grow but have been addressed by the recruitment of additional medical, nursing and administrative staff and effective leave management for medical staff. The planned refurbishment of the unit will also enable more patients to be seen in 2013–14. The unit plans to commence endoscopic ultrasound to enhance the diagnosis and treatment of gastrointestinal cancer.

Hospital in the Home

HITH is working on the development of a protocol with the Chronic Care Program for the respiratory service to identify patients in the community who are acutely deteriorating and who may benefit from a pre-emptive stay in HITH, potentially avoiding an admission to hospital. In the second half of 2013, the introduction of a dedicated pharmacist to HITH will assist with the increasingly complex and numerous medications being utilised both by patients in their homes and by those receiving treatment as day-only patients.

General/Acute Medicine

The training program for General Medicine was accredited by the Royal Australasian College of Physicians, and a team of registrars, including an Admitting Registrar for Medicine (ARM), was recruited to support this service. The service will enhance services already provided by the Medical Assessment and Planning Unit (MAPU). A multispecialty consultant team will be further developed in 2013–14 to better manage this cohort of patients and facilitate education of physician trainees in General Medicine and subspecialties.

Division of Pathology

The Division of Pathology provides specialist pathology services to the medical practitioners of the ACT and surrounding region. This includes pathology testing while patients are in hospital and when they return to their homes.

Services are provided in the acute setting at Canberra and Calvary hospitals and the National Capital Private Hospital and in the community through collection centres across the ACT. A home collection service for patients who are frail or unwell and who cannot attend these collection centres is also provided.

Analysis of collected samples is undertaken at the two laboratories in the ACT. The main laboratory is located at the Canberra Hospital and a branch laboratory is located at Calvary Hospital.

Pathology is a medical specialty looking at disease processes and their cause. Body tissue, blood and other bodily fluids are analysed to assist medical practitioners to identify the cause and severity of disease, and to monitor treatment. The Division of Pathology is made up of a range of clinical specialities: Anatomical Pathology, Chemical Pathology, Haematology, Cytogenetics, Immunology, Microbiology and Molecular Pathology. All areas are accredited with the National Association of Testing Authorities and the Royal College of Pathologists of Australasia.

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.

Achievements

Quality system

ACT Pathology undergoes three-yearly accreditation inspections by the National Association of Testing Authorities (NATA) and Royal College of Pathologists of Australasia (RCPA). The last accreditation assessment in 2012 saw an overall accreditation achievement at a high level. A large number of ACT pathology specialist and scientific staff have been invited to become NATA assessors and regularly inspect other laboratories in Australia and overseas.

The microbiology laboratory participates in a range of surveillance programs, including the Australian Group on Antimicrobial Resistance (AGAR) and the World Health Organization (WHO) influenza surveillance group, contributing to important epidemiological information locally and internationally. ACT Pathology is also a member of the Public Health Laboratory Network.

Social inclusion

Pathology testing now includes Aboriginal identification when this information has been provided. This data is then available to feed through to health databases such as the Pap smear register, notifiable diseases and cancer cases, and should enable better health policy planning.

Collaboration and performance

Pathology works in close collaboration with many areas of the Health Directorate to provide access to timely results, facilitate decision making and assist them to achieve their outputs.

While the number of requests for pathology from Canberra Hospital has slightly decreased overall, there has been an increase in the number of tests per request, resulting in a 2.6 per cent increase in tests.

Location	Number of requests 2011–12	Number of requests 2012–13	% increase in requests
Canberra Hospital	352,519	350,048	–0.7%
Calvary Hospital	94,951	100,411	5.8%

New technology

The Cytogenetic Department has implemented microarray analysis as the first line of investigation for the detection of chromosomal rearrangements in constitutional and products of conception referrals. This technology offers a higher level of resolution, improves the scope of detection of chromosome anomalies and replaces conventional karyotyping of chromosomes. The introduction of this service to ACT Pathology has contributed to patient care in genetic services.

Changes in technology

- New slide stainer: The Anatomical Pathology Department has introduced a new processor for the staining of tissue samples. This processor has a number of features that improve safety and quality. This includes decreased handling and use of dangerous chemicals by staff, and individual processing of samples to eliminate cross-contamination.
- Front-end automation: A PVT automated front-end processor was installed this year. This system improves processing and storage of patient samples received in the laboratory. It decreases the amount of manual handling of samples staff are required to do, as well as reducing pre-analytical errors and the incidence of repetitive strain type injury. It will benefit both patients (with improved quality) and staff (with improved work safe practice) and release staff to concentrate on more complex scientific duties.

E-health

Pathology embraces electronic delivery of pathology results for better management of patient care and the provision of continuity of services. Pathology results are currently:

- included in the discharge summary
- delivered to the ICU and renal department systems to support patient care and other databases in clinical areas
- delivered electronically to medical practitioners in the community.

Education

- Pathology holds Royal College of Pathologists of Australasia accreditation for medical postgraduate pathology training in all the major specialisations of pathology.
- Pathology is working in collaboration with the University of Canberra, Australian National University and Canberra Institute of Technology to continue to develop and support the various scientific and technical courses required in medical laboratory science. This includes both undergraduate and postgraduate courses. A number of ACT Pathology scientific staff prepare and provide lectures for these courses. In addition, students are supported in the pathology laboratories while undertaking their professional practice requirements. This initiative is already providing new graduates who are being introduced into the workforce in Canberra
- The scientific staff from cytogenetics contributed to the development of the University of Canberra course that is now the only postgraduate cytogenetic course to be offered in Australia.
- ACT Pathology continues to support staff continuing education through attendance at external conferences of national associations, including the Australian Association of Clinical Biochemists (AACB), Australian Institute of Medical Scientists and various industry workshops.

Investments in research

- Pathology is a scientific discipline with research as a cornerstone. Many of the pathologists and scientists are actively involved in their own research or work collaboratively with others. This demonstrates the important role of research in teaching, and Pathology's increasing link and contribution to the Australian National University Medical School. 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.
- ACT Pathology has been instrumental in a study to determine reference intervals for a healthy Australian population. This study, Aussie Normals, has been supported by the diagnostic industry through the availability of consumables. ACT Pathology scientific and clinical staff, in supporting this initiative, have been involved in pursuing harmonised reference intervals in clinical chemistry. This has resulted in a national workshop in 2012 and a satellite conference in association with the AACB national meeting. Publication of the findings will be presented later in 2013.
- The ACT Haematology Research Tissue Bank archives tissue samples from patients with haematological and related disorders. Set up in 2007, it has proven to be an important resource to support laboratory research and has enabled the department to apply for competitive grants.

Issues and challenges

The major challenge for the Division of Pathology in the future is dealing with increasing demand by clinicians and patients for more rapid, specific and high-tech testing for patient management, particularly in the molecular fields of cancer gene analysis and bacterial sequencing, in combination with maintaining a skilled workforce operating 24 hours a day. The future will see a significant increase in technology, including both automation and new technologies, that will require a workforce that is well informed and able to adapt to changes in laboratory practice. Therefore, it is imperative to maintain links with universities and other national bodies to foster a dynamic group of pathologists and scientists who form the critical link between clinical medicine and laboratory practice.

Another challenge for the Division of Pathology is managing demand on staff and resources. Community collection centres have been a major contributor to this increasing demand over recent years. To manage this increase in demand, two of Pathology's collection centres have been closed. This has enabled resources to be redirected and assist in responding to demand on public pathology services with the available workforce and resources. ACT Pathology's core business is the delivery of inpatient pathology services to Canberra and Calvary hospitals.

Future directions

Increased range of services

At the request of ACT Health staff specialists, the Molecular Pathology Department is in the process of implementing mutation marker assays to assist in the selection of suitable treatment modalities for cancer patients. This diagnostic service is likely to be offered later in 2013. The laboratory offers an already expanded respiratory pathogen testing service and is looking to expand this repertoire of testing in the future.

Research that promotes evidence-based practice

Pathology supports much of the clinical research being carried out in the public hospital system in the ACT by undertaking the assays directly or preparing special samples for forwarding to research institutes in other states. This activity is in addition to work initiated within various departments across pathology, which is often of a collaborative nature with the Australian National University and University of Canberra. ACT Pathology is currently supporting and contributing to in excess of 40 research projects, and it will continue to support such projects in the future.

Improve patient safety and quality of care

Pathology is working collaboratively with Health IT to introduce Computerised Physician Order Entry (CPOE). CPOE is an electronic ward ordering system that will improve completion of mandatory information required for pathology testing, improve legibility and thus accuracy of request information and provide decision-making support information to the requesting doctor. Having this up-front information for requesting doctors is expected to lead to more efficient ordering of pathology tests. In conjunction with the CPOE, a pathology collection system providing positive patient identification (PPID) for the collection of blood samples will be introduced. The introduction of both CPOE and PPID is expected to reduce pre-analytical errors that occur before the sample is presented to the laboratory for analysis. This will significantly improve patient safety. The process is necessarily long and intensive and we look forward to implementation in 2014.

Division of Surgery and Oral Health

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

Achievements

- Capital funding was received for the purchase and installation of two new CT scanners. The first, a state-of-the-art CT scanner, became operational on 3 July 2013. The second, a medium-range CT scanner, is expected to be operational by the end of August 2013.
- Medical Imaging implemented neuro-interventional services—in particular, coiling of intracranial aneurysms—which provide access for patients who have previously had to travel interstate for these services.
- In the past 12 months, there has been increasing interest from international radiologists in spending time at Canberra Hospital to further develop skills and training. These positions are sponsored by their individual governments.
- The appointment of a Nuclear Medicine Fellow assisted with the development of a career path and future teaching opportunities.
- Dr Robert Allen received an Interventional Radiology Society of Australia Gold Medal Award in recognition of his contribution to interventional radiology. Dr Allen is the third person to be awarded this honour.
- Mr Chris McLaren became an Honorary Life Member of the Australian and New Zealand Society of Nuclear Medicine in 2012. Mr McLaren is only the second nuclear medicine scientist to be granted this honour.
- In 2012–13, the federal government provided $345.9 million over three years to reduce public dental waiting lists across Australia. The ACT was the first jurisdiction to sign the National Partnership Agreement (NPA) in January 2013 and was allocated $5.5 million over three years. The funding has increased workforce capacity and increased utilisation of the private sector to reduce public dental waiting lists. At 30 April 2013, the Dental Health Program (DHP) met baseline NPA activity targets, attracting an additional $300,000 of NPA funding on 1 June 2013. This brings total NPA funding for 2012–13 to $954,000.
- At 30 June 2013, there were 1,659 people waiting for non-urgent restorative dental services, compared to 2,310 clients on the waiting list at 30 June 2012. At 30 June 2013, 2,447 clients were removed from the restorative waiting list, compared to 1,856 at 30 June 2012. This is an increase of 591 clients being removed in 12 months.
- One dental clinic in Civic was refurbished, and an additional clinic in Civic was constructed. A student tutorial room and orthopantomograph (OPG) x-ray machine, to increase the number of dentistry students, were completed.
- Vision-Impaired Persons Hospital Kits were introduced across the hospital in September 2012 for use by people who are blind or have low vision, as well as their families and carers. The kit provides information on a range of resources that enable patients to maintain a high level of independence and assist hospital staff to have a greater understanding of the needs of people who are blind or have low vision. The kit includes resources for use in hospital, such as signage to increase awareness of patients' needs, checklists to ensure patients are prepared and orientated to the ward environment, signed guide techniques for staff or carers and information about low vision services in the ACT.

- Mr Daniel Wood, Acting Assistant Director of Nursing, Wards, was awarded an ACT Health Australia Day Award.
- Two college ophthalmology trainees were re-accredited in September 2012 for three years.
- Dr Rohan Essex is coordinating a national research project on retinal surgery outcomes based in Canberra.
- The Pain Management Unit won the ACT Quality in Healthcare Award in 2012 for 'Access and Efficiency—Improving Customer Access to Multidisciplinary Pain Management Services' and the ACT Government Health Better Practice Award in 2013 for 'Improving Consumer Access to Multidisciplinary Pain Management Interventions'.
- The ACT Trauma Committee was formed to promote integration and coordination of the trauma system. Key representatives from Canberra Hospital and from hospitals in our region are members.
- Monthly Trauma Grand Rounds were established to improve the health outcomes of trauma patients by providing trauma education and training that are locally accessible.
- The Shock Trauma Service made a formal commitment to the Australian Trauma Quality Improvement Program. The aim of the program is to collaborate in improving care of seriously injured patients through sharing information, making joint efforts in trauma quality improvement projects and developing a 'next generation' national clinical quality registry for trauma.
- Ms Rebekah Ogilvie, Trauma Coordinator, was recognised this year for her research in major traumatic injury in young people when she was awarded the inaugural Skellern PhD Scholarship.
- A new Director of the Pain Management Unit commenced in April 2013.

Issues and challenges

- Demand for services increased but the division was able to respond with additional activity—for example:
  - In 2012–13, there were 6,464 elective surgery procedures undertaken, compared with 6,317 in 2011–12, which has exceeded the annual target of 6,300.
  - The Dental Health Program removed 3,098 clients from the central list for treatment in 2012–13, compared with 1,727 in 2011–12.
- The decanting of the Tuggeranong Dental Clinic to the Phillip Dental Clinic to allow for the refurbishment of the Tuggeranong Health Centre presented a number of challenges, including:
  - scheduling and relocation of staff and equipment to enable the continuation of service delivery to child and youth clients
  - negotiations with the Phillip Health Centre for additional office space to administer the National Child Oral Health Survey
  - good communication to allay staff concerns and anxiety about the relocation
  - a multi-pronged client communication strategy to inform clients of the changes to service delivery and access.

Future directions

- The installation of new CT scanners provides opportunities to offer new developments in diagnostic options.
- Medical Imaging has received funding to acquire a range of new, state-of-the-art equipment, including ultrasound machines, a gamma camera and a biplane angiography suite.
- The ACT Government has committed $1.6 million from 2013–14 over four years to fund a mobile dental van to provide dental care to residential aged care facilities, special schools, and pregnant and parenting students attending the Canberra College Cares Program. The operations of the mobile dental van are in the early planning stages.
- The newly built Belconnen Health Centre will open in November 2013 with 11 dental chairs—an additional six chairs compared with the old Belconnen Health Centre. The newly refurbished Tuggeranong Health Centre will open in the first half of 2014 with five dental chairs.
- The DHP continues to collaborate with allied health professionals to introduce orthodontic treatment for clients with cleft palate. Clinical training is occurring between the Canberra Hospital Cleft Palate Clinic and the DHP, and a mentorship has been established with a senior orthodontist at the Sydney Cleft Palate Clinic. Clients are being treated for general dental interventions, with full orthodontics expected to commence for clients referred by the Canberra Hospital Cleft Palate Clinic later in 2013.

- An upgrade to the dental electronic client information system, including digital radiography, will be completed in October 2013.

Formalisation of cross-border networking arrangements as part of the 2013 New South Wales Trauma Services Review will strengthen data linkage with New South Wales referral facilities and facilitate repatriation for ongoing care, which will link in with rehabilitation services available closer to home.

Division of Women, Youth and Children

The Division of Women, Youth and Children provides a broad range of primary, secondary and tertiary health care services. The provision of services is based on a family-centred, multidisciplinary approach to care in partnership with the consumer and other service providers. Services are provided at the Canberra Hospital, 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 service comprises:

- maternity services, including the Continuity at the Canberra Hospital (CatCH) Program and the Canberra Midwifery Program (CMP)
- women's health, including screening, gynaecology and programs targeting violence against women
- neonatology, including the Neonatal Intensive Care Unit, Special Care Nursery, specialist clinics, newborn hearing screening and ACT Newborn Retrieval Service
- paediatrics, including inpatient care, specialist clinics, community paediatricians and genetics
- Maternal and Child Health (MACH), including a universal home visit following birth, support for breastfeeding and parenting, immunisation and referral
- services that support children and their families with complex care needs:
  - Maternal and Child Health (MACH) Parenting Enhancement Program
  - Asthma Nurse Educator Service
  - Caring for Kids Program (care in the home for children with complex needs)
  - Child at Risk Health Unit (care for children affected by violence and abuse)
  - Integrated Multi-agencies for Parents and Children Together, which coordinates care for woman with complex care needs who are pregnant and/or have young children
  - child protection training for clinicians
- school-based nursing services, including immunisation, kindergarten health checks, school youth health checks and special school nurses
- nurse audiometry, providing hearing assessments to children and adults.

Achievements

Centenary Hospital for Women and Children

The new Centenary Hospital for Women and Children is one of the Health Infrastructure Program's major new facilities and features state-of-the-art equipment and infrastructure. The project includes the major refurbishment of the existing maternity building. The move into the Centenary Hospital for Women and Children took place in August 2012 and presented significant challenges, including:

- relocation of babies in the NICU and Special Care Nursery and women in the Maternity Unit
- communication with staff, which was of utmost importance to alleviate any concerns regarding the relocation
- a multi-pronged client communication strategy to inform clients of the changes to service delivery and access.

Community health programs

Community health programs provide services under a primary health care framework for children, families and women in the community. Programs and services are delivered to individuals or groups across a variety of settings in health centres, child and family centres, schools and clients' homes.

In 2012–13, there was increased demand for services and a need to develop new models for service delivery to try to address this demand. Extensive work was also done to prepare for the moves to the new or refurbished community health centres.

ACT Breastfeeding Strategic Framework

The *ACT Breastfeeding Strategic Framework 2010–2015* was launched on 10 November 2010. Its aim is to increase the number of infants being exclusively breastfed from birth to six months and to encourage ongoing breastfeeding with complementary foods until at least 12 months of age, in line with National Health and Medical Research Council recommendations. Implementation of the framework continues, with a focus on priority groups and consistency with the national breastfeeding strategic framework.

Key initiatives include the development of resources for priority and mainstream groups, health professional education, a whole-of-government approach to the 'Breastfeeding-Friendly Workplace' and enhanced breastfeeding data collection. A dedicated project officer led the implementation until June 2013. The development and implementation of the Breastfeeding Strategic Framework was funded by the ACT Population Health Division's Healthy Future budget and is a joint initiative of the Health Improvement Branch and the Women Youth and Children community health programs.

The implementation of the framework has been guided since its inception by the Breastfeeding Initiative Steering Committee. Implementation will now be coordinated through the Division of Women, Youth and Children and Policy and Government relations. The Division of Women, Youth and Children will manage the service delivery side of breastfeeding, including:

- exploration of the current service delivery model for breastfeeding
- ongoing education of health professionals and support for resource development
- the embedding of breastfeeding and the strategy into the core business of ACT Health by establishing a subcommittee
- ongoing Breastfeeding-Friendly Workplace re-accreditation for ACT Health
- the development of an ACT Health policy on the preparation of formula
- the embedding of breastfeeding into all relevant health and government policies and frameworks during the development process.

Women's Health Service

The Women's Health Service (WHS) has continued to implement an interprofessional primary health care (ACCESS) model for disadvantaged women who experience significant barriers to health service access. The counsellors, women's health nurses, nurse practitioner and staff specialist work collaboratively to provide comprehensive care to the priority population groups. The women's health nurses have maintained their expanded outreach to better target vulnerable groups. An evaluation framework for the ACCESS model has been developed by researchers from the Australian Primary Health Care Research Institute.

To support health professionals working with women who have been subjected to interpersonal violence, a training package for general practitioners has been developed and delivered in conjunction with Medicare Local, and presentations on trauma-informed care have been developed and delivered to other health professionals.

School Youth Health Nurse Program

The School Youth Health Nurse Program aims to promote positive health outcomes for young people and their families through the delivery of accessible, acceptable, appropriate and culturally respectful primary health care services in the school setting. It also provides the opportunity for young people, their parents and members of the school community to access a health professional in the school setting. This can be for matters relating to health or wellbeing and includes acting as a curriculum resource for staff. The external evaluation was completed in 2012 and, based on the positive results, the program was extended in 2013.

Immunisation

From 2013, the Human Papillomavirus (HPV) vaccination program, which has been offered to girls in Year 7, is being offered to boys. The School Health Team is offering the vaccination to Year 7 boys, with a two-year catch-up component for boys in year 9. The HPV virus can cause genital warts and a range of cancers, including cervical, penile and anal cancer.

Maternal and Child Health nursing partnership with Canberra College

The Maternal and Child Health (MACH) nursing partnership with Canberra College (CCCares), where MACH services are delivered to pregnant young women and young parents who are continuing their education and bringing their child to this unique school setting, continues to grow and develop. Over 100 young parents are engaged with MACH services through this partnership, and an increased number of sessions have been provided by MACH services. A community paediatrician now provides a clinic once a month.

National Perinatal Depression Initiative

The Australian Government Department of Health and Ageing and ACT Health have a five-year agreement for the National Perinatal Depression Initiative (NPDI), from 2008 to 2013, to improve prevention and early detection of antenatal and postnatal depression and provide better support and treatment for expectant and new mothers who are experiencing depression or are at risk of developing depression. The initiative is making consistent progress aligned with the agreed milestones of the NPDI. Progress and improvements against all outputs in the implementation plan are on track, with no significant risks or issues emerging.

The NPDI project particularly focuses on:

- routine and universal screening to identify women at risk of, or experiencing, perinatal depression (PND)
- follow-up integrated care pathways for women
- an education and training framework in perinatal mental health for multidisciplinary professionals
- community awareness of the risk factors related to PND, anxiety and adjustment to parenting
- improvement of data collection methods.

Health services to children and young people with complex health issues in all ACT Government schools

The Health Directorate and the Education and Training Directorate are working together on a project to develop a whole-of-government model addressing the provision of health services to children and young people with complex health issues in all ACT Government schools. A community consultation process was conducted in November 2012. A preferred model, named Healthcare Access At School (HAAS), was piloted in early 2013 with positive outcomes. Implementation will occur in 2013–14.

Centre for Newborn Care

The new Neonatal Intensive Care Unit (NICU) was built to accommodate up to 34 patients. Since the move to the Centenary Hospital for Women and Children in August 2012, occupancy in the NICU has been at 91 per cent.

Neonatal Intensive Care Unit Webcam

In the 2008–09 Budget, ACT Health allocated $200,000 to develop and implement a video streaming service for parents of infants at the Centre for Newborn Care Neonatal Intensive Care Unit (NICU).

The NICUCAM website provides general information on the services provided by the Centre for Newborn Care and can be accessed by the public. From this site, parents can access the secure password-protected portal to view their own babies daily between 6.00 am and 10.00 am and between 6.00 pm and 10.00 pm, via a webcam installed above the baby's cot in the Centre for Newborn Care.

Parents may provide the password and login to family members in Australia and overseas, which promotes bonding with the new baby.

A total of 10 babies can be on the webcam site at the same time, though to date six has been the maximum number. The website has received over 100,000 hits and has been accessed from 80 countries, as far afield as the United Kingdom, Canada, France, Italy, Hungary and India. In 2011, the program was awarded the national and, in 2012, the International Oceania–Pacific Project Management Award in the category Organisation/Change Management.

A technical design was developed to update the website and manage the cameras by NICUCAM staff. Solution went for tender and the successful company was offered the contract.

ACT Newborn Retrieval Service

The Newborn Retrieval Service, a satellite of the Newborn Emergency Transport Service (NETS) New South Wales, has been operational since 2008. Annually, 40 to 50 babies are retrieved from the ACT and New South Wales and taken as far as from Nowra to Canberra Hospital by the neonatal retrieval team, which consists of a neonatal nurse and medical officer. In addition, the service provides a timely, safe and coordinated transfer of babies to their local hospitals. The retrieval team (medical and nursing) is being trained in paediatric life support and provides a neonatal and infant (up to 10 months of age) medical emergency team at Canberra Hospital in the Centre for Newborn Care. The team also provides treatment and stabilisation of children up to the age of two years before transfer to Sydney to a Paediatric Intensive Care Unit.

An updated memorandum of understanding has been developed to increase service delivery to hospitals in New South Wales that are closer to Canberra than Sydney and to facilitate time-appropriate retrieval and back-transfer of convalescing neonates to improve patient flow.

Paediatric and Adolescent Health Services

The Paediatric Department, in addition to its general paediatrics duties, runs sub-speciality services in paediatric endocrinology, respiratory medicine and nephrology and conducts outreach clinics in Cooma and Pambula on a monthly basis. The department also strives to meet the needs of children requiring other sub-specialist services by hosting visiting specialists from Sydney in paediatric cardiology, gastroenterology, oncology and neurology. Paediatric research is conducted with involvement in vaccine and drug trials, as well as research on genetic renal disorders and endocrine and metabolism disorders in children. All paediatric staff specialists have an academic appointment and actively participate in Australian National University Medical School student teaching.

Outpatient waiting lists in paediatrics have been addressed by administrative improvements, the recruitment of two new paediatricians (1.8 full-time equivalent) and improved paediatric registrar participation in outpatient clinics. The work of the Chronic Care Coordinator nurse in the Outpatient Department has allowed for a cohesive, family- and child-centred approach for children with chronic disease.

The Paediatric Palliative Care Committee has improved palliative care services for children and their families through a collaborative, multidisciplinary and multi-agency approach. Improved links with Clare Holland House through a monthly interdisciplinary meeting and attendance at a conjoint meeting with New South Wales Paediatric Palliative Care Services ensure our paediatric palliative service aligns with current best practice.

The Paediatric Department has commenced strategic planning on improved resident and registrar training by developing a training program that will allow Australian National University graduates to undertake all but six months of their paediatric training in the ACT. Recognition is actively being sought from the Royal Australasian College of Physicians for local training in several paediatric sub-speciality rotations.

iPatCH (Paediatrics high dependency unit)

In the 2012–13 Budget, funding was allocated for two additional iPatCH beds. These beds have been identified in Ward 4B and will be utilised to provide closer monitoring of patients and a higher level of nursing care for sick children. iPaTCH has accepted NETS transfer of nine acutely unwell children from surrounding hospitals in New South Wales and Canberra. iPaTCH beds are not restricted to patients of the Paediatric Department; all specialities may admit paediatric patients into iPatCH care under the guidance of a consultant paediatrician.

Maternity and gynaecology services

Maternity and gynaecology services at Centenary Hospital for Women and Children provide care to women and children in the ACT and surrounding regional area. There were 3,342 births in 2012–13, compared to 2,974 in 2011–12 and 2,769 in 2010–11. In the past six months, outpatient antenatal care occasions of service were 3,425 for medical officers and 3,848 for midwifery. Outpatient gynaecology services provided 1,795 occasions of service.

Issues and challenges

In recent years, there have been significant changes in the mix between private and public sector births, and the number of public sector births has increased significantly. Between 2006–07 and 2011–12, there was only a 9 per cent increase in the total number of births in the ACT; this is less than 2 per cent a year. Over the same period, there was a 25 per cent increase in births in the public sector, while private hospitals experienced a 21 per cent reduction in birth rates over the same period.

Changes to the Medicare Safety Net have coincided with a significant decrease in private sector activity and a significant increase in public sector activity. This change was significant in 2010–11 and 2011–12, as many of the private sector bookings were previously made at the time of the safety net changes. The change in pattern and downturn of private sector activity unfortunately occurred too late to enable any change in planning for the construction of the new hospital. The planning of the facility was based on the projections for increases in demand. The total number of ACT births is consistent with the projections that were made. However, the safety net changes were not known at the time and therefore the shift from private to public sector was unexpected.

The Centenary Hospital for Women and Children has experienced pressure in relation to occupancy. A review into maternity services has been commissioned to look at ways in which the territory can work collaboratively to meet this unprecedented demand. The purpose of the review is to examine and provide an assessment of the model of care in the new Centenary Hospital for Women and Children Maternity Unit. It will also look at the capacity of ACT maternity services to meet current and future demand, taking into account recent changes to service demand as well as the model of care. The review team was sought from Women's Health Australasia (WHA), the peak body for hospitals and health services providing care to women and babies. The review team has conducted interviews with members of staff and consumers of the Centenary Hospital for Women and Children and will provide a report by September 2013. Strategies have been put in place to manage demand, such as:

- the opening of four short-stay postnatal beds as a short-term measure to manage the overflow of patients
- additional staff
- increased capacity for the continuity of the midwifery program.

Future directions

Centenary Hospital for Women and Children

Maternity and gynaecology services at Centenary Hospital for Women and Children provide care to women and children in the ACT and surrounding regional areas. The Centenary Hospital for Women and Children, stage 2 will open at the end of October 2013. At the completion of stage 2, the inpatient and outpatient paediatric service will relocate to level 1. The Antenatal and Gynaecology Outpatient Service, the Maternity Unit and the Fetal Medicine Unit will occupy level 2. Two assessment rooms, five birth centre beds and the new birthing suite, which have 13 labour birth recovery beds, will occupy level 3.

Community Paediatric and Child Health Service: Child Development Service

In early 2012, a discussion paper titled 'The Future of Community Paediatrics in the ACT Region—Beyond 2012' was sent to the Director-General of ACT Health, Dr Peggy Brown. It was subsequently endorsed for further exploration and a working group to be formed. This paper has stimulated stakeholders across government departments and non-government organisations involved in the provision of child and youth services to work together to develop a collaborative model to improve child development services in the ACT. This work will be incorporated into the Paediatric Services Strategic Plan.

The aim of this collaborative and multidisciplinary work is to examine the potential to transform the present Community Paediatric and Child Health Service (CPCHS) into a best practice, evidence-based, multi-disciplinary child development centre for the ACT and surrounding region.

Personal Child Health Record

In alignment with the *National Framework for Universal Child and Family Health Services*, ACT Health is committed to the progression of a national Personal Child Health Record (PCHR). The logical first step is to come into alignment with the recently updated New South Wales PCHR in consultation with ACT clinicians and other professionals who work with children. This approach was approved by the ACT Child Youth Health Reference Group and the ACT Maternity Services Network Forum. The rationale for this includes:

- extensive recent consumer consultation by New South Wales Health on their PCHR
- ongoing trials of an electronic version of the New South Wales PCHR
- consideration of those professionals, clinicians and families whose working and living arrangements straddle the ACT–New South Wales border
- substantial cost savings from printing this format.

Approval to adopt the New South Wales PCHR style and format has been given by New South Wales Health and the Executive Director of New South Wales Kids and Families. A working group will make minor local amendments and then seek final endorsement by the ACT Child Youth Health Reference Group and New South Wales Health.

Chronic Kids

The paediatric service is looking at the development and implementation of a chronic care strategy. This would aim to improve the service delivered to children and their families through a more integrated and comprehensive approach to chronic care management. The strategy would be based on the principles outlined in the ACT Chronic Conditions Strategy and the National Chronic Disease Strategy.

Paediatric Services Strategic Plan

The future direction for the Paediatric Department is to continue to strive to improve paediatric outpatient services and waiting times for families, to improve inpatient services and to ensure the timely and seamless discharge of children when hospital care is no longer required. The service is working to improve the flow of children through the Emergency Department to the ward and is undertaking a trial of a paediatric observation unit (Short Stay Ward) for children who require a longer period of observation for acute treatment prior to a decision to admit or discharge being made. The service is planning to develop an acute paediatric review clinic, which will give ACT general practitioners the ability to obtain an immediate paediatric review of a child they have concerns about who does not require presentation to the Emergency Department. Such a model will assist greatly in meeting the National Emergency Access Target (NEAT), reduce the burden on the Emergency Department and improve liaison with ACT general practitioners.

Calvary Health Care ACT

Calvary Hospital provides public health and hospital services in the ACT. These services include Emergency Medicine, Critical Care, Medical Care, Elective and Emergency Surgery, Day Surgery, Aged Care and Rehabilitation, Mental Health, and Inpatient and Community Specialist Palliative Care services from Clare Holland House (the ACT Hospice).

Calvary Hospital is operated by Calvary Health Care ACT (CHC ACT), a subsidiary of Little Company of Mary Health Care. CHC ACT has operated Calvary Hospital since its inception in 1979.

Funding for the operation of the public component of Calvary Hospital is provided by the Territory. The enduring arrangements between Calvary Health Care ACT and the Territory are described in the Calvary Network Agreement.

Each year the Territory and Calvary Health Care ACT negotiate required activity levels and funding arrangements. These are formalised in the annual Performance Plan, against which Calvary regularly reports its service to the local community and other people in need of public health and hospital services.

Achievements in the reporting period

- Achieving impressive results from the Australian Council on Health Care Standards accreditation survey of Calvary Health Care ACT against the recently introduced EquipNational criteria, which include the National Quality and Health Standards. Calvary Hospital is the first public health facility in the ACT to be reviewed and to receive unqualified accreditation against EquipNational requirements.
- Delivering record levels of service in all clinical areas and outpatient occasions of service.
- Redesigning Community Palliative Care Services provided from Clare Holland House. The Community Specialist Palliative Care Pathway provides patients with faster and more equitable access to palliative care services, with all patients being assessed and reviewed through a triage process and then being involved in choosing their preferred palliative care treatment program.
- Introducing the Palcare patient management system to enable greater involvement and improved coordination of primary care providers in their patients' palliative care treatment.
- Embedding the Calvary Patient Access Improvement Program, which is constructed around robust processes and cooperation between clinical areas, to provide improved patient access and flow and to achieve efficiency in elective and emergency admissions and surgery.
- Continuing to build the partnerships and processes associated with the networking of health and hospital services in the Territory.
- Increasing the number of people who received elective surgery procedures and reduced surgery waiting times.
- Completing the refurbishment of the Calvary Hospital Emergency Department, which has created additional treatment spaces and facilitated the streaming of patients into 'likely to be admitted' and 'see and treat' streams.
- Expanding Aboriginal and Torres Strait Islander liaison services through the appointment of a second Liaison Officer; these officers have direct contact with Indigenous patients and families and actively participate in Aboriginal and Torres Strait Islander networks in and around the ACT.
- Strengthening links between Clare Holland House and the Aboriginal and Torres Strait Islander communities to ensure Indigenous people have access to culturally sensitive and appropriate palliative and end-of-life care.
- Continuing the program of implementing technology which is shared with other health and hospital services in the Territory. Notable achievements in this area include: the roll-out of the ACT Patient Administration System (ACTPAS), creating a single electronic patient record across the Territory; the expansion of free wi-fi in many areas of Calvary for business and personal use; and the introduction of the MetaVision Clinical Information System in the Calvary Critical Care Unit.
- Improving the level of governance of clinical and administrative systems through the continuous review and refinement of the Calvary Hospital Committee Structure.
- Establishing the Australian Catholic University Clinical School on the Bruce campus, enriching clinical experience and practical learning opportunities for ACU students of nursing, midwifery and allied health.
- Enhancing the Graduate Program for Nursing, Midwifery and Allied Health staff, and building the importance of this program as a core element of the recruitment and retention strategies documented in the draft Calvary workforce plan.
- Advancing negotiations with the Territory on the planning and development of expanded services and new facilities on the Calvary Bruce campus.
- Refining the Calvary Health Care ACT Strategic Planning Framework, comprising a 15-Year Strategic Vision, a 5-Year Strategic Plan and the 2013–14 Local Services Plan.
- Expanding and formalising patient and consumer participation in the design, development, review and refinement of Calvary's services. The role of patients and consumers will be formalised in a Consumer and Carer Participation Strategy that will be completed in the third quarter of 2013.
- Actively contributing to the broader public health and hospital networks and partnerships in the ACT, with particular attention to the Local Hospital Network and the ACT Medicare Local.
- Creating the Calvary Health@Home Unit, comprising an expanded Hospital in the Home program and an innovative Calvary Medical Outreach Service. A pilot of the Outreach Service will commence in the fourth quarter of 2013.

- Implementing, in partnership with Carers ACT, the Carers at Calvary program, which introduces the assistance and support available to carers early in the patient journey, and facilitates the creation of carer services and support for the timely and safe discharge of patients to their preferred residential arrangement.
- Expanding the process for patient feedback, including the introduction of bedside patient experience surveys and follow-up phone calls to patients discharged after treatment for serious health ailments.
- Commencing the design of Calvary Hospital's Midwife-Led Model of Care, including an extensive public consultation process around the model and service. Design work has also been advanced for the creation of a birth centre at Calvary Hospital.
- Initiating the development process for expanded car-parking capacity at the Calvary Bruce campus.
- Enriching the Calvary community and the Calvary patient experience through the expanded and innovative engagement and deployment of the Calvary Volunteers Group.
- Refining the Calvary Refugee Mentoring program and offering participants more individualised work placements to assist with their settlement, assimilation and contribution to their new community.
- Continuing to collaborate with the Calvary Community Advisory Council.
- Improving staff engagement. In the most recent staff satisfaction survey, 63 per cent of respondents said they believed Calvary was 'a truly great place to work'.

Issues and analysis

The clear and transparent arrangements that now exist between Calvary and the Territory under the Calvary Network Agreement continued to provide a platform for open and productive clinical and administrative relationships that address contemporary circumstances and allow for collaborative future planning and development. This is of particular importance, as the Territory is committed to the expansion of public health and hospital services in North Canberra in close proximity to the major population growth areas of Gungahlin and Molonglo.

Calvary's levels of activity in the reporting period corresponded with the projected health needs of an ageing and growing population, in the context of improving services and developing new treatments. Calvary has made consistent progress in this area. Improved patient flow processes enable better forecasting of service levels; 24-hour coverage of emergency surgical services ensures earlier appropriate treatment for emergency presentations; enhanced discharge procedures featuring multidisciplinary collaboration are reducing patient length of stay; tracking of inpatient progress occurs in all medical and surgical wards, with the production of daily patient status reports; and the use of clinical pathways is being expanded from surgical patients to include many more medical patients.

The provision of services in non-acute settings is also being expanded at Calvary. More patients are receiving the later stages of their treatment and follow-up care in the Outpatient Clinic environment; the Calvary Hospital in the Home program has been expanded and a trial of direct external referrals to the service is under way; and a medical outreach service will commence shortly. In addition, a new ward area has been created specifically for patients transitioning from acute care to nursing home accommodation.

The Calvary Medical Inpatient Wards have been reconfigured to create standard patient numbers and common staffing levels. This process ensures equitable accommodation for patients across the various wards and enhances patient and staff safety by reducing the risk of transmission of infections and other illness through improved patient isolation options.

Engagement with patients and consumers at Calvary is growing as a result of their greater formal involvement and representation on clinical and non-clinical committees. In addition, consumers are engaged to comment on and contribute to any information being produced for patients and families.

Development and design work for expanded car-parking capacity at Calvary Hospital, which is expected to assist with peak demand, has commenced.

Future directions

Calvary Health Care ACT has identified a number of areas of focus for the short, medium and long term. These include:

- increasing the capability of our workforce and growing the engagement of the workforce in the development and delivery of services—a workforce plan will be published to describe the strategies to achieve this
- ensuring our conduct and service strongly represent our values of hospitality, healing, stewardship and respect
- striving to be more consistent in the provision of high-quality care, distinguished by patient engagement
- advancing our attention to patient safety with an even stronger focus on areas of preventable harm, including infection control, skin integrity and pressure ulcers, falls prevention, medication safety, the handling of blood products, nutrition, and pre-procedure consent and preparation
- enhancing our patient and family feedback processes to ensure our patients' experiences assist us to improve our service
- introducing new services and service expansion, as negotiated with the Territory and described in the Calvary Performance Plan
- continuing to explore ways care can be provided earlier, more rapidly and in the most appropriate setting
- exploring ways that technology can improve our services and working collaboratively with the Territory in the use of shared technology
- continuing the enhancement of budgetary and reporting processes to underpin our financial sustainability
- considering the environmental impact and whole-of-life costs in our procurement processes
- publishing and implementing the Calvary Health Care ACT Reconciliation Action Plan
- ensuring that we support and assist the vulnerable and needy in our community, and ensuring that they have access to our services.

Our future directions are documented in the Calvary Health Care ACT Local Services Plan for 2013–14.

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

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

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

This means focusing on:

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

Mental Health, Justice Health and Alcohol and Drug Services provide health services directly and through partnerships with community organisations. The services provided range from prevention and treatment to recovery and maintenance and harm minimisation. Consumer and carer participation is encouraged in all aspects of service planning and delivery. The division works in partnership with consumers, carers and a range of government and non-government service providers to ensure the best possible outcomes for clients.

The division delivers services at a number of locations, including hospital inpatient and outpatient settings, community health centres, detention centres and community settings such as people's homes. Services are outlined below.

Mental Health Services

- ACT-Wide Mental Health Services
- Child and Adolescent Mental Health Services
- Adult Mental Health Services

Justice Health Services

- Primary Health
- Forensic Mental Health

Alcohol and Drug Services

- Opioid Maintenance Treatment Services
- Withdrawal Services
- Counselling and Treatment Services
- Diversion Services
- Consultation and Liaison Services

Achievements

- Mental Health Services continue to monitor and review all episodes of seclusion and restraint. In 2013 the Early Support and Intervention Team will be reintroduced in the Adult Mental Health Unit to assist in the identification of consumers who are escalating and to work one on one to de-escalate. This initiative will be introduced in partnership with Ward Services to reduce aggression and consumer distress. A training package that focuses on engagement and de-escalation has been developed collaboratively with Ward Services.
- The Mental Health Community Policing Initiative (MHCPI) was developed after a review of ACT Policing mental health practices and procedures in 2010. A pilot was commenced in April 2011. This project was funded in 2011–12 and is now an ongoing initiative. In March 2013, the presence of Crisis Team clinicians in the Police Operations Centre was extended from four days per week to seven days per week. The clinicians are a dedicated resource for the police. They have access to the mental heath electronic clinical record, MHAGIC, and can provide information relevant to individuals.
- At the commencement of the MHCPI, there were, on average, 90 AFP-initiated emergency actions placed on consumers per month. This has dropped by 50 per cent, with an average over the past year of 45 per month. AFP, ambulance and MHCPI representatives are now providing mandatory in-service training to mental health teams.
- In April 2012, the Adult Mental Health Unit was commissioned. This is a purpose-built facility with an innovative model of care that has consumer engagement at its centre. The facility has a purpose-built High Dependency Unit, Low Dependency Unit and a therapy wing, which includes group therapy rooms, a gym and spiritual space. In 2013, additional allied health staff were employed in the Adult Mental Health Unit in the extended therapy program, and activities became available after hours and on the weekends.
- The Perinatal Mental Health Consultation Service provides specialist consultation and treatment planning for pregnant and postnatal women (up to 12 months postpartum). Since its inception, service demand has increased considerably. The program currently has approximately 80 registered clients. This year saw the implementation of a group program to support women with high levels of stress or distress. This group is co-facilitated with Child and Family Centre staff (Gungahlin) and has been beneficial for participants.
- The Child and Adolescent Mental Health Service (CAMHS) was reviewed in 2012 to develop a revised model of care in consideration of the mental health needs of children, adolescents and young adults up to the age of 25 years. The CAMHS Re-design Project was informed by consultation with staff members, service providers, consumers and carers to ensure the mental health needs of this client group could be met using evidence-based practices in the context of a recovery framework. The CAMHS Model of Care was endorsed by the ACT Health Re-development Committee in May 2013. Planning for a phased implementation process has commenced.
- At the Hume Health Centre, Justice Health Services have introduced:
  - a Suboxone Withdrawal and Maintenance Regime. This is the first time that buprenorphine has routinely been used to manage withdrawal and maintenance in an ACT correctional facility
  - Hepatitis C treatments, which are achieved through a shared care model with a referral pathway to the Gastroenterology Service of the Canberra Hospital. Up to 10 patients continue to be cared for under a complex treatment regime.

- In the Alcohol and Drug Services (ADS) program:
  - Following two pilot programs to implement influenza vaccination for clients of the Opioid Treatment Service, the program was rolled out as a yearly service in 2013.
  - The Alcohol and Drug Services overall program and the ADS Diversion team were the recipients of Aboriginal and Torres Strait Islander reconciliation awards, recognising the work being done across the program to provide access and service delivery to people from an Aboriginal and/or Torres Strait Islander background.
  - The ADS won the Quality in Health Care overall award in November 2012 for their opportunistic opioid treatment training program for community pharmacists, general practitioners and other health professionals.
  - In January 2013, counselling commenced in the Alexander Maconochie Centre. A dedicated counsellor employed by ADS is working with Alexander Maconochie Centre clients who have complex alcohol and other drug (AOD) issues to provide continuity of counselling care when they are discharged. A senior nurse also attends weekly to work with clients who are on opioid maintenance treatment and who are close to being released from the centre back into the community.
  - AOD psychotherapy and counselling are now provided at the Tuggeranong, Gunghalin, Hume and city health centres. Psychotherapy and counselling will commence at the enhanced Belconnen health centre when it opens later in 2013.
- Consumer and carer participation has remained a priority, and a number of consumers and carer consultants have been employed in the division. These roles support a cultural shift in Mental Health Services, particularly in recovery and consumer empowerment. Roles include systems advocacy for consumers, involvement in the review of the *Mental Health (Treatment and Care) Act 1994*, implementation of the recovery model, development and implementation of advance agreements, and staff training. The division also maintains full representation of consumers and carers on all relevant governance committees.
- The mental health services have been working to implement recovery principles and practices for a number of years. This work is supported through the actions of the *ACT Mental Health Services Plan 2009–2014* and the *National Standards for Mental Health Services 2010*. The ACT has also been involved in consultations on the National Mental Health Recovery Framework, to be released over the next 12 months, and this framework will help to further consolidate a recovery orientation of services. Training and education are offered so that staff and stakeholders can develop an understanding of recovery and how services can assist through the implementation of practices and processes that promote a person-centred, strengths-focused and collaborative approach to the planning and delivery of the division's services.
- The division implemented a smoke-free environment in response to concerns about passive smoking raised by consumers, carers and staff. On 1 January 2013, all areas of the division became smoke free. Staff completed training designed to assist consumers who smoke by providing education, support and access to a range of nicotine replacement therapies. The division won the 2013 Health Promotion Award for the Smoke-Free Initiative in the Outstanding Achievement to Address Unhealthy Behaviours category.
- Mental Health transitional clinicians have been employed in each of the four Adult Community Mental Health Teams. The primary function of these clinicians is to support the transition of, and coordinate care for, people exiting either of the two public ACT psychiatric inpatient units (the Adult Mental Health Unit or Calvary Psychiatry Ward 2N) into the community setting.
- A review of four Adult Community Mental Health Team catchment area boundaries was completed in late 2012. The boundaries between the City and Woden catchment areas were realigned and five suburbs were moved into the Woden catchment area. This will result in benefits of improved access to mental health services, including reduced waiting times for appointments, reallocation of clinical staff and reduced response time to referrals.
- The Aboriginal Liaison Service was expanded as a result of the recruitment of a senior mental health nurse to work with Winnunga Nimmityjah Aboriginal Health Service. The nurse provides direct mental health interventions and clinical management for consumers with mental health issues in that community who are seeking treatment and care.

Issues and challenges

- The review of the *Mental Health (Treatment and Care) Act 1994* continues. The review aims to ensure that the Act remains consistent with contemporary mental health policy and service delivery. Working groups are addressing several areas of detailed content of the Act. The revised Act is scheduled for consideration by the ACT Legislative Assembly in late 2013.
- The division is facing some challenges in finding staff to fill clinical vacancies. Strategies include the implementation of health professional officer career pathways to ensure ongoing development, mentoring and sustainability for health professional officers in this sector.

Future directions

- A streamlined induction process will be established at the Bimberi Youth Detention Centre, which will reduce duplication and engage specialist services when they are assessed as being clinically required.
- Strengthened medication management at Bimberi Youth Justice Centre has begun, with the recruitment of endorsed enrolled nurses who support a through-care model.
- Forensic Services will provide training on mental health awareness and processes to the magistrates of the ACT law courts. Preparation and organisation for the training have commenced. It is hoped this initiative will be expanded to other agencies, such as the Office of the Director of Public Prosecutions and Legal Aid services. Forensic Services has also continued to provide mental health awareness and education training to Bimberi youth workers as part of their training inductions.
- Alcohol and Drug Services are in the process of setting up a pharmacist-led Nicotine Replacement Clinic for clients of the Opioid Treatment Service. A pilot program will commence in August 2013 with an evaluation that will inform further development of this clinic.
- Funding for the enhancement of alcohol and drug outpatient services is in the planning phase, which includes consideration of a public opioid treatment clinic in the north of Canberra.
- The adult Mental Health Services Model of Care project is to review and develop mental health services currently provided to adults (18–64 years) within the ACT. The development of this model of care will inform the concept design of health infrastructure. The model of care will be based on evidence-based practice and comply with all relevant legislations.
- The implementation of the Child and Adolescent Mental Health Services (CAMHS) Model of Care is currently being planned for delivery during 2013–14.

Output 1.3 Public Health Services

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

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

The Population Health Division has primary responsibility for the management of population health issues within ACT Health. The Division undertakes the core functions of prevention, assessment, policy development and assurance, and contributes to local and national policy, program delivery and protocols on population health issues. As of 1 July 2012, the Population Health Division has implemented a new structure:

- The Health Improvement Branch is responsible for improving the health and wellbeing of the ACT population through promoting healthy behaviours and lifestyles—and providing ongoing monitoring and evaluation of health programs and policy. The Branch includes the ACT Cancer Registry, ACT Cervical Cytology Screening Program and the ACT Health Promotion Grants Program.
- 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, and analytical services.
- The Office of the Chief Health Officer (OCHO) is responsible for providing public health advice—both internally and externally to the division—as well as high-level project and policy work on behalf of the CHO. Key policy priority areas for the OCHO include gene technology; climate change; the Whole-of-Government Healthy Weight Initiative; and the Whole of Government Initiative on Injury Prevention.

Achievements

- The Population Health Division fulfilled its statutory and national reporting requirements for 2012–13. These included the collection of data for, and maintenance of, the ACT Cancer Registry and Maternal and Perinatal Data Collection. The Population Health Division fulfilled national reporting requirements on public health expenditure, cancer incidence and mortality, and maternal and perinatal statistics for the ACT.
- On 24 August 2012, the Minister for Health, Katy Gallagher, tabled the *2012 Chief Health Officer's Report*. The report is a legislated requirement under the Public Health Act and profiles the health of the ACT population, including mortality, morbidity, health-service use and social factors influencing health.
- The Population Health Division has a Survey Program that supports the monitoring of population health trends across the Australian Capital Territory. Survey results are published in a number of reports and health series publications which are utilised to inform health policy and program development. The Survey Program includes:
  - the ACT General Health Survey, a telephone computer-assisted technology household survey which collects information across a range of factors influencing health status in the ACT.
  - the ACT Secondary School Alcohol and Drug Survey, a classroom-based questionnaire conducted every three years, collecting information on risk behaviours of ACT secondary school students including alcohol, tobacco and illicit drug use
  - the ACT Year 6 Physical Activity and Nutrition Survey, a classroom-based questionnaire conducted every three years on children's weight status, physical activity and nutrition
- The report, *The Health of Aboriginal and Torres Strait Islander People in the ACT 2006–2011* was published in January 2013. This report provides a demographic overview of Aboriginal and Torres Strait Islander people living in the ACT and examines factors influencing their health profile.

- In 2012–13, the Population Health Division continued to strengthen its quality systems in population health data collection and reporting. This included working toward the development of systems for the electronic transmission of maternal and perinatal data in the ACT, with one notifier developing the capacity to transmit data electronically during this reporting period. The Population Health Division has also continued to build local capacity in data linkage between key population health data collections.
- In late June 2013, a new notifiable diseases database was implemented after a lengthy development period. The new system will enable more efficient recording and management of notifiable diseases, and will provide accurate, consistent information that complies with national reporting requirements. The database was one of the last remaining recommendations to be finalised from the evaluation of the response to the H1N1 Influenza 2009 pandemic.
- A food safety guide for businesses was finalised and translated into 11 languages to ensure food safety information was available to non-English speakers. The food safety guide provides comprehensive information about the most common food safety requirements.
- A food stall guideline for temporary food stalls was developed and translated into 12 languages. The food stall guideline is designed to assist organisers of food stalls at outdoor events in the ACT to meet all necessary food safety requirements.
- The *Food (Nutritional Information) Amendment Act 2011* commenced operation on 1 January 2013, requiring certain food businesses to display the kilojoule (kJ) content of their standard items on menus and price tags. The businesses will also need to display the statement 'The average adult daily energy intake is 8,700kJ' in one location on each menu board and food display stand. Kilojoule displays may encourage consumers to make healthier food choices and promote dietary awareness. They may also encourage food businesses to reformulate foods into healthier options.
- The Food Amendment Bill 2012 introduced a new requirement for food safety supervisors. From 1 September 2013, all registered food businesses are required to appoint a food safety supervisor responsible for ensuring that hygiene and food safety standards are achieved and maintained in food businesses. The food safety supervisor must complete prescribed training, which will remain current for five years. The ACT Health website provides full information about food safety supervisors, including training requirements.
- In February 2013, a team of 12 public health officers conducted food inspections during the three-day National Multicultural Festival as a strategy to minimise public health risks from serious breaches of the *Food Act 2001*. In total, approximately 300 inspections were conducted over the duration of the event. During inspections of food stalls, Public Health Officers routinely look for issues (breaches) that would give rise to unacceptable food safety risks including temperature control, poor hand-washing facilities and insufficient food storage. A number of food safety breaches were identified, including one food seizure and 12 voluntary disposals of deteriorated food items.
  - Prior to the event, the Environmental Health (EH) team undertook four community consultation forums. Two were attended by prospective stallholders and one was for a community organisation which requested an additional food safety talk. The final forum was aimed at festival volunteers.
  - The Pharmaceutical Service Section (PSS) attended a number of community consultation forums while establishing the kava exemption for the festival. Once the kava exemption was in place, a specific forum was held with the communities directly involved with the cultural use of kava, at which the exemption was clearly articulated and explained to stakeholders.
- The Health Protection Service responded to two major outbreaks of gastrointestinal illness among diners who reported eating at two restaurants in the ACT over the weekend of 11 and 12 May 2013. The first outbreak had 162 cases of gastrointestinal illness, with 78 of these confirmed as *Salmonella* infections. Of those that have been tested, *Salmonella typhimurium* 170 has been identified as the causative serotype. More than 90 cases of illness were reported in the second outbreak. During the investigation, Health Protection Service staff interviewed more than 400 people (both well and unwell) from both outbreaks, conducted multiple inspections of the implicated restaurants, and sampled and tested 109 food items from one restaurant. Interviews, inspections and testing of food supported the clinical and epidemiological findings. The response involved significant collaboration between Health Protection Service, the Canberra and Calvary hospitals, and local and interstate laboratories, and included the utilisation of the Health Emergency Coordination Centre. This collaboration and hard work by all, both in the outbreak investigation and in maintaining routine business operations, contributed to the successful investigation and resolution of the outbreak.
- The Health Protection Service conducted a Legionella Cooling Towers survey, Oriental Grocers food survey, Fresh Squeezed Juice survey and Ready to Eat food survey to determine the bacteriological status and compliance with the relevant legislation and codes of practice.

- The Chief Health Officer worked closely with the ACT Medicare Local, and both Canberra and Calvary Hospitals to coordinate and document 2013 winter preparedness activities. The subsequent 2013 ACT Health Sector Winter Plan was launched at a media release on 16 April 2013. The 2013 ACT Health Sector Winter Plan documents preparedness activities by agency including stockpiling of essential medicines and equipment, streamlining infectious disease testing, improving surveillance arrangements and developing health facility escalation plans.
- A review and major revision of the *Public Health Emergency Response Plan 2007* was undertaken. The revised Plan was endorsed in early 2013.
- In 2011, the Health Emergency Management Sub Committee agreed to develop four appendices to the Health Emergency Plan. The Health Emergency Plan Appendix I: ACTBurnPlan and Appendix II: HealthEvacPlan were endorsed by the Health Emergency Management Sub Committee out of session on 30 July 2012. The draft Health Emergency Plan Appendix III: HealthCBRNPlan was endorsed without change at the Health Emergency Management Sub Committee meeting of 18 June 2012. The draft Health Emergency Plan Appendix IV: Part A—Summer Plan, was also endorsed at the same meeting with minor amendment. The final draft appendix, Appendix IV: Part B—Winter Plan, remains a work in progress. The expected completion date is February 2014, following a trial over the 2013 winter. Once completed, all of the Health Emergency Plan appendices will be provided to the Security and Emergency Management Senior Officials Group, through the ACT Health Executive Council for information.
- The Population Health Division led a consultation process with the ACT Pacific Island community in 2012 regarding an ACT exemption for cultural kava use. Recommendations were subsequently provided to the Minister for Health. An amendment to the Medicines, Poisons and Therapeutic Goods Regulation 2008 was made on 25 January 2013 to enable use of kava for cultural purposes at declared public events. On 29 January 2013, the Minister for Health declared the National Multicultural Festival held in Canberra each year to be an exempt public event. These changes followed detailed consultation with the ACT Pacific Island community. Overall the serving of kava at the 2013 National Multicultural Festival was regarded to be a success. Officers of the Health Protection Service attended the event to observe stallholder compliance with the exemption.
- The 2011–12 ACT Health Annual Report noted that the Minister had agreed to introduce a new licensing scheme for community pharmacies under the *Public Health Act 1997*. This was successfully implemented by the Health Protection Service over 2012–13. The new licensing scheme came into effect on 1 March 2013 with all existing ACT pharmacies licensed by the required date.

Issues and challenges

- The Population Health Division implemented a new testing method for recreational waters. Since the introduction of the *Microbiological Guidelines for the ACT Recreational Waters* in 2010, the Health Protection Service has been striving to improve sample turnaround times and the responsiveness of the service on the Public Health status of the local lakes and rivers. This has reduced testing turnaround times from 48 hours to 24 hours and provided the capability to resample sites promptly and provide the community surety regarding the status of our local lakes.

Future directions

- The Health Improvement Branch is developing a new web platform for reporting on national and local indicators, as well as other population health priorities.
- The Population Health Division undertook an internal review of options to change the requirements for prescribing controlled medicines under the *Medicines, Poisons and Therapeutic Goods Act 2008*. The review followed a number of complaints from the medical and pharmacist communities that the current system imposes excessive regulatory burden and is not achieving its public health objectives. The Health Protection Service (HPS) will be implementing a new real-time monitoring system for controlled medicines in 2013–14. This will involve transmission of data from ACT pharmacies electronically in real time for every controlled medicine that is dispensed. The new system will provide the HPS with a vastly improved tool for monitoring the supply of controlled medicines in the ACT. This is with the view to minimise the risk of harms associated with their misuse, abuse and diversion.
- The ACT Government announced on 13 June 2013 that commercial solariums will be banned in the ACT from 31 December 2014. The ban is expected to help lower the incidence of skin cancers in the ACT, and is in line with similar bans in other jurisdictions commencing on the same date.

- ACT Health collaborated with the University of Canberra on the establishment of an accredited Environmental Health course in the ACT. The need for this collaboration was outlined in the 2011 Auditor-General's Report, which identified a necessity for ACT Health to promote the development of an accredited Environmental Health course at a local University to address the shortage of skilled Environmental Health Officers. The collaboration with the University of Canberra seeks to promote environmental health careers and help to address the Environmental Health Officer workforce shortage. The collaboration also hopes to facilitate communication between NSW regional local government, other enforcement agencies, tertiary institutions and ACT Health. It will also ensure the provision of appropriate undergraduate training and network opportunities for students embarking on a career in environmental health. The Environmental Health course is understood to commence in 2014.
- The Population Health Division is expanding the ambient air monitoring network by establishing an Ambient Air Quality National Environment Protection Measure Performance Monitoring Station in the Belconnen region. This station will assist with assessing and developing policies around ambient air quality. It is expected the establishment of the station at Florey will be completed by December 2013.
- Scoping and development work for a website featuring air quality data has been undertaken by the Population Health Division. The aim is to allow the public access to ambient air quality data in the Canberra region, with the view to having an Air Quality Index to provide an overall rating of the ambient air quality.
- The HPS continues work on developing further enforcement strategies regarding food regulation. This includes scoping work on a food hygiene grading scheme for food businesses, often called 'Scores on Doors', pending agreement from the ACT Government. This work will involve consultation with relevant stakeholders, including representatives from food industry, community and public health groups. The HPS will continue to consult with stakeholders concerning food regulation matters.
- The HPS is implementing the food safety supervisor training requirement, which will become mandatory on 1 September 2013. The HPS also continues to strengthen food safety information base for food businesses and the general public by reviewing current and developing new information.

Output 1.4 Cancer Services

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

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

The Capital Region Cancer Service (CRCS) Division is responsible for the provision of oncology, clinical haematology, radiation oncology, BreastScreen and immunology services to the ACT and surrounding region. Services are offered in the form of screening, inpatient and outpatient services and community-based psycho-social support services. The division also manages and coordinates clinical Outpatient administrative support, Health Centre Administration, Community Health Intake and Transcription Services.

The clinical services of CRCS integrate existing cancer services across the ACT and surrounding region to ensure a continuum of care for consumers, ranging from prevention and screening through to diagnosis, treatment, rehabilitation and palliative care. Services are provided on an area-wide basis and delivered at a number of locations, including hospital and community settings and the patient's home.

Achievements

- The Radiation Oncology department commenced operation of a fourth linear accelerator in July 2012. Additional staff recruited to support this expansion included a radiation oncologist, radiation therapists and nursing staff. This resulted in an increase in services provided.
- Demand for radiotherapy treatment services increased by 3.4 per cent, with 1,330 courses of treatment provided in 2012–13 compared to 1,286 courses in 2011–12.
- CRCS provided care for 1,566 new radiation oncology patients in 2012–13. This is a 2.7 per cent increase on the 1,525 new patients in the same period last year. CRCS provided care for 649 new patients from interstate; 642 of these patients were from NSW, representing 41.4 per cent of new patients provided with care.
- Brachytherapy treatment services provide a highly focused treatment option to a specific group of prostate cancer patients and cervical cancer patients. Indications are that demand for prostate cancer treatment is increasing. However, due to the success of screening and immunisation programs for cervical cancer, there has been a significant decrease in demand for cervical cancer treatment.
- Over the past 12 months, Radiation Oncology has developed the stereotactic radiosurgery (SRS) capability offered with the new linear accelerator to treat brain cancers. The SRS service was released for clinical operation in June 2013, with the first patient scheduled for treatment in early July 2013.
- The implementation of the 'CHARM' cancer information management system has provided a single system for scheduling, billing and ordering complex chemotherapy regimes for Medical Oncology, Haematology and Immunology. Medical Oncology, Haematology and Immunology have implemented electronic signing of chemotherapy orders and commenced the electronic documentation of patient notes, with the aim of eliminating paper records.
- The Haematology department achieved an end-of-year result 9 per cent over target for outpatient services despite critical haematologist shortages throughout the year. This was achieved through the significant commitment of the haematologists in ensuring that all urgent, category 1 and category 2 patients received appointments within the recommended timeframes.
- CRCS provided representation on the Cancer Council Australia Oncology Education Committee and the Therapeutic Goods Administration Advisory Committee on Prescription Medicine.
- The Medical Oncology Office Manager, Marilyn Cooper, was the recipient of the ACT Government Health Directorate Australia Day 2013 Achievement Medallion.
- Three new haematologists were recruited to CRCS this year, providing much needed specialist support to the department. Two of the specialists have commenced and the third is due to start in August 2013.

- The implementation of a Radiation Oncology Nurse Led Clinic in January 2013 has improved access for patients following radiation treatment. The clinic provides advice, treatment and medical review, as needed, for patients who have completed a course of radiation treatment.
- The first peripheral blood stem cell transplant was successfully trialled in an outpatient setting, achieving a reduction of four inpatient days for the overall care.
- Participation in radiotherapy clinical trials has increased with the appointment of a clinical trials data manager. Participation in technically based trials supports credentialing of processes and independent audit of dosimetry systems for the implementation of new radiotherapy techniques.
- All nine consultants in Medical Oncology have achieved academic appointments with the Australian National University Medical School and participate in teaching and research. Medical Oncology published four papers in 2012–13 and gave 16 conference presentations.
- Radiation Oncology successfully applied for an Allied Health Research Support grant to support the establishment of the Palliative Radiotherapy Rapid Access Clinic (PRRAC). This clinic will provide streamlined care for palliative patients requiring radiotherapy treatment. The grant funding is to support salary costs of a radiation therapist engaged in developing the communication aspects of the project.
- Canberra Hospital Outpatient Services commenced the initial phase of planning for the refurbishment of the waiting areas for Central Outpatients, Ear, Nose and Throat Department, Fracture Clinic, Sleep & Respiratory Department and Diabetes/Endocrinology departments. The refurbishment plans to increase seated waiting areas by at least 50 per cent, with specific consideration given to the needs of bariatric patients, wheelchair access, children's play area and improved signage.
- Breastscreen ACT achieved a participation rate of 56 per cent for women in the target age group of 50 to 69. This is the highest level achieved in the past five years.
- BreastScreen ACT underwent a two-day data audit as part of the BreastScreen Australia accreditation process. For the first time all criteria were met.
- CRCS developed and commenced a clinical audit project to introduce a regular program of clinical audit across all areas of CRCS. Initial baseline data was received for the areas of Patient Identification, Schedule 8 medication register, hand hygiene and falls assessment.
- The Care of the Dying Patient Collaborative Pathway pilot was implemented on wards 11A, 14B and 10A. The pathway reflects a shift from life-prolonging treatment to palliative care. This enhances comfort and acknowledges the need to actively make decisions that promote sensitive and appropriate care for the patient in the last predicted days of life. It also takes into account the wishes of the patient and family under their Respecting Patient Choices and advanced care plan needs. The pilot has produced excellent feedback to date.
- Gungahlin Community Health Centre opened in September 2012, offering a wide range of health services. Tuggeranong Health Centre was temporarily relocated to an alternative site at Greenway Waters Suites in January 2013, facilitating the commencement of work to refurbish and extend the existing centre.
- 4,111 cost-weighted admitted separations were provided by Cancer Services in 2012–13 against the target of 4,142. This constitudes a 2 per cent increase on those provided in 2011–12.
- 65,462 non-admitted occasions of service were provided by Cancer Services in 2012–13 against the target of 59,260. This is a 14 per cent increase on those provided in 2011–12 and reflects the high demand for services.
- Against a target of 100 per cent, 99.9 per cent of women received the results of their normal breast screen within 28 days.
- Against a target of 90 per cent, 94 per cent of women screened who required an assessment were assessed within 28 days of their screening appointment.

Issues and challenges

- Continued growth and increased demand for all CRCS services has challenged the physical space and resources across inpatient and outpatient services. The move to the new Canberra Region Cancer Centre will provide increased outpatient capacity. New models of service are being developed to reflect changes to treatment options and will be implemented in readiness for the move to the new centre.
- The Haematology department experienced shortages in the haematologist workforce, resulting in extremely high workloads and an increase in the number of less urgent patients waiting to be seen. With the commencement of new specialists in March and April the wait time is being reduced.
- Breastscreen continues to have challenges in recruiting women to the screening program. Activities continue to promote the program to new women and lapsed attendees.

Future directions

- The Canberra Region Cancer Centre is due to open in the second half of 2013. The new facility and improved models of care will enhance services for patients.
- The Palliative Radiotherapy Rapid Access Clinic (PRRAC) model of care will be established. This is a patient-centred approach to care whereby appointments are coordinated around patients and their requirements and the waiting time for treatment is reduced. A Radiation Therapist Advanced Practitioner role to support the clinic is being developed, and the clinic is planned to commence operation in August 2013.
- There will be further development of the stereotactic radiotherapy service to include treatment of a wider range of cancers.
- BreastScreen ACT is due to complete the National BreastScreen program accreditation process in November 2013. The data audit has been completed and the two-day site visit is scheduled for August 2013.
- The development of the Cancer Triage and Rapid Assessment model of care is nearing completion, with the implementation of a pilot planned for August 2013. This model of care aims to provide timely access to information and assessment for patients receiving outpatient treatment through CRCS Oncology and Haematology. It will focus on assessing concerns early, allowing treatment and support within the outpatient setting with the aim of reducing and diverting presentations to the emergency department.
- Belconnen Community Health Centre is scheduled to open for business on 11 November 2013. This is the largest of the new community health centres and it will provide a much wider range of services than was previously available in community health centres, and these will include renal dialysis.

Output 1.5 Rehabilitation, Aged and Community Care

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

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

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

The Rehabilitation, Aged and Community Care (RACC) division integrates public health system rehabilitation, aged and community and primary care services across the ACT. The division aims to improve the quality and accessibility of services to clients. RACC promotes a continuum of care covering the range of prevention, assessment, diagnosis, treatment, support, rehabilitation and maintenance.

RACC adopts an area-wide approach to client-centred care. To this end, RACC works closely with others to improve the communication between primary, acute, sub-acute and community health care services while fostering professional development and promoting best practice in rehabilitation, aged and community care.

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

The provision of these services includes:

- hospital-based admitted and outpatient geriatric and rehabilitation medicine services, including ortho-geriatrics, at both the Canberra Hospital and Calvary Public Hospital
- geriatric medicine and rehabilitation medicine outpatient services to regional New South Wales
- the Rapid Assessment of the Deteriorating and At-Risk Aged (RADAR) Service, providing service to older people in their own homes, including to residents of aged care facilities upon referral from a general practitioner
- aged care client assessment services
- residential aged care liaison
- community nursing and allied health services, such as podiatry, social work, nutrition and weight management, physiotherapy, continence services, occupational therapy and self-management of chronic conditions training courses
- the Transitional Therapy and Care Program (TTCP), providing allied health services to support clients in the post-hospital discharge period, either in a residential setting or in their own homes. RACC provides this service in partnership with Baptist Community Services
- falls injury prevention services, including falls assessment clinics, the Stepping On program and related health promotion activities
- transitional rehabilitation at the Rehabilitation Independent Living Unit (RILU)
- community-based multi-disciplinary rehabilitation services
- services provided by exercise physiologists, including programs for rehabilitation, cardiac rehabilitation and hydrotherapy
- vocational assessment and rehabilitation services
- driver assessment and rehabilitation services
- geriatric outpatient speech pathology and neuropsychology services
- a multi-disciplinary memory assessment service

- ACT Equipment Scheme
- Equipment Loan Service
- Domiciliary Oxygen and Respiratory Support Scheme
- ACT Continence Support Service
- Clinical Technology Services
- a specialised wheelchair and posture seating service
- prosthetics and orthotics services
- information and advice on assistive technologies by the Independent Living Centre (ILC).

Achievements

RACC made improvements to a range of facilities, systems and processes with the aim of improving service provisions, including the following:

- RACC Prosthetics and Orthotics implemented a triage clinic to better manage client need and wait times. This saw the non-urgent wait time fall from 20 weeks in June 2012 to 13 weeks in June 2013.
- The Domiciliary Oxygen and Respiratory Support Scheme improved contract arrangements and management of clients. This included annual review of all oxygen clients for the first time in the ACT and the ongoing annual review of all respiratory clients.
- Following a multi-disciplinary review of how the Spinal Cord Injury Review Clinic was conducted, format changes have allowed for an increase in the number of clients able to attend.
- Pain management support was introduced in the Rehabilitation Independent Living Unit (RILU) for clients attending the gym for therapy sessions. This has promoted good pain management, allowing the clients to achieve their goals with minimal disruption to their programs.
- Implementation of multi-disciplinary triage meetings daily has resulted in more timely processing and management of referrals to the Rapid Assessment of the Deteriorating and At-Risk Aged (RADAR) service. Clients referred to RADAR continue to be assessed within the target of one working day.
- The Exercise Physiology Department implemented a number of service improvements, including the rollout and completion of the Beat It Physical Activity and Lifestyle Program to Health Directorate staff, and the revision and development of standardised testing protocols for exercise tests.
- RACC strengthened existing initiatives and introduced innovations with the aim of further reducing falls in both community and hospital settings.

RACC introduced the following new services in 2012–13:

- Physiotherapy, nutrition, podiatry services and a nursing ambulatory care clinic are now provided at the new Gungahlin Community Health Centre, which opened in the second half of 2012.
- Additional workshop space at the Village Creek Centre was refurbished and equipped for the implementation of a custom medical-grade footwear service within the Clinical Technology Service.

RACC improved the coordination of geriatric and rehabilitation services across community, outpatient, Emergency Department and inpatient settings:

- This year saw the successful transition and discharge of the first ventilator-dependent tetraplegic client from inpatient rehabilitation services to the community. This was achieved through comprehensive clinical management, collaboration, and consultation across various health areas and ACT Government departments.
- RACC Nursing undertook a project aimed at enhancing the experience of elderly clients in the Emergency Department (ED). The project targeted clients either presenting from residential aged care facilities or who were over 85 years. The focus was on improved assessment, diagnosis and treatment of delirium. This project was undertaken collaboratively with the ED. As a result of the project, the average response time by the Department of Geriatric Medicine to the ED showed an improvement of almost 30 minutes. ED staff also report they are now better informed about delirium and dementia.
- A validated screening tool for malnutrition in the elderly population on 11A, the Acute Care of the Elderly ward at the Canberra Hospital, was introduced. The screen has resulted in more efficient referral to a dietician and timely follow-up.

- A successful partnership with Goodwin Aged Care Services resulted in an additional eight beds for Canberra Hospital clients approved and waiting for permanent residential aged care placement. This released eight acute beds to assist with access.

RACC undertook considerable learning and development activities, including the following:

- Sustaining a high level of student placement opportunities across the service, including opportunities for students from the University of Canberra, in a number of allied health professions (such as occupational therapy, clinical psychology, podiatry, physiotherapy, nutrition, prosthetics and speech pathology).
- A nursing-specific core education course on neurological rehabilitation was developed and delivered. This 12-module course is conducted in a cyclical manner on a fortnightly basis. This format is designed to capture all nursing staff over time, without being dependent on their particular scheduled shifts.
- The Department of Geriatric Medicine has received a Best Clinical Unit for Teaching nomination from the ANU Medical School for the past three years.
- Through training and mentoring, a career in geriatric medicine was promoted to junior medical officers and medical students.

In 2012–13, RACC undertook a number of workforce initiatives, including the following:

- The successful implementation of a Podiatry Assistant role in the Community Care Podiatry Service in 2011–12 led to the establishment of a second trainee position, commencing in April 2013.
- Recruitment was undertaken to a Transitional Therapy and Care Program (TTCP) Access Officer position at the Canberra Hospital. The purpose of the position is to improve access to, and occupancy of, the TTCP and to improve the transition from hospital for clients. The position has been operating since March 2013 and early indications are that there have been improvements in TTCP access.

RACC services, teams and staff members were nominated for or won the following in 2012–13:

- The ACT Equipment Scheme (ACTES) Equipment Mobile Repairs and Maintenance Service was evaluated and found to provide a high-quality service, winning an ACT Quality in Healthcare Award in the Innovative Models of Care category.
- Community Rehabilitation occupational therapy staff were finalists at the ACT Health Quality in Healthcare Awards for Getting on with It—Single Handed, a group designed to look at engagement in functional activities and care of low-function upper limbs.
- In January 2013, the Rehabilitation Nurse Practitioner was awarded an ACT Health Australia Day achievement medallion.
- In May 2013, the Rehabilitation Nurse Practitioner was awarded the inaugural Nurse Practitioner of the Year award at the ACT Nursing and Midwifery Excellence Awards.
- The Equipment Loan Service was awarded an ACT Health Australia Day Team achievement medallion for its contribution to clients in the community.
- At the Health Promotion Awards in June 2013, the Community Care Program was awarded the ACT Medicare Local Award for Outstanding Achievement in a Primary Health Care Setting for its Healthy Communities Outreach Health Program.
- RACC staff were also nominees and recipients of awards at the 2012–13 Allied Health Awards for Excellence, nominated for Allied Health Clinical Excellence, Allied Health Management and Leadership Excellence, and winning the Award for Allied Health Assistant Excellence.

RACC published and presented key work in 2012–13:

- The Department of Geriatric Medicine published and presented extensive work on:
  - cardiovascular and neurological diseases in older patients with osteoporotic hip fracture
  - interactions between serum adipokines and osteocalcin in older patients with hip fracture
  - hypertension and haemodynamic instability and falls in the elderly
  - hip fracture in stroke survivors
  - the impact of malnutrition on co-morbidities, bone metabolism and outcomes in older adults with hip fracture.
- Other RACC presentations at conferences in 2012–13 included:
  - 'Transition from Clinician to Supervisor—How Do We Develop the Health Professional Supervisors of the Future?'

- – 'How Do We Know Students Have Positive Clinical Experiences in our Health Service?'
- – 'Making Self-Reflection a Reality in Workplace Integrated Learning (WIL): Practical Strategies for Supervisors'
- – 'Adult Healthy Weight Service'
- – 'Social Inclusion through a Health Coaching Approach to Promoting Healthy Lifestyles in a Disadvantaged Community'—developed in collaboration with the Population Health Division as part of a joint Australian and Territory Government initiative under the National Partnership Agreement on Preventative Health
- – 'HWA Aged Care Workforce Reform—Introduction of a Discharge Support Allied Health Assistant Role in the Aged Care Setting'
- – 'MS and Driving: A Consideration for All Health Professionals'
- – 'DiabExercise: Improving Exercise Physiology Services for the Management of Type 2'.

Issues and challenges

- The upgrade of the Aged Care Assessment Team (ACAT) national software database to reflect changes to Commonwealth legislation required a significant time commitment, on the part of the ACAT team, to understand the changes and implications for the service in readiness for implementation by August 2013.
- Increasing demand for ACAT assessment remains a challenge to meeting the key performance indicator for priority 3 referrals. Strategies to improve this over the next six months include the review of intake processes and recruitment of casual and temporary staff to meet demand at peak times.
- Some specialist New South Wales services are no longer providing orthotics services to ACT clients, placing additional pressure on RACC Prosthetics and Orthotics.
- The lack of residential aged care facility beds in the community is continuing to impact on the average length of stay and separations in aged care. At 30 June 2013, there were 46 public hospital inpatients awaiting residential aged care facility placement.
- Significant work continues with the prospective decant of some services based on the Canberra Hospital campus as part of the Health Infrastructure Project. The challenges include providing existing services temporarily in a refurbished area and meeting expected increased demands over the next few years, while the University of Canberra Public Hospital is built.
- Geriatric staffing remains a challenge. Although three new consultant staff have been recruited since early 2011, there was a resignation in June 2013 and there is a retirement pending in September 2013. Advertising for recruitment to vacant positions and temporary backfill to cover maternity leave are imminent. In 2012–13, there were three Advanced Trainees in Geriatric Medicine.

Future directions

- Model of care projects are being finalised to support the expansion of community-based services in community health centres. This includes the provision of services, equipment and facilities to enhance the overall experience of clients and staff. A key focus is to deliver health services that are built around the client, addressing needs at the local level. Consumers and staff are central to the design of all new services and facilities.
- New nurse-led walk-in centres (WiC) will be located at the Belconnen and Tuggeranong Community Health Centre opening in 2014. The model of care for the new WiCs will be similar to that of the Canberra Hospital WiC, which is available for the one-off treatment of minor illness and injury. No appointment is necessary and the service is provided free to clients.
- Access to RACC nursing and allied health community-based services in Canberra's north will be improved as clinics at the new Belconnen Community Health Centre open in late 2013.
- Work continues with user groups in preparation for the building of the University of Canberra Public Hospital, a stand-alone subacute facility on the north side of Canberra. This exciting project will feature a centre of excellence for subacute care, including inpatient and ambulatory models of care for rehabilitation.
- There are plans to review the input of Community Geriatrics to have greater input into the assessment and follow-up of elderly clients presenting to ED, especially with falls, to expedite their safe discharge from ED and minimise the likelihood of re-presentation.
- In collaboration with other ACT Government directorates, including the Community Services Directorate, RACC will participate in the rollout of DisabilityCare Australia in the ACT.

Output 1.6 Early intervention and prevention

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

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

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

Early intervention is managed in many ways including the Health Directorate screening programs such as BreastScreen, cervical screening, and newborn hearing screening, as well as through immunisation programs.

The Health Directorate 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 better understanding, quantifying and preventing chronic disease across the wider ACT population.

Achievements

- The ACT maintained its position as the jurisdiction with the highest life expectancy in Australia. Projections suggest that life expectancy in the ACT will continue to increase over coming years. By 2015, life expectancy at birth in the ACT is projected to be 83.1 years for males (up 2.4 years from 2007) and 86.5 for females (up 2.5 years from 2007). Cancer, mental disorders and cardiovascular disease are the leading contributors to the total burden of disease in the ACT, contributing nearly half of the total disease burden.
- ACT Health will receive $8.75 million in facilitation payments through the National Partnership Agreement on Preventive Health (NPAPH) from July 2010 to June 2018. The partnership has been extended within the existing funding envelope, to add a further three years, from June 2015 until June 2018. The NPAPH is aimed at stimulating action in preventing chronic disease. The NPAPH funds the delivery of five different initiatives: Social Marketing; Healthy Children; Healthy Workers; Healthy Communities; and Enabling Infrastructure.
- Social Marketing: In December 2012, an ACT-developed campaign, 'Beyond Today...it's up to you' was launched to encourage healthy lifestyles and smoking cessation among the Aboriginal and Torres Strait Islander community.
- Social Marketing: In March 2013, information was sent to approximately 25,000 ACT residents aged 45-49 years to advise them of free health checks and the Get Healthy Service. Medicare Australia website data shows that the number of people claiming the health check Medicare Benefits Schedule items 701, 703, 705, 707 in the ACT in March–April 2013 had doubled compared to the same period in the previous year. Two weeks following the mail out, Get Healthy ACT data showed that the average number of participants joining the service had almost tripled.
- Healthy Children: ACT Health is receiving $4.09 million over seven years from July 2011, to deliver programs aimed at reducing the rates of overweight and obesity in children aged 0–18 years. These include:
  - *Healthy food at school*: an initiative to transform the healthy food and drink culture in ACT schools, in around 75 schools over the next five years. The program targets children from pre-school to Year 6.
  - *It's your move*: a research intervention with Deakin University, targeting high schools to increase physical activity and healthy eating and aiming to reduce unhealthy weight gain in young people aged 12–16 years.
  - *Ride or walk to school*: an initiative to encourage riding and walking to school in a minimum of 60 schools over the next five years.
- Healthy Workers: ACT Health is receiving $3.66 million over seven years for the delivery of programs that promote and support healthy lifestyles in and through ACT workplaces. The Healthy Workers program has achieved the following in 2012–13:
  - *Healthier Work*: The ACT Healthier Work Service was launched in May 2012 and has conducted site visits to over 100 ACT workplaces. A workplace incentives grants program was conducted in 2013 with 27 workplaces supported to initiate or consolidate staff health and wellbeing programs.

- *Public sector health promotion*: In partnership with the Chief Minister and Treasury, ACT Health supported the development of an ACT whole-of-government Workplace Health and Wellbeing Policy which was endorsed in May 2012. It also implemented a comprehensive staff health and wellbeing program within ACT Health known as 'my health' and facilitated a staff survey and public consultation on the development of a healthy food and drink choices policy for staff, volunteers and visitors to ACT Health facilities.

- Healthy Communities Initiative (HCI): This initiative receives funding under the NPAPH and aims to reduce the prevalence of overweight and obesity among adults not in paid employment in the Inner North of Canberra. Achievements in 2012–13 included:
  - increased coverage of programs such as Heart Foundation Walking and Heartmoves, to increase physical activity and improved nutritional intake
  - increased nutrition education by Community Health Dietitians, introduction of outreach clinics delivered by Continuing Care nursing and allied health staff, and improved food and nutrition intake through the Red Cross Foodcents program
  - increase in numbers of people participating in active recreation.
- Following a successful public consultation program, the Chief Minister announced a refocused Health Promotion Grants program. A new 'Healthy Canberra Grants' round will focus on tackling obesity across the population, and on improving children's health, including improving eating habits through school canteens and food education. A new 'Health Promotion Innovation Fund' will be also be introduced. This fund will offer smaller value grant funding opportunities several times per year.
- The ACT Health Food and Nutrition Strategic Framework 2012–18 was released in September 2012. This framework highlights healthy eating and optimal nutrition as priorities for the Health Directorate and creates greater recognition of the importance of nutrition in optimising health outcomes.
- To effectively tackle rising rates of overweight and obesity, broad action is required beyond the traditional health sector to make healthy choices easier in our neighbourhoods, workplaces and schools. Under the Whole of Government Healthy Weight Initiative, all Directorates of the ACT Government are working together to develop and implement actions to increase physical activity and improve nutrition across the ACT population. The development of the ACT's first whole of government action plan on obesity prevention is underway. The Whole of Government Healthy Weight Initiative was allocated $0.3 million under the 2012–13 ACT budget over three years.
- The ACT continued to achieve high childhood immunisation coverage in the general population. Coverage rates for children in all three cohorts were consistently above the national average. In 2012–13, 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 1-year-old children being fully immunised was exceeded in all quarters (93.1 per cent, 93 per cent, 92.5 per cent and 92.6 per cent).
- In July 2009 the National Partnership Agreement on Essential Vaccines was implemented. The objective of this Agreement is to improve the health and wellbeing of Australians through the cost-effective delivery of the National Immunisation Program. The Agreement sets out performance benchmarks that must be achieved for the ACT to be eligible for an incentive payment. The performance benchmarks associated with the essential vaccines Agreement are:
  1. maintaining or increasing vaccine coverage for Indigenous Australians
  2. maintaining or increasing coverage in agreed areas of low immunisation coverage
  3. maintaining or decreasing wastage and leakage
  4. maintaining or increasing vaccination coverage for 4-year olds.
- The ACT cannot be assessed against benchmark 2 (maintaining or increasing coverage in agreed areas of low immunisation coverage), as the ACT does not have any identified areas of low immunisation coverage.
- In 2012–13 the ACT achieved two of the three assessable benchmarks—maintaining or decreasing wastage and leakage (benchmark 3) and maintaining or increasing vaccination coverage for 4-year olds (benchmark 4).

- The ACT did not meet the performance benchmark 1, maintaining or increasing vaccine coverage for Indigenous Australians. The ACT only improved on the immunisation rates for Aboriginal and Torres Strait Islander children in the 4-year cohort. There was a drop in immunisation coverage for Aboriginal and Torres Strait Islander children at 12–15 months and 24–27 months. As there are very low numbers of Aboriginal and Torres Strait Islander children in each cohort the coverage data can fluctuate widely. For the period 1 April 2011 to 31 March 2012 the mean immunisation coverage for Aboriginal and Torres Strait Islander children in the ACT was:
  - 12–15 months—81.5 per cent
  - 24–27 months—91.6 per cent
  - 60–63 months—91.0 per cent.
- For the period 1 April 2010 to 31 March 2011, the mean immunisation coverage for 4-year old children in the ACT increased by 0.9 per cent from the previous year and was 92.3 per cent.
- The ACT Immunisation Strategy 2012–2016, was launched on 17 December 2012. It aims to expand the focus of immunisation to whole of life and to reduce hospital admissions for vaccine preventable diseases, particularly in high-risk groups. The primary objectives of the Strategy are to:
  - ensure the ongoing appropriateness, quality, safety and effectiveness of the ACT immunisation program
  - maintain or improve our current immunisation coverage
  - maintain or decrease our current levels of vaccine-preventable diseases in the Canberra community, thereby decreasing the pressures on primary health care such as GPs, walk in centres and tertiary health facilities such as hospitals, especially emergency departments
  - support and maintain the current high quality immunisation workforce with education and resources.
- As pregnant women are at higher risk of severe disease from influenza, the vaccine is recommended and funded for all pregnant women. There has historically been a low uptake of the influenza vaccine with pregnant women. To increase the influenza vaccination rates Health Protection Service liaised with the maternity units of TCH, Calvary and John James. Influenza promotion to parents and education to staff was provided. The vaccine is now offered to all women who are admitted to the antenatal units or outpatients of the antenatal clinics at TCH. Posters have also been provided to General Practitioners, obstetricians, child care centres and libraries.
- The Human Papillomavirus (HPV) vaccination program for boys commenced in 2013 and is offered to 12–13 year old boys (Year 7) via a school program with a two-year catch-up component for boys in Year 9. Under the National Immunisation Program (NIP) boys in Year 7 are eligible to receive the funded vaccine. As part of a catch-up program, boys in Year 9 in 2013 and 2014 are also being offered the vaccine. The vaccine is administered by the school health team. Boys in Year 10 and above who are 15 years of age or younger are able to access the vaccine through their general practitioner.
- To promote this new vaccination program the Health Protection Service and the Division of Women, Youth and Children provided communication to stakeholders which included:
  - letters and information to General Practitioners and general practice staff
  - articles in the 'Immunisation Newsletter'
  - media releases, education events and information on the ACT Health website.
- HPV vaccination course consists of three vaccinations. The administration of the first dose of the HPV vaccination program was completed by May 2013. A total of 5,739 doses of vaccine were administered to eligible students. Preliminary data indicates that the following coverage rates have been achieved for the first dose:
  - Year 7 girls**—**82.5 per cent
  - Year 7 boys**—**79.2 per cent
  - Year 9 boys**—**72.0 per cent.
- The Cervical Screening Program captures and reports data over a 2-year period as recommended by the National Cervical Screening Program. As of 30 June 2013, the ACT participation rate for the target population was 57.14 per cent. The AIHW report, *Cervical Screening in Australia 2010–2011*, again puts the ACT in the top three jurisdictions in Australia for participation in cervical screening and first overall in Australia for the five-year participation rate.

- During 2012–13, the Cervical Screening Program actively promoted cervical screening among community groups. The main message in this promotion is for young women to continue screening even if they have been vaccinated against HPV. Program staff have attended several notable women's health promotional events around the ACT to promote screening in the community. In addition several print media campaigns were implemented to promote screening among women in community publications as well as ACT Government publications targeting ACT Government staff. Several new brochures were designed and produced.
- BreastScreen ACT & SE NSW is part of a national population breast screening program that is aimed at reducing deaths from breast cancer through early detection. Further information can be found under Cancer Services on page 160 of this report.
- Newborn Hearing Screenings are provided to every newborn in the ACT and aim to identify babies born with significant hearing loss and introduce them to appropriate services as soon as possible. Further information can be found under Division of Women, Youth and Children on page 143 of this report. School-based nursing programs include immunisations and kindergarten health checks. The School Youth Health Nurse Program promotes positive health outcomes for young people by providing access to a nurse in the high school setting. Further information can be found under Division of Women, Youth and Children on page 143 of this report.
- As part of the Commonwealth-funded National Bowel Cancer Screening Project, endoscopy services are provided to patients. Further information can be found under Division of Medicine on page 133 of this report.
- Forty per cent of all Well Woman's Checks were provided to women from culturally and linguistically diverse backgrounds. This is above the target of 30 per cent, and is the same result as in the 2011–12 period.
- Ninety-six per cent of eligible children aged 0 to 14 who entered substitute and kinship care in the ACT were seen by the Child at Risk Health Unit's Out-of-Home Care Clinic. This is above the target of 80 per cent, and an increase of 16 per cent from the 2011–12 period.
- In May 2013, the ACT Minister for Health endorsed the *ACT Chronic Conditions Strategy—Improving Care and Support 2013–2018,* building on the previous strategy. The *ACT Chronic Conditions Strategy—Improving Care and Support 2013–2018* sets the direction of care and support for those living with chronic conditions in the ACT and outlines a collaborative approach to this vitally important area of healthcare. Implementation and evaluation of the Strategy is being overseen by the ACT Primary Health and Chronic Disease Steering Committee.

Issues and challenges

- The immunisation coverage rates for Aboriginal and Torres Strait Islander children in two of the three cohorts (12–15 months and 24–27 months) decreased in 2012–13.
- The very low numbers of Aboriginal and Torres Strait Islander children in the ACT means that ACT Aboriginal and Torres Strait Islander coverage data should be read with caution as the immunisation coverage rates can fluctuate greatly. Coverage rates can vary dramatically between cohorts and between reporting periods.
- Increasing and maintaining high immunisation coverage rates in Aboriginal and Torres Strait Islander children will continue to be a challenge. The Health Protection Service is actively pursuing different strategies to increase immunisation rates for Aboriginal and Torres Strait Islander children including: phone contact with children identified as overdue for immunisations, discussions with stakeholders, liaising with Winnunga Nimmityjah Aboriginal Health Service and investigating immunisation promotion opportunities with the Aboriginal and Torres Strait Islander community.
- Working collaboratively with the ACT Medicare Local, Closing the Gap unit to produce resources and educate communities on the importance of immunisation.
- Health Protection Service undertakes a quarterly mail-out to parents of children who are recorded in the Australian Childhood Immunisation Register as overdue for immunisation. This letter advises parents or guardians that their child is overdue for immunisation, reminds them of the importance of vaccination and enables any administered but unrecorded immunisations to be entered onto ACIR.

Future directions

- Following the successful implementation of the Whole of Government Healthy Weight Initiative, the ACT Government will commence collaborative action to reduce the burden of injury on the ACT population. Injury accounts for approximately 7 per cent of the burden of disease in the ACT, and addressing this issue is pivotal to reducing the incidence of premature mortality, chronic disability and the associated health system costs.
- The Minister for Health launched Future Directions for Tobacco Reduction 2013–2016 on World No Tobacco Day (31 May 2013). The purpose was to inform the Canberra community of the 12 initiatives proposed by ACT Health in tobacco control. These initiatives aim to investigate restricting access to tobacco to reduce demand and control supply and restricting places of tobacco use. The areas that will be looked at include outdoor areas at public swimming pools, children's playgrounds, among many others, where measures could be taken to reduce smoking and protect non-smokers from the effects of environmental tobacco smoke. The timeframes are outlined in Future Directions, with work on each initiative phased over the life of Future Directions.
- In 2012 the Population Health Division was successful in winning an Australian Research Council Grant in partnership with the Australian National University. This grant will enable the development of methods by which research in population health can be better used by policy-makers. In 2012–13 work began with decision-makers and policy advocates to identify barriers to the uptake of research evidence in population health and to develop a training model to improve processes by which researchers and policy-makers work together. Tools to assist policy-makers use evidence will be developed following this study.

Quality and Safety Unit

Safety and quality of care are core elements in the provision of health services. The Quality and Safety Unit (QSU) takes a lead role in planning, managing and evaluating patient safety and quality for the ACT Health Directorate. The QSU focuses on quality improvement, evaluation and review, clinical management systems and measurement, consumer engagement, clinical performance related to patient safety and quality, and risk management. The Workplace Safety section within the QSU has overarching responsibility for keeping Health Directorate staff healthy and safe.

The Business Plan for the QSU highlights three themes which underpin the functions of the unit. These themes are that care provided to consumers will be:

- consumer-centred
- driven by information
- organised for safety.

These themes have been compiled using:

- recommendations and information from reviews and monitoring processes carried out within the Health Directorate
- national and international health improvement methods
- national priority and reform processes.

National Safety and Quality Health Service Standards

QSU is committed to advancing the national agenda on patient safety and is working closely with the Australian Commission on Safety and Quality in Health Care to progress implementation of the 10 *National Safety and Quality Health Service Standards*.

The QSU also coordinates the accreditation process for the organisation. The Accreditation and Evaluation team is currently managing changes in accreditation practice to ensure that the Health Directorate is ready for its assessment against the 10 National Safety and Quality Health Service Standards in 2014.

Achievements

In 2012–13, the QSU carried out the following activities.

Policies and procedures

- Developed clear policy documents on important safety and quality issues such as:
  - consent and Treatment Policy and Standard Operating Procedures
  - responding to the use of non-prescription alcohol and other drugs in health settings
  - open disclosure
  - work health and safety, and the safety management system
  - dangerous substance management.
- Issued a Respiratory Policy to ensure appropriate respiratory protection is maintained for all relevant staff.
- Supported and monitored the quality of policy documents through the Policy Advisory Committee and staff training sessions on policy governance and policy writing.
- Completed the updated Work Health and Safety Management System and revised Work Health and Safety Policy to:
  - ensure the Health Directorate meets the *Work Health and Safety Act 2011* and associated regulations, codes of practice
  - provide appropriate guidance to staff in relation to best practice safety management.
- Developed two new RiskMan registers for Occupational Medicine and Workplace Safety Physiotherapy management and enhanced a number of RiskMan modules to meet changed needs and user requirements.

Accreditation

- Supported the Health Directorate through the Australian Council on Healthcare Standards (ACHS) Organisation Wide Survey to retain its accreditation status. The Health Directorate met all criteria to achieve accreditation for another four years with 28 marked achievements, 18 extensive achievements and 1 outstanding achievement.
- Updated the Safety and Quality Framework to include the new *National Safety and Quality Health Service Standards*. A consultation draft will be issued in early 2013–14.
- Supported the establishment of the 10 *National Safety and Quality Health Service Standards* Groups to provide strategic direction for the implementation of these standards and monitor progress on key activities.
- Developed a Health Directorate Quality Improvement and *National Safety and Quality Health Service Standards* (NSQHSS) Education strategy to improve understanding of change management and quality improvement methodology to support improvements in quality and safety practices.

Projects and programs

- Completed a project on behalf of the Local Hospital Network (LHN) Council to collect patient stories particularly related to bedside handover and discharge planning, to allow the LHN to make recommendations for improvements.
- Negotiated a budget bid to allow increased resourcing for the Respecting Patient Choices Program to increase community awareness and uptake of advance care plans.
- The Respecting Patient Choices program negotiated a successful partnership arrangement with Medicare Local ACT to support and promote Advance Care Planning to the wider ACT community and health professionals.
- Facilitated the ACT Quality in Healthcare Awards which showcase patient safety and quality initiatives across the territory; and the Health Directorate Better Practice Awards which celebrate local quality improvement activities.

Publications

- Developed a toolkit to support Chairs and Secretariats of committees who have consumer representatives on committees.
- Planning for future implementation of core standards for forms outlined in 'A National Framework for Advanced Care Directives' through working with the Medicare Local Aged Care Forums and Council on the Ageing ACT.
- Revised *The Dangerous Substances Manual* to meet updated legislation.
- Amended the *Safety Management System* document to reflect the changes to workplace legislation, in particular, the responsibilities of managers.

Staffing

- Made an appointment to the Patient Experience Team Leader position.

Training and education

- Implemented and evaluated training in bedside handover as part of the Effective Communication in Clinical Handover (ECCHO) Project, a national Australian Research Council Funding project in collaboration with the University of Technology Sydney and three other jurisdictions. Training is now being piloted in another ward. The project team presented at the International Council of Nurses Conference in May 2012. Held 'Open Disclosure Master Classes' for senior clinical and executive staff. These classes provide targeted skills to support staff when open disclosure discussions with patients and families are required. Partnered with the Healthcare Consumers Association ACT to provide forums on 'How to complain properly', consumer representative training and advocacy training.
- Participated in the Rural Health Education Foundation DVD and toolkit titled 'The Patient's Choice: Quality at the End of Life'.
- Provided education and training to staff on implementing the 10 *National Safety and Quality Health Service Standards*.

Issues and analysis

Transitioning to the 10 *National Safety and Quality Health Service Standards* from the Australian Council on Health Services Standards (ACHS) accreditation program is a significant change for the organisation. Implementation of the standards provides an opportunity to embed these standards in the organisation and further improve the safety and quality of our services.

A.10 Triple Bottom Line Report

	INDICATOR	2011–12 Result	2012–13 Result	% Change
ECONOMIC	**Employee Expenses**			
	Number of staff employed (head count)	6,228	6,540	5.0%
	Total employee expenditure (dollars)	$593,999,000	$628,781,000	5.9%
	Operating Statement			
	Total expenditure (dollars)	$1,177,762,000	$1,083,790,000	–8.0%
	Total own source revenue (dollars)	$255,862,000	$679,845,000	165.7%
	Total net cost of services (dollars)	$921,900,000	$403,945,000	–56.2%
	Economic Viability			
	Total assets (dollars)	$996,190,000	$1,110,925,000	11.5%
	Total liabilities (dollars)	$266,500,000	$290,956,000	9.2%
ENVIRONMENTAL*	**Transport**			
	Total number of fleet vehicles	321	322	0.3%
	Total transport fuel used (kilolitres)	365	362	–0.8%
	Total direct greenhouse emissions of the fleet (tonnes of CO^2e)	987	975	–1.2%
	Energy Use			
	Total office energy use (megajoules)	11,234,403	8,139,197	–27.6%
	Office energy use per FTE (megajoules)[1]	23,820	7,004	–70.6%
	Office energy use per square metre(megajoules)	1,642	466	–71.6%
	Greenhouse Emissions			
	Total office greenhouse emissions – direct and indirect (tonnes of CO^2e)[2]	1,644	1,957	19.0%
	Total office greenhouse emissions per FTE (tonnes of CO^2e/FTE)	3.90	1.68	–56.9%
	Total office greenhouse emissions per square metre (tonnes of CO^2e/ m^2)	0.27	0.11	–59.3%
	Water Consumption			
	Total water use (kilolitres)[3]	186,552	194,088	4.0%
	Office water use per FTE (kilolitres/FTE)	n/a	n/a	n/a
	Office water use per square metre (kilolitres/m^2)	n/a	n/a	n/a
	Resource Efficiency and Waste			
	Estimate of co-mingled office waste per FTE (litres)[4]	286.57	289.43	1.0%
	Estimate of paper recycled (litres)[5]	1,477,222	1,194,348	–19.1%
	Estimate of paper used (by reams) per FTE	7.11	7.38	3.8%

	INDICATOR	2011–12 Result	2012–13 Result	% Change
SOCIAL	**Diversity of Our Workforce**			
	Women (Female FTEs as a percentage of the total workforce)	76.06%	75.87%	–0.2%
	People with a disability (as a percentage of the total workforce)	1.88%	1.93%	2.7%
	Aboriginal and Torres Strait Islander people (as a percentage of the total workforce)	0.84%	0.99%	17.9%
	Staff with English as a second language (as a percentage of the total workforce)	18.10%	22.11%	22.2%
	Staff Health and Wellbeing			
	OH&S Incident Reports	1,209	1,355	12.1%
	Accepted claims for compensation	89	113	27.0%
	Staff receiving influenza vaccinations**	2,481	3,189	28.5%
	Workstation assessments requested	129	304	135.7%

*See C.13 page 267. Only office space used in the calculation of energy and greenhouse gas emissions.

**Staff receiving influenza vaccinations. This information is prepared by calendar year.

Notes

Total office energy use (megajoules) and greenhouse gas emissions

1 The difference between 2011–12 and 2012–13 energy use has resulted from the inclusion of 12 Moore Street Level 1, Carruthers Street Curtin, TCH campus Buildings 23 & 24, and office space within Buildings 2 & 6 and a small space in Building 12 Medical Records Department.

Total office greenhouse emissions – direct and indirect (tonnes of CO^2e)

2 The difference between 2011–12 and 2012–13 greenhouse gas emissions resulted from the inclusion of 12 Moore Street Level 1, Carruthers Street Curtin, TCH campus Buildings 23 & 24, office space within Buildings 2 & 6 TCH and a small space in Building 12 Medical Records Department.

Total water use (kilolitres)

3 This amount was incorrectly reported in the 2011–12 Annual report section A10 Triple Bottom Line as 183,174 kilolitres, which was an administrative error. 186,552 kilolitres is correct, as stated in C19 table of the 2011–12 report on page 318. This increase is due to the additional clinical space.

Resource Efficiency and Waste

4 Note the figure in 2011–12 was inclusive of 18 mths data. The adjusted figure for 12 mths is 209.1.

5 Note the figure in 2011–12 was inclusive of 18 mths data. The adjusted figure for 12 mths is 1,139,422.

SECTION B
CONSULTATION AND SCRUTINY REPORTING

B.1 Community engagement

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

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

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

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

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

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

- Listening and Learning: Consumer Feedback Policy and Standards
- implementation of the *Australian Charter of Healthcare Rights* and *Charter on the Rights of Children and Young People in Healthcare Services in Australia*
- Consumer, Carer and Community Representative program and Reimbursement Policy
- relationships with consumer advocacy agencies through service funding agreements
- Respecting Patient's Choices
- Patient and Family Centred Care Framework.

ACT Health has actively engaged with the community on a range of matters, as indicated in the following table:

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Policy and Government Relations Branch					
Chronic and Primary Health Policy Unit	Development of a new Chronic Conditions Strategy	6-week community consultation on draft Strategy in Oct./Nov. 2012. Feedback could be provided: • via an online questionnaire (Survey Monkey) • by attending a public forum on 16 Oct. 2012 • by email or by postal mail. Director-General bulletin to ACT Health staff. Stakeholders could email consultant directly. Face-to-face meetings also occurred.	Health Care Consumers' Association (HCCA), ACT Medicare Local, NGOs who support people with chronic conditions, medical, nursing and allied health clinicians, other ACT Health staff. Members of the Primary Health and Chronic Disease Strategy Steering Committee, the Local Hospital Network Council.	50	Finalisation of ACT Chronic Conditions Strategy—Improving Care and Support 2013–2018.
Chronic and Primary Health Policy Unit	Development of a new Palliative Care Services Plan	Face-to-face meetings held with key external organisations and groups. A draft Plan was submitted to a six week public consultation period from 26 Oct.–6 Dec. 2012; advertised in the *Canberra Times*, the Time to Talk website, the ACT Health Staff Bulletin and through emails to identified stakeholders. A further public forum was held on 21 Nov. 2012.	Key stakeholders, Calvary Health Care, Clare Holland House, Palliative Care ACT, key clinicians (multidisciplinary), consumers, (including Health Care Consumers Association), ACT Medicare Local, the Local Hospital Network Council and members of the ACT Palliative Care Strategy Steering Committee.	40	

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Policy and Government Relations Branch					
Chronic and Primary Health Policy Unit	Secretariat support of the ACT Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases (SHAHRD)	The ACT Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases (SHAHRD) provides advice to the ACT Minister for Health from community and consumer perspectives on issues related to health and wellbeing in the areas of sexual health and blood-borne diseases. SHAHRD likewise advises on the implementation of HIV/AIDS, Hepatitis C and Sexually Transmissible Infections: A Strategic Framework for the ACT 2007–2012. SHAHRD held a community consultation forum on the Future of HIV Prevention in the ACT, in May 2013.	Membership specifically includes individuals recruited for their experience, expertise and connection with relevant communities of interest. This approach values the participation of community organisations, affected communities and clinical communities in producing optimal health outcomes, and is based on a commitment to consultation and joint decision making.	10 members Approximately 35 people attended.	Ongoing input into policy and strategic directions for sexual health and blood-borne virus issues in the ACT.
Mental Health Policy Unit	Mental Health Promotion Prevention and Early Intervention (PPEI) Working Group	The evaluation and implementation working group oversees the implementation and evaluation of Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009–2014.	The evaluation and implementation working group met three times in 2012–13 with representation from the Mental Health Consumer Network, Mental Illness Education ACT, Carers ACT, the Women's Centre for Health Matters, ACT Health, ACT Education and Training Directorate, Justice and Community Safety Directorate, Community Services Directorate, Territory and Municipal Services Directorate.	There were four meetings with ten participants.	Ongoing implementation and evaluation of Building a Strong Foundation: A framework for Promoting Mental Health and Wellbeing in the ACT 2009–2014. Evaluation of the 2011–12 activities conducted.
Mental Health Policy Unit	ACT Suicide Prevention Implementation and Evaluation Working Group (SPIEWG)	The evaluation and implementation working group continues to oversee the implementation and evaluation of Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009–2014.	The evaluation and implementation working group was scheduled to meet bi-monthly with representation from ACT Medicare Local, Lifeline Canberra, Menslink, OzHelp Foundation, Carers ACT, Supportlink, Mental Health Consumer Network, Mental Health ACT, Education and Training Directorate, and Justice and Community Safety Directorate (JACSD), ACT Policing.	There were four meetings with an average of eight participants per meeting.	Ongoing implementation and evaluation of Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009–2014. Implementation of the Men's Suicide Prevention Conference, Let's Talk for Suicide Prevention and evaluation of the 2011–12 activities conducted.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Policy and Government Relations Branch					
Mental Health Policy	Review of the *ACT Mental Health (Treatment and Care) Act 1994*	Two exposure drafts released for six weeks' community consultation August 2012, April 2013. Community consultation meetings with stakeholder groups and broader community. Working groups with stakeholder membership developing recommendations for change. Broad stakeholder membership of review advisory group (over 40 groups including consumers and carers and human rights representatives).	Mental health consumers; mental health carers; disability consumers and carers advocacy groups; community agencies; Legal Aid; Human Rights Commission; government departments; health academics; clinicians; courts; Corrections; police; Public Advocate; Victims of Crime Commission; Ambulance Service; Official Visitors.	500	Consensus achieved on all amendments to the Act
Alcohol and Other Drug Policy Unit	Strategic Framework for the Management of Blood Borne Viruses in the Alexander Maconochie Centre	In August 2012 the draft Strategic Framework for the Management of Blood Borne Viruses in the Alexander Maconochie Centre (AMC) was publicly released. The targeted and public consultation period closed in Oct. 2012. The majority of responses received supported the Framework and the implementation of regulated equipment exchange in AMC. Submissions from the consultation, except in cases where permission to do so was not received, were published on the ACT Health website in mid-Jan. 2013.	Members of the public. Members of the AMC Health Policy and Services Advisory Committee including the Alcohol, Tobacco and Other Drug Association of the ACT (ATODA), the Mental Health Community Coalition and consumer representatives.	47 submissions were received.	The draft framework was amended to address relevant feedback and the framework is currently being considered by the ACT Government.
Alcohol and Other Drug Policy Unit	Staff and union consultation regarding implementation of regulated equipment exchange in AMC	The JACSD and ACT Health established a Joint Directorate Consultative Committee. Membership of this committee includes representatives from the Community and Public Sector Union (CPSU), Health Services Union (HSU), Australian Salaried Medical Officers Association and the Australian Nursing Federation. The Committee initially met in September 2012. Face-to-face staff consultations commenced in June 2013.	Unions and staff.	Face-to-face consultations with staff commenced in June 2013.	Consultations are not complete.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Policy and Government Relations Branch					
Aboriginal and Torres Strait Islander Health Unit	ACT Health Reconciliation Action Plan 2012–2015	Consultations with the Aboriginal and Torres Strait Islander communities included distributing a draft Reconciliation Action Plan 2012–2015 to key stakeholders and community-controlled organisations. A community workshop was held to present the action plan and the specific actions. Comments received were considered for inclusion in the final draft action plan. A formal launch of the action plan was held and involved community representatives. The final action plan was distributed to Aboriginal and Torres Strait Islander community organisations and individuals.	ACT Health's Reconciliation Action Plan Working Group includes representation from: the ACT Aboriginal and Torres Strait Islander Elected Body, United Ngunnawal Elders Council, ACT Torres Strait Islanders Corporation, Winnunga Nimmityjah Aboriginal Health Service and clients of the hospital system. Members of the working group were involved in the community workshop.	Ongoing consultations with over 20 Aboriginal and Torres Strait Islander organisations and individuals.	To meet ACT Health's commitment to Reconciliation and improving health outcomes for Aboriginal and Torres Strait Islander peoples of the ACT.
Aboriginal and Torres Strait Islander Health Unit	Antenatal care, pre-pregnancy and teenage sexual and reproductive health (Element 2 of the Council of Australian Governments Indigenous Early Childhood Development National Partnership Agreement)	High level consultation was progressed through the Advisory Group which includes representation from the ACT Aboriginal and Torres Strait Islander communities. Project officers consulted individually with government and non-government organisations and key stakeholders within the local Aboriginal and Torres Strait Islander communities.	Winnunga Nimmityjah Aboriginal Health Service, Gugan Gulwan Youth Aboriginal Corporation, West Belconnen Child and Family Services, The Junction Youth Health Service, Sexual Health and Family Planning ACT (SHFPACT), Indigenous Social Inclusion Company, Police Citizens Youth Club, Indigenous Student Support Unit through the Education Directorate, Education Directorate, Bimberi Youth Justice Centre, Medicare Local, Marymead.	Fourteen members make up the Advisory Group. More than 50 organisations and individuals have been consulted to date and this is ongoing. More than 100 students have participated in Core of Life sessions. Approximately 16 pregnant Aboriginal and Torres Strait Islander women attended antenatal Core of Life sessions. Three Core of Life Facilitator Training Workshops were conducted for 58 participants.	13 Core of Life education programs for Aboriginal and Torres Strait Islander youth occurred both in schools and the community sector. A breastfeeding DVD 'Give it a go' and two booklets Health in pregnancy and sexual health have been developed for young people.
Aboriginal and Torres Strait Islander Health Unit	ACT Health Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013–2018	Consultation and engagement with the Aboriginal and Torres Strait Islander communities included distributing to key stakeholders a draft workforce action plan for comment.	The draft workforce action plan was provided to: the ACT Aboriginal and Torres Strait Islander Health Forum that includes representation from the Commonwealth Department of Health and Ageing, the ACT Aboriginal and Torres Strait Islander Elected Body, ACT Medicare Local and Winnunga Nimmityjah Aboriginal Health Service. Members of the ACT Health Aboriginal and Torres Strait Islander Health Workforce Support Network were also consulted on the workforce action plan.	Consultations involved 7 representative groups that included Aboriginal and Torres Strait Islander members.	The ACT Health Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013–2018, which intends to increase the numbers of Aboriginal and Torres Strait Islander people employed in ACT Health and the healthcare sector to improve healthcare service delivery.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Rehabilitation, Aged and Community Care					
Community Care Program	HIP Gungahlin Community Health Centre opening	Community Open Day—marketing in community magazines, Canberra Times etc. Participation, involvement, community feedback.	Legislative Assembly members, community groups, ACT general public, Canberra Hospital and Health Services staff. Community Open Day—participation, involvement, community feedback, focus groups.	Approximately 300 visited the Health Centre. Marketing to 1000s of the general public.	Successful marketing of services available at Gungahlin Community Health Centre and other CH&HS sites. Referral to services. Very positive consumer feedback. Two successful community engagement sessions at Gungahlin Market Place. Many brochures handed out. Many questions about ACTH community services answered.
Community-based services	Seniors Expo	Face-to-face at Natex, marketing via public magazines.	Seniors.	100s	A large number of people attended the expo and visited stalls.
Community Care Program	Arthritis Expo	Face-to-face at Uniting Care Kippax, marketing via public magazines.	People who have arthritis.	20 people stopped at the stall.	Independent Living Centre brochures were provided to the community.
Community Care Program	Lung Foundation Expo	Face-to-face at Southern Cross Club, marketing via public magazines, TV, etc.	People with respiratory disease and their carers.	20	Raised community awareness of the Independent Living Centre.
Rehabilitation services	12B discussion group	Face-to-face.	Families and carers on 12B.	11	Information on Independent Living Centre provided to the community.
Community Care Program	Evaluation of Footsure meeting—culturally and linguistically diverse (CALD) needs	Survey to CALD group leaders.	Carers ACT CALD groups.	5	Feedback on appropriateness of Footsure sessions for CALD groups.
Office of the Allied Health Advisor					
Office of the Allied Health Advisor (AHA)	Review of the Orthoptics Workforce Project	Face-to-face, semi-structured interviews, focus groups, literature review of available evidence.	ACT Health key stakeholders, including Allied Health Professionals (orthoptists), consultant ophthalmologists, Visiting Medical Officers (VMO), ophthalmologists, nursing staff, Workforce Policy and Planning, community members, union representative, professional association representatives, tertiary education sector.	10	All submissions, feedback and evidence collated during the consultation phase will be considered for inclusion in the final evidence-based report, which will make recommendations to develop the orthoptics workforce.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Office of the Allied Health Advisor					
Office of the Allied Health Advisor	Extended Scope of Practice Physiotherapy Project	Face-to-face, semi-structured interviews, literature review of available evidence.	Community members, nursing, medical officers (Orthopaedics, Emergency Department and Rheumatology), Chief Pharmacist, tertiary education sector and physiotherapists.	35	Safe, effective and efficient model of care for musculoskeletal presentation to the Emergency Department and Orthopaedic Outpatients by extended scope physiotherapists. Safe and effective trial of limited (simple analgesia), protocol-based physiotherapy prescribing in Orthopaedic Outpatients.
Office of the Allied Health Advisor	Advanced Allied Health Assistant Project	Face-to-face, semi-structured interviews, focus groups, online survey, literature review of available evidence.	Allied health professionals, allied health assistants, Workforce Policy and Planning, vocational and tertiary education sectors, Healthcare Consumers Association ACT.	79 comprising 25 allied health professionals, 36 allied health assistants (AHA) and 18 AHA students.	All submissions, feedback and evidence collated during the consultation phase will be considered for inclusion in the final evidence-based report, which will make recommendations to develop the assistant workforce.
Nursing and Midwifery Office					
Nursing and Midwifery Office	Mechanisms to engage the professions of nursing and midwifery and the community	Nursing and midwifery website.	Available on the internet.	5000+	Open communication, timely promulgation of nursing and midwifery news.
Nursing and Midwifery Office	Mechanisms to engage the professions of nursing and midwifery and the community	Nursing and Midwifery newsletter.	Aged care sector, tertiary education sector, nurses and midwives, community members, professional organisations, private and public institutions.	600	Informed workforce and community.
Nursing and Midwifery Office	Australian War Memorial Remembrance Ceremony	Memorial service held during International Nurses and Midwives Week of celebrations.	Veterans, nurses and midwives, defence force personnel, community members.	200	Respect and honour to members of the defence forces who have served our country.
Nursing and Midwifery Office	Community representation	Community representation on the Council for Nurses and Midwives ACT, the peak nursing and midwifery forum for nurses and midwives from all sectors across the ACT.	Consumer Health Forum.	Healthcare consumer representation (x2).	Strategic workforce issues and professional matters conveyed to the Council for Nurses and Midwives; a community representative participates in decision making.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
E-Health and Clinical Records Branch					
E-health and Clinical Records	My eHealth consumer portal	Direct consultation	Focus Group—Chronic Care Patients. Individual consultations between clinician and patient. Health Care Consumers' Association.	40 200–300 10–15	The My e-Health consumer portal which was launched by the ACT Chief Minister on 10 Sept. 2012. My e-health is a secure online service which improves patients' access to their health information, and helps them keep track of their appointments. Consumers are able to view and update their personal information, access medical appointments and print Canberra Hospital inpatient discharge summaries. Approximately 60 patients have registered with the My e-Health consumer portal. Visit: ***www.myehealth@act.gov.au***
E-health and Clinical Records	Find a Health Service Mobile App.	Workshops, demonstrations, and focus groups	Health Care Consumers' Association e-Health Reference Group, Health Care Consumers' Association Self Help Organisations United Together (SHOUT) ACT Medicare Local HSD Steering Committee (with HCCA representation).	10–15 10–15 10–15 8–12 8–12	Find a Health Service mobile app., was launched by the ACT Chief Minister 8 April 2013; it was the first 'app.' of its kind to be released by the ACT Government. Find a Health Service mobile app. provides a structured and easy- to-use health services directory covering services in ACT and neighbouring NSW locations. The mobile app. makes health service information available at consumers' fingertips, with each service listing containing a description, opening hours, contact numbers and relevant links for more information. There is also practitioner information so consumers can find a provider by a language spoken, ethnicity or medical speciality. Additionally, there is a specific after-hours healthcare section incorporated in the app., which highlights what services are options in after-hours periods. Consumers can freely download the 'app.' from the App Store (for Apple Devices) and Google Play (for Android devices) to use on their iPhone, iPad, smartphone, mobile, or tablet device. The app. is also viewable by other internet-enabled mobile phones at: ***www.findahealthservice.act.gov.au/m***

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
E-Health and Clinical Records Branch					
E-health and Clinical Records	National eHealth Record System—Personally Controlled Electronic Health Record (PCEHR)	Direct public consultation in key locations of the Canberra Hospital and Health Services and brochure distribution.	Individual consultations Health Care Consumers' Association e-Health Reference Group.	Over 500 10–15	On 22 March 2013, Canberra Hospital began submitting discharge summaries to the National eHealth Record System PCEHR. ACT is the first jurisdiction to submit clinical information to the eHealth Record System and the second healthcare organisation to achieve this milestone. Individual consumers choose to participate, and choose to authorise access to healthcare providers. To date approximately 311 patients have participated in assisted registrations to have a National PCEHR. Visit: ***www.ehealth.gov.au***
Population Health Division					
Health Protection Service	Consultation on the introduction of the food safety supervisor requirement from 8 Aug.–21 Sept. 2012.	A media statement from the Minister for Health was released on 8 Aug. 2012 advising of the public consultation and discussion paper. A discussion paper was posted on the ACT Health website and the ACT Government Community Consultation page on 8 Aug. 2012. Three face-to-face consultation sessions were conducted.	Food businesses Food industry representatives Registered training organisations General public.	27 written submissions on the discussion paper were received. 96 people attended face-to-face consultation sessions.	All received submissions and views expressed during the consultation process were considered as part of the food safety supervisor requirement development process.
Health Protection Service	Kava Supply in ACT. Proposal to issue a local exemption to allow kava use for cultural purposes under the Medicines, Poisons and *Therapeutic Goods Act 2008*.	Consultation paper forwarded to ACT Pacific Island community leaders through the Office of Multicultural and Torres Strait Islander Affairs (OMATSIA). Face-to-face meeting with ACT Pacific Island community peak representative.	ACT Pacific Island Community	Broad community base as distributed by OMATSIA.	Exemption made through amendment to the Medicines, Poisons and Therapeutic Goods Regulation 2008 to allow kava use for cultural purposes at declared public events. The Minister for Health declared the annual National Multicultural Festival to be a declared exempt event in January 2013.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Population Health Division					
Health Protection Service	5th Community Pharmacy Agreement initiatives Proposals to adopt two Commonwealth initiatives under the Pharmaceutical Benefits Scheme (PBS) in the ACT: • continued dispensing of PBS Medicines in defined circumstances supply and PBS claiming from a medication chart in residential aged care facilities.	Consultation paper forwarded to pharmacy and medical stakeholders.	ACT pharmacies Pharmacy and medical professional organisations. Consumers	200	Minister agreement to adopt both initiatives under the Medicines, Poisons and *Therapeutic Goods Act 2008*.
Health Improvement Branch	Healthy Workplaces Advisory Group	Stakeholder representation on advisory group established to guide the development and delivery of the ACT Workplace Health Promotion program.	Representatives from government directorates and non-government organisations.	9 non-government representatives.	Ongoing advice to the ACT Workplace Health Promotion program.
Health Improvement Branch	My Healthy Food and Drink Choices Initiative	Consultation workshops, staff survey, written submissions.	ACT Health staff, stakeholders, volunteers and visitors.	810 staff completed an on-line survey. 28 staff attended workshops. 5 internal/external organisation/group submissions were received. 28 individual internal/external stakeholder submissions were received.	Advice on the development of an ACT Health policy.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Population Health Division					
Health Improvement Branch (in partnership with Policy and Government Relations—Aboriginal and Torres Strait Islander Health)	Beyond Today... it's up to you campaign	Community nominated local people to feature in the campaign. Working Group to drive campaign development – regular face-to-face meetings and email correspondence. Aboriginal and Torres Strait Islander Tobacco Control Advisory Group to oversee campaign development—regular meetings. Focus group testing of creative concepts.	Winnunga Nimmityjah Aboriginal Health Service; Gugan Gulwan Youth Aboriginal Corporation; ACT Aboriginal and Torres Strait Islander Elected Body; ACT Education and Training Directorate—Aboriginal and Torres Strait Islander Education; Medicare Local; ACT Health—Aboriginal and Torres Strait Islander Health Unit and Health Promotion; general community.	Ongoing consultations with the Working Group (7 members) and Advisory Group (15 members). 2 focus groups.	Working and Advisory Groups provided advice and direction on the campaign. People featured in the campaign were nominated by the community. Productive relationships fostered with the Aboriginal and Torres Strait Islander community. Campaign implemented in December 2012.
Health Improvement Branch	Cervical Screening program	Consultation and information sessions	Consultations with Medicare Local and The Pharmacy guild of Australia informing them of program and requesting support in reminding clients for the need to regularly screen, and display and dissemination of promotional and educational materials in surgeries and pharmacies.	2 organisations.	Ongoing advice and educational material to inform the community of the importance of regular screening regardless of vaccination status.
Health Improvement Branch	ACT Cervical Screening program	Information and educational sessions for women.	Winnunga Nimitijah Aboriginal Health Service, Gugan Gulwan Youth Aboriginal Association, Young Women's Christian Association, the Junction, CALD community groups, women's fitness centres, women's crisis accommodation groups, various Commonwealth and ACT government departments. National Aborigines and Islanders Day Observance Committee NAIDOC Week women's health expo CIT, Reid.	18 occasions of service, approximately 190 participants.	Ongoing advice and educational material to inform the community of the importance of regular screening regardless of vaccination status.
Health Improvement Branch	Healthy Communities Initiative Advisory Group (pilot project based in Inner North Canberra)	Stakeholder representation on advisory group established to guide the development and delivery of the Healthy Communities Initiative.	Representatives from government directorates and NGOs.	4 non-government representatives.	Ongoing advice to the Healthy Communities Initiative.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Population Health Division					
Health Improvement Branch	Fresh Tastes: healthy food at school	Semi-structured interviews and informal interviews held onsite. Student questionnaire delivered at several youth week events.	Key teachers at ACT primary schools. High school-aged students.	15 ACT primary schools 100 students.	Informed development of healthy food at school/Fresh Tastes program.
Health Improvement Branch	Healthy Children's Initiative and Social Marketing	10 in-depth interviews and 6 focus groups.	ACT parents.	57	Consultation report received and used to inform family engagement strategies for Healthy Children's Initiative, as well as social marketing campaign messages.
Health Improvement Branch	Ride or Walk to School (RWTS) initiative	Surveys and workshops Surveys.	ACT school students. Schools community (parents, teachers, residents).	560 416	Informed development of RWTS program. Informed development of RWTS program.
Health Improvement Branch	School Youth Health Nurse program evaluation	Interviews Surveys.	School Youth Health Nurses School staff Representatives from external organisation stakeholders Representatives from government stakeholders High school students Parents.	4 nurses 17 staff from 8 schools 8 individuals from 7 organisations 9 individuals from 3 Directorates 290 students from 6 schools 7 parents from 4 schools.	Evaluation report outlined the key issues for the maintenance and expansion of the School Youth Health Nurse program.
Health Improvement Branch	Health Promotion Grants program	Community representation within 4 funding round assessment panels.	Representatives from the community and non-government organisations.	4 participants.	Assessment of grant applications and input into the allocation of grants to community based projects.
Health Improvement Branch	Health Promotion Grants program	Community consultation on future directions ACT health promotion grants program.	Broad range of community organisations, schools, relevant government agencies and NGOs with previous involvement in health promotion in the ACT.	70 participants attended a public meeting. E-mail contact made with over 1000 contacts on the Health Improvement Branch database, requesting consultation input.	As a part of the consultation process we received 39 written submissions. Representatives from 37 organisations attended a public meeting to share their views on the proposed changes. In 2013–14 ACT Health is redirecting the focus of the program towards projects that aim to reduce the incidence of obesity, particularly amongst the ACT's children.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Capital Region Cancer Service					
Capital Region Cancer Service	Cancer support groups	Participation in meetings about specific issues.	Leukaemia Foundation, Prostate Cancer Support Group, Brain Tumour Group, Laryngectomy Support Group, Lung Cancer and Mesothelioma Support Group.	100	Ongoing meetings to communicate with cancer support groups.
Capital Region Cancer Service	Presentation at Medicare Local ovarian cancer education event	Presentation	General Practitioners.	85	GPs informed about ovarian cancer.
Capital Region Cancer Service	BreastScreen Community Reference Group	Participation in biannual meetings.	Representatives from Council on the Ageing, Cancer Council, Country Women's Association, Canberra Multicultural Community Forum, Bosom Buddies, Winnunga Nimmitjah Aboriginal Health Service, HCCA ACT, Women with Disabilities ACT.	10	Ongoing. Consumer ideas and feedback on resources and events to increase participation in the programs.
Community Health Centres	Review of administration roles and functions in Community Health Centres	Face-to-face meetings.	HCCA, Mental Health Consumer Network and Carers ACT.	30+	Feedback incorporated into proposed administration model.
Community Health Centres	Community Health Centre Health Infrastructure Program project	Open Day—Gungahlin Community Health Centre.	General public.	100+	Local community aware of services available at Gungahlin Community Health Centre.
Service and Capital Planning					
Redevelopment Unit	Aboriginal and Torres Strait Islander Alcohol and Other Drug Residential Rehabilitation Service (Ngunnawal Bush Healing Farm)	Ongoing key stakeholder consultation on the development of the model of care and design plans through regular meetings with the Aboriginal and Torres Strait Islander Advisory Board.	The Advisory Board includes individuals from the Aboriginal and Torres Strait Islander communities, representatives from non-government community organisations, ACT Health and the Commonwealth Department of Health and Ageing (ACT/NSW Office).	The Advisory Board consists of 15 members. The Board meet in July and November 2012. Co-chairs of the Board, Roslyn Brown, Aboriginal and Torres Strait Islander Elected Body and United Ngunnawal Elders Council and Ross O'Donoughue, Executive Director, Policy and Government Relations continue to meet on a regular basis to discuss progress.	The Advisory Board provided input to the model of care as well as preliminary and final sketch plans for the new facility.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Service and Capital Planning					
Redevelopment Unit	Aboriginal and Torres Strait Islander Alcohol and Other Drug Residential Rehabilitation Service (Ngunnawal Bush Healing Farm)	Community consultation on preliminary sketch plans for the new facility included media announcements, newsletters, online information, a listing on 'Time to Talk' ACT Government consultation web page, press advertising, emails, shopping centre displays, factsheets, posters and 'drop-in style' public information sessions.	• ACT community • ACT Government • ACT Health staff • potential service users and their families • Tharwa community and rural landholders • Aboriginal and Torres Strait Islander community and key stakeholders • Aboriginal and Torres Strait Islander organisations and service providers • alcohol and other drug and mental health related sector • other providers of residential alcohol and drug rehabilitation services.	45–50 people attended the public forums, and 143 people engaged with staff at shopping centre information displays. A web page for the preliminary sketch plan consultation received over 700 hits.	Further information requested by interested parties was provided on request. Comments on the preliminary sketch plans were used to guide the development of final sketch plans.
Health Care Consumers' Association (HCCA) – Health Infrastructure Program (HIP) project officers	Health Infrastructure Program community awareness	Throughout 2012–13 the HCCA was funded to conduct information sessions in the Canberra community to raise awareness of the HIP and to seek community comments on ACT Health service delivery and HIP planning.	Information sessions were conducted for a broad spectrum of the community including CALD groups, Community Councils, older persons, and people living with chronic conditions.	Over 400 individual members of the community participated in the information sessions.	Feedback and comments received by the HCCA were provided to ACT Health for consideration and to guide improvements in HIP planning, communication and community engagement.
Redevelopment Unit	University of Canberra Public Hospital Executive Reference Group	Consumer representatives on the committee.	Health Care Consumers' Association, ACT Mental Health Consumer Network, Carers ACT.	3	Leads the work for the development of the Service Delivery Plan, Concept Master Development Plan and Health Services Planning Unit Briefs.
Health Services Planning Unit	University of Canberra Public Hospital	User Group Meetings.	Carers ACT, Health Care Consumer' Association, ACT Mental Health Consumer Network.	11	Development of Health Planning Unit Briefs for detailed planning.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Service and Capital Planning					
Health Services Planning Unit	Clinical Services Plan	Draft Plan for consultation: • ACT Government Time to Talk posting • web page • Director-General newsletter • letters to identified stakeholders. • Survey Monkey for internal staff	• Steering Committee membership • ACT-wide health professionals • Local Hospital Network Council • Southern NSW and Murrumbidgee Local Health District • Health Care Consumers' Association representatives • unions • professional bodies • other ACT Government Directorates • community-based organisations • ACT Medicare Local	Extensive numbers through the various channels including 48 external agencies and consumer consultations.	• 31 written submissions were received from individuals, ACT Health business units, peak bodies and community based organisations. • 53 responses were received through the Survey Monkey. • Plan is being finalised.
Health Services Planning Unit	Cancer Services Plan	Membership Steering Committee	Local Hospital Network Council, Medicare Local, Southern NSW Local Health District, Health Care Consumers' Association and Consumer Representative.	5	Development of draft plan for community consultation.
Quality and Safety Unit					
Quality and Safety Unit	Patient Experience Narrative project	Patient interviews	Individual consumers who had an inpatient admission to a particular ward in February 2013.	12	Themes from the patient narratives will be presented to the Local Hospital Network who will then prepare recommendations for service improvement.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
People Strategy and Services Branch					
Workforce Policy and Planning Unit	Programs under the GP Workforce program: • Primary Health workforce officer role • Education Infrastructure Support Grant Payment (EISGP) • ACT Health—Australian National University General Practitioner (GP) Scholarships including the Peter Sharpe Scholarship for medical students studying Indigenous Health stream	Collaboration with Medicare Local GPWWG and direct communication with: • ANU • Medicare Local • GPs (one-to-one communication) Email, letter and phone call.	Key general practice stakeholders. Representatives from key ACT/ Commonwealth government and medical organisations as per the terms of reference. Special subgroups formed as per group's workplan requirements.	14 General Practitioner Workforce Working Group GPWWG members representing stakeholder organisations. 30 practices contacted about the change to EISGP claiming policy.	Ongoing: Providing input into development/enhancements of current programs, including the review of the GP Scholarships program. Providing expert advice on general practice workforce issues. Information disseminated regarding the change to EISGP claiming policy.
Workforce Policy and Planning Unit	Health Workforce Australia—National Clinical Training reform – ACT Region Integrated Clinical Training Network (ICTN)	Meetings: ACT Region Integrated Clinical Training Network Executive Management Group ICTN EMG, steering groups and reference group. Emails sent to ACT Region ICTN partners. Rounding on members one-on-one.	ACT and regional healthcare and health education providers. ACT Region ICTN Aboriginal Workforce Community.	ACT Region ICTN whole-of-network has over 40 members from 27 different organisations.	The ACT Region ICTN provides collaborated expert advice on clinical training and training placement growth in the ACT for the health workforce of the future, and provides infrastructure to maintain gains.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
People Strategy and Services Branch					
Workforce Policy and Planning Unit	Develop Health Workforce Plan 2013–2018 (ACT)	Presence on ACT Health website. Targeted emails to key stakeholders seeking input. Discussion paper and Workforce Plan published on ACT Health website. 2 face-to-face information sessions held in Woden and Belconnen for external stakeholders.	All Unions representing ACT Health employees and stakeholders across health, tertiary education, NGOs and community representatives.	Invitation to attend face-to-face information sessions regarding the Workforce Plan Discussion Paper sent to approximately 66 stakeholder groups. Workforce Plan draft sent to the 13 Unions on the ACT Health Union contact list as well as extensive internal circulation.	Informing the final version of the Workforce Plan. Written submissions received from the Australian Nursing Federation. 6 stakeholders attended the face-to-face information sessions.
Workforce Policy and Planning Unit	Decision whether to introduce the Physician Assistant role in the ACT.	Direct stakeholder emails and a face-to-face session for stakeholders.	Senior medical and nursing stakeholders in the ACT Public Sector, Unions, tertiary education representatives, Medicare Local and some interstate educational stakeholders.	17 representatives	Paper developed regarding the potential for introducing the Physician Assistant role in the ACT. No clear need identified for this role at this stage. This may be reviewed at a later stage.

B.2 Internal and external scrutiny

The following table summarises reports during the reporting year on aspects on the Health Directorate's operations.

Name of agency	Nature of inquiry/ report title	Recommendations/outcome of inquiry	Response to the outcome of inquiry
Protiviti	Review of controls and systems in place to ensure that reporting is adequate to meet the needs of activity based funding requirements	**Three recommendations were made relating to:** • establishing and formalising accountabilities and reporting structures with activity-based funding (ABF) program management. ABF business rules should also be defined, and supported by formalised policies and procedures • considering using additional resources to support current management and facilitate a more diversified and sustainable team with ABF skills • formalising data input procedures that address timeliness, completeness and accuracy. These procedures should be communicated to hospitals for consideration.	ACT Health agreed to all recommendations.
Pricewaterhouse Coopers	Review of information security	**Seventeen recommendations were made relating to:** • preparing an overarching information security risk assessment and information security policy, clarifying responsibilities for clear ownership and accountability for information security, and refreshing policies to ensure consistency and currency • formalising an Information Asset Register to improve identity of key information sources, including ownership and responsibilities of information assets • developing a document that defines information security requirements, associated policies and improves staff awareness • reviewing and updating information security policies and procedures for completeness, practicality and consistency; together with a compliance regime • defining a classification framework that outlines how different classes of information should be categorised and handled • assessment of which processes are used in multiple business areas, to streamline and standardise these processes • running security awareness training to meet the needs of those receiving the training • developing a compliance regime • including information security incidents in the incident reporting framework and categorising in accordance with the International Standards Organisation (ISO) 27002 • phasing out the usage of generic logons • restricting access to unapproved USB devices, where there is no business need • deploying email classification-marking software and associated staff training • implementing technology that prevents the copying of files to insecure locations • implementing an Electronic Records Document Management System, which is integrated and available to all staff • minimising the number of duplicate information requests from patients • investigating Mobile Device Management solutions to control ACT Health's information on mobile devices • assessing integration of mobile devices clinical workflows, efficiently and effectively in a secure manner.	ACT Health agreed to 11 recommendations. One recommendation was noted in relation to implementing an electronic records document management system. Three recommendations were partially agreed in relation to restricting access to USB devices, developing a strategy to phase out generic logons and minimising the number of duplicate information requests from patients. Two recommendations were agreed-in-principle relating to deploying e-mail classification marking software and implementing controls that prevent and detect copying of files to insecure locations.

Name of agency	Nature of inquiry/ report title	Recommendations/outcome of inquiry	Response to the outcome of inquiry
Pricewaterhouse Coopers	Review of purchasing of medical and surgical supplies	**Seven recommendations were made relating to:** • further formalising policies and procedures in relation to purchasing and inventory management • centralising monitoring and management of consignment stock function • updating stocktake procedures and determining the most appropriate levels of stock on hand • ensuring stock that is disposed of is recorded in the inventory management system • reviewing the option to create a register for re-usable items • ensuring the process of developing Surgeon preference cards is completed • Surgical and Oral Health extending the scope of its future internal reviews to include the consideration of the cost effectiveness of custom packs.	ACT Health agreed to four recommendations. Two recommendations that were partially agreed to related to stocktaking and stock obsolescence. One recommendation agreed to in principle related to reusable items.
Pricewaterhouse Coopers	Review of compliance with Freedom of Information (FOI) procedures	**Five recommendations were made relating to:** • updating the FOI guidance to further highlight compliance requirements and importance of compliance • keeping a formal registry of all training sessions held and recording the attendance of all staff via a compulsory sign-in sheet • updating procedural documents and guidance in relation to the performance of the FOI coordination role • updating the 'Guidance Package' to reflect current estimate rates and also the process for deducting the first 10 hours charges to align with the *Attorney-General's (Fees) Determination 2012* • ensuring that completed timesheets are returned with the requested FOI documents from the responsible areas, and include capturing the FOI Coordinator's time where applicants are to be charged fees.	ACT Health agreed to all recommendations.
Pricewaterhouse Coopers	Review of Oxygen and Equipment Schemes with Rehabilitation Aged and Community Care (RACC)	**Three recommendations were made relating to:** • upgrading the MES@LS application software to address the deficiencies of its current functionality • performing an assessment of available resources, funding, consumer preferences and risk level of different types of equipment in terms of programmed scheduled maintenance • investigating the ability to scan and save all related application forms and referrals into MES@LS against a certain piece of equipment on loan.	ACT Health agreed to all recommendations.

Name of agency	Nature of inquiry/ report title	Recommendations/outcome of inquiry	Response to the outcome of inquiry
Pricewaterhouse Coopers	Review of contractor compliance with health and safety	**Seven recommendations were made relating to:** • working with Shared Services Procurement to ensure that safety key performance indicators are incorporated into contracts that enable the relevant ACT Government entity to effectively manage contracts for significant breaches or repeat offences • updating their policies and induction to improve the level of detail contained in the *Work Health and Safety Act 2011* • seeking to have the Contractor Safe Work Practice and Compliance Policy classified, reviewed and finalised • establishing clear definitions for each class of contractor and their associated responsibilities and risk profiles • ensuring that project managers for small builds and refurbishments are aware of their accountabilities relating to sub-contractors used on campus • ensuring that project managers for small builds and refurbishments [i.e. non Health infrastructure Program (HIP) works] are aware of their accountabilities relating to sub-contractors used on campus • reviewing the contractor sign-in records to ensure that all relevant fields are included.	ACT Health agreed to five of the recommendations. One recommendation is noted relating to establishing clear definitions for each class of contractor. One recommendation has been agreed-in-principle relating to key performance indicators.
Pricewaterhouse Coopers	Review of governance practices relating to Health Infrastructure Program (HIP)	**Eleven recommendations were made relating to:** • reviewing the HIP project management governance documents in existence and having them updated, consolidated and made available from a single location • conducting a performance review of committees and meetings in operation with respect to project governance • reviewing risk management policies and procedures that extend to the identification and assessment of project risk, risk treatment, mechanisms to monitor, review and communicate on risks • implementing a regular independent review of the HIP to assess performance in line with the governance framework and to provide assurance that policies and procedures are in place to monitor project and contract management performance • developing and implementing project and contract management performance criteria • working with Shared Services Procurement to ensure that the contract management recommendation can be implemented • incorporating in policy the requirement for a project to identify in advance where specialist skills are required and obtain approval from a governance body such as the Expert Advisory Panel that it is appropriate • routinely reviewing and updating the governance framework • designing a project management framework to support the HIP • developing policies and procedures to assist staff with understanding the processes necessary to carry out their project management responsibilities • as part of updating the project management framework, developing a file cover sheet that lists all the key materials that would be expected for a given project.	ACT Health agreed to ten recommendations and one recommendation was noted in relation to developing risk management policies and procedures.

Name of agency	Nature of inquiry/ report title	Recommendations/outcome of inquiry	Response to the outcome of inquiry
Pricewaterhouse Coopers	Review of processes for managing deteriorating patients	**Five recommendations were made relating to:** • implementing a formal process for monitoring actions undertaken by clinical areas in response to issues identified by the Rapid Response Committee (RRC) • ensuring that ongoing reporting required by current procedures and guidelines is provided to the RRC • implementing a Medical Emergency Team (MET)-specific training session or refresher program to ensure that MET staff are aware of the policies and procedures to follow when responding to and finalising a MET call • reviewing current data audit procedures to include further focus on ensuring that data entered into and extracted from information management is complete and accurate • ensuring that adequate training and assistance is provided to staff in undertaking end-of-life conversations.	ACT Health agreed to all recommendations.
Auditor-General's Office	Final Audit Management Report, 30 June 2012	**Twelve recommendations were made relating to:** • finalising and settling its agreement for health services provided by Calvary Public Hospital with Calvary Health Care ACT Ltd • finalising the 'Digital Health Enterprise Technology Strategy and Implementation Plan'. This Plan should be reviewed and updated on a regular (annual) basis • reviewing, updating and approving its business continuity management arrangements on an annual basis as required by the Policy and Framework • documenting and approving business continuity and disaster recovery procedures for each revenue system • ensuring that user access lists for 'ProAct' are regularly reviewed and evidenced as such • developing and approving a formal policy for the reviewing of audit logs for the 'ProAct' system. ACT Health should also implement regular reviews (e.g. monthly or quarterly) of audit logs for the 'ProAct' system • reviewing its 'Data Quality Policy' on a regular basis • finalising and approving its project management policy for information systems and having this policy reviewed on a regular basis • finalising and approving support agreements for the Kestral and Room Master systems • ensuring that cross-border revenue is not offset against cross-border expenses when preparing its annual budget and financial statements • ensuring that all accountability indicators are measured on a basis that is consistent with their descriptions • ensuring that work papers supporting the results reported in the statement of performance are completed, prepared and reviewed prior to the certification of the statement of performance.	ACT Health agreed to all recommendations.

Name of agency	Nature of inquiry/ report title	Recommendations/outcome of inquiry	Response to the outcome of inquiry
Auditor-General's Office	Emergency Department Performance Information (Report No.6/2012 Tabled in the Legislative Assembly on 3 July 2012)	**Ten recommendations were made relating to**: • reviewing performance indicators for publicly reporting the performance of Canberra's hospitals' emergency departments to include and give a greater emphasis to qualitative indicators relating to clinical care and patient outcomes • developing essential Emergency Department Information System (EDIS) governance documentation • ACT Health, in conjunction with Shared Services Information Communication Technology (ICT), finalising the draft Business System Support Agreement between Shared Services ICT and ACT Health for EDIS • ACT Health and Calvary Public Hospital: – reviewing the current distribution of access to EDIS throughout the hospital and removing any users who do not have a specific and documented requirement for access to the system – developing policies, administrative procedures and system controls (if possible) that restrict the use of generic user accounts outside the Emergency Department work environment • ACT Health and Calvary Hospital identifying and documenting responsibilities for user access management and log monitoring for EDIS, and developing processes to monitor user activity within EDIS ACT Health reviewing: • the current EDIS upgrade project and linking it with current ACT Health Identity and Access Management and Rapid Sign-On initiatives that are currently underway • all available Emergency Department software to evaluate whether or not the current EDIS should be replaced with one that has strong confidentiality and integrity controls as well as appropriate process linkages • developing policy and administrative guidance for EDIS data validation activities for the two Canberra hospitals • implementing additional review and assurance controls over the preparation and reporting of Emergency Department timeliness performance information • noting the findings of this report and considering whether misconduct or breach of section 9 of the *Public Sector Management Act 1994* and executive contract applies • reinforcing to employees, especially executive staff, the need to act with integrity with respect to the maintenance of health records and associated data.	ACT Health agreed to all recommendations.

Name of agency	Nature of inquiry/ report title	Recommendations/outcome of inquiry	Response to the outcome of inquiry

Auditor-General's Office	Australian Capital Territory Public Service Recruitment Practices (Report No.8/ 2012 Tabled in the Legislative Assembly on 25 October 2012)	**Two recommendations were made relating to:**
		• ACT Health:
		    • improving recruitment timeliness by reviewing processes to identify potential opportunities for efficiencies in consultation with Shared Services Human Resources
		    • identifying and documenting reasons for delays in actual recruitment processes
		    • improving records management and documentation of recruitment processes
		• providing time-to-hire information to the Commissioner for Public Administration to assist with the preparation of the annual ACT Public Service Workforce Profile.
			ACT Health agreed to all recommendations.

Internal Audit and Risk Management branch	Review of whether the content and storage of medical records complies with medical and legal requirements	**Eight recommendations were made relating to:** • implementing recommendations in locations' action plans to assess the on-going use of facilities and to consider finding better locations and consider options for sentencing of those records • implementing action plans to remedy identified gaps so that ACT Health better complies with legislation whilst also implementing a revised and improved medium- to long-term strategy for storage of heath records • reviewing the contract between the commercial storage providers to assess options for improved services • implementing a consistent revised and improved medium- to long-term strategy for storage of heath records across ACT Health • undertaking an OHS risk assessment at facilities • considering finalising the records management program • considering updating its business continuity policy for the clinical record service • considering whether clinical divisions should include essential clinical record documentation as part of their audit schedule to reinforce good clinician documentation practice.	ACT Health agreed to five recommendations. Three recommendations were partially agreed relating to implementing recommendations in locations' action plans, implementing a consistent strategy for storage of health records and consider options for sentencing of those records.

Name of agency	Nature of inquiry/ report title	Recommendations/outcome of inquiry	Response to the outcome of inquiry
Protiviti	Review of Construction of the Adult Acute Mental Health Inpatient Unit	**Sixteen recommendations were made relating to:** • utilising business cases and budget submissions as the basis for funding allocation • the Redevelopment Unit developing initial assessment of the most appropriate governance and structural arrangements • increasing 'in house' major healthcare construction project expertise before continuing further with the HIP • defining the role of the primary user health service along with a clear definition of when it must be involved and what skills and capabilities it is expected to bring to that involvement • designing program governance with a clear outcome in mind both at a program as well as a project level • outlining a clear delegation structure for financial, design, contractual, scope and human resources matters being established and enforced • establishing an independent project assurance mechanism for the HIP • introducing the following governance arrangements for HIP projects: – a specific mandate (and capability and capacity) for the Redevelopment Unit to initiate reviews to assess a need for reconsideration of project strategy or management should this be required – the establishment of project 'gateways' at which the Redevelopment Committee should formally assess whether projects should be continued or suspended. • considering application of some of the better practice features of design sign-off • robustly assessing different contract forms to ensure the contract form used best manages the Territory's (and the project's) risk given the individual project circumstances • focusing more on core project management and cost control disciplines • assigning an experienced risk manager with appropriate skills, authority and accountability to ensure effective identification and management of risks • establishing a standard or better practice basis for monthly reporting from the projects within the program • taking responsibility for accumulation and monitoring of all cost sources associated with any project within the HIP • appointing a quantity surveyor with appropriate skills and knowledge of the program, to provide independent assurance on forecast final costs on projects • ensuring that any 'value engineering' or 'value management' activities include specificity on how savings will be achieved, a risk assessment associated with each savings initiative, and a tracking mechanism for achievement of savings.	ACT Health agreed to all recommendations

B.3 Legislative Assembly committee inquiries and reports

Standing Committee on Health, Community and Social Services

Report No.	Title	Date presented
7	Annual and Financial Reports 2010–11	June 2012

Recommendation	Government response	Directorate implementation
3. The Committee recommends that the Minister for Health provide an update on the development of the workforce retention strategy during the forthcoming Estimates process.	Agreed. The Workforce Plan for the Health Workforce of the ACT 2012–-2017 Discussion Document was made publicly available on 21 June 2012. The discussion paper collates key national and local workforce issues and considers strategies that may help to resolve or improve these issues and will be used to inform the development of the Workforce Plan for the Health Workforce of the ACT for the period 2012–2017. The paper can be located at: ***http://health.act.gov.au/professionals/workforce-planning/workforce-plan/workforce-plan-discussion-document.***	The ACT Health Workforce Plan 2013–2018 has been finalised and can be found on the ACT Health web site at ***http://health.act.gov.au***. The plan was developed following extensive input from a wide range of stakeholders, including ACT Health workers, other health care providers in the ACT, unions and consumer organisations. The plan progresses the national health workforce agenda by using the domains identified in Health Workforce Australia's National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015 as a framework.

Standing Committee on Public Accounts

Report No.	Title	Date presented
25	Review of Auditor-General's Report No. 1 of 2011—Waiting Lists for Elective Surgery and Medical Treatment	22 August 2012

Recommendation	Government response	Directorate implementation
1. The Committee recommends that the ACT Auditor-General should program a follow-up audit to examine the management of access to elective surgery across the ACT's public hospitals at the midpoint of the 8th ACT Legislative Assembly term.	Noted. The Auditor-General determines her work plan independently of Government advice.	Not applicable.

Report No.	Title	Date presented
29	Review of Auditor-General's Report No. 6 of 2012—Emergency Department Performance Information	3 July 2012

Recommendation	Government response	Directorate implementation
1. The Committee recommends that the Minister for Health give consideration to finalising the Government submission to the Standing Committee on Public Accounts in response to Auditor-General's Report No. 6 of 2012: Emergency Department Performance Information earlier than three months after the report being tabled.	Not agreed. There are a large number of recommendations in the Public Accounts Committee Report. The proposed timeframe for responding to the Public Accounts Committee recommendations was not achievable prior to the commencement of the caretaker conventions in the lead up to the Territory election in October 2012. This submission now addresses that response.	No further action required.
2. The Committee recommends that the Minister for Health make representations at the appropriate forums to progress the concept of a regular national audit by the Commonwealth Auditor-General of health performance and data integrity as it relates to Commonwealth agreements through the recently amended legislative provisions of the Commonwealth *Auditor-General Act 1997*.	Noted. The concept of data integrity on health performance monitoring is integral to ensuring consistent and accurate monitoring and assessment of performance across all jurisdictions. In light of issues that have arisen at Canberra Hospital emergency department, the Commonwealth will undoubtedly put in place processes to ensure accuracy of data. Issues relating to data integrity and reporting have been raised by the ACT at the recent Australian Health Ministers Council and work is underway on a National basis to improve the quality of information we report. At a local level, the ACT Health Directorate is implementing strategies to improve data quality controls across the organisation. A Director of Data Integrity position is being established to oversee processes and methods for data collection, collation and reporting. There is also a review underway to review the data governance structure across Health to ensure greater consistency and accountability for the data that is reported locally and to external agencies. The ACT Health Directorate has gone to tender to undertake a data integrity audit. This audit is aimed at assessing Health data assets to tighten up controls on the entry and security of health related information. On behalf of the Government, the Chief Minister has raised at a national level the issue of striving for nationally consistent measures for emergency department performance. It is the Government's aim to work with other jurisdictions to minimise the variable interpretation that currently exists around data definitions and reported data, ensuring that we obtain and report data that is comparable between States and Territories. The Government will also be seeking agreement from other jurisdictions to implement more qualitative measures of the effectiveness of outcomes for patients treated in the nation's emergency departments.	The Commonwealth and relevant national authorities will implement mechanisms to ensure data integrity as part of the National Health Reform Agreement.
3. The Committee recommends that the Government of the day review the security of information which identifies individual patients at the Canberra Hospital and report on the outcomes of this review to the ACT Legislative Assembly on the first sitting day of 2013.	Agreed in part. The Health Directorate is in the process of developing System Security Plans for all applications considered by the Health Directorate and Shared Services ICT to be either Government or Business Critical. This process is based on assurances in relation to the security of information which directly identifies patients. It is planned to have these security plans completed by June 2013. Two plans have been finalised to date, with another seven plans close to completion. These plans include all of the key applications that contain individual patient information. The timeframe specified by the Committee was not achievable and therefore is not agreed.	Security plans are being developed for all applications across ACT Health.

Recommendation	Government response	Directorate implementation
4. The Committee recommends that the Health Directorate in conjunction with Shared Services ICT ensure that appropriate training on every IT related hospital system, with a particular focus on the Emergency Department Information System (EDIS), is provided to all staff at the Canberra Hospital and Calvary Public Hospital.	Agreed. Training for systems is managed by Shared Services ICT Health and training is provided for staff at the commencement of duties and where training requirements are subsequently identified (ie when staff transfer to areas requiring application use or have extended leave that may require a refresher eg Maternity leave). New training packages have been developed for the EDIS which focus on the different roles of people within the emergency department (nurses, administrative staff, doctors). New systems are also being implemented which will require more formal training processes to be completed by all staff within the emergency department. Comprehensive training in the major systems (such as the ACT Patient Administration System) is provided for Canberra Hospital, Calvary Public Hospital and community services staff. Training is provided for the equipment lending system for the service at Kambah. Training is provided in relation to access to the Clinical Portal on an as-needs basis and immediately for staff identifying the requirement, and is otherwise scheduled. Training is provided for the Mental Health Assessment Generation and Information Collection (MHAGIC) system. Access is provided on the completion of training provided by Shared Services ICT Health. The other training and support model is managed through business units for all other application training and support. Specifically, emergency department training and system administration is managed locally by the each hospital service and training is provided to hospital staff by the ACT Health staff who manage the systems. Other IT related hospital systems are managed using a similar model to ED and training is addressed as needed and where appropriate scheduled for groups. A number of the IT related hospital systems may support specialist and limited user requirements to service a particular business need or functional requirement. Local business support models accommodate these requirements. There is also work underway assessing the Data Governance across the Directorate. One key recommendation will be to conduct a full scale audit of all data assets across the Directorate. This process will enable visibility of all data systems and processes. The Directorate will be able to assess current data assets and develop appropriate training and protocols for the collection, collation and reporting of health system information. This process will be ongoing with regular auditing of data to provide further evidence of additional training requirements.	Systems are in place to provide training for staff in all relevant applications. New training modules are being developed for the new version of EDIS.

Recommendation	Government response	Directorate implementation
5. The Committee recommends that robust data validation processes be established for the Canberra Hospital and that the Government of the day report to the ACT Legislative Assembly on the first sitting day of 2013 on their implementation.	Agreed in part. Validation of data in the Health Directorate occurs at a number of points along the continuum from the point of data collection in the source system to end use of the data for reporting and analysis. The first tier of validation involves review by administrative staff and system administrators at the time of data entry into the Emergency Department Information System, usually on a daily basis. A second tier of data validation occurs at the time when data is extracted from source systems and sent to the Health Directorate for centralised processing. This validation process occurs on a monthly basis whereby each record extracted from the source system is run through a series of validation checks against established criteria in order to assess the completeness, accuracy and quality of the data. These validations ensure that ACT data meets nationally mandated data specifications as well as additional validations developed within ACT Health based on analyses of data, such as cross-checking data sources with data extracts used for reporting purposes, and the auditing of data extracts back to source systems to ensure that no changes are made to data extracts. Each month a report is produced on records that fail the validation criteria and then sent back to the originating hospital for investigation at the point of service to determine if the record is correct or requires updating in the source system. Records flagged for investigation will keep re-appearing on consecutive monthly reports until such time as the data is corrected in the source system or advice is received that the record is accurate. These validation checks review all records for possible errors and validity, regardless of whether they have or have not met timeliness targets or other established benchmarks. They also include, where possible, validation checks that have been developed at the national level for checking the quality of Emergency Department data at the point when all State health authorities submit their data to national bodies. Additional checks that are designed to monitor and identify any significant change in trends at a more aggregate level have also been implemented in the Health Directorate at the point of analysis and reporting of Emergency Department data. Prior to the issues with emergency department data in 2012, a number of audit checks were in place to ensure data accuracy. This included audits by the staff who reviewed data following the completion of an emergency department record for any inconsistencies or inaccuracies. This process continues. However, in addition to these checks, additional, system-generated checks are undertaken which monitor any changes to data following the audit process as well as additional reports which have been developed to note any changes to results. These additional processes will provide the mechanisms to highlight any changes to data that are not supported by evidence. The Health Directorate is currently reviewing processes for data validation in other jurisdictions to ascertain if there are any areas for improvement based on experiences elsewhere. The timeframe specified by the Committee was not achievable and therefore not agreed.	Validation processes are already in place. Additional audit checks for EDIS will be implemented with the introduction of the new system in late 2013.

Recommendation	Government response	Directorate implementation
6. The Committee recommends that, consistent with the recommendation of the Auditor-General, the rapid sign-on system be implemented as soon as practicable and that the Government of the day report to the ACT Legislative Assembly at the earliest opportunity on its implementation.	Agreed. The ACT Government Health Directorate has been working with Shared Services ICT to develop and trial a pilot of the Rapid Sign-On technology to ensure that the human useability factors and technical feasibility are addressed to minimise the disruption to clinical workflow. The completion of this pilot will result in a recommendation and costs for consideration by the organisation to proceed to widespread implementation within the Health Directorate and its diverse applications. The Pilot timeframe is expected to be completed by end of December 2013 with the resulting cost model and implementation plan to be considered by the Health Directorate. This pilot will draw upon a variety of business and technical resources to integrate a number of key components to ensure that the Rapid Sign-On solution is easy to use for our staff, secure, robust and reliable. The implementation of the Rapid Sign-On Technology will focus in areas of highest need, such as the Emergency Department, with a progressive rollout that is likely to take a period of time before the entire organisation has all of the benefits. This timeframe will become clear following the completion of the pilot study. This is largely as a result of the level of training and change management that will be needed for a successful integration of technology into existing clinical work practices without impacting upon patient care.	The pilot project is due to be completed by the end of 2013. The assessment of the pilot will determine the roll-out of the technology.
7. The Committee recommends that all ACT Government directorates and agencies should have effective practices and processes in place to review all reports of the Auditor-General, and to assess the relevance of the findings and recommendations to their agency, regardless of whether the agency was involved in a specific audit.	Agreed. The Director-Generalof the ACT Government Health Directorate wrote to all ACT Government Directors-General. Directorates are reviewing their processes to ensure that this occurs.	Completed. The ACT Health Director-General wrote to all directors-general noting this recommendation.

Recommendation	Government response	Directorate implementation
8. The Committee recommends that all ACT Government directorates and agencies should prioritise as a matter of urgency an assessment of the adequacy of controls over their respective IT systems and applications. This should include consideration of the controls that affect the reliability of all IT systems and applications (general controls) and controls that are specific to each application (application controls).	Agreed. On 4 July 2012, the Chief Minister wrote to all Ministerial colleagues, and subsequently, the Director General of the ACT Government Health Directorate wrote to all ACT Government Directorates to draw their attention to this issue. Responses note that systems are in place across the ACT to ensure control of access to and use of IT systems. The Government's new Commerce and Works Directorate has responsibility for providing a secure ICT operating environment within which Directorates operate their business applications. Responsibility for specific applications and the internal controls necessary to address indentified risks lie with the respective Directorate. Security advice to Directorates is provided by the SS ICT Security Team. SS ICT has in place many of the controls required to maintain the security of applications (including but not limited to): • Whole of Government security policies, standards and procedures; • A dedicated security team with high levels of skill in all facets of ICT, Physical, Personnel and Information security, including forensics, web penetration assessment, security architecture, risk assessments and secure coding. Ready to assist directorates as required; • A detailed security audit program across the ACT governments networks to minimise vulnerabilities; • A Security Awareness training program available free of charge to all directorates; • Assistance in the provision of security templates and advice to facilitate Directorates assessing risks and treatment strategies for their applications; • Vulnerability assessment for both internally and externally facing applications; • Server build standards; • Robust and rigorous system and application change control processes; • A robust and secure Internet Gateway and communications network; • Good physical security controls around data centres; • Internet content filtering and Anti-spam; • Workstation end point protection to address malware; • Device encryption for Laptops; • Having encrypted 'Thumb-drives' available for secure transport and storage of files; • Server based anti malware protection; • Network Access control; • Backup and storage strategies tailored to directorate needs. Shared Services ICT Security assists business system owners to conduct system level risk assessments and complete system level security plans specific to each Directorate in accordance with Auditor General report 2/2012, Recommendation 3e. This assistance identifies and manages vulnerabilities in relation to issues of confidentiality, integrity and availability of application systems.	Completed. The ACT Health Director-General wrote to all directors-general noting this recommendation. In addition, security plans are being developed for all ACT Health systems (see recommendation 3 above).

Recommendation	Government response	Directorate implementation
9. The Committee recommends that the Government of the day detail to the ACT Legislative Assembly, at the earliest possible opportunity, how it will address and improve issues about achievements against throughput and triage targets as they relate to the Emergency Department at the Canberra Hospital	Agreed. The detailed plan to address issues in relation to access to emergency departments and improving performance was tabled on the last sitting day in March 2013.	Completed. The Minister for Health tabled the ED access plan in the ACT Legislative Assembly in March 2013.
10. The Committee recommends that clear guidelines be established concerning internal communication between the ACT Health Directorate, the Canberra Hospital and Calvary Public Hospital.	Noted. There are a number of formal committee meetings that ensure visibility and clarity on issues affecting all facets of the Health Directorate and Calvary Public Hospital. A monthly Finance and Performance meeting has been established to discuss matters relating to activity and financial pressures experienced by Calvary Public Hospital. Administrative officers from Health and Calvary attend the forum and were applicable, items discussed that are of concern can be further raised at regular Network Committee meetings for resolution. The ACT Health Directorate and Calvary Health Care ACT have established a Network Agreement to clarify the relationship between the Health Directorate and Calvary Public Hospital. As part of this, a regular meeting between both entities occurs as well as a formal monthly meeting being established between both parties to discuss issues related to pressures and activity. This provides the basis for the relationship between entities and provides clear guidelines in relation to communication between parties.	Systems are in place. The Calvary Network Agreement Committee provides for high-level communication between entities and the Finance and Performance Committee provides for more detailed operational matters to be discussed.
11. The Committee recommends that clear guidelines be established concerning external communication regarding matters concerning the ACT Health Directorate, the Canberra Hospital and Calvary Public Hospital.	Agreed. The Health Directorate works with a range of national organisations and committees to ensure that our information is consistent with national guidelines and standards. This includes representation on Committees established by the Australian Institute of Health and Welfare, the National Health Performance Authority, sub-committees of the Australian Health Ministers' Advisory Council and meetings arranged by the COAG Reform Council in relation to health matters. The Health Directorate will establish a communication plan to ensure that outcomes from these national meetings are communicated more effectively across the Directorate.	Clear guidelines and agency representation exist for all major national committees and organisations. Responsibilities are clearly articulated to relevant executives.

Recommendation	Government response	Directorate implementation
12. The Committee recommends that the Government of the day detail to the ACT Legislative Assembly, at the earliest possible opportunity, what action the Health Directorate has taken to assess whether a prevailing organisational culture at the Canberra Hospital contributed to the circumstances surrounding the alteration and misreporting of performance information.	Agreed. As a result of findings of data alteration at Canberra Hospital emergency department, the Health Directorate commissioned two audit reports, part of which involved the assessment of reasoning behind the need to tamper with this data. The outcome of these assessments can be found in the Audit Report conducted by PWC. In addition, the Health Directorate conducted the 4th in a series of organization-wide Workplace Culture Surveys over the period 19 March – 11 April 2012. This followed surveys conducted in 2005, 2007 and 2009, each of which was used to identify, promote and track the outcomes of key development initiatives across the organisation, as well as specific activities within divisions/branches and work areas. The surveys are undertaken by an independent organisation, which provides for benchmarking against similar services across the nation. The surveys cover a range of issues relating to staff management including responses to questions in relation to training and education, bullying and harassment, team dynamics, staff management and leadership. The 2012 survey had a response rate of 55%, with 3161 staff completing the survey. This is the highest response rate the organisation has achieved and is statistically significantly above average compared with similar organisations nationally. The overall culture has steadily improved and is above average compared with government public health care norms. The ‘Employee Quality of Working Life’ index (which is extracted from the general staff survey noted above) which considers a broad range of factors (including job satisfaction, workplace values, team norms, and management and leadership skills) has similarly shown significant improvements and places the Health Directorate 15% above government public health care norms. Training, reporting and perceptions of how bullying and harassment complaints are managed showed some of the biggest improvements. The detailed results and analysis of the 2012 Workplace Culture Survey are used to consider the priority areas of focus at both the organisation level and at division/branch/unit levels. Improving the workplace environment and responding to feedback from staff is a core responsibility of the ACT Government as an employer.	Completed. A response is provided in the government’s submission to the assembly. The response noted the work undertaken to assess organisational culture and systems in place to address issues raised from that assessment.
13. The Committee recommends that, given the Health Directorate’s failure to protect the privacy of the Executive who admitted to altering data—prior to any civil, criminal or administrative proceedings—the Health Directorate should: (i) issue a public apology to the individual concerned; and (ii) take appropriate steps to acknowledge the individual’s contributions to the operation and administration of the Canberra Hospital.	Noted. The naming of the Executive who admitted fault for altering emergency department data at Canberra Hospital was unfortunate. It was not the intention of the ACT Government Health Directorate, or the ACT Government to have this person’s name revealed, although legal advice indicated that there was no reason to withhold the staff member’s name. This Executive had a longstanding career in Health including working as a Clinical Nurse Consultant, a Director of Nursing of Canberra Hospital Emergency Department, before commencing as Executive Director, Critical Care Division. It is unfortunate that the hard work and commitment of this individual over a long period has been overshadowed by more recent events.	The government’s submission to the Public Accounts Committee noted the career of the person in question.

Recommendation	Government response	Directorate implementation
14. The Committee recommends that the Commissioner for Public Administration, in consultation with ACT Government directorates and agencies, develop a whole-of-government policy for the management of private information relating to ACT Public Service employees and recipients of ACT Government services.	Agreed. The Director-General has written to the Commissioner for Public Administration and is awaiting a response on this matter.	The Commissioner for Public Administration is developing an approach in relation to this matter (The ACT Health Director-General wrote to the Commissioner in September 2013 noting this recommendation).
15. The Committee recommends that the Government of the day should inform the ACT Legislative Assembly, at the earliest possible opportunity, if the emergency access targets under the National Partnership Agreement on Improving Public Hospital Services, will not be reached by the Canberra Hospital for the 2012 calendar year.	Agreed. Public Hospitals across the ACT have been working hard to improve the Territory's performance against the National Emergency Access Targets. The initial infrastructure required to increase emergency department and inpatient capacity will not be completed until 2013, and there have been delays in implementing new processes to improve patient flows. In the meantime, neither Canberra Hospital nor the ACT as a whole have reached the 64% target. (for the proportion of people with an emergency department length of stay of less than four hours) to achieve reward funding for the National Emergency Access Target in 2012. Current indications from the Commonwealth Department of Health and Ageing are that the ACT is not alone in this result. The current Deputy Director-General, Canberra Hospital and Health Services is reviewing the projects underway in order to establish a clear and coordinated approach across the entire hospital to reduce the barriers which create delays and result in system blockages. In addition, the emergency department at Canberra Hospital has implemented some recent initiatives that will assist in improving performance in 2013, including: • 'front loading'—a concept that enables treatment spaces to be available during peak hours of the day where patients can be assessed and treated by an ED doctor more rapidly; • The expansion of the Canberra Hospital Discharge Lounge. This enables patients to leave the inpatient wards earlier, freeing up inpatient beds and allowing for increased access from the emergency department; • Establishing criteria led discharge to provide better access to inpatient beds by eliminating delays. The National Health Performance Authority released the 2011–12 MyHospitals report on 14 December 2012. The report showed that both Canberra Hospital and Calvary Public Hospital were performing at or above the national average against other peer hospitals in terms of NEAT performance.	Completed. The assembly was informed that the ACT did not meet the 2012 NEAT target.
16. The Committee recommends that the 8th ACT Legislative Assembly Standing Committee on Public Accounts should give due consideration to conducting an inquiry into the process of future delivery of health care services across the Canberra Hospital and Calvary Public Hospital.	Noted. This is a matter for the Committee.	This is a matter for the new Public Accounts Committee.

Standing Committee on Health, Ageing, Community and Social Services

Report No.	Title	Date presented
	Annual and Financial Reports 2011–2012	Completed 16 May 2013.

Recommendation	Government response	Directorate implementation
6. That the Minister for Health provide the Committee with a detailed update of each health infrastructure project currently underway or in planning by 30 June 2013.	The Government response is still being developed as at 30 June 2013.	The detailed update was provided directly to the committee.

Select Committee on Estimates 2012–13

Report No.	Title	Date presented
1	Appropriation Bill 2012–2013 and Appropriation (Office of the Legislative Assembly) Bill 2012–2013	Completed 14 August 2012.

Recommendation	Government response	Directorate implementation
28. The Committee recommends that the ACT Government consult with Paramedics Australia regarding registration of paramedics as part of the National Health Practitioners Registration Scheme.	Agreed. The Health Directorate and the ACT Ambulance Service has already consulted with Paramedics Australia in relation to registration options of paramedics and will continue to consult with them until a National decision is made.	The ACT Paramedics Regulation Project Consultation Forum was held on 24 July 2012. Paramedics Australasia attended this forum and provided input. A copy of the Paramedics Australasia *Role Descriptors for Paramedics in Australia and New Zealand* was circulated to ACT paramedic stakeholders in February 2013. ACT Health is awaiting the final draft of the decision Regulatory Impact Statement to be provided for circulation and comment. • From July 2012 to January 2013, national consultation was undertaken to consider the AHMAC consultation paper 'Options for regulation of paramedics'. • Representatives from Council of Ambulance Authorities (CAA) member organisations attended consultation forums in each state and territory and a written submission was made by CAA. • AHWMC requested advice from the HWPC on the proposal to include paramedics as a profession in the national scheme. The decision Regulatory Impact Statement is still being developed by the Practitioner Regulation Subcommittee (PRSC), on behalf of the HWPC, for ministers to consider whether regulatory change is required.
29. The Committee recommends that the ACT Government detail to the Legislative Assembly the scope and timetable for all the e-health initiatives.	Agreed.	The e-health program of work and schedule are currently being updated for the 2013–14 financial year. Following completion of this update, information for the 2013–14 financial year will be provided to the assembly.

Recommendation	Government response	Directorate implementation
30. The Committee recommends ACT Health develop and report to the Legislative Assembly on the indicators it will use to measure the quality and the outcomes of care provided through the Canberra Hospital Emergency Department.	Agreed. The Government will provide a report for Assembly consideration noting the outcomes of the current processes underway to develop the basis for outcome measures for emergency department care. This process includes liaison with state and territory health authorities and a range of national bodies (such as the Australian Institute of Health and Welfare and the National Health Performance Authority). The report will note the work needed to fully develop, define, collect and report on any proposed measures. The Government will also take the results of this review to COAG for consideration in the establishment of new measures for Emergency Department care within the National Partnership Agreement on Improving Public Hospital Services.	The ACT is leading a process to establish new national emergency department outcome measures. The Australian Health Ministers' Advisory Council has endorsed a proposal to establish a project in 2013–14 to work with jurisdictions and relevant national bodies to develop options for AHMAC consideration in 2014. Some work has been undertaken by various bodies across Australia. This process will assist in consolidating efforts and providing a nationally consistent approach to ED outcome measurement.
31. The Committee recommends that the ACT Government engage with local midwife representatives to further develop an appropriate model for a stand-alone birth centre.	Not agreed. The planned sub acute hospital on the north side of Canberra will not have an associated nor a standalone birth centre as there needs to be provision for escalation upward to an acute facility for the purpose of managing obstetric emergencies. The Canberra Hospital has a birth centre and Calvary Public Hospital will also be progressing a continuity of midwifery care model which will provide improved access to midwifery care.	No further action required.
32. The Committee recommends that the ACT Government continues to grow the proportion of health funding allocated to mental health services towards 12 per cent of the total ACT Budget.	Agreed.	The ACT Government is progressively increasing the percentage of health funding allocated to mental health services. This has included a minimum annual allocation of $1 million in mental health growth funding in each of the last eight budgets, as well as construction and running costs of a new Adult Mental Health Inpatient Unit and Mental Health Assessment Unit at the Canberra Hospital. The ACT Government through the ALP–Greens Parliamentary Agreement on Government has committed to $35 million for mental health over the term of the eighth Legislative Assembly. This will support additional adult and older persons and new adolescent mental health inpatient beds, a secure mental health unit, additional community mental health services in both the public and community sector, youth-specific mental health services and suicide prevention-specific funding. During the term of the eighth Legislative Assembly the full roll-out of the National Disability Insurance Scheme will come into effect in the ACT. This will affect services currently provided through the Health budget, such as non-clinical supported accommodation, outreach support and vocational training. There will be significant opportunity for more people with serious and enduring mental illness to access these within the insurance-based system. The current mental health funding for these services will need to move into the ACT NDIS funding pool and hence impact on the apparent percentage of health funding allocated to mental health. The Commonwealth has also directly funded outreach and centre-based mental health services in the ACT that otherwise (e.g. in New Zealand) would have been counted in the ACT mental health budget (Personal Helpers and Mentors, PhaMS, and Day-to-Day Living programs).

Recommendation	Government response	Directorate implementation
33. The Committee recommends that the ACT Minister for Health report to the Legislative Assembly on what level of in-patient services the ACT Government provides to adults suffering eating disorders, and where ACT residents go if they need a higher level of service.	Agreed.	Inpatient services are provided for adults suffering from eating disorders in the medical wards of both the Canberra Hospital and Calvary Hospital (to enable medical support for these clients). In terms of mental health care and support, clients are admitted to Ward 2N at Calvary Hospital. Other inpatient services are provided in the private sector in both the ACT and New South Wales. All services at these facilities are voluntary admissions.
34. The Committee recommends the ACT Government advise the Legislative Assembly which local drug and alcohol services will be reduced as a result of cuts in Commonwealth funding, and what strategies will be implemented to cope with the unmet client need caused by these reductions.	Not agreed. This matter should be referred to the Commonwealth Government.	No further action required.
35. The Committee recommends that all Alexander Maconochie Centre detainees with Hepatitis C have timely access to Hepatitis C treatment, if they have the gene and body weight that makes them treatable with this treatment.	Agreed in principle.	Justice Health Services currently treats 10 people for Hepatitis C infection at any time. As part of the treatment protocol, patients consent to serial testing for Hepatitis C virus. Admission to gain access to the treatment program includes an understanding of, and a commitment to, complete treatment; a reasonable body mass (as obesity is a predictor of poor treatment response); and the specific genotype of the person's virus (genotypes 2 and 3 have better treatment outcomes). Potential patients 'awaiting assessment for the treatment programs' and those 'awaiting admission to the treatment program' are monitored with liver function testing at periods between six and 12 months. If there is a change in severity of the secondary liver effects, then re-prioritisation occurs, in consultation with the gastroenterology clinic at the Canberra Hospital. This is consistent with community standards.
36. The Committee recommends that a needle and syringe program be trialled in the Alexander Maconochie Centre so as to prevent further spread of blood borne diseases.	Agreed. On 15th August 2012, the Chief Minister released a draft blood borne virus management strategy for the Alexander Maconochie Centre which includes a proposal for detainees to be given regulated access to sterile injecting equipment on a 'one-for-one' exchange basis with the medical officer having responsibility for the equipment exchange. Consultation with industrial organisations on the proposed model for implementation will commence immediately to work through any concerns related to the model and to seek agreement with a view to the exchange being implemented in 2013.	Consultation is ongoing.

Recommendation	Government response	Directorate implementation
37. The Committee recommends the ACT Government take greater steps to target anti-smoking campaigns and programs to low income and vulnerable people.	Agreed in principle. The Health Directorate will explore options within its current campaigns and programs to target low income and vulnerable people.	On 31 May 2013 the Minister for Health launched *Future Directions for Tobacco Reduction 2013–2016*. Future Directions informs the Canberra community of the 12 initiatives proposed by ACT Health in tobacco control. These initiatives aim to investigate restricting access to tobacco to reduce demand and control supply, and restrict places of tobacco use. The areas that will be looked at include outdoor areas at public swimming pools and children's playgrounds, among many others, where measures could be taken to reduce smoking and protect non-smokers from the effects of environmental tobacco smoke. The ACT Government committed additional funding in the 2013–14 budget to enable continued implementation of the ACT Aboriginal and Torres Strait Islander Tobacco Control Strategy, including delivery of the Beyond Today campaign. Beyond Today is a social marketing campaign developed by the Health Directorate to encourage the uptake of healthy lifestyle behaviours and smoking cessation among Aboriginal and Torres Strait Islander communities in the ACT. The development of this campaign has been in close collaboration with the policy division's Aboriginal and Torres Strait Islander Unit and it is a key component of: the ACT Government Health Directorate's *Aboriginal and Torres Strait Islander Tobacco Control Strategy 2010–11 to 2013–14*; the *ACT Implementation Plan for the COAG National Partnership Agreement on Closing the Gap in Aboriginal and Torres Strait Islander Health Outcomes*; and the ACT Government Health Directorate's Implementation Plan for the national Measure Up campaign under the National Partnership Agreement on Preventive Health. The campaign was launched in December 2012. ACT Health, through a service funding agreement, continued to provide funding to Winnunga Nimmityjah Aboriginal Health Service for delivery of a multi-component smoking cessation and reduction program based on family, social and workplace networks. From 1 January 2012 there has been a smoke-free environment in the Division of Mental Health, Justice Health and Alcohol and Drug Services. This includes inpatient areas such as the Adult Mental Health Unit, the Alcohol and Drugs Withdrawal Unit, the Brian Hennessy Rehabilitation Centre and the Mental Health Assessment Unit. The aim of implementing a smoke-free environment is to provide a healthy and safe environment for all employees, patients, visitors and contractors. The Healthy Communities Initiative is a targeted campaign focusing on better health for low socioeconomic communities, which includes encouraging smoke-free behaviours. Work is also being undertaken in capacity building for allied health staff, such as podiatrists, in short smoking interventions for their patients.

Recommendation	Government response	Directorate implementation
38. The Committee recommends that the ACT Government develop a men's health plan and appropriate associated literature to improve men's health in the ACT.	Agreed in principle. The ACT Government is supporting men's health issues in line with a national men's health policy statement and specifically in the ACT across the suite of existing health strategies and plans, including: Towards a Healthier ACT 2010–15, ACT Chronic Diseases Strategy 2008–11 (under revision), ACT Corrections Health Plan 2008–12, Managing the Risk of Suicide 2009–14, and the ACT Primary Health Care Strategy 2011–14.	The ACT Chronic Conditions Strategy has been updated for 2013–18.
39. The Committee recommends that the ACT Government provide the Legislative Assembly with a copy of the report on the review of Lymphoedema services as soon as it is available.	Agreed. This report was commissioned by Calvary Health Care and related largely to the services provided at Calvary. The Territory is working with Calvary and the Medicare Local to determine ways to provide best practice services to consumers. The outcome of this work will be provided to the Minister and the report and recommendations will be provided to the Assembly.	The report has been provided to the committee. The Health Directorate is preparing a response to this report, which will include recommendations for progressing the need to meet unmet lymphoedema demand.
40. The Committee recommends the ACT Government establish more timely administration processes for Home and Community Care growth and indexation funds.	Agreed. 30 June 2012 marked the end of the national joint funding program for Health and Community Care. After that date, the ACT became responsible for services to Canberrans under 65 years of age (and Aboriginal and Torres Strait Islander people under 50 years). Administration processes in conjunction with these services will continue to be refined over the coming year.	The full level of community CPI has been paid to NGOs funded under the ACT HACC Program, with effect from 1 July 2013. A new Schedule B of the NPA outlining cross-billing arrangements for 2012–13 was issued on 14 June 2013. The new schedule was endorsed by the Chief Minister on 19 June 2013. Due to the late advice regarding the quantum of growth funds available under the NPA, there was insufficient time to allocate funds via an open tender process and ensure the funds were allocated to community service providers before 30 June 2013. A decision was made to utilise unallocated ACT HACC growth funds for 2012–13 as one-off funding in 2013–14 to develop and implement a coordinated service response for patient discharge targeted at the under-65s. The amount of growth funds available for 2013–14 and the timing of any funding process are dependent on finalisation of the NPA. Negotiations between the states and territories and the Commonwealth will continue to develop a Schedule B to reflect funding movements with greater accuracy. Under the NPA, 2013–14 is the final year of cross-billing.
41. The Committee recommends that the ACT Government develop a long-term strategy for the provision of staff for geriatrician services in the ACT.	Agreed.	There is still a shortage of geriatricians in Australia such that it has been difficult to recruit sufficient specialist staff from other cities. Regular advertising of positions has continued, with a new ad pending in July 2013. Through training and mentoring, a career in geriatric medicine will be promoted to JMO staff and medical students. The Department of Geriatric Medicine has received a Best Clinical Unit for Teaching nomination from ANU Medical School for the past three years and on one occasion won the award. In 2013 we recruited three Advanced Trainees in Geriatric Medicine and have others interested for 2014. We are expecting that some will move to long-term specialist careers in the ACT.

Recommendation	Government response	Directorate implementation
42. The Committee recommends that the ACT Government establish a plan in consultation with ACTION to resolve the problems with accessing the Village Creek Centre by public transport.	Agreed in principle. The relevant agencies will continue to look at ways to improve access to Village Creek by public transport.	RACC continued to meet with ACTION and Community Transport providers regarding public transport to Village Creek Centre. ACTION has now scheduled easy access, wheelchair-accessible buses for the majority of bus trips on Route 62 passing the centre on Summerland Circuit. Community Transport can be contacted to assist clients with transport. Scripting has been developed and provided to administration staff at Village Creek Centre so they can schedule appointments around client transport needs. The ACT Health Village Creek Centre website has been reviewed and provides updated information on transport options. ACTION has improved the safety of the Summerland Crescent bus stop by widening the access path and installing signage to direct passengers to the centre. There have been no direct complaints received by ACT Health relating to access to the Village Creek Centre by public transport since a Women's Safety Audit was undertaken in July 2012.
43. The Committee recommends the ACT Minister for Health update the Legislative Assembly on how and where funding from the National Partnership on a Commonwealth Dental Program will be targeted, and what changes will occur in delineation of staff roles.	Agreed. Once the detail is worked through with the Commonwealth a report will be provided to the Assembly.	Dental are still progressing consultations with the Commonwealth regarding the NPA implementation plan. It is envisaged this will be finalised before the end of the calendar year.
44. The Committee recommends that the ACT Government report to the Legislative Assembly when the issue of outstanding employee entitlements for Calvary Public Hospital staff is resolved, as soon as that occurs.	Agreed.	The Health Directorate has referred this matter to the Chief Minister and Treasury Directorate for advice. This matter is still under consideration.
45. The Committee recommends ACT Health proactively establish networks and relationships between medical staff and private midwives at the Canberra Hospital so as to ensure birthing women, in the ACT, can access Medicare benefits for use of a private midwife pre- and post-birth.	Agreed in principle. The Health Directorate is liaising with the one known privately practising midwife (PPM) to facilitate relationships with obstetricians and to foster engagement on her model of midwifery care. Professional Indemnity Insurance exemption for PPMs has now been extended to June 2015 and work has commenced nationally to develop collaborative relationships between PPMs and Health Services.	The ACT Maternity Services Network meets three-monthly to progress the implementation of jurisdictional actions in the Maternity Services Plan and other maternity issues, such as fostering collaborative arrangements between obstetricians and midwives. The Office of the Chief Nurse has recently allocated resources to commence the preliminary administrative changes so women can choose a private midwifery model of care at the Canberra Hospital. This work has commenced.

Recommendation	Government response	Directorate implementation
151. The Committee recommends that the ACT Government (a) report to the Legislative Assembly on its proposed expenditure during the 2012–13 financial year for alcohol and other drug services; and (b) clearly state its proposed expenditure for alcohol and other drug services in the budget papers for all future ACT Budgets.	Part a) Agreed in principle, Part b) Noted. In relation to Part a), the Government will provide detail on drug and alcohol services that are funded in 2012–13, however as with many health services there would be costs linked to drug and alcohol issues that are embedded in services including acute care, chronic disease, intensive care and cancer services. In relation to Part b), the Government will consider the detail to be provided in future budget papers in 2013. This consideration will address the impact of the agreed move to activity based funding on the current output structure for the Health Directorate.	This information was provided to the Select Committee on Estimates 2012–13 in July 2012. See Estimates Question on Notice No. E12-124.

Select Committee on Estimates 2013–14

Report No.	Title	Date presented
1	Inquiry into Appropriation Bill 2013–2014 and Appropriation (Office of the Legislative Assembly) Bill 2012–2013	Ongoing at 30 June 2013.

Recommendation	Government response	Directorate implementation
Not applicable.	Not applicable.	Not applicable.

B.4 Legislation report

The following is a list of all legislation that the ACT Health Directorate was responsible for during the reporting period:

- Blood Donation (Transmittable Diseases) Act 1985
- Drugs of Dependence Act 1989
- Epidemiological Studies (Confidentiality) Act 1992
- Food Act 2001
- Gene Technology Act 2003
- Gene Technology (GM Crop Moratorium) Act 2004
- Health Act 1993
- Health (National Health Funding Pool and Administration) Act 2013
- Health Practitioner Regulation National Law (ACT) Act 2010
- Health Professionals Act 2004
- Health Professionals (Special Events Exemptions) Act 2000
- Health Records (Privacy and Access) Act 1997
- Human Cloning and Embryo Research Act 2004
- Intoxicated People (Care and Protection) Act 1994
- Medicines, Poisons and Therapeutic Goods Act 2008
- Mental Health (Treatment and Care) Act 1994, except parts 8 and 9 and sections 141, 142 and 143
- Public Health Act 1997
- Radiation Protection Act 2006
- Smoke-Free Public Places Act 2003
- Smoking in Cars with Children (Prohibition) Act 2011
- Supervised Injecting Place Trial Act 1999, except sections 7, 8 and 13
- Tobacco Act 1927
- Transplantation and Anatomy Act 1978.

The following legislation was enacted during the reporting period:

- Health (National Health Funding Pool and Administration) Act 2013.

The following legislation is awaiting commencement:

- Food Amendment Act 2012, sections 7, 11 12 and 14.

SECTION C

LEGISLATIVE AND POLICY-BASED REPORTING

C.1 Risk management and internal audit

ACT Health's Audit and Risk Management Committee Charter governs the operation of the Audit and Risk Management Committee. The Audit and Risk Management Committee plays an essential role by providing assurance to the Director-General on ACT Health's governance and oversight in relation to risk management, internal systems and legislative compliance.

ACT Health's Audit and Risk Management Committee's ability to consider the internal control environment, governance and risk management activities objectively is facilitated by the mix of internal and external members, who are and supported by ACT Health's Manager, Internal Audit and Risk Management.

ACT Health's Audit and Risk Management Committee consists of five members: an independent chair, three senior executives from within ACT Health and one external member. Observers from ACT Health and the ACT Auditor-General's Office also attend meetings. The Audit and Risk Management Committee held five meetings in 2012–13.

The committee's attendances are set out below:

Name of member	Position	Duration	Meetings attended
Geoff Knuckey	Independent Chair	2 years	5
Ian Thompson	Deputy Chair	6.5 years	5
Tina Bracher	Member	2 months	1
Jeremy Chandler	External member	6 months	2
Judi Childs	Member	5.5 years	3
Stephen Goggs	Member	10 months	4
Bruce Jones	External member	6.5 years	3

The Internal Audit and Risk Management Branch of ACT Health promotes and improves ACT Health's corporate governance by conducting and coordinating internal audits, investigations and making recommendations for improvements. ACT Health's Strategic Internal Audit Program for the period from 1 January 2012 to 30 June 2013 is designed to align with ACT Health's strategic priorities and risks. The program is reviewed regularly to ensure that it continues to be effective.

In 2012–13, 10 internal audit assignments were completed. Two special reviews were also commissioned in response to issues of concern identified during the year.

Audit findings and recommendations are rated in line with ACT Health's *Integrated Risk Management Guidelines.* Throughout the year, the Manager, Internal Audit and Risk Management reported developments in implementing the Strategic Internal Audit program and implementation of audit recommendations to the Audit and Risk Management Committee.

The Audit and Risk Management Committee is also kept informed on implementation of recommendations made by the ACT Auditor-General's Office, where these apply to ACT Health.

In 2012–13, the ACT Health Risk Management Policy and Guidelines were reviewed in line with the International Standard for Risk Management AS/NZS ISO 31000. The revised documents clarify the governance arrangements and include clear responsibilities and measurable key performance indicators.

An Executives' Risk Management workshop was also held in 2012–13 to review the directorate's organisational risks. ACT Health's Executive Director's Council is responsible for:

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

C.2 Fraud prevention

ACT Health Fraud Management Framework, Policy and Plan govern the fraud management and prevention work across ACT Health. Divisions of ACT Health regularly undertake fraud risk assessments together with integrated risk assessments. Mitigating controls are put in place to address identified fraud threats and risks. The Executive Directors are responsible for managing fraud risk in their respective divisions.

The ACT Health Senior Executive Responsible for Business Integrity Risks is required to provide reports on fraud control activities to the Audit and Risk Management Committee at an agreed interval.

Staff receive fraud control and prevention training during orientation and through an eLearning program. Managers are provided with further fraud control and prevention information and training during the manager's orientation program. This is supported by targeted information that is provided to alert staff to responsibilities and protocols intended to improve systems or to mitigate identified fraud threats and risks.

There was one allegation of fraud made against an ACT Health employee during 2012–13. This allegation was investigated by the Commissioner for Public Administration. Following a preliminary investigation, it was determined that there was insufficient evidence to progress to a formal investigation.

C.3 Public interest disclosure

Public interest disclosure is managed in ACT Health in accordance with the *Public Interest Disclosure Act 2012*. Procedures for actioning public interest disclosures are carried out according to the Chief Minister and Treasury Directorate guidelines. ACT Health's public interest disclosure policy and procedures are available to all staff and the community on the Health website. The Senior Executive Responsible for Business Integrity Risk receives disclosures and determines the appropriate action in accordance with the Act.

Of the six disclosures unfinalised at the end of 2011–12:

- one was dismissed as the allegations lacked substance following the gathering of preliminary evidence
- one was subject to external review as part of an Auditor-General Performance Review, and recommendations from that review were translated into an action plan
- three were the subject of external investigation, with one revealing no evidence of misconduct, and the other two resulting in findings of misconduct and proposed disciplinary action
- one was discontinued following staff relocations and exits.

Of the two matters where the external investigation found misconduct substantiated:

- one related to bullying and harassment, failure to exercise reasonable care and skill, and failure to abide by lawful directions
- the other related to failure to exercise reasonable care and skill and failure to abide by lawful directions.

In each case the events described were restricted to the conduct of particular individuals and not considered to be a high risk of systematic recurrence.

No disclosures relating to disclosable conduct were received by ACT Health in 2012–13.

C.4 Freedom of information

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

Section 7 statement

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

Organisation

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

Powers

ACT Health holds a wide variety of statutory powers relating to health services in the ACT. A comprehensive list of legislation under which ACT Health exercises statutory powers can be found in Section B.4, Legislation report.

ACT Health has the authority to do all things that are necessary for the performance of its functions, including:

- the purchase, sale and lease of buildings and equipment
- the provision of financial assistance
- entering into arrangements with people or authorities for the provision of health services.

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

The *Health Records (Privacy and Access) Act 1997* assists consumers of health services to gain access to their medical records without having to apply under the *Freedom of Information Act 1989*.

The Health Services Commissioner holds power under the *Human Rights Commission Act 2005* to investigate and conciliate complaints about providers of health services. Consumers can contact the Commissioner's office by telephoning 02 6205 2222 or calling in person at Level 2, 12 Moore Street, Canberra City, ACT 2601.

Categories of documents

ACT Health holds several basic categories of documents, including:

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

Documents available on request

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

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

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

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

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

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

Freedom of Information procedures and initial contact points

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

Processing guidelines

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

In accordance with the whole-of-government policy, the decision letter, schedule of documents and the related documents are to be made available in PDF format on the open government website within 15 days. The decision maker will identify ‘certain information’ that is not to be published in accordance with the Act.

No application fees are charged for FOI requests—however ACT Health applies processing in accordance with the Attorney General (Fees) Determination for applications that require in excess of 10 hours processing time and/or 200 pages of documents.

Section 8 statement

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

Section 79 statement

The following tables summarise the results of FOI requests across ACT Health in 2012–13, and the time taken to finalise requests.

Description	
Initial applications lodged	38
Partial access	11
Access refused	4
Full release	4
Technical refusal	6
Withdrawn	8
Transferred	0
Not yet finalised (as at 30 June 2013)	5
Reviews lodged (under section 59 of the *Freedom of Information Act 1989*)	4
Number upheld	1
Number partial access	2
Number overturned	1
Number not yet finalised (as at 30 June 2013)	0
Applications to ACT Civil and Administrative Tribunal	0
Requests to amend records	0
Time taken to finalise requests	
Less than 31 days	13
31–45 days	1
46–60 days (third party consultation)	3
61–90 days	7
More than 90 days	1

C.5 Internal accountability

Senior executive and responsibilities

The organisational chart on pages 2 and 3 shows the structure of ACT Health at 30 June 2013. This chart includes the names of the senior executives responsible for each of the organisation's output areas.

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

Senior executive and organisational changes

ACT Health underwent an internal restructure during 2010–11. The purpose of this restructure was to improve the delivery of family- and patient-centred care, achieve good governance and accountability, and position the organisation to meet demand for services now and into the future.

Prior to implementation of the restructure, extensive consultation occurred with staff and stakeholders. One of the commitments coming out of this consultation was that a number of factors and decisions would be reviewed one year after implementation.

In 2012, ACT Health engaged the Nous Group to conduct an external review of ACT Health's 2011 restructure. Its purpose was to determine the effectiveness of the restructure and how well it was meeting its primary objectives. Following consideration of the considerable amount of feedback received during the six-week consultation process earlier in 2013, a detailed response to each of the recommendations in the final Nous report has been developed.

The review acknowledged that the majority of staff have been supportive of many of the structural changes put in place over the last two years, but opportunities have been identified for further refinement. A total of 36 recommendations were made in the review report. These will be a focus for ACT Health in the next 12 to 18 months to ensure that the structure continues to be a strong basis for the delivery of our diverse health services. Consultation has been undertaken with relevant staff and unions to discuss the details of how changes can best be implemented.

Senior executive

ACT Health is organised into groups and operational areas which report directly to the Director-General. The two groups—Canberra Hospital and Health Services, and Strategy and Corporate—are led by the Deputy Directors-General and are divided into direct clinical service divisions and strategic and corporate support branches. Canberra Hospital and Health Services employs the majority of staff working in ACT Health.

Senior executive positions across the organisation are as follows:

- Dr Peggy Brown — Director-General (DG)
- Stephen Goggs — Deputy Director-General (DDG), Strategy and Corporate
- Ian Thompson — Deputy Director-General (DDG), Canberra Hospital and Health Services
- Dr Frank Van Haren — Director, DonateLife ACT
- Dr Paul Kelly — Chief Health Officer, Population Health Division
- Elizabeth Trickett — Executive Director, Quality and Safety Unit
- Ron Foster — Chief Finance Officer, Financial Management Unit
- Judy Redmond — Chief Information Officer, E-health and Clinical Records Branch

- Phil Ghirardello — Executive Director, Performance and Innovation Branch
- Rosemary Kennedy — Executive Director, Business and Infrastructure Branch
- Ross O'Donoughue — Executive Director, Policy and Government Relations Branch
- Grant Carey-Ide — Executive Director, Service and Capital Planning Branch
- Judi Childs — Executive Director, People Strategy and Services
- Veronica Croome — Chief Nurse/Executive Director, Nursing and Midwifery
- Karen Murphy — Allied Health Advisor
- Prof Frank Bowden — Principal Medical Advisor/Executive Director, Medical Services
- Dr Helen Toyne — GP Advisor
- Prof Paul Gatenby AM — Director of Research
- Barbara Reid — Executive Director, Division of Surgery and Oral Health
- Elizabeth Chatham — Executive Director, Division of Women, Youth and Children
- Jeannette MacCullagh (A/g) — Executive Director, Division of Critical Care and Imaging
- Denise Lamb — Executive Director, Division of Capital Region Cancer Service
- Linda Kohlhagen — Executive Director, Division of Rehabilitation, Aged and Community Care
- Katrina Bracher — Executive Director, Division of Mental Health, Justice Health and Alcohol and Drug Services
- Prof Julia Potter — Executive Director, Division of Pathology
- Rosemary O'Donnell — Executive Director, Division of Medicine
- June Gunning — Director, Acute Support Services.

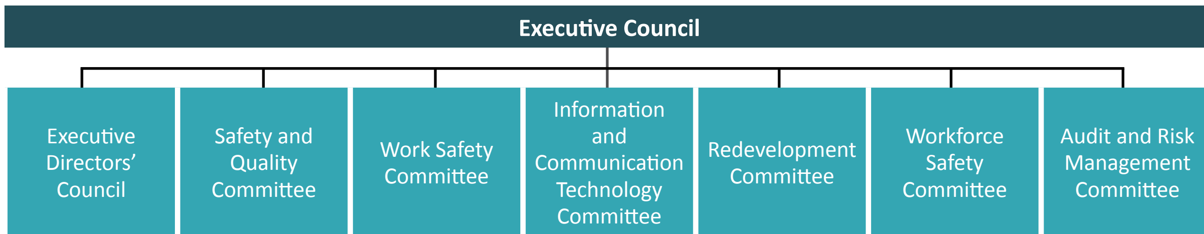
Senior management committees, roles and membership

ACT Health committees are established at the following levels:

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

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

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



Name of committee	Role of committee	Membership
Executive Council	At the centre of ACT Health's governance model is the Executive Council. The role of the council is to: • support the Director-General to meet responsibilities outlined in the *Health Act 1993* and other relevant legislation • make recommendations on the strategic direction, priorities and objectives of the organisation and endorse plans and actions to achieve the objectives • oversee finance, performance and human resources • set an example for the corporate culture throughout the organisation. The Executive Council is chaired by the Director-General and meets twice monthly; one of these meetings each month is focused on finance and performance and other matters, and the other meeting is focused on other business. A number of subcommittees report to the Executive Council, each dealing with different areas of accountability across ACT Health.	Director-General (Chair) Deputy Director-General, Canberra Hospital and Health Services Deputy Director-General, Strategy and Corporate Chief Finance Officer Chief Health Officer Executive Director, Quality and Safety Allied Health Advisor Chief Nurse/Executive Director, Nursing and Midwifery Principal Medical Advisor/Executive Director Medical Services Consumer Representative Academic Representative

Name of committee	Role of committee	Membership
Executive Directors Council	This council provides an opportunity for all executive members to communicate and collaboratively work in partnership with other areas of ACT Health to deliver patient-focused, high-quality care through influencing policy and strategic direction, managing policy governance and risk, and maximising operational effectiveness. The Executive Directors Council meets monthly and reports to the Executive Council on strategic operational matters and risk management.	Director-General (Chair) Deputy Director-General, Strategy and Corporate Deputy Director-General, Canberra Hospital and Health Services Director, Executive Coordination Manager, Communications and Marketing Manager, Internal Audit and Risk Management Chief Finance Officer Chief Health Officer Executive Director, Quality and Safety Chief Nurse Principal Medical Advisor Allied Health Advisor Chief Information Officer Director, Donate Life Executive Director, Performance and Innovation Executive Director, Business and Infrastructure Executive Director, Service and Capital Planning Executive Director, Policy and Government Relations Executive Director, People Strategy and Services Executive Director, Surgery and Oral Health Executive Director, Critical Care Executive Director, Women, Youth and Children Executive Director, Medicine Executive Director, Rehabilitation, Aged and Community Care Executive Director, Capital Region Cancer Service Executive Director, Mental Health, Justice Health and Alcohol and Drug Services Executive Director, Pathology Executive Director, Medical Services Executive Director, Nursing and Midwifery
Safety and Quality Committee	This committee comprises executive and professional adviser positions and academic and consumer representatives. Its role is to: • set strategic directions, priorities and objectives in quality and safety • oversee clinical practice improvement, quality improvement, accreditation, clinical governance matters (including sentinel events), consumer engagement and clinical policy • monitor research activity across ACT Health. The committee is chaired by the Director-General, meets monthly and reports to the Executive Council. Subcommittees: • Accreditation Steering Group • Health Technology and Assessment Committee • Health Interagency Clinical Review Committee • Medical and Dental Appointments Committee • Clinical Privileges Committee • Appropriate Use of Blood Reference Group.	Director-General Deputy Director-General, Corporate and Strategy Deputy Director-General, Canberra Hospital and Health Services Executive Director, Quality and Safety Unit Chief Information Officer Executive Director, Performance and Innovation Branch Executive Director, Business and Infrastructure Branch Executive Director, Service and Capital Planning Branch Executive Director, Policy and Government Relations Branch Executive Director, People Strategy and Services Chief Nurse Principal Medical Advisor Principal Allied Health Advisor Manager, Internal Audit and Risk Management Unit Consumer representatives (2)

Name of committee	Role of committee	Membership
Work Health and Safety Committee	This 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 the development of 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, allocation of resources and legislative arrangements • addresses whole-of-agency work health and safety issues unable to be resolved at division or branch level.	Director-General (Chair) Director, Workplace Safety To achieve a quorum, at least half of the members of the committee must be staff who are not nominated by ACT Health. Two representatives from each division/branch Tier 2 Health and Safety Committee—one manager and one Health and Safety Representative. Subcommittee members attend as visitors, as do others.
Information Communication and Technology Committee	This committee: • oversees the development of ACT Health IM&ICT plans, policies and frameworks, as required, ensuring whole-of-government issues are considered • monitors lifecycle ICT asset management frameworks, strategies and policies consistent with best practice • monitors IM&ICT risks • monitors, reviews and manages ICT asset, service and delivery and financial performance and infrastructure risk across ACT Health • ensures whole-of-ACT Government and ACT Health IM&ICT policies and standards are implemented across the organisation • prioritises IM&ICT initiatives • evaluates proposed IM&ICT initiatives and recommends supported business cases for all major IM&ICT projects to Executive Council • regularly reviews and reports on the status of ICT projects under development and, if required, recommends strategies to rectify significant variances of these.	Deputy Director-General, Strategy and Corporate Deputy Director-General, Canberra Hospital and Health Services Chair, Clinical Working Group or representative Chief Information Officer Executive Director, Performance and Innovation Executive Director, Business and Infrastructure Executive Director, Service and Capital Planning Executive Director, Policy and Government Relations Chief Health Officer Chief Nurse Principal Medical Advisor Executive Director, Critical Care Executive Director, Capital Region Cancer Service Executive Director, Rehabilitation, Aged Care and Community Care Executive Director, Surgery and Oral Health Executive Director, Womens, Youth and Children Executive Director, Mental Health, Justice Health and Alcohol and Drug Services Executive Director, Pathology Executive Director, Medicine Executive Director, Shared Services ICT or representative Chief Executive, Calvary Public Hospital or representative Health Care Consumer representative ACT Medicare Local representative

Name of committee	Role of committee	Membership
Redevelopment Committee	The ACT Health Redevelopment Committee is the chief decision-making body for the ACT Health Health Infrastructure Program (HIP). It is responsible for providing advice, monitoring progress and monitoring risk of the HIP.	Director-General, ACT Health (Chair) Deputy Director-General, Strategy and Corporate Deputy Director-General, Canberra Hospital and Health Services Executive Director, Policy Coordination and Development, Treasury Directorate Executive Director, Shared Services Procurement Executive Director, Shared Services ICT Executive Director, Service and Capital Planning Executive Director, Business and Infrastructure Chief Finance Officer Executive Director, People Strategy and Services Director-General, Commerce and Works Directorate Chief Information Officer, ACT Health Deputy Director-General, Chief Minister and Cabinet Directorate Chief Executive, Calvary Healthcare ACT Executive Director, Health Care Consumers' Association Senior Manager, Health Services Planning, Service and Capital Planning Executive Construction Director, Service and Capital Planning Senior Finance Manager, Service and Capital Planning Operations Manager, Service and Capital Planning Director, Health Infrastructure Branch, Shared Services Procurement, Commerce and Works Directorate The committee may invite other attendees, at the Chair's discretion.
Workforce Strategy Committee	To provide high-level advice to the Executive Council on all matters about the ACT Health workforce. This committee: • gives strategic context and direction for the development of the workforce, including a focus on planning, recruitment and retention strategies, organisational development, workplace culture and leadership and human resource management • ensures alignment and integration of strategies to broader Health Directorate objectives • provides strategic oversight of organisation redesign on the workforce profile and health and safety.	Principal Medical Advisor Executive Director, CRCS Executive Director, PSSB ACT Chief Nurse, Strategy and Corporate Lead Commissioning Manager Executive Director, Performance and Innovation Deputy Director-General, Strategy and Corporate Director, Workforce Policy and Planning Unit Director of Operations A/g Director of Acute Support Senior Data Officer, WPPU Executive Director, Business and Infrastructure Allied Health Manager Allied Health Advisor Executive Director, Surgery and Oral Health Director, Staff Development Unit Director, Community Care Program Senior Manager, Organisational Development Unit Deputy Director-General, Canberra Hospital Executive Director, Quality Improvement Workforce Initiatives Coordinator

Name of committee	Role of committee	Membership
Audit and Risk Management Committee		The committee consists of five members: • Chairperson—The chair of the audit committee is external and independent of the directorate • Deputy Chair—one Deputy Director-General, appointed for a fixed period • two senior executives • an external member with an appropriate business or audit background. The Internal Audit and Risk Manager is invited to all meetings of the ARMC. The secretariat role is performed by the Internal Audit and Risk Management Branch.

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

A range of forums provide the opportunity for stakeholder input. These include:

- ACT Health Human Research Ethics Committee—ongoing
- ACT Local Hospital Network Council (six times a year)—ongoing
- ACT Medicare Local/ACT Health Liaison Committee (quarterly)
- ACT Region Integrated Regional Clinical Training Network—ongoing
- Allied Health Forum (quarterly)—ongoing
- Clinical Senate (quarterly)—ongoing
- Director-General Forums (six-weekly)—ongoing
- GP Liaison Network (quarterly)—ongoing
- ACT Health/Community Services Directorate Liaison committee (quarterly)—ongoing
- ACT Health/Human Rights Commission (annual)—ongoing.
- Health Emergency Management Subcommittee (quarterly)—ongoing.
- Healthcare Consumers Liaison Committee (quarterly)—ongoing
- Integrated Regional Clinical Training Network—ongoing
- Leadership Network (three times a year)—ongoing
- Medical Staff Council (monthly)—ongoing
- Nursing and Midwifery Leaders meeting (monthly)—ongoing
- Private Hospitals Liaison Committee (quarterly)—ongoing
- Southern Local Hospital Network HN Liaison Committee—ongoing
- Tertiary Education Liaison Committee (quarterly)—ongoing

ACT Local Hospital Network Council

On 27 July 2011, the Chief Minister announced the establishment of the ACT Local Hospital Network Council. The council was established under amendments to the *Health Act 1993*, passed by the Legislative Assembly on 29 March 2011. It is responsible for providing strategic advice to the Director-General of ACT Health on matters critical to the ACT Local Hospital Network's success. The council's specific functions are set out in section 14 of the Act.

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

Part 3A of the Act requires that the council consist of not more than 10 members, appointed by the Minister. The council must include members who bring the necessary skills and experience to allow the council to perform its functions under the Act and include members who have expertise or experience in several areas, including, but not limited to: health management experience; expertise in clinical matters; and academic, teaching and research experience in the field of health services and consumers.

The Act requires the council to meet at least six times a year. ACT Health provides secretariat support to the council.

Clinical Senate

The role of the Senate is to provide a forum for a multidisciplinary group of clinicians, health experts and consumers with diverse perspectives to share their collective knowledge in discussing strategic clinical issues. The Clinical Senate makes recommendations and reports to the Director-General, ACT Health, and the Chair of ACT Medicare Local, who consider and respond formally and transparently to all recommendations.

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

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

Meetings are held three or four times a year. ACT Health provides secretariat support to the Senate.

Corporate and operational plans (and associated reporting and review)

Corporate Plan 2012–2017

The Corporate Plan 2012–2017 replaces the Corporate Plan 2010–2012. The plan articulates the key focus areas, priorities for improvement, key strategies for achieving the priorities, and achievements planned for the long term (five years).

The priorities of ACT Health are organised under four key focus areas.

Community and consumers—Partnering for better health outcomes

- Deliver patient and family-centred care
- Continue and strengthen partnerships
- Promote good health and wellbeing
- Improve access to appropriate health care
- Have robust safety and quality systems

Our resources—Building sustainability and improving efficiency

- Design sustainable services to deliver outcomes efficiently
- Strengthen decision support
- Embed a culture of research and innovation

Our processes—Strengthening governance

- Be accountable to government and the community
- Continue to strengthen clinical governance

Our people—Supporting and strengthening the teams

- Support our staff to reach their potential
- Promote a learning culture
- Provide high-level leadership

In 2012–13, ACT Health continued to measure 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 and the Public Hospitals Scorecard. The target achievements for each year are contained in ACT Health's Business Plan.

Clinical Services Plan

There is recognition that the demand for health services is increasing every year. Expanding health technologies, greater consumer expectations and an increasing and ageing population all contribute to this demand for public health services.

Following extensive consultation with our stakeholders towards the end of 2012, the Clinical Services Plan is now being finalised. The plan will provide strategic guidance for the development of publicly funded health services in the ACT. The strategies in the plan have been developed to position ACT Health to meet future demand for health services and improve access for those most in need.

There are a number of specific health services plans which cascade and align strategic directions from the Clinical Services Plan to enable the delivery of an integrated service and offer a continuum of care to patients. The focus areas of the plan are to:

- meet increasing demand for health services
- improve the patient journey
- improve the health of vulnerable people
- build and nurture a sustainable health system
- ensure the planning and delivery of health services is underpinned by the ACT Health Safety and Quality Framework.

ACT Primary Health Care Strategy 2011–2014

The Health Minister launched the *ACT Primary Health Care Strategy 2011–2014* on 14 December 2011, building on the previous health care strategy and setting the direction for primary health care into the future. The strategy aims to improve integration between general practice and the wider primary health care sector in the provision of primary health care.

The Primary Health and Chronic Disease Strategy Committee (PH&CDS) oversees implementation of the strategy. Six-monthly reports outlining progress against the annual implementation plan are provided to the ACT Health Executive Council and primary health care stakeholders.

Action areas where progress is being made include:

- improving access and reducing inequity
- improving continuity and coordination of care, especially for people with chronic conditions
- increasing the focus on health promotion, prevention, early intervention and consumer empowerment
- improving quality, safety, performance and accountability
- information management
- workforce
- infrastructure.

Successful ongoing activities include:

- the General Practice Aged Day Service (GPADS), which provides access to GPs for patients who are homebound or in residential aged care facilities
- the nurse led Walk-in Centre, which successfully meets health care needs in the community while relieving pressure on the public hospital system
- the GP Marketing and Support Officer role, which aims to increase the number of GPs living and working in the Canberra region, via an online, print and in-person campaign.

Implementation highlights include:

- provision of mini-health checks and follow-up reviews for the vulnerable or disadvantaged at the Early Morning Centre in central Canberra and at Ainslie Village
- provision of three full-time care coordinators to assist local Aboriginal and Torres Strait Islander people to manage the health system in relation to their chronic conditions
- establishment and promotion of the Get Healthy information and coaching service, which provides targeted messaging and a free personal health coach, and the ACT-wide Healthier Work Service, which supports employers to develop health and wellbeing initiatives in their workplaces
- provision of the Health Services Directory, which lists the majority of ACT Health's services as well as all ACT GP and pharmacy localities
- development and promotion of ACT Health policies and procedures to ensure better sharing of clinical information between and within the acute and primary health care sectors
- funding for the ACT Medicare Local to undertake the GP Workforce Scoping Study to provide jurisdictional information and mapping of the GP workforce across the ACT.

ACT Chronic Disease Strategy

The new *ACT Chronic Conditions Strategy—Improving Care and Support 2013–2018* (***www.health.act.gov.au/c/health?a=dlpubpoldoc&document=2825***) will provide overarching direction for chronic condition care and support in the ACT over the next five years and outlines the requirement for a coordinated approach across the government and non-government sectors. It concentrates on improving care and support services and is based on the commitment goals that every person living with a chronic condition:

- receives appropriate screening and early detection
- receives the right care in the right place at the right time from the right team
- has a plan which supports active participation in their care
- is aware of relevant support options and how to access them
- is provided with information and support to stay healthy and/or minimise the risk of other diseases
- does not have to repeat their story unnecessarily.

The key priorities in the draft strategy are to:

- optimise existing services through enhanced integration
- improve access
- better support those in the community
- improve person-centredness
- enhance detection and secondary prevention
- enhance governance and system enablers.

The Primary Health and Chronic Disease Steering Committee oversees implementation of the strategy and provides oversight and central coordination of related policies and initiatives. The committee is chaired by the Policy and Government Relations Branch and includes representation from relevant operational areas of ACT Health, the ACT Medicare Local, the Pharmacy Guild of Australia (ACT), the Health Care Consumers' Association of the ACT, Winnunga Nimmityjah Aboriginal Health Service, ANU Medical School, the Heart Foundation ACT, and Diabetes ACT, the University of Canberra, the Australian primary Health Care Research Institute and the Community Services Directorate. Six-monthly reports outlining progress against the annual implementation plan are provided to the ACT Health Executive Council and key stakeholders.

ACT Palliative Care Services Plan

The ACT Palliative Care Strategy 2007–2011 provided overarching direction for the delivery of palliative care services in the ACT in accordance with Palliative Care Australia's National Palliative Care Standards. From 2007 to 2011, the strategy made considerable progress in promoting coordinated palliative care services. In particular, achievements were made in:

- the availability of palliative care and bereavement information and education resources for community members
- increased liaison between palliative care services, residential aged care facilities and primary health care
- implementation of Australian Government-funded palliative care projects.

The development of the new draft ACT Palliative Care Services Plan 2013–2017 included extensive community consultation and an examination of likely future demand for palliative care, existing workforce needs and future needs, community education, support for non-government organisations and identification of possible future models of care.

As a result, the draft plan outlines a vision that 'people with a life-threatening illness in the ACT and their families and carers will have timely access to quality palliative care that is consumer and carer focused, respects their choices and is appropriate to their need'. It also outlines six key goals for the future development of ACT palliative care services, along with 16 associated strategies to achieve them. The six key goals are as follows:

1. ACT Health plays a leadership role in ensuring reliable access to quality palliative care in the ACT.
2. To ensure that palliative care services provide continuity of care and smooth transitions between settings.
3. The ACT community is well informed about all aspects of death and dying and individuals and families are able to make an informed choice about their treatment options.
4. To build capacity of palliative care services to meet the current and projected population demand.
5. To ensure an appropriately qualitative and sustainable workforce to provide the projected level of palliative care services in the ACT.
6. To develop the knowledge base to inform service and workforce development and quality improvement.

The draft plan is aligned with the draft Clinical Services Plan and in particular suggests the establishment of a single ACT Palliative Care Clinical Network, a proposal which was well received during the public consultation of the plan.

As this is a services plan, the document is long and contains technical language that may be a barrier to some consumers and time-poor clinicians. As a result, a one-page summary and a shortened version of the plan, which will be known as the ACT Palliative Care Services Plan 2013–2017, have been developed. The full technical paper will also be available.

The ACT Palliative Care Services Plan Steering Committee oversaw the development of this services plan. This committee included representatives from ACT Health, the ACT Medicare Local, the Southern New South Wales Local Health District, Calvary Health Care, Palliative Care ACT and the Health Care Consumers' Association of the ACT.

The plan is expected to be endorsed by the Minister in September 2013.

HIV/AIDS, Hepatitis C, Sexually Transmissible Infections: A Strategic Framework for the ACT 2007–2012

The *HIV/AIDS, Hepatitis C, Sexually Transmissible Infections—A Strategic Framework for the ACT 2007–2012* (***www.health.act.gov.au/c/health?a=dlpubpoldoc&document=915***) outlines a strategic approach to the management of HIV/AIDS, hepatitis C and sexually transmissible infections and provides a framework to guide cooperation between ACT Government and non-government organisations, private practitioners, researchers, service providers, community groups, affected communities and the broader ACT community.

The ACT framework confirms ACT Health's commitment to guiding principles such as harm minimisation and health promotion, a partnership approach, an evidence-based approach, access and equity, social determinants of health, a population health approach and human rights. Progress has been made towards the ACT framework's goals of:

- reducing the transmission in the ACT of HIV, hepatitis C virus (HCV) and sexually transmissible infections (STIs)
- increasing access for ACT residents to testing and treatment for HIV, HCV and STIs
- improving the health and wellbeing of ACT residents living with HIV/AIDS and HCV and reducing the morbidity associated with undiagnosed and untreated STIs.

The ACT Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases (SHAHRD) advises on the implementation of the ACT framework. It was agreed that the ACT framework be extended beyond 2012 to correspond with the development of the National Strategies for HIV, Hepatitis B, Hepatitis C, Sexually Transmissible Infections and Aboriginal and Torres Strait Islander Blood-Borne Virus and Sexually Transmissible Infections. The national strategies will be under development in 2013 for an estimated launch in July 2014. The new ACT framework will align with these strategies.

ACT Children's Plan

The *ACT Children's Plan* was launched in June 2010 to provide an aspirational whole-of-government and whole-of-community vision to make Canberra a great and safe place for children and to ensure their needs are a priority for the government and community. The *ACT Children's Plan* is operational from 2010 to 2014.

The aim of the *ACT Children's Plan* is that Canberra is a child- and youth-friendly city that supports all children and young people to reach their potential, make a contribution and share the benefits of our community. The plan proposes six building blocks to make Canberra a child-friendly city:

- opportunities for children to influence decisions about their lives and their community and to actively participate in their communities
- advocacy, promotion and protection of children's rights
- processes to assess the impact of law, policy and practice on children
- regular monitoring of the state of children's health, wellbeing, learning and development
- services, programs and environments that support children's optimal development and enhance parental, family and community capacity
- effective governance mechanisms across government and community.

Strategies, actions and projects fully implemented at the end of June 2012

A Picture of ACT's Children and Young People 2012 (***www.children.act.gov.au***) was released.

Major goals and projects commenced in 2012–13

- ACT Health contributed to the development of the *2013 A Picture of ACT Children and Young People*, which will be the third report on children's health, wellbeing, development and learning indicators.
- Drafting commenced for a Standard Operating Procedure (SOP) on Neglect of Medical Needs of Children and Young People to improve ACT Health's capacity to meet the needs of vulnerable children and their families.
- The ACT Health Child Protection Policy was reviewed and a Child Protection Practice Paper and SOP were drafted.

ACT Mental Health Services Plan 2009–2014

The *ACT Mental Health Services Plan 2009–2014* is a strategic-level document giving broad direction for the future development of public mental health services in the ACT. It was developed in consultation with stakeholders over a two-year period. The plan covers the years 2009 to 2014 but conveys a vision for how mental health services will be delivered in the ACT in 20 years' time. The guiding vision for mental health services in the ACT is that by 2020 the mental health needs of the community will be met by a comprehensive network of complementary and integrated mental health services that:

- enhance knowledge and understanding
- intervene and provide support early and for as long as is necessary
- as far as possible, address mental health issues in community settings, working with and developing natural systems of support.

The *ACT Mental Health Services Plan 2009–2014* states that consumer and carer participation will be richly woven through all aspects of service planning, delivery, research, teaching and evaluation, while peer support and advocacy services will be available as required to support consumers in their journey of recovery.

The plan aligns services with four developmental stages that, rather than promoting service delivery along age lines alone, will focus on developmental and life milestones to determine the most appropriate point of service.

Strategic directions

The plan sets goals for change and improvements in the mental health sector. Timelines for implementation have been indicated throughout the five-year life of the plan. Oversight of the implementation process was allocated to the Strategic Oversight Group (SOG). Co-chaired by a consumer representative and an ACT Health representative, the SOG includes consumer, carer, community and primary care representatives, with participation from ACT and Australian Government agencies. The SOG reports annually on implementation of the *ACT Mental Health Services Plan 2009–2014.*

In 2012–13, the ACT Government, in partnership with the community sector, consumers and carers, continued to work towards the guiding vision of the *ACT Mental Health Services Plan 2009–2014* by focusing on the four priorities outlined in it:

1. reinforcing capacity in the mental health sector
2. extending the mental health service system
3. innovating in the mental health service system
4. planning implementation of change.

Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009–2014

Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009–2014 aims to guide the implementation and development of activities to promote mental health and wellbeing, prevent mental illness and, where this is not possible, intervene early to detect and treat mental disorders.
The framework has three priorities:

1. Promoting mental health and wellbeing is everybody's business.
2. Preventing mental illness is a shared responsibility.
3. Early intervention requires strong inter-sectoral cooperation.

Oversight of the process is undertaken by the Mental Health Promotion, Prevention and Early Intervention Implementation and Evaluation Working Group, which includes consumer, carer, community, education, primary care and directorate representation.

The evaluation report, *Building a Strong Foundation: Evaluation Findings 2010–2011*, was finalised in 2013 and summarises the implementation findings from the second-year evaluation of the framework. Evaluation reports are available on the ACT Health website at ***www.health.act.gov.au/health-services/mental-health-justice-health-alcohol-drug-services/mental-health-policy/suicide-prevention/implementation-and-evaluation***. Highlights include:

- Twenty-four agencies reported that they had successfully embedded activities to promote mental health and wellbeing into their strategic plans and strategies.
- A review of international and national social marketing campaigns was completed in order to better inform future ACT integrated physical and mental health and wellbeing campaigns.
- A total of 5,500 people were successfully trained in workplace mental health literacy.
- The Alexander Maconochie Centre introduced extended visiting hours for families and set aside two private units in the Visitors' Centre for family visits. This is to encourage detainees to maintain and strengthen their family relationships while incarcerated.

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

Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009–2014 provides a service development framework to guide an integrated, whole-of-community approach to suicide prevention across the lifespan. The strategy's main strategic directions are 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 and partnerships between organisations providing suicide prevention and postvention services in the ACT.

The evaluation report, *Managing the Risk of Suicide: Evaluation Findings 2010–2011*, was finalised in 2013. This report summarises the implementation findings from the second-year evaluation of the strategy. Evaluation reports are available on the ACT Health website at ***www.health.act.gov.au/health-services/mental-health-justice-health-alcohol-drug-services/mental-health-policy/suicide-prevention/implementation-and-evaluation***.

ACT Health, in conjunction with the Centre for Mental Health Research at the Australian National University, is leading the way internationally in evaluating the outcomes of implementation and identifying the factors that affect implementation of both *Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009–2014* and *Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009–2014*.

Outcome and process evaluation data, collected from agencies identified as having responsibility for implementing actions, is collated and the findings from the surveys used to compile an annual report to the Legislative Assembly.

National Partnership Agreement Supporting National Mental Health Reform

The Council of Australian Governments signed a National Partnership Agreement Supporting National Mental Health Reform in 2012. This agreement provides $200 million in Commonwealth funding, alongside investments by the states and territories, to improve outcomes for people with severe and persistent mental illness. The two ACT projects being funded under the agreement are:

1. The Adult Mental Health Step-up, Step-down Outreach Support. Woden Community Services has been engaged to provide short-term early intervention to avoid acute hospital admission, and post-discharge follow-up support. Funding under the agreement allows for support for up to an additional 60 consumers per annum.
2. Supported Accommodation Outreach targeting people with serious mental illness and recent experience of involuntary institutional care. St Vincent de Paul has been engaged to provide supported accommodation and outreach for an additional 18 people annually who have serious mental illness and a history of involuntary institutional care.

Roadmap for National Mental Health Reform 2012–2022

The Council of Australian Governments endorsed the *Roadmap for National Mental Health Reform 2012–2022* in December 2012. The roadmap recommits the Australian Government and states and territories to whole-of-government and whole-of-lifespan approaches to mental health reform and to maintaining mental health as an ongoing national priority. A key commitment of the roadmap is the development of the successor to the Fourth National Mental Health Plan. The ACT Government is a member of the working group charged with this responsibility.

Fourth National Mental Health Plan

The *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009–2014* demonstrates a commitment to ongoing national mental health reform and identifies key actions to advance the vision of the National Mental Health Policy 2008. While led by health ministers, the plan takes a whole-of-government approach by involving sectors other than health. It provides a basis for governments to advance mental health activities in the various portfolio areas in a more integrated way, recognising that many sectors can contribute to better outcomes for people living with mental illness.

Two significant elements of the Fourth National Mental Health Plan have been progressed in 2012–13: the development of the National Mental Health Services Planning Framework and the National Mental Health Recovery Framework. When finalised, these two frameworks will appreciably contribute to the culture and provision of mental health services into the future.

A New Way—Aboriginal and Torres Strait Islander Health and Wellbeing Plan 2006–2011

The *ACT Aboriginal and Torres Strait Islander Health and Family Wellbeing Plan 2006–2011* was developed in response to the requirement of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) for each jurisdiction to develop a local implementation plan. A review of the plan was undertaken in 2012–13 by the Aboriginal and Torres Strait Islander Health Forum, which includes membership from ACT Health, the ACT Aboriginal and Torres Strait Islander Elected Body, Winnunga Nimmityjah Aboriginal Health Service and ACT Medicare Local. In this process, many factors were identified as affecting its implementation, most significantly the Closing the Gap Indigenous reform agenda, which was introduced halfway through implementation of the plan in 2008.

Development of a new ACT Aboriginal and Torres Strait Islander Health Plan commenced in 2013. The plan will incorporate learning from the review of the previous plan and outstanding action items which have been identified as ongoing strategies requiring implementation by the Health Forum. The new plan will also be informed by the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes and will seek to form linkages with the other national health-related plans developed in 2013:

- National Aboriginal and Torres Strait Islander Health Plan
- National Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Plan
- National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
- National Aboriginal and Torres Strait Islander Blood-Borne Viruses and Sexually Transmissible Infections Strategy
- National Aboriginal and Torres Strait Islander Drug Strategy.

The new health plan aims to promote a holistic approach to Aboriginal and Torres Strait Islander health planning for the ACT and surrounding community.

Health Workforce Plan 2013–18

The *ACT Health Workforce Plan 2013–2018* was released in 2012–13, aligning with national health workforce reform, including the Health Workforce Australia (HWA) *National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015*.

The principles that underpin the plan include workforce initiatives driven by consumer needs and cost-effectiveness, efficiency and sustainability. The plan provides a framework for actions by providing medium-term sustainable workforce planning strategies and associated actions which support the continued delivery of high-quality health services to the ACT region in an environment of increasing workforce challenges. The focus areas of the plan are strongly linked to ACT Health strategies and service plans which support more specific local needs.

The plan seeks to address health workforce issues through the use of five areas focus areas:

1. health workforce reform: improving service delivery
2. health workforce capacity: skills development
3. leadership and culture improvement for health system sustainability
4. health workforce planning
5. policy, funding and regulation.

The plan provides strategies under each focus area which provide direction, actions, accountabilities and measures of success which are able to be applied for operational workforce planning in all areas of ACT Health.

ACT Breastfeeding Strategic Framework 2010–2015

The *ACT Breastfeeding Strategic Framework 2010–20*15 (***www.health.act.gov.au/c/health?a=dlpubpoldoc&document=2777***) sets the context for the protection, promotion and support of breastfeeding in the ACT. The framework is consistent with, and supports the implementation of, the action areas in the *Australian National Breastfeeding Strategy 2010–2015*. While ACT Health is the lead agency to guide implementation, there is a whole-of-ACT Government commitment to this project, including the identification of strategies to support breastfeeding-friendly workplaces (BFW) across ACT Government directorates.

Significant achievements in 2012–13 include breastfeeding-friendly workplace accreditation for three directorates, including ACT Health, with others considering accreditation. An inclusive DVD for young parents was produced in 2012 as a collaborative initiative between the Aboriginal and Torres Strait Islander Health Unit, Gugan Gulwan Aboriginal Youth Corporation, Canberra College Cares and young parents in the ACT. There has been substantial support for health professional education, including support for candidates sitting for the International Board of Lactation Consultant Examiners (IBLCE). There has also been considerable collaboration with non-government organisations, including the Australian Breastfeeding Association.

Both public hospitals in the ACT are Baby-Friendly Health Initiative (BFHI) accredited. All breastfeeding resources developed are web compatible and most resources utilise ‘apps’ to be user-friendly for a young target audience.

Enhanced breastfeeding data has been collected since July 2011, with capability to report against the nationally agreed indicators: ‘exclusive’, ‘predominant’ and ‘any’ breastfeeding.

A dedicated project officer oversaw implementation of the framework in 2012–13, guided by a multidisciplinary Breastfeeding Initiative Steering Committee.

ACT Alcohol, Tobacco and Other Drug Strategy 2010–2014

Actions from the *ACT Alcohol, Tobacco and Other Drug Strategy 2010–2014* progressed in 2012–13 included:

- smoking reduction and cessation programs for target populations:
  - The Alcohol, Tobacco and Other Drugs Association ACT (ATODA) received funding in the 2012–13 ACT Health Promotion Grants Program Community Funding Round to conduct the Under 10% *project*. The project aims to support the ACT to be the first jurisdiction in Australia with a smoking prevalence under 10 per cent by providing targeted tobacco management and support to community services workers and clients with high smoking rates who experience disadvantage.

- ACT Health, in collaboration with a small reference group, developed a Brief Intervention Smoking Cessation E-learning Package, which has been available to ACT Health staff online since December 2012.
- ACT Health's 'Beyond Today … it's up to you' social marketing campaign to promote tobacco cessation and healthy lifestyle behaviours among the Aboriginal and Torres Strait Islander communities of the ACT and surrounding regions was launched in December 2012.

• drug treatment for people experiencing withdrawal, including those continuing on opioid maintenance treatment programs or choosing to cease opioid maintenance treatment:
  - ATODA developed a discussion paper on expanding access to all ACT alcohol, tobacco and other drug residential treatment for people receiving opioid maintenance therapy and engaged with key people nationally working in this area, including We Help Ourselves (WHOS), an interstate provider of residential treatment for people receiving opioid maintenance therapy.
  - Karralika Programs Inc. received three years of federal government funding to plan, implement and evaluate a pilot program admitting people on opioid maintenance therapy to its residential rehabilitation program. Implementation began in mid-2013.

• peer-based models of service delivery, support advocacy and community development:
  - The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA), in collaboration with ATODA and ACT Health, developed and implemented Australia's first overdose management program, which provides naloxone on prescription to potential overdose victims. The program is being evaluated by Professor Paul Dietze (Burnet Institute), Professor Simon Lenton (National Drug Research Institute), Dr Anna Olsen (Kirby Institute, UNSW) and Mr David McDonald (Social Research and Evaluation and Consultant to ATODA).

• drug diversion programs:
  - An external evaluation of ACT police and court drug diversion programs was undertaken. The evaluation was conducted by the Drug Policy Modelling Program, National Drug and Alcohol Research Centre and University of New South Wales and was completed in February 2013.

Sustainability Strategy

ACT Health continues to demonstrate its commitment to the principles of sustainability by monitoring its use of resources and integrating economic, social and environmental considerations into implementing measures to minimise the impact of agency activities on the environment. In 2012–13, it:

• continued to embed the ACT Health Sustainability Strategy into governance processes
• implemented the first phase of the Sustainability Action Plan by incorporating sustainability actions into key focus areas of ACT Health business activity. All actions have been classified as short-, medium- and long-term. Of the short-term actions (1–3 years), 93 per cent have now been completed. This equates to 59 actions.
• developed and endorsed Sustainability—Environmental Principles and Guidelines for Building and Infrastructure Projects, a document designed to guide and inform all future development of healthcare facilities, including sustainability checklists for master planning, building design, the construction phase and the operational stage
• implemented additional bicycle storage for visitors and staff on the Canberra Hospital campus
• used a restricted OfficeMax stationery catalogue to ensure cost minimisation, maximising value for money and embedding the principles of purchasing sustainable products
• conducted community consultation forums on future energy options for the Canberra Hospital campus as part of a feasibility study to best meet the sustainability goal of minimising CO^2 emissions associated with future infrastructure growth
• became a member of the Australasian Health Infrastructure Alliance Environmentally Sustainable Design Subcommittee, a forum whose mission is to share best practice between jurisdictions, pool resources to deliver infrastructure projects, leverage existing state-based projects at a national level and implement a common and unified understanding of sustainability in health care.

Quality and Safety Framework 2010–2015

The *Quality and Safety Framework 2010–2015* describes a vision and direction to improve safety and quality in ACT Health and sets out the key activities that will happen throughout the organisation to improve the safety and quality of services provided to consumers.

The plan includes a set of actions divided into three themes, which align with those of the Australian Commission on Safety and Quality in Health Care in its framework for a vision for safe and high-quality health care for Australia. These themes are that care will be:

- consumer-centred
- driven by information
- organised for safety.

To meet these themes, the Quality and Safety Unit has achieved the following:

- partnered with the Health Care Consumers' Association ACT to provide forums on 'how to complain properly', consumer representative training and advocacy training
- supported ACT Health through the Australian Council on Healthcare Standards (ACHS) Organisation-Wide Survey to retain its accreditation status. ACT Health met all criteria to achieve accreditation for another four years, with 28 marked achievements, 18 extensive achievements and one outstanding achievement
- implemented and evaluated training in bedside handover as part of the Effective Communication in Clinical Handover (ECCHO) project, a national Australian Research Council funding project in collaboration with the University of Technology Sydney and three other jurisdictions. Training is now being piloted in another ward. The project team presented at the International Council of Nurses Conference in May 2012
- supported the establishment of the 10 National Safety and Quality in Health Services Standards Groups to provide strategic direction for the implementation of these standards and monitor progress on key activities
- developed clear policy documents on important safety and quality issues such as:
  - consent and treatment policy and standard operating procedures
  - responding to the use of non-prescription alcohol and other drugs in health settings
  - open disclosure
  - work health and safety, and the safety management system
  - dangerous substance management
- held Open Disclosure Master Classes for senior clinical and executive staff. These classes provide targeted skills to support staff when open disclosure discussions with patients and families are required
- supported and monitored the quality of policy documents through the Policy Advisory Committee and staff training sessions on policy governance and policy writing
- provided education and training to staff on implementing the 10 National Safety and Quality Health Service Standards (NSQHSS)
- facilitated the ACT Quality in Healthcare Awards, which showcase patient safety and quality initiatives across the territory and the ACT Health Better Practice Awards, which celebrate local quality improvement activities
- developed an ACT Health Quality Improvement and National Safety and Quality Health Service Standards (NSQHSS) education strategy to improve understanding of change management and quality improvement methodology to support improvements in quality and safety practices
- worked to update the Safety and Quality Framework to include the new National Safety and Quality in Health Services Standards. A consultation draft will be issued in early 2013–14
- appointed a Patient Experience Leader
- completed a project on behalf of the Local Hospital Network (LHN) Council to collect patient stories relating particularly to bedside handover and discharge planning to allow the LHN Council to make recommendations for improvements
- developed a toolkit to support chairs and secretariats of committees who have consumer representatives on the committees
- made a successful budget bid to allow increased resourcing for the Respecting Patient Choices program to increase community awareness and uptake of advance care plans

- held an annual Thank You celebration for consumer representatives on ACT Health committees
- held regular liaison meetings with the Human Rights Commission to discuss processes and training opportunities for staff
- completed the divisional progress report, providing weekly updates of consumer feedback and status
- arranged guest presentations at Medicare Local Aged Care Forums and the Council on the Ageing ACT
- rolled out education and training on the National Recommendations for User-Applied Labelling of Injectable Medications, Fluids and Lines
- completed a training strategy to further support the implementation of open disclosure in ACT Health
- ACT Health coordinated and monitored preparations for the November 2012 Australian Council on Health Standards organisation-wide survey
- developed and implemented Canberra Hospital and Health Services-wide clinical audits that align with the National Safety and Quality Health Service Standards
- revised ACT Health incident management policy and associated standard operating procedures (SOP), including the Incident Management SOP, Significant Incident SOP and Open Disclosure SOP
- completed the first ACT Audit of Surgical Mortality Annual Report.

The framework is being reviewed for progress against the areas for action and alignment with the 10 National Safety and Quality Health Service Standards.

General Practice and Acute Sector Interaction Surveys

Several new services, communication strategies and process refinements have been put in place to improve the interaction between general practice and ACT Health, following two GP and acute sector interaction surveys conducted in 2009 and 2010. The combined report made 25 recommendations, which have now been implemented or are ongoing. Improvements have been wide-ranging and have included:

- expansion of the ACT Health GP website to include common external resources, integration with outpatient and surgical waiting times and referral guidelines for outpatient services across ACT Health
- establishment of an e-referral system, which allows clinician-to-clinician communication
- improvements to the quality and timeliness of discharge summaries, including education, clinical support and discharge summary awards
- development, endorsement and promotion to all staff of policies and standard operating procedures (SOPs) to ensure better access and sharing of clinical information between and within the acute and primary health care sectors
- improved communication and referral practices facilitated by interaction between the General Practice Liaison Unit, ehealth staff and general practices.

Formal communication channels between general practice and ACT Health continue to operate through the ACT Health and ACT Medicare Local quarterly meetings, GP Liaison Network quarterly meetings and the ACT GP Workforce Working Group.

C.6 Human resource performance

In 2012–13, the People Strategy and Services Branch in ACT Health focused on embedding the new branch structure to better support service delivery and planning for the future workforce. The branch has worked hard to implement continuous improvement and quality activities, including a major review of all policies and procedures and refinement of business processes in support of efficient and effective service delivery.

Key strategies for the branch are to improve employee engagement and performance through effective performance management and development; to improve the quality of management, leadership and organisational culture; and to implement specific strategies for the creation of new and innovative employment strategies.

Key achievements and major activities in 2012–13 are listed below.

- The completion of the ACT Health Workforce Plan 2013–2018 was a significant milestone for People Strategy and Services (PSS) in the reporting year. In conjunction with the Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013–2018, it establishes a strategic framework for innovation and reform in the workforce.
- Health Workforce Australia (HWA) released the Health Workforce 2025 series of reports, which clearly forecast the emerging workforce shortages in the domains of nursing and midwifery, medicine and allied health disciplines. These important reports make a substantial contribution to the evidence base driving significant national workforce reforms across the health sector. ACT Health strategies are described in more detail in Section A.9 of this report, under ‘Health workforce’.
- The staff in the branch have worked with colleagues in Health Service Planning to improve the effectiveness of workforce planning in tandem with support service planning and infrastructure development.
- The ACT Health Leadership Network continued to create opportunities to build collaborative relationships and partnerships across the directorate. The group met three times during the year, with speakers and presentations encouraging participants to develop their leadership skills, with a particular focus on change and resilience, ethics and self-awareness.
- HWA initiatives and projects to support the development of the future workforce are centrally coordinated by an HWA-funded team embedded within PSS. Within this team are the ACT Region Integrated Clinical Training Network (ICTN) coordinator and secretariat and the Simulated Learning Environment (SLE) project staff. Major achievements in 2012–13 include:
  - establishment of the ACT Region ICTN website
  - development of the web-based SLE lending library
  - commissioning of six two-bedroom units for the use of interstate students on clinical training placements, and
  - increasing clinical training placements across the region.
- In 2013, negotiations commenced on a number of replacement enterprise agreements covering all staff employed by ACT Health. Additionally, the renegotiation of the Visiting Medical Officer core conditions was undertaken.
- Significant investment in and commitment to the Respect, Equity and Diversity (RED) framework continued during 2012–13, with the RED contact officer network expanding to 90 officers and training now having been delivered to approximately 75 per cent of staff in the organisation. The RED contact officer network provides an important support to staff members who may be experiencing bullying and harassment, including the provision of information about potential next steps to address the behaviour.
- The results of the Australian Council on Health Standards Accreditation survey held in November 2012 were a gratifying affirmation that human resource practice within ACT Health is on track. It was awarded four Extensive Achievements and one Marked Achievement for the five human resource criteria in the standards. The Executive team of PSS was awarded an ACT Health Australia Day Award in recognition of this outcome.

- The Employment Inclusion Officer has developed a number of employment activities to facilitate the achievement of the ACTPS Employment Strategies. This officer also coordinates ACT Health's participation in the ACT Government's Aboriginal and Torres Strait Islander Traineeship Program and has developed a Traineeship Program for People with a Disability. To date, four Aboriginal and Torres Strait Islander traineeships and seven traineeships for people with a disability have been enabled. New programs are planned for implementation in the coming year, along with an expansion of the current programs.
  - The development and successful pilot of the People Manager Program was another highlight. This program focuses on developing and supporting front-line managers in a range of skill areas. The program will now be rolled out more extensively in the new financial year.
  - The continued commitment to ongoing development and enhancement of the workforce through a comprehensive and rigorous learning and development strategy delivered significant rewards in terms of qualifications and traineeships, as described in section C.8, Learning and development.

C.7 Staffing profile

Full-time equivalents (FTE) and headcount

	Female	Male	Total
FTE by gender	4,272.71	1,476.36	5,749.07
Headcount by gender	4,962.00	1,578.00	6,540.00
% of workforce (headcount)	76%	24%	

Classifications

Classification group	Female	Male	Total
Administrative Officers	771	169	940
Dental	13	4	17
Executive Officers	14	8	22
General Service Officers and equivalent	199	273	472
Health Assistants	58	6	64
Health Professional Officers	781	234	1,015
Information Technology Officers	0	2	2
Legal Officers	0	1	1
Medical Officers	383	431	814
Nursing Staff	2,357	269	2,626
Professional Officers	7	5	12
Senior Officers	249	124	373
Teacher	1	0	1
Technical Officers	127	50	177
Trainees and apprentices	2	2	4
TOTAL	**4,962**	**1,578**	**6,540**

Employment category by gender

Employment category	Female	Male	Total
Casual	280	96	376
Permanent full-time	2,322	887	3,209
Permanent part-time	1,516	132	1,648
Temporary full-time	645	428	1,073
Temporary part-time	199	35	234
TOTAL	**4,962**	**1,578**	**6,540**

Average length of service by age group by gender

Average length of service	Pre-Baby Boomers		Baby Boomers		Generation X		Generation Y		Total	
	F	M	F	M	F	M	F	M	F	M
0–2	4	2	177	43	427	191	745	313	1,353	549
2–4	2	3	179	40	305	121	377	106	863	270
4–6	3	2	175	61	249	98	214	43	641	204
6–8	5	0	140	41	215	65	93	17	453	123
8–10	5	2	148	41	160	61	48	9	361	113
10–12	2	1	152	38	124	32	21	3	299	74
12–14	1	1	95	27	78	18	8	0	182	46
14+ years	5	5	577	139	227	55	1	0	810	199

Generation	Birth years covered	Generation	Birth years covered
Pre-Baby Boomers	prior to 1946	Generation X	1965 to 1979 inclusive
Baby Boomers	1946 to 1964 inclusive	Generation Y	from 1980 and onwards

Total average length of service by gender

Gender	Average length of service
Female	7.4
Male	6.2
Total	7.1

Age profile

Age group	Female	Male	Total
<20	32	12	44
20–24	325	113	438
25–29	686	219	905
30–34	635	214	849
35–39	574	226	800
40–44	640	213	853
45–49	567	170	737
50–54	674	155	829
55–59	480	144	624
60–64	270	75	345
65–69	67	28	95
70+	12	9	21

Agency profile

Branch/division	FTE	Headcount
Canberra Hospital and Health Services	4,626.53	5,326
Director-General Reports	300.62	320
Special Purpose Account	13.56	17
Strategy and Corporate	808.36	877
Total	**5,750.07**	**6,540**

Agency profile by employment type

Branch/division	Permanent	Temporary	Casual
Canberra Hospital and Health Services	3,904	1,096	326
Director-General Reports	283	35	2
Special Purpose Account	5	9	3
Strategy and Corporate	665	167	45
Total	**4,857**	**1,307**	**376**

Equity and workplace diversity

	Category A	Category B	Category C		
	Aboriginal and/ or Torres Strait Islander	Culturally and linguistically diverse	People with a disability	Employees who identify in category A, B or C*	Women
Headcount	65	1,446	126	1,609	4,962
% of total staff	**0.99%**	**22.11%**	**1.93%**	**24.60%**	**75.87%**

*NB: Employees who identify in more than one equity and diversity category are counted only once.

Statistics exclude board members, staff not paid by the ACT Public Service and people on leave without pay. Staff members who had separated from the ACT Public Service but received a payment have been included.

C.8 Learning and development

Learning and development outcomes

An organisation-wide system is in place for the development, implementation and regular review of learning and development in ACT Health. This includes the ACT Health Learning Development Framework and reporting and associated policies, which support a learning culture to enhance staff capabilities, competency and legislative compliance. The Education Activity Register monitors executive approval for programs, annual evaluation and revision. A comprehensive calendar of learning opportunities is provided to staff on the intranet and the learning management system and annual data demonstrates a high degree of uptake of education and training.

In 2012–13 achievements included:

- Australian Council on Health Care Standards (ACHS) 2012 accreditation rating of EA (Extensive Achievement) for learning and development
- revision and implementation of the ACT Health Learning and Development Framework and assessment tool based on learning organisation principles
- significant revision of the essential education policy (mandatory training) and procedures. This policy also enunciates requirements for students, volunteers and contractors
- an extensive evaluation and revision of clinical programs to comply with the National Safety and Quality Health Service Standards and
- an increase in competency-based training to comply with the National Safety and Quality Health Service Standards, including revision or development of education and piloting of new assessment tools—for example, in life support programs and in aseptic technique.

ACT Health is committed to ensuring the quality of its education and training. This includes:

- auditing of the Education Activity Register, which monitors programs on the ACT Health learning management system to ensure they are reviewed, updated annually, linked to evidence-based practice and approved by an executive director. In 2012–13, 153 programs were listed on the Education Activity Register
- maintaining compliance with the Standards for NVR Registered Training Organisations 2011, with two nationally recognised programs offered in 2012–13
- evaluating learning and development programs—assessing outcomes and reporting to stakeholder groups
- providing professional development and networking for staff across the organisation engaged in work-based training and education initiatives, student clinical supervision, graduate support, and competency assessment to support the provision of safe, quality health care, as shown in the table below.

Program	Enrolments and attendees 2012–2013
TAE40110 Certificate IV in Training and Assessment	72 enrolments from nursing, midwifery, allied health, technical and administrative roles
Clinical support and supervision essentials	67 attendees (54 nursing and 13 allied health staff)
Trainers and Educators network	158 attendees over 5 meetings

Leadership and culture programs

- The ACT Health Leadership Network is composed of around 100 employees identified by the Health Executive as leaders and potential leaders who could most benefit from the network and contribute to its objectives. The three workshops held during the 2012 calendar year had leadership themes of identifying and focusing on strengths, positive organisational stories, ethical decision making, collaboration/teamwork and courageous leadership. Inspiring and informative guest speakers included Michael Milton (Paralympian), John Hill (St James Ethics Centre), Rechelle Hawkes (former Hockeyroos captain), Andrew Kefford (Deputy Director-General, Workforce Capability and Governance Division & Commissioner for Public Administration, ACT Public Service), and Margie Warrell (CEO, Global Courage Institute), with Health executive and staff also contributing strongly. Participants were encouraged to develop their individual and group thinking on these topics as well as to continue forming constructive partnerships with each other and across the organisation.

- The People Manager Program, developed and commenced in 2012–13, aims to develop knowledge and skills in people management, underpinned by Health's values. The PMP is for clinicians and non-clinicians in frontline supervisor and middle management positions who have people management responsibilities. It has received excellent evaluations from participants, who have appreciated the Health-focused examples and contexts used.
- The Critical Care Leadership Program is an inter-professional leadership program attended by Intensive Care Unit and Emergency Department clinical staff from the Canberra Hospital and Calvary Hospital. In 2012–13, two programs were attended by 50 staff.
- The Clinical Leadership and Communication Skills Development Program targets participants from graduate programs, nursing night duty, clinical development nurses and midwives, and upcoming nursing team leaders. The program was developed in response to evaluation and needs analysis of these groups. A total of 293 staff attended these sessions, which received positive evaluations.
- Managing and preventing bullying, harassment and discrimination training is available to all managers and all staff. More than 4,600 staff in the ACT Health workfoce have been trained since the program begun in 2011.

All-staff workshops	Managers' seminar	Total number of staff trained in 2012–13
1,385	101	1,486

The number of Respect Equity and Diversity (RED) contact officers at 30 June 2013 was 90. RED contact officers include nurses, allied health professionals, administrative staff and staff who work outside traditional business hours.

- ACT Health's combined efforts on RED training, policy development, case management and other initiatives resulted in it being shortlisted for an ACTPS Award for Excellence in the Respect category.

Recruitment and transition to practice programs

ACT Health implements highly successful programs to transition new nurses from student life to practice, including a Graduate Registered Nurse program, Enrolled Nurse program, and Allied Health Graduate Program. The programs provide a high level of clinical and professional support, care, feedback and guidance during the transition year. The evaluations demonstrated that the programs met participants' expectations and those of the clinical areas.

Participants' comments in evaluations included the following:

'Learning a lot about nursing in a practical capacity and becoming responsible for my own learning and my own actions. I also feel that I have made a positive contribution to other people's lives, and it is nice to know that my career can do this for people'.

'being able to work as a nurse, learning nursing skill from all different areas of the hospital and experiencing different types of nursing such as ward and clinic'.

'Gaining so many valuable skills whilst being supported'.

Program	Number of participants	Completions	Retention rate (stay in ACT Health after completion)
RN Graduate program 2012	99 over 3 intakes	98 (99%)	92 (93%)
RN Graduate program 2013	103 over 4 intakes	Program ongoing	Program ongoing
EN Graduate program 2012	17 over 2 intakes	6 completed 9 ongoing	5 employed, others ongoing because of maternity etc.
EN Graduate program 2013	5 commenced	Program ongoing	Program ongoing

The Allied Health Graduate Program was developed and piloted in 2012 to support new allied health professionals to integrate into the workforce with an interprofessional focus. The full program commenced in February 2013, with 27 participants, and will conclude in July 2013.

Nurse and Midwives Re-entry Programs and Overseas Qualified Nurse Programs: The re-entry programs recruit and provide educational support to nurses and midwives who have not worked in acute health care for up to 10 years. The Overseas-Qualified Nurse Program provides education and support for internationally qualified nurses to obtain registration in Australia and the possibility of obtaining a position in ACT Health. Both programs are accredited with the Nursing and Midwifery Board of Australia

2012–13	Completed	Currently participating	Recruited to ACT Health
Registered nurse re-entry	7	3	4
Midwifery re-entry	3	1	1
Overseas qualified	12	4	6

Essential Education programs

Safety education programs

Program	Description	Staff Trained
Manual Handling Education	A range of programs provided for clinical and non-clinical staff, students and volunteers	2,913 staff face-to-face 133 volunteers, 271 nursing and allied health students 30 medical students and interns 2,882 e-learning completions
Predict, Assess and Respond to Challenging or Aggressive Behaviour (PART)	Helps staff in high-risk areas to respond to challenging client behaviour safely and effectively in order to reduce the risk of harm to both clients and staff	111, nurses, allied health, administration staff and wardspersons
Chemotherapy safe handling	Provided for staff looking after patients who are receiving chemotherapy to comply with the Clinical Waste ACT, the Poisons and Dangerous Drugs Act, the Workplace Health and Safety Act and the Hazardous Chemicals and Dangerous Goods Act.	66 nurses

Child protection training

This is provided at three levels for staff according to their contact with children and young people and is delivered across all Health organisations and sections, including both Calvary Health Care hospitals and non-government agencies that receive funding from ACT Health. ACT Health volunteers are also provided with training. E-learning options are available for level 1 child protection training and the level 2 refresher training.

ACT Health continues to partner with the Community Services Directorate to provide What About Me, a series of workshops for government and non-government organisations aimed at increasing staff confidence and ability to work with vulnerable children and families.

Number of ACT Health staff attending child protection training 2012–13

Level of training	Total number trained*
Level 1 (face-to-face)	278
Level 2	797
Level 2 refresher (face-to-face)	121
Level 3	454
Level 3 refresher	212
Level 1 e-learning	719
Level 2 e-learning	569
Total 2012–13	3,150
Total 2011–12	2,830

*Staff may attend more than one level of training—for example, level 1 and level 3. The participant total reflects the full number of attendees at education sessions. These figures include all staff trained in ACT Health (and Calvary Bruce and Calvary John James).

Life support programs

Life support programs are provided in line with the requirements of the National Safety and Quality Health Service Standards (Standard 9). In 2012–13, all life support programs were revised in consultation with stakeholders to strengthen alignment with current guidelines, improve availability and access, and increase the numbers of accredited trainers and assessors. Programs in 2012–13 increased the use of simulation and scenarios to help solidify knowledge and skills.

The table below shows the training provided and the number of staff who attended:

Training	No. of participants
Basic Life Support—433 programs	3,354
Advanced Life Support—13 programs	167
Advanced Life Support Refresher—12 programs	113
Neonatal Life Support—9 programs	ACT Health—151, Calvary—45
Update Neonatal Life Support—6 programs	ACT Health—80, Calvary—11
Paediatric Life Support—8 programs facilitated by Advanced Paediatric Life Support (Victoria), held in Canberra	130
Paediatric Life Support Refresher, Canberra Hospital—4 programs	12

Note: The Basic Life Support program is now included in 13 Advanced Life Support programs, in which 167 staff were assessed on Basic Life Support.

Early Recognition of the Deteriorating Patient Program (COMPASS)

This program supports implementation of standard 9 of the National Safety and Quality Health Service Standards and is designed for nurses, midwives, physiotherapists, doctors and undergraduates, and is delivered by the Early Recognition of the Deteriorating Patient team. The COMPASS education program is used by facilities in every state and territory in Australia, and internationally. The COMPASS programs offered in 2012–13 are set out in the table below.

COMPASS Program	Number of sessions	Number of participants
Adult	29	475
Paediatric	5	11
Maternity	5	20
Adult refresher	48	997
Paediatric refresher	24	116
Maternity refresher	20	62

- A monthly Modified Early Warning Score (MEWS) and Medical Emergency Team (MET) forum is held to discuss case studies, audits and a topic of the month.
- New junior medical staff undertake COMPASS in the annual January medical orientation for junior doctors.

A new family-activated escalation program, Call and Respond Early (CARE) for patient safety, has been developed. This training included a 1.5-hour in-service for ward nursing staff, and an eight-hour CARE skills day was developed and delivered in conjunction with Organisational Development for CARE responders and senior ward nurses. There were 50 CARE in-services for 458 participants and five CARE skills days for 51 participants.

The Neonatal Early Warning Score (NEWS) pilot training has commenced for staff in the maternity unit. This training, developed by the NEWS project team, was led and delivered by neonatal and maternity clinical support nurses and clinical development nurses. To date there have been seven two-hour sessions for 48 participants.

Clinical programs

ACT Health provides a large number of clinical education programs. Some key programs are described below.

Night Duty Program

Night Duty Program is offered once or twice a month for 11 months of the year for nursing staff working night duty. The program includes professional issues, clinical education, invited guest speakers and competency assessment for clinical education. The Night Duty Program was conducted on 30 occasions during the year, with 962 staff attending.

Introduction to Perioperative Nursing Program

The Introduction to Perioperative Nursing Program was first developed to attract and retain nurses in response to staffing shortages in the Perioperative Unit.

- In February 2012, 16 nurses commenced the program, including eight graduate nurses and nurses from other areas in Canberra Hospital and regional New South Wales hospitals. The program is 12 months long and is completed in the following February, in line with the new graduate program. All graduate nurses elected to continue to work in the perioperative area. The 2012 program was extensively evaluated, indicating that the course had delivered orientation, provided basic skills and knowledge, and retained staff in the perioperative nursing specialties. Feedback from regional hospital participants was very positive, and places will continue to be offered to them.
- In February 2013, 13 nurses (including eight graduate nurses) commenced the program, including two participants from regional New South Wales. The program will continue until February 2014.

Perioperative Team Leader Program

The Perioperative Team Leader (TL) Program was developed to attract and educate nurses to fulfil the role of Scrub TL after hours. Following evaluation the program was changed to deliver a broader, team-orientated approach, providing education modules encompassing all perioperative nursing specialties. These include Scrub, Anaesthetics, the Extended Day Surgery Unit (EDSU) and the Post-Anaesthetic Care Unit. Perioperative level 1 registered nurses with a minimum of two years experience (12 months for EDSU) or level 2 perioperative registered nurses who have not yet worked as a team leader are the target groups for this program. Twelve nurses attended the first four modules and seven nurses attended the final module. The revised 2013 program was well received.

Paediatric Foundation Program

The Paediatric Foundation Program is aligned with the Nurse Graduate Program. The program allows the novice paediatric nurse to develop and consolidate their skills through workshops and learning modules.

In 2013, there were two intakes and a total of eight graduates. In August 2013, the first intake will complete the program. The second intake is due to complete it in November 2013.

Child and Adolescent Mental Health Program

This three-day program is run in conjunction with the Child and Adolescent Mental Health Service and provides health professionals with knowledge and management skills used in the care of the child and young person with an acute mental health problem. In 2012, 18 participants completed the program and paper-based evaluations demonstrated 100 per cent satisfaction, with ratings of 'good' to 'very good'. This program is re-scheduled for September 2013.

Peripheral Intravenous Cannulation Program

The program is for registered nurses and midwives, medical students and medical officers and radiographers, and third year student nurses in their final placement may also apply. In 2012–13, 10 workshops were conducted, with 159 participants, and 13 per cent completed all requirements. The focus is now on revising the content to more closely align with the 10 National Safety and Quality Health Service Standards, ACT Health policy and current literature, and on the development of an e-learning program for the theory component to encourage a higher rate of completion of all aspects of the program requirements.

Central Venous Access Devices Workshop

This program provides an overview of ACT Health policy and procedures in the care and management of central venous access devices and is available as a workshop and e-learning package. In 2012–13, 21 participants attended workshops and 69 staff completed the e-learning program.

Postgraduate Certificates for Nurses and Midwives

Two Postgraduate certificates are offered to nurses and midwives through the Australian Catholic University (ACU) in partnership with ACT Health. The ACU delivers an online component for two units, and an educator in the Staff Development Unit teaches an approved curriculum for the remaining two units. This education model combines theory and experiential learning. The advantages for ACT Health of using this model are that postgraduate study is tailored to work area need, students can work and study at the same time, and there are no fees for the ACT Health component.

- Graduate Certificate in Neonatal Nursing: In 2012, four students completed the online component through the Australian Catholic University. In 2013, nine students were enrolled in the ACT Health program, including the four students who completed the online subjects in 2012. Two students have continued on to study for a master's degree.
- Child and Adolescent Health Graduate Certificate: The course curriculum was revised and approved by the ACU in 2013. In 2012 six students were enrolled, five specialising in acute paediatrics and one in maternal and child health. All students completed the course and five went on to study for a master's degree. A further three students started in mid-semester, two specialising in acute paediatrics and one in maternal and child health. In 2013, 11 students enrolled, five specialising in acute paediatrics and six in maternal and child health. Three students completed the course at the end of semester 1, 2013, with two going on to a master's degree.

E-learning

Seven new e-learning programs were implemented in 2012–13 to support clinical and non-clinical areas and a further six are in final development. Ten programs were reviewed and updated as a result of evaluation feedback and changes to legislation or clinical practices. These developments with e-learning are set out in the table below.

Programs implemented 2012–13	Programs in final development and piloting
Finance Module 1 (basic finance processes)	B. Braun (infusion pumps)
Finances Practicalities (practical application of finance tools)	Ketamine (administration of pain management medication)
Tobacco Intervention	Respecting Patient Choices (patient choices regarding care)
Open Disclosure	Personal Safety and Conflict
Magnetic Resonance Imaging (to enable log on)	Patient ID and Procedure Matching
Certificate IV in Training and Assessment (supplementary)	Intrathecal Morphine (pain management)
Incident Management (Riskman)	
E-learning updates as a direct result of evaluations	
Child Protection Level 1	Australian Charter of Healthcare Rights
Child Protection Level 2 Refresher	Medication Packaging
Work Health and Safety Act 2011	Ethics, Fraud and Integrity
Consent	PCA Competency Test
Health Procurement	Aboriginal and Torres Strait Islander Awareness

Student support

The Secondary School Work Experience Program is a four-day placement offered to year 10, 11 and 12 students attending a high school or college in the ACT. The aim of the program is to give students a realistic idea of what it is like to work in health care and encourage them to choose career paths in health. In 2012–13, Health placed 251 secondary students. Positive feedback was received from students, teachers and workplaces.

Secondary students' comments included the following:

'I got the chance to see a very broad range of professionals within the ward, which was interesting and beneficial. I also got to interact a lot with patients and was able to do many activities with them.'

'I loved the people who I worked with because they were so friendly, accommodating and willing to educate me.'

'When the patients showed improvements, the excitement expressed by them was great. The therapist/patient relationship. The patients were really friendly. The personality of the nurses and observing the daily requirements and abilities a nurse is expected to provide. The nurses are such beautiful women and men who were continuously devoted and always shared such friendly smiles and words together.'

The Student Placement Unit assists with the management of clinical placements for nursing, midwifery, medical and allied health students. It provides a platform for pre-placement preparation, including e-learning programs for legislative compliance prior to clinical placement commencement. The student placement management system also assists with the reporting requirements of Health Workforce Australia in relation to student clinical placement activity. In 2012–13, there were 523 allied health placements. In the same period, 23,770 clinical placement days were provided to nursing and midwifery students. Clinical placement opportunities were offered in a variety of acute and primary health care areas.

The Allied Health Student Clinical Placement Mapping project commenced in 2012 to assess and identify capacity for growth in student numbers and clinical placements up to 2014 in allied health professions deemed to be in need of more clinical placements due to increased student numbers. This work was initiated to assist the Clinical Training Placements Reference Group, a subcommittee of the Integrated Regional Clinical Training Network (IRCTN). The project's initial focus has been on the collection of information relating to current and planned clinical placement activity and student numbers in physiotherapy at both ACT Health and Calvary Health Care ACT (public). The project has included the identification of barriers and enablers to increasing the number of placements offered, and highlighted the resources required to maintain and enhance the quality of the placements offered. The project will be finalised in late 2013.

Scholarships for allied health, nursing and midwifery

Allied health

The Office of the Allied Health Adviser supports and promotes ACT Health's commitment to ongoing learning and development through the Allied Health Postgraduate Scholarship Scheme. Scholarships are awarded to support recipients in their pursuit of further learning in clinical practice, education and training, research and/or management and leadership. Scholarships are awarded annually over academic (calendar) years, with the budget spread over two financial years.

The 2012–13 budget committed $71,345 to support 25 recipients completing their Semester 2, 2012, postgraduate study. However, actual payment for this study period was $50,194 due to the withdrawal of seven recipients. In Semester 3, 2012, a total of $18,277 was committed to seven recipients. However, following two withdrawals, actual payment made was $15,311. In the 2013 academic year, allied health postgraduate scholarships were awarded to 13 new applicants and 13 continued their study from 2012. Of the postgraduate courses being undertaken by the 2013 recipients, five are at Graduate Certificate level, one is at Graduate Diploma level and 20 are at Master's level. Twenty-five recipients commenced their study in Semester 1, 2013, representing a commitment of $62,326 and resulting in a total investment of $127,832 in allied health postgraduate scholarships for 2012–13.

Nursing and midwifery

The Nursing and Midwifery Post-Registration Scholarship Scheme, offered since November 2000, provides financial assistance with course tuition fees to support studies in a clinical, education, research and leadership or management area for enrolled and registered nurses and midwives, through the following scholarship programs:

- Aboriginal and Torres Strait Islander Enrolled Nursing Scholarships
- Joanna Briggs Institute Clinical Fellowship Scholarships
- Aboriginal and Torres Strait Islander Enrolled Nursing Scholarship
- Jennifer James Memorial Honours Degree Scholarship
- Nursing and Midwifery Travel Scholarship.

There has been a 25 per cent growth in post-registration scholarships and, in 2012–13, a record number of registered nurses, midwives and enrolled nurses received scholarship support.

ACT Health total learning and development activity

Learning and development activity for face-to-face programs and completion of e-learning programs by health division as recorded in the ACT Health learning management system, Capabiliti, from July 2012 to June 2013

Health division	No. of attendances	Hours	Salary	E-learning completed
Office of the Director-General	937	3,265	$147,804	656
DDG Strategy and Corporate	2,631	7,302	$296,665	1,628
DDG Canberra Hospital and Health Services	54,847	130,578	$4,899,055	16,351
Calvary*	54	N/A	N/A	N/A
Special Purpose Account	100	191	$7,455	58
TOTAL	**58,569**	**141,336**	**$5,350,979**	**18,693**

*Calvary hours and salary costs are not available.

ACT Health staff undertaking whole-of-government learning and development

Study assistance

In 2012—13, study assistance was provided to 212 employees to allow them to access paid leave and complete external study to develop capabilities that can be applied in the work environment. In addition to study leave, a total of $41,124 in financial assistance was provided to ACT Health staff.

ACTPS calendar of training

In 2012–13, 203 ACT Health staff attended training from the ACTPS training calendar, at a total cost of $73,588.29

Initiative	No. of participants
ACTPS Graduate Program	2
Young Professionals' Network (YPN)	N/A*
Future Leaders Program	4
Executive Development Program	1
PSM Program	N/A*
Sponsored Training for First-time and Frontline Managers	N/A*

*In 2012–13, the Public Sector Management Program, first-time and frontline Managers Program and YPN activities were not coordinated centrally, so there is no data available to report.

Future learning and development priorities

Key future learning priorities as determined by ACT Health executives are:

- education to support implementation of the National Safety and Quality Health Service Standards
- change management
- customer service
- dealing with difficult behaviours
- people management
- effective communication
- partnering with the tertiary sector for delivery of the nursing refresher and overseas qualified nurse programs.

C.9 Workplace health and safety

Our priority—a safe and healthy working environment for all employees

Workplace safety within ACT Health is a shared responsibility between managers, staff and the Workplace Safety section.

The Workplace Safety section:

- has overarching responsibility for ensuring that ACT Health has an effective workplace safety management system to identify, manage and monitor and report safety risks
- provides a holistic early intervention physiotherapy service to staff who have sustained a musculo-skeletal accident or injury in the workplace
- provides occupational medicine services across ACT Health to prevent the potential transmission of infectious disease to healthcare workers. These services include pre-employment screening, a vaccination program (including annual influenza vaccinations), an immunisation drop-in clinic, occupational risk exposure (ORE) and follow-up management, counselling and advice, cytotoxic screening, a mobile clinic for seasonal influenza vaccinations and product monitoring on safety devices, surveillance and education.

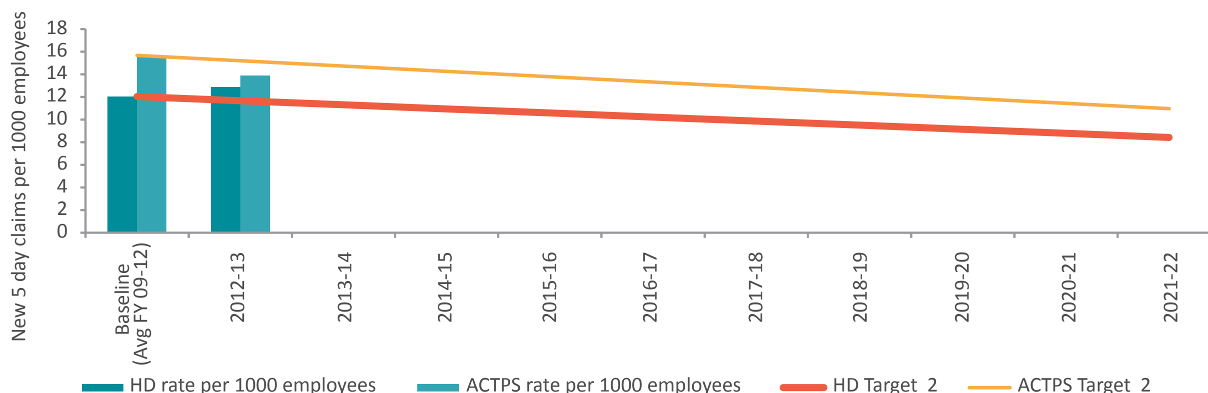
In addition to promoting workplace safety, ACT Health provides staff with health promotion opportunities. These aim to enhance the efforts already achieved in keeping directorate staff healthy and safe and ensure this is a sustainable goal.

Measures taken during 2012–13

Workplace safety measures undertaken during 2012–13 are set out below.

- The ACT Health Work Health Safety Management System was amended during the year to reflect changes to legislation and to focus on risk management. It includes enhanced asbestos management and removal procedures and an update of cytotoxic drug procedures. This system was designed to meet the Australian Standard 4804 and enables ACT Health to have an integrated safety system. Auditing against Australian Standard 4801 will enable ACT Health to continuously improve its safety management system.
- The ACT Health Workplace Safety Committee (the peak organisational body for occupational health and safety in ACT Health) met four times during the year. It is chaired by the Director-General and includes management and workplace health and safety representatives.
- The fourth year of electronic staff accident and incident reporting has resulted in consistent reporting and enabled ACT Health to quickly identify and implement relevant controls, as well as report to management and workplace health and safety representatives.
- Safety training remains a priority and continues to be provided for health and safety representatives, managers and new staff. E-learning packages were developed for work safety legislation, work station setup, and violence and aggression.
- The ACT Health Capital Asset Development Plan, and the resultant capital construction of new buildings and the refurbishment of existing buildings, has created a need to increase the level and extent of safety advice provided by Workplace Safety staff.
- The *Dangerous Goods and Hazardous Substances Manual* was re-issued in April 2013. This was supported by a Respiratory Policy.

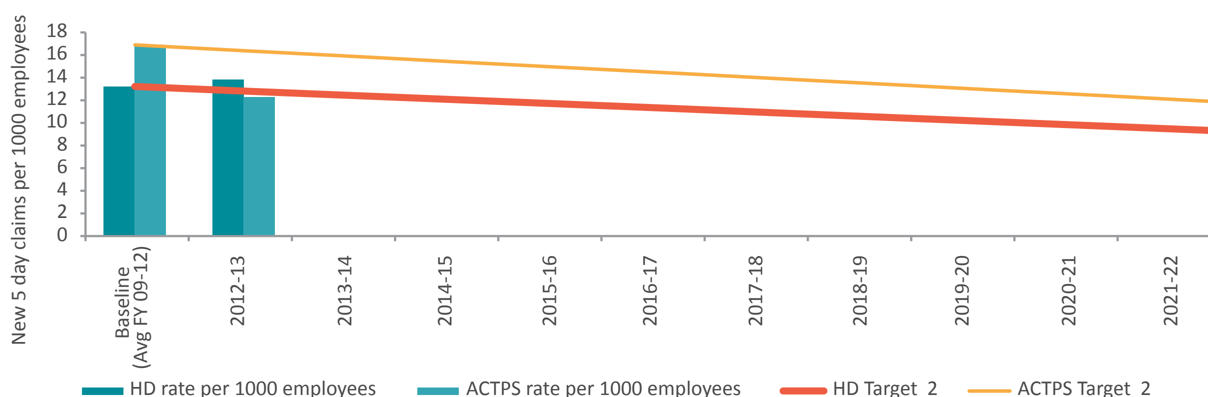
Target 2 — Reduce the incidence of claims resulting in one or more weeks off work by at least 30 per cent



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	60.0	71									
HD rate per 1000 employees	12.03	12.85									
HD Target 2	12.03	11.67	11.30	10.94	10.58	10.22	9.86	9.50	9.14	8.78	8.42
ACTPS # new 5 day claims	304.3	274									
ACTPS rate per 1000 employees	15.66	13.87									
ACTPS Target 2	15.66	15.19	14.72	14.25	13.78	13.31	12.84	12.37	11.90	11.43	10.96

Over the last 10 years ACT Health has consistently reduced the number of new claims that have exceeded five days incapacity per 1000 employees. This improvement varies on a year-to-year basis depending on the nature and complexity of a small number of claims. A small deterioration has occurred in overall performance between the 2009–2012 average and 2012–13. However, 2012–13 figures are still reflective of historical trends. Overall performance is very good against the ACT Public Service figures.

Target 3 — Reduce the incidence of claims for musculoskeletal disorders (MSK) resulting in one or more weeks off work by at least 30 per cent



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	31.0	36									
HD MSD rate per 1000 employees	6.21	6.52									
HD Target 3	6.21	6.03	5.84	5.65	5.47	5.28	5.10	4.91	4.72	4.54	4.35
ACTPS # new 5 day MSD claims	154.7	114									
ACTPS MSD rate per 1000 employees	7.96	5.77									
ACTPS Target 3	7.96	7.72	7.48	7.24	7.00	6.76	6.53	6.29	6.05	5.81	5.57

The report includes accepted claims only.

Dates are based on those claims received by Comcare in each financial year.

Both reports are based on injury or disease which results in one or more weeks off work.

ACT Health's performance has indicated a small deterioration compared with the preceding four years. This is reflective of the incidence of musculoskeletal claims in line with the risk profile for these types of injuries within ACT Health. ACT Health manages this risk through investing in proactive approaches to ensure that long-term trends do not reflect 2012–13 statistical performance. The overall trend in performance on these claims is improving with these early intervention strategies and proactive case management.

Other key performance indicators

Incidents, accidents, investigations and notices in 2012–13 were as follows:

- 1355 accident/incident reports were lodged during the 2012–13 financial year (not including non-individual or Redevelopment Unit contractors). This compares with 1209 lodged during 2011–12. Of these reports, 164 resulted in lost time of one day or more, compared with 153 in 2011–12.
- 74 accidents/incidents relating to ACT Health staff were notified to WorkSafe ACT under section 35 of the *Work Health and Safety Act 2011*, compared with 14 in 2011–12. In addition there were a number of instances where contractors working for ACT Health reported incidents directly to WorkSafe ACT.
- There was one outstanding provisional improvement notice (PIN) issued in 2011–12 (27 March 2012). The notice was in relation to potential unknown contaminants in level 5, 1 Moore Street affecting staff working there. The PIN was lifted by WorkSafe ACT on 6 September 2012. ACT Health has since relinquished occupancy of this floor. One further PIN was issued on 7 December 2012. This was because of an ongoing chemical smell that had been detected in the ACT Research School Endocrinology and Diabetics Laboratory in Building 10, level 6, TCH. This was lifted by the Health and Safety Representative on 5 March 2013 when the odour had been eliminated.
- At 30 June 2013, there were 243 elected Health and Safety representatives within ACT Health. There were 194 Health and Safety Representatives during the 2011–12 period.
- There were 304 workstation assessments completed by the Workplace Safety Early Intervention Physiotherapy Program during the 2012–13 financial year. Workstation assessments are conducted as part of workers, compensation return-to-work plans as well as for non-compensatory purposes. This is an increase from the 129 completed the previous year.
- Five improvement notices, failure to comply notices, prohibition notices or notices of non-compliance were issued to ACT Health under the *Work Health and Safety Act 2011*.

C.10 Workplace relations

Details of the Health Directorate's Special Employment Arrangements (SEAs) and Australian Workplace Agreements (AWAs) are set out in the table below. In the Health Directorate, SEAs are used to attract and retain special skills in high demand, including of medical and health practitioners and specialised skills in clinical support roles.

Description	No. of Individual SEAs	No. of Group SEAs*	Total employees covered by Group**	Total
	A	B	C	(A+C)
SEAs				
Number of SEAs at 30 June 2013	106	24	198	304
Number of SEAs entered into during period	14	4	216	230
Number of SEAs terminated during period	15	3	74	89
The number of SEAs providing for privately plated vehicles as at 30 June 2013	7	0	0	7
Number of SEAs for employees who have transferred from AWAs during period	0	0	0	0

* Agencies should record the number of group SEAs entered into during the reporting period

** Agencies should record the total number of individual SEAs entered into within the group/s during the reporting period

	Classification Range	Remuneration as at 30 June 2013
Individual and Group SEAs	SOC-SOA plus SITB	$85024 – $138208
	HPO2-HPO6	$20675 – $156296
	SPEC-SSPEC	$69807 – $593109
	TCMG2-TCMG3	$186210 – $236812
	MPSSP-MPCHF	$166284 – $188911
AWAs (includes AWAs ceased during reporting period)	SSPEC	$203848 – $272473
	SOC	$98089 – $131926

C.11 Human Rights Act 2004

Staff of ACT Health continue to be supported in their access to internal and external training opportunities relating to human rights issues. The Human Rights Commission provides regular training sessions on human rights matters for all ACT Health employees, which are widely advertised within the agency. Staff are encouraged to attend training sessions, which are provided free of charge. In addition, representatives from the Human Rights Commission attend ACT Health managers and staff orientation induction modules and provide information on the human rights responsibilities of staff. ACT Health is committed to building a human rights culture in the delivery of health services and to ensuring that ACT Health managers work within a human rights framework.

In ACT Health, education on the *Human Rights Act 2004* has been identified as essential for policy writers and for manager-level staff and above. The human rights training for managers program is conducted throughout the year by the Staff Development Unit. In addition, in consultation with the ACT Human Rights Commission, ACT Health has now developed an e-learning program to allow an alternative method of training, as well as the face-to-face sessions. The face-to-face training, delivered by internal trainers, was completed by 95 staff in 2012–13: 27 senior officers, 20 health professionals, 11 administration officers, 35 nurses, one medical scientist and one medical officer. Course evaluations completed by participants indicate that the training increased participants' awareness of their obligations under the Act. In respect of the e-learning program, 57 staff enrolled online and 34 completed the module. In total, 129 staff completed human rights training in 2012–13.

In 2012–13 ACT Health developed and published a number of brochures dealing with human rights issues of concern to the organisation. ACT Health printed 10,000 copies of the Healthcare Rights brochure, 30,000 copies of the Listening and Learning Consumer Feedback brochure, 10,000 copies of the Guide to Patient, Consumer, Carers and Family brochure, 500 copies of the Mental Health Charter of Rights brochure and 100 copies for each of the 12 language groups of the Victims Support Multilanguage brochure.

The Consumer Feedback and Engagement Team (CFET) of ACT Health values the partnership it has developed with the Human Rights Commission. The two bodies meet twice a year to discuss how they can work together to achieve positive outcomes. The commission regularly contacts CFET to find out whether a complaint it has received has also been submitted through the ACT Health consumer feedback management process. This is important as it assists to resolve issues as soon as possible for the consumer.

Liaison with the Human Rights and Regulatory Policy Unit of the Justice and Community Safety Directorate is initiated where staff developing legislation are uncertain about human rights issues and for the routine vetting of draft Bills. Issues identified in any ACT Health Bills as a result of the Legislative Assembly's scrutiny process are also brought to the attention of relevant staff. In 2012–13, ACT Health prepared 16 Cabinet submissions, two of which related to legislative proposals for which human rights compatibility statements were sought.

In 2012–13 ACT Health continued its major review of the *Mental Health (Treatment and Care) Act 1994*, which engages a number of significant human rights issues. Drafting instructions are being completed for the final amendment Bill following release of two exposure draft bills for public consultation in August 2012 and April 2013.

Recommendations for these amendments were made by a Review Advisory Committee comprising more than 40 stakeholder groups, including consumers and carers and ACT Human Rights Commission representatives. The amendments were also endorsed by a Policy Management Team comprising members of the government agencies involved in developing the final amendment Bill and including human rights law policy representation. Compatibility with the *Human Rights Act 2004* will be addressed as part of the explanatory statement accompanying the Bill.

In respect of litigation, one application involving ACT Health which raised issues arising under the Human Rights Act came before the ACT Supreme Court in 2012–13. The application arose from the administration of electro-convulsive therapy without the consumer's consent. The application before the court claims general damages, aggravated damages and exemplary damages for false imprisonment, assault and battery, and a breach of section 18 of the *Human Rights Act 2004*. The matter is still before the court.

C.12 Strategic Bushfire Management Plan

During 2012–13, ACT Health did not have any facilities located in rural or ember zones and was therefore not required by the ACT Emergency Services Agency (ESA) to prepare a Bushfire Operational Plan under the Strategic Bushfire Management Plan.

In 2010, the ESA completed fire/ember risk assessments to identify at-risk ACT Government owned and operated facilities during high fire danger periods for the ACT Elevated Fire Danger Plan. Assessments were made of government-owned or regulated properties where normal activities should be suspended when a catastrophic bushfire danger alert is in place.

One ACT Health facility was identified by the ESA assessment—the proposed rehabilitation centre known as the Ngunnawal Bush Healing Farm, located at Miowera, in the foothills of the Brindabella ranges, in the far west of the ACT.

Work progressed in 2012–13 to develop a Bushfire Operation Plan and a Bushfire Action Plan for the property and facility. It is anticipated these will be submitted to the ESA in 2013–14.

In addition, a Bushfire Assessment and Compliance Report was submitted as part of the development application process for the proposed facility.

C.13 Strategic asset management

Assets managed

The Health Directorate managed assets with a total written down value of $707.919 million as at 30 June 2013, including:

Built property assets	$620.485 million
Land	$36.827 million
Plant and equipment	$43.978 million
Leased plant and equipment	$6.629 million.

The estimated replacement value of these assets was $1,419.47 million, of which property assets were $1,316.78 million. The following table lists the Health Directorate's property assets.

The Canberra Hospital (TCH) campus	Area m^2
TCH Building 1—Tower Block	37,560
TCH Building 2—Reception/Administration	5,950
TCH Building 3—Oncology/Aged Care/Rehab	17,390
TCH Building 3—Linear Accelerator	1,650
TCH Building 4—ANU Medical School	4,115
TCH Building 5—Staff Training/Accommodation	8,230
TCH Building 6—Surgical Services/Offices	4,710
TCH Building 7—Alcohol & Drug	1,260
TCH Building 8—Pain Management	660
TCH Building 9—Accommodation	740
TCH Building 10—Pathology	10,250
TCH Building 11—Centenary Hospital for Women and Children Stage 1	14,554
TCH Building 12—Diagnostic & Treatment	18,870
TCH Building 13—Helipad Southern Car park	7,980
TCH Building 14—Child Care	627
TCH Building 15—To be refurbished	2,020
TCH Building 22—Information Management	243
TCH Building 23—Redevelopment Unit Offices	1,810
TCH Building 24— Health Administration Offices	1,332
TCH Building 25— Adult Acute Mental Health	5,436
TCH Building 26— Southern Car park	53,000
Gaunt Place Building 1—Dialysis Unit	871
Gaunt Place Building 2—RILU	688
Gaunt Place Buildings 3, 4, 5, 6 (Health Offices)	668
Yamba Drive car park (Phillip Blk 7, Sec 1)	N/A

Health facilities	Area m^2
Belconnen Health Centre	3,800
Dickson Health Centre	490
Gungahlin Health Centre	2,608
Phillip Health Centre	3,676
Tuggeranong Health Centre	4,524
Bruce—Arcadia House	467
Bruce—Brian Hennessy House	3,719
Health Protection Services—Holder	1,600
Monash—Health Protection	N/A
Lanyon Family Care Centre	194
Ngunnawal Family Care Centre	215
Weston—Independent Living Centre	1,143
Barton—Clare Holland House	1,600
Curtin—QEII Family Centre	1,120
Kambah—Step Up Step Down Unit	279
Fadden—Karralika	534
Isabella Plains—Karralika	1,400
O'Connor—Mental Illness Fellowship	200
Rivett—Burrangiri Respite Care Centre	1,054
Watson Hostel	2,431
Paddy's River—Mirowera	206
Duffy—Cancer Patient Accommodation	319
Student Accommodation—Phillip (3 units)	276
Student Accommodation—Belconnen (2 units)	220
Student Accommodation—Garran (1 unit)	117

During 2012–13, no assets were removed from the asset register. The following assets were added to the register:

Gungahlin Health Centre
Student Accommodation (2 units)—Phillip and Garran
Step Up Step Down Unit—Kambah

As at 30 June 2013, the Health Directorate did not have any potentially surplus properties.

Assets maintenance and upgrade

Works were undertaken at properties throughout the Health Directorate's portfolio in 2012–13. Works completed in the reporting year were:

- Canberra Hospital—provision of a four-bed observation unit in the Emergency Department
- Canberra Hospital—provision of an additional 'Hospital in the Home' bed
- Canberra Hospital—relocation of the discharge lounge to a larger and more convenient site on Level 2, Building 1
- Canberra Hospital—modification of inpatient ensuites for disabled access on Ward 6B
- Canberra Hospital—improvements to traffic safety on Hospital Road
- Florey Child Health Clinic—air-conditioning upgrade
- Karralika Fadden and Isabella Plains—building upgrades, including asbestos removal, heating unit replacement, pergola, fencing and drainage works
- City Health Centre—soundproofing of counselling rooms.
- Phillip Health Centre—replacement of air-conditioning chiller system.

Details of the capital works program are included in section C.14 of this report.

Property, plant and equipment are maintained to a high standard to meet health requirements. Expenditure on repairs and maintenance (excluding salaries) was $11.862 million, which represents 0.84 per cent of the replacement value.

Building audits

Ninety-six building condition assessments, hazardous materials audits and fire reports have been undertaken as part of a rolling three-year program to assess all buildings managed by the Health Directorate. 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 6,540 staff, of whom 1,162 occupy office-style accommodation in the sites listed in the table below, at an average utilisation rate of 14.6 square metres (m^{2}) per employee.

Location	Property	Owned/ Leased	Work points/staff on 30 June 2013	Office area (m^2)	Utilisation rate m^2 per employee
Civic	1 Moore Street Level 3	Leased	130	1,954	14.8
Civic	11 Moore Street Level 2&3	Leased	155	2,290	15.0
Civic	12 Moore Street Level 1*	Leased	n.a	447	n.a
Curtin	Carruthers Street	Leased	217	3,187	9.9
Garran	TCH Building 2	Owned	54	808	15.0
Garran	TCH Building 6	Owned	202	3,051	15.1
Garran	TCH Building 12 Medical Records	Owned	62	613	9.9
Garran	TCH Building 22	Leased	23	243	10.6
Garran	TCH Building 23	Owned	135	1,810	13.4
Garran	TCH Building 24	Owned	62	1,332	19.7
Holder	Health Protection Services	Owned	75	1,163	15.5
Phillip	1 Bowes Place	Leased	47	583	12.4

* Note: 12 Moore St is currently being fitted out for occupancy by 42 staff at a utilisation rate of 10.6 m^2 per employee.

The other 5,378 staff work 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.14 Capital works

Capital works within ACT Health occur under the leadership of the Service and Capital Planning Branch.

The Service and Capital Planning Branch is responsible for the delivery of the Health Infrastructure Program (HIP)—a significant investment in the future health services for the ACT community and surrounding region—as well as the Strategic Accommodation and Capital Upgrades Program.

In September 2012 upon the natural expiration of the contract with Thinc Health Australia to provide Project Director services for the HIP, ACT Health progressed plans for the integration of the Project Director role into the governance for the HIP.

The Service and Capital Planning Branch grew significantly in the latter half of 2012, with the direct engagement of staff with industry experience and expertise to support the work of the HIP.

The HIP, a major capital infrastructure program, is based on a complex mix of population growth and ageing, changing technology and provider and consumer expectations—all of which contribute to a significant increase in demand for health services in the ACT. Demand for health services is projected to increase rapidly over the next 10 years and beyond and the HIP is a planned, comprehensive and structured response to these pressures. Underpinned by future health services demand projections, the HIP encompasses models of care and service delivery, technology, workforce and infrastructure redesign work in conjunction with a significant capital works program over a 10-year period, up to 2022. This reporting year marked the fifth year of the HIP.

The ongoing program of capital works to buildings and plant to maintain and improve the existing infrastructure supporting the Health Directorate was transferred from the Business and Infrastructure Branch to the Service and Capital Planning Branch on 1 January 2013. The Capital Upgrades Program is funded annually, with prioritisation of work being determined by the ACT Health Executive under the following categories:

- building upgrades
- safety/security upgrades
- medical facility upgrades
- patient facility upgrades
- ambulatory care improvements
- augmentation of medical and administration offices.

Projects completed in 2012–13 under the HIP were as follows:

- Stage 1 of the Centenary Hospital for Women and Children (CHWC) was completed in August 2012 and clinical services commenced on 21 August 2012. Stage 1 of the facility provides permanent accommodation for the Neonatal Intensive Care Unit, Special Care Nursery, Birth Centre, maternity and gynaecology inpatient ward areas and administration. Ronald MacDonald House is also incorporated within this facility. It provides overnight accommodation for families and carers of children who are inpatients within the CHWC.
- The Calvary Hospital emergency department expansion was completed in December 2012, with capacity created for an additional six treatment spaces (four chair areas and two consulting rooms).
- The Gunghalin Community Health Centre was completed in August 2012, with service delivery commencing on 3 September 2012. The facility provides health services for the Gunghalin Community in the areas of dental health, allied health and community nursing.
- Duffy House was completed in August 2012. It provides accommodation for interstate cancer services patients and carers. The facility was developed with funding support from the Australian Government.

Works in progress under the HIP at 30 June 2013 were:

- Staging, decanting and continuity of services: these works are continuing. This project consists of multiple sub-projects that aim to relocate occupants of ACT Health facilities to allow building works to progress.
- Canberra Region Cancer Centre: this facility is nearing the final stages of construction. The facility is expected to be completed in September 2013. The new facility will provide an integrated treatment centre for cancer services for the Canberra region.
- University of Canberra Public Hospital achieved a number of milestones, with a site on the University of Canberra campus identified as the preferred location for the facility. A 'Heads of Agreement' was signed in September 2012 to support the agreement. Negotiations relating to acquisition of the land commenced during the reporting year. In addition, a draft service delivery plan to inform a concept design for the facility was developed based on user group consultation; site studies were undertaken on the preferred site; a report was prepared on possible procurement delivery models to be adopted; and an expression of interest for the principal consultant was advertised, with 18 submissions received.
- Tuggeranong Health Centre (refurbishment and stage 2): this project involves the refurbishment and extension of the physical infrastructure of the Tuggeranong Community Health Centre and the expansion and enhancement of services provided at the Tuggeranong Health Centre. The extension and refurbishment have been designed to meet the future health needs of the local population to 2021–22.
- Belconnen Community Health Centre (BCHC): physical works commenced in January 2012, with completion of construction expected in September 2013. The BCHC will provide an increased number of traditional community health services, such as dental, community nursing and community mental health. It will also provide an expanded range of higher order clinical services that were previously provided on hospital grounds, such as renal dialysis, some specialist outpatient services and chronic disease management.
- Stage 2 of the Centenary Hospital for Women and Children is nearing completion, with handover to ACT Health expected in late 2013.
- Adult Secure Mental Health Unit—Forward Design: work is proceeding to prepare a health facility brief before proceeding to design. The new purpose-built facility will be located on the former Quamby site at Symonston. It is expected that design works will commence in 2014.
- The Ngunnawal Bush Healing Farm project experienced delays relating to its development application (DA) process. During the reporting year, the model of care (phase 2) and the preliminary and final sketch plans for the facility were endorsed by the Redevelopment Committee. Construction documentation has been completed for the tendering of construction works. After community consultation and an initial submission of a DA in mid-2012, amended development applications were lodged for lease variation, design and siting of the facility in February 2013. In May 2013 the lease variation was approved with conditions by the Environment and Sustainable Development Directorate—ACT Planning and Land Authority. In June 2013 ACT Health was advised that applications for a review of this decision had been received by the ACT Civil and Administrative Tribunal. At 30 June 2013, the outcome of the design and siting DA was pending. In addition to this work, land management activities on the Miowera property have been ongoing, and planning for construction has progressed.

The following tables contain ACT Health capital works project information and the reconciliation schedule.

Capital works table—Health Directorate

Project	Proposed or Actual completion date	Original project value $'000	Revised project value $'000	Prior years expend $'000	2012–13 expend $'000	Total expend to date $'000
New works – Departmental						
Adult Secure Mental Health Unit (Finalising Design)	Jun-14	2,000	2,000	N/A	–	–
Staging and Decanting – Moving To Our Future	Sep-14	22,300	22,300	N/A	247	247
Health Infrastructure Program – Project Management	Dec-14	19,319	19,319	N/A	4,225	4,225
Enhanced Community Health Centre Backup Power	Jun-14	3,540	3,540	N/A	250	250
Replacement of CT Scanner at the Canberra Hospital	Aug-13	2,893	2,893	N/A	–	–
Major Building Plant Replacement and Upgrade	Jun-13	5,292	5,292	N/A	1,230	1,230
Capital Upgrades Program – Departmental						
Building Upgrades to address Condition Report Findings	Jun-14	580	580	N/A	379	379
Fire/Safety/Security	Jun-14	352	352	N/A	313	313
Mechanical Systems Upgrades	Jun-14	580	580	N/A	563	563
Facilities Improvements to Patient Accommodation	Jun-14	620	620	N/A	268	268
Ambulatory Care Improvements	Jun-14	680	680	N/A	41	41
Augmentation of Medical and Administrative Offices	Jun-14	420	420	N/A	262	262
Capital Upgrades Program – Territorial						
Residential Accommodation Refurbishment – Calvary	Jun-14	310	310	–	79	79
Installation of a Primary-Secondary Loop for the Environmental Cooling System to meet the needs of a Growing Hospital and Reduce Energy Costs	Oct-13	200	200	N/A	–	–
Improvements to Patient Safety – Expansion of Reticulated Suction System	Oct-13	50	50	N/A	–	–
Improvements to Keaney Environmental Cooling System which will provide redundancy	Oct-13	296	296	N/A	–	–
Installation of a Service Column in the Intensive Care Unit to Provide Reticulated Gas, Power and Data to a Cardiac Procedure Room	Jun-13	80	80	N/A	39	39
Works in progress – Departmental						
Clinical Services Redevelopment – Phase 3	Dec-14	25,700	21,800	4,283	-2,243	2,040
Integrated Cancer Care Centre – Phase 2	Sep-13	15,102	15,102	-	12,378	12,378
Staging, Decanting and Continuity of Services	Dec-14	19,430	19,430	1,815	3,765	5,580
Identity and Access Management	Dec-13	3,100	3,100	1,186	1,358	2,544

Project	Proposed or Actual completion date	Original project value $'000	Revised project value $'000	Prior years expend $'000	2012–13 expend $'000	Total expend to date $'000
Central Sterilising Service	Apr-15	17,270	17,270	103	152	255
North Side Hospital Specification and Documentation	Jun-14	4,000	4,000	257	625	882
Clinical Services Redevelopment – Phase 2	Jun-14	15,000	8,850	4,990	2,791	7,781
Tuggeranong Health Centre – Stage 2	Jun-14	14,000	14,000	0	1,424	1,424
HIP Change Management and Communication Support	Jun-14	4,117	4,117	1,968	1,054	3,022
National Health Reform	Aug-13	15,098	10,088	2,323	6,409	8,732
Integrated Canberra Region Cancer Centre – Phase 1	Sep-13	27,900	29,652	8,233	20,997	29,230
Enhanced Community Health Centre – Belconnen	Sep-13	51,344	51,344	8,592	30,433	39,025
Mental Health Young Persons Unit	Nov-13	775	775	121	–	121
Women and Children's Hospital	Nov-13	90,000	111,060	78,240	24,995	103,235
Refurbishment of Health Centre – Tuggeranong	Jun-14	5,000	5,000	999	4,001	5,000
Provision for Project Definition Planning	Jun-14	63,800	59,040	49,686	5,804	55,490
Adult Secure Mental Health Inpatient Unit – Forward Design	Jun-14	1,200	1,200	755	–	755
Aboriginal Torres Strait Islander Residential Alcohol & Other Drug Rehabilitation Facility	Aug-15	5,883	7,933	876	290	1,166
Linear Accelerator Procurement and Replacement	Dec-12	18,700	17,250	16,488	29	16,517
An E-Healthy Future	Mar-15	90,185	90,185	31,888	14,926	46,814
Digital Mammography	Jun-13	5,715	5,715	4,805	563	5,368
Neonatal Intensive Care Unit – Video Streaming Service	Jun-13	200	200	100	8	108
Projects – Physically complete but financially incomplete – Departmental						
New Multistorey Car Park TCH	Jun-13	29,000	42,720	41,881	97	41,978
Adult Mental Health Inpatient Unit	Apr-12	23,630	28,480	23,630	4,642	28,272
New Gungahlin Health Centre	Aug-12	18,000	18,000	13,880	3,546	17,426
Projects – Physically complete but financially incomplete – Territorial						
Fire Safety Upgrades – Calvary	Oct-12	300	300	210	14	224
Completed Projects – Physically and financially complete – Departmental						
Provision for Phase 1 CSR	Jun-13	57,000	26,630	26,630	-	26,630
ACT Health Skills Development Centre	Jun-13	1,300	1,010	901	109	1,010
Enhancement of Canberra Hospital Facilities (Design)	Jun-13	41,000	220	79	141	220
TCH Discharge Lounge Relocation	Jun-13	150	150	117	33	150
Elective Surgery (Commonwealth Funding)	Sep-09	4,680	4,680	4,452	228	4,680

Project	Proposed or Actual completion date	Original project value $'000	Revised project value $'000	Prior years expend $'000	2012–13 expend $'000	Total expend to date $'000
Building Upgrades to address Condition Report findings including Works to Bathrooms, Disability Access and Roofing	Jun-13	561	561	518	43	561
Energy Savings/Sustainability – Upgrade Works to Building Control Systems to Improve Efficiency and Installation of Bike Storage Facilities	Jun-13	300	300	183	117	300
Safety/Security Upgrades to address Outcomes of Fire Reports, Improve Access Control to Plant Rooms, Floor Covering Upgrades and Removal of Hazardous Materials	Jun-13	380	380	305	75	380
Mechanical Systems Upgrades to Plant and Equipment at the Canberra Hospital and various other ACT Health Facilities	Jun-13	600	600	589	11	600
Patient/Medical Facilities Upgrades including Refurbishment of Ambulatory Care Facilities, Provision of a Community Dialysis Self Care Facility and Upgrades to Patient Facilities	Jun-13	670	670	379	291	670
Workplace Improvements which will facilitate improved Patient Flows and Operations and Services at Canberra Hospital	Jun-13	590	590	523	67	590
Medical Facilities	Jun-13	520	520	N/A	520	520
Completed Projects – Physically and financially complete – Territorial						
Works Associated with the Installation of a MRI Equipment	Aug-12	70	70	N/A	70	70
Security Upgrades to Improve Staff and Patient Safety	Jun-13	50	50	N/A	50	50
Upgrade of Chiller	Jun-13	350	350	330	20	350
Upgrades to 6th Floor Kitchen, Theatre Storage and Xavier Level Public Toilets and Floor Finishes	Oct-12	285	285	110	175	285

Reconciliation schedule—capital works and capital injection

Approved Capital Works Program financing to capital injection as per cash flow statement

	Original $m	Section 16B $m	Variation $m	Deferred $m	Not drawn $m	Total $m
Capital works	197.651	15.651	0.000	–101.018	–7.129	105.155
ICT Capital Injections	28.584	0.361	0.000	–9.838	1.592	20.699
Other capital injections	11.647	1.424	0.000	–1.328	–7.629	4.114
Total Departmental	237.882	17.436	0.000	–112.184	–13.166	129.968
Total Territorial	**0.746**	**0.000**	**0.000**	**0.000**	**0.000**	**0.746**

C.15 Government contracting

Basis of requirement

1. *Government Procurement Act 2001*
2. Government Procurement Regulation 2007
3. Government Procurement Amendment Regulation 2009 (No. 1)

1. Procurement principles and processes

In 2012–13, ACT Health exercised all procurement activities in accordance with the government tender thresholds and complied with procurement policies and procedures as stated in the *Government Procurement Act 2001*, Government Procurement Regulation 2007 and Government Procurement Amendment Regulation 2009 (No. 1).

To ensure compliance with ACT Government procurement legislation, ACT Health:

i. sought advice on government procurement policies and procedures from Shared Services Procurement
ii. notified Shared Services Procurement of all procurements over $25,000 undertaken by ACT Health
iii. appropriately referred procurements requiring single, restrictive or open tender procurement processes to Shared Services Procurement, and
iv. referred, where necessary, all procurements requiring Government Procurement Board consideration and/or approval to Shared Services Procurement.

To confirm that contractors meet their employee and industrial relations obligations, all tenders and contracts drafted by Shared Services Procurement on behalf of ACT Health include conditions provided by the ACT Government Solicitor's office to reflect the *Government Procurement Act 2001*, Government Procurement Regulation 2007 and Government Procurement Amendment Regulation 2009 (No. 1). These include following the Ethical Suppliers Guideline and complying with government procurement on ethical suppliers.

In accordance with procurement legislation, ACT Health observed the highest standard of probity and ethical behaviour towards prospective tenderers. Such behaviour included, but was not limited to:

i. equality
ii. impartiality
iii. transparency
iv. fair dealing

To further support the procurement processes, in 2012–13 an e-learning package provides procedural guidance to all ACT Health employees engaged in procurement activities.

2. External sources of labour and services

In 2012–13, ACT Health engaged a range of external consultants and contractors to undertake services in the following areas:

i. frontline clinical health services
ii. structural and procedural reviews of current business models
iii. dispute resolution services, including complaint investigation and mediation services, and
iv. capital works projects.

To verify that ACT Health's contractors meet their employee and industrial relations obligations, ACT Health:

i. engaged the services of Shared Services Procurement to manage, where required, contracts on behalf of ACT Health, and
ii. used Shared Services Procurement documentation, including tender documentation and government contracts that encapsulate all relevant industrial relations legislation as advised by the ACT Government Solicitor's office.

ACT Health construction contracts above $500,000 were established using Shared Services Procurement for project management and contractor pre-qualification.

All Head Contractors and Project Managers engaged on ACT Health Infrastructure Program (HIP) capital works projects valued above $500,000 were pre-qualified by the Territory. All Principal Consultants engaged in contracts valued above $50,000 were also pre-qualified by the Territory under the appropriate pre-qualification category for consultants.

The following tables catalogue all ACT Health consultants, contractors and visiting medical officers (VMOs) for the reporting period.

Consultants

Name of Consultant	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Individual contracts which exceed $25,000; and smaller contracts awarded to the same consultant which, in total, exceed $25,000. Consultant – A person who has the knowledge and expertise to perform a task, project, or other which is not available within the Health Directorate and Produces a report, audit, investigation, or other to Health Directorate or third parties.						
Acute Services (Output 1.1)						
Mental Health, Justice Health and Alcohol and Drug Services (Output 1.2)						
Public Health Services (Output 1.3)						
Australian Health Care Associates	External Quality Reviews of ACT based Home and Community Care (HACC) agencies against The Community Care Common Standards (CCCS)	$49,673.00	01-Jul-12	30-Jun-13	No	
Medical Software Industry Association	Provision of consultancy services from MSIA – Monitoring Drugs of Dependence (MODDS)	$75,000.00	02-Jul-12	As per agreed milestones	Yes	Sole service provider with specialist knowledge
Cancer Services (Output 1.4)						
Rehabilitation, Aged and Community Care (Output 1.5)						
Early Intervention and Prevention (Output 1.6)						
Quorus Pty Ltd	Development of a New ACT Chronic Disease Strategy	$36,045.00	03-Jan-12	31-Dec-12	Yes	Expertise in field
The Miller Group – Social Policy and Management Consultants Pty Ltd	Consultant to Evaluate the Delivery and Impact of Healthier Work	$72,114.00	17-Jul-12	31-Mar-15	No	
Consultants distributed as Overheads of Outputs						
Canberra Property Management Pty Limited	Provision of Public Health Consultation Services for Water, Air and Related Issues	$48,097.54	17-Jan-13	17-Jan-18	No	
Grey Advantage Consulting Pty Ltd	Review Preventative Maintenance Program, and Review Analysis and Date Gathering	$121,480.00	20-Jun-12	20-Jun-13	No	
GS1 AUSTRALIA LTD	Consultancy for Location Based Service Project	$46,661.50	19-Oct-12	19-Oct-13	No	
Kaizen Management Services	Provision of a Consultant to Undertake Safety Audits for ACT Health to Australian Standards 4801 and 4804	$33,818.18	22-Dec-10	22-Dec-13	No	
Michael Reid and Associates Pty Ltd	Review of the governance arrangements within the Health Directorate	$63,823.50	21-Dec-12	30-Jun-13	Yes	Expertise in the review of Health's governance structure
Nous Group	Review of the Health Directorate's restructure and Review of the Smokefree Workplace Policy	$74,750.00	04-Sep-12	11-Dec-13	Yes	Expertise in field
PriceWaterhouseCoopers (PwC)	Provision of Internal Audit Services and professional services/investigations	$440,961.35	11-Sep-08	09-Jun-13	No	
Richard Paul Marshall	Activity Based Funding Implementation and Data Integrity Strategy Reports	$47,216.36	01-Nov-12	30-Dec-13	Yes	Specialist and Expertise Services
The Trustee for The Cogent Unit Trust T/A Cogent Business Solutions	Financial Governance and Management Consultancy	$46,888.64	28-Sep-12	28-Sep-13	No	
Ultrafeedback Pty Ltd	Patient satisfaction surveys	$77,365.53	30-May-12	31-May-14	No	
University of New South Wales	Consultant to evaluate the Australian Capital Territory Drug Diversion Programs	$86,456.12	08-Feb-12	30-Jun-12	No	

Contractors

Name of Contractor	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Individual contracts which exceed $25,000; and smaller contracts awarded to the same contractor which, in total, exceed $25,000. Contractor – A person who performs a Job, Task, Project on behalf of the organisation, i.e. a job that can be done by a staff member, but there are no resources to do it in house.						
Acute Services (Output 1.1)						
ACT Nursing Services Pty Ltd	Day to Day on Call Agency Nurses	$1,903,725.42	16-Feb-11	16-Feb-14	No	
Adecco	Provision of recruitment services	$180,660.52	31-May-10	28-Feb-13	No	
Calvary Health Care ACT Limited	Private Contracting of Elective Surgery in the ACT	$1,288,264.30	16-May-13	25-Dec-15	No	
Calvary Private Health Care Canberra Limited T/A Calvary John James Hospital	Private Contracting of Elective Surgery in the ACT	$2,002,751.58	30-Sep-10	25-Dec-15	No	
Canberra Afterhours Locum Medical Service	Canberra Afterhours Locum Medical Service	$1,153,931.40	30-Jun-10	30-Jun-13	No	
Hays Specialist Recruitment Australia Pty Ltd	Provision of contract staff	$236,710.80	27-May-10	26-May-13	No	
IPS Worldwide	Critical incident counselling services	$142,593.83	Month to month		No	
KLM Group Ltd	ACT/Southern NSW Critical Care Telehealth Solution-Supply, Installation and Associated Services	$464,090.00	28-May-12	30-Jun-14	Yes	Specialist knowledge and expertise in field
Mediserve Pty Ltd	Day to Day on Call Agency Nurses	$1,176,354.03	16-Feb-11	15-Feb-14	No	
National Health Call Centre Network Ltd	Participation in the National Call Centre Network	$1,073,984.00	01-Jul-12	30-Jun-13	No	
National Healthcare Services	Provision of Agency Nurses	$1,059,562.37	16-Feb-10	16-Feb-14	No	
Peoplebank Australia Pty Ltd	Contractor professional services	$89,145.00	28-Jun-12	28-Jun-13	No	
Professional Nursing Agency	Provision of Agency Nurses	$717,889.23	Month to month		Yes	Specialised nursing services
Resolutions (INT) Pty Ltd as Trustees for the Resolutions Trading Trust	Provision of Clinical Coding Services	$52,354.01	19-Oct-10	Ongoing	No	
Ross Human Directions Limited	Medical Records Database Services	$55,606.73	10-Jun-11	10-Jun-12	No	
The trustee for Nelson Family Trust trading as Just Better Care Canberra	Provision of Technical Nursing Care	$239,734.00	06-Dec-10	Ongoing	Yes	Expertise in technical nursing
The University of Queensland	Translation of Food Safety Guide from University of Queensland	$64,755.87	22-Jun-12	22-Jun-13	No	
University of South Australia	Allied Health Research Services	$80,233.00	03-Jun-11	03-Jun-12	No	
Mental Health, Justice Health and Alcohol and Drug Services (Output 1.2)						
ACT Mental Health Consumer Network Inc	ACT Mental Health Consumer Network Inc	$312,893.00	01-Jul-10	30-Jun-13	No	
Public Health Services (Output 1.3)						
Australian Breastfeeding Association, ACT and Sthn NSW Branch	Service Expansion to Support New and Breastfeeding Mothers and their Families	$42,411.68	17-May-11	30-Jun-12	No	

Name of Contractor	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
By George Studios Pty Limited	Development of a Parenting Education DVD for Young Aboriginal and Torres Strait Islander Parents	$37,094.55	20-Nov-12	20-Feb-13	Yes	Expertise in field
Environmental Health Services (TAS) Pty Ltd	Contractor Services for Statutory Compliance Under *Food Act 2001*	$55,203.00	26-May-11	30-Jun-12	No	
National Mail and Marketing	Provision of Warehousing, Pick/Packing and Distribution Services for Health Promotion Branch	$35,701.60	23-Aug-10	30-Jun-13	Yes	Specific and targeted services
School of Public Health trading as University of Sydney	Evaluation of GET Health Service	$61,233.85	29-Oct-10	Ongoing	No	
Taylor Nelson Sofres Australia Pty Limited	Gofor 2&5® Campaign Social Marketing Research Project	$30,000.00	09-Mar-10	Ongoing	Yes	Expertise in public health
XVT Solutions Pty Ltd	Replacement of the Monitoring of Drugs of Dependence System (MODDS)	$73,026.18	01-Feb-13	01-Feb-16	Yes	Specialist knowledge in business needs
Cancer Services (Output 1.4)						
Cancer Institute (NSW)	Provision of Services to Support the Maintenance of the ACT Cancer Registry	$175,193.88	03-Jun-11	Ongoing	No	
CharmHealth	Provision of CHARM Cancer Information Management System	$50,681.82	14-May-13	13-May-14	No	
Charterhouse Medical	Recruitment services	$97,546.80	13-Feb-12	27-Jun-13	No	
Mirrabooka Systems Pty Ltd	CAS lease, licence, maintenance, upgrade and report development	$30,929.51	01-Jul-12	30-Jun-13	No	
Rehabilitation, Aged and Community Care (Output 1.5)						
Early Intervention and Prevention (Output 1.6)						
Alcohol, Tobacco and Other Drug Association Australian Capital Territory Incorporated	ACT Comorbidity Smokefree Pilot Project	$383,844.27	01-Jun-10	Ongoing	No	
National Heart Foundation (ACT Division)	Provision of Chronic Disease Prevention Services	$416,224.27	15-Nov-09	30-Jun-12	No	
Paxus Australia Pty Ltd	Chronic Disease Management Register	$199,633.50	21-Sep-09	Ongoing	No	
Contractors distributed as Overheads of Outputs						
Christopher Bruce	Plumbing contractor	$97,336.47	Month to month		Yes	Specialised services rendered
Control & Electric Pty Ltd	Building Management System and Mandatory Testing of Fire Dampers and Compartmentilisation Testing	$284,422.37	14-Jun-11	14-Jun-12	No	
Dreamtime Public Relations	Media and Public Relations Services	$59,323.00	24-Apr-12	24-Apr-13	No	
Gammasonics Institute for Medical Research Pty Ltd	Radiation Compliance Testing of Radiation Sources within the ACT	$31,198.18	03-Aug-09	30-Jun-14	No	
Griffith Massage Centre	Remedial Massage for work-related strains	$54,746.30	01-Jul-08	Ongoing	No	
Lec Safe Australia Pty Ltd	Testing and Tagging Services	$75,261.94	07-Jul-10	06-Jul-13	No	
Protiviti Pty Ltd	Provision of Internal Audit and Risk Management Services	$187,065.59	11-Sep-08	09-Jun-13	Yes	Preferred Government Provider

Visiting medical officers

Title	Surname	First Name	Speciality	Description of contract	Date Contract Commences	Date Contract Expires	Total Amount Paid (exc. GST)
Acute Services (Output 1.1)							
Dr	Al-Sameraaii	Ahmad	Urology	VMO	01-Jun-13	31-May-16	$47,603.22
Dr	Albekaa	Safi	ENT Surgery	VMO	01-Nov-07	01-Nov-14	$62,145.96
Dr	Ansary	Saidul (BSSW Pty Ltd	Respiratory & Sleep	VMO	17-Dec-12	01-May-15	$137,297.62
Dr	Ashman	Bryan	Orthopaedic Surgery	VMO	01-Sep-12	31-Aug-15	$294,281.22
Dr	Aubin	Phil	Orthopaedic Surgery	VMO	02-Aug-10	02-Aug-13	$119,081.25
Dr	Auzins	Edwin	General Dentistry (OMFS)	VMO	02-Jul-11	01-Jul-14	$51,673.52
Dr	Bassett	Mark (Mark Bassett Pty Ltd)	Gastroenterology	VMO	25-Nov-09	25-Nov-16	$187,230.25
Dr	Bissaker	Peter	Cardiac Surgery	VMO	01-Aug-08	01-Aug-15	$411,793.68
Dr	Bradshaw	Stephen (Vascular Partners Pty Ltd)	Vascular Surgery	VMO	01-Feb-12	01-Aug-14	$308,394.54
Dr	Brady	Marc	General Dentistry (OMFS)	VMO	31-Oct-12	30-Oct-13	$49,390.27
Dr	Bromley	Jonathan	Gastroenterology & Hepatology & MAPU	VMO	01-Jan-11	31-Dec-14	$159,277.77
Dr	Buchanan	Guy	Anaesthesia	VMO	01-Dec-07	01-Dec-14	$34,757.16
Dr	Burke	Bill	Thoracic Medicine	VMO	02-Oct-10	02-Oct-13	$160,081.35
Dr	Burns	Alexander	Orthopaedic Surgery	VMO	01-Jun-08	01-Jun-15	$176,642.00
Dr	Carney	Gavin (Gavin M. Carney Pty Ltd)	Renal Medicine	VMO	24-Aug-10	01-Nov-14	$169,537.49
Dr	Chapman	Peter	ENT Surgery	VMO	01-Oct-07	01-Oct-14	$87,157.05
Dr	Chong	Guan (Dr Guan Chong Pty Ltd)	General Surgery	VMO	02-Jul-12	01-Jul-15	$277,099.96
Dr	Choy	Ellis	Plastic Surgery	VMO	02-Apr-13	01-Apr-14	$355,399.08
Dr	Close	Susanne (Susie Close Pty Ltd)	O&G	VMO	05-Oct-10	31-Jul-14	$55,231.48
Dr	Crawford	Anthony	Paediatrics	VMO	30-Nov-07	30-Nov-13	$37,552.60
Dr	Crawshaw	Ian	Paediatrics	VMO	01-Oct-07	30-Sep-14	$111,834.73
Dr	Damiani	Maurizio	Orthopaedic Surgery	VMO	06-Jul-10	06-Jul-13	$319,790.49
Dr	Davies	Stephen	Anaesthesia	VMO	01-Mar-08	01-Mar-15	$39,416.86
Dr	Davis	Ian	General Surgery	VMO	01-Sep-07	01-Sep-14	$226,773.45
Dr	Dorai Raj	Anna	Rheumatology	VMO	01-Sep-07	01-Sep-14	$130,770.82
Dr	Drummond	Catherine	Dermatology	VMO	01-Nov-10	31-Oct-14	$50,142.90
Dr	Edwards	Joanne	Paediatrics	VMO	22-Aug-12	21-Aug-13	$118,318.70
Dr	Ellingham	John	Cardiac Anaesthesia	VMO	29-Nov-09	29-Nov-16	$287,092.15
Dr	Fahey	Caroline	Anaesthesia	VMO	01-Sep-07	01-Sep-14	$105,062.00
Dr	Farhadieh	Rostam (Panthea Plastic Surgery Pty Ltd)	Plastic Surgery	VMO	01-Apr-13	07-Mar-18	$135,274.33
Dr	Findlay	Michael	Plastic Surgery	VMO	12-Jun-11	11-Jun-13	$45,921.69
Dr	Fitzgerald	Ailene	General Surgery	VMO	31-Jul-12	30-Jul-13	$206,545.84

Title	Surname	First Name	Speciality	Description of contract	Date Contract Commences	Date Contract Expires	Total Amount Paid (exc. GST)
Acute Services (Output 1.1) (Continued)							
Dr	Fletcher	Victoria	Anaesthesia	VMO	11-Feb-08	10-Feb-15	$166,065.52
Dr	Freckmann	Mary-Louise	Clinical Genetics	VMO	01-Jul-08	30-Jun-15	$64,749.55
Dr	French	James	Anaesthesia	VMO	02-Sep-12	01-Sep-15	$285,516.23
Dr	Fuller	John	Neurosurgery	VMO	12-Nov-10	01-Aug-13	$228,304.82
Dr	Gillmore	Colin	Anaesthesia	VMO	01-Feb-08	31-Jan-15	$71,258.61
Dr	Gross	Michael	Orthopaedic Surgery	VMO	10-Aug-12	09-Aug-13	$182,015.79
Dr	Hamid	Celine	Paediatric Surgery	VMO	08-Apr-13	09-Apr-14	$53,966.67
Dr	Hardman	David	Vascular Surgery	VMO	01-Jul-08	01-Jul-15	$370,319.54
Dr	Hayes	Deborah	Cardiology (Paediatrics)	VMO	02-Mar-12	01-Mar-15	$125,104.02
Dr	Hehir	Andrew	Anaesthesia	VMO	27-Jan-08	27-Jan-15	$299,717.62
Dr	Holz	Paul	Anaesthesia	VMO	01-Jul-13	01-Mar-14	$214,720.43
Dr	Hufton	Ian	Paediatric Medicine	VMO	02-Jul-11	01-Jul-14	$26,667.61
Dr	Jain	Tarun (T.J. Imaging Pty Ltd)	Radiology	VMO	05-Nov-12	04-Nov-13	$56,000.00
Dr	Jeans	Phil	General Surgery	VMO	12-Aug-12	11-Aug-15	$233,914.07
Dr	Kaye	Graham	Gastroenterology	VMO	07-Sep-10	30-Aug-14	$269,939.20
Dr	Khoo	Kenneth	General Medicine & Rheumatology	VMO	06-Jul-11	05-Jul-14	$73,183.65
Dr	Klar	Brendan	Orthopaedic Surgery	VMO	07-Aug-12	01-Aug-15	$218,964.95
Dr	Kulisiewicz	Gawel	Orthopaedic Surgery	VMO	07-Aug-09	07-Aug-15	$296,949.87
Dr	Kwan	Bernard	Anaesthesia	VMO	01-Sep-07	01-Sep-14	$60,075.95
Dr	Lah	Frank	Anaesthesia	VMO	01-Aug-11	31-Jul-14	$191,769.15
Dr	Lang	Robert	Anaesthesia	VMO	26-Jan-13	25-Jan-16	$244,222.44
Dr	Lee	Elaine	Anaesthesia	VMO	11-Oct-12	10-Oct-15	$484,541.19
Dr	Lee	Tack-Tsiew	ENT Surgery	VMO	01-Jun-08	01-Jun-15	$72,019.24
Dr	Leerdam	Carolyn	Paediatric Medicine	VMO	01-Feb-08	01-Feb-15	$30,815.65
Dr	Lim	James	General Surgery	VMO	30-Nov-10	29-Nov-13	$129,974.67
Dr	Lu	Don Bunnag	Anaesthesia	VMO	05-Oct-10	01-Dec-14	$57,810.45
Dr	Major	Jennifer	Anaesthesia	VMO	02-Nov-10	02-Nov-14	$35,004.65
Dr	Makeham	Timothy	ENT Surgery	VMO	14-Feb-11	13-Feb-14	$105,870.66
Dr	Malecky	George	Paediatric Surgery	VMO	01-Nov-07	31-Oct-14	$610,877.25
Dr	Malhotra	Ram	Neurology	VMO	01-Apr-11	31-Mar-14	$36,894.73
Dr	Marshall	Natalie	Anaesthesia	VMO	01-Aug-07	31-Jul-14	$396,631.63
Dr	McCredie	Simon	Urology	VMO	01-Jul-10	01-Jul-13	$176,080.24
Dr	McDonald	Tim	Paediatrics	VMO	01-Aug-07	01-Aug-14	$274,298.95
Dr	McInerney	Carmel	Anaesthesia	VMO	01-Jul-12	01-Jun-15	$55,436.62
Dr	Meares	Nicola	Anaesthesia	VMO	31-May-13	30-May-16	$36,225.41
Dr	Melhuish	Nicholas	Cardiac Anaesthesia	VMO	01-Oct-07	01-Oct-14	$255,382.08
Dr	Miller	Andrew	Dermatology	VMO	30-Nov-10	29-Nov-13	$64,448.75
Dr	Morrissey	Phillip (Dr P. Morrissey Pty Ltd)	Anaesthesia	VMO	01-Nov-10	01-Nov-13	$122,699.54

Title	Surname	First Name	Speciality	Description of contract	Date Contract Commences	Date Contract Expires	Total Amount Paid (exc. GST)
Acute Services (Output 1.1) (Continued)							
Dr	Mosse	Charles	General Surgery	VMO	05-Apr-11	30-Nov-13	$314,654.08
Dr	Mulcahy	Maurice	Urology	VMO	02-May-13	01-May-16	$154,910.37
Dr	Nagy	Attila	Anaesthesia	VMO	05-Sep-12	04-Sep-13	$25,232.35
Dr	Neilson	Wendell	Vascular Surgery	VMO	01-Jul-13	30-Jun-16	$53,451.45
Dr	O'Connor	Simon	Cardiology	VMO	01-Oct-07	30-Sep-14	$293,456.90
Dr	OKera	Salim	Ophthalmology	VMO	12-Apr-10	12-Apr-17	$82,292.62
Dr	Palnitkar	Girish (Brindabella Anaesthesia Pty Ltd)	Anaesthesia	VMO	01-Dec-10	14-Nov-13	$172,869.04
Dr	Peady	Clifford	Anaesthesia	VMO	24-Aug-10	01-Aug-14	$245,713.57
Dr	Peake	Ross	Anaesthesia	VMO	22-Jul-10	22-Jul-13	$180,953.75
Dr	Pham	Tuan	ENT Surgery	VMO	17-Aug-12	01-Jun-13	$313,452.82
Dr	Ponniah	Senthan	Anaesthesia	VMO	24-Jan-11	23-Jan-14	$147,677.68
Dr	Powell	Suzanna	Paediatric Medicine	VMO	01-Jun-08	31-May-15	$60,359.93
Dr	Quah	Yeow Leng (Valerie)	Anaesthesia	VMO	17-Jan-11	16-Jan-14	$95,505.95
Dr	Rajapakse	Yasantha Ranjeeva	Plastic Surgery	VMO	12-Sep-12	11-Sep-13	$317,062.87
Dr	Rangiah	David	General Surgery	VMO	31-Oct-11	01-Feb-15	$139,953.35
Dr	Reiner	David	Anaesthesia	VMO	01-Sep-11	31-Aug-14	$115,051.05
Dr	Riddell	James (J. Riddell Pty Ltd)	General Medicine & Gastroenterology	VMO	10-Dec-09	30-Nov-14	$26,122.75
Dr	Roberts	Chris	Orthopaedic Surgery	VMO	01-Nov-07	01-Nov-14	$78,635.08
Dr	Robertson	Tanya	General Practice	VMO	01-Jun-08	01-Jun-15	$146,251.20
Dr	Robson	Stephen	O&G	VMO	01-Aug-11	31-Jul-14	$107,629.73
Dr	Rosier	Michael	Paediatric Medicine	VMO	01-Aug-07	01-Aug-14	$96,346.14
Dr	Scott	Cameron (Scott Medical Services Pty Ltd)	OMFS	VMO	31-Aug-12	30-Aug-13	$55,000.00
Dr	Sjarif	Adrian	Plastic Surgery	VMO	21-Mar-13	20-Mar-14	$49,235.01
Dr	Simpson	Erroll	Paediatric Surgery	VMO	19-Jun-12	31-Oct-14	$311,931.55
Dr	Smith	Joseph	Orthopaedic Surgery	VMO	02-Mar-13	11-Mar-14	$330,858.71
Dr	Smith	Paul	Orthopaedic Surgery	VMO	02-Feb-11	01-Feb-14	$121,054.81
Dr	Smith	Damian	Orthopaedic Surgery	VMO	01-Jul-08	01-Jul-15	$268,285.96
Dr	Speldewinde	Geoffrey	Anaesthesia	VMO	01-Nov-07	01-Nov-14	$37,329.73
Dr	Stone	Hilton	ENT Surgery	VMO	01-Feb-11	31-Jan-14	$154,565.92
Dr	Stubbs	Geoffrey	Orthopaedic Surgery	VMO	24-Jan-11	23-Jan-14	$44,250.59
Dr	Subramaniam	Peter	Cardiothoracic Surgery	VMO	01-Jul-11	02-Sep-13	$804,198.53
Dr	Tharion	John	Thoracic Surgery	VMO	30-Aug-12	01-Aug-15	$411,195.65
Dr	Thomson	Andrew	Gastroenterology	VMO	01-Oct-07	01-Oct-14	$532,773.96
Dr	Upton	Zain (CZ Anaesthesia Pty Ltd)	Anaesthesia	VMO	10-Feb-11	09-Feb-14	$186,200.25
Dr	Vrancic	Sindy	Orthopaedic Surgery	VMO	01-Sep-09	01-Sep-16	$163,459.06

Title	Surname	First Name	Speciality	Description of contract	Date Contract Commences	Date Contract Expires	Total Amount Paid (exc. GST)
Acute Services (Output 1.1) (Continued)							
Dr	Walton	Ashley	Radiology	VMO	21-Apr-13	22-Apr-14	$45,345.45
Dr	Wilson	Michael (Janga Anaesthesia Pty Ltd)	Anaesthesia	VMO	01-Nov-07	01-Nov-14	$77,224.35
Dr	Witherspoon	Robert	OMFS	VMO	10-Dec-12	09-Dec-13	$142,609.95
Dr	Yuille	Rosemary	General Practice (Aboriginal Services)	VMO	23-Aug-10	30-Sep-14	$38,437.36
Mental Health, Justice Health and Alcohol and Drug Services (Output 1.2)							
Dr	Bromley	Jennifer	General Practice (Corrections Health Program)	VMO	06-Feb-10	06-Feb-14	$63,762.15
Dr	Eldridge	James Neil	General Practice (Corrections Health Program & Clinical Forensics ACT)	VMO	01-Feb-10	01-Feb-17	$172,714.58
Dr	Fernando	Sellupperumage Noel	Psychiatry	VMO	28-Feb-13	27-Feb-14	$77,036.34
Dr	Fitzgerald	Paul	Psychiatry	VMO	01-Aug-07	01-Aug-14	$154,437.56
Dr	George	Graham	Psychiatry	VMO	02-Dec-12	01-Dec-15	$160,558.00
Dr	Henderson	A Scott (A.S. Henderson Pty Ltd)	Psychiatry	VMO	01-Nov-07	31-Oct-14	$231,811.64
Dr	Kasinathan	John	Psychiatry	VMO	01-Jul-08	01-Jul-15	$331,984.56
Dr	Liang	Rachel	General Practitioner	VMO	24-Jul-12	23-Jul-13	$133,622.07
Dr	Owen	Cathy	Psychiatry	VMO	01-Nov-07	01-Nov-14	$73,133.76
Dr	Thomson	Graeme	General Practice (Corrections Health Program & Clinical Forensics ACT)	VMO	01-Mar-10	13-Jan-17	$218,932.56
Dr	Westcombe	David	Psychiatry	VMO	30-Nov-10	30-Nov-13	$186,414.18
Dr	Wurth	Peter	Psychiatry	VMO	01-Feb-08	31-Jan-15	$71,181.08
Public Health Services (Output 1.3)							
Dr	Storey	Desmond	General Dentistry	VMO	30-Nov-10	29-Nov-13	$35,719.11
Dr	Tin	Stephen	Dental Surgery	VMO	01-Sep-07	01-Sep-14	$49,659.56
Cancer Services (Output 1.4)							
Drs	Applied Imaging Pty Ltd	(Elizabeth Lim & Nigel Hunter)	Radiology – BreastScreen	VMOs	01-Sep-08	01-Sep-15	$81,700.72
Dr	Bell	Susanne	Radiology – BreastScreen	VMO	11-Nov-11	10-Nov-14	$138,590.02
Dr	Chen	Suet Wan	Radiology – BreastScreen	VMO	01-Nov-11	31-Oct-14	$100,997.67
Dr	Cranney	Brendan	Radiology – BreastScreen	VMO	02-Jul-11	01-Jul-14	$33,144.76
Dr	Hazan	Georges	Radiology – BreastScreen	VMO	01-Sep-08	01-Sep-15	$285,437.46

C.16 Community grants, assistance and sponsorship

In 2012–13, the Health Improvement Branch of ACT Health provided grants, assistance and sponsorship to various organisations as set out in the following tables.

2012–13 Community Funding Round

The Community Funding Round (CFR) in 2012–13 funded activities related to the promotion of health across the ACT population, including the reinforcement of healthy lifestyle messages. The CFR also aimed to enhance the capacity of individuals and community groups to positively control factors that determine health outcomes. Organisations funded through the CFR are expected to adopt the principles and practices of health promotion in the delivery of their projects.

Outcomes have not been reported in this section. While these projects were funded in 2012–13, deeds of grant specify that the deadline for reporting on outcomes is within three months of the expiration or termination of the deed. As none of these deeds has expired or terminated, the outcomes for the grants listed below are not yet available. All grants recipients are required to report on progress, and evaluations are undertaken as part of their agreements.

	Organisation/recipient	Project description/process/period of time engaged	Amount
1	A Gender Agenda	Being True to Ourselves: Developing and Sharing Personal Stories of Sex and Gender Diversity	$67,000
2	Alcohol, Tobacco and Other Drug Association ACT (ATODA)	Under 10% Project	$41,361
3	Arthritis ACT	Lowering the Barriers	$30,919
4	Asthma Foundation ACT	Asthma Swim Program	$50,522
5	Australian Breastfeeding Association ACT/SNSW	Improving breastfeeding rates in target groups identified in the ACT Breastfeeding Strategic Framework 2010–2015	$24,571
6	Basketball ACT	Night Hoops Inclusion Program (Night Basketball Hoops)	$12,359
7	Canberra Dance Theatre	'Life is a Work of Art'	$16,350
8	Canberra Environment and Sustainability Resource Centre	Food for Thought, ecotherapy food gardens	$30,018
9	Canberra Youth Theatre	CYT's Wellbeing and Inclusivity Program	$30,000
10	Football United—University of New South Wales	Empowered for Healthier Communities—a Football United Canberra Project	$37,161
11	Gungahlin Regional Community Service	Connecting the Pieces	$57,900
12	Health Care Consumers' Association	Health Literacy for All: building an inclusive community of support with empowered health consumers and their families and friends across a lifetime	$58,148
13	Mental Health Foundation ACT	Dramatic Recovery—a forum theatre project with mental health consumers	$28,620
14	Narrabundah Early Childhood School	Narrabundah Tucker Time	$27,100
15	Nican	Know Before You Go—building disability confidence and health outcomes through empowering social participation	$22,550
16	OzHelp Foundation	Community Tune-Up (CTU)	$49,265
17	Reclink Australia	Reclink Australia Active Arts Project (RAAAP) ACT	$83,642

	Organisation/recipient	Project description/process/period of time engaged	Amount
18	Royal Life Saving Society Australia—ACT Branch	ACT High Schools Lifesaving Pilot Program	$35,800
19	SHINE for Kids Co-operative Limited	Building resilience in a uniquely vulnerable group: children of prisoners	$75,400
20	St Vincent de Paul Family Services	Homeground	$21,563
21	Taylor Primary School	LifeStart	$20,000
22	The Canberra Raiders Pty Ltd	Raiders Recess	$45,000
23	Women's Centre for Health Matters	A professional approach to peer support for ACT women in prison and women exiting prison	$48,529
	23 projects		**$913,778**

2012–13 Stay On Your Feet® Falls Prevention Funding Round

This round provided funding for the development, implementation and evaluation of falls prevention programs. It assisted community-based groups, not-for-profit organisations, residential aged care facilities and relevant government agencies to reduce the incidence and severity of falls and falls-related injuries among older people in the ACT.

	Organisation/recipient	Project description/process/period of time engaged	Amount
1	Arthritis Foundation of the ACT, incorporating Osteoporosis ACT	Indigenous Falls Prevention Outreach Program	$26,452
2	Arthritis Foundation of the ACT, incorporating Osteoporosis ACT	Travelling Falls Prevention Expo	$43,578
3	Belconnen Community Service	Mature Strength and Balance	$16,991
4	Council on the Ageing (ACT) Inc.	Steady Med—Managing Medicines to Minimise Falls	$34,340
5	National Heart Foundation of Australia (ACT Division)	Heartmoves and Heart Foundation Walking—Reducing falls risk in residents living in aged care facilities	$18,300
6	Support Asian Women's Friendship Association Inc.	Stay Firm and Be Active for CALD Backgrounds Seniors	$15,786
7	Tandem Respite Inc.	Heartmoves @ Tandem	$15,000
8	YMCA of Canberra	Collaboration and evaluation—strengthening the YMCA's Mobiliser Program	$28,940
	8 projects		**$199,387**

2013 Healthy Schools, Healthy Children Funding Round

The Healthy Schools, Healthy Children Funding Round was delivered in collaboration with the ACT Education and Training Directorate. Its aim in 2013 was to create sustainable opportunities for healthy, active lifestyles through improved physical activity and healthy eating. Target groups are early childhood centres and schools. The funding round also aimed to facilitate communication, collaboration and partnerships between schools and their communities.

	Organisation/recipient	Project description/process/period of time engaged	Amount
1	Australian Red Cross	Food From Home	$30,130
2	Canberra and South-East Region Environment Centre	Grow Together	$37,091
3	Evatt Primary School	Eat well 4eva(tt)	$6,788
4	Kids Pantry Pty Ltd	Kids Pantry Program of Healthy Food@School Garden to Table Activities	$20,889
5	Kingsford Smith School	Growing Together—Garden to Table	$20,000
6	Malkara School	Vegetable Garden	$8,270
7	Monash School	From Little Things, Big Things Grow	$5,130
8	Mother Teresa School	Gungahlin Catholic Schools Joint Initiative for Active Travel to School	$19,990
9	North Ainslie Primary School P&C	The Healthy Eating Hub, Sensory Garden and No-Waste Chook Pen	$15,000
10	Nutrition Australia ACT	Food & ME—The Early Years	$20,000
11	Palmerston District Primary School	PRIDE International Garden to Gourmet Project	$14,488
12	Physical Activity Foundation Ltd	School Community Active Travel program (incorporating Ride or Walk to School)	$121,705
13	The Woden School	Growing a Healthy Life	$15,600
14	Theodore Primary School	Connecting children, their families and the school community through food	$3,000
15	Torrens Primary P-6 School	Fit habitz—'Catch Me If You Can' Torrens, Pearce and Chifley preschools	$2,380
16	Torrens Primary School	Torrens Primary School's Healthy Food + Healthy Choices = Healthy Kids Program	$11,504
	16 projects		**$351,965**

2012–13 Health Promotion Sponsorship Funding Round

One of the ways the ACT Health Promotion Grants Program contributed to improved health and wellbeing in our community was through the provision of sponsorship to sports, recreation, and arts and cultural organisations. The priority campaigns for 2012–13 were:

- Go for 2&5® (encouraging optimal fruit and vegetable consumption)
- Find thirty every day® (encouraging physical activity)
- Tap into water every day (promoting water as the drink of choice)
- Swap It Don't Stop It (encouraging healthy behaviours by swapping an unhealthy behaviour for a healthier alternative)
- SmokeFreeACT (aimed at reducing tobacco-related harms).

Sponsorship arrangements can also be used to facilitate improved health promotion policies, practices and cultures within community organisations, to help them work towards becoming a health-promoting organisation.

	Organisation/recipient	Amount
1	ACT Cricket Association	$10,000
2	ACT Gridiron Inc.	$20,000
3	ACT Veterans Athletic Club Inc.	$10,000
4	Australian Capital Territory Ultimate Association Incorporated	$10,000
5	Australian Dance Council—Ausdance (ACT) Inc.	$20,000
6	Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS)	$20,000
7	Australian National Botanic Gardens	$10,000
8	Barbershop Harmony Club of Canberra	$20,000
9	Basketball ACT	$10,000
10	Brindabella Dance Festival	$10,000
11	Canberra Raiders Pty Ltd.	$20,000
12	Capital Football	$10,000
13	Hall Rugby Union Football Club	$10,000
14	Kulture Break	$10,000
15	QL2 Dance Inc.	$10,000
16	Royal Life Saving Society Australia—ACT Branch Inc.	$20,000
17	Royal National Capital Agricultural Society	$20,000
18	The Village Festival of New Performance Inc.	$20,000
19	Touch Football ACT	$10,000
20	Tuggeranong BMX Club Inc.	$10,000
21	YMCA of Canberra Inc.	$20,000
	21 sponsorships	**$300,000**

2012–13 Communication and Learning and Development

The ACT Health Promotion Grants Program supported funded organisations through a learning and development program to build ongoing capacity in the sector for health promotion delivery. Examples of activities in the 2012–13 program include:

- the provision of workshops to enhance grant-writing skills
- the provision of a Health Coaching course to provide health practitioners with a structured system of evidence-based behaviour change protocols in the context of chronic condition self-management
- the provision of a Health Promotion Short Course for health professionals to increase participants' confidence to integrate health promotion into their practice
- provision of scholarship assistance to community sector workers to complete a Certificate III in Population Health.

The program also provided sponsorship for health professionals to attend the Population Health Congress 2012.

	Project description/process/period of time engaged	Amount
1	Health Coaching Course	$9,290
2	Scholarship assistance x 20 CIT Certificate III in Population Health	$7,464
3	Grants Application Writing Training—HCCA	$900
4	Grants Application Writing Training—Our Community P/L	$4,146
5	Grants Application Writing Coaching—HCCA	$1,540
6	Funding of Community Development Network (CDNet)	$6,759
	Total	**$30,099**

C.17 Territory records

Records Management Program

ACT Health's Records Management Program was approved by the Chief Executive of ACT Health in June 2009. The Records Management Program has been lodged with the Director of the Territory Records Office and continues to be the instrument under which ACT Health works.

Records management procedures

The Records Management Program comprises ACT Health's policy statement, detailed procedures, the Business Classification Scheme and a set of disposal schedules. In line with the *Territory Records Act 2002*, the directorate's Records Management Policy outlines a Records Management Program for ACT Health and details how the agency will adhere to the requirements of the Act.

This procedure provides a framework for ACT Health to create, systematically capture, register, classify, use, store, dispose of and retain records.

During 2011–12, a review commenced of ACT Health's Administrative Records Management Procedures Manual 2005 in consultation with the Territory Records Office. The revised Records Management Procedures and Guidelines have now been placed on the intranet and are available for all staff to view. The Records Management intranet site is under review. The updated site will include links to the Territory Records Office's standards and guidelines.

Records disposal schedules

A list of approved records disposal schedules is outlined below.

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

Training

Throughout 2012–13, the policy and procedures were promoted to staff through formal and in-the-workplace training and education sessions, thereby ensuring compliance across ACT Health.

A Records Management training module is included in the Managers Orientation program, conducted monthly and coordinated by the Staff Development Unit, and 117 managers have completed the program (see C.8 Learning and development).

Records Management staff provide in-classroom and on-the-job training to clients. An e-learning package and other records management training material are at an advanced stage of development and are being evaluated prior to finalisation.

A new TRIM user manual and fact sheets are available to all staff and these will be updated as required on the healthHUB (ACT Health's intranet).

Customised client-specific TRIM tutorials have been developed. Additionally, TRIM classroom-style training material and a syllabus have been finalised and training will commence in the near future.

Over 2012–13, a number of quality improvement initiatives were undertaken to evaluate the training provided. As a result of these evaluations, a number of improvements to the training program have been implemented, as noted. The training provided will continue to be evaluated and adjusted as required.

Preservation of Aboriginal and Torres Strait Islander information

Administrative records containing content about Aboriginal and Torres Strait Islander people mainly belong to the general record series about Health Community Programs, Health and Welfare Issues and Policy.

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

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

Public access to Territory records

In 2012–13, Health Records Management staff liaised closely with the Territory Records Office's Reference Archivist in response to public access requests under section 26 of the *Territory Records Act 2002*. During this period, six requests were received for access to records.

C.18 Commissioner for the Environment

ACT Health is responsible for reporting against the following recommendation from the *State of the Environment Report 2007–08*:

> Community wellbeing and safety is strengthened by ... Encouraging community health programs, particularly those aimed at exercise, healthy eating, mental wellbeing and minimising the excessive alcohol consumption.

The ACT *Aboriginal and Torres Strait Islander Health and Family Wellbeing Plan 2006–2011* was developed in response to the requirement of the National Strategic Framework for Aboriginal and Torres Strait Islander Health for each jurisdiction to develop a local implementation plan. A review of the plan was undertaken in 2012–13 by the Aboriginal and Torres Strait Islander Health Forum, which includes membership from ACT Health, the ACT Aboriginal and Torres Strait Islander Elected Body, Winnunga Nimmityjah Aboriginal Health Service and ACT Medicare Local. Through this process, many factors were identified as affecting its implementation, most significantly the Closing the Gap Indigenous reform agenda, which was introduced halfway through implementation of the plan in 2008.

Development of a new ACT Aboriginal and Torres Strait Islander Health Plan commenced in 2013. The new plan will incorporate learnings from the review of the previous plan and outstanding action items which have been identified as ongoing strategies requiring implementation by the Health Forum. These areas relate to, but are not limited to, early intervention, health promotion, service provision, workforce planning, local research, reporting and leadership. Please refer to C.21, Aboriginal and Torres Strait Islander Reporting, for further details.

Beyond Today—it's up to you, a smoking cessation and healthy lifestyle social marketing strategy targeting the Aboriginal and Torres Strait Islander communities of the ACT and surrounding region, was launched in December 2012. The campaign is the culmination of a significant engagement process with the ACT Aboriginal and Torres Strait Islander communities. The campaign features local members of the community telling stories across a range of materials, including posters, banners, a brochure, short videos and songs created locally and performed by local Aboriginal and Torres Strait Islander children and young people.

Progress continues in the establishment of the Aboriginal and Torres Strait Islander Alcohol and Other Drug Residential Rehabilitation Service (Ngunnawal Bush Healing Farm). This service will seek to improve health outcomes by addressing the complex issues that relate to drug and alcohol abuse. The service will provide culturally appropriate prevention, education, rehabilitation and outreach programs for Aboriginal and Torres Strait Islander peoples aged 18 years and over. Work is occurring to finalise the pre-tender cost estimate, construction program and governance arrangements for the service. Please refer to C.21, Aboriginal and Torres Strait Islander Reporting, for further details.

ACT Health has initiated a number of measures to improve community health in line with the commissioner's second recommendation relating to health promotion and care services. These include:

- the launch of *Beyond Today—it's up to you*
- promotion of tap water as the drink of choice to the ACT community, including lending portable 'Tap into water every day' water-dispensing units to community events, and working in partnership with the ACT Education Directorate to trial fixed water units in schools
- the Get Healthy Information and Coaching Service®, a free information and telephone-based health service to assist adults to identify and reach their health goals
- local support for the Australian Government's Swap It, Don't Stop It social marketing campaign, which encourages people to make sustainable, incremental changes in their lifestyle choices
- funding for a wide range of community-based health promotion activities through the ACT Health Promotion Grants program
- Kids at Play Active Play and the Eating Well Early Childhood project, which provides organisations responsible for early childhood services with support to promote healthy childhood habits
- SmartStart for Kids Program, funded to screen children for health risk factors and provide a school-based program for higher-risk child care

- the Healthy Food at Schools project, including support for schools to implement National Healthy Schools Canteen Guidelines in partnership with Nutrition Australia
- the Healthy Food at Children's Sports project, in partnership with Sport and Recreation and local sporting organisations
- the Active Travel to Schools project
- funding of the Heart Foundation's Active Living agenda—Heart Foundation Walking and the Heartmoves program
- ongoing implementation of the Australian Government's Healthy Communities Initiative
- implementation of a variety of workplace health promotion activities, including ACT Health Smoke-Free Workplace policy, and the development and piloting of a number of resources to support workplace health and wellbeing programs
- My Health—the Health Directorate's staff health and wellbeing program.

C.19 Ecologically sustainable development

The ACT Health Directorate actively supports whole-of-government sustainability initiatives and in 2012–13 continued to work closely with the Environment and Sustainable Development Directorate to embed climate change policy, energy policy and environmental sustainability into the delivery of service.

Sustainability planning

To assist with its planning processes, ACT Health developed the ACT Health Directorate Sustainability Strategy (2010), which outlines the current environmental challenges presented by increasing demands on health care in the ACT and provides a roadmap for a collaborative sustainable future. It encapsulates a picture of where the directorate wants to be in 30 years' time and takes into account all the key elements contributing to a sustainable and dynamic future. The Sustainability Strategy contains seven focus areas (Models of Care, Buildings and Infrastructure, the Digital Health Environment, Transport, Regulatory Environment, Workforce, and Partnerships and External Service Delivery).

During 2012–13, ACT Health undertook extensive work on finalising the Sustainability Action Plan, in line with the Sustainability Strategy. Development of the Action Plan was supported by ACT Health's Leadership Network, which consists of the agency's future leaders. These staff embraced development of the Action Plan, which contains short-, medium- and long-term actions to be implemented across the directorate, with 93 per cent of the short-term actions (1–3 years) already completed.

These actions include:

- significant reduction in operating costs
- improved quality of the internal environment for staff and visitors
- future-proofing of buildings so that they are able to adapt to future requirements
- informed design choices, based on whole-of-life considerations
- reduction in carbon emissions.

ACT Health continues to demonstrate its commitment to the principles of ecologically sustainable development by:

- closely monitoring its use of resources
- integrating economic, social and environmental considerations into decision-making
- implementing measures to minimise the impact of agency activities on the environment.

ACT Health developed the *Sustainability–Environmental Principles and Guidelines for Building and Infrastructure* document to inform all capital projects and major refurbishment works regarding sustainable design and functionality that aligns with the ACT Government's targets.

For the purpose of the Agency Resource Use Data Table at the end of this section, office space is classified as it is in section C.13 of this Annual Report; that is, fully inclusive of new office space. The Canberra Hospital campus buildings' housing office space has also been included this year.

Energy use

Total energy use in 2012–13 increased by 5,410,420 megajoules (approximately 2.35 per cent) compared with 2011–12, due to:

- increased building and clinical space associated with the Health Infrastructure Program (HIP)
- an increase in clinical demand across the directorate, both in the acute and non-acute areas.

New space in 2012–13, which had an impact on energy usage, included:

- the Centenary Hospital for Women and Children Stage 1, which opened in September 2012

- the Gungahlin Community Health Centre, which opened in August 2012
- the fully operational Adult Mental Health Unit
- additional beds implemented across the Canberra Hospital.

Other developments nearing completion which will increase energy usage in the near future include:

- Stage 2 of the Centenary Hospital for Women and Children
- Canberra Region Cancer Centre
- additional Canberra Hospital (TCH) beds currently being constructed
- the new Belconnen Enhanced Community Health Centre
- Tuggeranong Community Health Centre extension.

In 2012–13, the following initiatives to improve energy management were either implemented or continued across ACT Health:

- replacement of several gas-fired boilers at Canberra Hospital
- replacement of air-conditioning fan coil units throughout Building 1 at Canberra Hospital
- ongoing upgrade of electrical distribution boards across many areas of the directorate
- ongoing installation of energy-efficient, occupancy-sensor or time-controlled lighting for non-critical building lighting and air-conditioning systems
- continued review, monitoring and tracking of large plant equipment (e.g. high-energy use chillers and boilers), with programming adjustments made, where possible, by the building management system to maintain peak efficiency
- replacement of older, larger electrical equipment in non-acute areas with more energy-efficient units, e.g. pan flushers and utensil washers
- installation of boiler heat recovery and burner management systems.

Water consumption

ACT Health's main use of water is for the provision of clinical treatment and associated services for patients and clients. The most significant consumption of water is attributable to:

- patient services, clinical use associated with a 24-hour service, including bathrooms
- chilled and hot water services for air-conditioning systems for wards, operating rooms and treatment areas
- operations within the kitchens and preparation of patient meals
- an increase in building-related activities associated with the Health Infrastructure Program
- sterilisation of surgical instruments, including water used in autoclave units
- renal dialysis treatments

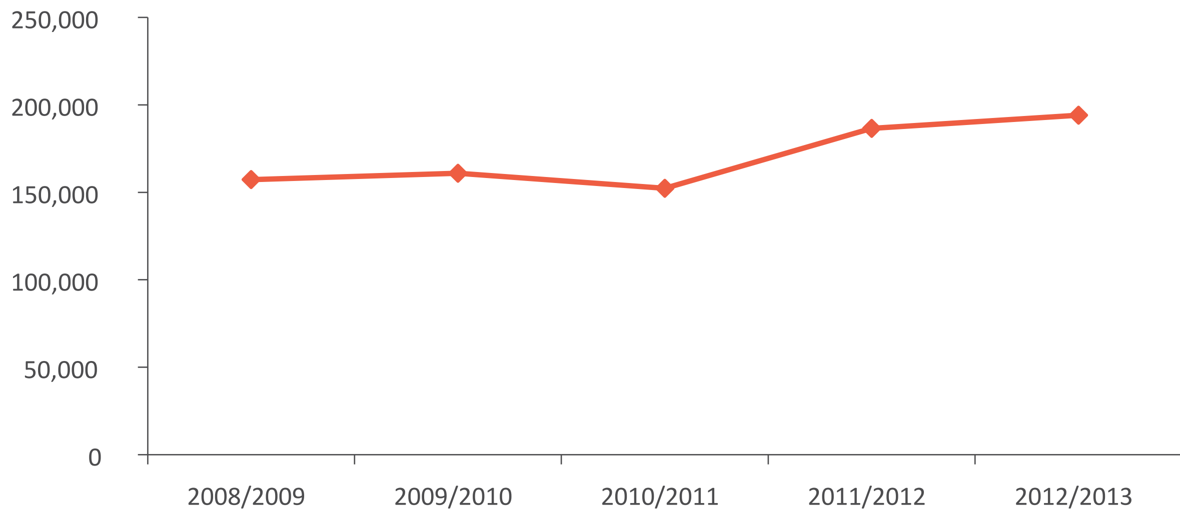
ACT Health's total water consumption increased from 186,552 kilolitres in 2011–12 to 194,088 kilolitres in 2012–13, an increase of 7,536 kilolitres or 4 per cent.

This increase is attributable to:

- operational activity associated with the use of the Centenary Hospital for Women and Children Stage 1 and the Adult Mental Health Unit. Both buildings add additional bathrooms and clinical requirements.
- construction requirements for the Canberra Region Cancer Centre and Stage 2 of the Centenary Hospital for Women and Children
- additional beds at the Canberra Hospital
- increased service delivery across ACT Health
- operational activity associated with the Gungahlin Community Health Centre.

The graph below summarises total water consumption data for ACT Health, represented as total kilolitres used, from 2008–09 when it was 154,711 kilolitres to 2012–13 when it was 194,088.

ACT Health Annual Water Consumption



The ongoing implementation and review of a variety of water efficiency initiatives continued through 2012–13, including:

- installation of flow restrictors on a range of plumbing fixtures (e.g. showers, hand basins and toilets for all new works and refurbishments)
- installation of six-star energy rating fixtures as replacements, where practical
- replacement of heating pipe work and associated works at TCH
- boiler upgrades at TCH
- continuation of restrictions on the use of potable water for outside watering at all Health Directorate facilities and deactivation of all garden sprinklers and decommissioning of fountains
- monitoring of water meters for cooling towers usage
- use of newly-installed tank water for outdoor garden watering and external washing of facilities, buildings and pavements.

Greenhouse gas emissions

ACT Health supports and participates in the Australian Government Department of Climate Change benchmarking through the Online System for Comprehensive Activity Reporting (OSCAR) database. OSCAR standardises the calculation of greenhouse gas emissions to produce comparable data sets on environmental performance.

Improved data gathering implemented during 2011–12 and 2012–13 enabled enhanced monitoring of greenhouse gas emission trends across ACT Health in future years.

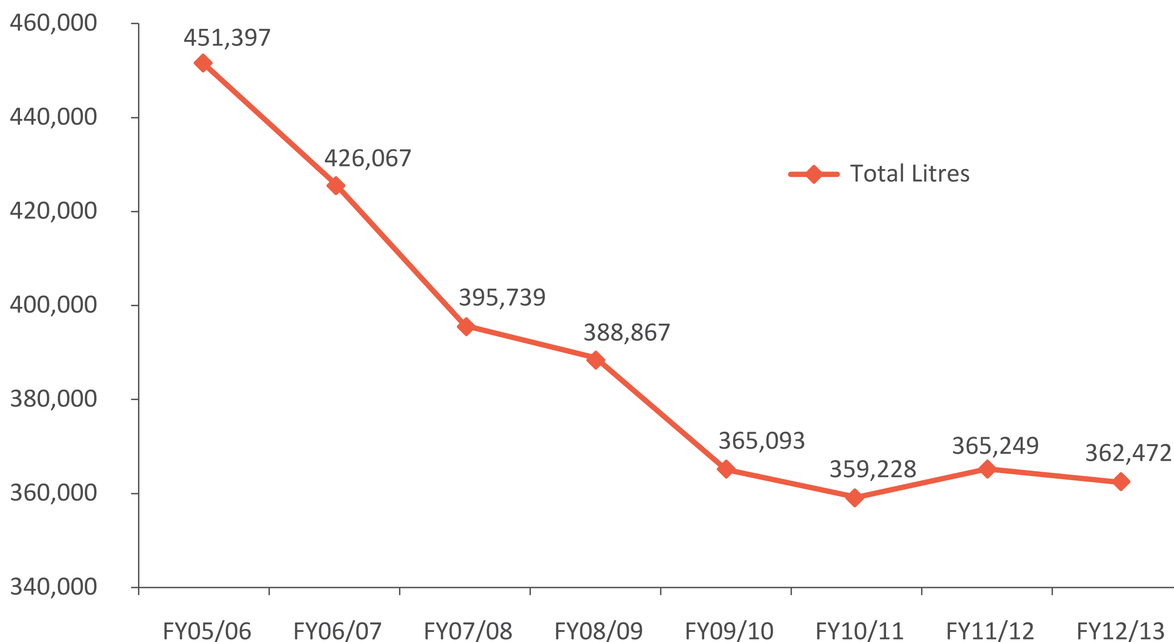
Transport

In 2012–13, the Health Directorate vehicle fleet increased in number by one vehicle. The following transport data was reported for 2012–13:

- Total fuel use reduced from 365.2kilolitres (petrol and diesel combined) reported for 2011–12 to 362.4 kilolitres for 2012–13. This is a reduction of 0.76 per cent.
- Total petrol fuel use was reported as 228.1 kilolitres; total diesel use was 134.4 kilolitres.
- Total number of vehicle kilometres travelled remained relatively static at 4,046,311 kilometres, compared to 4,056,252 kilometres reported for 2011–12, a reduction of 0.25 per cent.
- Vehicle utilisation decreased from 12,636 to 12,566 kilometres (0.6 per cent).
- Average fleet fuel consumption remained static at 8.97 litres per 100 kilometres relative to the 2011–12 figure of 9.00 litres per 100 kilometres.

- Total transport greenhouse gas emissions (all scopes) reduced from 987 tonnes CO^2-e to 975 tonnes, a reduction of 1.22 per cent.
- Transport greenhouse gas intensity improved from 0.16 tonnes CO^2-e per headcount to 0.15 tonnes per headcount (5.4 per cent).
- Total transport energy use was 12,988 gigajoules.

Fuel Utilisation Per Financial Year



- In June 2010, the Health Directorate entered into a contract with Carpool-It.com (Australia) Pty Ltd (also known as *MyCarpools*) for the development and hosting of a car-pooling system for staff. Subsequently the ACT Government introduced *MyCarpools* across ACT Government directorates and since June 2012 ACT Health has been participating in this program. Usage of the ACT Government's *MyCarpools* has steadily increased since its inception.
- Since 2012, 301 users have registered, with 110 of those users being staff of ACT Health. There are currently 15 car-pooling groups registered with *MyCarpools,* of which 13 are made up of ACT Health staff, resulting in ACT Health having the largest number of active car-pooling staff across the ACT Government.
- ACT Health will acquire two electrical vehicles in the next financial year.
- New bicycle facilities at Canberra Hospital have helped staff to use this mode of transport to work.

Waste minimisation (NoWaste)

ISS Health Services (ISS) provides a waste management solution for the Health Directorate under the terms of the ACT Health Domestic and Environmental Services Contract. ISS services are provided to 17 sites, including the Canberra Hospital.

Health Directorate and ISS developed and implemented a Health Waste Management Plan, which was endorsed in August 2012. The management of all waste services by one provider and in accordance with the waste plan facilitates the delivery of a uniform approach to waste management activities.

The Health Waste Management Plan complies with the principles of the ACT Sustainable Waste Strategy 2010–2015, which builds on the success of the NoWaste by 2010 ACT Government strategy released in 1996 and provides for:

- monitoring and measuring of all services through internal benchmarking activities, target setting, waste audits, waste data collection and reporting
- improved systems to recycle, reduce and reuse as many resources as possible from waste streams, including paper, cardboard, glass, plastic, cans, fluorescent tubes, metal, batteries, toner cartridges, and biodegradables.

- ACT Health is also a signatory to the ACT Government ACTSmart program, which aligns with and supports the initiatives of the Health Waste Management Plan, specifically in increasing recycling outputs. ACT Health and ISS are working closely with ACTSmart representatives to increase recycling outputs through education for staff and the implementation of recycling systems within administrative areas.
- ACT Health introduced waste streaming stations into the design of all new buildings coming on line through the Health Infrastructure Program (HIP).
- ACT Health collaborated with Australian National University (ANU) Medical School students on the ACT Green Hospitals Project 2010–2013. One of the aims of the project was to encourage and increase correct streaming of waste at the point of disposal in the Canberra Hospital theatres. The project delivered a 4.6 per cent reduction of waste incorrectly disposed of into the clinical waste stream, therefore reducing greenhouse gas emissions associated with clinical waste treatments and disposal.
- ACT Health received an EA rating (excellent achievement) from the Australian Council on Healthcare Standards (ACHS) for Waste and Environmental Management in relation to Criterion 3.2.3 EQUIP5 of the accreditation process undertaken in November 2012.

Agency resource use data

	Indicator as at 30 June	Unit		2011–12		2012–13
Line	**General**		**Office**	**Total**	**Office**	**Total**
L1	Occupancy – staff full-time equivalent	Numeric (FTE)	413	6,270	1,162[1]	6,540[2]
L2	Area office space – net lettable area	Square metres (m^2)	5,990	249,877[3]	17,481[4]	228,090
	Stationary Energy		**Office**	**Total**	**Office**	**Total**
L3	Electricity use	Kilowatt hours	2,514,171	35,382,895	1,715,888	34,664,956[5]
L4[6]	Renewable energy use (GreenPower + EDL land fill gases)	Kilowatt hours	1,122,211	8,908,951	N/a	3,328,618
L5	Percentage of renewable energy used (L4 / L3 x 100)	Percentage	44.63	25.20	N/a	9.60
L6	Natural Gas use	Megajoules	2,183,387	103,065,000	1,962,000	111,060,000
L7	Total energy use	Megajoules	11,234,403	230,443,422	8,139,197	235,853,842
	Intensities					
L8	Energy intensity per FTE (L7 / L1)	Megajoules / FTE	23,820	36,753	7,004	36,063
L9	Energy intensity per square metre (L7 / L2)	Megajoules / m^2	1,642	922	466	1,034
	Transport		**Office**	**Total**	**Office**	**Total**
L10	Total number of vehicles	Numeric	N/a	321	N/a	322
L11	Total vehicle kilometres travelled	Kilometres (km)	N/a	4,056,252	N/a	4,046,311
L12	Transport fuel (Petrol)	Kilolitres	N/a	212	N/a	228
L13	Transport fuel (Diesel)	Kilolitres	N/a	152	N/a	134
L14	Transport fuel (LPG)	Kilolitres	–	–	–	–
L15	Transport fuel (CNG)	Kilolitres	–	–	–	–
L16	Total transport energy use	Gigajoules	N/a	13,162	N/a	12,988
	Water		**Office**	**Total**	**Office**	**Total**
L17	Water use	Kilolitres	N/a	186,552[7]	N/a	194,088[8]
	Intensities					
L18	Water use per FTE (L17 / L1)	Kilolitres / FTE	N/a	29.75	N/a	29.68
L19	Water use per square metre (L17 / L2)	Kilolitres / m^2	N/a	0.70	N/a	0.85

Agency resource use data (continued)

Line	Indicator as at 30 June	Unit	2011–12		2012–13	
Line	General		Office	Total	Office	Total
	Resource Efficiency and Waste		**Office**	**Total**	**Office**	**Total**
L20	Reams of paper purchased	Reams	N/a	44,603	N/a	48,259[9]
L21	Recycled content of paper purchased	Percentage	N/a	7.41	N/a	4.95
L22	Estimate of general waste (based on bins collected)	Litres	N/a	25,904,736	N/a	19,805.577[10]
L23	Estimate of cominlged material recycled (based on bins collected)	Litres	N/a	1,796,850	N/a	1,892,880[11]
L24	Estimate of paper recycled (based on bins collected)	Litres	N/a	1,477,222	N/a	1,194,348[12]
L25	Estimate of organic material recycled (based on bins collected)	Litres	–	0%	–	0%
	Greenhouse Gas Emissions		**Office**	**Total**	**Office**	**Total**
L26	Total stationary energy greenhouse gas emissions (All Scopes)	Tonnes CO2-e	1,644	43,862	1,957	40,666
L27	Total transport greenhouse gas emissions (All Scopes)	Tonnes CO2-e	N/a	987	N/a	975
	Intensities					
L28	Greenhouse gas emissions per person (L26 / L1)	Tonnes CO2-e / FTE	3.90	7.0	1.68	6.21
L29	Greenhouse gas emissions per square metre (L26 / L2)	Tonnes CO2-e / m2	0.27	0.18	0.11	0.18
L30	Transport greenhouse gas emissions per person (L27 / L1)	Tonnes CO2-e / FTE	N/a	0.15	N/a	0.14

1 Variation to 2011–12 is the inclusion of 12 Moore Street Level 1, Carruthers Street Curtin, Buildings 23 & 24, office space within Buildings 2 & 6 TCH and Building 12 Medical Records Department.

2 Headcount, not FTE.

3 Includes 4,548m^2 that was included twice in 2011–12.

4 Variation to 2011–12 is the inclusion of 12 Moore Street Level 1, Carruthers Street Curtin, Buildings 23 & 24, office space within Buildings 2 & 6 TCH, and Building 12 Medical Records Department.

5 Reduction in consumption as space occupied by non-government entities has been removed.

6 Green Power being reported at whole-of-government level by TAMS.

7 This amount was incorrectly reported in the 2011–12 Annual report section A.10 Triple Bottom Line as 183,174 kilolitres. This was an administrative error and 186,552 kilolitres is correct, as stated in the C.19 table of the 2011–12 report on page 318.

8 Increase in water consumption due to the full year effect of a new building coming on line.

9 Figure reflects an 8 per cent increase of paper reams purchased associated with increased headcount/activity growth across all Health.

10 Note 2011–12 landfill litres reflected 18 months of data/weights. The adjusted 12-month landfill litres figure is 17,717,865 litres. 2012–13 landfill litres represents an increase of 2,087,712 litres (12 per cent) when compared to the adjusted figure from 2011–12. This is due to increased growth. TCH only.

11 2011–12 comingled recycled litres reflected 18 months of data/weights. The adjusted 12-month comingled recycled litres figure is 1,302,290 litres. 2012–13 comingled recycled litres represents an increase of 590,590 litres (45.3 per cent) when compared to the adjusted figure from 2011–12. This is due to improved recycling systems and increased growth. TCH only.

12 2011–12 paper recycled litres reflected 18 months of data/weights. The adjusted 12-month paper recycled litres figure is 1,139,422 litres. 2012–13 paper-recycled litres represents an increase of 54,926 litres (4.8 per cent) when compared to the adjusted figure from 2011–12, due to improved education/signage. Across all Health sites.

C.20 Climate change and greenhouse gas reduction policies and programs

The ACT Health Sustainability Strategy was developed in response to the ACT Government's *Climate Change Strategy 2007–2025: Weathering the Change* (2007), the *Canberra Plan* (2008) and the *Climate Change and Greenhouse Gas Reduction Act 2010*. These documents and legislation outline the government's commitment to sustainability and detail the greenhouse gas emissions reduction target of zero net emissions (carbon neutrality) by 2060.

Due to the nature and scale of its operations, the Health Directorate is a major consumer of energy and water, and generates a significant amount of waste.

The Health Infrastructure Program—a major hospital redevelopment initiative—provides an important opportunity to create ecologically sustainable health facilities. The challenge is to build intelligently, so that buildings use a minimum of non-renewable energy, produce a minimum of pollution and waste, and cost a minimum of energy dollars, while increasing the health, safety, and welfare of everyone who works in, visits or resides in them. These are the key components of sustainable design. New health facilities have incorporated many environmentally sustainable design principles such as:

- energy efficient lighting systems, including LEDs
- clean energy options
- cyclist facilities for sustainable transport.

ACT Health will strive to achieve higher levels of environmental performance in the future as we work toward meeting the Government's greenhouse gas emission and water consumption targets.

Sustainability in healthcare facilities need not compromise functionality, nor significantly increase the cost of designing and operating buildings. Well-designed sustainability initiatives can provide the following benefits:

- significant reduction in operating costs
- improved quality of the internal environment for staff and visitors
- future proofing of buildings so that they are able to adapt to future requirements
- informed design choices, based on whole-of-life considerations
- reduction in carbon emissions.

ACT Health's Sustainability Strategy (2010) outlines the current environmental challenges presented by the increasing demands in health care in the ACT and provides a vision for achieving a sustainable future.

Through delivery of the Sustainability Action Plan, ACT Health will progressively reduce its carbon footprint by embedding sustainability in all elements of its core business throuh the following business functions: Models of Care; Buildings and Infrastructure; The Digital Environment; Transport; Regulatory Environment; Workforce and Partnerships with External Services.

To date, ACT Health has completed 93 per cent of the short-term actions (59 short-term actions in total) towards a sustainable future, including:

- development of the *Environmental Principles and Guidelines for Building and Infrastructure Projects* under the Health Infrastructure Program
- improvement of access to information to consumers through the ACT Health consumer portal
- development of models of care in conjunction with consumers and staff, taking into account evidence-based design, supportive leadership and teams, and optimising patient/staff experiences
- establishment of new processes in community health centres that enable strong links with their local communities, improving communictaion flows and information and adapting services to local needs
- establishment of secure bicycle sheds, shower/change room facilities into current and future builds to support healthy transport options.

C.21 Aboriginal and Torres Strait Islander reporting

Early child development and growth (prenatal to age 3)

ACT Health continued to fund Winnunga Nimmityjah Aboriginal Health Service to deliver the Aboriginal Midwifery Access Program (AMAP) to ACT Aboriginal and Torres Strait Islander communities. The program is funded as part of Element 3 of the Council of Australian Governments' National Partnership Agreement on Aboriginal and Torres Strait Islander Early Childhood Development.

Comprehensive antenatal, postnatal and maternal and child health support is provided to women and their families through: outreach clinical and non-clinical assessments at home; referral to, and support in accessing, mainstream and specialist services; and the provision of information on mainstream services. From 1 July to 30 December 2012, 39 women received antenatal care and 44 women received postnatal care. The proportion of women smoking in pregnancy from 1 July to 30 December 2012 was 50 per cent and for the same period the proportion of women using alcohol in pregnancy was 10 per cent. From 1 January to 30 June 2013, 44 women received antenatal care and 35 women received postnatal care, For the same period the proportion of women smoking in pregnancy was 45 per cent and the proportion of women using alcohol in pregnancy was 7 per cent.

ACT Health engaged with key stakeholders in the Aboriginal and Torres Strait Islander communities on the '*Beyond Today ... it's up to you*' social marketing campaign, which promotes tobacco cessation and healthy lifestyle behaviours, including providing information on the effects of smoking in pregnancy and in families.

Early school engagement and performance (preschool to Year 3)

ACT Health continued to fund Winnunga Nimmityjah Aboriginal Health Service to deliver a Hearing Health Program for infants and children, which included provision of a comprehensive school-based screening service and the development and provision of appropriate education and treatment, including referral for surgical interventions. From 1 July to 30 December 2012, 514 infants and children (aged 0 to 14) were screened by an audiologist (some children were assessed more than once during the reporting period), 24 infants or children were seen by a GP for otitis media and seven were referred to other hearing specialist centres, and 28 schools were visited (including preschools), with 171 students receiving hearing assessments. Between 1 January and 30 June 2013, 246 infants and children were screened by the audiologist, 33 were seen by a GP for otitis media and four were referred to other hearing specialist centres. Thirteen schools were visited, with 116 students receiving hearing assessments.

Positive childhood and transition to adulthood

ACT Health provides funding to Gugan Gulwan Youth Aboriginal Corporation to deliver: the Youth Outreach Network—Street Beat; alcohol and other drug treatment support services, a Healthy Future preventative health program; and a Mental Health and Social and Emotional Wellbeing Program.

From 1 July to 30 December 2012, the Youth Outreach Network—Street Beat conducted 27 night patrols and 460 clients accessed the network. Between 1 January and 30 June 2013 there were 38 night patrols, with 736 clients accessing the service. The network supports early diagnosis, treatment and advice for young people on a range of health problems that relate to at-risk behaviour.

ACT Health is responsible for Element 2 of the Early Childhood Development National Partnership Agreement. The Antenatal Care, Pre-pregnancy and Teenage Sexual and Reproductive Health Project is progressing in line with agreed outcomes. An advisory group continues to meet bi-monthly to provide overall governance and project direction. A project working group meets as needed to provide input to strategies and resource development. Three key strategies were introduced to guide the project, including:

- Strategy 1: Support was provided for a workforce training initiative for teenage sexual and reproductive health through Sexual Health and Family Planning ACT. Training was delivered to workers from Winnunga Nimmityjah Aboriginal Health Service and Gugan Gulwan Aboriginal Youth Corporation. Following this training, consultation occurred with Canberra Sexual Health Centre to secure a project officer to deliver sexual health education, training and opportunistic testing for young Aboriginal and Torres Strait Islander people.
- Strategy 2: There was continued implementation of Core of Life (COL), a comprehensive life education program with a focus on the realities of pregnancy, birth and early parenting for Aboriginal and Torres Strait Islander young people and their peer groups. In 2012–13, the program, which is facilitated by a midwife, was delivered in schools, community services, health services, refuges and youth detention centres. Over 460 young people participated, approximately 40 per cent of whom identified as Aboriginal and/or Torres Strait Islander. Three COL facilitator training workshops were held, where 58 people were trained to deliver the program in partnership with the midwife, and a facilitators' network was established to provide professional support.
- Strategy 3: Resources developed to support strategies 1 and 2 between July 2012 and June 2013 include: installation of a HitNet Kiosk at the Gugan Gulwan Youth Aboriginal Corporation; investigations undertaken for another two kiosks for Bimberi Youth Justice Centre and the Junction Youth Health Service; development of an inclusive breastfeeding DVD for young people; and development of Health in Pregnancy and Sexual Health information booklets.

Substance use and misuse

ACT Health continued to fund Winnunga Nimmityjah Aboriginal Health Service to deliver a range of alcohol- and drug-related programs, including: Dual Diagnosis; the Youth Detoxification Support Service; the Opiate Program; Tackle Smoking; and Mental Health Liaison. Funding is also provided for a dedicated tobacco control worker to address priority areas of the ACT Aboriginal and Torres Strait Islander Tobacco Control Strategy.

ACT Health has progressed with the development of the Ngunnawal Bush Healing Farm, a residential rehabilitation service for Aboriginal and Torres Strait Islander people living in the ACT, which seeks to address the complex issues related to drug and alcohol abuse. The service will provide culturally appropriate prevention, education, rehabilitation and outreach programs for Aboriginal and Torres Strait Islander peoples aged 18 years and over.

The Aboriginal and Torres Strait Islander Advisory Board, whose membership includes the ACT Aboriginal and Torres Strait Islander Elected Body, United Ngunnawal Elders Council, community-organisations and ACT directorates, continued to provide advice and guide the development of the Ngunnawal Bush Healing Farm.

An Aboriginal and Torres Strait Islander Alcohol and Drug Liaison Officer is employed by ACT Health, providing support and education to alcohol and drug sector services and other services to assist in providing appropriate care to Aboriginal and Torres Strait Islander clients.

Functional and resilient families and communities

The *ACT Aboriginal and Torres Strait Islander Health and Family Wellbeing Plan 2006–2011* was developed in response to the requirement in the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) for each jurisdiction to develop a local implementation plan.

A review of the plan was undertaken in 2012–13 by the Aboriginal and Torres Strait Islander Health Forum, which includes membership from ACT Health, the ACT Aboriginal and Torres Strait Islander Elected Body, Winnunga Nimmityjah Aboriginal Health Services, ACT Medicare Local and the Commonwealth Department of Health and Ageing. Through this process, factors affecting its implementation were identified, most significantly the Closing the Gap Indigenous Reform Agenda, which was introduced halfway through the implementation of the plan in 2008.

Development of a new ACT Aboriginal and Torres Strait Islander Health Plan has commenced. This will incorporate what was learnt in the review of the previous plan, as well as outstanding action items identified as ongoing strategies requiring implementation by the Health Forum. The new plan will also be informed by the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes and will seek to form linkages with these other national health-related plans developed in 2013:

- National Aboriginal and Torres Strait Islander Health Plan
- National Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Plan
- National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
- National Aboriginal and Torres Strait Islander Blood-Borne Viruses and Sexually Transmissible Infections Strategy
- National Aboriginal and Torres Strait Islander Drug Strategy.

In July 2012, ACT Health launched its three-year *Reconciliation Action Plan 2012–2015*. The plan has a range of actions to bring about change and create a health environment that is culturally sensitive, where staff are aware that closing the gap in Aboriginal and Torres Strait Islander life expectancy is an important part of our organisation's business.

ACT Health's Reconciliation Action Plan Working Group and the Aboriginal and Torres Strait Islander Health Coordination Group provided support and guidance on the development of the plan. Consultations were undertaken internally with ACT Health line areas and externally with Aboriginal and Torres Strait Islander stakeholders.

Effective environment health systems

Infrastructure, water sanitation, fresh food and housing are of a consistently high standard in the ACT when compared to those of rural and remote environments. The ACT Government funds a range of Aboriginal and Torres Strait Islander and mainstream programs which ensure access to and availability of appropriate healthy living environments.

Economic participation and development

ACT Health progressed the development of an Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013–2018 that responds directly to: the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011–2015*; and the *ACT Public Service Employment Strategy for Aboriginal and Torres Strait Islander People—Building a culturally diverse workforce 2010*. The plan is formally linked to ACT Health's *Workforce Plan 2013–2018* and was endorsed by ACT Health's Executive Council in June 2013.

The Aboriginal and Torres Strait Islander Health Workforce Support Network continued to provide support and advice to Aboriginal and Torres Strait Islander staff employed in the health workforce and included members from ACT Health, ACT Medicare Local, Winnunga Nimmityjah Aboriginal Health Service, Gugan Gulwan Youth Aboriginal Corporation and Calvary Health Care ACT.

An Employment Inclusion Officer continued to facilitate ACT Health's involvement in the ACT Public Service Aboriginal and Torres Strait Islander Traineeship Program. In the July 2012 intake for the program, ACT Health employed four trainees. All trainees were assigned ACT Government mentors.

ACT Health implemented an Aboriginal and Torres Strait Islander Cultural Awareness and Skills Development Program in line with its Essential Education Policy. The training consists of three elements: staff orientation, an e-learning module and a skills development workshop.

In 2012–13, 1,033 health staff participated in staff orientation sessions and 991 staff completed the e-learning module and quiz. An evaluation of the pilot workshops was completed to inform the content and delivery of future workshops.

C.22 ACT Multicultural Strategy 2010–2013

A new Multicultural Health Policy Unit has been established and will commence operations from 1 July 2013. The unit will be placed alongside the Aboriginal and Torres Strait Islander Health Unit within the Policy and Government Relations Branch. The Multicultural Health Policy Unit will provide guidance across ACT Health to ensure that all ACT Health services (including primary health care, clinical health services and population programs, including health promotion and prevention) are delivered in culturally safe and appropriate ways. It is anticipated that all divisions and branches will work with the unit to: improve data collection; deliver culturally safe and appropriate services and information; engage culturally and linguistically diverse (CALD) consumers in providing feedback and participating in service planning and evaluation; and develop the cultural competency of all staff.

Focus area	Progress
Languages	ACT Health continued to promote service accessibility to people from multicultural backgrounds by promoting access to interpreter services. After a review involving significant consultation, the internal Migrant Health Unit, which provided in-house interpreting of Mandarin, Cantonese and Vietnamese, ceased operation in December 2012. All interpreting services are now accessed through the national Translating and Interpreting Service (TIS), and a revised standard operating procedure provides guidance on accessing this service. In 2012–13, expenditure on TIS telephone and on-site interpreting services totalled $410,000, with Mandarin, Arabic, Vietnamese and Cantonese interpreters most frequently accessed. **Key Performance Indicator (KPI)—That 100 per cent of ACT Government publications include accessibility block information—that is, information in alternative formats such as other languages.** One hundred per cent of ACT Health publications (but not all posters, because of space limitations) include ‘accessibility block’ information. Translated documents, including alternative formats such as large print or audio, can be requested by the client. The Office of Multicultural Affairs is informed accordingly. Health Promotion Grants were awarded to support the Health Care Consumers’ Association Inc. for Health Literacy for All, a project to develop a series of health literacy modules, including modules in an e-learning format that include a ‘translate’ function so material can be accessed in community languages; and the introduction of a multicultural QUIT module and training local bilingual presenters to deliver it. The Health Protection Services finalised a food safety guide for businesses, which was translated into 11 languages to ensure food safety information was available to CALD communities. The guide provides comprehensive information about the most common food safety requirements. Guidelines for temporary food stalls were also developed and translated into 12 languages. The guidelines are designed to assist organisers of food stalls at outdoor events in the ACT to meet all food safety requirements.
Children and young people	Health Promotion Grants supported Football United to deliver Empowered for Healthier Communities, which provides regular physical activity and leadership or life skills training for over 1,000 children and youth from diverse and disadvantaged backgrounds in the West Belconnen and Dickson regions of the ACT. In 2012–13, refugee children and youth were a focus of the project.
Adults, older people and aged care	Health Promotion Grants supported the Asian Women’s Friendship Association to provide Stay Firm and Be Active for CALD Background Seniors, a program to provide seniors and their carers from CALD backgrounds, specifically those from Asian backgrounds, with informative and constructive weekly Tai Chi classes.

Focus area	Progress
Women	The Health Directorate has continued to address the specific needs of women from multicultural backgrounds by: • providing women's health services across the ACT to enhance access by women of culturally and linguistically diverse (CALD) backgrounds • delivering a women's health talk to 195 women at the CIT English as a Second Language course • developing a project plan to increase liaison with cultural communities in which female circumcision is practised • with identified funding, commencing recruitment to a part-time women's health nurse position to provide holistic health promotion on women's health, including the impact of female circumcision. Nursing, medical and counselling services are provided to women who experience significant barriers to accessing health services, including language and culture. **KPI—Proportion of clients attending Well Women's Checks at the Women's Health Service from multicultural backgrounds.** In 2012–13, 266 CALD women (40 per cent of all clients) accessed this service. The BreastScreen ACT program has continued to address the specific needs of women from multicultural backgrounds by providing free breast screening services to all women in the ACT aged over 40. BreastScreen ACT recommends regular screening of the target group—women aged 50 to 69 years—which has been effective in reducing deaths from breast cancer through early detection. The program has implemented a recruitment plan (in consultation with multicultural representatives) with specific strategies that aim to increase the participation of women in this group. Work has also occurred to develop and produce general breast screening information brochures in Chinese, Vietnamese, Croatian, Greek, Italian and Spanish. **KPI—Percentage of women with multicultural backgrounds in the BreastScreen ACT program.** In 2012–13, 767 CALD women (5.5 per cent of all clients) accessed the BreastScreen ACT service. Health Promotion Grants supported the Australian Breastfeeding Association ACT/SNSW to improve breastfeeding rates (initiation and duration) among specific target groups, including women from CALD backgrounds. This is done by delivering targeted peer support training programs and breastfeeding information sessions and increasing the number of establishments or organisations in the ACT that are Breast-Friendly Workplace accredited. ACT Health supported the Health Care Consumers' Association to employ a Consumer Coordinator/ Multicultural Liaison Officer in 2012–13 to facilitate involvement and perspective from consumers in the development of service planning for the Health Infrastructure Program. The Consumer Coordinator/ Multicultural Liaison Officer fostered networks with multicultural community organisations and diverse communities about the health system, particularly regarding the Health Infrastructure Program, consumer participation and health literacy, including the development of suitable information resources.
Refugees, asylum seekers and humanitarian entrants	ACT Health continued to seek to meet the needs of refugees, asylum seekers and humanitarian entrants by providing access to health and wellbeing services so that this target group can maintain their dignity and physical and mental health. It did so by: • continuing to provide Medicare-ineligible asylum seekers with the same access as Health Care Card holders to public dental and community health services • collaborating with the Commonwealth Department of Immigration and Citizenship in accommodating the housing and health care needs of 50 immigration detainees in the ACT community • continuing to promote awareness of the ACT Services Access Card introduced for refugees in October 2011. The card is designed to provide access to services, without the need for refugees to re-tell their trauma or refugee story. Health Promotion Grants supported Arthritis ACT, incorporating Osteoporosis ACT, to deliver Lowering the Barriers, which involved finding representatives from a range of disadvantaged groups, including refugees, to share their life stories with one another in the context of workshops with one simple health message: 'You are the most important health provider for you.'
Intercultural harmony and religious acceptance	ACT Health promoted or conducted general programs for staff to enhance their understanding of the rights of their colleagues and clients. These initiatives included: • Respect, Equity and Diversity (RED) training, and establishment of the RED contact officer network • Human Rights Act training • workshops on managing and preventing discrimination, bullying and harassment • Australian Charter of Healthcare Rights training • e-learning packages on managing work aggression and violence. The Health Directorate has implemented cultural awareness training for staff, to promote a caring and competent health workforce.

C.23 ACT Strategic Plan for Positive Ageing 2010–2014

Focus area	Progress
Information and communication	ACT Health promotion communication campaigns aim to reach a wide population, including seniors, to influence behaviour. Many messages are focused on preventing chronic disease. There has been local promotion of the national Measure Up and Swap It, Don't Stop It social marketing campaigns, including websites providing people with information on how they can change their lifestyles to become more active and have a healthy diet: ***www.measureup.gov.au*** and ***www.swapit.gov.au***. The '*Beyond Today ... it's up to you*' campaign was developed to encourage healthy lifestyles and smoking cessation among the ACT Aboriginal and Torres Strait Islander community. Messages were designed to reach the elders in this community to facilitate behaviour change (***www.health.act.gov.au/health-services/aboriginal-torres-strait-islander/information/beyond-today***). The Get Healthy Information and Coaching Service® (GHICS) is a free ACT Health telephone coaching service staffed by qualified health coaches and aimed at helping adults to make lifestyle changes regarding healthy eating, physical activity and how to reach and maintain a healthy weight. Between 1 July 2010 and ongoing. 18.4 per cent or nearly one in five people using the service were aged over 60 years and approximately two in five (40.1 per cent) were aged 50 or over. The 'Find an ACT health service' page includes up-to-date information about aged care health services in Canberra and surrounding regions (***www.health.act.gov.au/health-services/find-a-health-service***). Heart Foundation Heartmoves is a gentle physical activity program which receives funding through ACT Health. It is designed to be safe for people with stable long-term health conditions such as heart disease, diabetes or obesity and is suitable for anyone who has not exercised in a while. Two Heartmoves groups are based at Canberra Senior Centre in Turner. Heart Foundation Walking receives funding through ACT Health. The Heart Foundation supports Australians to lead active, healthy lives by encouraging them to join or start Heart Foundation Walking groups, which are fun and a great way to meet new people. Some walking groups target, among others, people aged over 50.

Focus area	Progress
Health and wellbeing	Funded by the ACT Government, Carers ACT released over 20 Mental Health E-bulletins for Carers in 2012–13. Carers ACT also held numerous forums for carers on such topics as: • the second exposure draft of the Mental Health (Treatment and Care) Act • ending homelessness based on the common ground model • the prevalence and disease burden of tobacco addiction on people living with mental health issues and research findings on implementing smoke-free policies in mental health services • medicines and mental health carers • navigating the mental health system. In addition, throughout the reporting period, Carers ACT hosted a moderated Mental Health Carers Voice Online Discussion Forum, which covered many topics relevant to carers. In the reporting period, 100 per cent of Mental Health Service committees had representation from consumers and carers. ACT Health is continuing to prepare for the introduction of an electronic medication management (EMM) solution, which will: support transparent communication of medication history across care settings; enable electronic prescribing, management and administration of medications; and support high-quality patient care through improved medication safety. Following a request for quotation, a preferred vendor was selected. Contract negotiations are underway. An implementation planning study and a review of high-level requirements will be undertaken prior to implementation of the EMM solution. ACT Health is continuing to work with the Department of Health and Ageing and the National E-Health Transition Authority in relation to the national PCEHR system. ACT Health began submitting discharge summaries to the national e-health record system on 22 March 2013. Healthcare consumers who are admitted to the Canberra Hospital are now asked to indicate whether they would like their discharge summary sent to their national e-health record. Consumers can change their preference at any time prior to discharge. ACT Health is working collaboratively with the Department of Health and Ageing to enable provision of an assisted registration service for ACT Health consumers. This would enable healthcare consumers to quickly and easily register for an e-health record. A discharge support Allied Health Assistant (AHA) was employed in the acute care of the elderly ward (11A) to facilitate the implementation of care plans and follow-on referrals for elderly clients discharged home from the hospital. The role of the 11A discharge support AHA is to: • make contact with the client and carer/family while they are still in hospital and explore their needs after discharge • ensure that the arranged services are implemented and appropriate • liaise with the client and carer/family and provide further information post-discharge • work with the occupational therapy team in assessing the need and provision of equipment after discharge. The 11A discharge support AHA has supported many clients to return home. In 2012–13, the 11A discharge support AHA received 179 referrals and conducted 731 occasions of service. The Respecting Patient Choices (RPC) program works with community agencies and groups, peak bodies and other government agencies to promote and improve the uptake of Advance Care Planning (ACP) in the ACT. A total of 298 advance care plans were processed through the program. A total of 215 consumer consultations/referrals and information queries/packs were undertaken or processed through the program. Over 26 RPC/ACP presentations were given to ACT Health, community and professional groups. The RPC program participated in the COTA Seniors Expo at EPIC on Thursday, 21 March 2013. The RPC program staff were invited to participate in a Local Hospital Network sponsored End of Life Issues and Decision-Making Community Engagement Forum, held on the 4 May 2013. The RPC program hosted two facilitator training workshops and 14 participants completed their training. A facilitator peer education group was also hosted, with five attending.

Focus area	Progress
Health and wellbeing (continued)	The RPC submitted a successful budget proposal for increased RPC program resources to enhance and improve the uptake of ACP in the ACT. The RPC program negotiated a successful partnership arrangement with Medicare Local ACT to support and promote advance care planning to the wider ACT community and health professionals. Rehabilitation, Aged and Community Care provide a Falls and Falls Injury Prevention Assessment Clinic. This is a free ACT Health service targeting people over the age of 65, or 55 years for Aboriginal and Torres Strait Islanders, who are at high risk of falling. Falls Prevention Clinics are designed to provide a multi-disciplinary assessment and intervention service. Clinic staff work with older adults to assess individual fall risks and provide a comprehensive falls reduction plan. The clinic health professional team comprises a registered nurse, occupational therapist and physiotherapist. Rehabilitation, Aged and Community Care also provides Stepping On, a seven-week program run three to four times per year for people over the age of 70 who are active and well but fear falling or have previously had a fall. The program focuses on exercise, education and preventative strategies. It is also staffed by a multi-disciplinary team, including an occupational therapist, a physiotherapist and other educators. In 2012–13, the Falls and Falls Injury Prevention Service continued to promote falls awareness through involvement in community expos, including the Seniors Week expo, as well as running a month-long initiative at the Canberra Hospital and community health centres to link in with the New South Wales April Falls Day initiative. These activities promoted the service through access to falls prevention staff and the provision of fact sheets for community, clients and staff. The Falls and Falls Injury Prevention Service has commenced a joint initiative with the community Renal Service to provide targeted falls prevention advice to people receiving dialysis in community settings. In 2012–13, 488 people were assessed in falls clinics. Eight grants from the ACT Health Promotion Grants Program were provided through the 2012–13 Stay On Your Feet Falls Prevention Funding Round, to a total value of $199,387. Grants were awarded to projects to prevent falls, manage medicines to minimise falls and reduce falls risk in aged care facilities. These activities involved partnerships with a range of providers such as the Heart Foundation and the YMCA. The ACT Chronic Conditions Strategy: Improving Care and Support 2013–2018 has the key priorities of integrated service provision and improved access and support for those living with chronic conditions. Older Canberrans have the highest incident of chronic disease in our community and will benefit from the introduction of the strategy. This strategy builds on the previous ACT Chronic Disease Strategy 2008–2011, which saw the development of a range of specialist services for people with complex chronic conditions, including the establishment of advance care planning clinics within the Chronic Care Program.
Support services	Hearing augmentation has been incorporated into several health facilities. There are plans to include hearing loops in facilities yet to be designed.
Transport and mobility	Rehabilitation, Aged and Community Care provides a driver assessment service for older people. Team members include a geriatrician, neuropsychologist, occupational therapist, and a full-time driving instructor for older drivers. In 2012–13, 189 driving assessments were conducted for clients aged 75 years and over.

C.24 ACT Women's Plan

Economic priority

Strategic outcome

Women and girls equally and fully participate in and benefit from the ACT economy.

Priority areas

- responsive education, training and lifelong learning
- flexible workplaces
- economic independence and opportunities
- leadership and decision making

Indicators of progress

Evidence of:

- education and training pathways for women and girls
- increased opportunities for the advancement of women in the workforce
- increased economic leadership and decision-making opportunities for women and girls
- improved financial equity.

Seventy-six per cent of the 6540 staff employed by ACT Health are female. The range of educational, leadership and other opportunities offered by the directorate and set out below is available to all staff.

Study assistance is available to ACT Health staff to access programs of study to meet their training and development needs. The program assists employees to undertake external study leading to a qualification related to their employment by providing discretionary access to paid study leave and/or financial assistance.

ACT Health provides access to flexible working arrangements to support a healthy work–life balance. These arrangements include generous maternity leave provisions and access to part-time work after maternity leave. Breastfeeding mothers are supported through paid lactation breaks.

The Leadership Network is a collaborative initiative to capitalise on the talent and experience of ACT Health employees. Summit workshops are held three times a year in addition to project group work across divisions, leading to significant networking and development opportunities.

The directorate offers the following scholarships for staff:

- Allied Health Postgraduate Scholarships
- Allied Health Undergraduate Scholarships
- Nursing and Midwifery Aboriginal and Torres Strait Islander Enrolled Nursing Scholarships
- Nursing and Midwifery Post-Registration Scholarships
- Nursing and Midwifery Postgraduate Diploma in Mental Health Scholarships
- Nursing and Midwifery Jennifer James Honours Degree Memorial Scholarships
- Nursing and Midwifery Joanna Briggs Clinical Fellowship Scholarships
- Nursing and Midwifery Student Clinical Placements
- Personal Classification Level 2—Career Advancement.

The ACT Health Loan Scheme for Tertiary Study (LSTS) is available for all staff to support advanced payment of fees for tertiary education. The purpose is to promote a positive learning organisation environment that increases the knowledge and skill levels of staff.

Social priority

Strategic outcome

Women and girls equally and fully participate in sustaining their families and communities and enjoy community inclusion and wellbeing.

Priority areas

- safe and respectful relationships
- good health and wellbeing
- safe and accessible housing

Indicators of progress

Evidence of:

- recognition of women and girls' contributions to the community
- increased community leadership and decision-making opportunities for women and girls
- affordable and accessible gender and culturally sensitive services
- pathways for women experiencing disadvantage, social exclusion and isolation
- addressing violence against women and their children and protection and support for victims.

The Women's Health Service provided 40 per cent of well women's clinics to culturally and linguistically diverse women, exceeding the target of 30 per cent.

The BreastScreen program provides free breast screening services to all women in the ACT aged over 40. Work has occurred to develop and produce general breast screening information brochures in Chinese, Vietnamese, Croatian, Greek, Italian and Spanish. In 2012–13, 767 CALD women (5.5 per cent of all clients) accessed the ACT BreastScreen service.

ACT Health is implementing Element 2 of the Council of Australian Governments' Aboriginal and Torres Strait Islander Early Childhood Development National Partnership Agreement's antenatal care, pre-pregnancy and teenage sexual and reproductive health project. This includes implementing the Core of Life reality-based education program for young people on pregnancy and parenting and supporting sexual health information and education activities for Aboriginal and Torres Strait Islander young people.

ACT Health funds the Women's Centre for Health Matters, which provides support to conduct research related to women experiencing disadvantage, social exclusion and isolation—for example, Women with Disabilities ACT and the Women and Prisons Group.

Karralika Programs Inc. supports adults and their families through a range of alcohol and drug programs. Karralika offers access to subsidised childcare for parents undertaking their programs from Communities@Work. The arrangement with Communities@Work was established a number of years ago, when Karralika Programs Inc. ceased to provide childcare internally. ACT Health is actively looking at opportunities to improve access to subsidised childcare for parents undertaking drug treatment programs in the ACT.

The Women's Health Service gives priority to women who experience significant barriers to health service access.

The ACT Healthcare Survey includes a section on results by gender. The questions cover being treated with respect, respect for privacy, respect for cultural, social or religious needs, personal safety, and ease of access to consumer information. Survey results guide service improvement.

Canberra Hospital and Health Services participated in a benchmarking study for inpatients through Best Practice Australia in February 2013. The two separate surveys measured information related to the new National Safety and Quality Standards and asked a series of questions related to patient experience, including patients' greatest expectations and how they rate those expectations.

ACT Health is making consistent progress towards the agreed milestones of the National Perinatal Depression Initiative (NPDI). Progress and improvements against all outputs in the implementation plan are on track, with no significant risks or issues emerging. ACT NPDI activities continue to support maternity services, including the community-based Maternal and Child Health Service, the Antenatal Clinic, Continuum of Care at the Canberra Hospital, the Canberra Midwifery Program at the Centenary Hospital for Women and Children, Canberra Hospital, the Calvary Health Care Maternity Unit, Mental Health Services and related non-government services.

ACT Health also funds the Pre- and Ante-natal Depression Support and Information Service (PANDSI) to provide psychosocial support and information for women at risk of perinatal depression.

The Perinatal Mental Health Consultation Service (PMHCS) is a consultation and referral service for women with moderate to severe mental health presentations in the perinatal period. The PMHCS is a tertiary service that provides specialist opinion and treatment planning for expectant and postnatal women for up to 12 months postpartum. The service aims to improve perinatal mental health by working in collaboration with existing antenatal and postnatal services and other community health agencies. Psychiatry clinics, staffed by a multidisciplinary health professional team, provide structured therapies for women likely to benefit from a time-limited psychological approach.

PMHCS has implemented an Outreach Assessment Clinic linked to the Antenatal Clinic at the Centenary Hospital for Women and Children, Canberra Hospital. A PMHCS health specialist provides assessments for referred women who are unlikely to engage over the telephone or attend the PMHCS. This initiative also serves to strengthen the skills and knowledge of midwives at the clinic in perinatal mental health issues.

Trauma-informed care seminars for health professionals: The Women's Health Service provides interprofessional and holistic medical, nursing and counselling services for women affected by violence.

The ACT Health Family Violence policy was developed for implementation in 2013–14.

Environmental priority

Strategic outcome

Women and girls equally and fully participate in planning and sharing a safe, accessible and sustainable city.

Nil response from ACT Health.

Improving women's access to health care services and information: A strategic framework 2010–2015

Improving women's access to health care services and information: A strategic framework 2010–2015 informs the directions for the delivery of health services to ACT women up to 2015. Improving women's access to health care services and information benefits not only women but also the whole community through the diverse roles that women play. For disadvantaged and vulnerable women, improving access to health services is a significant contributor to improved health outcomes. The Women's Health Advisory Group, which comprises key community and consumer members, oversees implementation of the framework.

Highlights in 2012–13 are set out below.

- ACT Health is implementing triple bottom line annual reporting, including, where appropriate, gender impact statements.
- The national Pregnancy, Birth and Baby website is being enhanced and will include ACT-specific links to maternity information.
- The ACT Maternity Services Advisory Network is guiding the implementation of action in the national Maternity Services Plan and advising on priorities and improvements to maternity care in the region.
- The Centenary Hospital for Women and Children opened in 2012. The new hospital co-locates services, including paediatrics, maternity services, the neonatal intensive care unit, gynaecology, foetal medicine, the birth centre and specialised outpatient services, in a purpose-built three-storey building.
- Antenatal care, pre-pregnancy and teenage sexual and reproductive health (APTSRH) project: the Core of Life realities-based life education program for Aboriginal and Torres Strait Islander youth is well established across the ACT. Negotiations are underway to offer sexual health information, education and clinical services to young people in the coming year.
- National Perinatal Depression Initiative (NPDI): ACT Health services continue to offer routine and universal screening using the Edinburgh Postnatal Depression Scale for PND at antenatal and postnatal visits.
- In September 2012, ACT Health achieved Breastfeeding-Friendly Workplace accreditation.

C.25 Model Litigant Guidelines

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

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

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

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

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

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

It is important to note that, while the obligation to comply with the Model Litigant Guidelines is conferred on the agency, the ACTGS acts on behalf of the Health Directorate in all litigation and provides advice in accordance with the obligations applying under the *Law Officers Act 2011*. The ACTGS has advised that it is not aware of any breaches of the Model Litigant Guidelines in Health Directorate matters during 2012–13.

C.26 Notices of non-compliance

In 2012–13 the Health Directorate did not receive any notices of non-compliance in relation to the *Dangerous Substances Act 2004*.

Five notices of non-compliance were issued in relation to the *Work Health and Safety Act 2011:*

- Notice 5824 was issued on 14 August 2012 to the Director-General of the ACT Health Directorate. Worksafe ACT has advised that it is satisfied that all the requirements have been met and that the notice has been complied with. The notice required the directorate to review and amend its work safety systems to ensure that, if any further notifiable incidents occur at the Canberra Hospital, the incident site is not disturbed until an inspector arrives at the site or any earlier time the inspector directs. This does not prevent any actions prescribed by section 39(3) of the Act.
- Notice 5825 was issued on 14 August 2012 to the Director-General of the ACT Health Directorate. Worksafe ACT has advised that it is satisfied that all the requirements have been met and that the notice has been complied with. The notice required the directorate to ensure that the regulator is notified immediately, by the fastest possible means, after becoming aware that a notifiable incident out of the conduct of the business or undertaking has occurred at the Canberra Hospital.
- Notice 6072 was issued on 3 May 2013 to the Executive Director, Business and Infrastructure of the ACT Health Directorate. Worksafe ACT advised on 27 June 2013 that it is satisfied that all the requirements have been met and that the notice has been complied with. The notice directed the Health Directorate to implement control measures at the Canberra Hospital to eliminate or minimise risks to health and safety associated with the use of electrical equipment supplied through a socket outlet. These measures include installing appropriate residual current devices (RCD) to switchboards or portable RCD cord sets/plug adapters until switchboards have been upgraded. All reasonable steps must also be taken to ensure that the RCDs used at the workplace are tested regularly by a competent person to ensure they are operating effectively.
- Notice 6073 was issued on 3 May 2013 to the Executive Director, Business and Infrastructure of the ACT Health Directorate. Worksafe ACT advised on 27 June 2013 that it is satisfied that all the requirements have been met and that the notice has been complied with. The notice required the directorate to have a competent person undertake an electrical audit of the food preparation area and bio-medical workshop as a matter of urgency and disconnect (or isolate) any unsafe electrical equipment from the electrical supply until it is repaired or tested and found to be safe.
- Notice 6074 was issued on 3 May 2013 to the Executive Director, Business and Infrastructure of the ACT Health Directorate. Worksafe ACT advised on 27 June 2013 that it is satisfied that all the requirements have been met and that the notice has been complied with. The notice required the directorate implement control measures at the Canberra Hospital to eliminate or minimise risks to health and safety associated with the use of electrical equipment supplied through a socket outlet. These measures include installing appropriate RCDs to switchboards or portable RCD cord sets/plug adaptors until switchboards have been upgraded. All reasonable steps must also be taken to ensure that the RCDs used at the workplace are tested regularly by a competent person to ensure that they are operating effectively.

ANNEXED REPORTS

ACT Local Hospital Network Directorate Financial and Performance Statements 2012–13

Management discussion and analysis for the ACT Local Hospital Network Directorate for the financial year ended 30 June 2013

General overview

Purpose

The ACT Local Hospital Network is a new Directorate setup to receive and distribute funding for public hospital services under the National Health Reform Agreement. The ACT Local Hospital Network receives Activity Based Funding from both the Commonwealth and the ACT Governments and Block Funding including training and research. The ACT Local Hospital Network 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 Hospital.

Changes in administrative structure

The ACT Local Hospital Network commenced operation on 1 July 2012 and is administered by the Director-General of the Health Directorate and supported by Health Directorate staff.

Risk management

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

- Estimated public hospital activity is higher than the actual activity delivered by the entities in the ACT Local Hospital Network that results in a reduction to funding from the Commonwealth Government; and
- The Commonwealth Government revises the National Healthcare Specific Purpose Payment for 2013–14. The Specific Purpose Payment funding can change due to population estimates and indexation factors.

The Government and the Directorate have responded to these risks by including in the implementation of the National Health Reform Agreement two years of transition with the Commonwealth Government funding contribution limited to the Specific Purpose Payment in 2012–13 and 2013–14. The Commonwealth Government will fund 45 per cent of the growth in public hospital activity from 2014–15 and the ACT Government and the Directorate will agree on the process for managing fluctuation in activity and costs from 2014–15 during development of the budget.

In the event that there is a material reduction to the Commonwealth Government Specific Purpose Payment during 2013–14, the Directorate will consider alternative funding options including working with the Chief Minister and Treasury Directorate as necessary.

The above risks are monitored regularly throughout the year.

Financial performance

The following financial information is based on audited financial statements for 2012–13, and the forward estimates contained in the 2013–14 Budget Paper Number 4.

Total net cost of services

	Budget 2012–13 $m	Actual 2012–13 $m	Forward Estimate 2013–14 $m	Forward Estimate 2014–15 $m	Forward Estimate 2015–16 $m
Total Expenses	718.7	713.8	906.3	964.6	1,036.2
Total Own Source Revenue	289.6	165.0	356.3	397.7	442.0
Net Cost of Services	429.1	548.8	550.0	566.9	594.2

Comparison to budget

The Directorate's net cost of services for 2012–13 of $548.8 million was $119.7 million or 27.9 per cent higher than the 2012–13 budget (refer to Attachment A). The increase relates to delays in the enactment of legislation to enable the establishment of the Local Hospital Network's National Health Funding Pool bank account. As a result of the delays in legislation, Commonwealth Government funding which was to be received as Own Source Revenue was instead paid to the Chief Minister and Treasury Directorate and on-passed to the ACT Local Hospital Network Directorate as Government Payment for Outputs.

Comparison to 2011–12 actual expenses

The Directorate began operations in 2012–13 so there are no comparisons for 2011–12.

Future trends

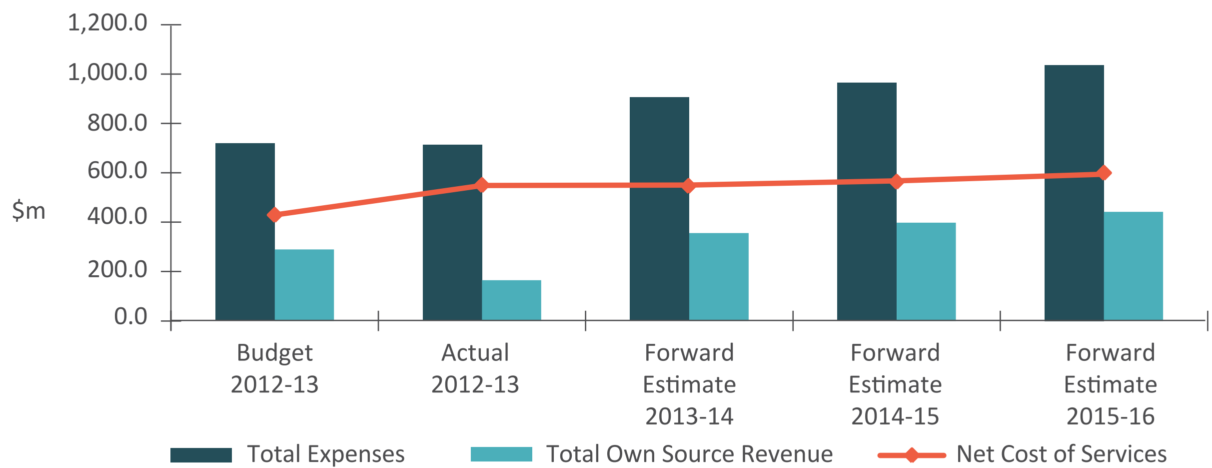


Figure 1: Net Cost of Services

As shown above in Figure 1, the net cost of services are expected to slightly rise each year through to 2015–16.

Total expenditure

Components of expenditure

Figure 2 below shows that for the financial year ended 30 June 2013, the Directorate paid 99.3 per cent of expenditure as Grants and Purchased Services ($708.9 million), and 0.7 per cent for Transfer Expenses ($4.8 million), spending a total of $713.8 million.

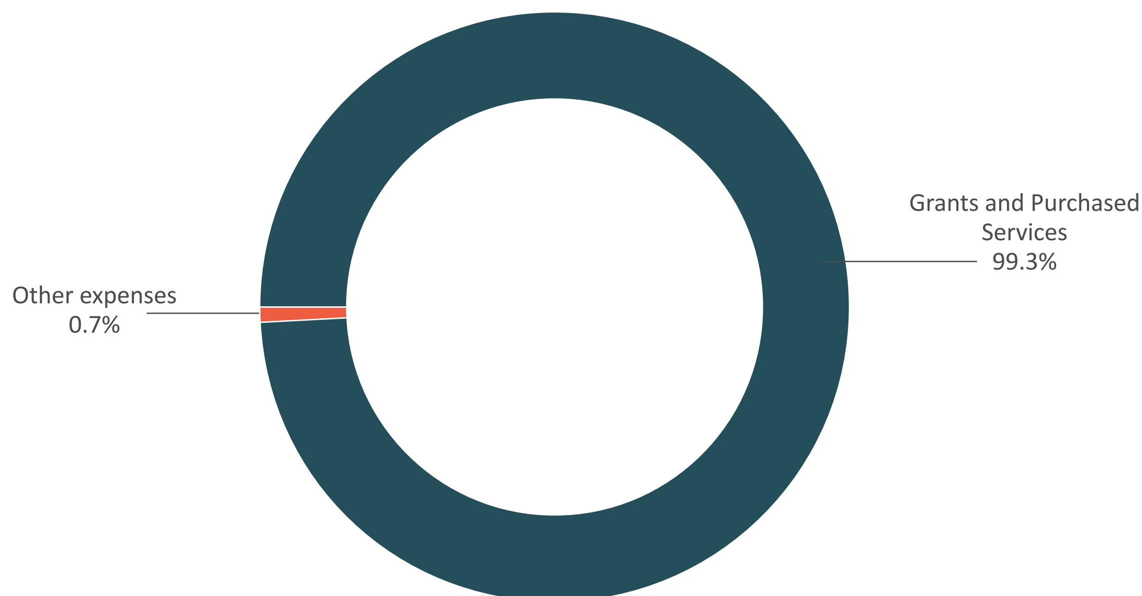


Figure 2: Components of Expenditure

Comparison to budget

Total expenses of $713.8 million were ($4.9 million), or 0.7 per cent lower than the original 2012–13 budget of $718.7 million.

This variation was predominantly due to:

- a reduction in Commonwealth Government National Healthcare funding of $3.1 million associated with population and indexation factors, and
- a change to the method for Cross Border Health payments between States and Territories. Under the new arrangements, the Commonwealth Government funded component of cross border activity is subtracted from the residents State/Territory's National Healthcare Specific Purpose Payment and paid to the provider State/Territory.

Comparison to 2011–12 actual expenses

The Directorate began operations in 2012–13 so there are no comparisons for 2011–12.

Future trends

Expenses are budgeted to steadily increase until 2015–16.

Total revenue

Components of revenue

Figure 3 below indicates that for the financial year ended 30 June 2013, the Directorate received 77.2 per cent of its total revenue of $725.3 million from Government Payment for Outputs ($560.3 million), 11.5 per cent from Cross Border User Charges ($83.3 million), with the remaining 11.3 per cent made up of Grants from the Commonwealth ($81.7 million).

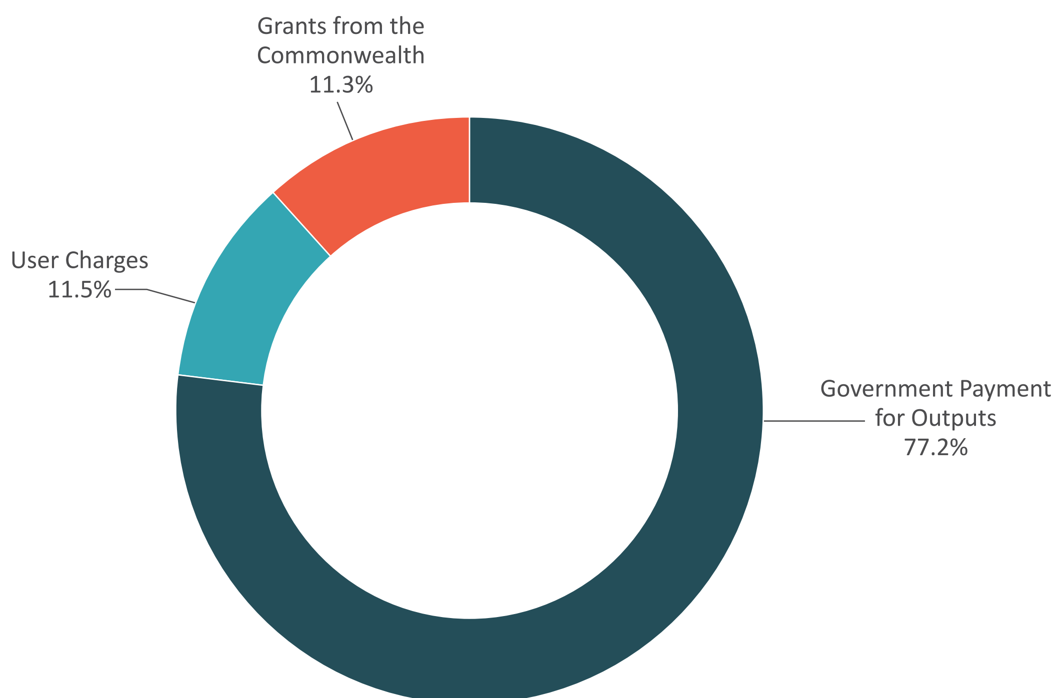


Figure 3: Components of Own Source Revenue

Comparison to budget

Own source revenue for the year ending 30 June 2013 was $165.0 million, which was $124.6 million or 43.0 per cent lower than the 2012–13 budget of $289.6 million. The reduction is due to delays in the enactment of legislation to enable the establishment of the Local Hospital Network's National Health Funding Pool bank account. As a result of the delays in legislation, Commonwealth Government funding which was to be received as own source revenue was instead paid to the Chief Minister and Treasury Directorate and on-passed to the ACT Local Hospital Network Directorate as Government Payment for Outputs. In addition, there was a reduction in Commonwealth Government National Healthcare funding of $3.1 million associated with population and indexation factors.

Comparison to 2011–12 actual income

The Directorate began operations in 2012–13 so there are no comparisons for 2011–12.

Future trends

Total own source revenue is expected to increase steadily until 2015–16.

Financial position

The purpose of the Directorate is to receive Activity Based and Block Funding from the National Health Funding Pool created under the National Health Reform Agreement, and to purchase hospital services from ACT public hospitals. The ACT Local Hospital Network Directorate was never intended to have assets nor liabilities on its balance sheet, therefore no budget was set.

Total assets

Components of total assets

Figure 4 below indicates that, as at 30 June 2013, the Directorate held 97.3 per cent of its assets in receivables.

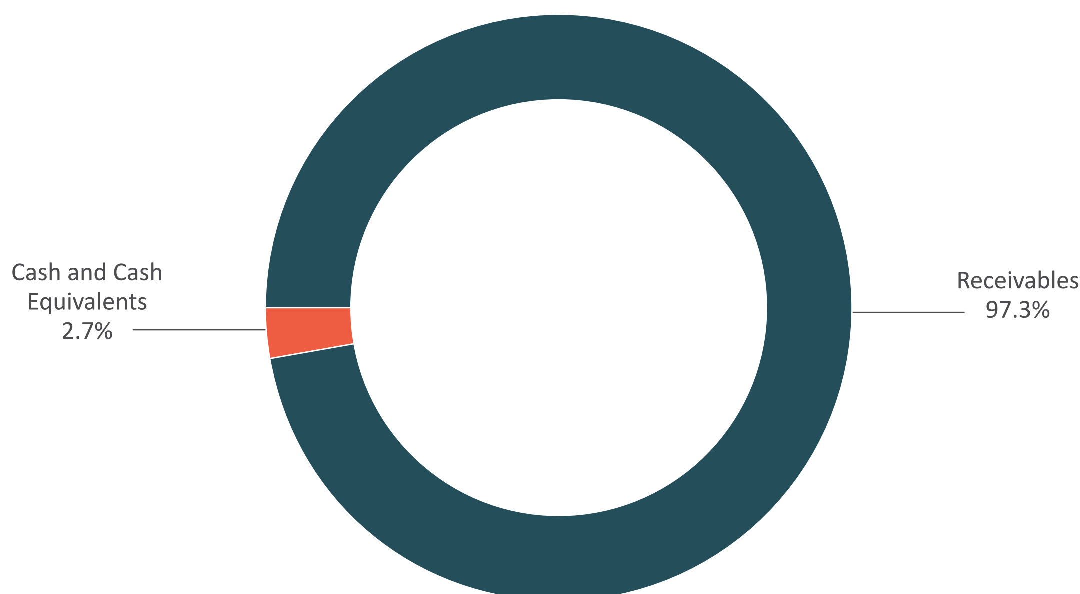


Figure 4: Total Assets as at 30 June 2013

Comparison to budget

The total asset position as at 30 June 2013 is $86.8 million, which is $86.8 million higher than the 2012–13 budget of $0 million.

The variance reflects the increase in:

- Cash and Cash Equivalents ($2.3 million)—due to the provision of a cash buffer from Chief Minister and Treasury Directorate to allow for the timing of Goods and Services Tax (GST) transactions; and
- Receivables ($84.5 million)—which relates to the cross border receivables from New South Wales and an Australian Taxation Office refund for GST.

Comparison to 2011–12 actual

The Directorate began operations in 2012–13 so there are no comparisons for 2011–12.

Total liabilities

Components of total liabilities

Figure 5 below indicates that 100 per cent of the Directorate's liabilities relates to payables.

Figure 5: Total Liabilities as at 30 June 2013

Comparison to budget

The Directorate's liabilities as at 30 June 2013, of $71.8 million, is $71.8 million higher than the 2012–13 budget of $0 million.

This is due to higher payables ($71.8 million) which relates to cross border payments to the New South Wales Government and the ACT Health Directorate.

Comparison to 2011–12 actual

The Directorate began operations in 2012–13 so there are no comparisons for 2011–12.

Net assets

The Directorate's net assets as at 30 June 2013 was $15.0 million higher than the nil position budgeted.

This is mainly due to cross border revenue of $114.1 million being higher than the budget of $102.6 million, and capital injection of $3.5 million to cover timing of GST refunds from the Australian Taxation Office.

Attachment A—Comparison of net cost of services to budget 2012–13

	Original Budget	Plus AAO Transfers	Total Funding	Less Actual	Variance to be Explained	
Description	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**%**
Expenses						
Purchased Services	696,592	–	696,592	708,909	–12,317	–1.77%
Other Expenses	17,418	–	17,418	–	17,418	100.00%
Transfer Expenses	4,730	–	4,730	4,842	–112	–2.36%
Total Expenses	**718,740**	**–**	**718,740**	**713,751**	**4,989**	**0.69%**
Own Source Revenue						
User Charges	120,000	–	120,000	83,300	36,700	30.58%
Grants from Commonwealth	169,605	–	169,605	81,695	87,910	51.83%
Other Revenue	–	–	–	–	–	–
Total Own Source Revenue	**289,605**	**–**	**289,605**	**164,995**	**124,610**	**43.03%**
Total Net Cost of Services	**429,135**	**–**	**429,135**	**548,755**	**– 119,620**	**–27.87%**

ACT AUDITOR-GENERAL'S OFFICE

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 2013 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
Telephone: 02 6207 0833 | Facsimile: 02 6207 0826 | Email: actauditorgeneral@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 2013:

(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 2013 and the results of its operations and cash flows for the year then ended.

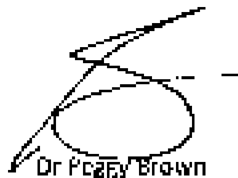
This audit opinion should be read in conjunction with the other information disclosed in this report.

Dr Maxine Cooper
Auditor-General
9 September 2013

ACT Local Hospital Network Directorate
Financial Statements
For the Year Ended 30 June 2013

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 2013 and the financial position of the Directorate on that date.



Dr Peggy Brown

Director-General

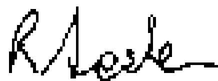
ACT Local Hospital Network Directorate

9 September 2013

ACT Local Hospital Network Directorate
Financial Statements
For the Year Ended 30 June 2013

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 2013 and the financial position of the Directorate on that date.



Mr Ron Foster

Chief Finance Officer

ACT Local Hospital Network Directorate

9 September 2013

ACT Local Hospital Network Directorate Controlled Financial Statements For the Year Ended 30 June 2013

ACT Local Hospital Network Directorate Operating Statement For the Year Ended 30 June 2013

	Note No.	Actual 2013 $'000	Original Budget 2013 $'000
Income			
Revenue			
Government Payment for Outputs	3	560,272	429,135
User Charges – Non-ACT Government	4	83,300	120,000
Grants from the Commonwealth	5	81,695	169,605
Total Revenue		**725,267**	**718,740**
Total Income		**725,267**	**718,740**
Expenses			
Grants and Purchased Services	6	708,909	696,592
Other Expenses[a]		–	17,418
Transfer Expenses	7	4,842	4,730
Total Expenses		**713,751**	**718,740**
Operating Surplus		**11,516**	**–**
Total Comprehensive Income		**11,516**	**–**

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

There are no prior year comparative figures because the ACT Local Hospital Network Directorate commenced operations on 1 July 2012.

a. Although 'Cross Border Health Costs' payable to New South Wales was budgeted on this line, the actual costs of $15.5 million have been reclassified and included with 'Grants and Purchased Services'.

ACT Local Hospital Network Directorate Balance Sheet As at 30 June 2013

	Note No.	Actual 2013 $'000	Original Budget 2013 $'000
Current Assets			
Cash and Cash Equivalents	11	2,323	–
Receivables	12	84,477	–
Total Current Assets		**86,800**	**–**
Total Assets		**86,800**	**–**
Current Liabilities			
Payables	13	71,784	–
Total Current Liabilities		**71,784**	**–**
Total Liabilities		**71,784**	**–**
Net Assets		**15,016**	**–**
Equity			
Accumulated Funds		15,016	–
Total Equity		**15,016**	**–**

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

There are no prior year comparative figures because the ACT Local Hospital Network Directorate commenced operations on 1 July 2012.

ACT Local Hospital Network Directorate Statement of Changes in Equity For the Year Ended 30 June 2013

	Accumulated Funds Actual 2013 $'000	Total Equity Actual 2013 $'000	Original Budget 2013 $'000
Balance at the Beginning of the Reporting Period	–	–	–
Comprehensive Income			
Operating Surplus	11,516	11,516	–
Total Comprehensive Income	**11,516**	**11,516**	**–**
Transactions Involving Owners Affecting Accumulated Funds			
Capital Injections	3,500	3,500	–
Total Transactions Involving Owners Affecting Accumulated Funds	**3,500**	**3,500**	**–**
Balance at the End of the Reporting Period	**15,016**	**15,016**	**–**

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

ACT Local Hospital Network Directorate Cash Flow Statement For the Year Ended 30 June 2013

	Note No.	Actual 2013 $'000	Original Budget 2013 $'000
Cash Flows from Operating Activities			
Receipts			
Government Payment for Outputs		560,272	429,135
User Charges		–	120,000
Grants received from Commonwealth		81,695	169,605
Goods and Services Tax Input Tax Credits from the Australian Taxation Office		14,372	–
Total Receipts from Operating Activities		**656,339**	**718,740**
Payments			
Grants and Purchased Services		637,125	696,592
Goods and Services Tax Paid to Suppliers		15,549	–
Other		–	17,418
Payments to Health Directorate		4,842	4,730
Total Payments from Operating Activities		**657,516**	**718,740**
Net Cash Outflows from Operating Activities	**18**	**(1,177)**	**–**
Cash Flows from Financing Activities			
Receipts			
Capital Injections		3,500	–
Total Receipts from Financing Activities		**3,500**	**–**
Net Cash Inflows from Financing Activities		**3,500**	**–**
Net Increase in Cash and Cash Equivalents		**2,323**	**–**
Cash and Cash Equivalents at the End of the Reporting Period		**2,323**	**–**

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

There are no prior year comparative figures because the ACT Local Hospital Network Directorate commenced operations on 1 July 2012.

ACT Local Hospital Network Directorate Controlled Statement of Appropriation For the Year Ended 30 June 2013

	Original Budget 2013 $'000	Total Appropriated 2013 $'000	Appropriation Drawn 2013 $'000
Controlled			
Government Payment for Outputs	429,135	560,272	560,272
Capital Injections	–	3,500	3,500
Total Controlled Appropriation	**429,135**	**563,772**	**563,772**

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

There are no prior year comparative figures because the ACT Local Hospital Network Directorate commenced operations on 1 July 2012.

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 is due to delays in enacting legislation, the *Health (National Health Funding Pool and Administration) Act 2013*, to establish the ACT State Pool account under the National Health Reform Agreement. The delays in establishing the ACT State Pool Account resulted in Grants from the Commonwealth under the National Health Reform Agreement (including a component of cross border revenue) not being able to be received by the Directorate. This amount was paid to the Chief Minister and Treasury Directorate until March 2013, amounting to $131.1 million, which was then paid to the Directorate as Government Payment for Outputs.

Capital Injection

The difference between the Original Budget and Total Appropriated to the Directorate is due to the need for provision of a cash buffer to deal with the delay between outflows of GST and the receiving of input tax credits from the Australian Taxation Office.

ACT Local Hospital Network Directorate Controlled Note Index

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Note 1. Objectives of the ACT Local Hospital Network Directorate

Operations and Principal Activities

In 2011 the ACT Government become a signatory to the National Health Reform Agreement which introduced new financial and governance arrangements for Australian public hospital services and new arrangements for primary health care and aged care.

On 29 March 2011, the ACT Government took the first step toward implementing the ACT Local Hospital Network when the ACT Legislative Assembly passed amendments to the *Health Act 1993*. These amendments provided a legislative basis for the establishment of the ACT Local Hospital Network Directorate (the Directorate) and a skill-based ACT Local Hospital Council (Council).

The Directorate commenced operation on 1 July 2012 and is administrated by the Director-General of the Health Directorate and supported by Health Directorate staff.

The Council provides advice to the Director-General on the clinical and corporate governance framework needed to support improvement of standards of patient care and services under the local hospital network and ways in which to support, encourage and facilitate community and clinician involvement in the planning of services that form part of the Directorate.

The Council also reports to the Minister for Health on the state of the local hospital network and any recommendations relating to the improvement of health services provided by the Directorate that the Council considers necessary.

The Directorate receives Activity Based Funding from the Commonwealth and ACT Governments and block funding for teaching, training 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 Accounting

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

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

i. an Operating Statement for the year;

ii. a Balance Sheet at the end of the year;

iii. a Statement of Changes in Equity for the year;

iv. a Cash Flow Statement for the year;

v. a Statement of Appropriation for the year;

vi. an Operating Statement for each class of output for the year;

vii. a summary of the significant accounting policies adopted for the year; and

viii. such other statements as are necessary to fairly reflect the financial operations of the Directorate during the year and its financial position at the end of the year.

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

i. Australian Accounting Standards; and

ii. ACT Accounting and Disclosure Policies.

The 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.

(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 2013 together with the financial position of the Directorate as at 30 June 2013.

Note 2. Summary of Significant Accounting Policies (Continued)

(d) Comparative Figures

Budget Figures

To facilitate a comparison with Budget Papers, as required by the *Financial Management Act 1996,* budget information for 2012-2013 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 are not provided because the Directorate commenced operations on 1 July 2012.

(e) Rounding

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

(f) Revenue Recognition

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

Cross Border (Interstate) Health Revenue

Revenue for cross border (interstate) health services is recognised when the number of patients and complexities of treatments provided can be measured reliably using the National Efficient price that is determined by the Independent Hospital Pricing Authority. Actual patient numbers and services are settled following an acquittal process undertaken in subsequent years and variations to the revenue recognised is accounted for in the year of settlement.

The National Health Reform Agreement specifies that each jurisdiction will make funding contributions through the National Health Funding Pool for services provided by other jurisdictions to its residents either on an ad hoc basis reflecting actual activity, or on a regular basis as scheduled through a Cross Border agreement.

Commonwealth Grants

Commonwealth Grants relate to Activity Based Funding and Block Funding under the National Health Reforms. They also include the Commonwealth funding component of cross border health costs for New South Wales residents treated in ACT public hospitals.

Activity Based Funding refers to a system for funding public hospital services provided to individual patients using national classifications, price weights and nationally efficient price as set by the Independent Hospital Pricing Authority.

Block funding is provided to support public hospital functions that are recognised by the Independent Hospital Pricing Authority as services acceptable to be funded on this basis and that conform to the Independent Hospital Pricing Authority's national pricing model.

Commonwealth grants in 2012–13 were based on the former National Healthcare Specific Purpose Payment method. Commonwealth funding to states and territories becomes uncapped and will be informed by the Independent Hospital Pricing Authority's pricing model from 2014–15.

Note 2. Summary of Significant Accounting Policies (Continued)

(g) Waivers of Debt

Debts that are waived during the year under Section 131 of the *Financial Management Act 1996* are expenses during the year in which the right to payment was waived. Further details of waivers are disclosed at Note 9: Waivers, Impairment Losses and Write-Offs.

(h) Current and Non-Current Items

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

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

(i) Cash and Cash Equivalents

For the purposes of the Cash Flow Statement and the Balance Sheet, cash includes cash at bank and cash on hand. Cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and which are subject to an insignificant risk of changes in value.

(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 New South Wales patients treated in an ACT public hospital for the 2012–13 financial year. Under the National Health Reform Agreement, States and Territories are required to pay for Cross Border activity using the National Efficient Price that is determined by the Independent Hospital Pricing Authority. The actual level of revenue will be subject to an acquittal process to be completed in subsequent years.

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

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

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

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

Note 2. Summary of Significant Accounting Policies (Continued)

(k) Payables

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

(l) Employee Costs and Employee Benefits Liabilities

The Directorate was established as a consequence of the ACT implementing the National Health Reform Agreement. The objective of the Directorate is to receive Activity Based Funding and Block Funding from the Commonwealth and ACT Governments, and to purchase hospital services from ACT public hospitals. The Directorate does not employ any staff. All staff providing administrative support are employed by the Health Directorate. Therefore, the Directorate does not incur any employee costs and does not have any employee benefit liabilities.

(m) Equity Contributed by the 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) Significant Accounting Judgements and Estimates

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

Cross Border (Interstate) Health Receivables: is an estimation based on the number of interstate patients converted into a National Weighted Activity Unit and paid at the National Efficient Price consistent with the National Health Reform Agreement. Interstate patient numbers for the current year is an estimation based on the actual patient numbers for the nine months to 31 March 2013. Actual patient numbers and services are settled following an acquittal process undertaken in subsequent years and variations to the revenue recognised are accounted for in the year of settlement.

Note 2. Summary of Significant Accounting Policies (Continued)

(o) Impact of Accounting Standards Issued but Yet to be Applied

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

- AASB 9 Financial Instruments (application date 1 January 2015);
- AASB 13 Fair Value Measurement (application date 1 January 2013);
- AASB 1055 Budgetary Reporting (application date 1 July 2014);
- AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Interpretations 2, 5, 10, 12, 19 & 127] (application date 1 January 2015);
- AASB 2011-7 Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards [AASB 1, 2, 3, 5, 7, 9, 2009–11, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 139, 1023 & 1038 and Interpretations 5, 9, 16 & 17] (application date 1 January 2013 for for-profit entities and 1 January 2014 for not-for-profit entities);
- AASB 2011-8 Amendments to Australian Accounting Standards arising from AASB 13 [AASB 1, 2, 3, 4, 5, 7, 9, 2009–11, 101, 107, 112, 118, 119, 120, 121, 128, 131, 132, 133, 134, 136, 138, 139, 140, 141, 1004, 1023 & 1038 and Interpretations 2, 4, 12, 13, 14, 17, 19, 131 & 132] (application date 1 January 2013);
- AASB 2011–10 Amendments to Australian Accounting Standards arising from AASB 119 (September 2011) [AASB 1, AASB 8, AASB 101, AASB 124, AASB 134, AASB 1049 & AASB 2011-8 and Interpretation 14] (application date 1 January 2013);
- AASB 2012-2 Amendments to Australian Accounting Standards – Disclosures – Offsetting Financial Assets and Financial Liabilities [AASB 7 & AASB 132] (application date 1 January 2013);
- AASB 2012-3 Amendments to Australian Accounting Standards – Offsetting Financial Assets and Financial Liabilities [AASB 132] (application date 1 January 2014);
- AASB 2012-5 Amendments to Australian Accounting Standards arising from Annual Improvements 2009–2011 Cycle [AASB 1, AASB 1010, AASB 116, AASB 132 & AASB 134 and Interpretation 2] (application date 1 January 2013);
- AASB 2012-6 Amendments to Australian Accounting Standards – Mandatory Effective Date AASB 9 and Transition Disclosures [AASB 9, AASB 2009–11, AASB 2010-7 & AASB 2011-8] (application date 1 January 2013);
- AASB 2012–10 Amendments to Australian Accounting Standards – Transition Guidance and Other Amendments [AASB 1, 5, 7, 8, 10, 11, 12, 13, 101, 102, 108, 112, 118, 119, 127, 128, 132, 133, 134, 137, 1023, 1038, 1039, 1049 & 2011-7 and Interpretation 12] (application date 1 January 2013); and
- AASB 2013-3 Amendments to AASB 136 – Recoverable Amount Disclosures for Non–Financial Assets (application date 1 January 2014).

Note 3. Government Payment for Outputs

Government Payment for Outputs is revenue received from the ACT Government for the purchase of hospital services from ACT public hospitals. The ACT Government pays Government Payment for Outputs appropriation on a fortnightly basis.

	2013 $'000
Revenue from the ACT Government	
Government Payment for Outputs[a]	560,272
Total Government Payment for Outputs	**560,272**

a. Government Payment for Outputs is to fund the purchase of hospital services from public hospitals in the ACT.

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 state or territory governments. This revenue is driven by demand for health services from interstate patients and is not for profit in nature.

	2013 $'000
User Charges – Non-ACT Government	
Cross Border (Interstate) Health Revenue[a]	83,300
Total User Charges – Non-ACT Government	**83,300**

a. Cross Border (Interstate) Health Revenue relates to revenue earned at the National Efficient Price for the treatment of residents from New South Wales in ACT public hospitals.

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.

	2013 $'000
Grants from the Commonwealth	
Grants	81,695
Total Grants from the Commonwealth	**81,695**

Note 6. Grants and Purchased Services

Grants and Purchased Services reflect public hospital payments to the Canberra Hospital, Calvary Public Hospital, Clare Holland House and Queen Elizabeth II Hospital.

	2013 $'000
Purchased Services	
Payments to Service Providers	
Canberra Hospital	537,917
Calvary Public Hospital	148,517
Clare Holland House	4,564
Queen Elizabeth II Hospital	2,410
Cross Border (Intertstate) Health Costs – New South Wales	15,501
Total Grants and Purchased Services	**708,909**

Note 7. Transfer Expenses

Transfer Expenses relate to the on-passing of Commonwealth public health funding to the Health Directorate.

	2013 $'000
Transfer Expenses	4,842
Total Transfer Expenses	**4,842**

Note 8. Auditor's Remuneration

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

	2013 $'000
Audit Services	
Audit fees paid to the ACT Auditor-General's Office	50
Total Audit Fees	**50**
No other services were provided by the ACT Auditor-General's 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.

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 the reporting period.

Note 11. Cash and Cash Equivalents

The Directorate holds a number of bank accounts on which it does not earn interest. In 2012–13 as part of the whole-of-government banking arrangements, the Directorate transitioned banking services from the Commonwealth Bank to Westpac Banking Corporation. These funds are able to be withdrawn upon request.

	2013 $'000
Cash at Bank	2,323
Total Cash and Cash Equivalents	**2,323**

Note 12. Receivables

	2013 $'000
Current Receivables	
Accrued Revenue[a]	83,300
	83,300
Net GST Receivables	1,177
	1,177
Total Current Receivables	**84,477**
Total Receivables	**84,477**

a. Accrued revenue consists of cross border receivable owed from the New South Wales Ministry of Health for admitted and non-admitted patient services provided to residents of New South Wales.

Note 12. Receivables (Continued)

Ageing of Receivables	Not Overdue $'000	Past Due Less Than 30 days $'000	Past Due 30 to 60 days $'000	Past Due Greater Than 60 days $'000	Total $'000
2013					
Not Impaired Receivables[a]	84,477	–	–	–	84,477
Impaired Receivables	–	–	–	–	–

a. This mainly relates to cross border receivables, which is funding due from the New South Wales Ministry of Health for admitted and non-admitted patient services provided to residents of New South Wales. 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. $63.1 million of the net Receivable owing (ie $83.3 million as disclosed above minus $15.5 million owed to the New South Wales Government as disclosed in Note 13: Payables) to the Directorate was received on 27 August 2013 as an initial payment, until the full year reconciliation has been finalised.

Classification of ACT Government/Non-ACT Government Receivables	2013 $'000
Receivables with Non-ACT Government Entities	
Net Other Receivables	83,300
Net Good and Services Tax Receivables	1,177
Total Receivables with Non-ACT Government Entities	**84,477**
Total Receivables	**84,477**

Note 13. Payables

	2013 $'000
Current Payables	
Accrued Expenses[a]	71,784
Total Current Payables	**71,784**
Total Payables	**71,784**

a. Accrued expenses consists of cross border payables owed to the Health Directorate and the New South Wales Ministry of Health for admitted and non-admitted patient services provided to residents of New South Wales in the Canberra Hospital and Health Services and residents of the ACT in New South Wales hospitals respectively.

	2013 $'000
Payables are aged as follows:	
Not Overdue	71,784
Overdue for Less than 30 Days	–
Overdue for 30 to 60 Days	–
Overdue for More than 60 Days	–
Total Payables	**71,784**
Classification of ACT Government/Non-ACT Government Payables	
Payables with ACT Government Entities	
Accrued Expenses[a]	56,283
Total Payables with ACT Government Entities	**56,283**
Payables with Non-ACT Government Entities	
Accrued Expenses[b]	15,501
Total Payables with Non-ACT Government Entities	**15,501**
Total Payables	**71,784**

a. This is cross border payables owed to the Health Directorate for admitted and non-admitted patient services provided to residents of New South Wales in the Canberra Hospital and Health Services.

b. This is cross border payables owed to the New South Wales Ministry of Health for admitted and non-admitted patient services provided to residents of the ACT in New South Wales hospitals.

Note 14. 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 Bank 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 the Directorate holds no investments.

The Directorate's receivables consist of amounts owed from the New South Wales Ministry of Health. As the New South Wales Government has a AAA credit rating it is considered that there is a very low risk of default for these receivables.

Liquidity Risk

Liquidity risk is the risk that the Directorate will encounter difficulties in meeting obligations associated with financial liabilities that are settled by delivering cash or another financial asset.

The main source of cash to pay these obligations is appropriation from the ACT Government which is paid on a fortnightly basis during the year. The Directorate manages its liquidity risk through forecasting appropriation drawdown requirements to enable payment of anticipated obligations.

Price Risk

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

Note 14. 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 2013 $'000	Fair Value 2013 $'000
Financial Assets		
Cash and Cash Equivalents	2,323	2,323
Receivables	84,477	84,477
Total Financial Assets	**86,800**	**86,800**
Financial Liabilities		
Payables	71,784	71,784
Total Financial Liabilities	**71,784**	**71,784**

The following table sets out the Directorate's maturity analysis for financial assets and liabilities as well as the exposure to interest rates, including average weighted interest rates by maturity period as at 30 June 2013. All financial assets and liabilities which have a floating interest rate or are non-interest bearing will mature in 1 year or less. All amounts appearing in the following maturity analysis are shown on an undiscounted cash flow basis.

				Fixed Interest Maturing in:				
	Note No.	Weighted Average Interest Rate	Floating Interest Rate $'000	1 Year or Less $'000	Over 1 to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	11		–	–	–	–	2,323	2,323
Receivables	12		–	–	–	–	84,477	84,477
Total Financial Assets			**–**	**–**	**–**	**–**	**86,800**	**86,800**
Financial Liabilities								
Payables	13		–	–	–	–	71,784	71,784
Total Financial Liabilities			**–**	**–**	**–**	**–**	**71,784**	**71,784**
Net Financial Assets			**–**	**–**	**–**	**–**	**15,016**	**15,016**

Note 14. Financial Instruments (Continued)

	2013 $'000
Carrying Amount of Each Specified Category of Financial Asset and Financial Liability	
Financial Assets	
Loans and Receivables Measured at Amortised Cost	84,477
Financial Liabilities	
Financial Liabilities Measured at Amortised Cost	71,784

Fair Value Hierarchy

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

Note 15. Commitments

The Directorate has no commitments as at 30 June 2013.

Note 16. Contingent Liabilities and Contingent Assets

There were no contingent liabilities or contingent assets as at 30 June 2013.

There were no indemnities as at 30 June 2013.

Note 17. Events Occurring After Balance Date

There were no events occurring after the balance date, which would affect the financial statements as at 30 June 2013, or in the future reporting periods.

Note 18. 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	
	2013 $'000
Total Cash and Cash Equivalents Recorded in the Balance Sheet	2,323
Cash and Cash Equivalents at the end of the reporting period as recorded in the Cash Flow Statement	**2,323**

b. Reconciliation of Net Cash Outflows from Operating Activities to the Operating Surplus/(Deficit)	
	2013 $'000
Operating Surplus	11,516
Cash Before Changes in Operating Assets and Liabilities	**11,516**
Changes in Operating Assets and Liabilities	
(Increase) in Receivables	(84,477)
Increase in Payables	71,784
Net Changes in Operating Assets and Liabilities	**(12,693)**
Net Cash Outflows from Operating Activities	**(1,177)**

Note 19. Service Concession Assets

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

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

The amount of funding provided for in the 2012–13 financial year was $167.8 million in recurrent funding, recognised in the Health Directorate's ($14.7 million) and ACT Local Hospital Network Directorate's ($153.1 million) grants and purchased services expenditure, and $0.7 million for capital upgrades of assets subject to these service concession arrangements. This is recognised as Territorial grants expenditure.

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

ACT Local Hospital Network Directorate Statement of Performance

ACT AUDITOR-GENERAL'S OFFICE

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) has been reviewed.

Responsibility for the statement of performance

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

The auditor's responsibility

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

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

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

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

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

Electronic presentation of the statement of performance

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

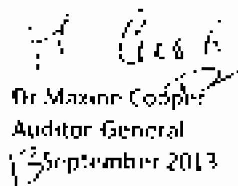
Independence

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

Review opinion

Based on the review procedures, no matters have come to my attention which indicate that the results of the accountability indicators, reported in the statement of performance of the Directorate for the year ended 30 June 2013, 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.

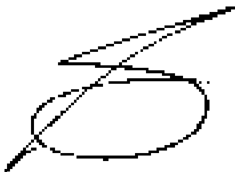


Dr Maxine Cooper
Auditor-General
13 September 2013

ACT Local Hospital Network Directorate
Statement of Performance
For the Year Ended 30 June 2013

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 2013 and also fairly reflects the judgements exercised in preparing it.



Dr Peggy Brown
Director-General
Health Directorate
13 September 2013

Output Class 1: ACT Local Hospital Network

Description

The ACT Local Hospital Network receives funding under National Health Reform Agreement and purchases public hospital services from Canberra Hospital, Calvary Public Hospital, Clare Holland House and Queen Elizabeth II Hospital.

	Original Target 2012–13	Amended Target 2012–13	Actual Result 2012–13	% Variance from Original/ Amended Target[1]	Explanation of Material Variances	Notes
Total cost ($000's)	718,740		713,751	(7%)	The variance in total costs follows a reduction in Commonwealth National Healthcare Specific Purpose Payment funding linked to population and indexation adjustments.	
Government payment for outputs (GPO) ($000's)	429,135	542,282	560,272	3%	The increase to the original target follows the approval of a Supplementary Appropriation due to delays in legislation to enable the operation of the ACT State Pool Account. The 3% increase in GPO from the amended target relates to a change to the payment arrangements for Cross Border activity between States and Territories.	
Accountability Indicators						
1. Number of national weighted activity units	117,494		120,748	3%		2
1.1 Acute Services – Calvary Public Hospital[3]						
a. Cost weighted patient separations	24,844		22,002	(11%)	The Original Target for 2012–13 included total activity for mental health, cancer, aged care and rehabilitation services and Clare Holland House (reported at outputs 1.2, 1.3, 1.4 and 1.5 respectively). The removal of the targets for outputs 1.2, 1.3, 1.4, 1.5 would reduce the target for 2012–13 to 21,742, which is closely matched by the result for the period.	4
b. Non-admitted occasions of services	53,736		58,576	9%	Calvary Hospital outpatient services have experienced significant growth in all areas in 2012–13.	5

Notes

1. If the target has not been amended the variance is from the original target, otherwise the variance is from the amended target.
2. National weighted activity unit is the 'currency' that is used to express the price weights for all services that are funded on an activity basis.
3. These measures relates to Calvary Public Hospital only, for similar measures related to Canberra Hospital, refer to the Health Directorate Performance Report.
4. Cost weighted separations for all hospital episodes at Calvary Public Hospital, excluding those reported elsewhere (Mental Health, Cancer Services and Aged Care and Rehabilitation Service) and unqualified neonates (well babies, who are counted as part of their mother's admission). Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of activity performed.
5. Non-admitted patient services provided at Calvary Public Hospital, excluding those services provided by Mental Health, Cancer Services and the Aged Care and Rehabilitation Service.

Output Class 1: ACT Local Hospital Network (Continued)

	Original Target 2012–13	Actual Result 2012–13	% Variance from Original Target	Explanation of Material Variances	Notes
1.1 Acute Services – Calvary Public Hospital (Continued)[3]					
c. Percentage of category one elective surgery patients who receive surgery within 30 days of listing	97%	97%	–		6
1.2 Mental Health – Calvary Public Hospital[3]					
a. Cost weighted separations	1,424	1,256	(12%)	The variance relates to a drop in demand for services at Calvary Ward 2N.	7
b. Admitted patient separations	670	493	(26%)	The variance relates to a drop in demand for services at Calvary Ward 2N.	8
c. Percentage of clients with outcome measures completed	65%	88%	35%	The 2012–13 target of 65% was set in-line with the target for the Health Directorate which includes community based services. Calvary Hospital clients are all inpatients and as a result have a higher rate of outcome measures completed.	9
d. The proportion of clients contacted by a Health Directorate community facility during the 7 days post discharge from the inpatient services	75%	76%	1%		10
1.3 Cancer Services – Calvary Public Hospital[3]					
a. Cost weighted admitted patient separations	271	249	(8%)	Calvary manages a relatively small number of cost weighted inpatient separations that are directly related to cancer admissions (totalling less than 1% of all separations). The small numbers can result in major fluctuations within and between years.	11

Notes

6. Category one patients are those assessed by the treating medical officer as the highest priority for elective surgery requiring surgery within 30 days of assessment by a surgeon at Calvary Public Hospital.
7. Cost weighted separations for mental health relate to the Ward 2N and the Older Person's Mental Health Inpatient Unit (OPMHIU) at Calvary Public Hospital. Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of activity performed. Ward 2N is the mental health inpatient unit at Calvary Public Hospital.
8. Raw separations from Calvary Public Hospital Ward 2N and OPMHIU. Raw separations count the number of inpatient hospital episodes.
9. Percentage of inpatient clients admitted to Calvary Public Hospital Ward 2N and OPMHIU with mandatory outcome measures completed per admission episode. The purpose of measuring clinical outcomes is to see whether consumers of public mental health services are getting better as a result of the services they receive.
10. The proportion of mental health clients admitted to Calvary Public Hospital and contacted by Mental Health Community Services during the 7 days post discharge from hospital.
11. Inpatient cost weighted activity for patients of the Cancer Services at Calvary Public Hospital. Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of activity performed.

Output Class 1: ACT Local Hospital Network (Continued)

	Original Target 2012–13	Actual Result 2012–13	% Variance from Original Target	Explanation of Material Variances	Notes
1.3 Cancer Services – Calvary Public Hospital (Continued)[3]					
b. Non-admitted occasions of service	2,620	3,070	17%	The variance is due to increased demand for services within these cancer units. Significant growth has occurred in Medical Oncology.	12
1.4 Rehabilitation and Aged Care – Calvary Public Hospital[3]					
a. Cost weighted admitted patient separations	789	745	(6%)	The variance is due to less complex patients requiring treatment in 2012–13. While there has been an increase in the number of rehabilitation patients in 2012–13 compared to 2011–12, the average length of stay for these patients has decreased when compared with the previous year due to a decrease in acuity.	13
b. Sub acute service – episodes of care	256	270	5%	The average length of stay for rehabilitation patients has reduced significantly over the past year. This improvement in discharging people from hospital to home or to more appropriate services has resulted in an increase in throughput for the services.	14
c. Sub acute service – occupied bed days	9,500	6,937	(27%)	The variance is due to difficulties in the recruitment of specialist geriatricians, a reduction in demand for services and reduced length of stay (on average) for rehabilitation patients.	15
1.5 Clare Holland House[16]					
a. Cost weighted patient separations	618	618	–		17

Notes

12. Medical oncology outpatient services at Calvary Public Hospital.
13. Inpatient cost weighted activity for patients of the Aged Care and Rehabilitation Service at Calvary Public Hospital. Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of activity performed.
14. The total number of persons separated from the sub-acute services at Calvary Public Hospital.
15. Total number of persons separated from the sub-acute service at Calvary Public Hospital.
16. This measure relates to Clare Holland House, for similar measures related to Canberra Hospital, refer to the Health Directorate Performance Report.
17. Inpatient cost weighted activity for patients of the Clare Holland House. Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of activity performed.

ACT Local Hospital Network strategic indicators

On 29 March 2011, the ACT Government took the first step towards implementing the ACT Local Hospital Network (ACT LHN) when the ACT Legislative Assembly passed amendments to the *Health Act 1993*. These amendments provided a legislative basis for the establishment of the ACT LHN and a skill-based ACT LHN Council.

The ACT LHN consists of a networked system that will hold service contracts with ACT Health. The ACT LHN comprises the Canberra Hospital, Calvary Public Hospital, Clare Holland House (CHH) and the Queen Elizabeth II Family Centre (QEII).

Under the reforms outlined in the National Health Reform Agreement, the ACT Government will continue to manage system-wide public hospital service planning and performance, including the purchasing of public hospital services and capital planning, and will be responsible for the management of the performance of the ACT LHN.

Performance of the ACT LHN will be subject to a national performance framework (the Health Performance Framework) to be administered by the independent National Performance Authority. The framework will include a range of performance indicators that will be publicly available on the MyHospitals website and will outline a remediation process to be implemented for underperforming LHNs.

The ACT and the Commonwealth have agreed to a networked service arrangement. This means the ACT Government will not have a single service agreement with the ACT LHN but will have four separate service agreements with each constituent entity of the ACT LHN.

The following strategic indicators include some of the major performance benchmarks implemented by the Commonwealth Government under the requirements of the national health reforms. These initiatives include a range of performance benchmarks and governance arrangements to be met by states and territories.

ACT public hospitals—Canberra Hospital and Calvary Public Hospital

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

Clinically recommended time by urgency category	2012 target	2012 result	2013 target
One (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)	95%	98%	97%
Two (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)	55%	57%	66%
Three (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). The Health Directorate establishes a 365-day maximum desirable waiting time for category 3 patients.	82%	89%	86%

Note: Targets and results are based on calendar year data.

Performance indicator 2: The proportion of Emergency Department presentations whose length of stay in the Emergency Department is four hours or less

	2012 target	2012 result	2013 target
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.	64%	57%	65%

Note: Targets and results are based on calendar year data.

Clare Holland House (CHH)

The ACT Government, through the Health Directorate, provides funding for inpatient, outpatient and community-based specialist palliative care services in the ACT. These include Clare Holland House, an interdisciplinary service including a 19-bed inpatient hospice, specialist outreach services to people's homes (Home-Based Palliative Care), consultancy services to hospitals, a nurse educator, a nurse practitioner, bereavement services and the Calvary Centre for Palliative Care Research, all managed by Calvary Health Care ACT.

Performance indicator 3: Reaching the optimum occupancy rate for Clare Holland House inpatient beds

	2012–13 target	2012–13 result
Percentage of CCH inpatients beds in use	85%	76%

Performance indicator 4: The number of home-based palliative care occasions of service provided by CHH

	2012–13 target	2012–13 result
The number of people receiving home-based palliative care services provided by CHH (off-campus occasions of service provided by nurses)	5,250	3,433

Queen Elizabeth II Family Centre (QEII)

The ACT Government, through the Health Directorate, also provides funding to the Canberra Mothercraft Society to manage the Queen Elizabeth II Family Centre. The centre provides residential primary health care and parenting programs for families with young children who are experiencing complex health and behavioural difficulties in the first three years of an infant's life.

Performance indicator 5: The total number of admissions to the Queen Elizabeth II Family Centre

	2012–13 target	2012–13 result
Total admissions	1,400	1,674

Performance indicator 6: Maintain the waiting time for admission of urgent people to the Queen Elizabeth Family Centre

	2012–13 target	2012–13 result
Proportion of admissions of urgent clients equal to or less than 2 days	100%	47%

Performance indicator 7: Reaching the optimum occupancy rate for the Queen Elizabeth II Family Centre

	2012–13 target	2012–13 result
Percentage of QEII inpatients beds in use	85%	94%

Performance indicator 8: The proportion of patients readmitted to the Queen Elizabeth II Centre following their separation from the centre

	2012–13 target	2012–13 result
The proportion of people separated from QEII who are readmitted to QEII	<5%	0%

Chief Psychiatrist Annual Report 2012–13

The *Mental Health (Treatment and Care) Act 1994* was implemented in the Australian Capital Territory on 6 February 1995.

Section 120

A report prepared by the Chief Psychiatrist under the *Annual Reports (Government Agencies) Act 2004* for a financial year must include:

a. statistics in relation to people who have a mental illness during the year
b. details of any arrangements with New South Wales during the year in relation to people who have a mental illness.

Emergency apprehension

The following table shows the number of emergency apprehensions in 2012–13, with a breakdown of who initiated them.

	Emergency action	Police officer	Mental health officer	Medical practitioner
Total	876	617	165	94

Emergency detention

The following table shows the number of emergency detention notifications issued in 2012–13 in comparison to previous years. Applications for extension of emergency detention (for a further period of up to seven days) and applications for mental health orders and variations of mental health orders are made to the ACT Civil and Administrative Tribunal.

Emergency detentions	July 09–June 10	July 10–June 11	July 11–June 12	July 12–June 13
Total	505	596	614	689

Outcome of those detained

	July 09–June 10	July 10–June 11	July 11–June 12	July 12–June 13
Revocation of 72-hr detention and/or 72-hr detention being allowed to lapse	302	322	389	363
Applications for extension of involuntary detention	204	274	225	326

Psychiatric treatment orders

Under the *Mental Health (Treatment and Care) Act 1994*, the Chief Psychiatrist is responsible for the treatment and care of a person to whom a psychiatric treatment order (PTO) applies. The maximum duration of a PTO is six months.

	July 09–June 10	July 10–June 11	July 11–June 12	July 12–June 13
PTOs granted by the tribunal	790	884	864	924
PTOs revoked	69	119	148	127
Breach of PTO	68	59	76	82
Restriction orders	3	3	5	16

Other matters

The *Mental Health (Treatment and Care) Act 1994* provides for the authorisation of involuntary electro-convulsive therapy (ECT), including emergency ECT. It also has provisions for the interstate application of mental health laws, including for the transfer of people to and from the ACT.

The *Crimes Act 1900* provides for the court to order removal of an individual to the Canberra Hospital for the purposes of an emergency assessment to determine whether immediate treatment and care are required.

	July 09–June 10	July 10–June 11	July 11–June 12	July 12–June 13
Application for ECT authorised	19	17	16	13
Application for emergency ECT authorised	0	2	0	1
Transfers to/from NSW	12	4	10	8
Court ordered removal for assessment—s309 of the *Crimes Act 1900*	25	26	54	40

Key points arising

The following trends in key areas of activity related to the Office of the Chief Psychiatrist are noteworthy.

In 2012–13, 876 people were apprehended and brought to the Canberra Hospital for assessment. This is a decrease of 7 per cent from the previous year, when it was 942. This likely reflects the increasing level of mental health education provided to the police and other stakeholders. Emergency detention revocations have decreased from 389 to 363, a 7 per cent decrease in comparison to the same reporting period last year. This reflects efforts to move to least restrictive care at an early opportunity if at all possible. Notwithstanding this, there was a greater number of applications for extension of further involuntary detention (of up to seven days), indicating the treating team's efforts to continue to appropriately stabilise an acute episode of illness. Increased stability during an admission provides a greater chance of successful ongoing management when a person is discharged to the community.

The ACT Civil and Administrative Tribunal (ACAT) granted 924 psychiatric treatment orders (PTO). This is an increase of 6 per cent from 2011–12. Upon application by a consultant psychiatrist, or of its own motion, ACAT revoked 127 orders, compared to 148 in the previous reporting period. Community psychiatry is proactive in management without orders where possible.

There were 14 electro-convulsive therapy applications authorised, a negligible decrease from the previous year. There was only one application for emergency ECT made to the tribunal and after a full hearing and review this application was able to be revoked. Thus, for the 2012–13 year, no emergency ECT needed to be authorised by the tribunal under the provisions in Part 7 of the Act, introduced in 2005.

Eight cross-border agreements were made between the ACT and New South Wales. The ACT accepted four transfers from New South Wales and four transfers were made to New South Wales facilities. Breach of PTOs increased from 76 to 82. This amounts to an increase of 7 per cent from 2011–12. Thirty-five people were brought to the Mental Health Assessment Unit for medication or assessment purposes. 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 40 referrals for assessment pursuant to section 309 of the *Crimes Act 1900*, a decrease of 25 per cent from the previous year. Of these, 24 people required admission to the Adult Mental Health Unit for assessment purposes, with 16 being returned to court on the same day. The Court Liaison Service is often able to provide assessment and advice to the courts at the time of the hearing, which in some circumstances means that a section 309 referral is not required.

The review of the current *Mental Health (Treatment and Care) Act 1994* continues, and a revised amendment bill is expected to be presented to cabinet before the end of 2013.

Dr Peter Norrie

Chief Psychiatrist

Human Research Ethics Committee Annual Report 2012–13

The ACT Health Human Research Ethics Committee (HREC) continues its work of reviewing human research projects to ensure they meet the ethical standards set out in the National Statement on Ethical Conduct in Human Research (2007), prepared by the National Health and Medical Research Council (NHMRC), the Australian Research Council and the Australian Vice-Chancellors' Committee. During the reporting period, HREC contributed to the NHMRC consultation papers on the McKeon review.

The HREC and its subcommittees strive to provide ethical review and approval in the shortest possible time, conscious of the pressures on researchers and their teams. During the reporting period, HREC improved on its previous average of 30 days. In 2012, the average time taken from submission to approval was 23.5 days. There were 115 full and 174 low-risk applications in 2012–13.

HREC has continued to prepare for the advent of national programs of single ethical approval of multisite research and, in September 2012, achieved NHMRC certification to act as lead HREC in the single review system. The Human Research Ethics Manager, Ms August Marchesi, has continued to represent HREC and the ACT Health Directorate on the Jurisdictional Working Group that is progressing the single review system. By the end of 2013, the ACT expects to sign the memorandum of understanding with other jurisdictions which will mark the start of the national single review system.

The Ethics Committee has introduced a new Social Research Subcommittee (SRSC). After preparations in 2012, membership was established and the first meeting held in February 2013. SRSC has proved to be a valuable addition to the HREC process. Applications involving social research, including data linkage and internet-based programs, are increasing, and HREC is grateful to have the advice of expert members of the SRSC.

The Clinical Trials Subcommittee (CTSC) and the Survey Resource Group (SRG) have continued to provide HREC with expert advice on the merit and integrity of research proposals. June 2013 saw the resignation of Associate Professor Zsuzsoka Kecskes as Chair of SRG. Associate Professor Kecskes was a long-serving and dedicated chair and I am pleased to have this opportunity to thank her for her inestimable work in growing this group, as a valued resource to HREC and ACT Health.

HREC membership includes a lawyer, female and male laypersons, a minister of religion, a psychologist, a member providing Indigenous knowledge and expertise, and senior clinicians from Canberra Hospital. The chairman is a former specialist in obstetrics and gynaecology, a former dean and postgraduate dean and an adjunct professor of medical education. New members appointed in the past year have been a pharmacist, a hepatologist and a paediatrician. The work of the members of the main committee and various subcommittees is greatly valued.

On behalf of HREC and its subcommittees, I thank the administrative staff for their tireless work in keeping HREC and its processes operating at the highest standards. August Marchesi, Sarah Flood and Gillian Fox have provided another year of exceptional work in supporting HREC.

Membership of the committee

Professor John Biggs	Chairman
A/Professor Peter Hickman	Deputy Chair
Professor Walter Abhayaratna	member
Professor Geoff Farrell	member
Professor Doug Boer	member
Professor Paul Pavli	member (resigned April 2013)
A/Professor Frank van Haren	member
Dr Dipti Talaulikar	member
Dr Jason Mazanov	member
Dr Louise Morauta	member

Dr Marian Currie	member
Dr Tony Huynh	member
Dr Manoj Singh	member
Rev Doug Hutchinson	member
Mr Ray Lovett	member
Mr Ray Comer	member (resigned October 2012)
Mr Luke Williamson	member
Ms Kimberley Baillie	member
Mr John Morrissey	member
Ms Lyn Todd	member
Ms Julie Kussy	member

Number of research projects

During 2012–13, HREC reviewed 115 proposals; 105 were approved. Of the remaining 10 proposals, one was withdrawn by the applicant, one was declined due to ACT-specific legislative restrictions, and eight remain in consultation, progressing towards approval.

Meetings of the Ethics Committee

The committee met 11 times from 1 July 2012 to 30 June 2013. Meetings are held monthly.

Subcommittees

The Clinical Trials Subcommittee (CTSC) reviewed 53 proposals, in each instance making recommendations to the main committee.

The Social Research Subcommittee (SRSC), which first met in February 2013, reviewed 18 proposals, in each instance making recommendations to the main committee.

The Low Risk Subcommittee (LRSC) reviewed 174 proposals and approved 157. Of the remaining 17, five were referred for consideration by the main committee, one was withdrawn by the applicant and 11 are in consultation.

The Survey Resource Group (SRG) reviewed 70 proposals providing endorsement of survey tools and/or recommendations to the main committee and LRSC.

Key points arising

The work, over a three-year period, of preparing HREC for the national single review system has produced many reforms and innovations in processes and administration. In October 2012, the Chairman delivered presentations on this work to Canberra Hospital Grand Rounds and to the Society of Research Administrators International Conference in Orlando, Florida. In 2013, an article authored by the chairman and manager was published in the *Journal of Research Administration* in the United States of America.

Mental Health ACT Official Visitors Annual Report 2012–13

Introduction

Mental Health Official Visitors are appointed by the Minister for Health to visit and inspect psychiatric inpatient facilities and make inquiries as to the care and treatment of patients, as set out in the *Mental Health (Treatment and Care) Act 1994*. Matters covered include:

- the adequacy of services for the assessment and treatment of persons with mental dysfunction or a mental illness
- the appropriateness of recreation, occupation, education, training and rehabilitation services
- whether services are provided in the least restrictive environment possible and in the least intrusive manner possible
- any contraventions of the Mental Health (Treatment and Care) Act
- any complaint received from a person receiving treatment and care for mental illness or dysfunction.

Currently, Mental Health Official Visitors' roles cover the mental health services provided at the Brian Hennessy Rehabilitation Centre (BHRC), Ward 2N, the Older Persons Mental Health Inpatient Unit (OPMHIU) and Hyson Green (providing private mental services) at Calvary Public Hospital, as well as the Adult Mental Health Unit (AMHU), formerly the Psychiatric Services Unit (PSU), at Canberra Hospital.

The Official Visitors enjoyed attending the New South Wales Official Visitors Conference in Sydney as guests of the New South Wales service in August. This served as an important liaison activity, and Official Visitors benefited from the educative function of the conference as well as from the informal discussions about the Official Visitor role. The Principal Official Visitor was reappointed during this period and one Official Visitor resigned.

Visits

Since December 2002, the Official Visitors have operated a monthly pre-determined schedule of formal visits to each of the facilities. Prior notice of the visit is given to the facility to reinforce a cooperative as opposed to an inspectorial approach with unit staff. In 2012–13, Official Visitors made 60 scheduled formal visits to the five mental health facilities.

Formal visits by the Official Visitors were supplemented by follow-up visits as required. Other visits were made on request by patients of the facilities following contact either by telephone or through messages left in the Official Visitors' suggestion boxes, which are located in the facilities.

A duty telephone service is provided to the public. This requires a mobile telephone to be staffed on a roster basis by the Official Visitors. A log of the calls is maintained by each rostered Official Visitor and responses to concerns sometimes include a visit to the care facility. Contact details for mental health services such as the Mental Health Crisis Team are provided if deemed appropriate.

Staff at the facilities have been extremely cooperative and open with the Official Visitors. In many instances, staff have gone out of their way to assist the Official Visitors in carrying out their duties. Detailed reports are provided to the team leaders and to senior mental health staff after each visit. The reports summarise all matters raised during the visits by patients and staff and discussed with the team leader. Half-yearly reports are provided to the Minister for Health.

Adequacy of assessment and treatment services

ACT Mental Health and its staff are committed to improving the quality of care at all facilities. The staff at the facilities endeavour to improve the experiences of their patients and to develop practices and procedures aimed at the long-term benefit of patients. After more than a year of operating, the AMHU at Canberra Hospital continued to be favourably commented on by many consumers.

The Official Visitors continue to be impressed by Hyson Green and the OPMHIU, which present as very well equipped and well staffed. Both are modern, light, spacious and designed for comfort and safety. For the first time in three years, Hyson Green remained open during the Christmas period. The OPMHIU and BHRC facilitate their staff accompanying patients into the community after discharge and assisting in their follow-up.

Calvary Ward 2N provides a wide range of activities for their patients, including discussion groups. Positive comments are consistently received from consumers at the unit. Staff are favourably mentioned and generally the patients comment that they experience a calm and pleasant stay. The new smoking bans have not posed too many problems.

Appropriateness of recreation, occupation, education, training and rehabilitation services

Each facility operates a range of these types of programs and made changes in 2012–13 to improve the relevance and effectiveness of these activities. The general direction is to enhance the services provided.

BHRC's rehabilitation and recreation focus is on patient participation in community programs outside the facility—for example, activities at the Belconnen Community Centre. Patients are encouraged to commence external courses. Within the facility, programs tailored to individual patient needs are offered, such as healthy cooking lessons, media studies, relaxation techniques and gardening. Computer access is also available. Consumer meetings have been held regularly. The facility has been challenged by managing forensic patients.

Calvary Ward 2N has daily activities on weekdays for all patients and was recently commended by an accreditation team for its community engagement. Group programs run by Ward 2N and Hyson Green are very popular with inpatients and outpatients. The OPMHIU encourages patients to be as active and independent as possible, although activities are restricted by the age and disabilities of consumers.

Whether services are provided in the least restrictive environment possible

Inpatients in psychiatric facilities are admitted on a voluntary or involuntary basis. Enforcing involuntary detention involves a reduction of an individual's freedom while treating their mental illness. Patient safety is a paramount concern, as is the safety of the staff involved. While all facilities must primarily assist patients to improve their mental health, they focus on enhancing the skills patients need to reintegrate into the community and aim to discourage dependency on inpatient facilities and reduce the duration of their admission time.

The AMHU continued to emphasise reducing both the frequency and the duration of seclusion, and during visits this year it was very evident that the rate of seclusion in the facility had been reduced.

Commendably, BHRC has made many efforts to ensure its consumers are integrated where possible into community-based programs to facilitate their transition from the facility into the community.

Any contraventions of the Mental Health (Treatment and Care) Act

No contraventions have come to the attention of the Official Visitors.

Complaints received from persons receiving treatment and care for mental illness or dysfunction

In general, patients and their carers provide positive feedback about their experiences in the facilities. Issues taken up with and acted on by the units include:

- treatment issues
- maintenance and cleanliness issues
- smoking bans
- discharge plans
- lack of stimulation

- gym access
- physical facilities
- access to staff or perceived inadequacies in treatment and interpersonal relationships
- adequacy or otherwise of food provided for patients
- any developing trends—for example, in Absence Without Leave (AWOL), electro-convulsive therapy (ECT) treatment numbers and seclusions.

Reports to the Minister for Health

The Principal Official Visitor provided the following written reports to the Minister for Health:

- two half-yearly reports for the reporting year.

Mental Health Official Visitors

People working as Mental Health Official Visitors during the period were:

- Sue Connor, Principal Official Visitor
- Pamela Burton, Official Visitor
- Kay Barralet, Official Visitor
- Shannon Pickles, Official Visitor.

Average length of service by gender

Average length of service (years)	Female	Male	Total
0–2	1	1	2
2–4	0	0	0
4–6	0	0	0
6–8	1	0	1
8–12	1	0	1

Total average length of service by gender

Gender	Average length of service
Female	7 years, 3 months
Male	1.5 years
Total	5.5 years

Sue Connor
Principal Official Visitor
14 July 2013

Radiation Council Annual Report 2012–13

Chair's review

It is my pleasure to present the Annual Report of the Radiation Council for 2012–13.

The Radiation Council has had a productive year and has continued to address issues concerning licensing, registration and radiation safety requirements to provide adequate radiation protection to the community. The council continues to address issues and update procedures to maintain compliance with the *Radiation Protection Act 2006*.

The council continues to monitor the development of codes of practice, standards and regulations from the Australian Radiation Protection and Nuclear Safety Agency (ARPANSA) regarding radiation safety. Information received from ARPANSA is considered in decisions made by the council.

The council welcomes Dr A Javaid, who was appointed from October 2012 for a three-year term. We also welcome the reappointment of Dr S Geoghegan for a further three years.

I wish to express my appreciation to the members of the council for their expert contribution and to the staff of the Health Protection Service for their ongoing support.

Council functions

The *Radiation Protection Act 2006* ***www.legislation.act.gov.au*** controls the safe use, storage, transportation and disposal of radioactive material and irradiating apparatus. The Radiation Council is established under Part 5 of the *Radiation Protection Act 2006*, and has the following functions:

- issuing licences
- registering regulated radiation sources
- advising the Minister on radiation protection issues
- exercising any other function given to it under the *Radiation Protection Act 2006* or another territory law.

Council membership

The composition of the Radiation Council is specified in the *Radiation Protection Act 2006* and must consist of:

- one member who is a doctor registered under the *Health Practitioner Regulation National Law (ACT)* in the specialist area of radiology
- one member with expert knowledge of the physical properties or biological effects of radiation
- a person who, in the Minister's opinion, has qualifications or experience relevant to assisting the council to carry out its functions
- a member of the public

A council member must not be appointed for longer than three years.

Mr A Agostino	Chair
Prof. L K Fifield	Deputy Chair
Dr M Despois	Member
Ms E Croft	Member
Dr A Javaid	Member
Dr S Geoghegan	Member
Mrs J I Bennett	Community Representative
Health Protection Service of ACT Health	Secretariat

Council meetings 2012–13

The council meets approximately every six weeks and met nine times during the year. Meetings were held in July, September, October and November of 2012 and in January, February, April, May and June of 2013.

Regulatory standards

A number of standards, codes of practice, safety guides, and recommendations are used by the council as a reference when considering matters relating to radiation protection policies, practices, conditions to be attached to licences, registrations and exemptions from the application of the *Radiation Protection Act 2006*. This includes the ARPANSA publications, such as the Radiation Protection Series (RPS) publications, 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 and legislation across all Australian jurisdictions for both ionising and non-ionising radiation. The Directory is a constantly evolving document that reflects the best radiation protection practice of the time. The Directory is updated following a prescribed process, designed to meet the *COAG Principles and Guidelines for National Standard Setting and Regulatory Action by Ministerial Councils and Standard-setting Bodies (November 1997)*, and after amendments are endorsed by the Australian Health Ministers' Conference.

The Directory was republished in July 2011 to include Amendment No. 5. This amendment added two Codes of Practice to Schedule 11; the Code of Practice for Radiation Protection in Veterinary Medicine (RPS17) and the Code of Practice for Radiation Protection in the Application of Ionizing Radiation by Chiropractors (RPS19).

The council is regularly briefed on developments with regard to the work of the National Radiation Health Committee (RHC) of ARPANSA. The ACT has a jurisdictional representative from ACT Health appointed to the RHC.

Council activities

Approvals and decisions

Licences

In 2012–13 the council issued 186 new licences to deal with a radiation source. Together with licences re-issued during the year, the total number of radiation licence holders in the ACT was 1057.

Registrations

In 2012–13 the council registered 52 new radiation sources. Together with sources re-registered during the year, the total number of registered radiation sources in the ACT was 553.

Radiation incidents

The following radiation incidents were reported to the council during the year:

Radiotherapy: three incidents

- two* incidents involved misalignment of treatment area
- one incident involved equipment malfunction

Nuclear medicine: one incident

- one incident involved the contamination with or dispersal of a radioactive material.

Soil density gauges: one incident

- one* incident involved damage to, or malfunctioning of, a radiation apparatus or sealed source.

Following investigation, three of the reported incidents (marked above with an asterisk—*) were referred to ARPANSA for inclusion on the Australian Radiation Incident Register. In line with the *ACT Health Risk Management Guidelines*, the three incidents referred to ARPANSA were considered to be of minor consequence. The remaining two 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 2012–13.

Contact details

All correspondence should be addressed to:

Secretariat
Radiation Council
c/o Health Protection Service
Locked Bag 5005
WESTON CREEK ACT 2611
Phone: (02) 62051700
Email: ***hps@act.gov.au***
Website: ***www.health.act.gov.au\radiationsafety***

Tony Agostino
Chair, July 2013

Veterinary Surgeons Board Annual Report 2012–13

Requirement for the report

This report is provided in accordance with the *Annual Reports (Government Agencies) Act 2004* and the Annual Reports (Government Agencies) Notice 2013 (No. 1).

Functions, aim and goals of the Board

The ACT Veterinary Surgeons Board administers Schedule 12, Veterinary Surgeons, to the Health Professionals Regulation 2004. The *Health Professionals Act 2004* charges the Board with responsibility for the registration of appropriately qualified persons as veterinary surgeons and veterinary specialists, enabling them to practise veterinary surgery in the Australian Capital Territory. The Board:

- ensures that the interests of the public and the welfare of animals in the ACT are protected
- ensures that only properly qualified persons are registered as veterinary surgeons in the ACT
- provides advice to government agencies and interest groups
- conducts inquiries, as required, to ensure professional standards of practice are met.

Membership of the Board

President
Dr Kevin Doyle AM

Deputy President
Dr John Aspley Davis

Members
Dr Simon Morris
Dr Roger Meischke
Dr Sarah Webb
Dr Steven Roberts

Community Representative
Ms Eileen Jerga AM

Secretariat
Health Protection Service

All members serve the Board in a personal and honorary capacity.

Meetings of the Board

From 1 July 2012 to 30 June 2013, the Board met on eight occasions. Meetings were generally held monthly at Howard Florey Centenary House, 25 Mulley Street, Holder.

President's report

I am pleased to present the Annual Report of the Veterinary Surgeons Board for the year ended 30 June 2013.

The Board previously reported its relocation from the Health Professions Registration Boards to the Health Protection Service (HPS) of the ACT Government Health Directorate, located at Howard Florey Centenary House in Holder. As a result of the relocation, a new database was required. This was developed to allow a better service for registered veterinary surgeons and the Board. The testing of the database was completed in 2012.

The relocation created difficulties for the Board in that some records and corporate memory were lost. In addition, when managed as one of nine health profession boards served by a professional secretariat, the Board had access to resources beyond its part-time registrar/executive officer. This has not been possible within the HPS. While extra resources have been made available, their duties have had to be carried out in addition to their ongoing tasks. It has become clear that a part-time registrar/executive officer is not adequate. The Board agreed at its March 2013 meeting to appoint a full-time registrar. Efforts are being made to ensure that the move of the Board to the Territory and Municipal Services Directorate will provide access to the necessary resources.

The Board reported last year that it was clear that changes must be made to the legislation to update it and to bring it into line with contemporary legislation. This included harmonising it with the legislation of the other jurisdictions and providing for national recognition of veterinary registration (NRVR). The Board supports NRVR and will continue to work on its implementation.

The Board sets high standards for professional competence in order to ensure public protection, which includes supporting and enforcing the mandatory professional indemnity insurance.

The Board has been active in the affairs of the Australasian Veterinary Boards Council (AVBC), on which it is represented by Dr John Aspley Davis. The Board supports AVBC efforts to promote cooperation in strategic planning for the future of registered veterinary surgeons and to help improve veterinary services provided to the community. This year the AVBC conference was held in Cairns.

Dr Steven Roberts was appointed to the Board during the year and provides particular expertise on horses.

My appreciation is extended to all members of the Board for their considerable efforts during the year and over the term of their appointments.

As a result of the review into the ACT Government and the recommendation made in its final report, *Governing the City State: One ACT Government—One ACT Public Service*, the Board's secretariat transferred to the Territory and Municipal Services Directorate on 9 July 2013, following the 2013–14 registration renewal process. The Board thanks the Health Protection Service for its support to the Board.

Registration

At 30 June 2013, 261 veterinary surgeons had current registrations in the ACT. The Board continued to process applications for initial registrations and registrations under the provisions of the Mutual Recognition Act.

Number of registrants

Year	2006	2007	2008	2009	2010	2011	2012	2013
Total	246	253	260	236	272	256	245	261

Activities

The Board addressed issues related to the following topics during the year:

- professional standards matters
- recency of practice
- continuing professional development
- national recognition of veterinary registration
- policy review
- database.

Complaints and disciplinary action

The Board recognises that many complaints emerge from poor communication between parties about the service to be provided or the service that is provided. This can result in intransigence from both parties in resolving complaints.

In 2012–13, the Board jointly reviewed the complaint process with the Human Rights Commission and the Government Solicitor's Office. The Board is pleased to report the success of the revised process. All complaints made to the Board have been processed and the vast majority resolved, with only three complaints ongoing.

The Board investigated a number of complaints or professional standards issues throughout the year.

Matters of significance

National recognition of veterinary registration

The Board supports the process being put in place by the AVBC and Primary Industries Standing Committee to move towards National Recognition of Veterinary Registration (NRVR). Each jurisdiction will retain its own board and legislation but will recognise registration in other jurisdictions as a right to practise in every jurisdiction without further registration. This will achieve mobility of veterinary surgeons between jurisdictions and assist in the aim of achieving consistency of standards. The Board hopes to introduce processes in the next financial year for NRVR in the ACT.

Continuing veterinary professional development

Continuing professional development (CPD) is compulsory in all the ACT health professions. The ACT is among a number of Australian jurisdictions to have compulsory CPD for veterinary surgeons. It is important that all registered veterinary surgeons demonstrate a commitment to continuing professional development if they wish to renew their registration.

Australasian Veterinary Boards Council

The annual general meeting of the Australasian Veterinary Boards Council (AVBC) was held in Cairns in May 2013. Dr John Aspley Davis is the Board's representative on the council. There was attendance by representatives and their registrars from the New Zealand Veterinary Council and all state and territory boards. Reports were submitted and discussed on issues concerning registration, uniformity of legislation, the National Veterinary Examination, National Recognition of Veterinary Registration and the accreditation of university undergraduate courses, both in Australia and with those whom we have a mutual recognition agreement—namely, the Royal College of Veterinary Surgeons in the United Kingdom. AVBC also accepts graduates who have qualified under the remit of the American Veterinary Medical Association, which includes an increasing number of faculties not on the North American continent, and the South African Veterinary Board. This time, via Skype, all the states and territories signed off on a mutual recognition agreement with South Africa which entitles graduates of Australia and New Zealand to practise there without further examination. Previously, the recognition was only in favour of South African graduates.

Finances

The Board is not a territory authority for the purposes of the *Financial Management Act 1996* (see the Financial Management (Territory Authorities) Declaration 2005 (No. 1)). The Board is self-funding, with account management undertaken by the Health Protection Service as part of its secretariat function. A summary of the Board's finances is provided for information.

Carryover	$139,093
Revenue	$77,667
Expenditure	$82,676
Carried forward	$132,084

Liaison with Australian Veterinary Association (AVA)

The Board maintains liaison with the AVA to ensure a free exchange of views and information. The AVA provides continuing education, mentoring and other forms of assistance to veterinarians in the ACT. This is particularly important for new graduates.

The Board takes this opportunity to acknowledge the cooperation of the AVA.

Contact details

The ACT Veterinary Surgeons Board was transferred to the Territory and Municipal Services Directorate on 9 July 2013. Information on the Board can be found at ***www.tams.act.gov.au/parks-recreation/plants_and_animals/veterinary-surgeons-board***.

Dr Kevin Doyle
President

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