ACT Government

ANNUAL REPORT 2015–16

Health Directorate

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

ACT Government Health Directorate

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CONTENTS

ABBREVIATIONS AND ACRONYMS

Abbreviation/ acronym	Meaning
AAQ	Ambient Air Quality
ABF	Activity-based Funding
ACAT	Aged Care Assessment Team
ACAT	ACT Civil and Administrative Tribunal
ACHS	Australian Council on Healthcare Standards
ACIR	Australian Childhood Immunisation Register
ACP	Advance Care Planning
ACT	Australian Capital Territory
ACTGAL	ACT Government Analytical Laboratory
ACTHPGP	ACT Health Promotion Grants Program
ACTPAS	ACT Patient Administration System
ACTPAS	ACT Patient Admission System
ACTPS	ACT Public Service
ACU	Australian Catholic University
ADON	Assistant Director of Nursing
AFP	Australian Federal Police
AHA	Allied Health Assistant
AHWMC	Australian Health Workforce Ministerial Advisory Council
AIHW	Australian Institute of Health and Welfare
AIN	Assistants in Nursing
AINDP	Assistants in Nursing Development Program
AMC	Alexander Maconochie Centre
AMHU	Adult Mental Health Unit
AMU	Acute Medical Unit
ANU	Australian National University
ARIns	Attraction and Retention Initiatives
ARPANSA	Australian Radiation Protection and Nuclear Safety Agency
ASBA	Australian School Based Apprenticeship
ASSAD	Australian Secondary School Alcohol and Drug
ASK	Action Success Knowledge
ATSI	Aboriginal and Torres Strait Islander
ATSIHWWG	Aboriginal and Torres Strait Islander Health Workforce Working Group
AUGP	Academic Unit of General Practice
AWA	Australian Workplace Agreement
CACHS	Cancer, Ambulatory and Community Health Support
CAHO	Chief Allied Health Office
CALD	Culturally and Linguistically Diverse
Calvary	Calvary Public Hospital Bruce
CAMHS	Child and Adolescent Mental Health Services

Abbreviation/ acronym	Meaning
CatCH	Continuity at the Canberra Hospital
CCO	Community Care Order
CDNMs	Clinical Development Nurses and Midwives
CDS	Child Development Service
CHASERS	Canberra Hospital Acute Subacute Early Rehabilitation Service
CHEWIE	Canberra Hospital Essential Works – Infrastructure and Engineering
CHHS	Canberra Hospital and Health Services
CHISEL	Conformal Hypofractionated Image Guided ('Stereotactic') Radiotherapy
CHWC	Centenary Hospital for Women and Children
CIT	Canberra Institute of Technology
CMTEDD	Chief Minister, Treasury and Economic Development Directorate
CNC	Clinical Nurse Consultant
CNGF	Carbon Neutral Government Fund
COSEI	Continuity of Services Essential Infrastructure
CPCHS	Community Paediatric and Child Health Service
CRCC	Canberra Region Cancer Centre
CRMEC	Canberra Region Medical Education Council
CRRS	Capital Region Retrieval Service
CSD	Community Services Directorate
CSSE	Clinical Supervision Support Essentials
CT	Computed Tomography
CTSC	Clinical Trials Subcommittee
CVAD	Central Venous Access Devices
DAPIS	Drugs and Poisons Information System
DBMAS	Dementia Behaviour Management Assessment Services
DECO	Detention Exit Community Outreach
DMFT	Decayed, Missing, or Filled Teeth
DNW	Did Not Wait
DON	Director of Nursing
DTPa	Diptheria, Tetanus, Pertussis
EAR	Education Activity Register
ECCR	European Council for Cardiovascular Research
ECEC	Early Childhood Education and Care
ECGs	Electrocardiographs
ECT	Electro-convulsive therapy
ED	Emergency Department
EDIS	Emergency Department Information Solution
EMU	Emergency Medicine Unit

Abbreviation/ acronym	Meaning
EN	Enrolled Nurse
ENPDP	Enrolled Nurse Professional Development Program
ENT	Ear, nose and throat
ENTTPP	Enrolled Nurse Transition to Practice Program
EPAU	Early Pregnancy Assessment Unit
EPD	Environment and Planning Directorate
ESD	Environmentally Sustainable Development
ESP	Enterprise Sustainability Platform
ETS	Emergo Train System
FBT	Fringe Benefits Tax
FCCO	Forensic Community Care Order
FEIG	Food Environment Implementation Group
FSP	Final Sketch Plan
FTE	Full-time Equivalent
GEHU	Gastroenterology and Hepatology Unit
GOCC	Goals of Care Conversation
GP	General Practitioner
GPB	Government Procurement Board
HAAS	Healthcare Access at School
HEMU	Health Emergency Management Unit
HETI	Health Education and Training Unit
HIB	Health Improvement Branch
HIP	Hospital-Initiated Postponements
HITH	Hospital in the Home
HREC	Human Research Ethics Committee
HSR	Health and Safety Representatives
HWA	Health Workforce Australia
HWI	Healthy Weight Initiative
HWPC	Health Workforce Principal Committee
HWPC	Health Workforce Principle Committee
IA&RM	Internal Audit and Risk Management
IAGG	International Association of Gerontology and Geriatrics
ICT	Information and Communications Technology
IHPA	Independent Hospital Pricing Authority
IMRT	Intensity Modulated Radiation Therapy
IPMO	Integrated Program Management Office
IT	Information Technology
IYM	It's Your Move
JACS	Justice and Community Safety Directorate
KPI	Key Performance Indicator
LED	Light-emitting Diode
LGBTI	Lesbian, gay, bisexual, transgender and intersex
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer

Abbreviation/ acronym	Meaning
LRSC	Low Risk Subcommittee
MACH	Maternal and Child Health
MAU	Maternity Assessment Unit
MCHPU	Multicultural Health Policy Unit
MDC	Mobile Dental Clinic
MDMA	Methylenedioxymethylamphetamine
MHAGIC	Mental Health Assessment Generation and Information Collection
MLA	Member of the Legislative Assembly
MRI	Magnetic resonance imaging
MSD	Musculoskeletal Disorder
MUD	Mandatory Update Day
NBCSP	National Bowel Cancer Screening Program
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NEAT	National Emergency Access Target
NEPM	National Environmental Protection Measure
NEST	National Elective Surgery Time
NEST	National Elective Surgery Target
NHMRC	National Health and Medical Research Council
NHPA	National Hospital Performance Authority
NMA	National Mutual Acceptance
NMBA	Nursing and Midwifery Board of Australia
NSQH	National Safety and Quality Health
NSQHS	National Safety and Quality Health Service
OCHO	Office of the Chief Health Officer
OPMH	Older Persons Mental Health Service
PAC	Public Accounts Committee
PAL	Peer Assisted Learning
PART	Predict, Assess and Respond to Challenging/Aggressive Behaviour
PARTY	Prevent Alcohol and Risk-related Trauma in Youth
PBS	Pharmaceutical Benefits Scheme
PCW	Procurement and Capital Works
PHN	Primary Health Network
PIN	Provisional Improvement Notice
PMP	People Manager Program
PMS	Performance Monitoring Station
PPID	Positive patient identification
PSSB	People Strategy and Services Branch
PTO	Psychiatric Treatment Order
PV	Photovoltaic
QMS	Quality Management System
QR	Quick Response
RACC	Rehabilitation, Aged and Community Care

Abbreviation/ acronym	Meaning
RACGP	Royal Australian College of General Practitioners
RAP	Reconciliation Action Plan
RAS	Regional Assessment Service
RAU	Rapid Assessment Unit
RED	Respect, Equity and Diversity
REMR	Renal Electronic Medical Record
RFID	Radio-frequency Identification
RILU	Rehabilitation Independent Living Unit
RMP	Resource Management Plan
RN	Registered Nurse
RO	Reverse Osmosis
RTO	Registered Training Organisation
RWTS	Ride or Walk to School
S&D	Staging and Decanting
SAB	Staphylococcus Aureus Bacteraemia
SABR	Stereotactic Ablative Radiotherapy
SAS	Special Access Scheme
SCON	Simple Cannabis Offence Notification
SCPU	Student Clinical Placement Unit
SEA	Special Employment Arrangements
SIG	System Innovation Group
SIP	System Innovation Program
SLA	Service Level Agreement
SKIP	School Kids Intervention Program
SNSW	Southern NSW
SNSWLHD	Southern NSW Local Health District
SoER	State of the Environment Report
SRS	Stereotactic Radiosurgery
SRSC	Social Research Subcommittee
STEMI	ST Segment Elevation Myocardial Infarction
TGA	Therapeutic Goods Administration
THC	tetrahydrocannabinol
TIC	Terminal Illness Cannabis
UC	University of Canberra
UCPH	University of Canberra Public Hospital
VMAT	Volumetric Arc Therapy
VMO	Visiting Medical Officer
WHSMS	Work Health and Safety Management System
WiC	Walk-in Centre
WPS	Workplace Safety
YTD	Year-to-date

GLOSSARY OF TECHNICAL TERMS

Term	Meaning
Acute care	An episode of acute care for an admitted patient is one in which the principal clinical intent is to provide short-term hospital admission focused on the treatment of emergency conditions or the conduct of an elective procedure.
Benchmarking	The process of assessing the performance of an organisation of entity within an organisation by comparing it to the performance of a similar entity, a national average, or the best performing entity within the same field in order to assess performance and determine opportunities for improvement.
Community-based organisations	Not-for-profit organisations within the community that have specialist skills in the management of certain health issues. These organisations provide services such as health services for disadvantaged young people, drug and alcohol rehabilitation, Aboriginal and Torres Strait Islander health services and supported accommodation for people with mental illness.
Decant	To rehouse people while their buildings are being refurbished or rebuilt.
Length of stay	The number of days (or part thereof) that each admitted patient stays in hospital. Patients who are admitted and discharged on the same day have a length of stay of one day.
Occasions of service	A measure of services provided to patients—usually used in the outpatient or community health setting.
Patient journey	A patient's experience of travelling or moving through the health system at pre-hospital to hospital and to community care.
Patient-centred care	Refocusing the delivery of health care around the needs of the patient rather than other stakeholders, such as providers.
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.
Social enterprises	Social enterprises use sound business principles to return financial and societal benefits to the community.
Social procurement	Engaging mainstream suppliers that include social benefits as part of delivering goods and services.
Subacute	Intermediate care provided between acute care and community-based care. Subacute care includes services such as rehabilitation that can be provided in a less invasive environment than an acute hospital setting.
Tertiary services	Tertiary services are generally those provided in a complex, highly specialised hospital environment.
Toolbox meetings	A toolbox meeting is a short daily, weekly or monthly meeting usually to discuss safety matters in an informal and clear manner.

OTHER SOURCES OF INFORMATION

ACT Health publications are available at ACT Government community libraries, the Health Directorate library located at Canberra Hospital, Garran, and from community health centres.

Copies of the ACT Health 2015–16 Annual Report are also available online at: *www.health.act.gov.au/annual-report*

Information can also be accessed through the:

> Health Directorate website at www.health.act.gov.au
> Access Canberra website at www.accesscanberra.act.gov.au
> 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 2016
> ACT Human Rights Commission Annual Report 2015–16
> Australian hospital statistics, Australian Institute of Health and Welfare
> Australia's health 2014, Australian Institute of Health and Welfare.

Websites referenced in this report

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Access Canberra	*www.accesscanberra.act.gov.au*
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Pharmacists to administer influenza vaccinations	*http://www.health.act.gov.au/public-information/businesses/pharmaceutical-services/pharmacist-vaccinations*

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Physical Activity Foundation Ride or Walk to School	*http://paf.org.au/programs/ride-or-walk-to-school/*
Population Health Division	*http://www.health.act.gov.au/healthy-living/population-health*
Population Health Division Strategic Framework 2013–2016	*http://www.health.act.gov.au/sites/default/files//Population%20Health%20Strategic%20Framework.pdf6*
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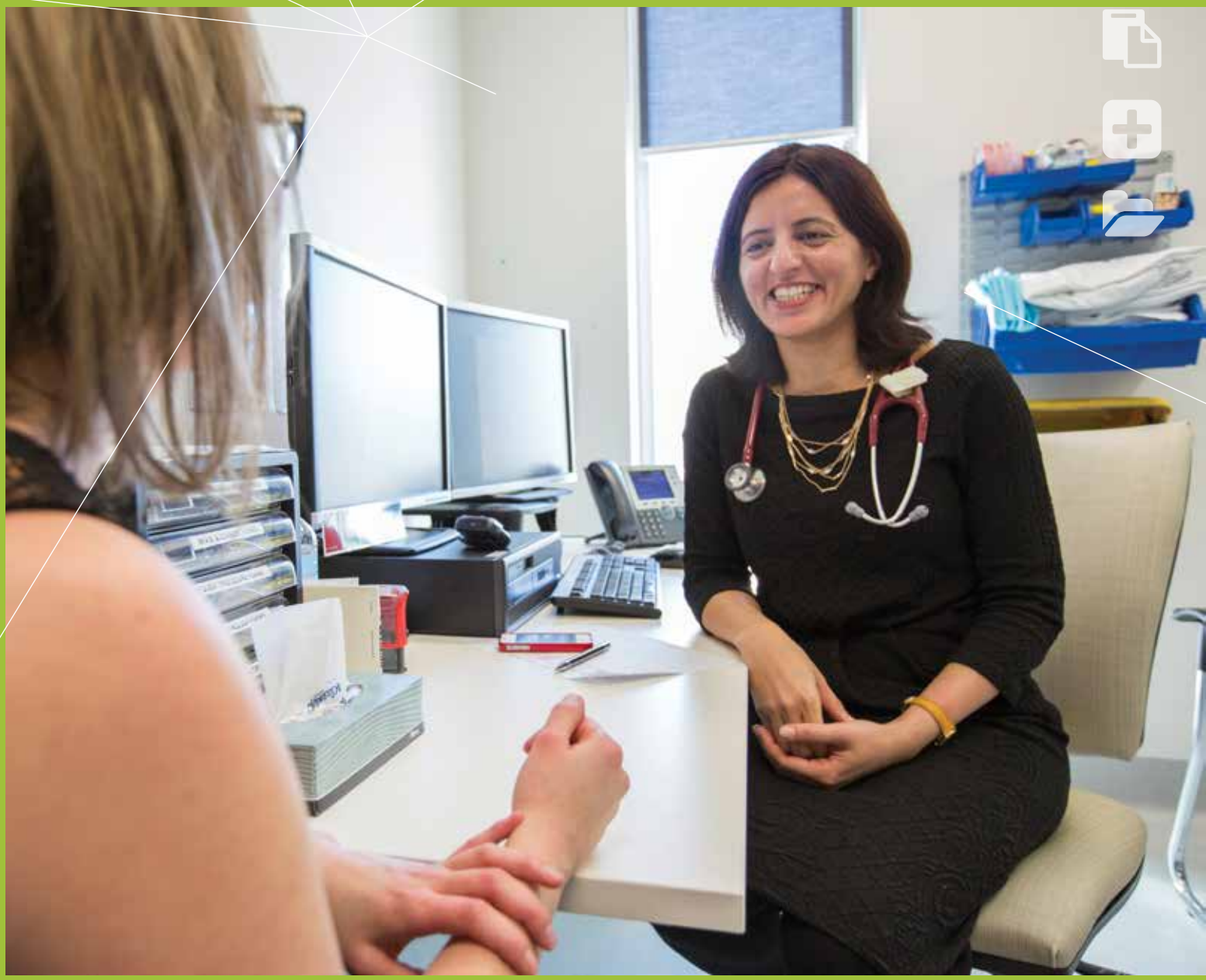
Public Health Act 1997	*http://www.legislation.act.gov.au/a/1997-69/current/pdf/1997-69.pdf*
Public Sector Management Act 2006	*http://www.legislation.act.gov.au/di/2006-187/current/pdf/2006-187.pdf)*
Registered Training Organisation (RTO)	*http://www.asqa.gov.au/about/australias-vet-sector/standards-for-registered-training-organisations-(rtos)-2015.html*
Review of the Auditor-General's Report No. 1 of 2016: Calvary public hospital financial and performance reporting and management	*http://www.parliament.act.gov.au/__data/assets/pdf_file/0006/871917/8th-PAC-27-AG1-2016.pdf*
Review of the Auditor-General's Report No. 4 of 2014: Gastroenterology and Hepatology Unit, Canberra Hospital	*http://www.parliament.act.gov.au/__data/assets/pdf_file/0006/871917/8th-PAC-27-AG1-2016.pdf*
Ride or Walk to School Program	*http://www.health.act.gov.au/healthy-living/healthy-children-and-young-people/ride-or-walk-school*
Road Transport (Alcohol and Drugs) Act 1977	*http://www.legislation.act.gov.au/a/1977-17/default.asp*
Road Transport (Alcohol and Drugs) Act 1977 Report on Analytical Findings February 2015	*http://health.act.gov.au/sites/default/files/Publications/Road%20Transport%20%28Alcohol%20and%20Drugs%29%20Act%201977%20Report%20on%20Analytical%20Findings%20February%202015.pdf*
Smoke-Free Public Places Act 2003	*http://www.legislation.act.gov.au/a/2003-51/default.asp*
Smoke-Free Public Places Amendment Bill 2016	*http://www.legislation.act.gov.au/b/db_53581/default.asp*
Are You at Risk? (targeted immunisation promotional activities)	*http://www.health.act.gov.au/our-services/immunisation/are-you-risk*
Healthy Food and Drink Choices	*http://www.health.act.gov.au/healthy-living/health-improvement*
Towards Zero Growth: Healthy Weight Action Plan	*http://www.health.act.gov.au/sites/default/files/Towards%20Zero%20Growth%20Healthy%20Weight%20Action%20Plan.pdf*
Tobacco and Other Smoking Products Act 1927	*http://www.legislation.act.gov.au/a/1927-14/*
Tobacco Control, Smoking Products and Smoke-Free Environments	*http://www.health.act.gov.au/public-information/public-health/tobacco-and-smoke-free*
Towards Culturally Appropriate and Inclusive Services – A Co-ordinating Framework for ACT Health (2014–18)	*http://www.health.act.gov.au/sites/default/files//Policy_and_Plan/Multicultural%20Co-ordinating%20Framework%20-%20Towards%20Culturally%20Appropriate%20and%20Inclusive%20Services%202014-2018.pdf*
Transplantation and Anatomy Act 1978	*http://www.legislation.act.gov.au/a/1978-44/current/pdf/1978-44.pdf*
Work Health and Safety Act 2011	*http://www.legislation.act.gov.au/a/2011-35/*
Workforce Plan 2013–2018	*http://health.act.gov.au/sites/default/files/Policy_and_Plan/Workforce%20Plan%202013-2018.pdf*
World Cancer Day	*http://www.health.act.gov.au/our-services/cancer-services/world-cancer-day-2016*



PART A:
TRANSMITTAL CERTIFICATE

A. TRANSMITTAL CERTIFICATE

ACT Government
Health

Office of the Director-General

Mr Simon Corbell MLA
Minister for Health
ACT Legislative Assembly
London Circuit
Canberra ACT 2601

Dear Minister

This Report has been prepared under section 5(1) of the *Annual Reports (Government Agencies) Act 2004* and in accordance with the requirements under the Annual Report Directions.

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

I certify that information in the attached Annual Report, and information provided for whole of government reporting, is an honest and accurate account and that all material information on the operations of ACT Health has been included for the period 1 July 2015 to 30 June 2016.

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

Section 13 of the *Annual Reports (Government Agencies) Act 2004* requires that you cause a copy of the Report to be laid before the Legislative Assembly within 4 months of the end of the financial year.

Yours sincerely

Nicole Feely
Director-General

5 October 2016

GPO Box 825 Canberra ACT 2601 | Ph: 6205 0823 | Email: DGACTHealth@act.gov.au I www.act.gov.au

PART B: ORGANISATIONAL OVERVIEW AND PERFORMANCE

B.1 ORGANISATIONAL OVERVIEW

VISION, MISSION AND VALUES

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

Our vision and values, developed by ACT Health staff, represent what we believe is important and worthwhile. We provide services where the patient is the central focus of everything we do and this patient-centric care is delivered within a workplace culture that showcases our values of care, excellence, integrity and collaboration.

We often see people in our community when they are at their most vulnerable. The way we interact with them directly influences how they experience our care. Compliments and complaints received from our health care consumers reflect our commitment to our values as exemplified through our behaviour.

Our values are:

> Care: Go the extra distance in delivering services to our patients, clients and consumers. Be diligent, compassionate and conscientious in providing a safe and supportive environment for everyone. Be sensitive in managing information and ensuring an individual's privacy. Be attentive to the needs of others when listening and responding to feedback from staff, clinicians and consumers

> Excellence: Be prepared for change and strive for continuous learning and quality improvements. Acknowledge and reward innovation in practice and outcomes. Develop and contribute to an environment where every member of the team is the right person for their job, and is empowered to perform to the highest possible standard

> Collaboration: Actively communicate to achieve the best results by giving time, attention and effort to others. Respect and acknowledge everyone's input, skills and experience by working together and contributing to solutions. Share knowledge and resources willingly with your colleagues

> Integrity: Be open, honest and trustworthy when communicating with others, and ensure correct information is provided in a timely way. Be accountable, reflective and open to feedback. Be true to yourself, your profession, consumers, colleagues and the government.

ROLE, FUNCTIONS AND SERVICES

ACT Health aims to deliver better services to our:

> Community on behalf of our Government

> Government to meet the needs of our community.

We aim for improved efficiency in the use of resources by designing sustainable services that deliver outcomes efficiently, and embed a culture of research and innovation within the organisation.

ACT Health aims to help staff reach their potential, by providing high-level leadership and promoting a learning culture.

The *ACT Health Corporate Plan* provides direction to the organisation to:

> meet increasing demand for health services

> improve the health of vulnerable people

> improve the patient journey

> build and nurture a sustainable health system

> ensure the principle of safety and quality underpin all we do.

ACT Health has strengthened the foundations of our health system by:

> enhancing service delivery

> redeveloping capital infrastructure through our Health Infrastructure Program

CLIENTS AND STAKEHOLDERS

ACT Health partners with the community and consumers to improve health outcomes by:

> delivering patient and family-centred care

> strengthening partnerships

> promoting good health and wellbeing

> improving access to appropriate health care

> having robust safety and quality systems.

ACT Health works closely with other ACT Government agencies, including the:

> Community Services Directorate (CSD)

- Justice and Community Safety Directorate (JACS)
- Chief Minister, Treasury and Economic Development Directorate
- ACT Ambulance Service
- ACT Policing

ACT Health has formalised consultative arrangements with a range of agencies. These include:

- The ACT HealthCare Consumers' Association
- Capital Health Networks
- Mental health, alcohol and drug, and other community service providers.

The tertiary and training sectors are key partners in the planning, development and delivery of healthcare services.

ACT Health has formal partnership arrangements in place with:

- The Australian National University (ANU) Medical School,
- University of Canberra (UC)
- Australian Catholic University (ACU)
- Canberra Institute of Technology (CIT).

ORGANISATIONAL STRUCTURE

The ACT Health Director-General leads the organisation in the delivery of its vision.

ACT Health's Canberra Hospital and Health Services (CHHS) Division provides acute, subacute, primary and community-based health services to the ACT and surrounding region through its key service divisions.

The Little Company of Mary also provides public hospital services through Calvary Public Hospital, under a contractual agreement with ACT Health.

ACT Health's Strategy and Corporate Division provides corporate and strategic support to clinical service areas by:

- supporting national health reforms and National Partnership Agreements
- developing strategies for attracting and retaining the health workforce
- maintaining critical physical and technological infrastructure for public hospitals and health services

The Health Planning and Infrastructure Division manages the single largest capital works project undertaken in the history of the ACT. This includes:

- developing whole-of-government plans (as they relate to the Health Directorate and health services), the Health Directorate Corporate Plan, territory-wide strategic plans and clinical service plans that have a territory-wide impact
- directing and managing the directorate's Health Infrastructure Program, including health planning, coordination, management and implementation
- delivering strategic accommodation, the Capital Upgrades Program and the Arts in Health Program.

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

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

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

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

ORGANISATIONAL CHART

Kim Smith – Strategy & Corporate until 12/2/16. Paul Carmody until 17/5/16. Warren Prentice until 3/6/16. David Blythe appointed from 8/2/16. Chris Bone appointed from 2/11/15. Conrad Barr replaced John Wollard on 27/6/16.

ENVIRONMENT AND THE PLANNING FRAMEWORK

ACT Health's vision is 'Your Health—Our Priority'. To contribute to the broader ACT Government vision, this vision is supported by a range of strategic plans that identify objectives for the organisation.

There is recognition that the demand for health services is increasing every year.

New health technologies, higher consumer expectations an ageing population, and a growing consumer base all contribute to this demand.

The Corporate Plan articulates:

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

In 2015–16, ACT Health continued to measure its performance against these areas through:

> key performance measures identified in the ACT Public Health Service's quarterly performance report
> ACT Health's strategic and accountability indicator sets in the ACT Budget Papers.

SUMMARY OF PERFORMANCE

SUMMARY OF PERFORMANCE

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

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

Life expectancy at birth is:

> 85.2 years for females in the ACT, against a national average of 84.4 years
> 81.4 years for males, against a national average of 80.3 years.

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

For more information, see Strategic Objective 8: Management of Chronic Disease: Maintenance of the Highest Life Expectancy at Birth in Australia, page 32.

ACT Health assessed 100 per cent of emergency dental clients within 24 hours and saw a lower than the national result in the Decayed, Missing, or Filled Teeth (DMFT) index at ages six years and 12 years. The DMFT index at six years in the ACT was 1.03, compared to the national result of 2.13. At 12 years the ACT result was 0.70, compared to the national result of 1.05.

For more information, see:

> Strategic Objective 2: No Waiting for Access to Emergency Dental Health Services, page 30
> Strategic Objective 13: Achieve Lower than the Australian Average in the Decayed, Missing, or Filled Teeth Index, page 34.

Results show that 13,396 people were removed from the ACT elective surgery waiting list during 2015–16.

For more information, see Strategic Objective 1: Removals from Waiting List for Elective Surgery, page 29.

For radiotherapy, 100 per cent of emergency, 81 per cent of palliative and 82 per cent of radical radiotherapy patients commenced treatment within targeted time frames for 2015–16.

For more information, see Strategic Objective 3: Improving Timeliness of Access to Radiotherapy Services, page 30.

For women aged 50 to 69 years, 58 per cent had a breast screen in the 24 months prior to the counting period. This is slightly below the target of 60 per cent.

For more information, see Strategic Objective 4: Improving the Breast Screen Participation Rate for Women aged 50 to 69 years, page 30.

For the two-year Cervical Screening Program participation rate the ACT achieved a result of 57.9 per cent, on par with national average, which demonstrates the effectiveness of health promotion activities.

For more information, see Strategic Objective 12: Higher Participation Rate in the Cervical Screening Program than the National Average, page 34.

Public mental health services were effective in providing appropriate care to mental health clients, with only 9 per cent of clients returning to hospital within 28 days of discharge from an ACT public acute psychiatric unit following an acute episode of care. This is 1 per cent below the target of 10 per cent.

For more information, see Strategic Objective 6: Maintaining Reduced Rates of Patient Return to an ACT Public Acute Psychiatric Inpatient Unit, page 31.

ACT public hospitals achieved a mean bed occupancy rate of 86 per cent in 2015–16, consistent with the 2014–15 result.

For more information, see the Strategic Objective 7: Reaching the Optimum Occupancy Rate for all Overnight Hospital Beds section, page 31.

The ACT rate of admissions in persons aged 75 years and over with a fractured neck of femur was 5.5 per 1,000 persons in the ACT population, which is slightly above the long-term target of 5.3 per 1,000.

For more information, see Strategic Objective 14: Reducing the Risk of Fractured Femurs in ACT Residents Aged Over 75 years, page 34.

The prevalence of diabetes in the ACT of 4.3 per cent, which is similar to the national rate of 4.7 per cent.

For more information, see Strategic Objective 10: Lower Prevalence of Diabetes than the National Average, page 33.

The overall ACT Aboriginal and Torres Strait Islander immunisation rate of 90 per cent indicates a high level of investment in public health services to minimise the incidence of vaccine preventable diseases among the ACT's Aboriginal and Torres Strait Islander population.

For more information, see Strategic Objective 11: Addressing Gaps in Aboriginal and Torres Strait Islander Immunisation Status, page 33.

Results from the 2014 Australian Secondary School Alcohol and Drug Survey (ASSAD) show that 5.2 per cent of students were smokers in that year, slightly above the national average of 5.1 per cent.

For more information, see Strategic Objective 15: Reduction in the Youth Smoking Rate, page 34.

Our public hospitals continue to perform better than targets for:

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

For detailed information, see the ACT Local Hospital Network strategic objectives and indicators, page 35.

OUTLOOK FOR 2016–17

2016–2017 will be a pivotal year for ACT Health, as it moves to a new level of health service delivery to better meet the needs of the Canberra community for the future.

While the service remains committed to its core values – of care, excellence, collaboration and integrity – it will explore new opportunities for innovation, efficiency and sustainability, while delivering on ongoing commitments to provide more doctors, nurses and better health services for Canberra.

To help meet these challenges, ACT Health will receive a record investment of $1.6 billion in 2016–17.

2016–17 WILL BE ANOTHER YEAR OF GROWTH AND ACHIEVEMENT FOR ACT HEALTH.

The Canberra Hospital Emergency Department is under increasing pressure as a result of an ageing population with increasingly complex conditions, low bulk billing rates and its role as the major trauma centre for the ACT and surrounding regions.

Major reform is needed to allow doctors, nurses and other hospital staff to be able to continue delivering high-quality care in a way that allows them to meet national targets for timeliness.

In 2016–17, the Health Directorate will undertake significant reform of Canberra Hospital's Emergency Department to improve timeliness and access to emergency health care.

A three-tiered approach, focused on infrastructure, staffing and reforms, is being implemented including:

> Infrastructure: a $23 million dollar expansion of Canberra Hospital Emergency Department is currently underway, which will increase its capacity by more than a third. This is part of the ACT Government's $900 million Health Infrastructure Program that is changing the way health services are being delivered in the territory.
> Staffing: recruiting more staff to deliver timely access to emergency health care.
> Reforms: improving the current processes and work practices to allow staff to operate as efficiently and effectively as possible. For example, an Emergency Department Navigator has been appointed to improve the patient journey by overseeing access to services and supporting patient flow from triage to leaving Emergency Department.

Other strategic and operational initiatives to be pursued in 2016–17 include:

> delivering the $5 million Acute Ischaemic Stroke Unit, the $4.6 million intensive care bed and the $5.3 million expansion of trauma services at Canberra Hospital
> providing almost $29 million to employ a further 54 staff in the expanded Emergency Department at Canberra Hospital and $2 million for a new Emergency Department physician at Calvary Hospital
> funding $1.3 million for an additional 300 endoscopy services
> investing in new projects and improving health infrastructure such as the $2.4 million supported accommodation for people with mental health conditions and the $95.3 million infrastructure maintenance package

- continuing to strengthen mental health services by providing $2.7 million for two more beds at the Adult Mental Health Unit, $3.9 million for three targeted mental health programs and the $43.4 million for the operation of the Secure Mental Health Unit
- strengthening non–government organisations, to deliver tailored health programs and care to their clients including $1.3 million Aboriginal and Torres Strait Islander services and $176,000 for the Early Morning Centre
- researching, developing and delivering new and innovative techniques to improve care for patients through the establishment of a $7.3 million genomic service and $1.3 million for deep brain stimulation for people with Parkinson's Disease
- addressing the increased demand for drug treatment by providing $8 million to increase the capacity of front line services, including $2 million to specifically address family violence issues
- more funding for prevention and detection services such as the $1.3 million sexual health expansion, $507,000 for forensic chemistry and $4.2 million for growth in outpatient services.

INTERNAL ACCOUNTABILITY

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

Table 1 identifies the Senior Executives across the organisation.

TABLE 1: SENIOR EXECUTIVES

Senior Executive	Position
Nicole Feely	Director-General
Ian Thompson	Deputy Director-General, Canberra Hospital and Health Services
Dr Paul Kelly	Chief Health Officer, Population Health Division
Kim Smith	Deputy Director-General, Strategy and Corporate (until 12/2/16)
Paul Carmody	Deputy Director-General, Health Planning and Infrastructure (until 17/5/16)
Shaun Strachan (A/g)	Deputy Director-General, System Innovation Group
Ron Foster	Chief Finance Officer (until 4/4/16)
Cheryl Harkins (A/g)	Executive Director, Finance, Performance and Data Innovation
Brad Burch (A/g)	Executive Director, Strategic Partners, Infrastructure, Business and Digital Innovation
Matt Wright (A/g)	Executive Director, Access Innovation Partner
Yu-Lan Chan (A/g)	Executive Director, Workforce and Culture Innovation Partner
A/Prof Frank Van Haren	Director, DonateLife ACT
Liz Sharpe	Director, Strategic Projects
Dr Andrew Mitchell	Director, Territory-Wide Surgical Services
Warren Prentice (A/g)	Chief Information Officer, ehealth and Clinical Records Branch (until 3/6/16)
Phil Ghirardello	Executive Director, Performance Information Branch
Rosemary Kennedy	Executive Director, Business and Infrastructure Branch
Ross O'Donoughue	Executive Director, Policy and Government Relations Branch
Liesl Centenara (A/g)	Executive Director, People Strategy and Services Branch
Veronica Croome	ACT Chief Nurse
Dr Christina Wilkinson (A/g)	Chief Medical Administrator (until 26/6/16)
Karen Murphy	Chief Allied Health Officer
Prof Kirsty Douglas	Director, Academic Unit of General Practice and Professor of General Practice, ANU Medical School
Dr Marianne Bookallil	GP Advisor
A/Prof Deborah Browne	Executive Director, HealthCARE Improvement Division
Rosemary O'Donnell	Executive Director, Medicine
Katrina Bracher	Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
Prof Peter Collignon	Executive Director, Pathology
Linda Kohlhagen	Executive Director, Rehabilitation, Aged and Community Care
Barbara Reid	Executive Director, Surgery and Oral Health
Elizabeth Chatham	Executive Director, Women Youth and Children
Mark Dykgraaf	Executive Director, Critical Care
Adrian Scott	Executive Director, Clinical Support Services
Denise Lamb	Executive Director, Cancer, Ambulatory and Community Health Support
David Blythe	Principal Medical Adviser (from 8/2/16)
Chris Bone	Chief of Clinical Operations (from 2/11/15)
John Wollard	Executive Director, Health Protection Service (until 26/6/16)
Joanne Greenfield	Executive Director, Health Improvement
Dr Andrew Pengilley	Deputy Chief Health Officer, Office of Chief Health Officer

Senior management committees and roles

ACT Health committees are established at the following levels:

> Tier 1: directorate level
> Tier 2: division/branch level and Tier 1 subcommittees
> Tier 3: unit/team level.

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

Figure 1 shows the relationship between the Executive Council and other councils and committees.

FIGURE 1: RELATIONSHIP BETWEEN THE EXECUTIVE COUNCIL AND OTHER COUNCILS AND COMMITTEES

EXECUTIVE COUNCIL

The overarching governance committee for ACT Health is the Executive Council chaired by the Director-General. Its role is to:

> support the Director-General to meet responsibilities outlined in the Health Act 1993 and other relevant legislation
> make recommendations on the strategic direction, priorities and objectives of the organisation and endorse plans and actions to achieve the objectives
> oversee finance, performance and human resources
> set an example for the corporate culture throughout the organisation.
> The Executive Council meets twice monthly, where:
> one meeting focuses on finance, performance and other matters
> one meeting focuses on other business.

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

EXECUTIVE DIRECTORS' COUNCIL

The Executive Directors' Council provides an opportunity for all executive members to communicate and collaboratively work in partnership with other areas of ACT Health to deliver patient-focused, high-quality care by:

> influencing policy and strategic direction
> managing policy governance and risk
> maximising operational effectiveness.

Executive Directors' Quality and Safety Committee

The Executive Directors' Quality and Safety Committee provides high-level advice to the Executive Council on all matters regarding quality and safety and ensures impacts on patient safety are considered in decision-making. The committee:

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

Work Health and Safety Committee

The Work Health and Safety Committee:

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

Information Communication and Technology Committee

The Information Communication and Technology Committee:

> oversees the development of Health Directorate information management and information and communications technology (IM&ICT) plans, policies and frameworks, as required, ensuring whole-of-government issues are considered
> monitors lifecycle information and communications technology (ICT) asset management frameworks, strategies and policies and ensures these are

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

Health Infrastructure Program Strategic Committee

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

- providing advice
- monitoring progress
- monitoring risk in the Health Infrastructure Program.

Audit and Risk Management Committee

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

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

CANBERRA HOSPITAL AND HEALTH SERVICES OVERVIEW

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

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

ACHIEVEMENTS

During 2015–16, CHHS undertook a range of reform activities, which were designed to improve patient flow through Canberra Hospital, particularly the Emergency Department. The major focus areas were:

- improving our performance against the National Emergency Access Target (NEAT)
- conducting an elective surgery blitz by implementing the Longwait Reduction Strategy
- improving Medical Imaging services.

For more information, see section B.2 Performance analysis—Health Directorate strategic indicators—Strategic Objective 1: Removals from Waiting List for Elective Surgery, page 29.

Performance against targets

NEAT specifies that 90 per cent of all patients will leave the Emergency Department within four hours by being:

- discharged
- admitted to hospital or
- transferred to another hospital for treatment.

Between 1 March and 30 June 2016, the NEAT performance at Canberra Hospital was 68.6 per cent, compared with 57.5 per cent for the same period in 2015. This was achieved despite a 9 per cent increase in the number of presentations in 2016 compared with the same period of 2015.

For the month of June 2016 (up to 30 June 2016) the result was 72.7 per cent compared with 58.2 per cent for the same period in 2015.

Waiting lists

From November 2015 to 30 June 2016, the number of patients on waiting lists for Magnetic Resonance Imaging (MRI) scans, Computed Tomography (CT) scans and ultrasounds at Canberra Hospital reduced, with the number of patients waiting for:

- MRI scans reducing from more than 1,000 patients to approximately 300 patients
- CT scans reducing from 550 patients to no patients
- ultrasounds reducing from more than 1,100 patients to approximately 500 patients.

AT 30 JUNE 2016, THERE WAS NO WAITING LIST FOR CT SCANS.

CT scan patients with an outpatient's referral were able to book an appointment to have their scan performed within 48 hours. Improved efficiencies in medical imaging services have also resulted in reduced waiting times for Emergency Department patients requiring a CT scan, with:

- 75 per cent of these patients being seen within 45 minutes
- 25 per cent of these patients being seen within 90 minutes.

The strategy to reduce the number of patients waiting longer than the clinically recommended times for elective surgery has resulted in over 1,000 additional patients being removed from the Elective Surgery Waiting List in 2015–16.

Advance Care Planning

The Respecting Patient Choices program continues to provide Advance Care Planning (ACP) for CHHS and the wider ACT community. This includes participants completing:

- an Enduring Power of Attorney
- a Statement of Choices and Health Direction document.

The program continues to collaborate with, and fund, the Health Care Consumers Association of the ACT to raise awareness of ACP in the community. In 2015–16, activity increased, with:

- consumer contacts increasing by 56 per cent
- consultations increasing by 44 per cent
- completed documents received through the program increasing by 60 per cent.

Contact details: For more information on ACP, email rpc@act.gov.au or phone 02 6244 3344.

Surveys

Distribution of the Patient Experience inpatient survey began in March 2016. The survey collects information verbally or in writing from patients who have recently been discharged from Canberra Hospital. This information represents the patient's perspective and will be used to:

- identify and focus on areas where we need to improve our services
- generate additional ideas for service improvements
- identify service areas where we met or exceeded our patients' expectations.

Contact details: For more information, contact the Patient Experience Survey Coordinator via email at PtExpSurveys@act.gov.au or phone 02 6174 8190.

Quality improvement

Ongoing improvement in the quality and safety of care we provide our consumers is at the heart of a high-quality healthcare service. To support this aim, the HealthCARE Improvement Division is developing a Quality Improvement platform to assist staff to integrate clinical care improvements into their daily practice. The platform currently:

- features an Improvement Library, which is a 'go to' staff resource that provides feedback from clinical units across CHHS
- provides staff with tools and techniques to support them in their ongoing improvement work
- allows us to target improvements for the safe care of our patients.

OUTLOOK FOR 2016–17

The Division of Medicine will implement the Acute Medical Unit (AMU) model, incorporating the Medical Assessment and Planning Unit. The AMU will be a physician-led medical admissions short-stay unit. It will be structured to promote the inter-specialty and interdisciplinary care of patients who require unplanned admission to an internal medicine unit at Canberra Hospital.

New funding is being delivered as part of the 2016–17 ACT Budget to enhance the acute stroke service in the ACT. It will provide an additional four specialised clinical staff, which will provide faster assessments and more interventions for stroke treatment. This includes:

- more timely assessments for clot breakdown treatment at Canberra Hospital and Calvary Hospital
- adopting evidence-based care for patients who would benefit from clot retrieval using interventional radiology services at Canberra Hospital.

ACT Health has received Government approval to commence a trial of publicly funded homebirth. The trial will be conducted over three years up to a total number of 24 births per year. A framework document for the service has been written and endorsed. Expressions of interest for the homebirth trial will be taken from 4 October 2016.

The Secure Mental Health Unit is scheduled to open in November 2016. The will form part of an integrated care pathway for those people who need care and treatment as a result of their mental illness and associated comorbidity.

In 2016–17, staffing for the Trauma Service at Canberra Hospital will increase to provide Canberrans with more timely access to effective, efficient and flexible trauma care when they need it.

Palliative Care services based at Canberra Hospital will be expanded to:

> increase medical services for inpatients
> provide a paediatric palliative care nurse to specifically address the needs of children and young adolescents in the ACT.

STRATEGY AND CORPORATE DIVISION OVERVIEW

The Strategy and Corporate Division:

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

The Strategy and Corporate Division consists of seven branches:

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

Strategy and Corporate Division administers ACT Health's contract for the provision of Public Hospital services by Calvary Health Care ACT at Bruce and at Clare Holland House, and supports these close working relationships.

Calvary Health Care Bruce ACT's report on its achievements in 2015–2016 is provided in the following annexed report:

Attachments—Annexed and subsumed public authority reports—Calvary Health Care Ltd Annual Report 2015–16, page 218.

ACADEMIC UNIT OF GENERAL PRACTICE

The Academic Unit of General Practice (AUGP) is co-funded by the ACT Health Directorate and the Australian National University (ANU) Medical School. It is supported by research officers, nurses and administrative staff.

The AUGP has education, research and advocacy roles and contributes to State and national policy development through the work of the GP Advisor, Integrated Clinical Training Network and Health Workforce Australia.

The AUGP has contributed significantly to:

> delivering the ANU Medical School Program
> delivering junior medical officer training
> supporting GP vocational trainees
> supporting practicing doctors' medical education programs.

Senior AUGP staff have pivotal roles with:

> the ANU Medical School
> ACT Health
> the Department of Health
> the Royal Australian College of General Practitioners (RACGP)
> the Capital Health Network
> the Australian Association of Academic Primary Care
> the Canberra Regional Medical Education Council
> the Confederation of Postgraduate Medical Education Councils.

The AUGP teaching and research GPs also provide clinical services in the community to ensure they are actively involved in all aspects of general practice.

The AUGP leads research using ACT Health Kindergarten Health Check data. Other research activities include those associated with:

> integrated service development
> clinical research
> individual routes to health and healing
> social determinants of medical care
> scholarship in teaching and learning.

Key achievements

During 2015–16, AUGP's key achievements included the following:

> delivering ANU Medical School Program
> supporting the Healer's Art
> conducting supervisor and registrar teaching
> supporting the GP Workforce Infrastructure Program
> funding the Peter Sharp Scholarship
> conducting Kindergarten Health Check research
> conducting Treating Adult Obesity in General Practice research
> conducting Refugee Health research
> conducting Integration in Primary Health Care research
> conducting Vertical Integration of GP Education research
> auditing referrals and discharges between residential aged care Facilities and hospitals

> conducting Teach-the-Teacher workshops
> participating in GP Grand Rounds.

Strategic partnerships have been maintained with the Research School of Population Health at the ANU, and with Capital Health Network.

Future directions

Research efforts will continue in the areas of primary care in vulnerable populations, medical education and child health.

Canberra Region Medical Education Council

The Canberra Region Medical Education Council (CRMEC) performs accreditation functions for intern training and education programs in the ACT and region for:

> Canberra Hospital and Health Services (CHHS)
> Calvary Health Care ACT
> Goulburn Base Hospital
> Bega District Hospital.

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

Key achievements

Accreditation activities that occurred in 2015–16 included the following:

> On 22 July 2015, the CRMEC, in conjunction with the New South Wales (NSW) Health Education and Training Unit (HETI), undertook accreditation for Bega District Hospital. The hospital was awarded a three-year accreditation with:
  - two Commendations
  - four Provisos
  - three Recommendations.
> On 11 and 12 November 2015, the CRMEC undertook the accreditation of Calvary Health Care ACT. Calvary Health Care ACT was awarded a three-year accreditation with:
  - two Commendations
  - five Provisos
  - six Recommendations.
> For CHHS the CRMEC undertook accreditation of new terms, change of terms and monitoring of Provisos.

Other key activities for the CRMEC in 2015–16 included the following:

> The inaugural meeting for Directors of Training was held to discuss current issues around registrar training and pathways for junior doctors into specialty training. A report summarising training across the network was written. The report found that, overall, junior doctors are having an excellent training experience across the network.
> The CRMEC was involved in the Review of Intern Training, which involved making multiple submissions and being represented on the Health Workforce Principal Committee (HWPC) Working Group.
> The CRMEC was also involved in the Confederation of Postgraduate Medical Education Councils meeting and activities.

Future directions

Key activities for the CRMEC for 2016–17 include the following:

> Reviewing supervisor capacity and quality across the region. This review will:
  - examine supervision across all levels: student, prevocational and specialty training
  - provide recommendations for support, planning and capacity.
> Continuing to develop a CRMEC logo and website, which should be in operation by May 2016.
> In conjunction with HETI, undertaking accreditation of Goulburn Hospital in August 2016.
> Continuing to develop partnerships. In August 2016 CRMEC is partnering with HETI in organising a two-day education forum to explore training issues across NSW and the ACT. Our partnership with South Australia Medical Education and Training continues to be strong.

Business and Infrastructure Branch

Business and Infrastructure Branch is responsible for providing a range of infrastructure and strategic support services to all ACT Health acute and non-acute sites across the ACT.

The Business and Infrastructure Branch portfolio includes the following services:

> Business Continuity Management
> Communications
> Corporate Records Management
> Domestic and Environmental Services
> Fire and Emergency Coordination and Training
> Fleet Management
> Food Services
> Main Reception / Switchboard
> Parking
> Procurement and Asset Management
> Property Management and Maintenance

- Residential Accommodation
- Security Services
- Sterilising Services
- Supply Services
- Sustainability
- Volunteer Management.

Key achievements

Courtesy Bus

In June 2015, a Courtesy Bus service was introduced at the Canberra Hospital campus. The service is designed to assist patients, visitors and staff with mobility difficulties to navigate across the campus. The decision to run the service was based on feedback received from consumers, specifically regarding the distance from the multi-storey car park to the main hospital and the Centenary Hospital for Women and Children (CHWC).

The service has been received favourably by the community and staff, with positive feedback having been received since its implementation.

In 2016–17, ACT Health will seek further feedback on the service as part of quality improvement practices.

Food services

In the 2014–15 Annual Report, Business and Infrastructure Branch reported on the success of a Meal Service Quality Improvement Project, in a report named A Quality Improvement Journey in Service Delivery to Aged Care – The Canberra Hospital Experience. The project resulted in improved menu items and packaging, as well as greater 'access' to meals through the use of coloured tray mats to identify which patients require some or full assistance with their meal.

The Food Services Department at Canberra Hospital submitted the project for consideration in the 2015 Rosemary Pirie Excellence Awards. The National Board of the Institute of Hospitality and HealthCare Australia select a recipient or organisation to be awarded the national Rosemary Pirie Excellence Award in recognition of the contribution they have made toward providing excellence in Health and Aged Care Food or Hotel Services Training and Quality assurance.

The Meal Service Quality Improvement Project was awarded the Rosemary Pirie Excellence Award at the 34th Institute of Hospitality in HealthCare National Conference in October 2015.

THE MEAL SERVICE QUALITY IMPROVEMENT PROJECT WAS AWARDED THE ROSEMARY PIRIE EXCELLENCE AWARD AT THE 34TH INSTITUTE OF HOSPITALITY IN HEALTHCARE NATIONAL CONFERENCE.

Sterilising Services accreditation

ACT Health Sterilising Services has been successfully accredited for ISO 9001:2008 Quality Management System (QMS) since 2006. This is a three-year re-certification cycle, which was last achieved on 30 November 2014. An annual surveillance assessment is required to maintain re-certification. The surveillance assessment was conducted on 21 August 2015 and all objectives were achieved.

Sustainability

In August 2015, the Minister for Health and Minister for the Environment, Simon Corbell MLA, announced that ACT Health were successful in their application to the ACT Government Carbon Neutral Government Fund (CNGF).

The application will fund:

- the installation of photovoltaic (PV) solar panels (500KW) on the roof of the Southern (multi-storey) Car Park at Canberra Hospital
- an LED replacement program for existing hospital infrastructure.

Issues and challenges

ACT Health's energy usage continues to grow in line with increased activity and significant additional infrastructure that has come online in the past few years. Canberra Hospital is one of the ACT Government's largest user of electricity, consuming almost 20 per cent of the Territory's electricity to power its critical 24-hour service.

Hospitals are high energy consumers due to:

- their size and operation
- the number of bathrooms and operating theatres
- the energy requirements of the numerous pathology services, Medical Imaging services and diagnostic equipment.

All contribute to the volume of energy consumed, particularly at Canberra Hospital which is the region's tertiary referral hospital and major trauma centre.

Installing PV solar panels on the multi-storey car park and LED lighting throughout existing buildings will assist to reduce the energy usage in the future.

Future directions

It is important that new technologies and innovative solutions be introduced and implemented to:

> service both the current and future demands of support services
> enhance the patient-focused service delivery across all areas of health care.

Business and Infrastructure Branch's implementation of an automated identification system for assets, patients and staff will continue to progress.

Currently, the project is standardising the identifiers used in linear barcodes and Radio-frequency Identification (RFID) formats that are used in ACT Health. In implementing this system, the branch has adopted international standards and developed a Location-based Services Framework. This work is supported through GS1 Australia.

At Canberra Hospital the standards have been implemented to identify patients and staff when collecting pathology samples. Work is continuing to implement these standards to support real-time tracking and location identification of movable and portable assets.

To further improve the Courtesy Bus service, a live GPS tracking device has been installed in the bus to provide consumers with real-time route information. The live route map will be accessible on the ACT Health website and via a Quick Response (QR) code.

Business and Infrastructure Branch will also continue to review systems and processes as part of quality improvements and to gain efficiencies.

eHealth and Clinical Records Branch

Key achievements

The eHealth and Clinical Records Branch oversaw improvements to a range of existing information and communication technology (ICT) solutions, including the following:

> Introducing a new electronic clinical record system for the Walk-in Centres (WiCs) at Tuggeranong and Belconnen, to support clinical and administrative workflows.
> Introducing the QFlow system at Belconnen Community Health Centre, to streamline appointment processes and healthcare consumer assistance processes.
> Expanding the use of an improved clinical record search and registration solution, known as Active Search. This functionality leverages the patient master index to provide advanced searching tools that support fast, effective patient record searches and reduce duplicate record creation rates.
> Continuing to rollout a rapid access technology solution which enables Canberra Hospital clinical staff to log into shared computers within 4–6 seconds.
> Introducing a new system for the Revenue and Financial Services Unit.
> Enhancing the ACT Health Clinical Portal, including introducing a surgical safety checklist.
> Expanding the eRostering system for a range of community-based staff.
> Introducing the Epiphany system, for storing echocardiograms and generating associated reports.
> Expanding the Renal Service information system, to provide access for Renal Service staff operating in NSW regional locations.

A range of existing systems were also upgraded, including:

> the risk and incident management system
> systems used by the Clinical Record Service, Facilities Management, Medical Imaging, Emergency Department, Equipment Loans Service, Thoracic Unit, and the Renal Service.

In addition, e-learning packages were developed for a number of ACT Health clinical systems.

Future directions

eHealth and Clinical Records Branch is working towards implementing a range of initiatives to support staff in delivering high-quality care to our healthcare consumers. These initiatives will build on the solid eHealth foundation that has been established over the past few years. The objectives that guide these initiatives include:

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

POPULATION HEALTH DIVISION OVERVIEW

The Population Health Division has primary responsibility for managing 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.

The division consists of:

> Health Improvement Branch (HIB)
> Health Protection Service
> Office of the Chief Health Officer (OCHO)
> Health Emergency Management Unit (HEMU).

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

The HIB has carriage of policy and program delivery in the areas of health promotion and preventive health.

The HIB also collects, analyses and disseminates information on the health status and health-related behaviours of the ACT population. This information can be used to monitor, evaluate and guide health planning and policy.

The Health Protection Service manages risks and implements strategies for the prevention of, and timely response to, public health incidents. This is achieved through a range of regulatory and policy activities relating to areas such as:

> food safety
> communicable disease control
> environmental health
> pharmaceutical products
> tobacco control
> analytical services.

The 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 ACT Chief Health Officer. Key policy priority areas for the OCHO include:

> obesity and injury prevention and reduction
> medicinal cannabis
> loose-fill asbestos
> organ and tissue donation
> gene technology
> climate change.

The HEMU provides direction and advice to support ACT Health responses to:

> incidents
> emergencies
> public health risks
> disasters that occur locally, nationally and internationally.

ACHIEVEMENTS

Population Health Division has introduced several legislative changes since February 2016 to protect or improve the health of the population:

> Smoke-Free Public Places Amendment Bill 2016: this amendment restricts the sale, promotion and use of personal vaporisers (e-cigarettes).
> Medicines, Poisons and Therapeutic Goods Regulation 2008: this amendment allows pharmacists to administer vaccinations to adult patients without a prescription.
> Transplantation and Anatomy Amendment Bill 2016: this amendment introduces a more efficient organ donation process.
> Smoke-Free Public Places Amendment Bill 2016: this amendment will streamline the process for establishing new smoke-free areas.
> Medicines, Poisons and Therapeutic Goods Regulation 2008: this amendment introduces a more streamlined and flexible process for prescribing controlled medicines.

In June 2016, Population Health Division released Healthy Canberra: the 2016 Chief Health Officer's Report, which focused on four key areas:

> Healthy City
> Healthy Weight
> Healthy Lifestyle
> Healthy People.

This year's report is complemented by a new HealthStats ACT website, which provides health statistics on a broad range of population health topics.

The Population Health Division continued to work closely with Chief Minister, Treasury and Economic Development Directorate (CMTEDD) to implement the Healthy Weight Initiative (HWI) and aligned programs to reduce the burden of overweight and obesity-related chronic diseases and demand on the health services, including the following:

> Releasing the Healthy Weight Initiative Progress Report 2016. This report outlines how policy- and program-level actions have progressed since the implementation of the HWI. The reporting timeframe covers from the HWI's inception in October 2013 through to June 2016. The report found some positive progress has been made towards meeting almost half of the HWI health targets, but there are areas where more work is needed to ensure momentum is maintained in the long-term.
> Introducing the Choose Healthier local business pilot project which is a pilot of five businesses that have increased their promotion and availability of healthy food and drinks, and reduced the marketing of unhealthy food and drinks, particularly towards children.

- Releasing the ACT Health Promotion Grants Program Report which provides a snapshot of how the ACT Government's investment in the ACT Health Promotion Grants Program has improved health outcomes across the ACT. Over 90 per cent of the ACT Health Promotion Grants Program funding was provided to programs that address issues of overweight and obesity in the ACT.
- Continuing to deliver programs and campaigns that improve the health and wellbeing of the ACT community, including:
  - Kids at Play
  - Good Habits for Life
  - Fresh Tastes
  - Ride or Walk to School
  - It's Your Move.

The ACT continued to lead the country in immunisation rates for children under five years old, with rates consistently above 90 per cent in all age cohorts.

OUTLOOK FOR 2016–17

The Population Health Division will undertake work to establish a Medicinal Cannabis Scheme in the ACT to give people safe and legal access to high-quality medicinal cannabis products.

In 2016–17, amendments will be made to the *Medicines Poisons and Therapeutic Goods Regulation 2008* to introduce a more flexible approach when applying for ACT Chief Health Officer approval for controlled medicines.

In 2016–17, the *Public Health Amendment Bill 2016* will be introduced to allow public health officers to better manage insanitary conditions resulting from hoarding and domestic squalor in the ACT.

HEALTH PLANNING AND INFRASTRUCTURE DIVISION OVERVIEW

During 2015–16, Health Planning and Infrastructure Division had corporate responsibility for:

- the project direction and management of the Directorate's Health Infrastructure Program, including coordination, management and implementation
- strategic accommodation
- the Capital Upgrades Program
- the Arts in Health Program
- the Woden Relocation Project.

ACHIEVEMENTS

2015–16 marked the eighth year of the Health Infrastructure Program.

A range of projects within the Health Infrastructure Program have been completed, others are ongoing and a number recently commenced. Planning, designing and constructing facilities is aligned with concurrent activity relating to:

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

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

Section C.3 Capital works, page 193, provides a detailed description of the progress on Health Infrastructure Program works, and works undertaken as part of the Capital Upgrades Program.

Projects delivered in 2015–16 by the Health Planning and Infrastructure Division as part of the Health Infrastructure Program, or under the Capital Upgrades Program, included:

- refurbishing the Central Outpatients Department
- constructing a new cryogenics facility at Canberra Hospital
- completing the Calvary Hospital Car Park
- constructing the new modular Building 15 at Canberra Hospital.

The Arts in Health Program includes the development and implementation of briefs for art in new Health Infrastructure Program projects.

The year 2015–16 saw the completion of projects at Belconnen Community Health Centre and Paediatric Emergency, Apheresis in the Canberra Region Cancer Centre and continued procurement of works for the Centenary Hospital for Women and Children (CHWC). The program also saw a pilot dance project in association with Ausdance ACT at the CHWC. These projects have been funded by the Canberra Hospital Foundation, including donations by Ausdance ACT and some in kind donations by artists.

Procurement of works of art for the Secure Mental Health Unit is underway and a brief for art at the University of Canberra Public Hospital is in progress.

OUTLOOK FOR 2016–2017

The following Health Planning and Infrastructure Program projects are programmed to be completed in 2016–17:

- the Emergency Department Expansion Project
- Ngunnawal Bush Healing Farm
- Secure Mental Health Unit
- Calvary Hospital – Operating Theatre Upgrade and Medical Imaging Department Upgrade

- Hospital Road upgrades to provide additional capacity to Canberra Hospital
- installation of internal signage across Canberra Hospital campus.

The following project will continue construction throughout 2016–17:

- University of Canberra Public Hospital.

The following Health Infrastructure projects are programmed to commence construction in 2016–17:

- Southern Carpark Solar Panel Project
- Electrical Main Switchboard Replacement at Canberra Hospital.

CORPORATE AND OPERATIONS PLANS

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

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

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

ACT ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKFORCE ACTION PLAN 2013–2018

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

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

ACT HEALTH WORKFORCE PLAN 2013–18

The *ACT Health Workforce Plan 2013–2018* aligns with national health workforce reforms, including the research and evidence provided by the Health Workforce Australia (HWA) *National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015*. The plan provides strategies under focus areas for direction, action, accountabilities and measures of success, which are able to be applied to operational workforce planning in all areas of ACT Health.

ACT BREASTFEEDING STRATEGIC FRAMEWORK 2010–2015

The ACT Breastfeeding Strategic Framework 2010–2015 sets the context for protecting, promoting and supporting breastfeeding in the ACT. The framework supported the implementation of the action areas in the *Australian National Breastfeeding Strategy 2010–2015*.

ACT CHRONIC CONDITIONS STRATEGY 2013–2018

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

ACT HEALTH CORPORATE GOVERNANCE STATEMENT, 2015

The *ACT Health Corporate Governance Statement, 2015* provides an overview of the organisation. It is a starting point for gaining further detailed information on organisational:

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

ACT HEALTH CORPORATE PLAN 2012–2017

The *ACT Health Corporate Plan 2012–2017* articulates:

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

In 2015–16, ACT Health continued to measure its performance against these areas through key performance measures identified in:

- the ACT Public Health Service's quarterly performance reports
- ACT Health's strategic and accountability indicator sets in the ACT Budget Papers.
- The target achievements for each year are contained in ACT Health's Business Plan.

ACT HEALTH QUALITY AND CLINICAL GOVERNANCE FRAMEWORK 2015–2018

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

ACT HEALTH RECONCILIATION ACTION PLAN 2015–18

The *ACT Health Reconciliation Action Plan 2015–18* will build on the previous plan, which was created to foster a cultural change in the health environment. The new plan ensures that ACT Health will continue working towards reconciliation and to making a difference in health outcomes for Aboriginal and Torres Strait Islander peoples.

In reflecting on our cultural awareness training achievements to date, ACT Health is resolved to further our commitment to building a culturally proficient organisation. We will do this by increasing our awareness of reconciliation and encouraging conversations within ACT Health on how we can work towards creating a cultural proficient workforce that recognises that health is not just the physical wellbeing of an individual but the social, emotional and cultural wellbeing of the whole community.

ACT AND SOUTHERN NSW LOCAL HEALTH DISTRICT CANCER SERVICES PLAN 2015–2020

The *ACT and Southern NSW Local Health District Cancer Services Plan 2015–2020* acknowledges the necessity for close collaboration between the ACT and Southern NSW Local Health District (SNSWLHD) health services when planning cancer services for the region's population. The plan:

> provides overarching strategic direction for cancer services across both the ACT and SNSWLHD
> highlights the need to work together in order to provide person-centred care that is equitable and timely
> recognises that the number of people needing cancer treatments in the Southern NSW (SNSW) region is expected to grow significantly, which reflects an ageing demographic, and that this is a very important part of our health service planning
> builds on Australia's very strong role in recognising that a fully comprehensive approach to cancer control needs to consider the role of primary and secondary prevention
> addresses that with improvements in the science of cancer, we need clinicians who are skilled at dealing with the human dimensions of care, and that this is crucial area of workforce capability.

In addition, the plan addresses the requirement for modern cancer services to have strong linkages between disciplines such as:

> research, an area in which Canberra Hospital has had great success
> cancer service clinicians, e.g. Medical Oncology
> clinical trials in new cancer therapeutics.

The role of ACT Health in developing a national-level centre of excellence in cancer services at Canberra Hospital is pivotal to delivering the plan, whereby:

> the Canberra Hospital service functions as the main tertiary Oncology referral service for the region and provides the leadership and support required in regional areas
> clinicians in SNSW hospitals deliver considerable cancer-related care, e.g. surgery, medical oncology day centres and palliative care.

ACT HEALTH SUSTAINABILITY STRATEGY 2010–2015

The *ACT Health Sustainability Strategy 2010–15* is designed to meet the challenges that climate change will have on the ACT. It provides a roadmap for collaborative action between ACT Health and all stakeholders, clients and staff, including other government departments. The roadmap ensures business and clinical services (including planning for the future) are linked with the strategy and incorporate actions and achievements to deliver the objective of a sustainable health system for the future.

A renewed ACT Health Sustainability Strategy for 2016–2020 has been drafted. It embraces the roadmap as a checklist for deciding what actions to take and actively tracks progress towards the established aims and objectives. The renewed strategy will lead a plan of action that also captures strategies from and aligns timescales with the *ACT Health Resource Management Plan 2016–2020*.

POPULATION HEALTH DIVISION STRATEGIC FRAMEWORK 2013–2016

The *Population Health Division Strategic Framework 2013–2016* verifies the role of the Population Health Division in the context of other key players working in public health in the ACT. The framework identifies strategic objectives for the division to meet in improving the health of the ACT.

ACT IMMUNISATION STRATEGY 2012–2016

The *ACT Immunisation Strategy 2012–2016* provides a framework for improving immunisation services and coverage within the ACT. It continues the work achieved in the previous immunisation strategy by building on its achievements and identifying further focus areas for immunisation.

FUTURE DIRECTIONS FOR TOBACCO REDUCTION IN THE ACT 2013–2016

The ACT Government's *Future Directions for Tobacco Reduction in the ACT 2013–2016* was launched on 31 May 2013, World No Tobacco Day. It focuses on two key action areas for further development:

> restricting access to tobacco
> restricting places of tobacco use.

ACT HEALTH MENTAL HEALTH SERVICE PLANNING

ACT Health is working with the ACT Capital Health Network to develop a consistent jurisdictional approach for mental health planning for the ACT. The Capital Health Networks across Australia are tasked by the Commonwealth Government to develop regional mental health plans that are endorsed by the Local Hospital Networks.

ACT LYMPHOEDEMA PLAN 2015–2018

The *ACT Lymphoedema Services Plan 2015–2018* is a high-level strategic planning document that guides the delivery of public lymphoedema services to residents of the ACT and surrounding region.

The plan promotes communication and collaboration across public and private services in the ACT and surrounding region. In addition, a framework for services has been developed and a Lymphoedema Services Network has been established in order to better meet the needs of people in the ACT region and respond to increasing demand in an efficient and sustainable way.

The plan highlights a 'Hub and Spoke' model for service provision to enable a critical mass of specialist clinicians to provide treatment and to provide education to General Practices and staff in community and hospital settings. The Hub will be based at Calvary Hospital and the Spokes will include a northside and a southside community health centre.

ACT PALLIATIVE CARE SERVICES PLAN 2013–2017

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

IMPROVING WOMEN'S ACCESS TO HEALTH CARE SERVICES AND INFORMATION: A STRATEGIC FRAMEWORK 2010–2015

The *Improving Women's Access to Health Care Services and Information: A Strategic Framework 2015–2016* has provided the overarching strategic directions, i.e. long-term objectives, for ACT Health to enable and enhance women's access to and satisfaction with healthcare services. The target group for this framework is females aged 12 years and over.

MYHEALTH STRATEGY

In January 2015, ACT Health demonstrated its commitment to staff wellbeing, by establishing the MyHealth Manager role with recurrent annual funding The M*yHealth Staff Health and Wellbeing Strategy and Action Plan 2016–2018* provides a framework to enable ACT Health to develop, implement and monitor wellbeing initiatives to December 2018. The strategy's overall objectives fall under the categories People, Places and Culture, and the four key focus areas are:

> Emotional Wellbeing
> Smoke-Free Environment
> Healthy Eating and Drinking
> Physical Health.

TOWARDS CULTURALLY APPROPRIATE AND INCLUSIVE SERVICES – A CO-ORDINATING FRAMEWORK FOR ACT HEALTH (2014–18)

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

After extensive consultation, the MCHPU released *Towards Culturally Appropriate and Inclusive Services – A Co-ordinating Framework for ACT Health (2014–18)* to improve responsiveness to cultural and linguistic diversity across the organisation.

For more information, see B.1 Organisational overview—2015–16 strategic priorities—Improving services and information for people from culturally and linguistically diverse backgrounds, page 25.

SYSTEM INNOVATION GROUP

The System Innovation Group (SIG) is a new organisational unit headed by the Deputy Director-General, ACT Health System Innovation Group.

SIG partners with other areas of the organisation to lead innovation in the areas of:

> access, quality and mental health
> workforce and culture
> strategic partners, infrastructure, business and digital
> finance, performance and data innovation.

ACT Health established the SIG to manage the System Innovation Program (SIP), which was approved by the ACT Government in November 2015.

The SIP is ACT Health's approach for achieving continuous improvement in ACT Health services. The approach aims to strengthen the delivery of health care by focusing on patient-centred care and enriching the patient experience.

SIP outcomes are delivered across seven key organisation-wide themes:

> Access
> Quality
> Mental Health
> Innovation and Sustainability
> Strategic Partners
> Infrastructure
> Culture.

The SIP objectives include improving access to services, increasing efficiency and freeing up hospital capacity by implementing contemporary service delivery solutions and models of care.

More specifically the SIP is focusing on:

> Improving efficiency by:
  – increasing the bed efficiency equivalent to 50 overnight beds by 2018–19
  – achieving savings totalling $97.2m between 2016–17 and 2019–20.
> Progressively improving ACT Health's performance against the National Emergency Access Target (NEAT), by the achieving the following targets:
  – 69 per cent by 30 June 2016
  – 77 per cent by 30 August 2016
  – 90 per cent by June 2017.

- Improving our performance against the National Elective Surgery Target (NEST) by:
  - reducing the number of paediatric patients classified as 'long wait' to zero
  - reducing the remaining 'long wait' list by 90 per cent.
- Reducing the need for category 4 and 5 presentations to attend the ED.

In addition, ACT Health has committed to becoming a leading public healthcare organisation in terms of culture, including:

- revitalising ACT Health's values
- improving the methods of managing organisational change
- continuing initiatives to address and prevent inappropriate workplace behaviour.

SIP is driven by a process of transformational change through an Integrated Program Management Office (IPMO), which is administered under SIG.

The IPMO is responsible for coordinating and reporting for ACT Health SIP.

ACHIEVEMENTS

During 2015–16, SIG's achievements included:

- establishing the SIG itself and the SIP
- establishing the IPMO
- providing centralised coordination, support and governance to 93 projects across ACT Health
- improving ACT Health's performance against the NEAT to meet our 30 June 2016 target of 69 per cent
- improving ACT Health's performance against the NEST by conducting more than 1,300 additional 'long wait' elective surgery cases by June 2016
- reviewing Medical Imaging services, which has resulted in significant improvements in outpatient waiting times for CT and MRI scans
- developing a Strategic Asset Management Framework.

OUTLOOK FOR 2016–2017

Initiatives to be pursued in 2016–17 include:

- developing Strategic Asset Management Plans
- developing a Performance Excellence Framework
- implementing Activity-based Funding and Activity-based Management
- transitioning from a consultant-led to an in-house Program Management Office capability.

2015–16 STRATEGIC PRIORITIES

Strategic and operational initiatives pursued in 2015–16 included:

- continuing to meet the growth in the demand for services across acute care, mental health, palliative care, women's and children's, outpatients and community health
- providing increased community mental health, alcohol and other drug treatment services including supportive accommodation, Crisis Assessment and Treatment Team, self-harm diversion, specialist drug treatment and support for people with psychogeriatric conditions
- continuing work to improve health and wellbeing within the Aboriginal and Torres Strait Islander community;
- continuing to support a reduction in the burden of chronic disease and the related increasing costs of health care through a range of programs to promote and support healthy lifestyles
- increasing the level of elective surgery operations provided for the ACT community
- strengthening the capacity of non-government organisations to deliver specialist drug treatment and support services.

MEETING GROWTH IN DEMAND

Overview

In 2015–16, ACT public hospitals had increased demand for:

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

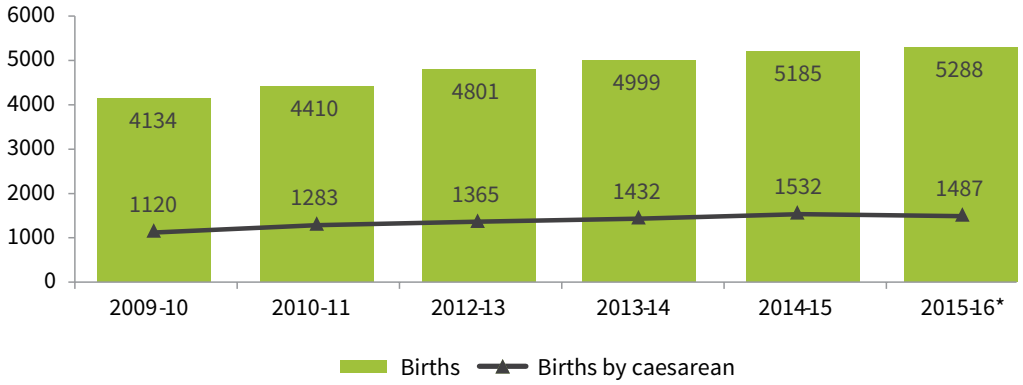
To meet growing demand for hospital services, the 2015–16 ACT Budget provided further funding for an additional 19 beds across ACT public hospitals. The 2015–16 Budget was $1.5 billion, which is a 7 per cent increase on 2014–15.

Births

In 2015–16, preliminary figures show there were a total of 5,288 births at ACT public hospitals, an increase of 2 per cent from 2014–15. As shown in Figure 2, the result for 2015–16 is the highest number of births within a single year for ACT Health.

In 2015–16, the number of births by caesarean section equates to 28 per cent of all births.

FIGURE 2: ACT PUBLIC HOSPITALS BIRTHING INSTANCES VS. CAESAREAN



**Preliminary figures used for 2015–16. Source: ACT Health Admitted Patient Care Dataset*

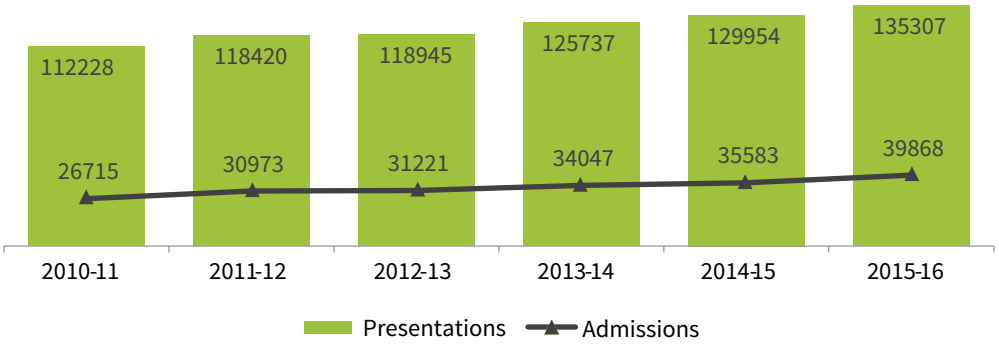
Emergency Department presentations

Figure 3 shows that in 2015–16 ACT public hospital Emergency Departments had 135,307 presentations, a 4 per cent increase on 2014–15.

Admissions to hospital via the Emergency Department increased by 12 per cent to 39,868 in 2015–16.

More information: For detailed information on improving Emergency Department timeliness, see B.2 Performance Analysis, ACT Local Hospital Network strategic objectives and indicators, Strategic Objective 2: Improved Emergency Department Timeliness, page 35.

FIGURE 3: ACT PUBLIC HOSPITALS PRESENTATIONS TO THE EMERGENCY DEPARTMENT VS. ADMISSIONS TO HOSPITAL VIA THE ED



Source: ACT Health Emergency Department Published Dataset.

Alcohol and Other Drug Services

In mid-2015, the ACT Government announced one-off funding of $800,000 to increase the capacity of specialist drug treatment and support services, to prevent and reduce increasing methamphetamine and other drug-related harms. The funding allowed:

- new staff to be hired
- services to provide treatment earlier through improved management of waiting lists.

IN THE RECENT 2016–17 BUDGET ANNOUNCEMENT, THE ACT GOVERNMENT ANNOUNCED $6 MILLION OVER FOUR YEARS FOR MORE DRUG TREATMENT AND SUPPORT SERVICES.

This includes annual funding to:

- maintain the additional capacity created in 2015–16
- rollout the successful naloxone program for those at risk of opioid overdose, through the Canberra Alliance for Harm Minimisation and Advocacy
- provide booster training sessions for drug treatment and support workers
- assess alcohol and other drug education and training needs of those working in allied sectors and to customise and deliver training
- increase the capacity of drug rehabilitation programs to provide post-treatment support in conjunction with peer treatment support workers.

IMPROVING HEALTH AND WELLBEING WITHIN THE ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITY

The Ngunnawal Bush Healing Farm will provide a culturally appropriate alcohol and other drug residential rehabilitation facility for adult Aboriginal and Torres Strait Islander people in the ACT. The initial service will be an eight-bed facility with scope to increase to 16 beds, subject to future funding decisions.

Construction of the facility is expected to be completed in the second half of 2016. Development approvals and negotiations to secure a service provider are progressing.

IMPROVING SERVICES AND INFORMATION FOR PEOPLE FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

The Multicultural Health Policy Unit continued to facilitate implementation of *Towards Culturally Appropriate and Inclusive Services – A Co-ordinating Framework for ACT Health (2014–18)*, focusing on four key areas:

> improving data collection
> providing culturally appropriate services and information
> engaging Culturally and Linguistically Diverse (CALD) consumers in providing feedback and participating in service planning and review
> developing organisational cultural competence.

The Multicultural Health Policy Unit also introduced:

> a Language Services Policy and related procedure on the use of interpreters
> a comprehensive ACT Health Guide to Language Services.

The unit was also finalist in the safety category of the 2015 ACT Safety and Quality in Health Care Awards for increasing interpreter use in clinical services.

THE MULTICULTURAL HEALTH POLICY UNIT WAS A FINALIST IN THE 2015 ACT SAFETY AND QUALITY IN HEALTH CARE AWARDS.

The unit presented the keynote address at a Health Literacy Conference, which was held in Melbourne in March 2016.

The unit also increased the training and learning opportunities provided to staff by:

> further developing intranet-based resources and other resources
> providing face-to-face and e-learning on cultural competence and working with interpreters
> in partnership with the Centre for Culture, Ethnicity and Health (Victoria), developing the Health Literacy Development Course, which focuses on cultural diversity
> maintaining the ACT Health Multicultural Reference Group, which has participants from key external organisations.

In May 2016, the unit received additional resources to include a focus on other groups facing similar issues of stigma, discrimination and difficultly accessing responsive health services, including:

> lesbian, gay, bisexual, transgender and intersex (LGBTI) people
> people living with disabilities.

IMPLEMENTING PROGRAMS THAT PROMOTE AND SUPPORT HEALTHY LIFESTYLES

ACT Aboriginal and Torres Strait Islander Health Plan

ACT Health is currently developing a new *ACT Aboriginal and Torres Strait Islander Health Plan: Priorities for the Next Five Years 2016-2020* (Health Plan). In line with feedback from initial consultations held in August and December 2014, the Health Plan will:

> respond to key areas outlined in the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 and the ACT Aboriginal and Torres Strait Islander Agreement 2015–2018
> be consistent with the values and principles of the United Nations Declaration on the Rights of Indigenous Peoples.

The Health Plan will include identifying key priority areas for action such as:

> mental health and social and emotional wellbeing
> chronic disease
> community health
> culturally skilled workforce
> health performance
> quality improvement.

Tobacco control

During 2015–16, the Government continued to implement initiatives to reduce smoking rates among Aboriginal and Torres Strait Islander peoples in the ACT.

Ongoing funding was provided to Winnunga Nimmityjah Aboriginal Health Service (Winnunga) and Gugan Gulwan Youth Aboriginal Corporation (Gugan Gulwan) to continue the Tackle Smoking Program and Street Beat Youth Outreach Network. One-off funding was also provided to Winnunga and Gugan Gulwan to support additional smoking cessation activities, including:

> developing new information materials
> conducting group activities
> purchasing new educational resources for tobacco workers
> providing staff education and professional development
> providing free Nicotine Replacement Therapy for pregnant women and their cohabitants (where costs would otherwise be associated)
> participating in community education and events.

One-off funding was also provided to the Alcohol, Tobacco, and Other Drug Association ACT (ATODA) to:

> write a report on reducing smoking in the ACT among Aboriginal and Torres Strait Islander women who are pregnant or who have young children
> implement a small smoking cessation capacity building project in response to some of the recommendations contained in the report.

A review of the previous ACT Aboriginal and Torres Strait Islander Tobacco Control Strategy has been completed and development of a revised strategy has commenced.

INCREASING ELECTIVE SURGERY LEVELS

During 2015–16, ACT significantly reduced the number of people waiting beyond recommended timeframes for surgery. A Whole-of-Territory elective surgery plan is being developed to manage demand into the future.

More information: For detailed information on elective surgery, see:

> B.2 Performance Analysis, Health Directorate strategic indicators, Strategic Objective 1: Removals from Waiting List for Elective Surgery, page 29.
> B.2 Performance Analysis, ACT Local Hospital Network strategic objectives and indicators, Strategic Objective 1: Percentage of Elective Surgery Cases Admitted on Time by Clinical Urgency, page 35.

B.2 PERFORMANCE ANALYSIS

OVERVIEW

ACT Health continually strives to provide a safe and high-quality health care system, and is continually implementing service improvements to increase safety for all patients. This section discusses our performance against the strategic objectives/indicators specified in the ACT Budget Papers. Due to the differing type and nature of services provided at each public hospital campus the targets for some indicators are different.

Table 2 provides an overview of ACT Health's performance against the specified strategic objectives/indicators.

TABLE 2: PERFORMANCE ANALYSIS OVERVIEW

Strategic objective/indicator	2015–16 performance comment	More information
Health Directorate		
Strategic Objective 1: Removals from Waiting List for Elective Surgery	ACT public hospitals performed 13,396 elective surgery procedures, a 13% increase on the 11,875 reported for 2014–15.	Strategic Objective 1: Removals from Waiting List for Elective Surgery, page 29
Strategic Objective 2: No Waiting for Access to Emergency Dental Health Services	ACT public hospitals achieved the target throughout 2015–16.	Strategic Objective 2: No Waiting for Access to Emergency Dental Health Services, page 30
Strategic Objective 3: Improving Timeliness of Access to Radiotherapy Services	ACT public hospitals achieved the set targets for Emergency radiotherapy services, however were not able to achieve the 90% required for Palliative and Radical categorised patients.	Strategic Objective 3: Improving Timeliness of Access to Radiotherapy Services, page 30
Strategic Objective 4: Improving the Breast Screen Participation Rate for Women aged 50 to 69 years	The participation rate for women aged 50–69 years was 58%, which is below the target of 60%.	Strategic Objective 4: Improving the Breast Screen Participation Rate for Women aged 50 to 69 years, page 30
Strategic Objective 5: Reducing the Usage of Seclusion in Mental Health Episodes	ACT public hospitals reported a seclusion result of 3%, an improvement on last year's seclusion rate of 5%.	Strategic Objective 5: Reducing the Usage of Seclusion in Mental Health Episodes, page 31
Strategic Objective 6: Maintaining Reduced Rates of Patient Return to an ACT Public Acute Psychiatric Inpatient Unit	ACT public hospitals achieved a result of 9%, in line with the <10% target.	Strategic Objective 6: Maintaining Reduced Rates of Patient Return to an ACT Public Acute Psychiatric Inpatient Unit, page 31
Strategic Objective 7: Reaching the Optimum Occupancy Rate for all Overnight Hospital Beds	ACT public hospitals reported a combined occupancy rate of 86%, which is 4% less than the 2015–16 target of 90%.	Strategic Objective 7: Reaching the Optimum Occupancy Rate for all Overnight Hospital Beds, page 31
Strategic Objective 8: Management of Chronic Disease: Maintenance of the Highest Life Expectancy at Birth in Australia	The ACT continues to enjoy the highest life expectancy of any jurisdiction in Australia.	Strategic Objective 8: Management of Chronic Disease: Maintenance of the Highest Life Expectancy at Birth in Australia, page 32
Strategic Objective 9: Lower Prevalence of Circulatory Disease than the National Average	The proportion of the ACT population with some form of circulatory disease was 19.8%, above the national rate of 18.3%.	Strategic Objective 9: Lower Prevalence of Circulatory Disease than the National Average, page 33
Strategic Objective 10: Lower Prevalence of Diabetes than the National Average	The prevalence of diabetes in the ACT is 4.3%, similar to the national rate of 4.7%.	Strategic Objective 10: Lower Prevalence of Diabetes than the National Average, page 33
Strategic Objective 11: Addressing Gaps in Aboriginal and Torres Strait Islander Immunisation Status	The overall immunisation rate for ACT Aboriginal and Torres Strait Islander population was 90%.	Strategic Objective 11: Addressing Gaps in Aboriginal and Torres Strait Islander Immunisation Status, page 33
Strategic Objective 12: Higher Participation Rate in the Cervical Screening Program than the National Average	The ACT's two-year participation rate for the target population is on par with the National average of 58%.	Strategic Objective 12: Higher Participation Rate in the Cervical Screening Program than the National Average, page 34
Strategic Objective 13: Achieve Lower than the Australian Average in the Decayed, Missing, or Filled Teeth Index	The ACT DMFT index result was lower than the national average for the DMFT index.	Strategic Objective 13: Achieve Lower than the Australian Average in the Decayed, Missing, or Filled Teeth Index, page 34

Strategic objective/indicator	2015–16 performance comment	More information
Health Directorate (continued)		
Strategic Objective 14: Reducing the Risk of Fractured Femurs in ACT Residents Aged Over 75 years	In 2014–15, the ACT rate of admissions in persons aged 75 years and over with a fractured neck of femur was 5.5 per 1,000 persons in the ACT population.	Strategic Objective 14: Reducing the Risk of Fractured Femurs in ACT Residents Aged Over 75 years, page 34
Strategic Objective 15: Reduction in the Youth Smoking Rate	The proportion of ACT students reporting to be smokers in 2014 was 5.2%, slightly higher than the national average of 5.1%.	Strategic Objective 15: Reduction in the Youth Smoking Rate, page 34
ACT Local Hospital Network		
Strategic Objective 1: Percentage of Elective Surgery Cases Admitted on Time by Clinical Urgency	The demand for elective surgery continued to increase in 2015–16, which has impacted the ability to meet the targets.	Strategic Objective 1: Percentage of Elective Surgery Cases Admitted on Time by Clinical Urgency, page 35
Strategic Objective 2: Improved Emergency Department Timeliness	See below	Strategic Objective 2: Improved Emergency Department Timeliness, page 35
Strategic Indicator 2.1: The proportion of Emergency Department presentations that are treated within clinically appropriate timeframes	ACT Emergency Departments achieved targets for seen on time for both category one and category five patients. The ACT's Emergency Departments are reviewing their processes, and working with their colleagues throughout the hospitals to eliminate barriers that delay access to required services and to improve patient flow through the hospitals.	Strategic Indicator 2.1: The proportion of Emergency Department presentations treated within clinically appropriate timeframes, by triage category, 2015–16, page 35
Strategic Indicator 2.2: The proportion of Emergency Department presentations whose length of stay in the Emergency Department is four hours or less	ACT public hospital Emergency Departments continued to improve the proportion of patients who presented to Emergency Departments who stayed less than four hours from arrival to either admission or departure. The full year result of 66% is a 3% improvement on the previous year.	Strategic Indicator 2.2: The proportion of Emergency Department presentations whose length of stay in the Emergency Department is four hours or less, 2015–16, page 36
Strategic Objective 3: Maximising the Quality of Hospital Services	See below	Strategic Objective 3: Maximising the Quality of Hospital Services, page 37
Strategic Indicator 3.1: The Proportion of People who Undergo a Surgical Operation Requiring an Unplanned Return to the Operating Theatre within a Single Episode of Care due to Complications of their Primary Condition	Both Canberra Hospital and Calvary Public Hospital performed better than 2015–16 targets.	Strategic Indicator 3.1: The proportion of people who undergo a surgical operation requiring an unplanned return to the operating theatre within a single episode of care due to complications of their primary condition, page 37
Strategic Indicator 3.2: The Proportion of People Separated from ACT Public Hospitals who are re-admitted to Hospital within 28 Days of their Separation due to Complications of their Condition (where the re-admission was unforeseen at the time of separation)	Canberra and Calvary Public Hospitals performed better than the 2015–16 target.	Strategic Indicator 3.2: The proportion of people separated from ACT public hospitals who are readmitted to hospital within 28 days of their separation due to complications of their condition (where the re-admission was unforeseen at the time of separation), page 37
Strategic Indicator 3.3: The Number of People Admitted to Hospitals per 10,000 Occupied Bed Days who Acquire a Staphylococcus Aureus Bacteraemia Infection (SAB infection) During their Stay	Performance for both Canberra and Calvary Public Hospitals was better than the national benchmark	Strategic Indicator 3.3: The number of people admitted to hospitals per 10,000 occupied bed days who acquire a *Staphylococcus aureus* bacteraemia infection (SAB infection) during their stay, page 38
Strategic Indicator 3.4: The Estimated Hand Hygiene Rate	Canberra and Calvary Public Hospitals continued to perform better than the national benchmark of 70% during the most recent audit.	Strategic Indicator 3.4: The Estimated Hand Hygiene Rate, page 38

HEALTH DIRECTORATE STRATEGIC INDICATORS

Strategic Objective 1: Removals from Waiting List for Elective Surgery

The ACT Government provided additional funding in the 2015–16 financial year for a long wait reduction strategy (also known as 'the blitz') to boost access to elective surgery and to reduce the number of people waiting for elective surgery for longer than clinically recommended. During this time ACT Health significantly reduced the number of people waiting beyond recommended timeframes. ACT Health is developing a Whole-of-Territory elective surgery plan to ensure we manage demand into the future.

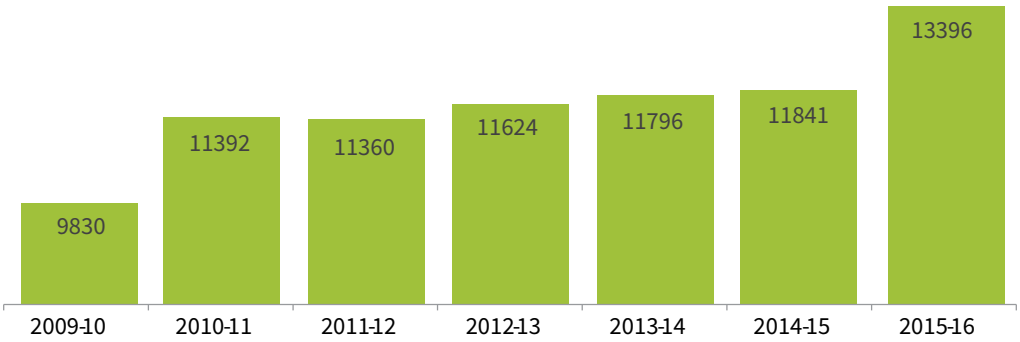
Strategic Indicator 1: The number of people removed from the ACT elective surgery waiting lists (this may include public patients treated in private hospitals), 2015–16

	2015–16 target	2015–16 result
People removed from the ACT elective surgery waiting list for surgery	12,500*	13,396

**In November 2015 a long wait reduction strategy was announced which provided additional surgeries over 2015–16.*

In 2015–16, ACT public hospitals performed 13,396 elective surgeries, a 13 per cent increase on 2014–15 (see Figure 1).

FIGURE 4: NUMBER OF ELECTIVE SURGERIES PERFORMED, 2009–10 TO 2015–16



Source: ACT Health Elective Surgery Waiting List Published Dataset

ACT Health implemented a number of initiatives to address increasing public elective surgery demand including:

- providing surgery to some patients at private hospitals
- increasing the number of surgeries in public hospitals
- improving partnerships with Southern NSW to enable NSW patients to have surgery closer to home.

ACT Health is undertaking an in-depth analysis of elective surgery in the Territory, with a focus on improving theatre utilisation and session allocation to meet demand for specialty groups.

Strategic Objective 2: No Waiting for Access to Emergency Dental Health Services

Strategic Indicator 2: The percentage of assessed emergency clients offered an appointment within 24 hours, 2015–16

	2015–16 target	2015–16 result
Percentage of assessed emergency clients offered an appointment within 24 hours	100%	100%

Source: ACT Health Dental published data

ACT Health's target is to see all emergency dental clients within 24 hours of being assessed as an emergency client. The ACT Dental Health Program has continued to achieve this target throughout 2015–16.

Strategic Objective 3: Improving Timeliness of Access to Radiotherapy Services

Strategic Indicator 3: The percentage of cancer patients who commence radiotherapy treatment within standard time frames, by category, 2015–16

Category	2015–16 target	2015–16 result
Emergency — treatment started within 48 hours	100%	100%
Palliative — treatment started within 2 weeks	90%	81%
Radical — treatment started within 4 weeks	90%	82%

Source: ACT Health Radiation Oncology published data (CAS)

ACT Health is committed to commencing treatment for radiation therapy patients within the waiting time guidelines specified in Radiation Oncology Practice Standards. In 2015–16, the department achieved the following:

> 81 per cent of palliative patients received radiation therapy treatment within two weeks.

> 82 per cent of radical patients received radiation therapy treatment within four weeks.

Table 3 provides comparative figures since 2011–12.

TABLE 3: COMPARATIVE TIMEFRAMES FOR PERCENTAGE OF CANCER PATIENTS WHO COMMENCE RADIOTHERAPY TREATMENT WITHIN STANDARD TIME FRAMES, BY CATEGORY, 2011–12 TO 2015–16

July to June	2011–12	2012–13	2013–14	2014–15	2015–16
Emergency: within 48 hours	100%	100%	100%	100%	100%
Palliative: with 2 weeks	100%	100%	100%	95%	81%
Radical: within 4 weeks	94%	98%	100%	99%	82%

Source: ACT Health Radiation Therapy Dataset

The performance in radiotherapy wait times was impacted by the increased complexity of treatment techniques and related treatment delivery times. This consequently decreased access to radiotherapy services. Radiation therapist staff shortages were a factor influencing the negative impact on treatment waiting times.

During 2015-16, all four linear accelerators typically worked at full capacity and measures implemented to reduce wait times included change in equipment maintenance schedules, extending operational hours and reallocating staff undertaking research and project work to provide clinical services. Recruitment activity to source additional radiation therapist staff is underway.

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

Strategic Indicator 4: The proportion of women aged 50 to 69 years who had a breast screen in the 24 months prior to each counting period, 2015–16

	2015–16 target	2015–16 result
Proportion of women aged 50 to 69 years who have a breast screen	60%	58%

Source: ACT Health BreastScreen published data (BIS)

In 2015–16, ACT Health focused on initiatives to encourage GPs to refer women to the Breast Screen program. A total of 17,869 breast screens were performed for ACT residents in 2015–16, compared with the 15,566 screening procedures reported for the same period in 2014–15.

Strategic Objective 5: Reducing the Usage of Seclusion in Mental Health Episodes

Strategic Indicator 5: The proportion of mental health clients who are subject to a seclusion episode while being an admitted patient in an ACT public mental health inpatient unit, 2015–16

	2015–16 target	2015–16 result
The proportion of mental health clients who are subject to a seclusion episode while being an admitted patient in an ACT public mental health inpatient unit	<3%	3%

Source: ACT Health Mental Health published data (MHAGIC)

As shown in Table 4, in 2015–16, the ACT seclusion result was in line with our local target of less than 3 per cent and an improvement when compared to the previous year's result of 5 per cent.

TABLE 4: CHANGE TO THE PROPORTION OF MENTAL HEALTH CLIENTS WHO ARE SUBJECT TO A SECLUSION EPISODE WHILE BEING AN ADMITTED PATIENT IN AN ACT PUBLIC MENTAL HEALTH INPATIENT UNIT, 2015–16

ACT public hospitals – Mental Health Seclusion Rates		
2013–14	2014–15	2015–16
2%	5%	3%

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

Nationally, the highest rates of seclusion occur in adult mental health units. Reducing seclusion remains a high priority for the staff in the Adult Mental Health Unit and strategies were successfully implemented in 2015–16 to reduce the ACT's seclusion rates.

Strategic Objective 6: Maintaining Reduced Rates of Patient Return to an ACT Public Acute Psychiatric Inpatient Unit

Strategic Indicator 6: The proportion of clients who return to hospital within 28 days of discharge from an ACT public acute psychiatric unit following an acute episode of care, 2015–16

	2015–16 target	2015–16 result
Proportion of clients who return to hospital within 28 days of discharge from an ACT acute psychiatric mental health inpatient unit	<10%	9%

Source: ACT Health Mental Health published data (MHAGIC)

Strategic Objective 7: Reaching the Optimum Occupancy Rate for all Overnight Hospital Beds

Strategic Indicator 7: The mean percentage of overnight hospital beds in use, by hospital and total, 2015–16

Mean percentage of overnight hospital beds in use	2015–16 target	2015–16 result
ACT Public Hospitals	90%	86%
Canberra Hospital	90%	91%
Calvary Public Hospital	90%	75%

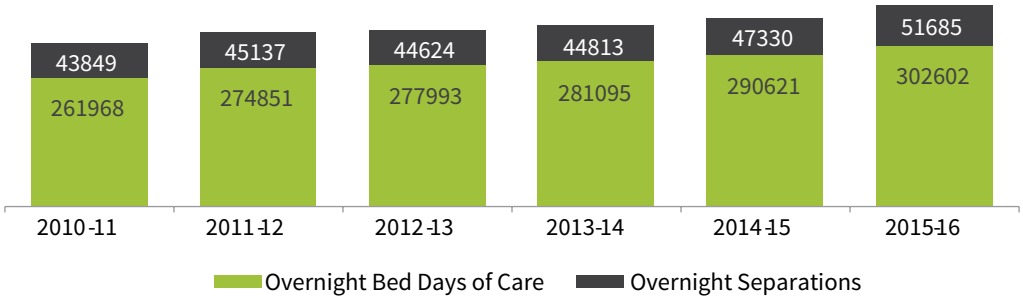
Source: ACT Health Admitted Patient Care published

In 2015–16, ACT public hospitals reported a combined occupancy rate of 86 per cent, seeing performance being better than target.

In 2015–16, ACT public hospitals provided 302,602 overnight hospital bed days of care, which is a 4 per cent increase on 2014–15

Figure 5 shows the number of overnight bed days and overnight separations.

FIGURE 5: OVERNIGHT BED DAYS OF CARE VERSUS OVERNIGHT SEPARATIONS, 2010–11 TO 2015–16



Source: ACT Health Admitted Patient Care Dataset

As shown in Table 5, the average length of stay for overnight patients in ACT public hospitals in 2015–16 was just under 6 days. ACT Health has been working on reducing unnecessary hospital lengths of stay to bring performance in line with the national average.

TABLE 5: AVERAGE LENGTH OF STAY IN HOSPITAL FOR OVERNIGHT PATIENTS, BY HOSPITAL AND TOTAL, 2013–14 TO 2015–16

Year	Canberra Hospital	Calvary Public Hospital	ACT public hospitals	National average
2012–13	6.2 days	6.3 days	6.3 days	5.8 days
2013–14	6.3 days	6.3 days	6.3 days	5.7 days
2014–15	6.4 days	5.7 days	6.2 days	5.7 days
2015–16	6.1 days	5.6 days	5.9 days	n/a

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

Strategic Objective 8: Management of Chronic Disease: Maintenance of the Highest Life Expectancy at Birth in Australia

STRATEGIC INDICATOR 8: LIFE EXPECTANCY AT BIRTH IN THE ACT AND AUSTRALIA, BY SEX, 2014

	ACT rate (years)	National rate (years)
Females	85.2	84.4
Males	81.4	80.3

Source: ABS 2015, Deaths, Australia, 2014, cat. no. 33030, ABS, Canberra.

Australians are living longer and gains in life expectancy are continuing. Potentially avoidable deaths refer to deaths from certain conditions that are considered avoidable given timely and effective health care. Nationally, potentially avoidable deaths have continued to fall to 107 per 100,000 in 2013, from 125 per 100,000 in 2007. A similar trend was observed in the ACT with potentially avoidable deaths falling from 103 per 100,000 in 2007 to 99 per 100,000 in 2013.

Source: Australian Government Productivity Commission. Report on Government Services 2016, Overview E attachment tables, Canberra: AGPC; 2016.

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

Strategic Objective 9: Lower Prevalence of Circulatory Disease than the National Average

Strategic Indicator 9: The Proportion of the ACT Population with Some Form of Cardiovascular Disease

	ACT Rate	National Rate
Proportion of the population diagnosed with any form of circulatory disease	19.8%[c]	18.3%[b]
Proportion of the population with some form of heart, stroke or vascular disease	3.7%[a]	5.2%[a]
Proportion with hypertension	12.1%[a]	11.3%[a]

Source:

(a) Australian Health Survey: First Results, 2014–15. Australian Bureau of Statistics Cat. No: 4364.0.55.001 Data cube DO002 table 2.3 published December 2015 Non-age standardised proportions .

(b) Australian Health Survey: First Results, 2014–15. Australian Bureau of Statistics Cat. No: 4364.0.55.001 Data cube DO003 table 3.3 published December 2015. Non-age standardised proportions.

(c) Australian Health Survey: First Results, 2014–15. Australian Bureau of Statistics Cat. No: 4364.0.55.001 Data cube DO027 table 3.3 published March 2016. Non-age standardised proportions.

Footnote: ACT specific tables for 2014–15 Australian Health Survey results were not available at the time data was collected for the 2016–17 Budget Statements C; so proportions for heart, stoke and vascular disease, ACT and national, were used for this indicator.

The prevalence of circulatory disease is an important indicator of general population health as it is a major cause of mortality and morbidity.

The main risk factor for circulatory disease is age. Population projections suggest that the ACT population is ageing faster than other jurisdictions, however the population is still younger than the national average having a median age of 35 years in 2015 compared with national median age of 37 years. While people of all ages can present with a chronic disease, the ageing of the population and longer life spans mean that chronic diseases will place major demands on the health system for workforce and financial resources.

Other risk factors for circulatory disease are high blood pressure, overweight and obesity, high cholesterol, poor diet, insufficient physical activity and smoking. With increasing prevalence of some of these risk factors in younger cohorts, such as high obesity rates, it is likely that chronic diseases will occur at younger ages.

Strategic Objective 10: Lower Prevalence of Diabetes than the National Average

Strategic Indicator 10: The Proportion of the ACT Population Diagnosed with Some Form of Diabetes

	ACT Rate	National Rate[1]
Prevalence of diabetes in the ACT	4.3%	4.7%

Source: Australian Health Survey: First Results, 2014–15. Australian Bureau of Statistics Catalogue No: 4364.0.55.001, Data cube D002 Table 2.3 age standardised proportions.

This indicator provides a marker of the success of prevention and early intervention initiatives. The self-reported prevalence of diabetes in Australia has more than doubled over the past 25 years.

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

Source: "National indicators for monitoring diabetes" (2007), Australian Institute of Health and Welfare Canberra, AIHW cat. no. CVD 38.

Strategic Objective 11: Addressing Gaps in Aboriginal and Torres Strait Islander Immunisation Status

Strategic Indicator 11: Immunisation Rates – ACT Aboriginal and Torres Strait Islander Population, by age and total, 2015–16

Immunisation rates for vaccines in the national schedule for the ACT indigenous population:	2015–16 target	2015–16 result
12 to 15 months	≥90%	94%
24 to 27 months[1]	≥90%	84%
60 to 63 months	≥90%	91%
All	**≥90%**	**90%**

Notes:

1 The coverage rates above are annualised rates calculated from quarterly reports on childhood immunisation coverage for the September 2015, December 2015, March 2016 and June 2016 quarters. Data is from the Australian Childhood Immunisation Register (ACIR). The data show the proportion of children fully immunised at age 12-15 months, 24-27 months and 60-63 months according to the National Immunisation Program Schedule.

From December 2014, meningococcal C (given at 12 months), and dose 2 measles, mumps, rubella and dose 1 varicella (given as MMRV at 18 months) were included in the definition of fully immunised for the 24-27 month cohort. The more vaccines included in the assessment, the higher likelihood of reduced coverage rates. Reduced immunisation coverage rates have been experienced in all Australian jurisdictions and for all children as well as Aboriginal and Torres Strait Islander children. Coverage rates in this cohort are expected to increase over time as the changes become more routine.

The immunisation rate provides an indication of the level of investment in public health services to minimise the incidence of vaccine preventable diseases. The ACT's Aboriginal and Torres Strait Islander population has a lower rate of immunisation than the general population in all three cohorts.

The coverage rates of Aboriginal and Torres Strait Islander children in the ACT at 24–27 months is the lowest of all Australian States or Territories and is nearly 3.5 per cent below the national average.

ACT Health strives to increase the immunisation coverage rates for Aboriginal and Torres Strait Islander children through a suite of activities. Postcards are sent to the parents of all Aboriginal and Torres Strait Islander children to remind them when vaccinations are due. Promotional materials to raise the awareness of immunisation have been produced and a pack that will be given to mothers soon after birth is in development. The ACT aims to increase immunisation coverage rates for all Aboriginal and Torres Strait Islander children through a targeted immunisation strategy.

It should be noted that due to the very low numbers of Aboriginal and Torres Strait Islander children in the ACT, significant rate fluctuations can occur between reporting periods.

Strategic Objective 12: Higher Participation Rate in the Cervical Screening Program than the National Average

Strategic Indicator 12: Two Year Participation Rate in the Cervical Screening Program, 2013–14

	ACT rate	National rate
Two year participation rate	58%	58%

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

The Cervical Screening Program captures and reports data over a two year period as recommended by the National Cervical Screening Program. The Australian Institute of Health and Welfare (AIHW) report, Cervical Screening in Australia 2013–2014, shows the ACT as one of the four best performing jurisdictions in Australia for participation in cervical screening and as the best perfuming jurisdiction for the five-year participation rate.

Strategic Objective 13: Achieve Lower than the Australian Average in the Decayed, Missing, or Filled Teeth Index

Strategic Indicator 13: The Mean Number of Teeth with Dental Decay, Missing or Filled Teeth at Ages 6 and 12 years, 2009

	ACT rate	National rate
dmft index at 6 years	1.03	2.13
DMFT Index at 12 years	0.70	1.05

Source: The dental health of Australia's children by remoteness: Child Dental Health Survey, 2009 (Published: Australian Institute of Health and Welfare, 2013).

Strategic Objective 14: Reducing the Risk of Fractured Femurs in ACT Residents Aged Over 75 years

Strategic Indicator 14: Rate of Broken Hips (Fractured Neck of Femur) for those aged over 75 years, 2014–15

	2014–15 result	Long-term target
Rate per 1,000 people in the ACT population	5.5	5.3

Source: ACT Health Admitted Patient Care data, 2014–15

This indicator provides an indication of the success of public and community health initiatives to prevent hip fractures. In 2014-15, the ACT rate of admissions in persons aged 75 years and over with a fractured neck of femur was 5.5 per 1,000 persons in the ACT population.

Strategic Objective 15: Reduction in the Youth Smoking Rate

Strategic Indicator 15: Percentage of Persons Aged 12 to 17 Years Who Smoke Regularly, 2014

	2014 outcome	National rate
Percentage of persons aged 12 to17 who are current smokers	5.2%	5.1%

Source: ASSAD confidentialised unit record files 2014, ACT Health. Australian secondary students' use of tobacco in 2014 report, The Cancer Council Victoria, October 2015

Results from the 2014 Australian Secondary School Alcohol and Drug Survey (ASSAD) show that 5.2 per cent of students were current smokers in that year. This represents a significant decline in current smoking from 20.5 per cent of students in 1999.

The proportion of ACT students reporting to be current smokers in 2014 is similar to the national average of 5.1 per cent.

ACT LOCAL HOSPITAL NETWORK STRATEGIC OBJECTIVES AND INDICATORS

Strategic Objectives and Indicators

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

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

Strategic Objective 1: Percentage of Elective Surgery Cases Admitted on Time by Clinical Urgency

Strategic Indicator 1: Percentage of Elective Surgery Cases Admitted on Time by Clinical Urgency, 2015–16

Clinically recommended time by urgency category	2015–16 target	2015–16 result
Urgent – admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency	100%	86%
Semi-urgent – admission within 90 days is desirable for a condition causing some pain, dysfunction or disability which is not likely to deteriorate quickly or become an emergency	78%	57%
Non-urgent – admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is not likely to deteriorate quickly and which does not have the potential to become an emergency	91%	71%

Source: ACT Health Elective Surgery published

Strategic Objective 2: Improved Emergency Department Timeliness

Strategic Indicator 2.1: The proportion of Emergency Department presentations treated within clinically appropriate timeframes, by triage category, 2015–16

Triage category	2015–16 target	2015–16 result
One (resuscitation seen immediately)	100%	100%
Two (emergency seen within 10 minutes)	80%	78%
Three (urgent seen within 30 minutes)	75%	47%
Four (semi-urgent seen within 60 minutes)	70%	56%
Five (non-urgent seen within 120 minutes)	70%	89%
All Presentations	70%	59%

Source: ACT Health Emergency Department published data

Emergency Department timeliness measures how long patients wait to receive their care. In 2015–16, ACT public hospital Emergency Departments reported an overall result of 59 per cent, the same as the result for 2014–15. The 4 per cent increase in presentations experienced in 2015–16 (5,344 additional presentations) has impacted on the ability to treat all patients within recommended timeframes. The ACT met the target for triage categories one and five.

Table 6 shows the breakdown by hospital for the percentage of patients treated within clinically appropriate timeframes by triage category in 2015–16.

TABLE 6: THE PROPORTION OF EMERGENCY DEPARTMENT PRESENTATIONS TREATED WITHIN CLINICALLY APPROPRIATE TIMEFRAMES, BY HOSPITAL, BY TRIAGE CATEGORY, 2015–16

Triage category	2015–16 target	ACT Public Hospitals combined 2015–16 results	Canberra Hospital 2015–16 results	Calvary Public Hospital 2015–16 results	National average 2014–15 results
Category 1 (resuscitation – seen immediately)	100%	100%	100%	100%	100%
Category 2 (emergency – seen within 10 minutes)	80%	78%	77%	78%	79%
Category 3 (urgent – seen within 30 minutes)	75%	47%	38%	57%	68%
Category 4 (semi-urgent – seen within 60 minutes)	70%	56%	46%	70%	74%
Category 5 (non-urgent – seen within 120 minutes)	70%	89%	85%	94%	92%
All presentations	70%	59%	52%	69%	74%

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

Strategic Indicator 2.2: The proportion of Emergency Department presentations whose length of stay in the Emergency Department is four hours or less, 2015–16

	2015–16 target	2015–16 result
The proportion of Emergency Department presentations who either physically leave the Emergency Department for admission to hospital, are referred for treatment or are discharged, whose total time in the Emergency Department is within four hours.	69%	66%

Source: ACT Health Emergency Department published data

Revised target agreed by Cabinet, November 2015

As shown in Table 7, in 2015–16, ACT public hospital Emergency Departments continued to improve the proportion of patients who presented to Emergency Departments who stayed less than four hours from arrival to either admission or departure. In 2015–16 there was a 3 per cent improvement compared to 2014–15.

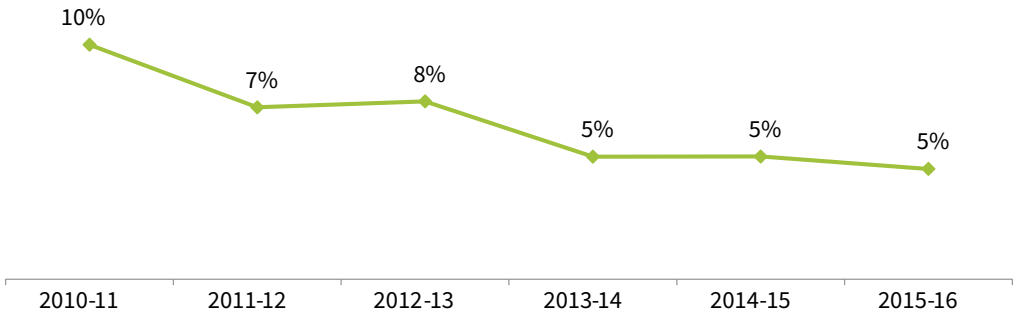
TABLE 7: FOUR HOUR RULE ACT VS. AUSTRALIA, 2011–12 TO 2015–16

Financial year	ACT performance	National average
2011–12	58%	64%
2012–13	57%	67%
2013–14	62%	73%
2014–15	63%	73%
2015–16	66%	n/a

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

As shown in Figure 6, in 2015–16, the proportion of patients who did not wait (DNW) for treatment was 5 per cent. This is consistent with the result for 2014–15.

FIGURE 6: DID NOT WAIT FOR TREATMENT RATES



Source: ACT Health Emergency Department Published Dataset

Strategic Objective 3: Maximising the Quality of Hospital Services

The following four indicators are a selection of the patient safety and service quality indicators that are used to monitor ACT public hospital services. Given the nature of these indicators, small changes in numbers can skew results and trends in performance over time are more meaningful. Canberra Hospital is a major teaching and referral hospital that manages more complex patients and higher levels of complications so has higher targets than Calvary for strategic indicators 3.1 and 3.2.

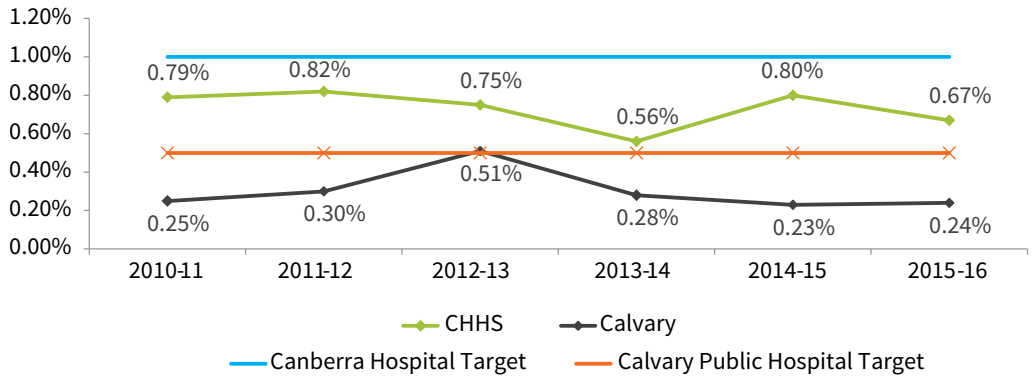
Strategic Indicator 3.1: The proportion of people who undergo a surgical operation requiring an unplanned return to the operating theatre within a single episode of care due to complications of their primary condition

	2015–16 target	2015–16 result
Canberra Hospital	<1.0%	0.67%
Calvary Public Hospital	<0.5%	0.24%

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

Both Canberra and Calvary Public Hospitals have consistently performed better than target (see Figure 7).

FIGURE 7: UNPLANNED RETURN TO THE OPERATING THEATRE WITHIN AN EPISODE OF CARE



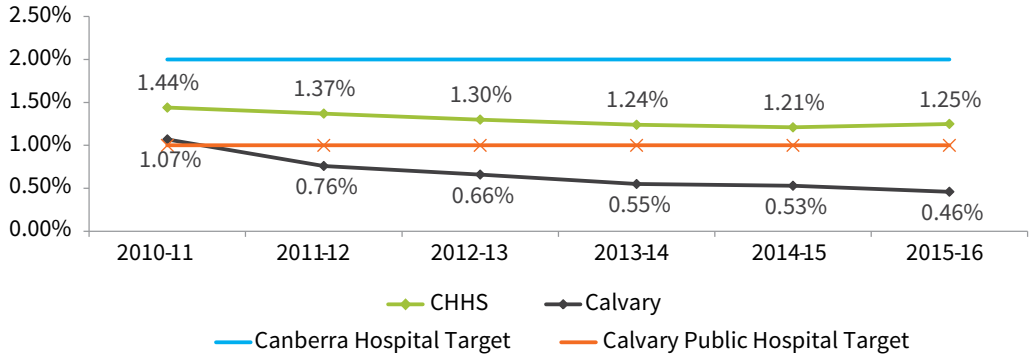
** Preliminary figures used for 2015–16. Source: ACT Health Admitted Patient Care Dataset and ACTPAS.*

Strategic Indicator 3.2: The proportion of people separated from ACT public hospitals who are readmitted to hospital within 28 days of their separation due to complications of their condition (where the re-admission was unforeseen at the time of separation)

	2015–16 target	2015–16 result
Canberra Hospital	<2.0%	1.25%
Calvary Public Hospital	<1.0%	0.46%

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

FIGURE 8: RATE OF UNPLANNED HOSPITAL ADMISSIONS WITHIN 28 DAYS OF DISCHARGE



Source: ACT Health Admitted Patient Care Dataset and ACTPAS

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

	2015–16 target	2015–16 result
Canberra Hospital	<2 per 10,000	1.45 per 10,000
Calvary Public Hospital	<2 per 10,000	0.21 per 10,000

Source: ACT Health Infection Control database

The measurement methodology for this indicator was altered to meet the national quality and safety standards definition. It now measures the number of people admitted to hospitals who acquire a SAB infection during their hospital stay per 10,000 occupied bed days.

ACT Health infection control officers continue to develop and implement programs to limit the transfer of infections within public hospitals. This includes education programs for clinicians, patients, general staff and visitors. Table 8 provides SAB rates for from 2013.

TABLE 8: CANBERRA AND CALVARY HOSPITALS SAB RATES, 2012–13 TO 2015–16

Financial year	Canberra Hospital	Calvary Public Hospital	Target
2012–13	1.55	0.32	2.00
2013–14	1.05	0.33	2.00
2014–15	1.00	0.32	2.00
2015–16	1.45	0.21	2.00

Source: ACT Health Admitted Patient Care Dataset, ACTPAS

Strategic Indicator 3.4: The Estimated Hand Hygiene Rate

The estimated hand hygiene rate for a hospital is calculated by dividing the number of observed hand hygiene 'moments' where proper hand hygiene was practiced during an audit period, by the total number of observed hand hygiene 'moments' (where had hygiene should be practiced) in the same audit period.

Hospital	2015–16 target	March 2016 audit result
Canberra Hospital	70%	83%
Calvary Public Hospital	70%	87%

Source: Hand Hygiene Australia online database

HEALTH DIRECTORATE OUTPUTS

OUTPUT 1.1: ACUTE SERVICES

Canberra Hospital provides a comprehensive range of acute care, including inpatient, outpatient, and Emergency Department services. The key strategic priority for acute services is to deliver timely access to effective and safe hospital care services.

This means focusing on:

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

Overview

Acute services are provided by the Divisions of:

> Critical Care
> Medicine
> Pathology
> Surgery and Oral Health
> Women, Youth and Children
> Director of Operations.

Division of Critical Care

The Division of Critical Care is responsible for delivering acute and critical care and providing retrieval services. These are provided as inpatient and outpatient services at Canberra Hospital, with a strong emphasis on accessible and timely care, delivered to a high standard of safety and quality. This is underpinned by the division's commitment to research and training. The division includes the:

> Retrieval Service (road and air)
> Emergency Department
> Intensive Care Unit
> Acute Surgical Unit
> Discharge Lounge and Medi-Hotel
> Medical Assessment and Planning Unit
> Acute Clinical Services Unit, comprising the Acute Surgical Unit, the Medical Emergency Team and the Early Recognition of the Deteriorating Patient Team.

Division of Medicine

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

The Division of Medicine comprises:

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

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

Division of Pathology

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

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.

Division of Surgery and Oral Health

The Division of Surgery and Oral Health is responsible for delivering dental health programs for children, target youth and adults in the ACT and surrounding region. These programs provide:

> inpatient and outpatient surgical services
> prevention and treatment services.

The division includes:

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

Division of Women, Youth and Children

The Division of Women, Youth and Children provides a broad range of primary, secondary and tertiary healthcare services. Service provision is based on a family-centred, multidisciplinary approach to care, in partnership with the consumer and other service providers. Services are provided:

> at Canberra Hospital
> in community health centres
> in community-based settings, including clients' homes, schools, and child and family centres.

The Division of Women, Youth and Children comprises:

> maternity services, including:
  - the Continuity at the Canberra Hospital (CatCH) Program
  - the Canberra Midwifery Program (CMP)
  - the Maternity Assessment Unit (MAU)
  - the Early Pregnancy Assessment Unit (EPAU)
  - the Fetal Medicine Unit (FMU)
> women's health, including:
  - screening, gynaecology
  - the Women's Health Service, which prioritises women who experience barriers to accessing mainstream services

- neonatology, including:
  - the Neonatal Intensive Care Unit (NICU)
  - Special Care Nursery (SCN)
  - specialist clinics
  - newborn hearing screening
  - the ACT Newborn Retrieval Service
- paediatrics, including:
  - inpatient care
  - specialist clinics
  - community paediatricians
- genetics service
- school-based nursing services, including:
  - immunisation
  - kindergarten health checks
  - school youth health checks
- nurse audiometry, which provides hearing assessments to children and adults
- the Maternal and Child Health (MACH) nursing service, including:
  - a universal home visit following birth
  - support for breastfeeding and parenting
  - immunisation
  - referral services
- Services that support children and their families with complex care needs, including:
  - the MACH Parenting Enhancement Program
  - the Asthma Nurse Educator Service
  - the Child at Risk Health Unit (care for children affected by violence and abuse)
  - the Integrated Multi-agencies for Parents and Children Together service, which coordinates care for woman with complex care needs who are pregnant and/or have young children
  - child protection training for clinicians
  - the Healthcare Access At Schools (HAAS) Program.

Director of Operations

In 2015, a new executive position, the Director of Operations, was established to provide a single point of accountability for patient flow. The position also has responsibility for implementing the reform projects being undertaken across Canberra Hospital and Health Services (CHHS). The Director of Operations has line management responsibility for:

- Medical Imaging
- Patient Flow (formerly the Access Unit).

Performance against accountability indicators

Emergency Department

A $23 million expansion of the Emergency Department commenced in 2015, delivering an extra 1,000 square metres of floor space, including 21 additional treatment spaces and three additional ambulance bays. Added to this is $29 million in additional funding to provide 54 new Emergency Department staff over the four years to financial year 2019–20. This will ensure that as demand continues to grow for emergency health care, patients will receive timely access to emergency care.

THE EMERGENCY DEPARTMENT NOW HAS AN ADDITIONAL 21 TREATMENT SPACES AND THREE ADDITIONAL AMBULANCE BAYS. ADDITIONAL FUNDING WILL ALSO PROVIDE 54 NEW EMERGENCY DEPARTMENT STAFF.

In May 2016, a new Paediatric Streaming model opened, providing:

- six new paediatric emergency beds
- two consultation rooms
- a private sub-waiting area, which is separate to the Emergency Department's main waiting area.

Paediatric patients are now seen in a private and family-friendly setting, which includes:

- a play area
- a beverage bay for refreshments
- toilet facilities with change tables.

In June 2016, the third phase of the rebuilding program opened. This includes the new fast track area, which now has 10 bed spaces and three procedure rooms. This area is immediately behind the main reception and has its own dedicated waiting area. It will treat patients with less acute conditions and be instrumental in continuing to improve the timeliness of care through the Emergency Department.

The Emergency Medicine Unit (EMU) also opened in late June 2016. The EMU is a 12-bed, purpose-built unit that provides care to patients who require care for less than 24 hours. This represents an increase of an additional three beds to this important service.

In September 2015, a review of Canberra Hospital's Emergency Department identified a suite of opportunities to improve patient flow through the Emergency Department and the hospital.

The review recommended a whole-of-hospital approach to improving patient flow by examining the performance of the Emergency Department against national benchmarks, i.e. National Emergency Access Target (NEAT), and patient flow through the hospital more broadly. A number of projects were designed to improve CHHS performance in these areas.

Key initiatives to improve patient flow within the Emergency Department included:

> Creating and staffing an Emergency Department Navigator role. This role is operational 24 hours a day, seven days a week and promotes patient flow through the Emergency Department by working collaboratively with:
  - senior Emergency Department staff
  - the Patient Flow Unit
  - after-hours hospital management
  - hospital-wide multidisciplinary teams.
> Implementing Emergency Department Team-based Care, which provides an early assessment of patients by pre-determined teams of senior and junior doctors. The assessment is conducted as soon as possible after triage and makes high-level treatment plans. It is expected this will lead to earlier disposition planning and bed bookings for admitted patients. The model also supports improved supervision of junior doctors and clarifies responsibility lines.

These measures were put in place in early 2016, and have assisted in achieving significant improvements in the number of patients with a stay in Emergency Department of less than four hours. For example, for June 2016 the result was 72.7 per cent of patients stayed in the Emergency Department for less than four hours, compared with 58.2 per cent for the same period in 2015.

Broader reforms focused on supporting whole-of-hospital patient flow and access to assist Emergency Department efficiency and improve the patient journey. The key objectives of improved flow are:

> improved clinical outcomes
> reduced inpatient length of stay
> optimal bed utilisation
> improved performance against the NEAT and the National Elective Surgery Target (NEST).

Projects that focused on supporting whole-of-hospital patient flow and access include:

> strengthening the Patient Flow Unit with responsibility for all bed decisions, allocations and escalations with a real-time information management system
> developing and implementing a Medical Engagement Strategy to maintain and enhance the performance of the organisation by improving the active and positive contribution of medical staff within their normal working roles
> establishing a Long Length of Stay Committee to identify barriers for discharge especially for patients with maintenance care type
> developing and implementing a Key Performance Indicator Dashboard to measure and track performance across all divisions and departments
> introducing the Early Discharge Program, which focused on:
  - removing identified delays from the discharge process by empowering patients to engage in the discharge process
  - ensuring all patients have an estimated date for discharge (EDD)
  - prioritising pathology and pharmacy services for patients identified for discharge.

Elective and emergency surgery

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

The increasing demand for elective and emergency surgery has continued into the 2015–16 period. ACT Health continues to review where and how surgery is delivered in the ACT, to ensure that patients are receiving their surgery in the right facility at the right time.

ACT public hospitals have made significant improvements in how quickly patients access their elective surgery, within clinically recommended timeframes. These improvements have continued in 2015–16.

In November 2015, ACT Health commenced a comprehensive strategy to reduce the number of patients waiting longer than clinically recommended for elective surgery. This resulted in the removal of over 1,000 additional patients from the Elective Surgery Waiting List in 2015–16 when compared to the previous year. In addition, theatre utilisation rates across the ACT have steadily increased.

The ACT Health System Innovation Program (SIP) has targeted theatre efficiency as one of its top 10 items for review and change.

For more information, see B.1 Organisational overview—System Innovation Group, page22.

In partnership with the private hospital sector, the Elective Joint Replacement Program continued and provided approximately 320 joint replacements in 2015–16. This is an increase of nearly 90 per cent since the program commenced in 2014, and is achieving a dramatic decrease in the orthopaedic joint waitlist. This program will continue through 2016–17, with the aim of further reducing patients' waiting time for joint replacements.

Acute Care services

An additional bed in the Intensive Care Unit has provided additional intensive care capacity.

The Capital Region Retrieval Service (CRRS) continued to see an increase in annual total activity (missions and consults) from 786 in 2014–2015 to 820 in 2015–2016. The CRSS was successful in recruiting staff to support the service, however additional recruitment continues. Despite this, the Service was still able to deliver a higher number of missions and consults compared to 2014–15.

The ACT Government launched Canberra's first Mobile Dental Clinic (MDC) in 2015, improving access to dental health services for Canberrans residing in aged care facilities. In 2015–16, the MDC visited 16 aged care facilities and provided dental care to 532 clients and 2,232 services, ranging from preventive to restorative and denture services.

Trauma activity in the ACT is growing significantly and parallels the activity of ACT Hospital Emergency Departments. In 2016–17, ACT Health will commence an expanded Trauma Service to improve the service provided to trauma patients by:

> reducing the time taken to access the operating theatre
> ensuring fewer returns to theatre due to complications
> reducing the length of Intensive Care Unit stay
> reducing the overall length of inpatient stay
> providing earlier access to rehabilitation medicine.

ACT Health is engaged in networking with Southern NSW Local Health District (SNSWLHD) through a series of critical care initiatives, which focus on:

> building collaborative relationships between Critical Care services throughout the region
> improving coordination and transfer processes for between services, such as the cross-border agreement for ST Segment Elevation Myocardial Infarction (STEMI) ECG Reading Service.

In a collaborative approach, CHHS, SNSWLHD and the Ambulance Service of NSW (ASNSW) have developed a regional STEMI pathway, which provides patients in the region with access to timely, best practice treatment, and facilitates SNSWLHD patients to be returned to facilities in their region as soon as clinically appropriate.

Other achievements

Dental Health

The Dental Health Program has continued to achieve the mean waiting time target of six months for clients on the dental services waiting list. The Dental Health Program has achieved the target with clients on the waiting list having a year-to-date (YTD) mean waiting time of 5.93 months at the end of June 2016. In June 2015, the YTD mean waiting time was reported at 4.15 months and in June 2014 YTD it was reported at 5.01 months.

The National Partnership Agreement on Adult Public Dental Services has been extended by the Commonwealth until 31 December 2016. This initiative has enabled the ACT Restorative Waiting List:

> to be reduced
> achieve a lower than six month mean waiting time
> meet appointment timeframes for those clients triaged as emergency or priority patients.

During 2015, a new dental service was introduced for children and adolescents with special needs. This outreach service involves collaboration with ACT Special Schools and includes health education, dental assessments and treatment and family support. Since the service commenced, 175 children received oral health assessments and treatment and 32 groups received oral health education

Medical Imaging

In December 2016, a review of the Medical Imaging Department identified opportunities for increased productivity and capacity. As a result a project was implemented with the objectives of:

> improving daily productivity
> providing additional capacity to meet increasing demands for medical imaging services
> reducing the length of the outpatient waitlist for CT scans and MRI scans.

At 20 June 2016 the project had:

> extended MRI outpatients' operating hours, leading to a reduction in the MRI outpatient waitlist by 30 per cent
> increased MRI outpatient studies per day by 50 per cent, an increase of 20 per day
> increased CT outpatient studies to a minimum of 15 per day, leading to a reduction in the CT outpatient waitlist and providing patients requiring a CT scan with an appointment within five days
> provided quarantined MRI/CT and US spots for the Emergency Department, leading to improved response times for Emergency Department patients requiring medical imaging
> provided additional capacity for inpatients requiring medical imaging, contributing to reductions in the length of stay for patients

Since November 2015, the waiting lists for scans have reduced, as follows:

> the MRI waiting list scan has reduced from more than 1,000 to approximately 300
> the waiting list for CT scans has reduced from 550 to zero
> the waiting list for ultrasounds has reduced from more than 1,100 to approximately 500.

Cardiology

The Canberra Hospital Cardiology Department, the ACT Ambulance Service and Canberra Hospital Emergency Department have improved the management of STEMI patients at Canberra Hospital by:

> streamlining the processes that activate the Cardiac Catheter Lab
> transmitting Electrocardiographs (ECGs) directly from the ambulance to the Cardiology Department.

Hospital in the Home Program

In 2015–16, the Hospital in the Home (HITH) Program at Canberra Hospital expanded the physical treatment space by up to three spaces. HITH has increased activity by 13 per cent compared to the same period last year. This equates to 20–22 patients a day receiving acute medical care in their homes.

Relocated Northside Dialysis Unit

At the beginning of 2015–16, the Northside Dialysis Unit relocated from Calvary Hospital to the Belconnen Community Health Centre. The move offers a number of advantages to clients accessing the service, including providing:

> easy access to co-located allied health services
> access to dieticians and podiatry
> longer opening hours.

The unit plans to offer nocturnal dialysis. In addition, a self-care dialysis facility has been set up at Weston. This allows patients who cannot dialyse at home to manage their own care at their convenience in a community facility.

Hepatitis C treatment

The Gastroenterology and Hepatology Unit implemented a dedicated General Practitioner (GP) treatment referral program that allows GPs to prescribe a new Hepatitis C treatment to patients. This program was implemented with collaboration from the:

> Pharmacy Department
> Liver Clinic
> GP Liaison Unit.

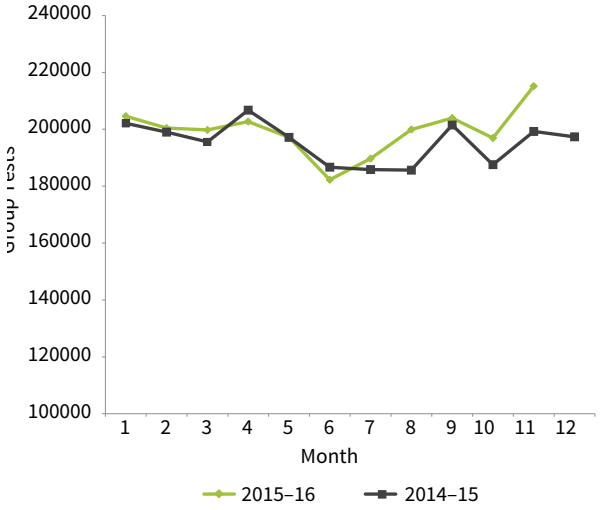
This new process means that GPs can care for these patients in the primary care sector, in consultation with consultants from the Liver Clinic. This creates efficiencies in outpatient clinics and an improved patient experience. Since the launch of this service in March 2016, 180 GP referrals have been processed.

Pathology

ACT Pathology undergoes accreditation inspections by the National Association of Testing Authorities and Royal College of Pathologists of Australasia. The new system of accreditation practices came into effect beginning January 2016. ACT Pathology underwent the first surveillance reassessment in March 2016 and achieved continued accreditation for all laboratories. In March 2017, the mid-term reassessment will be conducted for ACT Pathology, as part of the new four-yearly cycles.

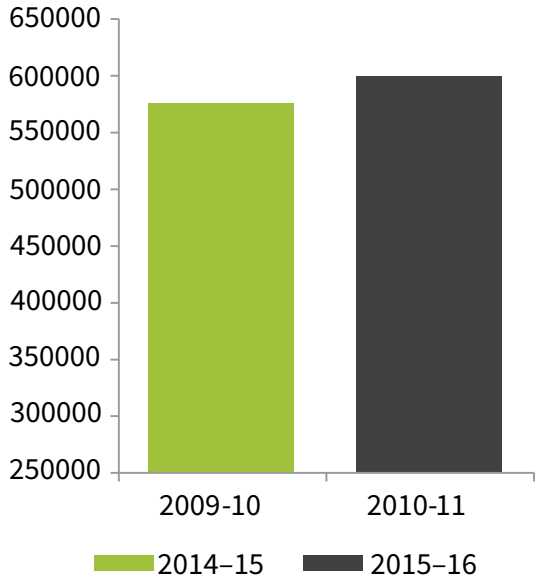
Figure 9 shows the total number of 'grouped' pathology tests performed for 2014–15 compared with those for 2015–16. Grouping some of the pathology tests provides a more accurate representation of work load because some tests are performed simultaneously on the one analyser. The tests are, therefore, recorded together as one 'group' test, rather than separate tests.

FIGURE 9: TOTAL NUMBER OF 'GROUPED' PATHOLOGY TESTS



The total patient referrals include both inpatients and outpatients. As shown in Figure 10, total referrals during 2015–16 increased by 3 per cent when compared to 2014–15.

FIGURE 10: TOTAL PATIENT REFERRALS



The Australian Council on Healthcare Standards (ACHS) Clinical Indicators demonstrate timeliness of reporting of results for selected Canberra Hospital Emergency Department tests. As shown in Table 9:

> The potassium result is regularly above target. However, the result is slightly lower than reported in 2014–15, because for three months the department had issues with an essential piece of equipment, which had a marginal impact on the overall turnaround times for this result.

> The haemoglobin result is below target. Analysis of the cause found that the data included specimens where a blood film was required for analysis, due to one or more parameters being flagged as abnormal. These specimens caused an increase to the average turnaround time for haemoglobin. Having identified this, data for July 2016 shows the turnaround time to have been met in 90.3 per cent of cases.

> The coagulation result is below target, which reflects a definition issue that does not take into account the centrifugation time required in sample preparation.

TABLE 9: ACHS CLINICAL INDICATORS

Test	2015–16 Canberra Hospital	ACHS target
Potassium (% results in <60 mins)	83.7%	81.5%
Haemoglobin (% results in <40 mins)	86.3%	89.5%
Coagulation Testing (% results in <40 mins)	64.4%	70%

Child Development Service

In response to the National Disability Insurance Scheme (NDIS), a collaborative approach to child development service provision commenced from January 2015, as Stage 1 of the Child Development Service (CDS). The CDS provides:

> access to allied health and medical assessment for children who are ACT residents and at risk of developmental delay

> referral to appropriate services, including the NDIS

> a model of intervention and supports for those children not eligible for the NDIS, including group programs and parent supports.

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

Integrating the Community Paediatric and Child Health Service (CPCHS) and CDS services has resulted in:

> multidisciplinary health assessments, involving CDS allied health staff and Child Health Medical Officers from CPCHS, to be conducted for children with complex developmental concerns

> early development groups for children not eligible for early intervention services funded by NDIS, to be run through Child and Family Centres by Early Childhood Teachers and funded by the Education and Training Directorate

> Community Paediatricians (Health) and Early Intervention Psychologists (Education and Training Directorate) to be relocated to Holder to provide developmental and health assessments.

ACT Health continues to work closely with the Community Services Directorate and Education and Training Directorate to further progress this work.

Child Youth Health Services Network for the ACT and Region

The Child Youth Health Service Network for the ACT and region has been established to provide strategic leadership and collaboration across services providing care to children. This will improve the health outcomes for all children and young people in the ACT and region. This Clinical Network aims to enhance the patient journey and the child and youth friendliness of healthcare services in the ACT.

Early intervention and prevention

Recurrent funding has been identified to enable the Trauma Service to continue to provide the Prevent Alcohol and Risk-related Trauma in Youth (PARTY) Program. This is in response to the success of this program in 2015–16 and the continued trend in alcohol-associated harm and hospitalisation in the ACT. PARTY is targeted at high school students and provides:

> talks from ambulance workers and trauma surgeons
> tours of the hospital
> interaction with rehabilitation equipment
> meetings with young trauma survivors.

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

Due to some concerns from the community, ACT Health in collaboration with the Education and Training Directorate, reviewed the needs of children in specialist schools and undertook a consultation process involving:

> ACT Health
> the Education and Training Directorate
> teachers
> unions
> parents.

A revised HAAS model was developed to address the health needs of the entire specialist school community and meet the concerns that have been raised through the consultation process. The revised HAAS model uses a combination of Level 2 RNs, First Aid Officers and school staff in a tiered approach to health care.

Implementation of the revised HAAS Model of Care commenced in the ACT public specialist schools in April 2016.

Awards and presentations

In October 2015, the ACT Health Diabetes Service was designated a Diabetes Centre of Excellence by the National Association of Diabetes Centres. This award is a four-year award and is valid until 2019.

Future directions

Acute care admissions

An emphasis will be placed on the care of acute admissions to CHHS. This will include:

> developing models of prevention of admission
> streamlining the flow between patient to inpatient services
> modifying the patient discharge process to streamline how patients are directed to appropriate services in the community.

Director of Operations

The Director of Operations will continue to develop processes to improve patient flow across CHHS. Patient flow will be improved by establishing projects, including:

> expanding the capability of the transit lounge for patients leaving the hospital
> improving capacity for transporting patients at the time of discharge
> consolidating services that improve patient flow.

Medical Imaging

Medical Imaging will continue to develop access and service improvements including:

> creating additional capacity in ultrasound services to reduce outpatient waitlists
> developing further strategies to reduce the MRI scan outpatient waitlist.

Division of Medicine

The Division of Medicine will:

> implement the Acute Medical Unit (AMU) model, incorporating the Medical Assessment and Planning Unit to:

- create a more streamlined process from presentation to admission
- improve the clinical care provided to our patients, including reducing the length of stay

> progress more team-based models appropriate to care across the division

> provide more community-based services in the new community health centres in Gastroenterology, Liver and Renal Services.

Gastroenterology and Hepatology Unit

Work is underway to improve access to and management of endoscopy services provided by the Gastroenterology and Hepatology Unit (GEHU) at Canberra Hospital. Demand for these services continues to increase year on year.

ACT Health and SNSWLHD have been working closely together to arrange for patients to gain more timely access to surgery and/or procedures, closer to their home. This work aims to improve wait times for those patients requiring a procedure. Work has commenced to develop processes to better manage the demand and flow of patients within the GEHU.

Back Pain redesign

Back pain is a relatively common problem in the Australian community with implications for:

> work productivity

> mental health

> interpersonal relationships

> the overall health budget.

Early initial intervention using a multidisciplinary approach is effective in reducing long-term disability.

2016–17 ACT Government budget funding has been committed to achieve a more integrated and resourced patient-centred intervention for both community and hospital presentations. Ideally, the solution will be community based. The proposed pathway will:

> streamline the flow of patients who present with back pain through the Emergency Department to the community-based solution

> ensure that these patients receive the best possible care through an efficient use of CHHS and community resources.

Acute Medical Unit

The Acute Medical Unit (AMU) will be a physician-led medical admissions short-stay unit structured to promote the inter-specialty and interdisciplinary care of patients who require unplanned admission to an internal medicine unit at Canberra Hospital.

Patients will be assessed and managed in this unit with the intention of adhering to evidence-based pathways of care when appropriate. This will:

> create a more streamlined process from presentation to admission

> improve the clinical care provided to our patients, including reducing the length of stay.

In collaboration with all physician-based units at Canberra Hospital and Acute Support allied health services, the AMU is being designed and established, with implementation due in November 2016.

Acute Stroke Pathway

Stroke incidence is increasing rapidly in the ACT as the population grows and the proportion of older people increases. The total number of admissions to Canberra Hospital stroke unit has risen from approximately 450 per year in 2004 to 650 per year in 2014 and is likely to continue to rise. Of these, approximately half are acute ischaemic strokes.

The 2016–17 ACT Government budget allocated $5 million for better acute stroke services and access to treatment in the ACT .This will be delivered through a coordinated network comprising Canberra and Calvary Public Hospitals. This enhancement will ensure:

> timely assessment of clot breakdown at both Canberra Hospital and Calvary Public Hospital, Bruce

> that evidence-based care is adopted for a smaller proportion of patients who would benefit from clot retrieval using existing advanced technology at Canberra Hospital.

ACT Renal Service

The Belconnen Community Health Centre will be one of the first public nocturnal dialysis providers in Australia, with rollout to commence in 2017. Nocturnal dialysis is undertaken throughout the night for approximately 8–10 hours for patients suitable for this option.

The service has deployed a comprehensive Renal Electronic Medical Record (REMR). The REMR provides access to information on dialysis treatment episodes and access to relevant patient pathology records and clinical records, irrespective of how that patient moves through the system, as part of the Renal Services Network across ACT and NSW.

Cardiac Imaging Medicine

In conjunction with the work being undertaken to improve care for patients with Acute Coronary Syndrome, Cardiology is working to establish a specific Coronary Angiography Computed Tomography Service. This service will:

> build on existing cardiology services, such as the Chest Pain Evaluation Unit

> contribute to identifying a patient's underlying cardiac conditions.

Rapid Access Clinics

The Division of Medicine is exploring the development of Rapid Access Clinics for all subspecialties within the division. The service aims to provide patients with direct timely access to expert assessment and investigation, focusing on early intervention and prevention and negating the need for an admission to hospital in some cases. Rapid Access Clinics will have strong ties to the AMU.

Pathology

Pathology will continue to work collaboratively with Health IT to introduce an electronic ward ordering system that will:

> improve completion rates of mandatory information required for pathology testing
> improve legibility and thus accuracy of requested information
> provide decision-making support information to the requesting doctor.

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

The pilot of the electronic ward ordering system went live in June 2016 in two wards within Canberra Hospital. The success of the pilot will result in this program being rolled out throughout Canberra Hospital, which will improve patient safety and reduce double ordering of tests.

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

ACT Health has completed the framework that will introduce a model of patient care that allows privately practising, eligible midwives to admit their private patients to the Centenary Hospital for Women and Children (CHWC) or birthing services. This Model of Care is about to be introduced by the Division of Women, Youth and Children. The first two eligible midwives have been appointed. This is scheduled to commence at the beginning of 2017.

Publically Funded Homebirth Service

ACT Health has received Government approval to commence a trial of publicly funded homebirths. The trial will be conducted over three years up to a total number of 24 births per year. A framework document for the service has been written and endorsed. Expressions of interest for the homebirth trial will be taken from 4 October 2016. The first babies born as part of the trial are expected from 30 January 2017.

Consumer Survey for Parents and Children

In addition to the Patient Experience inpatient survey, which began in March 2016, a patient experience survey for parents of children in CHWC is currently in development. The information from this will provide the parent's perspective and will be used to:

> identify and focus on areas where we need to improve our services
> generate additional ideas for service improvements
> identify service areas where we met or exceeded our patients' expectations.

OUTPUT 1.2: MENTAL HEALTH, JUSTICE HEALTH AND ALCOHOL AND DRUG SERVICES

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

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

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

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

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

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

This means focusing on:

> ensuring timely access to emergency mental health care
> ensuring that public and community mental health services in the ACT provide people with appropriate assessment, treatment and care that result in improved mental health outcomes
> providing community- and hospital-based alcohol and drug services
> providing health assessments and care for people detained in corrective facilities
> engaging and liaising with community sector services, primary care and other government agencies that provide support and shared care arrangements.

Overview

The health services provided by Mental Health, Justice Health and Alcohol and Drug Services directly and through its partnerships with community organisations range from prevention and treatment to recovery and maintenance and harm minimisation. Consumer and carer participation is encouraged in all aspects of service planning and delivery.

The division delivers services at a number of locations, including:

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

These services include:

> Adult Acute Mental Health Services
> Adult Mental Health Unit (AMHU)
> Mental Health Short Stay Unit
> Mental Health Consultation Liaison—Canberra Hospital
> Adult Community Mental Health Services
> Belconnen Mental Health Team
> City Mental Health Team
> Gungahlin Mental Health Team
> Tuggeranong Mental Health Team
> Woden Mental Health Team
> Crisis Assessment and Treatment Team
> Mobile Intensive Treatment Team- North
> Rehabilitation and Specialty Mental Health Services
> Aboriginal and Torres Strait Islander Mental Health Services
> Adult Mental Health Day Service
> Brian Hennessy Rehabilitation Centre
> Mental Health Comorbidity Clinician
> Mental Health Service for People with Intellectual Disabilities
> Neuropsychology
> Older Persons Mental Health Team
> Justice Health Services
> Forensic Mental Health Services
> Justice Health Primary Health
> Secure Mental Health Unit (in development)
> Child and Adolescent Mental Health Services (CAMHS)
> CAMHS North Community Team
> CAMHS South Community Team
> Childhood Early Intervention Program
> Early Intervention Team
> Dialectical Behaviour Therapy Program (DBT)
> Perinatal Infant Mental Health Consultation Service (PMHCS)
> Eating Disorders Program
> The Cottage
> Alcohol and Drug Program
> Consultation and Liaison Service
> Counselling and Treatment Services
> Police and Court Drug Diversion Services
> Opioid Treatment Service
> Withdrawal Services

Performance against accountability indicators

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

> Exceeded the target of 120,000 occasions of service within the Adult Mental Health Services Program. This achievement is the result of an adult mental health team being established for the people of Gungahlin, through the Gungahlin Community Health Centre.
> Exceeded the target of 65,000 occasions of services within the Child and Adolescent Mental Health Services (CAMHS) Program by 10 per cent. This is due to the Choice and Partnership Model being implemented within the CAMHS community teams and an increase in referrals to perinatal consultation services.
> Exceeded the target of 106, 000 occasions of service within the ACT-wide Mental Health Services Program by 1 per cent. This higher than expected level of activity was predominately achieved due to:
  - the high levels of contact with the Crisis Assessment and Treatment Team
  - additional ACT Budget 2015–16 funding for the Older Person's Mental Health Community Team, the Crisis Assessment and Treatment Team and the Mobile Intensive Treatment Team.
> Achieved the target of 98 per cent of all new clients who are on pharmacotherapy treatment for opioid dependency having a completed management plan.
> Exceeded the target of 108,000 occasions of service within Justice Health Services Program by 40 per cent. This achievement can be attributed to the increased number of detainees at the Alexander Maconochie Centre (AMC).
> Achieved 100 per cent of all detainees admitted to the AMC having a completed health assessment within 24 hours of detention.
> Achieved 100 per cent of all young people admitted to Bimberi Youth Justice Centre having a completed health assessment within 24 hours of detention.

Emergency mental health care

ACT Health is a national leader in reducing seclusion and restraint in mental health inpatient settings. Reducing seclusion remains a high priority for the staff and this is reflected in a reduction of seclusion rates during the 2015–16 reporting period when compared with the previous financial year. Seclusion review meetings continue on a monthly basis to continue to monitor seclusion episodes and implement ongoing strategies for the reduction of seclusion and restraint episodes.

The Mental Health Short Stay Unit was commissioned on 27 January 2016 and is a six-bed standalone unit adjacent to Canberra Hospital Emergency Department. It is staffed with appropriately trained mental health medical and nursing staff. The unit is operational 24 hours a day, 365 days a year. It provides people presenting to the Emergency Department with the opportunity for:

> extended clinical observation
> crisis stabilisation
> mental health assessment and intervention.

These services are available for up to 48 hours.

Mental health services

The *Mental Health Act 2015* commenced on 1 March 2016. The Act gives people in the ACT living with a mental illness, or their carers and family members, greater opportunity to contribute to decisions on their treatment, care and support. The Act was developed over several years with extensive stakeholder engagement. The Act's objectives and principles uphold the human rights of people with a mental illness and acknowledge the importance of carers. The Act empowers people with mental illnesses and mental disorders to make critical decisions about their treatment, care and support to the best of their ability, and with the involvement of carers, close family and friends.

The community Adult Model of Care was redesigned to ensure an improved integrated flow of patients from both inpatient and community settings, including crisis, assertive outreach, clinic and home-based care. The Crisis Assessment and Treatment Team expanded to provide additional intensive in-home support for people experiencing acute mental health problems.

In October 2015, a community mental health team began providing services to the Gungahlin region, at the Gungahlin Community Health Centre. Before October 2015, services were provided to this area as an extension from the Belconnen Mental Health Team.

Staff have been recruited to develop the therapeutic program, provide training, and develop policy and standards for the new 25-bed Secure Mental Health Unit, which is due to open in November 2016.

In April 2016, the Supported Accommodation Team became operational and began accepting referrals. This service provides intensive in-reach clinical services for a number of people who have significant chronic and severe mental health issues and are living in the community in supported accommodation.

The Older Person's Community Mental Health Team expanded to provide intensive support for people with psychogeriatric conditions who are:

> living in residential care or
> transitioning from an acute inpatient unit to residential care.

The Consultation and Liaison service expanded to provide after-hours support seven days a week. The service assists people who have mental health-related issues when they are admitted to the general wards of Canberra Hospital.

Alcohol and Drug Services

Specialist Drug Treatment Services expanded the outreach specialist medical, counselling and case management services provided at community health centres to complement the existing services provided at Canberra Hospital. This service is now offering clinics one day a week at both at Belconnen Community Health Centre and Tuggeranong Community Health Centre.

In May 2016, the Police Drug Diversion Service, in collaboration with ACT Policing began a trial of voluntary diversions for adults taken into custody for intoxication. The aim is to offer assessment and referral following release from the City watch house, to assist people to access health services and support.

In October 2015, the Youth Drug and Alcohol Program expanded to include an in-reach service provision at Gugan Gulwan Youth Aboriginal Cooperation. The in-reach provides individual counselling, consultation and a collaborative small group initiative.

In March 2016, the Alcohol and Drug Service Consultation and Liaison services at Canberra Hospital expanded to provide seven day per week service.

Justice Health Services

In January 2016, the primary health team within Justice Health Services expanded their services to more effectively deliver health services to the AMC. Between 2015 and 2016, an additional 110 beds will be available at the:

> Bimberi Youth Justice Centre
> Periodic Detention Centre
> Symonston Correctional Centre.

Engaging and liaising with other support and shared care organisations

In January 2016, the CAMHS, partnered with the Education and Training Directorate, began a new program that provides early identification and treatment of children with emerging mental illnesses/disorders.

The Adult Mental Health Unit (AMHU) continued to experience challenges in the timely discharge of some patients. Primarily this is related to accessing appropriate housing options. Work is progressing to improve inter-agency relationships, particularly with ACT Housing, Disability ACT and the National Disability Insurance Agency (NDIA) to:

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

Aggression and Violence Divisional Framework

An Aggression and Violence Divisional Framework has been adopted and is supported by clinical guidelines, which are being implemented throughout the adult inpatient mental health units. These guiding documents:

> provide further clinical guidance and support to staff in the early identification and management of aggression and violence
> contribute to the ongoing strategy to reduce seclusion and restraint episodes.

Future directions

The Mental Health, Justice Health and Alcohol and Drug Services workforce continues to be challenged by the increase in growth across the service. A workforce committee has been established to oversee the development of a Workforce Strategy, Planning and Development Framework.

The planning and implementation requirements for the commencement of the NDIS have been significant. An implementation plan has been developed to ensure appropriate services are available for eligible people for the transition of care arrangements to the NDIA and to support those people who may not be eligible or who may have difficulties accessing these services.

Mental health services

The Secure Mental Health Unit is planned to open in November 2016. The Secure Mental Health Unit will form part of an integrated care pathway for those people who need care and treatment as a result of their mental illness and associated comorbidity. The unit will contribute to the care continuum of mental health services provided through ACT Health.

The Secure Mental Health Unit is a newly-constructed and purpose-built facility providing inpatient services and operating 24 hours a day, seven days a week. It will support a person's treatment, care and recovery by responding to the needs of:

> people with moderate to severe mental illness who are or are likely to become involved with the criminal justice system (forensic)
> civil people who cannot be treated in a less restrictive environment.

In the first phase, the Secure Mental Health Unit will open with 10 beds available. A dedicated Model of Care has been produced for the unit outlining:

> the approach to care, treatment, recovery and security
> that a person's requirements for privacy and dignity must be considered within the guiding principles of the ACT Human Rights Act 2004, the Mental Health Act 2015 and the Mental Health (Secure Facilities) Act 2016.

The Model of Care also outlines the connections between the Secure Mental Health Unit and Forensic Mental Health Services within the AMC.

A workforce development and recruitment plan has been developed for the Secure Mental Health Unit, which includes the staging of the recruitment of staff in line with the commissioning/staging of beds. Training opportunities, such as scholarships, will be offered to staff to facilitate their development in the area of Forensic Mental Health.

The 2016–17 ACT Budget provided funding for the following:

> The CAMHS Mental Health Follow-up for Young People and Intensive Clinical Rehabilitation Service. This service will provide an assertive outreach program focused on providing intensive interventions to young people:
  - with a history of severe, and/or disruptive mental illness
  - who struggle to sustain engagement with mental health services
  - who have limited supports, reduced social functioning and/or secondary psychosocial issues.

This service will significantly enhance access to continued comprehensive mental health treatment for young people who have difficulties attending office-based treatment.

> Expanding the Mental Health Detention Exit Community Outreach (DECO) Program. This will allow the community sector DECO provider to work with the Forensic Mental Health Service to provide the treatment and short-term support services required to assist people leaving the Secure Mental Health Unit to re-establish themselves in the community. The community sector will also work with ACT Health to co-design the Mental Health Recovery College, supporting innovative practices with the Adult Mental Health Day Service of the University of Canberra Public Hospital. Funding is also available to provide additional intensive and specialised support services for older people by expanding the existing Older Person's Mental Health Community Team.
> For the AMHU to increase the number of commissioned mental health inpatient beds from 35 to 37. The additional beds will be accommodated within the existing AMHU Model of Care Framework and improve:
  - access to acute mental health services
  - patient flow through Canberra Hospital Emergency Department.

Justice Health Services

The number of staff in the Forensic Mental Health Services Team will increase. The team is located at the AMC. This increase will:

> assist in meeting the demand created by increased detainee numbers
> enhance the existing service
> strengthen the capacity to provide early intervention and treatment
> expand access to services
> improve continuity of care in the prison population.

OUTPUT 1.3: PUBLIC HEALTH SERVICES

The aim of Output 1.3 is to improve the health status of the ACT population through interventions which:

> promote behaviour changes to reduce susceptibility to illness
> alter the ACT environment to promote the health of the population
> promote interventions that remove or mitigate population health hazards.

This includes programs that:

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

Performance against accountability indicators

The 2014–15 target of 8,500 samples analysed per annum was not increased for the 2015–16 financial year and effectively gives an estimated 45 per cent increase for the two years 2013–14 to 2015–16.

As shown in Table 14, the number of samples analysed significantly exceeded the 2015–16 target. The Output is based on samples having completed their analyses. The target for compliance of licensable, registrable and non licensable activities at time of inspection was not met due to an increase in noncompliant premises identified through:

> routine inspections
> complaint-based inspections
> re-inspections of noncompliant premises.

TABLE 10: OUTPUT 1.3: PUBLIC HEALTH SERVICES

Output 1.3: Public Health Services	2015–16 targets	2015–16 outcome	2016–17 targets
Samples analysed	8,500	12,693	11,500
Compliance of licensable, registrable and non licensable activities at time of inspection	85%	69%1	85%
Response time to environmental health hazards, communicable disease hazards relating to measles and meningococcal infections and food poisoning outbreaks is less than 24 hours	100%	100%	100%
Percentage of Health Protection Service's regulated business/ activities who have access to Multi-year licenses/registrations.	75%	100%	n/a

Note: Due to an increase in noncompliant premises identified through routine inspections, complaint-based inspections and re-inspections of noncompliant premises.

An increase in Samples Analysed occurred for the following categories in 2015–16 compared with 2014–15:

> Illicit Drugs: 35.4 per cent
> Food samples: 19.3 per cent.
> A decrease in Samples Analysed occurred for the following categories in 2015–16 compared with 2014–15:
> Oral Fluid samples: 23.6 per cent
> Asbestos samples: 17.6 per cent.

Promote smoke-free areas

The *Health Protection Service* successfully implemented major *tobacco control and smoke-free* policy reforms in the ACT with the concurrent passage of two smoke-free amendment Bills through the ACT Legislative Assembly in March and April of 2016.

The *Smoke-Free Public Places Amendment Bill 2016* was passed into legislation on 10 March 2016. The Bill allows for new smoke-free public places and events to be established by Ministerial declaration under the *Smoke-Free Public Places Act 2003.* Previously, new smoke-free areas could only be declared by primary legislation, making it a complex and time consuming process. This contributed to the ACT falling behind other jurisdictions in terms of legislated smoke-free areas. The new legislation streamlines the process for establishing new smoke-free areas, while setting up a framework to ensure a robust assessment of the costs and benefits associated with making a specific public place or event smoke-free.

Smoke-free areas are a vital tool to reduce tobacco-related harms in the community. They help to de-normalise smoking, which helps to prevent children and young people from taking up the habit. They also support smokers who are trying to quit by reducing social cues to smoke. This initiative will help enhance the health of the ACT community and ensure all Canberrans can enjoy more public amenities without exposure to second-hand smoke.

On 5 April 2016 the ACT Legislative Assembly passed the Smoke-Free Legislation Amendment Bill 2016 to restrict the sale, promotion and use of personal vaporisers, also referred to as e-cigarettes. The Bill applies the same restrictions to personal vaporisers that currently apply to tobacco. It:

> prohibits the sale of personal vaporisers to children
> bans the use of personal vaporisers in smoke-free areas
> places restrictions on personal vaporiser advertisements, displays and marketing.

In doing so, it minimises potential health harms to the community from personal vaporiser usage and protects against the renormalisation of smoking behaviour. The new legislation is effective from 1 August 2016.

The primary aim of the new legislation is to protect the progress made in the ACT over the last few decades to discourage people from smoking, in particular to prevent the uptake of personal vaporisers by non-smokers, including children and young people. The new legislation was specifically drafted to protect public health, without constraining access to personal vaporisers for adults, including adult smokers wanting to quit traditional tobacco products.

The new legislation saw the ACT become the third Australian jurisdiction to directly regulate personal vaporisers behind Queensland and NSW and the second jurisdiction behind Queensland to ban their use in existing smoke-free areas.

The community benefits of the passage of these two smoke-free Bills are tangibly broad in scope. These positive outcomes are a direct result of the many months of evidenced-based, detailed and innovative policy analysis and development by the Health Protection Service staff.

Altering the ACT environment

In December 2015, an extensive clean-up was conducted under the *Public Health Act 1997* due to an insanitary condition. The property had an accumulation of food and other material in and around the house. The food was decaying and odorous, providing harbourage for vermin and impacting upon neighbours. Ongoing monitoring of the property has continued since the clean-up to monitor recurrence.

Due to tendency for relapses to occur and difficulties in managing hoarding cases the Health Protection Service has initiated the development of a multi-agency model for handling hoarding cases. It is facilitated by the Hoarding Case Management Group, which is an intergovernmental advisory group that:

> discusses the management of issues caused by hoarding-like behaviours in the ACT
> provides operational advice on the best practice management of hoarding issues.

This group has representation from relevant government areas, including:

> ACT Mental Health
> ACT Housing
> ACT Fire and Rescue
> Access Canberra
> select non-government organisations, such as the Canberra Living Conditions Network and the RSPCA.

Interventions and mitigations

In February 2016, a team of three public health officers conducted inspections on stall holders serving kava during the three-day National Multicultural Festival. Over 300 food stall inspections were made over the three-day event. The Health Protection Service provided food safety education to stallholders at the National Multicultural Festival in the form of information sessions and printed materials. Food safety information sheets and checklists have been translated into 11 non-English languages.

The National Multicultural Festival has been declared as a public event in recognition of the cultural importance of kava customs to Pacific Islander people and an exemption granted under the *Medicines, Poisons and Therapeutic Goods Act 2008* to serve kava. *Kava* is listed as a prescription only medicine under the Standard for the Uniform Scheduling of Medicines and Poisons (Poisons Standard). The Act adopts the Poisons Standard by reference. The Act also contains provisions to grant a public event exemption to allow the possession and supply of kava at public events. This means that kava may not be supplied in the ACT without either a prescription or a declared public event exemption. Organisers of public events may apply for an exemption to serve kava at a public event.

On 18 March 2016, amendments to the *Transplantation and Anatomy Act 1978* came into effect to allow suitably trained officers to remove whole organs to:

> support tissue transplantation outcomes
> enable a coroner to direct (before the death of an intended organ donor) that coroner consent is not required to release the body for organ or tissue donation.

These changes will support the best transplant outcomes for the recipient.

On behalf of Access Canberra, the Health Protection Service:

> registers food businesses
> conducts routine food safety inspections of registered premises
> processes food business registration renewals
> provides food safety advice
> undertakes inspections at Declared Events.

The Health Protection Service also communicates regularly with other arms of Access Canberra to ensure food business registrations are consistent with broader regulatory requirements, including liquor licensing, construction and safety. This engagement across Access Canberra reduces the regulatory burden on food business proprietors and ensures consistent advice is provided.

From 1 January 2015, the *Food Act 2001* was amended to omit certain food businesses from the requirements of the Act, to minimise the regulatory burdens placed on volunteer non-profit community organisations. However, any business that conducts food services at a declared regulated event is subject to the requirements of the Act. The Minister for Health has declared the following to be regulated events:

> National Multicultural Festival
> National Folk Festival
> Curry Festival in the City
> Enlighten Night Noodle Markets.

In line with the ACT Government's commitment to transparency, the Health Protection Service has published an online *Food Business Inspection Manual* to assist in delivering a consistent and open approach to food safety regulation. The Health Protection Service has also developed an online Food Business Self-Assessment Checklist to support food businesses:

> identify potential areas for improvement
> achieve compliance with food safety standards.

In February 2016, a team of 13 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, over 320 inspections were conducted over the duration of the event.

During inspections of food stalls, public health officers routinely look for issues (breaches) that would lead to unacceptable food safety risks, including:

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

A number of food safety breaches were identified, resulting in three food seizures and eight incidents of voluntary disposal of food.

In line with ACT Government regulatory reforms and reducing red tape, the Health Protection Service began implementing multi-year licences and registrations for businesses and individuals. The aim was 75 per cent of all licences and registrations by the end of the financial year. The Health Protection Service achieved 100 per cent compliance in this area.

In May 2016, the Health Protection Service's *ACT Government Analytical Laboratory* (ACTGAL) completed a long-term project (identified as a gap in 2007) to develop and routinely deliver training courses to the Australian Federal Police (AFP) and ACT Fire and Rescue on the ACTGAL's involvement, responsibility and capability in relation to clandestine laboratory investigation. The first training was delivered on 4 May 2016 as part of the ACT Fire and Rescue Hazmat Level II Technicians course, and approximately 15 staff from forensic chemistry and ACT Fire and Rescue attended.

The training comprised a:

> presentation on clandestine laboratories
> practical session organised by forensic chemistry for both attendees of the ACT Fire and Rescue course and ACTGAL chemists.

Following consultation that occurred in 2015 and in line with ACT Government regulatory reforms and reducing red tape, the Health Protection Service is progressing with amendments to the *Medicines, Poisons and Therapeutic Goods Regulation* provisions for *controlled medicines*. These changes will allow prescribers to apply for a category of approval rather than having to apply each time that they need to increase a dose for a patient or change the drug.

These changes will allow the Health Protection Service to allocate resources to focus on identifying risk-based activities and reducing the harms inherently associated with controlled medicines. This will be achieved by increasing:

> monitoring
> inspections
> subsequent regulatory compliance activity.

The *Medicines, Poisons and Therapeutic Goods Regulation 2008* was amended on 1 March 2016 to allow *pharmacists to administer influenza vaccinations* to adults in the ACT without a prescription and in accordance with directions as established by the ACT Chief Health Officer.

Health status evaluations and reports

Population Health Division undertook or published the following population health surveys and data collections in 2015–16:

> The ACT General Health Survey, which is a telephone computer-assisted technology household survey that collects information on a range of factors influencing health status.
> The ACT Physical Activity and Nutrition Survey, which is a classroom-based tablet questionnaire collecting information on the physical activity and nutrition behaviour and the measured weight status of a sample of year 6 children.

The division produced a range of reports, information products and resources including:

> The biennial ACT Chief Health Officer Report 2016, Healthy Canberra, which outlines the health status of ACT residents from July 2012 to June 2014.
> HealthStats ACT, an interactive web-based data platform with dynamic and static health statistics on a broad range of ACT population health topics. HealthStats ACT will be regularly updated and is accessible at any time.
> The Health and Wellbeing of Older Persons in the ACT report, which provides an overview of the health and wellbeing of the ACT's population aged 65 years and over, including:
  - a demographic profile
  - social indicators relevant to health
  - health status and quality of life
  - mortality
  - health service use.

The division also:

> improved the completeness and timeliness of maternal and perinatal data and continued to report nationally against key indicators
> through the NSW Cancer Institute, improved the quality and efficiency of ACT Cancer Registry data collection
> increased availability of public hospital data for data-linkage purposes
> continued to link different data sets with the Centre for Health Record Linkage in NSW
> commenced a review of the Epidemiology section survey program.

Population Health Division contributed data to a range of reports, evaluations and research projects including:

> The ACT Government's A Picture of the ACT's Children and Young People
> The Australian Institute of Health and Welfare's (AIHW's) Australia's Mothers and Babies report
> The ACT Government's Healthy Weight Initiative evaluation
> The Better Cardiac Care for Aboriginal and Torres Strait Islander People joint State and Federal collaborative project

The Health Protection Service's ACTGAL published the *Road Transport (Alcohol and Drugs) Act 1977 Report on Analytical Findings February 2015* report. The report is based on the toxicological analyses of blood taken from drivers involved in motor vehicle accidents as required by the *Road Transport (Alcohol and Drugs) Act 1977*, which specifies offences relating to driving while having ingested drugs and/or alcohol. The report includes the confirmed results of oral fluid samples taken under Section 20 of the Act when police conduct a random oral fluid testing program using a presumptive immunoassay-based screening technology. Since November 2011, the laboratory has provided the confirmatory testing of the three prescribed drugs:

> delta-9-tetrahydrocannabinol (THC)
> methylamphetamine
> 3,4-methylenedioxymethylamphetamine (MDMA).

The ANU's National Centre for Epidemiology and Population Health has been contracted by ACT Health to conduct a ground-breaking and unique study to provide additional information of the risk of developing mesothelioma from living in a house containing loose-fill asbestos (a 'Mr Fluffy' house). The study will be conducted in four parts and is expected to take two years to complete. Parts one and two were completed in 2015–16. More information can be found on the *study webpage*.

Health hazards and countermeasures

The Population Health Division successfully conducted Exercise Kanthos on 26 August 2015 at Exhibition Park in Canberra.

Exercise Kanthos was a multi-agency, mixed mode health emergency exercise using the Emergo Train System (ETS) to simulate a coordinated response to an industrial accident at a healthcare facility. The exercise involved 65 participants from:

> three ACT hospitals
> ACT Ambulance Service
> ACT Fire and Rescue
> ACT Policing
> NSW Health.

The exercise scenario involved five severe burn injuries to construction workers and the requirement for the coordinated evacuation and redistribution of 82 patients throughout the ACT Health sector. The response to the scenario was managed in real time using the ETS to simulate burns management and hospital surge capacity measures.

During Exercise Kanthos, hospital emergency operation centres were simulated, practicing major incident command, control and coordination of the ACT health sector. Cross-border liaison with NSW Health for extra jurisdictional assistance was also practiced during the exercise.

Population Health Division's Health Emergency Management Unit (HEMU) also conducted Exercise Alimentaria on 3 June 2016 at Exhibition Park in Canberra. This discussion exercise involved 47 participants from across ACT Government and the health sector. The scenario involved a deliberate contamination of food that:

> resulted in multiple sick persons
> affected more than one food business
> involved multiple facets of ACT Government.

The main objective of the exercise was to test the public health response and coordination of the ACT health sector in the event of a large scale deliberate food contamination event.

Future directions

Promote smoke-free areas

The Health Protection Service is prioritising establishing new smoke-free public places and events in and around Canberra. This is in accordance with the findings of a community consultation on Outdoor Smoke-free Areas undertaken in late 2015. Priority will be given to exploring smoke-free options at places frequently used by children and their families, or at places where people congregate in close proximity, such as playgrounds and bus waiting areas.

Interventions and mitigations

The Population Health Division has and will continue to lead (with colleagues from across Government) the development and implementation of a Medicinal Cannabis Scheme in the ACT.

Two expert advisory groups will be appointed with representation from across the spectrum of government agencies, non-government agencies, medical specialists and law enforcement to inform the development of the scheme.

The scheme will give people safe and legal access to high-quality medicinal cannabis products in appropriate clinical circumstances, and is expected to be in place in 2017.

The ACT Government is committed to ensuring that available medicines are safe and effective.

Health hazards and countermeasures

The Health Protection Service continues to progress work on improvements to controlled medicines regulation in the ACT, including:

> enhancing the Drugs and Poisons Information System (DAPIS)
> educating prescribers on the new controlled medicines framework.

On August 9 2016, the *Public Health Amendment Bill 2016* was passed by the Legislative Assembly. The Bill will allow improved public health management of insanitary conditions resulting from hoarding and domestic squalor in the ACT.

OUTPUT 1.4: CANCER SERVICES

Overview

The Division of Cancer, Ambulatory and Community Health Support (CACHS) provides:

> a comprehensive range of cancer screening, assessment, diagnostic and treatment services
> palliative care services
> administration support to Ambulatory and Community Health sites
> nursing and allied health support to central outpatients and the Ophthalmology service.

Services are provided in inpatient, outpatient and community settings.

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

> ensuring that population screening rates for breast and cervical cancers meet targets
> ensuring that the waiting time for access to essential services, such as radiotherapy, are consistent with agreed benchmarks
> increasing the proportion of women screened through the BreastScreen Australia Program for the target population (aged 50 to 69 years) to 70 per cent over time

During 2015–16, a project was undertaken to strengthen services by:

improving the patient experience

> decreasing the length of inpatient stays
> improving timeliness of admissions
> improving patient flow across all inpatient and outpatient CACHS services.

Staff from across all disciplines and services within the division attended training and committed to participate in the service improvement projects. Outcomes that have been achieved to date are:

> decreased length of stay, in particular for Haematology and Medical Oncology patients
> improved timeliness of admissions
> improved patient flow in outpatients and screening clinics
> improved access to treatment information in patient files
> increased referrals from GPs to BreastScreen ACT
> improved Health Roundtable benchmarked data
> reduced call abandonment rates despite servicing an increased number of calls.

In October 2015, a queue management system (QFlow) was implemented at Belconnen Community Health Centre. QFlow functionality is similar to touch screen ticketing kiosks used in government shopfronts. With English and eight alternative language options clients can register their arrival for an appointment or request assistance from reception staff using these kiosks. QFlow updates the primary appointment system and directs the client to the correct area for their appointment. Reception staff are now able to streamline the process of assisting clients. Average times to access services have reduced and the time waiting at reception has reduced to less than two minutes because of better client flow.

During December 2015, a new breast screening clinic opened at the Belconnen Community Health Centre. The opening of a third location for screening in Canberra has provided more choice and improved access for women in Canberra's north. It also builds capacity for future growth, as the target population for screening increases.

The 2016 World Cancer Day on 4 February 2016 provided an opportunity to highlight what each of us, and the Canberra Region Cancer Centre (CRCC), can do to reduce the impact of cancer on our community. The theme for 2016 is 'We Can, I Can' and it aims to explore how everyone can contribute to reducing the global burden of cancer by achieving greater equity in cancer care and making fighting cancer a priority.

During 2–4 February 2016, in the lead up to World Cancer Day, Canberrans were invited to participate in the three-day *World Cancer Day* event at the CRCC, which provided:

> cancer information sessions
> daily tours of the CRCC
> the opportunity to browse approximately 30 supporter stalls.

All events over the three days were very well attended and supported.

The Rapid Assessment Unit (RAU) for Cancer Services provides an alternative access point for cancer patients, currently receiving or three months post-treatment, who require management of symptoms and side effects relating to their cancer and/or cancer treatment.

Using ACT Government budget funding, the unit expanded in 2015–16 with the addition of a Nurse Practitioner and Advanced Practice Nurse to the service. This ongoing change in model has resulted in an increased capacity to manage cancer patients outside of the Emergency Department. Further work is being undertaken to improve access to the service and subsequently increase the ability to assess and treat patients, thereby reducing Emergency Department presentations and admissions to hospital.

The division participates in Canberra Hospital's hand hygiene audit programs. To improve the compliance rates CACHS trialled the 'Hand in Hand Program – Volunteers Auditing Hand Hygiene'. The trial was established to determine if volunteers conducting hand hygiene audits and providing hand hygiene information to patients and families/carers was an effective and appropriate method of monitoring and improving consumer understanding of hand hygiene.

Ten volunteers were trained in auditing staff hand hygiene practices by the Infection Control Clinical Nurse Consultant (CNC), using the Canberra Hospital snapshot audit tool.
The volunteers were well accepted by the staff as auditors, and they provided weekly audit results to the staff via the CNCs. The volunteers also engaged consumers in hand hygiene education. The impact of this has been hard to determine, but further work with the rollout of the new hand hygiene bookmark is currently underway.

The Community Development Officer position was established (0.5FTE) and based at the Gungahlin Community Health Centre. Over the past eight months key achievements of this position include:

> Developing and implementing the Gungahlin Community Health Centre Culturally and Linguistically Diverse (CALD) Access Project, in partnership with the Multicultural Policy Unit. Tours for local CALD groups are scheduled to begin in August 2016.
> Establishing ongoing liaison and networks with a range of local community groups and service providers, including Commonground Canberra, through Northside Community Services.
> Establishing an ongoing collaboration with GPs through Capital Health Network.

Performance against accountability indicators

BreastScreen ACT's access and uptake has had continued success during 2015–16 with:

> 100 per cent of women receiving screening results within 28 days
> for women requiring further investigation at an assessment clinic, 90 per cent were provided an appointment within 28 days from their initial breast screening appointment.

Breast cancer screening

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

Despite a comprehensive recruitment and promotion program, breast screening participation for the 50–69 year old cohort in the ACT has remained steady at 58 per cent. BreastScreen ACT continues to review recruitment strategies and develop new initiatives to improve participation rates.

BreastScreen Australia Program

BreastScreen ACT continues to actively promote the program by:

> using Electoral Roll data to send invitations to women in the target age group
> sending routine re-screen invitation letters
> phoning lapsed attendees and women who do not respond to invitation letters or who fail to attend appointments
> distributing information packs to all GPs in Canberra
> conducting community and professional information sessions
> staffing stalls at various conventions
> distributing additional resources.

In December 2015, BreastScreen ACT opened a new screening service in Belconnen. This new service will increase the capacity of the program and enable greater access to screening for women in the north and west of Canberra.

In January 2016, the program installed a new mammography and tomosynthesis machine in Civic. This state-of-the-art technology enables three-dimensional imaging of the breast and is used in assessment clinics.

Radiation Oncology

Technology capabilities are a critical component of the Radiation Therapy service. Funding has recently been approved to replace end-of-life major equipment. This will provide further efficiencies and improve access to the service and to more current and targeted radiation therapy treatments, such as Intensity Modulated Radiation Therapy (IMRT).

The planned integration of the oncology information system with other ACT Health systems will support:

> increased efficiency
> streamlined processes
> establishing a complete electronic medical record.

Implementing new technologies provides improved treatments and outcomes for patients. However, the increasing complexity, planning and treatment time is resulting in an increase in demand for Radiation Oncologists, Radiation Therapists and Physics groups and presents ongoing challenges to ensure patients are treated within recommended timelines.

Radiation Oncology will continue developing the following clinical projects:

> expanding the Stereotactic Radiosurgery/ Radiotherapy service to include extra cranial treatment sites
> expanding verification imaging capabilities, including developing a credentialing program
> expanding the application of IMRT to include prostate cancer treatment
> expanding the use the oncology information management system
> continuing to develop scripting to further automate radiotherapy treatment planning system processes and provide process efficiencies
> increasing access to IMRT in Radiation Oncology from the current 16 per cent of patients to the recommended 30 to 40 per cent, depending on clinical case mix.

Achievements over the last year include:

> implementing respiratory gating techniques including:
  – four-dimensional image acquisition, to improve tumour definition
  – deep inspiration breath hold techniques, to reduce the radiation dose to critical organs
> implementing IMRT for prostate and other large field pelvic cancer treatments, which has increased access to IMRT from the previous 12 per cent to 16 per cent of patients
> implementing Cone Beam CT (CBCT), which provides three-dimensional volumetric anatomical data for treatment verification imaging
> increasing patient participation in clinical trials, both investigator initiated trials and cooperative group clinical trials
> upgrading the Stereotactic Radiosurgery (SRS) imaging system, which improves the efficiency of the SRS treatment process
> implementing Stereotactic Ablative Radiotherapy (SABR) for patients with lung cancer.

Participating in the Highly Conformal Hypofractionated Image Guided ('Stereotactic') Radiotherapy (CHISEL) clinical trial supported development of the SABR clinical technique now offered to our patients.

Awards and nominations

Table 11 identifies the key awards and nominations for 2015–16.

TABLE 11: KEY AWARDS AND NOMINATIONS

Name	Award/nomination
Dr Desmond Yip	Achieved his Professorship through the Australian National University (ANU)
Denise Lamb, Executive Director	Finalist in the 2015 ACT Public Service Awards for Excellence in the Executive Leadership category
Megan Nutt, Anne Booms and Ward 14B	Finalists in the 2016 Nursing and Midwifery Awards

In addition, the Immunology Unit received the highest level of accreditation from the Joint College Training in Immunology and Allergy.

Future directions

Breast cancer screening

The Expanded Target Age Group Project, which promotes screening to women aged 70–74 years, is entering the final year. The participation rate in this cohort has increased from 33.21 per cent in July 2014 to 54 per cent in June 2016. The aim is to achieve 55 per cent participation by June 2017.

Cancer Services

In 2016–17, Cancer Services will focus on:

> maintaining high-quality, safe care for all patients by reviewing and evaluating current models of care, for example:
  – the Palliative Care consultation service model will be reviewed following the employment of additional resources
  – the role of the Clinical Nurse Specialists expertise to inform and progress shared care models
  – further expansion of the RAU

> increasing the rotation of nursing staff to enable a more mobile workforce to service the division as a whole
> providing regular forums and space for clinical staff to put forward their ideas for improving the patient experience and develop improvements in care
> continuing the Lean Oncology projects to further reduce the length of stay and increase capacity in the outpatient setting.

Radiation Oncology

Radiation remains an important modality for cancer treatment. With improved clinical outcomes of cancer treatment and increased survival rates, minimising radiation therapy-related toxicities becomes a priority. To support this, future directions for Radiation Oncology include:

> developing the advanced IMRT treatment Volumetric Arc Therapy (VMAT), which provides more precise targeting of the tumour and spares normal tissues, thus minimising related toxicities
> improving efficiencies by reducing treatment delivery times, which will provide increased access to radiation therapy services
> implementing a replacement treatment planning system that will support more complex planning techniques and provide system efficiencies
> developing SRS for metastatic spinal disease
> investigating software that provides efficiencies in the planning and treatment delivery for cranial SRS with multiple targets
> replacing end-of-life Linear Accelerators, which will provide state-of–the-art treatment delivery and imaging modalities
> investigating the feasibility of expanding the brachytherapy service to:
  – provide intraoperative brachytherapy for breast cancer
  – use surface moulds to treat skin cancers.
> increasing participation in clinical trials and translational biological laboratory research studies

Essential services wait times

Capitalising on and sustaining the work undertaken to reduce the waiting list requires that outpatient services focus on:

> implementing demand management strategies
> increasing capacity on a service by service basis.

Further work will continue by developing:

> eligibility and exclusion criteria
> pre-appointment questionnaires
> new models of care, including nurse-led initial review/triaging clinics
> booking rules to assist booking and scheduling staff to appropriately book appointments.

OUTPUT 1.5: REHABILITATION, AGED AND COMMUNITY CARE

The aim of Output 1.5 is to provide an integrated, effective and timely response to rehabilitation, aged care and community care services in inpatient, outpatient, Emergency Department, subacute and community-based settings.

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

> ensuring that hospitalised older persons wait an appropriate time for access to a comprehensive assessment by the Aged Care Assessment Team (ACAT), which assists in their:
  – safe return home with appropriate support
  – accessing appropriately supported residential accommodation
> improving discharge planning to minimise the likelihood of readmission or inadequate support for independent living, following completion of hospital care
> ensuring that access is consistent with clinical need, is timely for community-based nursing and allied health services and that community-based services are in place to better provide for the acute and post-acute healthcare needs of the community.

Overview

During 2015–16, the National Disability Insurance Scheme (NDIS) continued to be rolled out in the ACT. RACC continues to work with clients and the NDIA to support the rollout. Processes and communication strategies are being developed to assist clients, inpatients, staff and providers access the scheme and understand the process once accepted into the scheme.

RACC continues to provide services and equipment funding in line with existing eligibility criteria for clients who are ineligible to access the scheme and for those aged 65 and over.

From July 2015, the Commonwealth implemented a number of reforms to the aged care system including a national approach to aged care assessment through a central, identifiable entry point known as My Aged Care. The ACT Aged Care Assessment Team began using this system on 1 July 2015. To improve performance and client outcomes, RACC staff meet monthly with the My Aged Care Regional Assessment Service (RAS). RAS are responsible for conducting face-to-face home support assessments for older people seeking entry-level support at home. This service ensures clients are referred to the most appropriate aged care services.

Performance against accountability indicators

The Community Nursing and Allied Health performance exceeded the 2015–16 targets for:

> number of nursing occasions of service, which was set at 84,000 and achieved 91,779
> number of allied health regional services, which was set at 25,000 and achieved 31,829.

An increase in the number of occasions of service for Community Nursing and Allied Health can be attributed partly to the health complexity of consumers, noting that service delivery may be extended to multiple visits, e.g. chronic wounds with comorbidities. This reflects:

> demographic changes regarding the ageing population
> an increase in chronic disease
> consumers preferring to stay in their own homes for as long as possible.

The service capacity provided by these teams has increased due to:

> improved staffing levels gained from budget funding from 2013–15
> implementing changes in models of care.

Hospitalised older persons

RACC supports 44 inpatient beds at Canberra Hospital for older people, including 26 acute and 18 subacute beds. After a period of staff shortages, the Geriatrician Team is fully staffed enabling the team to better respond to the needs of the hospitalised elderly patients.

There have been several improvements to care for the hospitalised elderly patients in the Acute Care of the Elderly Unit (Ward 11A). Improvements in food services have been developed to provide a more appropriate service that better caters for the needs of the elderly.

This service has been developed in partnership with the food services team and includes dedicated food service staff for this area. Having dedicated and trained food service staff who are familiar to the patients is important for those with dementia because they are able to interact with them in a more engaging and meaningful manner, for example:

> providing words of encouragement
> opening packets/drinks or
> placing a straw in a drink.

Frailty and associated falls are areas of risk and are being addressed by establishing a Falls Minimisation Room. This four-bed room has a dedicated Assistant in Nursing allocated to ensure continuous:

> observation
> interaction/diversion activities
> monitoring under the supervision of a RN.

Access to services

There is increasing demand for some community-based allied health services, such as Nutrition, Occupational Therapy and Physiotherapy. In response to these increases, changes have occurred in their models of care including:

> The Community Occupational Therapy service established a clinic assessment model based at the Independent Living Centre in Weston. This has improved efficiency by offering an alternate service to home visits while providing exposure to the shopfront displays for people with limited physical capacity.
> The Community Physiotherapy service has established clinics run by physiotherapy assistants to review and provide exercise guidance for non complex clients. This allows the physiotherapists to see more complex cases.
> Access to health coaching provided by community care health professionals has improved by establishing individual health coaching clinics. Individual clinics significantly improve access to consumers who would not be able to participate in or be suitable for a group intervention, e.g. non-English speaking consumers or those with mental health conditions, such as social anxiety.

The Tuggeranong Walk-in-Centre (WiC) opened on 26 June 2014 and the Belconnen WiC on 1 July 2014. The centres provide nurse-led services to the ACT community between 7:30 am and 10:00 pm, 365 days a year.

Presentations to the WiCs continue to increase, however, the number of clients who did not wait remains very low. The top presentations for the WiCs for 2015–16 have been:

> urinary tract infections
> common colds
> wound dressings
> wounds and lacerations
> ear conditions
> skin conditions
> muscularskeletal conditions
> gastro diarrhoea
> gastro vomiting
> ear, nose and throat (ENT) conditions
> upper respiratory tract infections, i.e. sore throats.

The WiCs provide an alternative to attending an Emergency Department, leaving Emergency Departments with greater capacity to assist the more serious cases of injury and illness.

Rehabilitation

RACC introduced the Rehabilitation at Home Program in September 2015, which:

> provides specialised Multidisciplinary Allied Health services to adults in the ACT
> facilitates early discharge from inpatient units at Canberra Hospital by providing home-based subacute therapy.

The program also aims to prevent avoidable admission to hospital by providing therapy in the patient's home.

In February 2016, the Canberra Hospital Acute Subacute Early Rehabilitation Service (CHASERS) commenced. The goal is to improve the triaging and fast-tracking of acute patients into appropriate subacute services. It aims to create a more proactive model of rehabilitation and to prevent functional decline in patients through early intervention. In the three months since the CHASERS Program commenced, the total number of rehabilitation consultations increased by 21 per cent while consultation times reduced by 20 per cent.

The RACC Speech Pathology Service is participating in a cluster randomised control trial with Queensland University: Action Success Knowledge Program (ASK trial) – Reducing the impact of aphasia in stroke patients and their caregivers a year post onset via a brief early intervention program. The research is led by a team of leading international researchers in aphasia. Canberra Hospital is the only participating site in the ACT.

A number of initiatives have also been introduced to improve rehabilitation services in the ACT, including the use of new technology to assist people achieve their goals. This has included:

> ableX, which is a solution designed to accelerate the rehabilitation of arms and hands after a stroke or brain injury. The system comprises a suite of computer-based exercises in a game format, which are designed to promote both movement and cognitive skills.
> Neurofeedback, which is a form of brain training that uses electrical brain recordings to take a client through a process of brain self-regulation. Neurofeedback requires very little physical or psychological effort from a patient. This can help create a more activated, alert, awake brain.
> Introducing neurofeedback therapy in Clinical Psychology services, which will also allow psychological interventions to be successfully provided to rehabilitation and aged care clients, who previously were not able to engage meaningfully in conventional psychological therapy. This therapy will improve therapeutic access to clients who are severely depressed with very impaired motivation and volition.

Dementia care

The Dementia Care in Hospitals Program continued throughout the year. This program is an all-of-hospital education program aimed at improving hospital care of patients with cognitive impairment. It is delivered in partnership with Alzheimer's Australia ACT and supported by Carer's ACT and the Health Care Consumers' Association.

The program is intended to be rolled out to all acute medical and surgical wards of Canberra Hospital by the end of 2016.

Partnership negotiations have been undertaken with Alzheimer's Australia ACT and Dementia Behaviour Management Assessment Services (DBMAS) to develop a support model. The model will focus on developing person-centred care approaches, including considering changes to the care environment to minimise behaviour escalation/crisis situations.

Awards and presentations

As explained in Table 12, a number of RACC staff received awards during 2015–16.

TABLE 12: RACC STAFF AWARDS

Name	Award
Jo Dix, Allied Health Assistant	Awarded the Allied Health Assistant Excellence award
Roslyn Stanton, Physiotherapy Clinical Educator	Completed her PhD 'Feedback in Rehabilitation following Stroke' in April 2016
Anna Snodin	Awarded the Allied Health Clinical Excellence Award for 2015 for her: contribution to the aphasia project in the Rehabilitation Independent Living Unit (RILU) team work and ability to support and develop other staff members
Sema Diler	Awarded the Early Career Excellence Award 2016, which included a professional development grant
Kathryn O'Flynn	Nominated for the Early Career Excellence Award 2016 and was awarded a Certificate of Commendation and professional development grant
Sema Diler, Occupational Therapy	Received the 2016 award for Allied Health Early Career Excellence
Dominic Furphy, Physiotherapy Manager	Received the 2016 award for Allied Health Management and Leadership Excellence

As explained in Table 13, a number of RACC staff gave notable presentations during 2015–16.

RACC STAFF PRESENTED AT EVENTS AROUND THE WORLD, INCLUDING AUSTRALIA, GERMANY, ITALY, POLAND AND THAILAND.

TABLE 13: RACC STAFF PRESENTATIONS

Name/position	Presentation title	Event details
Judith Barker, Community Nursing Nurse Practitioner, Wounds	Management of patients with venous leg ulcers: Current best practice	European Wound Management Association Conference, May 2016, Germany
Judith Barker, Community Nursing Nurse Practitioner, Wounds, on behalf of Wounds Australia	Overview of the venous leg ulcer guideline and Aseptic technique	
Cheryl Jannaway, Stoma Clinical Nurse Consultant	Advantage of a stoma nurse in Community (poster)	AASTN/APFCP 40th biannual conference, October 2015
Rosalyn Stanton, Physiotherapy Clinical Educator	The effect of information feedback on training standing up following stroke: a feasibility study	Combined SMART Strokes SSA conference in Melbourne, in September 2015, and at the Australian Physiotherapy Association conference, on the Gold Coast, October 2015
Anil Paramadhathil, Director, Geriatric Medicine	Re-presentations to ED by elderly patients – Can this be reduced?	General Practice Liaison Officer National Conference in Canberra, March 2016 Preventing Unnecessary Hospital Emergency Department Transfers for Older People Forum, Melbourne, 5-6 May 2016
D Huang, G Spyropoulos, K Nicholls and A Fisher	Trends in orthogeriatric admissions in Canberra Hospital in the 21st century (2005–2014)	Canberra Health Annual Research Meeting, August 2015
N Soerjadi, W Srikusanukul and A Fisher	Renal dysfunction in elderly hospitalised medical patients: types, prevalence, clinical characteristics and relation to short-term outcomes	Canberra Health Annual Research Meeting, August 2015
B Lau, W Srikusanukul and A Fisher	Iron status in acute care elderly patients: relation to co-morbidity and short-term outcomes	Canberra Health Annual Research Meeting, August 2015
A Fisher	Bone-cardiovascular axis: biomarkers of bone metabolism as indicators of cardiovascular diseases and predictors of outcomes in orthogeriatric patients	19th Annual Meeting of European Council for Cardiovascular Research (ECCR), October 2015, Poiano, Lake Garda, Italy
	Cardiovascular diseases and osteoporosis: bidirectional pathophysiological links and practical considerations	PCS 2nd Annual World Congress of Cardiothoracic-Renal Diseases-2015, October 2015, Warsaw, Poland
HH Naing, W Srikusalanukul and A Fisher	Characteristics and risk factors for geriatric hospital readmissions	International Association of Gerontology and Geriatrics (IAGG) Congress 2015, October 2015, Thailand
N Soerjadi, W Srikusalanukul and A Fisher	Acute kidney injury in hospitalised elderly medical patients: types, incidence, risk factors and relation to clinical outcomes	Royal Australasian College of Physicians Annual Congress 2016, May 2016, Adelaide
A Haque, A Paramadhathil,W Srikusalanukul and A Fisher	Characteristics of hip fracture patients with and without previous minimal trauma fractures: are we missing secondary prevention?	Royal Australasian College of Physicians Annual Congress 2016, May 2016, Adelaide
HH Naing, W Srikusalanukul and A Fisher	Osteocalcin: pathophysiological links and clinical considerations with and without diabetes mellitus [AT25]	Australian and New Zealand Society for Geriatric Medicine Annual Scientific Meeting, June 2016, Cairns, Queensland
B Lau, W Srikusalanukul and A Fisher	Anaemia in hospitalised geriatric patients: an underestimated problem [OR 44]	Australian and New Zealand Society for Geriatric Medicine Annual Scientific Meeting, June 2016, Cairns, Queensland
N Soerjadi, W Srikusalanukul and A Fisher	Chronic kidney disease(CKD) in hospitalised geriatric patients: prevalence, characteristics and impact on outcomes [OR 43]	Australian and New Zealand Society for Geriatric Medicine Annual Scientific Meeting, June 2016, Cairns, Queensland

Future directions

Hospitalised older persons

It is anticipated that with the current ageing population, the demand on hospital beds by elderly patients will increase. A new Model of Care (Ortho-geriatrics) is currently being developed to provide efficient and effective care for elderly patients with hip fractures.

Partnerships with the following external stakeholders are being strengthened to facilitate seamless care across various care settings:

> Capital Health Network
> Alzheimer's Australia.

DBMAS are working alongside hospital staff on a regular basis to provide case-specific support with selected clients that are eligible for DBMAS.

Discharge planning

RACC will continue to strengthen the strategies introduced in 2015–16 in regards to patients experiencing a long length of stay. This includes increasing referrals to:

> ambulatory services, including Community Rehabilitation teams or
> community-based services.

This will support the principle of rehabilitation continuing outside the inpatient setting being implemented.

Some patients are experiencing significant wait times when accessing supported accommodation and home modification services. In addition, carer needs are increasing. RACC will continue to work collaboratively with the NDIA regarding long stay patients whose discharge is reliant on the NDIS.

Access to services

The Commonwealth Government announced further reforms to aged care services in the 2015–16 Budget, including a commitment to a single 'care at home' program. RACC will continue to adapt our service model in response to these reforms.

Upgrades to the My Aged Care system continue on a regular basis, including the introduction of a new web-based referral form for GP, Community and Hospital referrers. RACC will continue to work with the Commonwealth to ensure appropriate education is provided on these new initiatives.

The University of Canberra Public Hospital (UCPH) has entered its construction phase. Extensive planning has gone into ensuring that the patient spaces support the Model of Care by providing the best therapeutic space. This includes the innovative use of Information and Communications Technology (ICT) solutions to future proof the potential of UCPH.

Throughout 2016–17, medical, nursing, allied health and administrative staff will concentrate on bringing the vision of the RACC Model of Care together with some innovative changes and supports to clinical practice. Research will be an important part of UCPH. The collaborative relationship with University of Canberra will be enhanced, including the opportunity for combined research projects.

OUTPUT 1.6: EARLY INTERVENTION AND PREVENTION

The aim of Output 1.6 to improve the health and wellbeing of the ACT population through a range of programs, services and initiatives, focused on early intervention, prevention and health promotion.

The key strategic priorities for early intervention and prevention include:

> encouraging and promoting healthy lifestyle choices to decrease the rates of conditions such as obesity and diabetes and reduce risky health behaviours, such as smoking and alcohol consumption
> maintaining high levels of immunisation.

Overview

ACT Health aims to improve the health and wellbeing of the ACT population through a range of programs, services and initiatives, focused on early intervention, prevention and health promotion. The key strategic priorities for early intervention and prevention include:

> screening for cancer
> encouraging and promoting healthy lifestyle choices to decrease the rates of conditions such as obesity and diabetes
> reducing risky health behaviours such as smoking and alcohol consumption
> maintaining high levels of immunisation.

Tackling the risk factors for chronic disease including the relatively high rates of overweight and obesity is a long-term endeavour. The *ACT Chief Health Officer's Report 2016* shows some success, with the ACT:

> reducing smoking rates across the general population
> achieving relatively high immunisation rates
> achieving some early signs of improvements in children's diet with a fall in sugary drink consumption.

Performance against accountability indicators

The ACT continued to achieve high *childhood immunisation* coverage in the general population. During the first three-quarters of 2015–16 the Australian Childhood Immunisation Register (ACIR) reported the ACT as above the national average for children fully immunised in all three age cohorts, which are:

> 12 months
> 24 months
> five years.

Well Women's Checks were provided to 46 per cent of women from CALD communities, which is an improvement on the 2014–15 result. In collaboration with the Health Improvement Branch (HIB) which oversees the Cervical Screening Register, eligibility for Well Women's Checks was reviewed to include:

> young women who had previously not initiated cervical screening
> women who have not been screened for over three years.

This is believed to be consistent with the eligibility criteria targeting vulnerable women.

In 2015–16, 97 per cent of children aged 0 to 14 who entered substitute and kinship care in the ACT were referred to the Child at Risk Health Unit's Out-of-Home Care Clinic. This is in line with the target of 90 per cent.

Promoting healthy lifestyle choices

ACT Health continued to support the implementation of the *Towards Zero Growth: Healthy Weight Action Plan*. The ACT Chief Health Officer is the technical advisor to the steering group for this whole-of-government initiative.

The Population Health Division chairs the ACT Healthy Weight Initiative Food Environment Implementation Group (FEIG). The FEIG oversaw a community consultation examining methods of:

> increasing the availability and promotion of healthy food and drinks
> reducing unhealthy food and drink marketing.

The consultation received over 500 responses and the findings will inform future actions.

The *Choose Healthier* pilot project is being delivered by ACT Health in partnership with the Canberra Business Chamber and supported by the ACT Nutrition Support Service. Five local businesses are participating in the pilot project to trial voluntary actions to increase the promotion and availability of healthier food and drinks:

> The Hellenic Club in Woden has introduced three new healthier children's meals to their menu. The meals are promoted with Choose Healthier branded in-store marketing and colour-in placemats.
> Limelight Cinema in Tuggeranong has introduced a low kilojoule frozen yoghurt and is marketing it as a 'combo' with a bottle of water at a competitive price.
> Tommy & Me café in Macgregor has introduced additional healthier choices to the standard menu, including a new refillable snack pack for toddlers. The refillable snack packs can be filled with a wide range of easy to hold, nutritious choices.
> Two IGA supermarkets, Nicholls and Drakeford, are highlighting and promoting healthier food and drink choices from within each grocery category. This comprises Choose Healthier shelf tickets, banners, floor decals and fridge surrounds. A 'hero shelf' at the front of each store is being stocked with healthier convenience meal options.

Strategies found to be successful under the pilot will be promoted to other businesses Canberra-wide.

ACT Health supported increased access to free drinking water at public events through its eight portable water refill stations. These supplied 17 events with over 22,000 litres of drinking water during the period 1 July 2015–1 May 2016.

The Population Health Division has responsibility for the overarching evaluation of the Healthy Weight Initiative (HWI). The first HWI evaluation report was incorporated into the annual *HWI Report Card,* for which CMTEDD has responsibility, and released as the HWI Progress Report to June 2016. Early indications suggest:

> fewer children are drinking sugary drinks on a regular basis
> children are eating adequate amounts of fruit
> we are on track to meet our target of zero growth in the proportion of children and adults affected by overweight and obesity in the ACT.

The HWI is a whole-of-government approach focused on addressing the main drivers of the obesity epidemic by making improvements in active living environments and food environments across the ACT. An overarching Steering Committee monitors and coordinates policy and program actions across six key themes:

> schools
> workplaces
> urban planning
> food environment
> social inclusion
> information and data.

The ACT Health Promotion Grants Program has provided over $2.7 million for 39 community organisations to tackle the risk factors for chronic diseases, including:

> preventing overweight and obesity
> reducing alcohol- and tobacco-related harms
> promoting healthy active ageing.

Examples of results of this investment to date include:

> One in three adults in the target group have been reached by the Heart Foundation LiveLighter healthy weight education campaign, with over 28,000 website visits and more than 2,300 people registering for the free meal and activity planner.
> Fifty pharmacies across the ACT are participating in the Pharmacy Guild of Australia Community Pharmacy Smoking Cessation Program with 290 pharmacists and assistants having completed face-to-face smoking cessation counselling training.
> Sixty-eight local sporting clubs have been accredited under the Australian Drug Foundation Good Sports Program to make sporting clubs healthier, safer and more family friendly. Twenty-one clubs have also received healthy eating accreditation to improve healthy food promotion and supply.
> The Foundation for Alcohol Research and Education Pregnant Pause campaign raised awareness of the message that zero alcohol consumption is the safest option when pregnant.
> The Lyneham Pre-School Unit at Lyneham Primary School used creative art activities to promote fresh food to pre-schoolers. The project saw an increase in fresh food and a decrease in processed foods in children's lunch boxes and an increase in fruit and vegetable consumption.
> Fifty-two schools have been involved in the Physical Activity Foundation Ride or Walk to School Program, reaching over 20,000 students. Two-thirds of these participating schools reported an increase in active travel at their school.

Children

ACT Health delivers a range of programs for children and young people aged 0–18 years aimed at reducing the risk factors that contribute to:

> the development of chronic disease later in life
> the rates of overweight and obesity.

Sixty-five Early Childhood Education and Care (ECEC) services in Canberra participated in the *Kids at Play (Active Play)* Program from July 2015 to June 2016, reaching over 3,000 children aged three to five years of age. The program contributes to improved developmental outcomes for children aged three to five years in ECEC services by building the capacity of early childhood educators and increasing awareness of the importance of active play with parents.

Sixty-three schools are participating in the *Fresh Tastes: healthy food at school* program, reaching approximately 24,500 students. More schools are becoming involved each term. Fresh Tastes supports ACT primary schools to:

> improve student, family and teacher knowledge of, access and consumption of healthy food and drinks
> implement relevant policies, e.g. ACT Public School Food and Drink Policy.

Fresh Tastes provides curriculum support for:

> nutrition education
> growing and cooking healthy food
> healthy food and drink options.

As of June 2016, 599 teachers have participated in professional learning on delivering nutrition education to students. A number of businesses and community organisations partner and support the schools.

Fifty-two ACT primary schools are involved in the *Ride or Walk to School (RWTS)* Program, which aims to increase physical activity, reaching approximately 20,000 students. RWTS Program data is indicating an increase in active travel to/from school in Year 6 students. The program is delivered by the Physical Activity Foundation through an ACT Health, Healthy Canberra Grant. The RWTS Program will expand in 2016–17, using a revised model. At least 56 new primary and high schools will have access to an active travel to school program over the next two years.

Four RWTS schools are currently trialling infrastructure improvements around schools and promoting strategies to better engage parents under a pilot known as Active Streets. This pilot is implemented by Territory and Municipal Services in partnership with ACT Health and will be extended to more RWTS schools over the next two years.

Nine ACT high schools are participating in *It's Your Move (IYM)*, which supports students to design and implement their own innovative school health improvement projects. These projects aim to increase physical activity and healthy eating and reduce unhealthy weight gain in young people aged 12–16 years. IYM was piloted from 2012–2014 in three ACT high schools and demonstrated promising results with the rates of overweight and obesity in the target group decreasing or remaining stable over the study period. This program informed the development of IYM learning materials, for use in 2017, by year nine and ten students. IYM incorporates:

> systems thinking
> design thinking
> student innovation
> digital technology.

The elective will be ready for delivery in 2017.

Families

Good Habits for Life is a locally developed behaviour change campaign, which targets families with young children, and encourages physical activity and healthy eating. Between July 2015 and June 2016 there were 54,540 unique page views to the Good Habits for Life website. In April 2016, the program's Sugar Swap Challenge was delivered and encouraged families to swap sugary cereals, drinks and snacks for healthier options. Over 800 people signed up for the challenge.

Tobacco smoking remains the single most preventable cause of death and disease in Australia. The ACT has a strong record of achieving tobacco control and smoke-free environments, which is reflected in our rates of tobacco use. Smoking rates are higher among certain subgroups in the ACT, including young pregnant women. The Smoking in Pregnancy Project, funded under the 2015–16 ACT Budget Initiative, is implementing:

> smoking care training for health professionals
> counselling and, if required, appropriate nicotine replacement therapy for pregnant women and their partners
> behaviour change campaigns to help reduce smoking rates in young women and young pregnant women.

Workers

ACT Health delivers programs to promote and support healthy lifestyles within, and through, ACT workplaces.

The ACT *Healthier Work* Service developed and now partially funded by ACT Health is implemented by Access Canberra. It supports ACT workplaces to implement staff health and wellbeing programs. In 2015–16, over 140 local businesses are engaged in the program and over 70 businesses across a range of sectors achieved Healthier Work recognition.

ACT Health runs 'my health' a comprehensive staff health and wellbeing program for the ACT Health workforce of over 6,000 employees. As a part of the program, ACT Health introduced the *Healthy Food and Drink Choices* Policy to increase the range and number of healthy food and drink choices available to staff, volunteers and visitors at ACT Health facilities and events. As a result:

> drink vending machines are now largely compliant with the Policy
> contracts for food outlets across ACT Health include a requirement to comply with the Policy.

The Population Health Division continued to develop and participate in *targeted immunisation promotional activities*. The Population Health Division had representatives on the ACT Health stalls at the Canberra Retirement, Lifestyle and Travel Expo (May 2016) and the Seniors Week Expo (March 2016) to promote the importance of immunisation for older people.

The Office of the ACT Chief Health Officer has been working with the Capital Health Network to develop a website called Live Healthy Canberra. The website will provide a searchable directory of local programs that help people to improve their physical activity and nutrition levels.

The Healthy Weight Initiative Evaluation Implementation Group proposed that a project be developed to improve the data capture and management tools available in the Active travel space. The group is chaired by ACT Health.

The Territory and Municipal Services Directorate developed a Cordon Count Canberra App, which enables observers to count cyclists and walkers. It is available across all mobile devices and was used during the *annual cordon count* in February–March 2016. An option for 'intercept' survey questions has been added to the app by ACT Health to allow for deeper analysis of active travel participation. The intercept feature has been extensively tested and is ready for implementation in counting situations where more in-depth questions can be asked.

The ACT Chief Health Officer has signed an agreement with Capital Health Network to share biometric data related to weight. This data will provide a more detailed understanding of the level of overweight and obesity in the ACT population and inform the development of targeted interventions.

Early intervention and prevention programs

In May 2013, the ACT Minister for Health endorsed the *ACT Chronic Conditions Strategy—Improving Care and Support 2013–18*, building on the previous strategy. The strategy sets the direction of care and support for those living with chronic conditions in the ACT and outlines a collaborative approach to this vitally important area of health care. The strategy's implementation and evaluation is being overseen by the ACT Primary Health and Chronic Condition Steering Committee.

At 30 May 2016, the *ACT Cervical Screening* Program had participation tracking at 57.9%, which is the third highest in Australia and higher than the national average. During 2015–16:

> 34, 030 women were screened and provided their details to the register

- 19, 514 reminder letters were sent out to prompt women who were overdue for their screen test
- 66 information sessions were held to promote two-yearly cervical screening even among women who are vaccinated against Human Papilloma Virus (HPV)
- the program continued to promote the importance of 'regular cervical screening test' through social media, to community groups, at women's health events and through 98 per cent of general practices
- the program delivered messages via community radio in 21 languages to promote screening to women from the Aboriginal and Torres Strait Islander community, and women from non-English speaking backgrounds.

BreastScreen ACT is part of a national population breast screening program that is aimed at reducing deaths from breast cancer through early detection.

For more information, see B.2 Performance analysis—Output 1.4: Cancer Services, page 56.

The results of the kindergarten health checks continue to be sent to the family's GP (if nominated on the consent form) for ongoing support.

The School Kids Intervention Program (SKIP) commenced as a pilot on February 2015. This program is for children 4–12 years who are overweight, either on the:

- 85% percentile or above with comorbidities or
- 95% percentile without comorbidities.

The program is family-oriented and multidisciplinary information, including:

- nutrition
- paediatric (medical)
- psychology
- exercise physiology.

SKIP has received 95 referrals since it began to May 2016.

As part of the Commonwealth-funded National Bowel Cancer Screening Program (NBCSP), endoscopy services are provided to patients. CHHS operates a nurse-led colonoscopy pathway to support NBCSP participants.

Immunisation rates

The Population Health Division worked with the Commonwealth Department of Health to implement changes to the *National Immunisation Program Schedule* in the ACT. Changes included:

- in March 2016, adding a Diptheria, Tetanus, Pertussis (DTPa) booster for children at 18 months
- on 1 January 2016, introducing the national No Jab No Pay requirements.

A new program was introduced in 2015–16, involving sending postcards to parents of children at 12 months, 18 months and four years to remind them that their child's next immunisation is due soon. Preliminary results indicate the introduction of this program has reduced the number of letters being sent to families of children overdue for immunisations in the three cohorts. In addition, this targeted program was expanded for the Aboriginal and Torres Strait Islander community to include reminder postcards at two, four and six months.

Educational activities have continued during 2015–16 for both new and existing immunisation programs. Education evenings were held for immunisation providers in:

- January 2016, to discuss No Jab No Pay, new immunisation programs and pertussis in review
- April 2016, to discuss Influenza vaccination.

Both evenings were well received with in excess of 140 attendees at each session. Staff from the Population Health Division also conducted opportunistic outreach immunisation education for a variety of audiences, including:

- at Capital Health Network Nurse Network meetings
- for new and post graduate paediatric nursing students
- for Canberra Institute of Technology (CIT) enrolled nursing students
- for nursing staff within the maternity units at the major hospitals.

Aboriginal and Torres Strait Islander vaccination coverage rates continue to fluctuate and must always be read with caution given the low numbers of Aboriginal and Torres Strait Islander children in the ACT. During 2015–16, the ACT was above the national average in cohort 1 and maintained rates above 90 per cent in cohort 3. Coverage rates in cohort 2 still remain a challenge and can be attributed partly to changes in the definition of 'fully immunised' in December 2014. Further targeted activities that were introduced during the financial year included:

- mailing reminder postcards
- developing new posters and pamphlets
- continuing to mail quarterly letters to families with children overdue for immunisation.

The introduction of the national 'No Jab No Pay' requirements, which links family assistance payments to immunisation status, has resulted in an increase in the number of overseas immunisation record transcriptions and distribution in catch-up vaccinations.

Future directions

Promoting healthy lifestyle choices

ACT Health will continue to support implementation of the *Towards Zero Growth: Healthy Weight Action Plan*. This will include renewed efforts to make it easier for Canberrans to make healthier choices by:

> improving our food environment, including for example including in workplaces, schools, shops, restaurants and sport and recreation venues
> disseminate information via a range of multi-media channels.

ACT Health will produce an annual evaluation of the HWI.

Health promotion programs in schools will expand in 2016–17.

The ACT will continue to work with the Commonwealth Department of Health during 2016–17 to implement changes to the National Immunisation Program Schedule. New vaccines to be added include Zostavax for persons over 70 years, which is anticipated to be introduced in November 2016.

Further changes to reporting requirements as a result of No Jab No Pay will include extending the ACIR to become a whole-of-life register.

Early intervention and prevention programs

From May 2017, the Commonwealth Department of Health is renewing the Cervical Screening Program based on the latest evidence. The program will include:

> a new test pathway
> new testing frequency recommendations
> a new National Cancer Register.

B.3 SCRUTINY

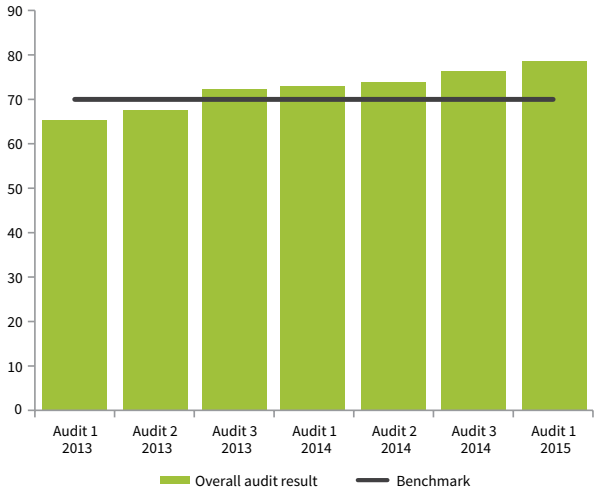
INTRODUCTION/OVERVIEW

ACT Health responds to requests from ACT Legislative Assembly Committees, including reports automatically referred from the ACT Auditor-General's Office as required to assist with and ensure proper examination of matters.

ACT Health also responds to complaints that are referred from the ACT Ombudsman Office. In 2015–16, ACT Health received one complaint referred from the ACT Ombudsman.

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

Annual and Financial Reports 2013–14	
Reporting Entity	Standing Committee on Health, Ageing, Community and Social Services
Report Number	5
Link to report	http://www.parliament.act.gov.au/in-committees/standing_committees/Health,-Ageing,-Community-and-Social-Services/annual-and-financial-reports-2013-2014/reports?inquiry=649333
Report Title	Annual and Financial Reports 2013-14
Government Response Title	Standing Committee on Health, Ageing, Community and Social Services: Report No 5 Report on Annual and Financial reports 2013-14 – Government Response.
Date Tabled	4 August 2015
Recommendation Number and Summary of recommendation	**Recommendation 10** The Committee recommends that the ACT Government consider annual benchmarking for emergency department timeliness against peer group hospitals to provide a better indication of how the ACT is performing compared to similar hospitals. **Recommendation 12** The Committee recommends that ACT Government consider establishing targets to measure how effectively diversion to other health care and human services management programs is working to reduce frequent re-presentations at emergency departments. **Recommendation 13** The Committee recommends that ACT Government look to revise its information systems promptly in order to facilitate the recording and reporting of timeliness measures for non-elective surgery. **Recommendation 14** The Committee recommends that the ACT Government undertake additional efforts to ensure that hospital staff comply with hand washing guidelines.
Action	**Recommendation 10** – Agreed ACT Health will endeavour to incorporate national peer group hospital results into our annual report for benchmarking purposes. Currently, ACT Health does not have access to national datasets for the purpose of generating our own national comparative figures. As such, ACT relies on data that is made available to jurisdictions via national publications. ACT Health currently sources national peer group results and individual hospitals performance results from federal bodies such as the Australian Institute of Health & Welfare (AIHW) and the National Hospital Performance Authority (NHPA) annual hospital publications retrospectivity. As these national publications can often take some time before they are made available to jurisdictions, ACT Health cannot guarantee that the inclusion of the most recent national data into our annual report. Nevertheless, ACT Health will incorporate historic publicised national results into our annual report as per data availability. **Recommendation 12** – Agreed in Principle ACT Health is working with the ACT Primary Health Network (PHN) (formally ACT Medicare Local) to develop initiatives which are aimed at reducing pressure on Emergency Departments by providing better community based options. This initiative will initially focus on those with chronic conditions and those who present regularly at ED's. Further extension will be determined following an evaluation of the work with the ACT PHN. **Recommendation 13** – Agreed This recommendation is currently a high priority for ACT Health. ACT Health currently working on ways to improve the capturing and reporting of non elective surgery information to provide greater transparency in of this area.

Annual and Financial Reports 2013–14	
Action	**Recommendation 14** – Agreed ACT Health strives to achieve continuous improvements in all areas including compliance with hand hygiene requirements. Since 2010 the Hand Hygiene Program at Canberra Hospital and Health Services (CHHS) has been coordinated via the Infection Prevention and Control Unit (IPCU) at Canberra Hospital, and has involved a multi-factorial approach to hand hygiene compliance ranging through education, audit and feedback, promotional activities, equipment and supplies, and focused area or unit specific intervention, with specific examples listed below. During this time the Hand Hygiene program has not only expanded significantly across the health service, but has also resulted in a steady increase in hand hygiene compliance (see graph), although further improvement is required, especially among Medical Practitioners.
	Following each audit period the IPCU analyses the results according to the ward area, moment of hand hygiene and type of healthcare worker, to determine the areas to target with specific interventions prior to the next audit cycle. Whilst the IPCU has been essential in coordinating the program, the importance of individual ward areas and healthcare worker groups in leading and driving the program at a local level needs to be recognised.
Action	
	Program • CHHS run the hand hygiene program as per the '5 moments' set out by Hand Hygiene Australia in conjunction with the Commission on Safety and Quality. • The program now takes in 21 wards/units across the service, leaving only three areas which will be on the program by the third and final round of 2015. • All staff undertake essential infection prevention and control training and to date for 2015 2500 staff have been trained in the '5 moments of Hand Hygiene' and infection control practices. This number includes doctors, nurses and allied health. • Round 1 of 2015 involved 18 units with a total of 6091 moments collected, with an overall rate of 78.7 per cent being achieved. • IPCU run auditor training monthly successful completion of which requires passing an exam to ensure the data collected is valid and accurate. • Each ward/unit collects their own moments and this has been an effective way to collect the data as it ensures staff own the information within their unit. They also see and handle problems or issues and address them as they arise, which is a more effective way to learn. • In addition to the national hand hygiene program, ACT Health run an auditing process of which the hand hygiene snapshot is a part. The snapshot reflects the national program and allows auditing to take place in the community and the outpatient setting. • Alcohol hand rub is readily available across ACT Health to make it easy to perform hand hygiene. It is available at the entry to wards, point of use within wards and in all outpatient settings.
	Interventions include: • International Hand Hygiene Day (children from Woden Valley Childcare Centre helped to raise awareness); International infection control day in October (wear pink t-shirts and encourage wards to hold hand hygiene awareness days, e.g. 10A and women's and children often hold pink days); Infection control, 'Bug Busters' and hand hygiene newsletters are circulated every month; IPCU nurses provide on-the-spot positive and constructive feedback to staff from all disciplines. • Feedback from each audit period is provided to those wards/units that have been part of the Hand Hygiene program, including compliance rates and graphs to display.

	• Education and promotion is provided to wards/units that don't meet the national benchmark during an audit period. • The Infection Control have fun days to promote hand hygiene and good infection control practices, e.g. an annual 'Bake off' with the theme of 'My Hospital Rules'. • 'No touch' hand hygiene stations are situated in all foyers and entry points across the ACT Health. • A DVD has been developed and is on a replay loop in the foyer (this DVD was based on Chesterfield Hospital in the UK). • Skin assessment service is provided by infection control to ensure staff who develop skin irritations are reviewed.
Status	Complete

ACT Auditor-General's Office Performance Audit Report — Report No 8 of 2013 — Management of funding for community services	
Reporting Entity	ACT Auditor-General's Office
Report Number	8
Report Title	ACT Auditor-General's Office Performance Audit Report – Report No 8 of 2013 – Management of funding for community services
Link to report	*http://www.audit.act.gov.au/auditreports/reports2013/Report_08-2013_-_Management_of_Funding_for_Community_Services.pdf*
Government Response/ Submission Title	Government Response – Review of Auditor-General's Report No 8 of 2013: Management of Funding for Community Services.
Date Tabled	6 August 2015
Recommendation Number and Summary of Recommendation	**Recommendation 3** The Health Directorate should include in its grant procedures a requirements to undertake a risk assessment of grant recipients and reflect the level of risk in payment instalments arrangements. **Recommendation 6** The Health Directorate should enhance its service delivery and design for its Mental Health services through formalising its consideration of service design. **Recommendation 7** Service Funding Agreements should be amended to include a standard reporting template which, among other things, specified the relationship between key performance indicators, outputs and outcomes.
Action	**Recommendation 3** – Agreed There are a range of risk management processes already in place within the ACT Health Promotion Grants Program (ACTHPGP). These processes sit at various stages of the grants management cycle, and include initial eligibility checking of grant applicant organisations against a range of measures (including performance against previous ACT Government grants if relevant); confirmation of insurance; and registration of the organisation. Financial audits are also requested and reviewed. In addition, the ACTHPGP will implement a formal risk assessment process, via a risk assessment matrix, and risk will be assessed against the volume of funding being applied for. A review of the ACTHPGP in 2013 has resulted in a preference for larger value longer term grants, compared to the average value of grants previously awarded. As a result of this, payment instalment arrangements will be included in the new Deeds of Grant, administered from March 2014, commensurate with the scale of funding being awarded. The level of risk will be reflected in payment instalments and the deed of grant. Where appropriate performance benchmarks will be set and these will need to be demonstratively met before instalment payments are made. **Recommendation 6** – Agree in principle Health Directorate is facilitating development of the Government's Mental Health and Well being Framework 2015-25, which will inform the Mental Health Services Plan 2015-20. This will provide better alignment between planning and implementation including the objectives of mental health service funding agreements. **Recommendation 7** – Agreed The Health Directorate will incorporate the results of current national health reforms in its agreement with the community sector. Health Directorate is cognisant of the national work underway to develop standard approach to performance indicators, measures, and data sets in relation to mental health. The ACT Health Mental Health Policy Unit will work with the ACT Mental Health Community Coalition to develop standard reporting templates for similar services
Status	Complete

Inquiry into the Appropriation Bill 2015–16 and Appropriation (Office of the Legislative Assembly) Bill 2015–16	
Reporting Entity	Select Committee on Estimates 2015–16
Report Number	1
Report Title	Inquiry into the Appropriation Bill 2015–16 and Appropriation (Office of the Legislative Assembly) Bill 2015–16
Link to report	*http://www.parliament.act.gov.au/__data/assets/pdf_file/0003/756309/Estimates-2015-Vol-1-report.pdf*
Government Response Title	The Government Response to the Report of the Select Committee on Estimates 2015–16 on the Inquiry into the Appropriation Bill 2015–16 and Appropriation (Office of the Legislative Assembly) Bill 2015–16
Date Tabled	11 August 2015
Recommendation Number and Summary of Recommendation	**Recommendation 103** The Committee recommends that the ACT Government consider provide the results of the independent review of medical training culture at the Canberra Hospital to the Legislative Assembly within three months of receipt. **Recommendation 104** The Committee recommends that the ACT Government continue to work with all First Ministers and the Commonwealth Government to ensure sustainable health funding for State and Territory governments so they can continue to deliver high quality health services to the community. **Recommendation 105** The Committee recommends that the ACT Government collect data on why non-elective surgeries get cancelled and report back to the Legislative Assembly on how it will address the issues driving cancellations. **Recommendation 106** The Committee recommends that the ACT Government detail to the Legislative Assembly the proposed timetable and funding for the design and construction of the proposed new building 2/3, known as the 'Tower Block'. **Recommendation 107** The Committee recommends that the ACT Government detail to the Legislative Assembly the expenditure of $40 million previously allocated for the proposed new building 2/3 at Canberra Hospital, known as the 'Tower Block'. **Recommendation 108** The Committee recommends that the Health Directorate produce and use a standard table of definitions of 'bed' including definitions of acute, subacute, non-acute, and overnight and day beds, in-patient and out-patient beds, bed spaces and traditional and non-traditional beds. **Recommendation 109** The Committee recommends the ACT Government consider an improved way of communicating how health services and health outcomes are delivered to the community. **Recommendation 110** The Committee recommends that the ACT Government provide clear definitions for counting staff numbers including head count, fulltime employees, fulltime employees (ACT funded) and fulltime employees (externally funded) and fulltime employees (all funding sources), full time equivalents and agreed abbreviations. **Recommendation 111** The Committee recommends that the ACT Government provide a breakdown of Full Time Equivalents in its annual reports indicating the number of positions externally funded and the number funded by the ACT Government. **Recommendation 112** The Committee recommends that any decision-making by the ACT Government around community access to health services be undertaken with proper community consultation. **Recommendation 113** The Committee recommends that the ACT Government conduct a review into the number of patients admitted to the Adult Mental Health Unit with predominantly drug-related issues rather than mental health issues and that a plan be formulated for managing drug addicted/affected patients. **Recommendation 114** The Committee recommends that a whole-of-government inquiry be carried out, and the findings presented to the Legislative Assembly by March 2016, on the inpatient and outpatient services, support programs and care models for adolescents facing mental health issues. **Recommendation 115** The Committee recommends that the ACT Government table a copy of the framework for the Adult Mental Health Unit by the last sitting day in 2015. **Recommendation 116** The Committee recommends the ACT Government should consider addressing the social determinants of obesity through a whole-of-government approach, in conjunction with the obesity clinic.

Inquiry into the Appropriation Bill 2015–16 and Appropriation (Office of the Legislative Assembly) Bill 2015–16	
Recommendation Number and Summary of Recommendation	**Recommendation 117** The Committee recommends that the ACT Government investigate additional ways to ensure that breast screen services reach women at a level equivalent to at least that of other Australian states. **Recommendation 118** The Committee recommends the ACT Government explore opportunities to create a more child and family friendly space at Clare Holland House when they care for paediatric patients. This could include consideration of: • different needs of preschool, primary and secondary aged children; • providing specialist paediatric staff, either temporarily or permanently, when treating paediatric patients and their families; and • providing age appropriate temporary or permanent physical spaces for paediatric patients and their families. **Recommendation 119** The Committee recommends that the ACT Government consider determining the cost of alcohol-related injuries and diseases on the ACT community with regard to: • financial cost; • staff time; and • facilitation, • and report to the Legislative Assembly by the last sitting day in 2015. **Recommendation 120** The Committee recommends that the ACT Government consider determining the cost of tobacco-related injuries and diseases on the ACT community with regard to: • financial cost; • staff time; and • facilitation, • and report to the Legislative Assembly by the last sitting day in 2015.
Action	**Recommendation 103** – Noted On 17 June 2015, Mr Simon Corbell MLA, Minister for Health, announced an independent review into the training culture for doctors in specialist training programs at Canberra Hospital. The Review of The Clinical Training Culture at Canberra Hospital is being undertaken by an independent consultancy firm, KPMG. That work is now well advanced. The Minister has indicated that the report will be made available publicly subject to Government consideration. **Recommendation 104** – Agreed The Government is actively engaged with other jurisdictions and the Commonwealth with the objective of addressing the Health funding cuts announced in the Commonwealth's 2014–15 Budget. **Recommendation 105 –** Agreed The ACT Government is reviewing its data collection processes and electronic capabilities on the recording of non-elective surgery postponements. A response that detailed how the ACT Government is addressing issues driving cancellations was provided to the Legislative Assembly through Question Taken on Notice No. 75. **Recommendation 106** – Noted A business case for the Building 2/3 redevelopment will be considered in future budgets. **Recommendation 107** – Agreed ACT Health informed the Select Committee on Estimates 2015–16 that the Capital Works Project referred to in Recommendation 107 was formally ceased in the 2013-14 Budget and replaced by a new Capital Works Project in the 2013-14 Budget titled "Clinical Services and Inpatient Unit Design and Infrastructure Expansion" ($40.8 million). **Recommendation 108** – Not Agreed ACT Health does not report beds by care types, rather whether they are considered to be an overnight or same day bed. ACT Health currently has a total of 1,068 available beds in our public hospitals. Of these, 901 are considered to be overnight with the remaining 167 considered as same day beds. The beds available in our public hospitals treat a variety of differing care types and acuity levels. Whether the patients in our inpatient wards are acute or sub-acute is based on demand. **Recommendation 109** – Noted **Recommendation 110** – Agreed in principle The only term used in relation to staffing in the Budget papers is "Full-Time Equivalents" and this is defined in the on-line Readers Guide to the 2015–16 Budget (see page 43) http://apps.treasury.act.gov.au/__data/assets/pdf_file/0005/733838/2015-16-Readers-Guide-to-the-Budget.pdf. Other definitions and abbreviations are also contained in the Glossary which is at Attachment B to the Readers Guide. **Recommendation 111** – Noted Consideration will be given to providing this breakdown in the next Annual Report Directions. **Recommendation 112** – Noted ACT Health already consults widely with the community and key stakeholders around community access to health services and will continue to do so.

Inquiry into the Appropriation Bill 2015–16 and Appropriation (Office of the Legislative Assembly) Bill 2015–16	
	Recommendation 113 – Not Agreed ACT Health has clear admission criteria for the assessment and treatment of people with mental health issues or drug related issues. The decision to admit is made by a consultant doctor. The Adult Mental Health Unit (AMHU) was commissioned in April 2012 to provide specialised mental health assessment, treatment and care for voluntary and involuntary people presenting with an acute mental illness that cannot be managed effectively in a less restrictive environment. If people are assessed in the Emergency Department as having an acute mental illness, they are admitted into AMHU under the care of a treating Psychiatrist. If people are assessed as having drug related issues, they are medically stabilized and either admitted into the Withdrawal Unit under the care of an Addictions Physician or discharged home with referrals for community based Alcohol and Drug related care. If people are assessed as having both a mental illness and an addiction that requires inpatient care, they are admitted to the area that specialises in the patient's predominant presenting issues.
Action	**Recommendation 114** – Not Agreed The responsibility for responding to adolescents facing mental health issues is divided between the ACT and Commonwealth Governments. An estimated 25 per cent of young people will experience mental health problems in a given year, of these young people approximately 85 per cent will experience mild to moderate mental health problems and 15 per cent will experience severe mental illnesses. The Commonwealth Government has responsibility for primary mental health interventions for adolescents experiencing mild to moderate mental health problems; and the ACT Government, through ACT Health has responsibility for providing specialist mental health services for adolescents experiencing severe mental illnesses. ACT Health engages with Commonwealth funded mental health programs and services which are the primary contact for the majority of adolescents experiencing mental health problems. This engagement includes liaison with GPs, direct engagement with the Capital Health Network (reconstituted ACT Medicare Local) and headspace ACT. ACT Health has already undertaken considerable work reviewing the models of care for public child, adolescent and youth mental health services, and is currently undertaking the work regarding models of care for community adult mental health. The reviews are informing the ACT Health purchase of adolescent and youth mental health services from the community sector. In addition, ACT Health has reviewed mental health inpatient services for adolescents while undertaking planning for the health infrastructure projects at Canberra Hospital. **Recommendation 115** – Agreed in principle The Framework is in the process of being developed, and will include consultation with carer and consumer peak bodies. It is envisaged that the Framework will be completed in late 2015. Consideration will be given to tabling the Framework once it is finalised. **Recommendation 116** – Noted The Government is already addressing the social determinants of obesity prevention and health promotion through the whole of government Healthy Weight Initiative across a range of focus areas. The obesity clinic is a one-to-one clinical intervention for people with morbid obesity and does not focus on population level obesity prevention or promotional activities related to healthy weight. **Recommendation 117** – Agreed In the Australian Monitoring Report 2012-2013 (due for release in September 2015), the 'age-standardised' participation rate of 54.2 per cent for the ACT is above the national average of 53.7 per cent. **Recommendation 118** – Agreed This recommendation will be further explored in discussions between Calvary and ACT Health. Clare Holland House has one respite care bed that is utilised as required for the provision of specialist paediatric palliative care. If a paediatric patient is admitted to Clare Holland House, the ACT Paediatric Palliative Care Network (comprising Canberra Hospital Paediatric Unit, Bear Cottage, Prince of Wales and Westmead Hospitals) provides particular education and training in relation to patient-specific paediatric issues and this is organised prior to or during the admission. Clare Holland House conducts several paediatric specific in-service training sessions each year to educate staff of what may be expected when caring for a child. For paediatric patients, families, parents and carers are encouraged to make the room as homely as they wish. There is a covered children's playground and a range of toys, music, DVDs and electronic games that can be lent to children. **Recommendation 119** – Not agreed Collins & Lapsley (2008) estimated that the economic costs [for Australia] associated with licit and illicit drug use in 2004-05 amounted to $56.1 billion, comprising $31.5 billion due to tobacco and $15.3 billion to alcohol. Determining the ACT specific costs would require the commissioning of special studies and this is not feasible within the required timeframe and available resources. **Recommendation 120** – Not agreed Collins & Lapsley (2008) estimated that the economic costs [for Australia] associated with licit and illicit drug use in 2004-05 amounted to $56.1 billion, comprising $31.5 billion due to tobacco and $15.3 billion to alcohol. Determining the ACT specific costs would require the commissioning of special studies and this is not feasible within the required timeframe and available resources.

Inquiry into the Appropriation Bill 2015–16 and Appropriation (Office of the Legislative Assembly) Bill 2015–16	
Status	Complete

Auditor-General's Report — Gastroenterology and Hepatology Unit, Canberra Hospital	
Reporting Entity	ACT Auditor-General's Office
Report Number	4
Report Title	Auditor–General's Report – Gastroenterology and Hepatology Unit, Canberra Hospital
Link to report	*http://www.parliament.act.gov.au/__data/assets/pdf_file/0008/603773/Report-No-4-of-2014-Gastroenterology-and-Hepatology-Unit,-Canberra-Hospital.pdf*
Government Response/ Submission Title	Auditor–General's Report No 4 of 2014- Gastroenterology and Hepatology Unit, Canberra Hospital – Government Response
Date Tabled	13 August 2015
Recommendation Number and Summary of recommendation	**Recommendation 1 (Chapter 3)** The Health Directorate should improve the governance of the GEHU by: a) the three month outpatient administration structure pilot (commenced 17 March 2014) being evaluated to inform how best to provide medical transcription and outpatient referral processing and scheduling of services; b) recording actions items and outcomes for the Division of Medicine Executive Meeting and the meetings between Executive and the GEHU. These should record decisions and actions agreed; be tabled and approved at subsequent meetings; and evidenced as such. Key messages from these meetings should be routinely communicated to staff and management; c) The GEHU developing and implementing a business or action plan that prioritises strategies in the Directorate and Divisional strategic plans. The GEHU business or action plan should include key performance indicators (refer to recommendation 3d) and be regularly reviewed, at least annually, and finding from this reported to the Division of Medicine Executive Meeting. d) The GEHU documenting its risks as part The GEHU developing, monitoring and reporting on key performance indicators (including setting targets) that cover all of its activities: » endoscopy (already the subject of a key performance indicator and target); » care for inpatients with gastroenterological diseases; » medical services; » clinics for outpatients with viral hepatitis, liver disease inflammatory bowel disease, gastrointestinal cancer and other complex gastrointestinal disorders; and » clinics for participants in the National Bowel Cancer Screening Program e) The GEHU documenting its risks as part of its Business Plan, and reporting (at least annually) on any risk issues to the Division of Medicine Executive Meeting
Recommendation Number and Summary of recommendation	Recommendation 2 (Chapter 4) The Health Directorate should develop and implement an action plan to reduce and stabilise the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care. This plan should include actions to: a) Define targets (including specific ones for categories and the number of clients triaged per full time staff specialist) and adopt guidelines for GEHU triaging. b) Increase the use of electronic referrals to the GEHU by GPs. c) Require that all GEHU health professionals report incidents where patient care has the potential to be compromised because of an incident, and do this using Riskman. d) Investigate options to improve clinic organisation to be able to respond to varying patient demand. e) Specify initial appointments per clinic and the type of patients seen in each clinic (general or sub-specialty) to provide clear direction on the work they are expected to complete in a four week clinic cycle. f) Develop a process to guide clinic appointments being organised according to the urgency of a patient's symptoms (their triage category) and not according to referral type (named or generic/NTANS; or general gastroenterology or sub-specialty). g) Electronically perform referring, triaging and scheduling and if this is not possible, having as many steps in the process as possible performed electronically. h) Incorporate information on probable waiting times and alternative treatment options in letters provided to all registered GEHU patients by GEHU administration. i) Assess the merits and limitation of introducing 'open' endoscopy referrals in the GEHU. j) Develop and implement criteria that must be met before GEHU outpatients schedule an appointment. k) Affirm and/or expand the role of GPs (e.g. shared care) in supporting patients attending GEHU outpatients. l) Use Riskman data and reports to address areas of concerns identified thorough incident reporting. m) Collect analyse and report on GEHU data in order to strategically manage GEHU resources and demand for GEHU services.

Auditor-General's Report — Gastroenterology and Hepatology Unit, Canberra Hospital	
Action	**Recommendation 1 (Chapter 3)** a) Agreed A revised reporting structure for administrative staff has been implemented in the GEHU. All administration staff have been combined under one management model to provide overall leadership and management of all GEHU referrals. Senior medical specialists are leading this work with significant progress towards triaging and booking patients. This has resulted in: » standardisation of core procedures » accurate and consistent reporting processes » creation of professional structure » maximisation of clinician time spent of clinical functions » standardised role descriptions for administrative staff have been developed b) Agreed-in-Part A detailed Action Statement, rather than Minutes of the meeting, is utilised. The Action Statement records meeting attendees, the action, information about discussions relating to the action, the outcome/decision and the progress of each item. The Unit Director then facilitates communication of the actions to the staff of the GEHU. The Division of Medicine Executive, GEHU Unit Director and Business Support Officer have arranged ongoing fortnightly meetings which commenced in July 2014. c) Agreed The Division of Medicine has a Business Plan that encompasses all clinical areas within the Division, including the GEHU. This Business Plan has been completed. The GEHU has a specific Scorecard that is reported on monthly in the Scorecard meetings with Canberra Hospital Executive. The reporting includes KPIs for the GEHU and the results of each month as well as information regarding variances from the target. d) Agreed The GEHU reports on KPIs on a monthly basis is the divisional scorecard meetings. KPIs report on referral management, endoscopy waiting lists, GEHU procedures and occasions of service. e) Agreed GEHU risks are documented in the Divisional Business Plan as well as the Divisional Risk Register. The Business Plan reflects risks and their operation management strategies. This is undertaken in collaboration with Unit staff as appropriate. Risks are reported on in the divisional Quality and Safety meeting which meets monthly and the Tier 1 Canberra Hospital and Health Services Quality and Safety Meeting which meets quarterly. When incidents are reported through the IT system Riskman, a copy is sent to the relevant executive member (unit director/DON/ADON etc) who reviews each risk and actions taken.

Auditor-General's Report — Gastroenterology and Hepatology Unit, Canberra Hospital	
Action	**Recommendation 2 (Chapter 4)** a) Agreed Targets have been developed in order to increase access to GEHU services and minimise waiting time. The Unit is progressing this and has met with all the Staff Specialists to increase new patients and increase patients seen across all services. Targets have been agreed via Performance Plans between the Division of Medicine Executive Clinicians to increase the number of clinics and decrease the number patients awaiting appointment. b) Agreed All GEHU consultants are triaging electronically via the Clinical Portal. c) Agree All clinicians of the GEHU are aware that they must report all incidents in the Riskman system. d) Agreed The Executive Director of Medicine and Clinical Director of Medicine have met with the doctors of the GEHU and have finalised clinic allocations which allows for increased clinic time for some doctors and incorporates an increased emphasis on seeing of new referrals for each clinic, allowing for more patients to be seen overall. A locum staff specialist has been recruited to add additional endoscopy clinics in June and July 2015. e) Agreed Through meetings with the Division of Medicine Executive and GEHU clinicians, agreements have been put in place for each clinician's clinic, including the number of patients (initials and follow ups) to be seen in each clinic. f) Agreed Service Leads have been appointed to manage outpatient referrals for the GEHU. This work has ensured that referrals are distributed equitably to all clinicians of the unit and the number of GEHU patients with referrals awaiting clinical triage continues to decrease. g) Agreed Changes have been introduced to improve processes for acceptance and registration of referrals. A focus on increasing Gastroenterology Consultants utilisation of IT systems to triage has been undertaken in an effort to streamline referral processing. h) Agreed A Service Innovation and Redesign Framework project has been undertaken to manage the demand and flow of patients within GEHU who require outpatient clinic visits and procedures. This project aims to improve flow, create efficiencies and to improve utilisation of available resources. i) Agreed The assessment has been completed. j) Agreed This has been completed and the work is led by the Unit's Service Leads. Service Leads have been appointed to manage outpatient referrals for the GEHU. This work has ensured that referrals are distributed equitably to all clinicians of the unit and the number of GEHU patients with referrals awaiting clinical triage continues to decrease. Work around Health Pathways in collaboration with ACT Medicare Local will assist in defining the patient journey and the role of GPs and the tertiary Gastroenterology service at Canberra. HealthPathways, including a Gastroenterology pathway, has been active as of April 2015. The pathway triggers for specialist referral which are GEHU promulgated. The HealthPathways system is also used in the tertiary care setting by the GEHU when discharging patients to their primary care provider/GP. k) Agreed Work around Health Pathways in collaboration with ACT Medicare Local has assisted in defining the patient journey and the role of GPs and the tertiary Gastroenterology service at Canberra Hospital. The gastroenterology pathways provide evidence based guidelines to manage patients within primary care. Liver Services are provided in the form of outreach at the AMC in collaboration with Justice Health. Outreach services are also being explored for the ATSI patients at Winnunga Nimmitjara to increase access and compliance with management of liver treatment for ATSI patients. l) Agreed All clinicians of the GEHU are aware that they must report all incidents in the Riskman system. m) Agreed Data specific to the GEHU is now reported on a monthly basis at Divisional meetings which allows the service transparent visibility of demand and enables improved resource management.
Status	Complete

Auditor-General's Report — Integrity of data in Health Directorate	
Reporting Entity	ACT Auditor-General's Office
Report Number	5
Report Title	Auditor – General's Report – Integrity of data in Health Directorate
Link to report	*http://www.audit.act.gov.au/auditreports/reports2015/Report%20No%205%20of%202015%20Integrity%20of%20Data%20in%20the%20Health%20Directorate.pdf*
Government Response/ Submission Title	Government Response to the Auditor – General's Report No 5 of 2015 – Integrity of data in Health Directorate
Date Tabled	17 September 2015
Recommendation Number and Summary of recommendation	**Recommendation 1** As ACT Health implements its Information Management Strategy 2015–16, change management initiatives should include: • Training staff to ensure they have an adequate understanding of the strategy and specifically data integrity activities; and • Documenting and allocating responsibility for data integrity activities for the key systems including ACTPAS, EDIS and the data warehouse. **Recommendation 2** Outcome measures for data quality, including metrics, should be developed and incorporated into the Information Management Strategy. These should be monitored to ensure the adequacy of data integrity, particularly related to ABF data. **Recommendation 3** ACT Health's Information Management Strategy should clearly articulate the following: Key data risks associated with ABF-related data and submissions to national bodies; Frequency, scope of control assessments and other assurance activities that will be undertaken to provide assurance in relation to ABF data integrity The ABF data integrity risks and control assessments will need to be updated from year to year as national submission requirements change. **Recommendation 4** HIGH PRIORITY RECOMMENDATION ACT Health should develop an emergency department data dictionary to standardise the definition of ABF related data and define ABF-related data mapping from EDIS in both hospitals to the data warehouse. **Recommendation 5** Calvary Public hospital should align its EDIS record close period (currently 7 days) with that of Canberra Hospital (Currently 2 days). ACT Health should undertake a monthly assessment to monitor changes to patient records after the close period. **Recommendation 6** Canberra Hospital should finalise its draft EDIS training documents and implement a mandatory requirement to staff to complete EDIS training before receiving access to the system. **Recommendation 7** HIGH PRIORITY RECOMMENDATION Both Canberra and Calvary should establish useable audit logs for EDIS to allow monitoring activities after the close-off period. The audit logs should be reviewed regularly with results presented to the accountable hospital executives and to the Health Directorate. **Recommendation 8** HIGH PRIORITY RECOMMENDATION ACT Health should finalise and implement the Non-admitted Patient Activity Data Standards. **Recommendation 9** HIGH PRIORITY RECOMMENDATION ACT Health should develop and implement overarching policies and procedures related to data validation processes and activities. These should provide a consistent framework that is flexible and adaptable when needed to reflect local processes and organisational structure. **Recommendation 10** ACT Health should review the capability of its data warehouse and develop robust processes to track validation activities performed by the hospitals. It should also define and promulgate business rules required in correcting ABF-related data to ensure consistency across hospitals. **Recommendation 11** HIGH PRORITY RECOMMENDATION ACT Health should develop KPIs for the validation of data that can be supported by information from the data warehouse.

Auditor-General's Report — Integrity of data in Health Directorate	
Recommendation Number and Summary of recommendation	**Recommendation 12** HIGH PRIORITY RECOMMENDATION ACT Health should finalise its business rules for data validation and incorporate these in its data warehouse, then re-commence the distribution of validation reports for the Non-admitted Patient areas at Canberra Hospital and Calvary Public Hospital and for the Calvary Public Hospital Emergency Department. **Recommendation 13** HIGH PRIORITY RECOMMENDATION ACT Health should perform an analytical review to quality assure the six-monthly data submission before it is sent to IHPA. **Recommendation 15** HIGH PRIORITY RECOMMENDATION ACT Health should undertake further investigation into the inconsistencies and anomalies identified by the data analytics, taking a risk-based approach to the investigation and focusing on the areas that have the potential to materially affect ABF data and funding. As a priority, ACT Health should review the mapping of processes to extract data from emergency department systems to the data warehouse. **Recommendation 16** Canberra Hospital and Calvary Public Hospital should review patient records on a random and weekly basis with a focus on the fields that are included in ABF reporting Both hospitals should conduct refresher training on the use of the "type of visit" field **Recommendation 17** HIGH PRIORITY RECOMMENDATION ACT Health should investigate the root causes of errors in non-admitted data, including errors in Indigenous status, postcode and funding sources and develop and implement policies and procedures for improvement. ACT Health should implement a single patient administration system and standardise data management policies and procedures across all public outpatient clinics. **Recommendation 18** Canberra and Calvary Hospitals should improve their clinical coding with the following process changes: Where coding is completed before the availability of the discharge summary, the record should be flagged to facilitate subsequent identification of potentially incorrectly coded episodes. Where discharge summaries conflict with information in the record, a query should be forwarded to the treating clinician for clarification. These queries should be followed up and documented for future reference.
Action	**Recommendation 1** – Agreed The ACT Health Information Management Integrity Strategy will be disseminated more widely across ACT Health to ensure that all staff are aware of its content and the relationship between staff actions and data integrity. ACT Health has finalised its data custodian guidelines which document and allocate responsibilities for data integrity activities for key systems in ACT Health. **Recommendation 2** – Agreed The Data Credentialing Framework, which is referred to in the Information Management Strategy, includes the development of key performance measures for data quality and data quality assurance processes. These measures will provide quality assessments of all major ACT data sets, including data submitted for ABF purposes. **Recommendation 3** – Agreed ACT Health will amend its Information Management Strategy to ensure that key data risks and control assessments for ABF data is implicit within the Document. At present, the Strategy provides details about data quality control processes. However, additional specific references will be made in relation to ABF data validation and quality assurance processes. **Recommendation 4** – Agreed ACT Health notes the separate use at each ACT public hospital of codes relating to the type of ED presentation. This matter, while important to address, has a very limited financial impact. Notwithstanding this, standardised approaches to recording this information have been implemented, and ACT Health is developing the necessary data dictionary for the system. **Recommendation 5** – Agreed ACT Health has implemented a range of activities to improve data integrity within the emergency department system. These include: • Removal of generic log-ons on all but one machine due to operational requirements • Swipe care access to machines • Adding the mandatory requirement for people to provide reasons for any change to records • Automated assigning of names to any changes • Automated checking of emergency department data to determine if inappropriate patterns are occurring ACT Health will increase this activity to include more robust audit process now that these other activities are in place and working (see Recommendation 7).

Auditor-General's Report — Integrity of data in Health Directorate	
Actions	**Recommendation 6** – Agreed Training documents have been finalised and an on-line training package has been completed. **Recommendation 7** – Agree in principle As is noted in the report the EDIS audit logging functions can have a significant impact on system performance. Initial work has been completed to provide additional audits of activity within the emergency department as well as the initiatives already in place that minimise access to the system and minimise the possibility of inappropriate changes being made without a clear audit path. While audit logging is desirable, this level of data quality assurance must be balanced against the need to provide a responsive service to emergency patients. Relevant areas of ACT Health will work with the Director of Information Integrity to develop a sustainable method of managing this risk. **Recommendation 8** – Agreed ACT Health has commenced implementing the non-admitted standards. As noted in the report, data standards for Non-admitted data are less mature than in other domains of health activity and relevant areas of ACT Health will continue to develop and implement the standards as requirements change over time. **Recommendation 9** – Agreed ACT Health established a new Data Credentialing Framework in 2014 which includes greater access to data validation processes and improved data validation and quality assurance systems. The main issues within the framework have been addressed and the programme of work will continue as the capability of ACT Health's reporting infrastructure expands. **Recommendation 10** – Agreed As noted above in Recommendation 9, ACT Health is developing systems to better communicate data validation processes, as well as establishing formal and informal forums to discuss data quality matters. This process will improve data quality and provide the basis for changes to source systems to reduce the possibility of further data errors. **Recommendation 11** – Agreed The establishment of KPIs and reports is incorporated within the Data Credentialing Framework. This framework also includes an escalation process to ensure that data issues are addressed as required. **Recommendation 12** – Agreed New validations for Non-admitted care have been developed based on the Non-admitted Patient Data Standards. In addition, ACT Health has implemented processes that provides for improved communication of data quality issues with business areas across the organisation. Validations for Calvary Hospital emergency department activity have recommenced following completion of the work required by Calvary to enable this to occur. **Recommendation 13** – Agreed ACT Health has implemented further validations and analysis on submissions to relevant national bodies, particularly with regard to the final data transform process flagged in the report. **Recommendation 15** – Agreed ACT Health agrees that improved data analytics will provide for increased data quality over time. ACT Health has directed efforts to focus on the areas with the highest material impact (admitted services) and work is underway to maximise data quality in non-admitted services through the development of more robust standards and validation techniques. ACT Health is also investigating the apparent anomalies with ED data, noting that the impact of them would not be material in a funding sense. **Recommendation 16** – Agreed The report noted that coding errors were within nationally and internationally accepted standards. A number of systems are in place to identify issues and follow-up on discharge summaries. ACT Health and Calvary will review these with the view to introduce enhanced approaches that further minimise errors. In addition, ACT Health will undertake external coding audits as a further means of demonstrating compliance with relevant standards. **Recommendation 17** – Agree in principle ACT Health has already established new processes to focus on and improve data quality within non-admitted services. Some errors identified in the report have already been addressed and data re-submitted to IHPA. The new Advancing Data group (within non-admitted services) and the work to finalise the non-admitted data standards will provide a firm basis for improved data quality in this area. On top of this, new formal and informal forums will also be established to provide information to those responsible for entering data into systems related to non-admitted care. ACT Health will need to undertake a review of the impact and capacity of establishing a single system for non-admitted services. **Recommendation 18** – Agree in principle ACT Health will investigate the feasibility of implementing an automatic validation to detect the small number of overlapping episodes.
Status	Complete

Inquiry into the Exposure Draft of the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 and related discussion paper	
Reporting Entity	Standing Committee on Health, Ageing, Community and Social Services
Report Number	6
Report Title	Inquiry into the Exposure Draft of the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 and related discussion paper
Link to report	*http://www.parliament.act.gov.au/in-committees/standing_committees/Health,-Ageing,-Community-and-Social-Services/inquiry-into-exposure-draft-of-the-drugs-of-dependence-cannabis-use-for-medical-purposes-amendment-bill-2014-and-related-discussion-paper/report?inquiry=624651*
Government Response/ Submission Title	Government Response to the Standing Committee on Health, Ageing, Community and Social Services Inquiry into the Exposure Draft of the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 and related discussion paper.
Date Tabled	19 November 2015
Recommendation Number and Summary of recommendation	**Recommendation 1** The Committee recommends that the ACT Government write to the Commonwealth Minister for Health requesting the Commonwealth Government: • consider including Sativex and Marinol on the PBS to improve affordability; • consider providing easily accessible guidance material to medical practitioners on: » how to go about prescribing approved pharmaceutical cannabis products off-label; » the requirements of the Special Access Scheme and associated importation requirements; • simplify off-label prescribing and Special Access Schemes so that the processes can be navigated by medical practitioners with ease and are not excessively protracted; and • consider expanding access to approved pharmaceutical cannabis products for additional indications. **Recommendation 2** To facilitate the research and development of medicinal cannabis and cannabinoid preparations, the Committee recommends that the ACT Government write to the Commonwealth Minister for Health requesting the Commonwealth Government investigate amending the Poisons Standard by: • amending Schedule 9 to facilitate medical or scientific research; and • moving other non-psychoactive, non-addictive cannabinoids into a lesser schedule as has been done for cannabidiol. **Recommendation 3** The Committee recommends that the ACT Government work together with other State, Territory and Commonwealth governments to conduct further clinical trials of pharmaceutical products and crude cannabis. **Recommendation 4** The Committee recommends that the ACT Government work together with other State, Territory and Commonwealth governments to help facilitate ACT patient access to upcoming interstate trials. **Recommendation 5** The Committee recommends that the ACT Legislative Assembly reject the proposed Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014. **Recommendation 6** The Committee supports a national approach to medicinal cannabis and encourages the ACT Government to continue to work with the Commonwealth, States and Territory on a national medicinal cannabis scheme. **Recommendation 7** The Committee recommends that if the ACT acts independently of the Commonwealth or other State and Territory jurisdictions on a medicinal cannabis scheme it needs to address the regulatory concerns raised in this report.

Inquiry into the Exposure Draft of the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 and related discussion paper	
Action	**Recommendation 1** – Agree in principle consider including Sativex and Marinol on the PBS to improve affordability; The ACT Government will write to the Commonwealth Minister for Health to request that consideration be given for Sativex to be included on the Pharmaceutical Benefits Scheme (PBS). Marinol is not currently listed on the Australian Register of Therapeutic Goods and will need to be registered prior to any application regarding potential listing on the PBS being pursued. Application to allow the sale of Marinol while unregistered in Australia can be made through the Special Access Scheme (SAS). However, the ACT notes that the decision to supply pharmaceuticals in Australia is a commercial decision that rests with the product sponsor. It should also be noted that issues around the legal storage and distribution of Sativex will need to be addressed if it is to be remarketed in Australia, as it requires refrigeration. consider providing easily accessible guidance material to medical practitioners on: how to go about prescribing approved pharmaceutical cannabis products off-label; Not agreed There are no regulatory barriers to medical practitioners prescribing registered products for off-label use. However, a prescription itself does not guarantee that the sponsor will make the product available for the off-label purpose requested by a medical practitioner. Further, the ACT Government considers that off-label prescribing of approved pharmaceutical products is common practice and well understood by medical practitioners the requirements of the Special Access Scheme and associated importation requirements; Agreed The ACT Government will write to the Commonwealth Minister for Health suggesting that guidance materials be developed in relation to the Special Access Scheme and associated importation requirements. simplify off-label prescribing and Special Access Schemes so that the processes can be navigated by medical practitioners with ease and are not excessively protracted; Agreed The ACT Government notes that there are multiple steps involved in accessing the Special Access Scheme. However, these steps are considered necessary to ensure the TGA can meet its obligations of responsibility in maintaining a balance between ensuring individuals gain timely access to important new therapeutic developments and maintaining broader community interest that therapeutic products available in Australia are evaluated for quality, safety and efficacy. There may, however, be some scope to streamline these processes. The ACT Government will write to the Commonwealth Minister for Health requesting that opportunities to simplify and streamline processes related to the Special Access Scheme be explored.

Inquiry into the Exposure Draft of the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 and related discussion paper	
Action	• consider expanding access to approved pharmaceutical cannabis products for additional indications**.** Agreed The ACT Government supports a timely, proactive response from the Commonwealth when new research supports the medicinal use of cannabis in the treatment of additional conditions. For this to occur, the product sponsor must agree to expand the indications for use – a commercial decision. The ACT Government will write to the Commonwealth Minister for Health requesting that the TGA work with relevant sponsors to explore the potential for indications to be expanded. However, it should be noted that medical practitioners already have the ability to prescribe pharmaceutical cannabis products (through the Special Access Scheme) for any indication they consider appropriate. It is noted that in such cases, the prescriber bears the responsibility for prescribing an unapproved product (as outlined in the Committee's Report) which could be one of the reasons medical practitioners are reluctant to prescribe products for off-label use. **Recommendation 2** • amending Schedule 9 to facilitate medical or scientific research Not agreed The ACT Government does not consider that this is necessary as there are already mechanisms under Commonwealth, ACT and other jurisdictions' medicines and poisons legislation to enable medical or scientific research (including clinical trials) with Schedule 9 substances. • moving other non-psychoactive, non-addictive cannabinoids into a lesser schedule as has been done for cannabidiol Agreed The ACT Minister for Health will write to the Commonwealth Minister for Health seeking consideration of the rescheduling of other non-psychoactive, non-addictive cannabinoids into a lesser schedule (as has been done for cannabidiol) where there is appropriate profiling and research. It should be noted that this would be dependent on industry or another party submitting a rescheduling application to the TGA (as occurred in late 2014 when the Victorian and Western Australian Departments of Health made an application to the Commonwealth to have cannabidiol classified as a Schedule 4 substance, which is the least restrictive schedule for prescription medicines). After public consultation, the decision was made to classify cannabidiol as a Schedule 4 substance from 1 June 2015. An alternative is for the Commonwealth to prepare its own internal rescheduling submission. There is minimal precedent for this, however, it has been done on occasions (e.g. rescheduling of sodium oxybate).
Action	**Recommendation 3** – Agree in principle The ACT Government will continue to work with the Commonwealth, States and Territory governments on a national medicinal cannabis scheme, noting that is has already given its support to the trials recently announced by the NSW Government. The actual conduct of clinical trials depends on a number of factors including the funding, methodology (including population size) and availability of product. The ACT Government will continue to facilitate awareness of the process required to conduct clinical trials within the ACT. **Recommendation 4** – Agreed The ACT Government will continue to work with the Commonwealth, State and Territory governments to help facilitate ACT patient access to upcoming interstate trials, where appropriate. The ACT Government has been actively engaged with the process of developing the framework for the recently announced NSW trials. It should be recognised that many of those patients potentially eligible for upcoming trials in NSW may already be accessing treatment within the NSW medical system, for example, children with complex seizure disorders. **Recommendation 5** – Agreed The ACT Government supports the compassionate intent behind the Draft Bill. However, the practical implementation of the scheme proposed in the Draft Bill would be extremely challenging. The ACT Government reiterates its support for a national approach and the supply of a regulated, quality-controlled product. **Recommendation 6** – Noted The ACT Government strongly supports the development of a nationally consistent regulatory framework. The ACT Government will continue to work with the Commonwealth, State and Territory governments on a national medicinal cannabis scheme, noting the recent support given at a national level to the Regulator of Medicinal Cannabis Bill 2014 (the National Bill).The National Bill proposes the establishment of a national Office of Medicinal Cannabis. **Recommendation 7** – Noted The ACT Government agrees that there are regulatory concerns as well as other issues to address in relation to the Draft Bill. These have been outlined previously in the ACT Government's submission to the Standing Committee. The ACT Government is supportive of the compassionate intent of the Draft Bill and notes that there is scope for further investigation of appropriate means for making medicinal cannabis available in the ACT. It acknowledges recent developments in cannabis policy nationally. The ACT Government prefers a national approach in which standardized medicinal cannabis products are available.

Inquiry into the Exposure Draft of the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 and related discussion paper	
	On 17 October 2015 the Commonwealth Government announced that it would seek parliamentary approval to amend the Narcotics Drugs Act 1967 to allow the controlled cultivation of cannabis for medicinal and scientific purposes in Australia. The Commonwealth expects that material grown under its licensing scheme would be available in 2017 at the earliest. Commonwealth legislation would facilitate cannabis being grown to manufacture medicinal or research products, and may lead to commercial growers becoming established in Australia. It will be designed to allow 'farm to pharmacy' control of the cannabis crop to be compliant with Australia's obligations under the Single Convention on Narcotic Drugs 1961. The licensing of a commercial supply of cannabis, either in the ACT or another state, could facilitate the provision of standardized medicinal products in the ACT. Commonwealth legislation would not alter the legal status of non-licensed medicinal cannabis products. The Government of Victoria has, on 6 October 2015, announced its intention to license the cultivation of cannabis for distribution under the authority of a medical practitioner. The exact form of this scheme will not be known until legislation is introduced into the Victorian parliament, and it will take some time for a production and regulatory process to become established. The licensing of a cannabis crop in Victoria will require Commonwealth agreement.
Action	The ACT Government is supportive of the use of medicinal cannabis in a clinical trial setting. Palliative care is a potential area of interest in which clinical trials could be performed in the ACT. However, clinical trials are subject to ethical approval processes, require the engagement of clinicians wishing to conduct them, and have a prescribed duration. The ACT Government cannot dictate these methodological requirements. The ACT Government is supportive of further investigation of the feasibility of a Terminal Illness Cannabis Scheme (TIC scheme) similar to that which operates in NSW. There are several regulatory models under which such a scheme could operate, including administrative and legislative options for providing legal relief to people possessing cannabis for the management of a terminal illness. A TIC scheme could operate in parallel with the existing Simple Cannabis Offence Notification (SCON) scheme in the ACT. There are options for capacity building which could assist people accessing medicinal cannabis products. Education of medical professionals as to the appropriate indications and methods of using cannabis is currently lacking and could be formally supported by the tertiary education sector. Laboratory testing of cannabis products would provide information about the medical suitability of strains currently being accessed for medicinal use and could be technically achieved with appropriate laboratory resourcing. The ACT Government is committed to ensuring that any medicinal cannabis scheme introduced addresses the regulatory concerns outlined in the Standing Committee's Report.
Status	Complete

Review of the Auditor-General's Report No. 4 of 2014: Gastroenterology and Hepatology Unit, Canberra Hospital	
Reporting Entity	Standing Committee on Public Accounts
Report Number	19
Report Title	Review of the Auditor-General's Report No. 4 of 2014: Gastroenterology and Hepatology Unit, Canberra Hospital
Link to report	*http://www.parliament.act.gov.au/__data/assets/pdf_file/0006/871917/8th-PAC-27-AG1-2016.pdf*
Government Response Title	Government Response to Public Accounts Committee Report No 19: Review of Auditor-General's Report No 4 of 2014: Gastroenterology and Hepatology Unit, Canberra Hospital.
Date Tabled	10 March 2016
Action	**Recommendation 1** – Agreed The Government tabled its response to PAC Report No. 19 on 10 March 2016. The update on implementation of the Auditor-General's recommendations, as per recommendation 1, and tabled by the responsible Minister on 10 March 2016, is attached.
Status	Complete

Annual and Financial Reports 2014–15	
Reporting Entity	Standing Committee on Health, Ageing, Community and Social Services
Report Number	7
Report Title	Annual and Financial Reports 2014–15
Link to report	*http://www.parliament.act.gov.au/__data/assets/pdf_file/0019/830053/8th-HACS-07-AR14–15.pdf*
Government Response/ Submission Title	The Government Response is not due as at 30 June 2016
Date Tabled	10 March 2016
Recommendation Number and Summary of Recommendation	**Recommendation 12** The Committee recommends that ACT Health investigate any negative effects upon graduate nurses from the current 12 month contract employment arrangements **Recommendation 13** The Committee recommends that ACT Health survey staff attitudes to diversity and Aboriginal and Torres Strait Islander people through its three-yearly survey and report its findings in the ACT Health Annual Report **Recommendation 14** The Committee recommends that ACT Health explore the reasons behind low completion rates for traineeships and for other Aboriginal and Torres Strait Islander programs. **Recommendation 15** The Committee recommends ACT Health require ACT Health Promotion Grant applicants to list on their applications any other grants applied for.
Action	Not applicable
Status	In progress

Auditor-General's Report No. 1 of 2016: Calvary Public Hospital Financial and Performance Reporting and Management	
Reporting Entity	ACT Auditor-General's Office
Report Number	1
Report Title	Auditor-General's Report No. 1 of 2016: Calvary Public Hospital Financial and Performance Reporting and Management
Link to report	*http://www.audit.act.gov.au/auditreports/reports2016/Report%20No.%201%20of%202016%20Calvary%20Public%20Hospital%20Financial%20and%20Performance%20Reporting%20and%20Management.pdf*
Government Response/ Submission Title	The Government Response is not due as at 30 June 2016
Date Tabled	3 May 2016
Recommendation Number and Summary of Recommendation	**Recommendation 1** The ACT Government should examine: a) the fundamental issue of whether or not the Calvary Network Agreement is the most appropriate mechanism for delivering Public Hospital services; and b) whether the Public Hospital staff employed by Calvary Health Care ACT Ltd should be engaged under the terms and conditions of the Public Sector Management Act 1994 and associated enterprise agreements. **Recommendation 2** The ACT Health Directorate and the Little Company of Mary Health Care Ltd should review, negotiate and amend the Calvary Network Agreement to address weaknesses identified in this audit report. **Recommendation 3** The ACT Health Directorate should document its consideration and management of risks associated with the purchase of public hospital services from Calvary Health Care ACT Ltd, including conducting a risk assessment and documenting the management of identified risks. **Recommendation 4** Calvary Health Care ACT Ltd should seek written confirmation from the ACT Health Directorate that the reporting of the external audit of 2014–2015 Calvary Public Hospital's financial reports is adequate for the purposes of clause 14.1 (a) of the Calvary Network Agreement, which requires the provision of externally audited annual reports for the public hospital to the ACT Government. **Recommendation 5** The ACT Health Directorate, in consultation with the Little Company of Mary Health Care Ltd and Calvary Health Care ACT Ltd, should commit to a timeframe for the finalisation and implementation of the successor to the interim funding model for Calvary Public Hospital services.
	Recommendation 6 The Little Company of Mary Health Care Ltd and Calvary Health Care ACT Ltd should undertake investigations of inappropriate workplace behaviours by its Public Hospital staff in accordance with the Public Sector Management Act 1994 and any related regulations and relevant enterprise agreements. **Recommendation 7** Calvary Health Care ACT Ltd should include the following in its reporting to the ACT Health Directorate in relation the Calvary Network Agreement: a) reconciliation of year to date revenue to the actual funding paid year to date, including explanations for reconciling items; and b) information on the basis of how revenue items have been recognised, to ensure only approved funded items have been included in the revenue reported. **Recommendation 8** The Little Company of Mary Health Care Ltd and Calvary Health Care ACT Ltd should continue to review, amend and promulgate employee behaviour and conduct documents, including policies relating to employees' conduct and 'whistleblowing', so that Calvary Health Care ACT Ltd public hospital staff are provided with information on: a) their duties and obligations under the Public Sector Management Act 1994, including their obligation to report any corrupt or fraudulent conduct or any possible maladministration to an appropriate authority; and b) options, including the making of a public interest disclosure under the Public Interest Disclosure Act 2012, for the reporting of any corrupt or fraudulent conduct or any possible maladministration to appropriate ACT public sector authorities, such as the ACT Health Directorate, the Commissioner for Public Administration or the ACT Auditor Gener al.
Action	Not applicable
Status	In progress

Inquiry into Youth Suicide and Self Harm in the ACT	
Reporting Entity	Standing Committee on Health, Ageing, Community and Social Services
Report Number	8
Report Title	Inquiry into Youth Suicide and Self Harm in the ACT
Link to report	*http://www.parliament.act.gov.au/__data/assets/pdf_file/0004/871915/8th-HACS-08-Inquiry-Into-Youth-Suicide-And-Self-Harm.pdf*
Government Response/ Submission Title	The Government Response is not due as at 30 June 2016
Date Tabled	9 June 2016
Recommendation Number and Summary of Recommendation	**Recommendation 1** The Committee recommends that the ACT Government update the Legislative Assembly on both the development of the national database, and progress made in relation to improving the collection of ACT data, particularly in relation to receiving consistent data from community based organisations. **Recommendation 2** The Committee recommends that the ACT Government update this Committee in relation to Australian Government funding negotiations in relation to mental health funding, including the Capital Health Network. **Recommendation 3** The Committee recommends that the ACT Legislative Assembly consider re-examining this matter when funding and research outcomes are made public in order to determine the most appropriate way to further develop early intervention measures, education approaches and access to service for suicide prevention activities in the ACT.
Action	Not applicable
Status	In progress

Review of the Auditor-General's Report No. 1 of 2016: Calvary public hospital financial and performance reporting and management	
Reporting Entity	Standing Committee on Public Accounts
Report Number	27
Report Title	Review of the Auditor-General's Report No. 1 of 2016: Calvary public hospital financial and performance reporting and management
Link to report	*http://www.parliament.act.gov.au/__data/assets/pdf_file/0006/871917/8th-PAC-27-AG1-2016.pdf*
Government Response/ Submission Title	The Government Response is not due as at 30 June 2016
Date Tabled	9 June 2016
Recommendation Number and Summary of Recommendation	**Recommendation 1** The Committee recommends that the ACT Government take appropriate steps to ensure that its response to Auditor-General's Report No. 1 of 2016: Calvary Public Hospital Financial and Performance Reporting, is tabled by the end of the first sitting week in August 2016. **Recommendation 2** The Committee recommends that the ACT Government report to the ACT Legislative Assembly by the last sitting day in August 2017, on the progress of its implementation of the recommendations made in Auditor-General's Report No. 1 of 2016: Calvary Public Hospital Financial and Performance Reporting, that have been accepted either in-whole or in-part. This should include: (i) a summary of action to date, either completed or in progress (including milestones completed); and (ii) the proposed action (including timetable), for implementing recommendations (or parts thereof), where action has not yet commenced. **Recommendation 3** The Committee recommends that the ACT Government take appropriate steps to improve its contract management capability of all government contracts it enters into on behalf of the Territory. This should include: (i) clear allocation of contract management roles within acquiring entities; and (ii) adequately resourcing, relative to the size of each contract, the respective contract management functions within each acquiring entity to effectively manage the contract(s). **Recommendation 4** The Committee recommends that the ACT Government take appropriate steps to ensure that all contract acquiring entities within ACT Government monitor contractor performance in accordance with contract provisions, and where applicable, take appropriate steps to act on contractor underperformance. **Recommendation 5** The Committee recommends that the ACT Government take appropriate steps, as part of specific contract provisions, to require contracting entities delivering services on behalf of the Territory to ensure, relative to the size of each contract, that: (i) public interest disclosure policies and procedures are developed, implemented and appropriate steps taken to monitor compliance; and (ii) an employee code of conduct is developed, promoted and appropriate steps are taken to monitor compliance.
Action	Not applicable
Status	In progress

Inquiry into the Appropriation Bill 2016–17 and Appropriation (Office of the Legislative Assembly) Bill 2016–17	
Reporting Entity	Select Committee on Estimates 2016–17
Report Number	1
Report Title	Inquiry into the Appropriation Bill 2016–17 and Appropriation (Office of the Legislative Assembly) Bill 2016–17
Link to report	Not applicable
Government Response Title	As at 30 June 2016 the inquiry is ongoing
Recommendation Number and Summary of Recommendation	Not applicable
Action	Not applicable
Status	Ongoing

B.4 RISK MANAGEMENT

INTRODUCTION/ OVERVIEW

ACT Health provides a high-quality service to our community, safe and effective care to our consumers and maintains a safe environment for patients, visitors and employees. To achieve this, ACT Health is committed to managing risks that may prevent its objectives from being achieved.

DEVELOPING THE RISK MANAGEMENT PLAN

In line with ACT Government risk management protocols, the ACT Health Risk Management policy, framework and guidelines are maintained in full compliance with the International Standard for risk management, *AS/NZS ISO 31000:2009.* The documents provide clear governance arrangements, including responsibilities and measurable Key Performance Indicators (KPIs).

ACT Health is committed to establishing a risk culture that demonstrates the principles of risk management through:

> proactive, timely identification and reporting of actual as well as perceived risks by staff
> including risk management in the planning, implementation and maintenance phases of all ACT Health systems, processes, policies and procedures.

MONITORING RISKS

Executive Risk Management forums and workshops are held regularly to review the directorate's organisational-level risks.

IDENTIFYING AND RESPONDING TO EMERGING RISKS

ACT Health's Executive Directors' Council is responsible for:

> monitoring the timely, effective management of organisational-level risks
> managing the escalation of risks to an organisational level.

B.5 INTERNAL AUDIT

INTRODUCTION/ OVERVIEW

The *ACT Government Internal Audit Framework* provides guidance to all internal audit functions within the ACT Government. ACT Health's Internal Audit Charter and Internal Audit Policy and Procedures are based on this legislation and guide the work performed by ACT Health's Internal Audit, Risk Management and Compliance Branch.

INTERNAL AUDIT ARRANGEMENTS

ACT Health's Internal Audit, Risk Management and Compliance Branch promote and improve ACT Health's corporate governance by:

> conducting internal audits and investigations
> making recommendations for improvements.

In 2015–16, eight internal audit assignments were completed, as follows:

> Internal Audit of Mental Health (Treatment and Care) Act 1994 Involuntary Provisions (IA&RM)
> Assessment of ACT Health's framework to manage staff misconduct and workplace issues-Deloitte
> Internal Audit of Quality Management Processes within the ACT Government Analytical Laboratory (ACTGAL)-Axiom
> Assurance Mapping Exercise – Pathology and National Standard No7: Blood & Blood Products
> Internal Audit of Clinical Incident Response and Reporting Processes within Canberra Hospital and Health Services
> Review of Internal Audit Function
> ACT Health Promotion Framework
> Records Management (HP Records Manager) Review.

Audit findings and recommendations are rated in line with ACT Health's Risk Management Guidelines.

Throughout the year, the Director, Internal Audit, Risk Management and Compliance reported developments in implementing:

> the Strategic Internal Audit Program
> audit recommendations to the Executive Directors' Council and to the Audit and Risk Management Committee.

The Audit and Risk Management Committee is also informed of the implementation of recommendations made by the ACT Auditor-General's Office, where these apply to ACT Health.

INTERNAL AUDIT COMMITTEE

ACT Health's Audit and Risk Management Committee Charter and Terms of Reference govern the operation of the Audit and Risk Management Committee, which provides:

> assurance to the Director-General on ACT Health's governance
> oversight in relation to risk management, internal systems and legislative compliance.

During 2015–16 the composition of the five committee members changed and as from 10 May 2016 is as follows:

> an independent chair
> an independent deputy chair
> one independent member
> two senior executives from ACT Health.

Observers from ACT Health and the ACT Auditor-General's Office also attended meetings.

In 2015–16, the Audit and Risk Management Committee held five meetings, including the meeting to review the financial statements. Attendances are set out in Table 14.

TABLE 14: AUDIT AND RISK MANAGEMENT COMMITTEE MEETINGS

Name of member	Position	Duration on the committee	Meetings attended
Mr Geoff Knuckey	Independent Chairperson	5 years	5
Mr Jeremy Chandler	External member and Deputy Chairperson	3.5 years	5
Mr Ian Thompson	Member	9.5 years	5
Ms Katrina Bracher	Member	3 years	5
Mr Kim Smith	Member	0.5 of a year	0
Ms Nicole Feely	Observer	N/A	1
ACT Auditor-General's Office	Observer	N/A	5

B.6 FRAUD PREVENTION

INTRODUCTION/ OVERVIEW

ACT Health's fraud prevention and prevention strategy aims to foster an environment that promotes the highest standards of ethical behaviour.

RISK ASSESSMENTS CONDUCTED

Divisions of ACT Health undertake fraud risk assessments, in line with ACT Health Risk Management protocols. Mitigating controls are put in place to address fraud threats and risks. The ACT Health Senior Executive responsible for Business Integrity Risk:

> analyses trends and risk assessments for fraud and other integrity breaches
> provides biannual reports to the Audit and Risk Management Committee.

There was one fraud matter reported in 2015–16, which has been finalised.

FRAUD CONTROL PLANS

Under the provisions of section 13 of the *Public Sector Management Act 2006* the Director-General of each agency is required to ensure that threats to the integrity of the agency are addressed in a detailed fraud and prevention plan.

To address this obligation ACT Health has:

> a Fraud and Corruption Policy
> a Fraud and Corruption Plan.

FRAUD PREVENTION STRATEGIES

In ACT Health, the Director-General, Deputy Directors-General and Executive Directors are responsible for:

> managing fraud and corruption
> ensuring compliance with the policy and plan at all levels within their areas.

FRAUD AWARENESS TRAINING

Staff receive fraud control and prevention training during orientation and through an e-learning program titled Ethics, Integrity and Fraud Prevention.

Managers are provided with further fraud control and prevention information and training during managers' orientation programs.

Staff and manager training is supported by targeted information that alerts staff to the responsibilities and protocols intended to improve systems or mitigate identified fraud threats and risks.

B.7 WORK HEALTH AND SAFETY

INTRODUCTION/ OVERVIEW

Work Health and Safety within ACT Health is primarily the responsibility of the management team. This responsibility is shared with all staff. Workplace Safety (WPS) has overarching responsibility for ensuring that ACT Health has an effective Work Health and Safety Management System (WHSMS). The WHSMS assists management and staff to:

> identify, manage, monitor and report incidents, safety hazards and their associated risks
> meet legislative compliance as far as is reasonably practicable.

WPS provides occupational medicine services across ACT Health to prevent potential infectious disease being transmitted to healthcare workers. These services include:

> pre-employment screening
> a vaccination program, including annual influenza vaccinations
> occupational risk exposure and follow-up management, counselling and advice
> cytotoxic screening
> monitoring safety devices
> health surveillance
> education.

WPS also provides a holistic early intervention physiotherapy service to staff who have sustained musculoskeletal injuries. This assists in:

> reducing time off work
> facilitating early return to work
> improving staff morale
> decreasing workers compensation claims.

A priority is educating staff to increase their awareness of:

> safe work practices
> Work Health Safety
> training available to staff, managers and Health and Safety Representatives (HSRs)
> ergonomic environments.

WPS has operational responsibility for the Riskman system. This allows ACT Health to configure the system to meet business needs, including:

> providing support to stakeholders
> using the system to coordinate issues with the ACT Health's divisions and services.

WORK HEALTH AND SAFETY ACT 2011 REPORTING

Table 15 identifies the number of incidents, accidents, investigations and Provisional Improvement Notices (PINs) reported in 2015–16, as required by the reporting requirements of the *Work Health and Safety Act 2011*.

TABLE 15: *WORK HEALTH AND SAFETY ACT 2011* REPORTING

Year	No. of staff incidents*	Lost time injury of one day or more*	No. of staff incidents notified to ACT WorkSafe*	No. of PINs
2015–16	1,299	159	21	1
2014–15	1,318	151	40	2
2013–14	1,367	158	54	N/A

*Source: *(under section 35 of the Work Health and Safety Act 2011) Workplace Safety Team Riskman Staff Incident Register*

One PIN was issued on 12 February 2016 in relation to hazards in a compactors area of the Cancer, Ambulatory and Community Health Support (CACHS) Radiation Oncology File room. The PIN was withdrawn on 23 February 2016 after remedial action.

No Prohibition Notices or Improvement Notices were issued to ACT Health during 2015–16.

There were no ACT Health workplace fatalities in 2015–16.

WORKER CONSULTATION ARRANGEMENTS

ACT Health has three tiers of Work Health and Safety Committees.

The Tier 1 Work Health and Safety Committee is the peak organisational body for Work Health and Safety in ACT Health and met four times during 2015–16. This committee is chaired by the Director-General or Deputy Director-General and includes management representatives and workplace HSRs.

Tier 2 Health and Safety Committees are chaired by Executive Directors and represent major divisions and branches. Tier 2 committees meet quarterly and monthly.

Tier 3 Health and Safety Committees represent localised work areas and bring together groups within similar locations/job types. Tier 3 committees meet monthly.

HEALTH AND SAFETY REPRESENTATIVES

As shown in Table 16, at 30 June 2016 there were 274 elected Health and Safety Representatives (HSRs) within ACT Health.

TABLE 16: NUMBER OF HSRS

Year	Number of HSRs
2015–16	274
2014–15	268

Source: Workplace Safety Team 2016

INJURY PREVENTION PROGRAMS

Riskman

The electronic staff accident and incident reporting system (Riskman) is now in its seventh year of operation. Riskman continues to provide organisational reporting and enables ACT Health to quickly:

> identify and implement relevant controls
> report incident and trend data to management and workplace HSRs.

The Riskman system continues to be developed to meet organisational needs both in clinical and non-clinical areas. Various registers and extensions were upgraded in 2015–16 to:

> provide customised and dash board reports, indicator sets and body charts
> improve functionality.

The Riskman system now consists of 15 registers and associated extensions, up from nine in 2014–15.

Staff/management feedback was utilised to develop a more user-friendly system, which allows higher quality reporting to management and committees. An Occupational Medicine Unit Riskman module has been developed to capture data for staff screening and immunisation, including annual influenza vaccinations and occupational risk exposures.

The Riskman system interfaces with the Chris21 payroll system and the ACT Patient Administration System (ACTPAS) system to automatically populate validated staff and patient demographic data. This reduces data entry while increasing data quality.

Safety training and auditing

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

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

ACT Health continues to be accredited by WorkSafe ACT as a Registered Training Organisation (RTO) to provide tailored HSR training for our staff.

ACT Health has developed its own internal safety auditing tool in response to feedback from management and staff. This enables ACT Health to meet corporate and legislative requirements. External WHSMS auditing is undertaken by a qualified contractors.

WPS Early Intervention Physiotherapy Program

As shown in Table 17, the WPS Early Intervention Physiotherapy Program completed 583 workstation assessments during 2015–16. Workstation assessments may also be conducted to support an employee returning to work where a work or non-work injury has occurred.

TABLE 17: NUMBER OF WORKSTATION ASSESSMENTS

Year	Total number of WPS Workstation assessments
2015–16	583
2014–15	579

Source: Workplace Safety Early Intervention Physiotherapy Team

PERFORMANCE AGAINST AUSTRALIAN WORK HEALTH AND SAFETY STRATEGY 2012–22 TARGETS

As shown in Figure 11 and Table 18, in 2015–16, ACT Health continued to reduce the number of new claims that exceeded five days off work per 1,000 employees. This is due to early intervention strategies and proactive case management.

The 2015–16 figures are consistent with historical trends, and overall performance continues to be very good against both the Health Directorate and ACT Public Service (ACTPS) targets.

Target 1: A reduction of at least 30 per cent in the incidence rate of claims resulting in one or more weeks off work

FIGURE 11: INCIDENT RATE OF CLAIMS RESULTING IN ONE OR MORE WEEKS OFF WORK

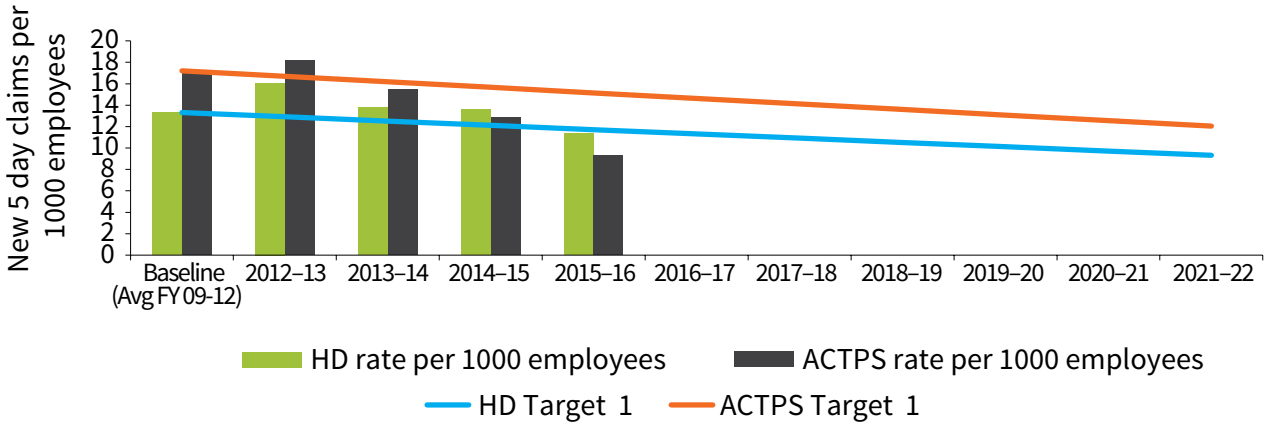


TABLE 18: INCIDENT RATE OF CLAIMS RESULTING IN ONE OR MORE WEEKS OFF WORK

Health	Health Directorate — no. new 5 day claims	Health Directorate — rate per 1000 employees	Health Directorate Target 1	ACTPS — no. new 5 day claims	ACTPS rate per 1,000 employees	ACTPS Target 1
Baseline (Avg FY 09-12)	67.00	13.31	13.31	336.33	17.21	17.21
2012–13	87.00	16.07	12.92	371	18.17	16.69
2013–14	81.00	13.79	12.52	326	15.48	16.18
2014–15	83.00	13.62	12.12	280	12.89	15.66
2015–16	72.00	11.37	11.72	205	9.33	15.14
2016–17	-	-	11.32	-	-	14.63
2017–18	-	-	10.92	-	-	14.11
2018–19	-	-	10.52	-	-	13.60
2019–20	-	-	10.12	-	-	13.08
2020–21	-	-	9.72	-	-	12.56
2021–22	-	-	9.32	-	-	12.05

Target 2: a reduction of at least 30 per cent in the incidence rate of claims for musculoskeletal disorders resulting in one or more weeks off work

As shown in Figure 12 and Table 19, in 2015–16, ACT Health reduced the incidence of musculoskeletal disorder (MSD) claims resulting in five days or more off work. This continues a trend from previous years and brings the incidence rate below the target level. The overall trend in performance on these claims has been achieved with early intervention strategies and proactive case management.

See: Injury prevention programs, page 93.

FIGURE 12: INCIDENT RATE OF CLAIMS FOR MUSCULOSKELETAL DISORDERS RESULTING IN FIVE DAYS OFF WORK

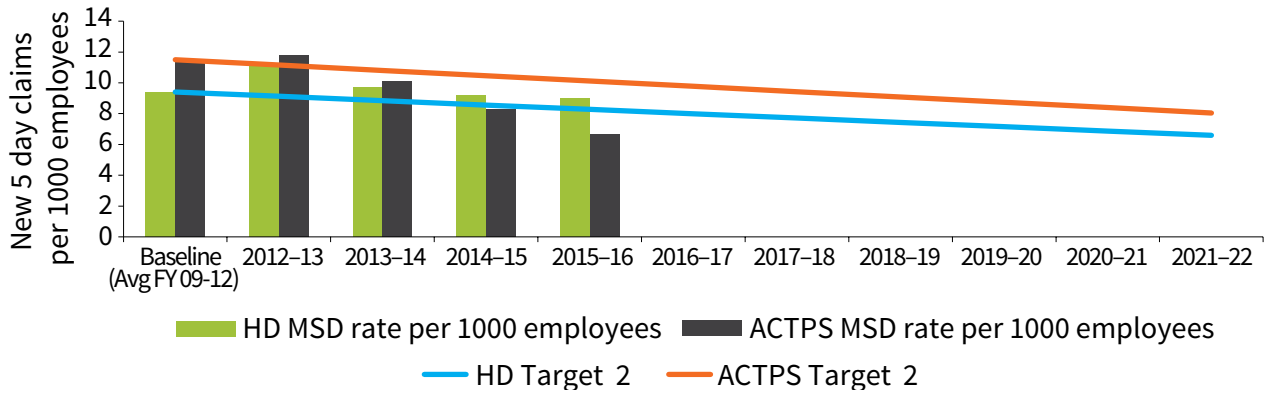


TABLE 19: INCIDENT RATE OF CLAIMS FOR MUSCULOSKELETAL DISORDERS RESULTING IN FIVE DAYS OFF WORK

Health	Health Directorate — no. new 5 day MSD claims	Health Directorate — MSD rate per 1000 employees	Health Directorate Target 2	ACTPS — no. new 5 day MSD claims	ACTPS MSD rate per 1,000 employees	ACTPS Target 2
Baseline (Avg FY 09-12)	47.33	9.41	9.41	224.67	11.50	11.50
2012–13	60.00	11.08	9.12	240	11.76	11.15
2013–14	57.00	9.71	8.84	213	10.11	10.81
2014–15	56.00	9.19	8.56	180	8.28	10.46
2015–16	57.00	9.00	8.28	146	6.64	10.12
2016–17	-	-	8.00	-	-	9.77
2017–18	-	-	7.71	-	-	9.43
2018–19	-	-	7.43	-	-	9.08
2019–20	-	-	7.15	-	-	8.74
2020–21	-	-	6.87	-	-	8.39
2021–22	-	-	6.58	-	-	8.05

Dates are based on those claims received by Comcare in each financial year.
Past years' claim numbers may differ from results published in previous annual reports due to maturation of claims data.
The report includes accepted claims which result in one or more weeks off work.
Data includes claims up to 30 June 2016.

B.8 HUMAN RESOURCES MANAGEMENT

INTRODUCTION/ OVERVIEW

ACT Health has a dispersed model for human resources management with many areas sharing responsibility for staff-related issues. Business units are responsible for deciding their workforce composition below executive level. They make their own recruitment decisions and undertake day-to-day management duties. People Strategy and Services Branch (PSSB) assists business units with their human resources functions, especially in complex or difficult cases. The most common areas where this occurs are where:

> allegations of misconduct have been made
> team interventions are required to address specific workplace culture issues
> advice on public sector employment obligations is needed
> it is difficult to recruit staff with particular skills or qualifications.

PSSB is also responsible for whole-of-Directorate and/or strategic human resources issues, such as:

> providing general clinical and leadership training
> conducting enterprise bargaining negotiations
> conducting high-level workforce planning and Directorate-wide people policy.

The Chief Minister, Treasury and Economic Development Directorate (CMTEDD) provide whole-of-service human resources policy, strategy and programs. It:

> sets targets for the employment of Aboriginal and Torres Strait Islanders and People with Disability
> authorises the employment of executives
> provides transactional human resources services through its Shared Services centre.

All powers in relation to the appointment, engagement and employment of staff are exercised on delegation from the head of service or the Director-General of ACT Health.

HUMAN RESOURCE MANAGEMENT

Health care now reflects a shift to community-based services and a focus on recovery and consumer-oriented services. The dynamic healthcare environment, coupled with significant new social trends, means that health service delivery is expected to continue changing into the future. ACT Health recognises that the delivery of quality health services across the ACT and surrounding region requires a focus on the people who will be delivering these services within this evolving environment.

ACT Health continues to be an active participant of the national health workforce committees, including the:

> Australian Health Workforce Ministerial Advisory Council (AHWMC)
> Health Workforce Principle Committee (HWPC)
> Aboriginal and Torres Strait Islander Health Workforce Working Group (ATSIHWWG).

WORKFORCE PLANNING

A skilled and sustainable workforce is fundamental to the success of ACT Health in delivering health care to the people of the ACT and surrounding areas.

ACT Health continues to implement the *Workforce Plan 2013–2018*, which has five focus areas:

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

ACT Health has been active and represented in national forums for workforce and competency standards across all professional disciplines.

The Canberra Region Medical Education Council (CRMEC) was further developed to support health workforce reform and 'grow our own' strategies. The council:

> undertakes accreditation of intern training
> provides expert advice regarding the quality of education, training and welfare for junior medical officers
> provides leadership in postgraduate medical education within the ACT and linked regional networks.

ACT Health also supported training and scholarships, including:

> supporting training of Epidemiologists in Population Health Division
> supporting scholarship programs in Nursing and Midwifery to enhance the workforce

> supporting scholarships and the post graduate scholarship scheme
> conducting the ACT Allied Health Symposium to support the multiple allied health disciplines.

In support of strategy 3.3, we assisted leaders to support education, sustainability and change management by:

> updating the Essential Care Program to introduce team nursing and change management requirements
> continuing to develop and implement extended scope physiotherapy roles
> recommencing psychology internship programs in Mental Health, Justice Health, Alcohol and Drug Services
> establishing the social work new graduate year program, which was established by the Chief Allied Health Advisor's office
> establishing placements for medical students in the Renal Services speciality field.

Strategy 2.4 has a target of 80 per cent of ACT Health staff will complete the Aboriginal and Torres Strait Islander cultural awareness e-learning assessment by 2018. During 2015–16, 506 staff registered and completed the program.

The renal network has been established with Canberra Hospital and Health Services (CHHS) and Southern NSW Local Health District (SNSWLHD). It provides centralised clinical governance of all dialysis and renal outpatient services and opportunities for employees to gain valuable skills in the field.

The ACT Health Reconciliation Action Plan has been endorsed by Reconciliation Australia and includes strategic workforce actions in relation to Australia's first peoples.

The Corporate Champions Ageing workforce program Age Management Plan was developed with the support of SageCo and Commonwealth funding.

Development of the next workforce plan will begin within the next 12 months.

ACT Health continues to report against the *ACT Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013–2018*, including regular reports to ATSIHWWG.

ACT Health, as the leading employer of healthcare professionals in the region, has established partnerships with relevant educational facilities to continue the 'grow our own' approach, which continues to be successful.

Another initiative implemented by ACT Health is the use of targeted recruitment. We have been able to attract well-qualified candidates with the specific skill sets required by ACT Health by directly targeting prospective applicants through:

> advertising in profession-specific areas, such as:
  - healthcare professional publications and journals
  - healthcare-specific electronic job boards, social media sites and databases
> participating in healthcare conferences, seminars and career expos, including visual displays, promotional materials and spokespeople.

This has resulted in a number of successful recruitment outcomes.

To ensure ongoing service delivery, ACT Health recognises the need to optimise its work roles, capabilities and mix of skills. A particular emphasis over the last 12 months has been the review of Work-Level Standards across craft groups to ensure relevance and usability for the workforce.

Moving forward, ACT Health is exploring the implementation of interdisciplinary teams, where staff across multiple therapy disciplines share a common patient population and patient care goals, and responsibility for complementary tasks.

These interdisciplinary teams will be actively interdependent as the care given in this manner crosses traditional boundaries and blends the practices and expertise of each discipline involved. This approach will enhance focus on patient-centred care and prevent duplication of assessments and workloads.

RETENTION STRATEGIES

Retaining positive and motivated employees is vital for successful healthcare service delivery. Effective retention strategies often begin during the employee recruitment process. ACT Health provides a realistic view of our environment, advancement opportunities and job expectations to potential employees during the recruitment phase as this can positively influence employee retention.

The exit rate for permanent employees of ACT Health is 7.9 per cent. The overall ACT Health employee separation rate for permanent, temporary and casual employees leaving the organisation is 14.6 per cent, which is lower than the national average separation rate of 16 per cent.

Source: The Australian Human Resources Institute.

Ongoing professional development is available to all staff, both clinical and non-clinical, through a range of avenues including:

> internal and external training
> targeted employment projects
> as agreed through performance development plans.

Workplace culture

Workplace culture and staff engagement continue to be an area of priority, given its strong correlation with retention, staff engagement and overall performance. The fifth in a series of organisation-wide workplace culture surveys was conducted in November 2015, with a response rate of 54 per cent. ACT Health benchmarked comparably with other public healthcare organisations. The high-level results were released in late February 2016 and since then a number of activities have been undertaken, including:

> distributing reports to Executives and Managers
> presenting results to staff by the Director-General and Executives
> internal analysis of data and trends
> developing action plans for the organisation and divisions/branches.

In addition, the Director-General has committed to a longer term goal of becoming a leading public healthcare organisation in terms of culture.

Where a team seeks to enhance its culture, targeted assistance is available that provides:

> expert analysis of workplace culture issues
> targeted strategies that take into account the unique factors of each team.

In 2015–16, 40 teams across the organisation received this support, mostly from within CHHS as it holds the largest workforce group. The full range of professions participated in the interventions, including:

> medical staff
> nursing staff
> administrative staff
> support staff.

Evaluation has found positive improvement outcomes.

Staff health and wellbeing

In 2015–16, ACT Health strengthened its commitment to support staff health and wellbeing. The *MyHealth Staff Health and Wellbeing Strategy and Action Plan 2016–2018* was developed and outlines the priorities and objectives for the next three years. The strategy will be supported by 95 MyHealth Champions from across ACT Health. The two key areas of focus for MyHealth are to promote and support:

> physical health, including a smoke-free environment
> mental health, including addressing trauma prevention and management.

As shown in Table 20, during 2015–16 the MyHealth Program delivered a range of initiatives.

TABLE 20: MYHEALTH INITIATIVES

Workshop/program	Number of workshops	Participants in 2015–16
A.L.E.R.T (Awareness & Links Enable Resilient Teams)	13	210
Blood Donor Challenge	N/A	71
Compassion Fatigue	4	92
Conflict Resolution	2	27
Conversations for Life	1	10
EAP Seminars	4	49
Get Active Challenge	N/A	274
Happy Body at Work	N/A	100
Health Checks	9	191
Managing Psychological Illness in the Workplace	6	93
Quit Skills for Managers	2	16
Seated Massage	70	455
Smoking Cessation Seminars	1	3
Work Life Balance	2	21
TOTAL	**114**	**1612**

EMPLOYMENT STRATEGIES

ACT Health has continued its employment inclusion partnership with CMTEDD, which commenced in April 2015. The partnership focuses on opportunities for people with a disability and Aboriginal and Torres Strait Islander people, aiming to increase the number of inclusion staff across all directorates.

ACT Health permanently engaged an Employment Inclusion Manager in June 2014 to increase employment of people with a disability and Aboriginal and Torres Strait Islander people. To increase staff awareness of employment inclusion, monthly seminars were held during the second half of 2015 to inform managers of:

> the benefits of employment inclusion
> the support and funding that is available to managers to take up inclusion placements.

The Employment Inclusion Manager also met with individual managers to discuss the above.

As part of the ACT Health and CMTEDD partnership on inclusion employment initiatives, the monthly ACT Health Inclusion Seminars and presentations were opened up to all ACT Government Directorates.

The Employment Inclusion Manager has created and maintained a panel of Disability and Aboriginal and Torres Strait Islander employment providers. The providers can:

> identify people who are available to work with ACT Health
> provide support and advice about workplace modifications, adjustments and support

- potentially, provide funding for workplace modifications, adjustments and support
- provide assistance, support, education and training to supervisors and colleagues in the workplace.

An inclusion Employment Register for Aboriginal and Torres Strait Islander peoples and people with disability has been created and is maintained to assist with and promote inclusion employment.

Aboriginal and Torres Strait Islander people

The Reconciliation Action Plan (RAP) Committee consists of representatives from:

- ACT Health
- the ACT Aboriginal and Torres Strait Islander Elected Body and community.

The committee worked in consultation with Reconciliation Australia to create the third *ACT Health Reconciliation Action Plan, for the period covering 2015–18*. The *Health Reconciliation Action Plan 2015–18* was launched in October 2015.

The RAP Committee will continue to meet on a regular basis to:

- monitor and assess how ACT Health is progressing towards meeting the targets, goals and outcomes that are an essential component of the plan
- report to the ACT Health Coordination Group.

Managers are encouraged to use the enterprise agreement's flexible working arrangements, where appropriate, to achieve a healthy balance between operational needs and work-life balance. Aboriginal and Torres Strait Islander employees are provided with details of their entitlements to attend culturally significant events. The RAP Committee can also provide guidance and support to staff and managers.

People with a disability

In 2015, the Disability Employment Action Plan Committee was established. It consists of representatives from across ACT Health. The committee worked in consultation with other ACT Government Directorates including the:

- ACT Human Rights Commission
- Australian Network on Disability
- Commonwealth Human Rights office.

In 2015–16, objectives stated in the *ACT Health Disability Employment Action Plan 2015–18* have been undertaken, completed and/or are ongoing for the duration of the plan:

- Action 1: The 2015–16 Workforce Profile for people with a disability found that 2 per cent of ACT Health staff identify as a person with a disability.
- Action 2: Providing ongoing support, mentoring and assistance to supervisors and managers that employ or are looking to employ staff with a disability.
- Action 4: Staff are provided with access to awareness training, Inclusion Seminars and external provider presentations regarding effective communication with clients and employees with a disability.
- Action 7: A copy of or access to the ACT Health Disability Employment Action Plan 2015–18 is provided to every new staff member at orientation and made available electronically to staff via the ACT Health HUB. It is also available to the public on the ACT Health website.

Apprenticeships

Since commencing Inclusion Australian School Based Apprenticeship (ASBA) placements for Aboriginal and Torres Strait Islander apprentices in 2013, ACT Health has now has seven Inclusion ASBAs. In 2015–16, this comprised:

- five ASBAs being people with disability
- two ASBAs being Aboriginal and Torres Strait Islander people.

The ASBA Program continues to grow and we will be working to increase these numbers in the upcoming financial year. An Inclusion ASBA Register has been created to assist and promote employment of Inclusion ASBAs within individual areas and units.

Traineeships

Through our employment inclusion partnership with CMTEDD, ACT Health will participate in in the 2016–17:

- ACT Public Service (ACTPS) Graduate Program
- Aboriginal and Torres Strait Islander Traineeship.

The Aboriginal and Torres Strait Islander Traineeship commenced in August 2015 and finished in August 2016. The next program will start in February 2017.

In 2017, traineeships will include:

- a disability placement traineeship
- cadetships
- other development programs.

LEARNING AND DEVELOPMENT PROGRAMS

ACT Health implements governance strategies to ensure its workforce undertakes education and training to maintain the skills and information needed to fulfil their quality and safety responsibilities.

Planned and integrated education is based on the annual organisational learning needs analysis and identified organisational requirements. A Learning and Development Framework provides guidance on creating a learning organisation by integrating strategies into business practices, and a Standard Operating Procedure guides the design, development and approval of training programs.

ACT Health is a Registered Training Organisation (RTO), which provides a quality framework for delivery of training in line with the standards for *RTO 2015*.

Key achievements 2015–16

Capabiliti

An electronic course quality control system, the Education Activity Register (EAR), was implemented on the Capabiliti learning management system in April 2016. This provides a more rigorous means of monitoring the quality of programs registered on Capabiliti to ensure programs:

> are linked to evidence-based practice
> are evaluated
> involve consumers
> are appropriately authorised and version controlled.

It also provides better quality evidence for accreditation by enabling:

> information on previous versions to be accessed, for auditing purposes
> attendance data to be managed
> workplace in-services to be better categorised.

Leadership, management and supervision programs

The *Leadership and Management Development Strategy 2016–18* has been developed. It:

> aligns development activities and experiences to Health LEADS Australia, which is the Australian health leadership capability framework
> takes into consideration the ACTPS Shared Capability Framework.

A range of leadership and management development programs will be offered from 2016–17.

A manager's orientation pathway has been developed. This commenced with a major revision of the existing manager's orientation program, based on evaluation outcomes and stakeholder feedback. The program was restructured to develop a pathway that includes:

> e-learning programs
> a manager's resource toolkit on the intranet
> a one-day interactive case study-based session.

The pilot program was held in May 2016 and received extremely positive feedback.

Aboriginal and Torres Strait Islander Awareness e-learning Program

An Aboriginal and Torres Strait Islander Awareness e-learning Program has been developed after extensive consultation with both staff and consumer stakeholders. It is due to be published and available on Capabiliti in July 2016.

Leadership and culture programs

A suite of leadership and management programs were offered to staff in 2015–16, all of which had practical skills development elements.

The People Manager Program (PMP) continues to develop knowledge and skills in people management and is underpinned by ACT Health's values. The PMP is for clinicians and non-clinicians in frontline supervisor and middle management positions who have people management responsibilities. It consists of five half-day modules.

The ACT Health Leadership Network runs annually and is composed of around 100 employees identified by the executive as leaders and early career leaders. In 2015, the theme of the three workshops was Leadership for Patient-Centred Care. Participants further developed their individual leadership skills by:

> hearing presentations from guest speakers
> examining contemporary leadership research
> participating in network discussions.

The Leadership Network encourages collaboration and forms constructive partnerships across the organisation. It aims to reinforce the education received from the summit to improve and strengthen patient-centred care within their immediate areas.

The Leadership Network members:

> worked in small collaborative groups
> formed constructive partnerships across the organisation
> met outside the Leadership Network summit days.

This reinforced the education they received from the summit and encouraged them to consider ways of improving and strengthening patient-centred care within their immediate work areas.

Leadership programs were developed and delivered for CHHS and for Strategy and Corporate executives, senior and middle managers. Topics included:

> optimising the patient experience
> sponsoring successful projects
> coaching to full potential
> leading change
> spurring innovation.

The ACTPS Performance Framework was supported by the development and delivery of workshops for supervisors and managers. The workshops focused on providing the practical skills required for performance conversations and on providing feedback, including feedback on conduct and behaviour. Table 21 shows the number of workshops that were conducted and the number of participants in each.

TABLE 21: ACTPS PERFORMANCE FRAMEWORK PROGRAM WORKSHOPS

Program	Number of workshops	Participants in 2015–16
People Manager Program (5 modules)	21	465
Leadership Network	3	130
Canberra Hospital and Health Service Leadership programs	11	260
Strategy and Corporate Leadership Program	4	100
Let's talk...Performance	6	58

Managers and staff were provided with training in managing and preventing bullying, harassment and discrimination. Since the program began in 2011, over 5,400 staff and managers have been trained, which represents over 75 per cent of the workforce.

In 2015–16, 303 staff attended Respect@Work training and 49 staff attended one-hour refresher training. A specific Respect@Work training program was developed in 2015–16 to meet the needs of the ACT Health medical workforce, with 141 doctors attending this training.

At 30 June 2016, ACT Health had 106 Respect, Equity and Diversity (RED) contact officers. RED contact officers include:

> nurses
> allied health professionals
> doctors
> administrative staff
> staff who work outside traditional business hours.

RED contact officers met quarterly and participated in two significant development activities to support their role, including:

> an information session on people who identify themselves as Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ)
> an information session on the 2015 Workplace Culture Survey results.

Education programs developed in partnership with consumers and consumer groups

A number of education programs are provided for ACT Health staff to improve the patient experience by addressing the requirements of the *National Safety and Quality Health Service Standards, Standard 2 – 'Partnering with Consumers*'. The education sessions are delivered to an interprofessional audience. Table 22 provides course details, including attendances and a statement of consumer involvement.

TABLE 22: CONSUMER AND CONSUMER GROUP PARTNERED COURSES

Course	Attendance/ completions	Consumer involvement
Australian Charter of Health Care Rights e-learning	142	
Consent In-service	37	Consumer stories included in presentation
Involving Consumers in Quality Improvement	5	Consumer stories included in presentation
Partnering with Consumers- Patient Experience Program Activities	92	Consumer as co-presenter
Patient experience In-service	5	Consumer stories included in presentation
Patient stories- collecting and analysing	11	
Respecting Patient Choices e-learning	187	
Working with consumer representatives	7	Reviewed in April 2015 Consumers provided feedback
Writing Consumer Publications – e-learning	64	

ACT Health aims to involve consumers in other training provided to healthcare staff. An audit of the EAR indicates 64 per cent of programs currently involve consumers in planning, delivering or evaluating education provided to clinical staff.

The Consumers in Education Working Group is currently:

> developing training, in partnership with consumer organisations, for consumers who want to become involved in education programs for staff
> establishing guidelines for educators on how to involve consumers in education programs.

The Goals of Care Conversation (GOCC) Education Working Group is a developing a new initiative, the purpose of which is to provide education that supports healthcare professionals when engaging in a GOCC with patients, their families or the substitute decision maker. The GOCC promotes shared decision-making and the development of a GOCC plan.

The ACT Health Cultural Competence Program

The ACT Health Cultural Competence Program was developed to provide nurses and allied health staff with the opportunity to enhance the cultural awareness while working with Culturally and Linguistically Diverse (CALD) consumers and staff. In 2015–16, the target group was broadened to include all staff.

The content of the program meets the requirements of Standard 2 of the *National Safety and Quality Health Service Standards (2012)*. Cultural Competence has also been recognised as a driving influence towards CALD services within ACT Health and is noted by item 4.2 of the *Towards Culturally Appropriate and Inclusive Services – A Co-ordinating Framework ACT Health (2014–18)*.

Participants can complete either an e-learning program or a two-hour face-to-face education session. A shortened version of the education session is also embedded in the Clinical Supervision Support Essentials (CSSE) Program and the Certificate IV in Training and Assessment courses.

In 2015–16, 115 participants attended the face-to-face programs and 330 staff completed the e-learning.

Safety training

A range of targeted health-specific manual tasks programs are provided to meet the safety requirements of various work groups in the clinical and administrative environment. Workers in high-risk areas complete annual refreshers.

In 2015–16, 1,685 staff completed e-learning programs. Face-to-face training in manual tasks was completed by:

> 2,796 staff
> 275 volunteers
> 861 tertiary students attending clinical placements.

In 2016, a new process was implemented to manage the increasing number of tertiary students requiring training. A train-the-trainer program and resource materials were developed for facilitators from major tertiary institutions to enable them to train their own students prior to placement. In-house training for students is still provided to some groups.

Staff also have access to training to assist with managing challenging and aggressive behaviour from clients. During 2015–16, there were a total of 1,377 completions across the five e-learning modules on Personal Aggression and Conflict Awareness. The face-to-face, skills-based Predict, Assess and Respond to Challenging/Aggressive Behaviour (PART) Program or refresher course was completed by 242 staff.

Medication safety is a key requirement for patient safety and of the NSQHS standards. ACT Health provides education and assessment to Enrolled Nurses (ENs), Registered Nurses (RNs), and registered midwives caring for patients who require medications as a part of their treatment. In 2015–16, 312 staff completed the medication e-learning package during the orientation process, with 60 per cent passing in their initial assessment. A further workshop and assessment is provided for those who do not achieve 100 per cent in their initial assessment. A five and a half hour workshop is also included in the Nursing and Midwifery Orientation Program. A further 1,020 staff completed the Medication Safety Legislation and Processes e-learning Program.

An initial needs analysis, consultation with work areas across CHHS and review of Riskman data indicated a need to increase knowledge and work practices to mitigate the risk of staff exposure to and patient harm from cytotoxic medicines. As a result a quality improvement project was undertaken to implement education and awareness strategies. Implemented strategies included:

> developing a Cytotoxic Awareness pack for work areas, which is included in associated training programs
> collecting follow-up data to measure effectiveness.

In addition, the Chemotherapy Safe Handling Program has been revised to reflect these outcomes and now includes a Cytotoxic Awareness course. The program provides a basic skill set for clinical staff working with patients receiving chemotherapy and cytotoxic medicines in clinical areas outside Cancer Services. In 2015–16, 95 staff attended workshops and work area in-services on cytotoxic awareness.

Essential education and clinical education

ACT Health corporate orientation

The aim of orientation is to ensure all new staff are:

> welcomed
> informed of legislative requirements
> conversant on how ACT Health contributes to the local community
> aware of requirements of their job role as a public servant
> aware of their obligation to complete essential education requirements.

In 2015–16, 13 ACT Health Orientation sessions were provided to and attended by 1,097 staff and volunteers. In addition, 150 staff were deemed to have completed the requirements through recognition of prior learning, as approved by their Executive Director.

The Workplace Induction Pathway complements the ACT Health Corporate Orientation Program to ensure staff are orientated to their work area and adhere to the responsibilities of their role and work safety. In 2015–16, a total of 1,313 staff completed the Workplace Induction Pathway, either via e-learning training and/or completing the assessment form. An additional 31 staff were deemed to have completed requirements through recognition of prior learning.

Managers orientation

All new managers to ACT Health are required to complete the Managers Orientation Program, which aims to:

> welcome new managers and provide essential information in an easily accessible format
> ensure all managers in ACT Health are made aware of their obligations under legislation and ACT Government and ACT Health policies and procedures
> provide an introduction to their responsibilities and common issues in managing staff
> facilitate the development of effective interprofessional relationships and a network of peers
> assist new managers and those in leadership roles identify areas where they may need to access further information or undertake more in-depth training.

In 2015–16, a total of 88 managers attended the ACT Health Managers Orientation Program and seven managers were provided with recognition of prior learning.

Orientation for Interns, Residents and Registrars

In addition to the ACT Health Corporate Orientation, two tailored orientation sessions were held for Interns, Residents and Registrars. These sessions were attended by 192 staff.

Nursing and Midwifery Orientation

The Nursing and Midwifery Orientation Program is conducted over two days every month. The program contains clinical essential education and organisational requirements linked to the NSQHS standards. In 2015–16, a total of 295 Nurses and Midwives attended the Nursing and Midwifery Orientation Program, with:

> 294 attending on the first day
> 295 attending on the second day.

Child protection

Three levels of child protection training are provided to ACT Health staff depending on their role and the likelihood of them having contact with children and young people as part of their work.

Additional one-hour question and answer sessions are provided to discuss child protection concerns and provide further advice on reporting and child abuse/neglect matters. These sessions are provided for radiographers at the CHHS and nursing staff from:

> the Emergency Department
> the Neonatal Intensive Care Unit
> the Special Care Nursery.

In 2015–16, a stakeholder group was established to:

> review and redevelop child protection training courses
> reduce programs from three to two levels.

The new packages are scheduled to be launched in January 2017.

ACT Health has continued its partnership with the Community Services Directorate in providing the ‘What About Me’ series of workshops for government and non-government organisations. The aim is to increase staff confidence in their ability to work with vulnerable children and families.

Table 23 lists the training courses and identifies the number of participants that attended each.

TABLE 23: NUMBER OF STAFF WHO ATTENDED CHILD PROTECTION TRAINING

Child protection training	Participants
Level 2 face-to-face	388
Level 3 face-to-face	365
Level 3 refresher face-to-face	329
In-service	49
Level 1 e-learning ACT Health	684
Level 2 e-learning ACT Health	369
Level 1 e-learning Calvary Bruce	59
Level 2 e-learning Calvary Bruce	127
Level 1 e-learning Calvary John James	407
Level 1 e-learning Calvary John James	275
Total	3052

Currently, staff may attend more than one level of training, e.g. level 1 and level 3. The participant total reflects the number of attendees at education sessions. These figures include staff from ACT Health, Calvary Bruce and Calvary John James.

Life support programs

ACT Health provides life support training and assessment programs that align with:

> current National Safety and Quality Standards
> current Australian Resuscitation Council guidelines
> the ACT Health Essential Education Policy.

The courses provide staff with the knowledge and skills necessary to effectively manage resuscitation. Table 24 identifies the number of staff who received training in life support programs during 2015–16.

TABLE 24: NUMBER OF STAFF WHO ATTENDED LIFE SUPPORT COURSES

Life support courses	Attendance
Advanced Life Support	192
Advanced Life Support Refresher	148
Basic Life Support e-learning (prerequisite for assessment)	3636
Basic Life Support workshops and/or assessment sessions	3042
Basic Life Support Train the Trainer and refresher programs	58
Neonatal Advanced Life Support	194 plus 63 from Calvary
Neonatal Advanced Life Support Refresher – e-learning plus assessment	147
Paediatric Life Support	115 plus 18 from Calvary

Mandatory Update Day

The Mandatory Update Day (MUD) Program offers nurses and midwives annual refresher training in essential and highly recommended education in a day-long program. It is offered as an alternative to completing separate sessions on different days or e-learning courses.

An evaluation survey of relevant staff in 2015 indicated that the majority considered the program to be the preferred means of completing essential education. In 2015–16, 24 MUD Programs were conducted, attended by 950 staff.

Human Rights Act training for managers

Education on the *Human Rights Act 2004* is provided through an e-learning program, which was developed in consultation with the ACT Human Rights Commission. This is essential education for policy writers and managers in ACT Health. It is available for all staff to complete. In 2015–16, 139 staff completed the e-learning program.

COMPASS

The Early Recognition of the Deteriorating Patient Program (COMPASS) is designed for:

> nurses
> physiotherapists
> doctors
> undergraduates.

It is delivered by the Early Recognition of the Deteriorating Patient team. Specific workshops and refresher courses:

> focus on adult, paediatric, maternity or neonatal patients
> aim to enable health professionals to recognise the deteriorating patient and initiate appropriate and timely interventions.

In 2015–16, 1,591 staff attended workshops and refreshers and 509 completed an e-learning quiz.

Assistants in Nursing Development Program

The Assistants in Nursing Development Program (AINDP) is a new program, which commenced in November 2015. The aim of the program is to provide educational opportunities that support and develop the role of the Assistants in Nursing (AIN) working within ACT Health. An AIN supports RNs and/or registered midwives in providing personal care and maintaining a safe environment.

The program consists of four two-hour education sessions conducted throughout the year. Each session is offered twice to enable as many AINs as possible to attend. During the sessions AINs engage in practical learning activities, including attending workshops in:

> communication and partnerships with consumers
> infection control
> empathy.

In 2015–16, four workshops were held with a total of 53 participants.

Enrolled Nurse Professional Development Program

The evidence-based Enrolled Nurse Professional Development Program (ENPDP) provides updates on current trends in clinical practice through interactive learning. The content is aligned with several of the National Safety and Quality Health Services Standards.

Table 25 lists the ENPDP course offerings and identifies the number of courses and participants for each.

TABLE 25: NUMBER OF STAFF WHO ATTENDED ENPDP COURSES

Courses	Duration	Number of courses	Number of participants
Monthly modules	2 hours	6	74
Enrolled Nurse Forum	6.5 hours	1	105
Scope of Practice in-services	N/A	3	21
Graduate Clinical Debrief and Education	2 hours	23	216
Graduate Workshop	4 hours	3	31

An EN Forum was held in September 2015 with the theme 'At the Heart of Patient-Centred Care'. It was attended by ENs from ACT Health and Regional NSW with very positive feedback. A further forum is currently in development for 2016.

Invasive devices education programs

During 2015–16, four invasive device education programs were conducted.

Peripheral intravenous cannulation education

Peripheral intravenous cannulation education is provided to RNs, ENs, midwives, medical officers and radiographers caring for patients requiring cannula access for their treatment. The program consists of three parts:

> the theoretical component is undertaken via a self-directed learning package, which was completed by 72 staff
> a two-hour, face-to-face workshop to practice cannulation was attended by 153 staff
> clinical competencies are completed in the clinical setting.

A further workshop was held for Visiting Medical Officers (VMOs) with 91 attendees.

Venepuncture and blood culture collection

The Venepuncture and Blood Culture Collection Program offers education and clinical skills assessment for venepuncture and blood culture collection for RNs, ENs, midwives and medical officers.

An e-learning program was completed by 136 staff and the practical workshop was attended by 127 staff. Clinical competence assessment is completed in the clinical setting.

Central Venous Access Devices

ACT Health offers Central Venous Access Devices (CVAD) education and clinical skills-based assessment to RNs, midwives and medical officers caring for patients requiring central venous access for their treatment.

The program uses a blended approach, with an e-learning program completed by 275 staff in 2015–16. This is a prerequisite for completing the clinical competency assessments carried out in the clinical setting.

Indwelling urinary catheter

In 2015–16, 187 staff completed the indwelling urinary catheter e-learning program.

Newborn assessment

The purpose of the Newborn Assessment Workshop is to support the education of midwives, nurses and medical staff to develop the knowledge and clinical skills for newborn assessment.

Five workshops were held in 2015–16, with a total of 55 staff educated. Of these:

> 33 were from ACT Health
> nine were from Calvary
> 13 were from other facilities.

Wound management

ACT Health provides e-learning courses on wound assessment and management. In 2016 a new initiative was introduced, which involved changes to the bimonthly Wound Management Program. The day-long program, which previously covered multiple topics, now focuses on a single topic, such as:

> managing and assessing pressure injury, or
> incontinence associated dermatitis.

This change allows participants to explore the theory and practical aspects of the subject in greater detail. Presenters now include product educators. Attendance numbers have increased and the evaluations are positive.

In 2015–16:

> 211 staff completed the e-learning modules
> 77 staff completed the monthly face-to-face sessions on wound management
> 101 staff completed the bimonthly Wound Management Day (6.5 hours)
> 96 staff completed the negative pressure dressing and fistula management workshops
> an additional 179 staff attended clinical area in-services.

The Night Duty Continuing Education Program

The Night Duty Continuing Education Program supports educational opportunities for those staff working mostly night duty who may otherwise have limited access to in-service education. The program offers two sessions per week during 15 weeks of the calendar year to allow different staff rotations and equitable opportunity to attend. Program content includes:

> annual essential education topics and assessments
> clinical updates
> professional and workplace culture topics
> key organisational changes.

A total of 1019 people attended the 30 sessions conducted in 2015–16. Evaluations indicate that sessions are generally well received and relevant to attendees.

Paediatric programs

During 2015–16, three paediatric programs were offered.

Child and Adolescent Mental Health Program

The three-day Child and Adolescent Mental Health Program is run in conjunction with the Child and Adolescent Mental Health Services. It provides health professionals with knowledge and management skills useful when caring for a child or young person with an acute mental health problem. The course is run every 12 months.

In 2016, 23 participants from paediatric and mental health areas are enrolled in the program.

Paediatric High Dependency Nursing Program

The Paediatric High Dependency Nursing Program is a six-module course. It is offered to RNs and focuses on caring for an acutely ill child or young person. The 2016 program is currently running with 15 participants, comprising:

> Six RNs from paediatrics
> Six RNs from the Emergency Department
> Three RNs from the Intensive Care Unit.

Paediatric Oncology Nursing Program

The Paediatric Oncology Nursing Program is run annually in conjunction with the Sydney Children's Hospital Rural Outreach Service. It is targeted at nurses from both ACT Health and the Southern Children's Healthcare Network. It provides participants with information on treating and managing the acutely unwell paediatric oncology patient.

In 2016, 12 participants from both ACT Health and the Southern Children's Healthcare Network completed the program.

Perioperative Nursing Foundation Program

The Perioperative Nursing Foundation Program was developed to attract and retain nurses within the Perioperative Unit. It is delivered annually in line with ACT Health Transition to Practice Nursing Programs.

In 2016, seven graduate nurses participating in the program elected to continue to work in the perioperative area after they successfully completed the program. Five nurses from other clinical areas also attended the program for aseptic technique and surgical scrubbing, gowning and gloving training.

Allied health clinical education

Across allied health, clinical education is coordinated through the Chief Allied Health Office (CAHO) and provided by designated Clinical Educators. In 2015–16, the number of permanent Clinical Educator positions increased to 13 with the establishment of a full-time Clinical Educator for Psychology.

A Professional Development Grant Program was established to enhance workplace education. Six allied health teams were recipients of these inaugural grants. The grants are provided to resource clinical education initiatives for allied health staff. To be eligible the educational opportunity must be interprofessional or across division-focused and aligned with ACT Health strategic priorities.

The annual Allied Health Symposium 'All in the Mind? Foundations for Good Mental Health' was held on 6 April 2016 and 200 allied health staff attended from across the ACTPS.

Recruitment, Graduate and Transition to Practice programs

One of ACT Health's recruitment and retention strategies is to recruit ENs, RNs and allied health graduates and conduct Transition to Practice programs.

The programs focus on the graduate learning experience by providing a high level of clinical and professional support, care, feedback and guidance during the transition year.

Table 26 provides intake details for Transition to Practice programs.

TABLE 26: NUMBER OF PARTICIPANTS IN TRANSITION TO PRACTICE PROGRAMS

Intakes	No. intakes 2015–16	No. participants
Enrolled Nurse Transition to Practice Program	3	23
Registered Nurse Transition to Practice Program	4	89*

**Intakes in financial year – however participants may finish the program in the next financial year*

Education to support Transition to Practice RNs:

- incorporates a curriculum tailored to suit the learning needs of new RNs
- is aligned with the University of Canberra curriculum.

Graduates completing all program requirements are eligible for advanced standing (credit) for one unit of study towards a Postgraduate Diploma in Nursing Practice.

The ACT Health Enrolled Nurse Transition to Practice Program (ENTTPP) education provides a diverse range of learning opportunities throughout the organisation. The content of the ENTTPP is:

- guided by the National Competency Standards for the Enrolled Nurse (NMBA, 2016)
- aligned with Standard 1 of the National Safety and Quality Health Service Standards (2012) (https://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf).

The CAHO facilitates the Allied Health Graduate Program twice each year to build the capabilities required for effective interprofessional collaboration. A formal evaluation of the Allied Health Graduate Program was completed in 2015–16. This evaluation found statistically significant improvements in:

- the value participants placed on interprofessional collaboration post-program compared to pre-program
- participants' confidence and self-perceived ability to implement interprofessional practice.

The Interprofessional Graduate Program is facilitated by a team of education coordinators from:

- nursing
- midwifery
- medicine
- allied health.

It provides an opportunity for new graduates from all health professional areas at ACT Health to learn with, from and about each other on topics of organisation-wide importance.

Table 27 provides education details for new graduate programs.

TABLE 27: NUMBER OF PARTICIPANTS IN NEW GRADUATE EDUCATION PROGRAMS 2015–16

Program	No. participants
Allied Health New Graduate Program 2015–16 (includes six modules; runs twice per year)	36 participants from 12 disciplines
Interprofessional Graduate Program 2015–16 Conducted twice per year	168 participants from 13 disciplines
RN TTP education sessions	838 attendances

Re-entry programs for Registered Nurses/Midwives and Overseas Qualified Nurse

The ACT Health Re-entry (Refresher) recruits and provides educational support to RNs and midwives who have not worked in health care for up to 10 years.

The Overseas Qualified Nurses Program provides education and support for nurses qualified in other countries to gain registration in Australia.

All programs require ACT regional residency as a criteria to apply. Programs are accredited with the Nursing and Midwifery Board of Australia (NMBA).

In 2015–16, eight participants enrolled in the RN Refresher Program and 17 in the Overseas Qualified Nurse Program.

Education for Health staff who support, assess and educate others

ACT Health has a suite of programs to provide professional development to staff from all disciplines who are responsible for providing:

- workplace learning support and education
- competency assessment
- student clinical supervision.

These programs support compliance with *NSQHS Standard 1*. The standard requires that:

- competency-based training is provided to clinical staff
- supervision is provided for individuals to fulfil their designated roles.

Table 28 provides course details.

TABLE 28: EDUCATIONAL PROGRAMS PROVIDED IN 2015–16

Program name	Program description	No. sessions and attendees
Teaching on the run	This program is provided by allied health Clinical Educators for staff who provide clinical teaching and supervision.	17 sessions 252 participants
Peer Assisted Learning	The Peer Assisted Learning (PAL) course provides training in clinical supervision for supervisors who are directly working as the supervisor of more than one student.	4 sessions 40 participants
Allied Health Assistants supervision and delegation	Delegation to Allied Health Assistants – using innovative technology to improve patient care – a workshop for AHAs and AHPs.	1 session 50 participants
Allied Health Assistants supervision	'Are you ready to supervise and give feedback' – a workshop for AHAs who are supervising AHA students.	1 session 55 participants
Allied Health Clinical Educators Network	This education-focused network meets six times a year and involves Clinical Educators or primary supervisors from over 25 different allied health professions. The aim of the network is to support allied health Clinical Educators (or equivalent) in consistent delivery of high-quality clinical education across all allied health professions within ACT Health.	6 sessions 111 participants
The Clinical Support and Supervision Program	This interprofessional program provides introductory training for professionals who fulfil a preceptorship or clinical supervision role with new staff, graduates or undergraduate students in the clinical environment.	42 completed the e-learning 74 attended the one-day workshop
TAE40110 Certificate IV in Training and Assessment and associated courses	In 2015–2016, participants were offered a choice of completing the full qualification or completing selected units grouped in modules. Following a national upgrade of the qualification, a review of participant completions, feedback, and workplace requirements was undertaken. It was decided to only offer relevant selected skills sets and competency units rather than the full qualification from May 2016. The new short programs will be targeted to workplace required skills, be more flexible, and reduce the workload required for completion.	A total of 39 new enrolments, of those: 8 enrolled in the full qualification 31 enrolled in selected modules.
Clinical Development Nurse/Midwife Professional Development Program	Clinical Development Nurses and Midwives (CDNMs) provide workplace learning and support for nursing and midwifery staff. CDNMs are provided a monthly professional development program with content aligned with the National Safety and Quality Service Standards, Organisational core values. Sessions provides a forum to network with like peers, discuss advances in practice, documentation and/or equipment.	10 sessions 103 participants
ACT Health Trainers and Educators Network	The Trainers and Educators Network is a forum that discusses best practice in learning and development and enables sharing of ideas and initiatives. In 2015–16 the network covered issues such as the systems processes, interprofessional learning and simulated learning.	Four meetings 71 participants

Scholarships to support further learning for Allied Health, nursing and midwifery

The CAHO supports ongoing learning and development through the Allied Health Postgraduate Scholarship Scheme. The scheme supports allied health professionals to undertake further learning at postgraduate level in either:

> clinical practice
> education and training
> research
> management and leadership.

In 2015–16 the CAHO provided 49 postgraduate scholarship payments. The funding provided between 50 to 100 per cent of course costs. In the 2016 calendar year, a total of 44 recipients were awarded scholarships, reflecting a growth of 19 per cent on the 2015 calendar year.

The CAHO also promoted the 2015 round of the Allied Health Assistant Training Support fund, which enabled seven AHAs to upskill and achieve the Certificate IV in Allied Health Assistance and various skills sets.

ACT Health, through the Nursing and Midwifery Office, provides educational scholarship opportunities for nurses and midwives employed within the public health sector. The scholarships support the ongoing professional development and skill level requirements for nurses and midwives to further promote the safety and quality care of health services for the ACT and surrounding community.

Scholarships are awarded twice each year and applications continue to grow steadily to encompass education for the contemporary scopes of clinical, educational, leadership, management and research practice. In 2015–16, scholarship applications were received from 198 nurses and midwives. The most highly represented practice group accessing scholarships in this period were nurses from the practice settings of Mental Health, Justice Health, Alcohol and Drug Services.

Additional scholarships to support participation and presentation at professional conferences were awarded to 11 nurses and midwives. Additional support was provided for two Aboriginal and Torres Strait Islander enrolled nursing students.

Student support programs

Postgraduate certificates for ACT Health Nurses and Midwives

In collaboration with the Australian Catholic University (ACU), postgraduate certificates are offered to nurses and midwives in:

> Neonatal Nursing
> Child and Adolescent Health.

The ACU delivers an online component for two units, and educators in the ACT Health Staff Development Unit teach a curriculum approved by ACU for the remaining two units in each course.

This education model combines theory and experiential learning. The advantages for ACT Health of using this model are that participating staff are well educated for local practice, with their study tailored to work area requirements. ACT Health staff who are students are able to work and study at the same time and do not pay fees for the ACT Health component.

Once postgraduate certificates are completed students have an option to continue and undertake a Masters degree in their speciality.

Table 29 provides course details.

TABLE 29: POSTGRADUATE CERTIFICATES

Course	June–December 2015	January–June 2016
Neonatal	Four students with three completing in December	Four students with one completing in June
Child and Adolescent Health (includes either acute paediatrics or a maternal and child health specialty)	Six students with four completing in December	Seven students with three students completing in June
Master's, Neonatal and Paediatrics	One student completed in December	Three students continuing in June

Currently, an expression of interest is being sought from nursing staff working in the High Dependency Unit to undertake a Graduate Certificate in Paediatric Nursing Studies (Intensive Care) from the Australian College of Nursing.

Tertiary students

The Student Clinical Placement Unit (SCPU) reports directly to the ACT Chief Nurse. It coordinates the clinical placements for nursing, midwifery, medical and allied health students, in accordance with the Deeds and Schedules that exist with education providers.

In 2015–16, SCPU:

> worked collaboratively with 37 tertiary and vocational training educational institutions from across Australia
> provided professional development opportunities within ACT Health facilities for RNs and midwives from regional health services and the Australian Defence Force.

A diverse range of clinical placement options are available for students, providing them with opportunities to integrate theoretical learning with clinical practice.

In 2015–16, 2,788 placements were organised for students, equating to 44,194 clinical placement days. Of these:

> 44,414 clinical placement days were provided to nursing and midwifery students
> 31,624 clinical placement days were provided to allied health students.

This is an increase of 11 per cent when compared to 2014–15 data.

Activities and initiatives in 2015–16 included:

> enhancing the client view of the Student Placement Online system, to improve the student interface with SCPU
> improving compliance with placement prerequisites.

This system is the platform for:

> registering placement requests
> monitoring compliance
> providing students with access to e-learning before their placement.

Night duty clinical placements were again organised for third-year nursing students. Closer collaborative relationships with local education providers, including a 'Think Tank' for key stakeholders, have led to improved approaches to placement planning and evaluation.

Work Experience in ACT Health for School Students

ACT Health provides educational and practical healthcare work experience placements to ACT Year 10, 11 and 12 secondary students in either clinical or non-clinical areas. The program ensures that any risk to patients, students and the organisation are mitigated while providing an opportunity for students to experience the health care setting and encouraging secondary students to pursue a career in health care.

ACT Health is strongly committed to employment inclusion and encourages students who are Aboriginal or Torres Strait Islander or students with disability to participate in work experience.

In 2015–16, 268 work experience students completed placements from a mix of government, catholic and independent schools.

The ACT Health Orientation evaluation asks new staff commencing employment to identify if they were previously a work experience student in ACT Health. In 2015–16, 56 new staff identified as having attended the work experience program.

e-learning

Currently, 90 e-learning courses are available on the learning management system, Capabiliti. The courses are available 24 hours a day, seven days a week and comprise both essential (all staff) and non-essential training.

There were a total of 28,867 completions of e-learning programs in 2015–16. This was a decrease from the previous financial year due to a large number of completions of once-only programs in the previous year for national accreditation.

During 2015–16, 21 new courses were implemented on Capabiliti. In addition, 12 courses are under development or review, and a further 33 courses were evaluated and redeveloped.

Table 30, Table 31 and Table 32 provide details.

TABLE 30: COURSES DEVELOPED AND IMPLEMENTED IN 2015–16

Courses developed and implemented in 2015–16	
An Introduction to Atypical Parkinson's Disease	Paediatric High Dependency Nursing Module 2
Apomorphine Therapy for Parkinson's Disease	Paediatric High Dependency Nursing Module 3
Basic Life Support	Paediatric High Dependency Nursing Module 4
Care of the patient with a subcutaneous infusion	Preventing Falls and Harm from falls
Clinical Vision (CV5)	Regional Local Anaesthetic Technique
eHealth x 8 courses	The Mental Health Act 2015
Paediatric High Dependency Nursing Module 1	What the Law Expects

TABLE 31: COURSES CURRENTLY UNDER DEVELOPMENT OR REVIEW

Courses currently under development or review	
Aboriginal and Torres Strait Islander Cultural awareness	Ethics, Fraud and Integrity
Aseptic Technique	Female Mutilation awareness
Basic Life Support	Haemophilia
Cardiac Pacing	Interpreter Services
Ebola x 3 modules	Laser Safety x 2 modules
Electronic Medication Chart	Scrubbing for a Caesarean

TABLE 32: COURSES EVALUATED AND REDEVELOPED IN 2015–16

Courses evaluated and redeveloped 2015–16	
An Introduction to Parkinson's	Medication Package for Orientation
Australian Charter Health Care Rights	Medication Safety – Medication Legislation Processes
Child Protection Level 1	Module 1 – Essential Finance
Child Protection Level 2 Refresher	Module 2 – Finance Practicalities
Clinical Support and Supervision Essentials	Neonatal Resuscitation Update
COMPASS General Quiz	Neurovascular Observations in Orthopaedic Patients
Consent	Open Disclosure
DonateLife	PCA Competency Test
DonateLife Designated Officer Training	Performance Plan Record
Fire and Emergency	Performance Plan Review
Government Procurement	Privacy and Confidentiality
Human Rights Act	Records Management
Infection prevention and control, Occupational Medicine and Waste Management	Respecting Patient Choices
Intrathecal Epidural Single Dose Morphine	Theatre Etiquette, Surgical, Scrubbing, Gowning and Gloving
Ketamine for pain management	Work Health and Safety Act 2011
Magnetic Resonance Imaging Safety Refresher	Workplace Induction Pathway
	Writing Consumer Publications

Demonstrated commitment to whole-of-government learning and development initiatives

Table 33 shows ACT Health's participation in whole-of-government learning and development initiatives and the number of ACT Health staff receiving study assistance.

TABLE 33: ACT HEALTH'S PARTICIPATION IN WHOLE-OF-GOVERNMENT LEARNING AND DEVELOPMENT INITIATIVES

Initiative	No. of ACT Health participants 2015–16
ACTPS Graduate Program	3
Shared Services Calendar of Training	209
Study Assistance	233

ACT Health total learning and development activity

Table 34 provides details for learning and development activity for face-to-face programs and e-learning completions by division during 2015–16.

TABLE 34: LEARNING AND DEVELOPMENT ACTIVITY FOR FACE-TO-FACE PROGRAMS AND COMPLETION OF E-LEARNING BY DIVISION, 2015–16

Health division	No. of attendances	Hours	Salary	E-learning completed
Canberra Hospital and Health Services	61,107	121,253	4,974,737	25,378
Health Infrastructure	138	471	24,461	69
Office of the Director-General	78	225	8,258	109
Population Health	378	1221	59,161	430
Special Purpose Account	47	48	2,131	20
Strategy and Corporate	2,773	5131	231,436	1,250
System Innovation Group	44	137	8,992	28
Other (non-staff)*	2,497	N/A	N/A	1,583
Calvary**	125	N/A	N/A	N/A
Total	**67,187**	**128,486**	**5,309,176**	**28,867**

*Notes: *Other category may include some Calvary staff who use the ACT Health LMS *Calvary hours and salary costs are not available. An additional 887 tertiary students completed training programs with ACT Health*

Future learning and development key priorities

Priorities for 2016–17 and beyond include:

> implementing the Senior Doctor Leadership Program

> implementing the Emerging Manager Program

> developing and implementing major enhancements to the Learning Management System, Capabiliti

> developing and implementing a revised model for delivering child protection training.

The Senior Doctor Leadership Program is designed for Clinical and Unit Directors. It focuses on building skills for the practical application of people leadership principles. Delivery will begin in August 2016. This program will address one of the seven recommendations of the *Review of the Clinical Training Culture at Canberra Hospital and Health Services (KPMG, June 2015)*, which was

> "Develop and institute mandatory leadership and management training for all clinicians who hold a leadership or management position."

The Emerging Manager Program is designed for aspiring managers. The program was developed through stakeholder consultation following the identification of a potential development gap for clinical and non-clinical staff aspiring to management. The program was piloted in September 2016.

Major enhancements to the learning management system, Capabiliti, will be developed and implemented to:

> manage learning assignment rules so that individual or group Learning Pathways can be created to better manage:
  - essential education, divisional and workplace-recommended learning
  - individual requirements for a job role

> manage online performance plans with links to learning plans.

The revised model for delivering child protection training will have two levels, consisting of:

> a foundation e-learning package available to all staff, which is to be completed every three years

> a second level comprising an additional half-day, face-to-face session targeted to those staff and managers who work:
  - directly with children and young people or
  - with adults with possible reduced parenting capacity who have children in their care.

ATTRACTION AND RETENTION INITIATIVES

Table 35 provides details for Attraction and Retention Initiatives (ARIns).

TABLE 35: ATTRACTION AND RETENTION INITIATIVES

Description	No. of individual ARIns (A)	Number of group ARIns (B)	Total employees covered by group ARIns (C)	Total A + C
Number of ARIns at 30 June 2016	201	14	162	363
Number of SEAs that have become ARIns during period	55	14	162	217
Number of ARIns entered into during period	146	0	0	146
Number of ARIns terminated during period*	46	6	138	184
Number of ARIns for Privately plated vehicles as at 30 June 2016	6	0	0	6

** The number of ARIns terminated during the period depicts the number of staff who had the payment of an ARIn cease during the period due to resignation, or ineligibility for payment under a group SEA. It does not represent the number of ARIns terminating.*

AUSTRALIAN WORKPLACE AGREEMENTS

Table 36 provides the Australian Workplace Agreement (AWA) details.

TABLE 36: AUSTRALIAN WORKPLACE AGREEMENTS

Description	No. of individual (A)	Number of group (B)	Total employees covered by group (C)	Total A + C
Number of AWAs at 30 June 2016	2	0	0	2
Number of AWAs terminated/ lapsed (including formal termination and those that have lapsed due to staff departures)	0	0	0	0

Table 37 provides classification and remuneration rates.

TABLE 37: CLASSIFICATION AND REMUNERATION RATES

	Classification Range	Remuneration as at 30 June 2016
Individual and Group ARIns	DEN1/2, DEN3, DEN4	$94,920 – $173,027
	HPO1-HPO6	$71,355 – $144,001
	SITA – SITB	$139,750 – $167,000
	SOA, SOB, SOC	$109,967 – $171,711
	TCMG1 – TCMG3	$191,496 – $199,772
	SPEC, SSPEC	$73,921 – $596,868
AWAs (includes AWAs ceasing during reporting period)	SOGC	$104,967 – $106,356
	SSPEC	$215,686 – $322,042

OUR WORKFORCE

Table 38 shows Full-time Equivalent (FTE) and headcount by division/branch.

TABLE 38: FTE AND HEADCOUNT BY DIVISION/BRANCH

Division/branch	FTE	Headcount
Canberra Hospital and Health Services	5309.3	6100
Health Planning and Infrastructure	43.1	45
Office of the Director-General	97.8	104
Population Health	173.9	186
Strategy and Corporate	667.9	724
System Innovation Group	22.3	23
Special Purpose Account	9.9	13
Total	**6324.2**	**7195**

Table 39 shows headcount by division/branch and employment type.

TABLE 39: HEADCOUNT BY DIVISION/BRANCH AND EMPLOYMENT TYPE

Division/branch	Permanent	Temporary	Casual
Canberra Hospital and Health Services	4377	1427	296
Health Planning and Infrastructure	30	15	0
Office of the Director-General	84	19	1
Population Health	161	24	1
Strategy and Corporate	604	57	63
System Innovation Group	20	3	0
Special Purpose Account	5	7	1
Total	**5281**	**1552**	**362**

Table 40 shows FTE and headcount by gender.

TABLE 40: FTE AND HEADCOUNT BY GENDER

	Female	Male	Total
Full-time Equivalent	4688.3	1636.0	6324.2
Headcount	5430	1765	7195
Percentage of workforce (based on headcount)	75.5%	24.5%	100.0%

Table 41 shows headcount by classification and gender.

TABLE 41: HEADCOUNT BY CLASSIFICATION AND GENDER

Classification groups	Female	Male	Total
Administrative Officers	799	183	982
Dental	11	5	16
Executive Officers	14	13	27
General Service Officers and Equivalent	204	311	515
Health Assistants	86	11	97
Health Professional Officers	867	238	1105
Information Technology Officers	0	1	1
Legal Officers	0	1	1
Medical Officers	430	474	904
Nursing Staff	2632	341	2973
Professional Officers	10	5	15
Senior Officers	260	136	396
Technical Officers	114	42	156
Trainees and Apprentices	3	4	7
Grand Total	**5430**	**1765**	**7195**

Table 42 shows headcount by employment category and gender.

TABLE 42: HEADCOUNT BY EMPLOYMENT CATEGORY AND GENDER

Employment category	Female	Male	Total
Casual	261	101	362
Permanent Full-time	2442	983	3425
Permanent Part-time	1657	199	1856
Temporary Full-time	783	428	1211
Temporary Part-time	287	54	341
TOTAL	**5430**	**1765**	**7195**

Table 43 shows headcount by diversity group.

TABLE 43: HEADCOUNT BY DIVERSITY GROUP

	Headcount	Percentage of agency workforce
Aboriginal and Torres Strait Islander	78	1.1%
Culturally and Linguistically Diverse	1828	25.4%
People with disability	145	2.0%

Note: Employees may identify with more than one of the diversity groups.

Table 44 shows headcount by age group and gender.

TABLE 44: HEADCOUNT BY AGE GROUP AND GENDER

Age Group	Female	Male	Total
Under 25	321	84	405
25-34	1543	542	2085
35-44	1338	469	1807
45-54	1274	392	1666
55 and over	954	278	1232

Table 45 shows the average length of service by gender (headcount).

TABLE 45: AVERAGE LENGTH OF SERVICE BY GENDER (HEADCOUNT)

	Female	Male	Total
Average years of service	7.8	6.6	7.5

Table 46 shows headcount by length of service, generation and gender.

TABLE 46: HEADCOUNT BY LENGTH OF SERVICE, GENERATION AND GENDER

Length of service (years)	Pre-Baby Boomers		Baby Boomers		Generation X		Generation Y		Total	
	F	M	F	M	F	M	F	M	F	M
0-2	2	0	125	45	319	136	835	340	1281	521
2-4	1	1	106	29	272	107	501	177	880	314
4-6	0	0	120	36	271	101	317	124	708	261
6-8	0	1	123	26	243	74	221	46	587	147
8-10	2	0	109	41	215	68	128	16	454	125
10-12	4	1	112	31	158	52	65	12	339	96
12-14	2	0	108	33	115	39	34	6	259	78
14 plus	3	3	527	136	371	81	21	3	922	223

Note: |Pre-Baby Boomers cover the years prior to 1946.
Baby Boomers cover the years from 1946 to 1964 inclusive. Generation X covers the years from 1965 to 1979 inclusive.Generation Y covers the years from 1980 onwards

Table 47 shows recruitment and separation rates by division.

TABLE 47: RECRUITMENT AND SEPARATION RATES BY DIVISION

Division	Recruitment rate	Separation rate
Canberra Hospital and Health Services	10.2%	8.1%
Health Planning and Infrastructure	3.3%	0.0%
Director Generals Reports	13.0%	8.3%
Population Health	14.9%	4.5%
Strategy and Corporate	9.5%	7.0%
System Innovation Group	10.5%	20.9%
Special Purpose Accounts	0.0%	0.0%
Total	**10.2%**	**7.9%**

Table 48 shows recruitment and separation rates by classification group.

TABLE 48: RECRUITMENT AND SEPARATION RATES BY CLASSIFICATION GROUP

Classification group	Recruitment rate	Separation rate
Administrative Officers	10.3%	8.4%
Dental	0.0%	0.0%
General Service Officers and Equivalent	8.1%	6.2%
Health Assistants	14.8%	8.2%
Health Professional Officers	11.3%	9.6%
Information Technology Officers	0.0%	0.0%
Legal Officers	0.0%	0.0%
Medical Officers	11.4%	5.7%
Nursing Staff	10.2%	8.0%
Professional Officers	0.0%	0.0%
Senior Officers	9.2%	7.5%
Teacher	0.0%	100.0%
Technical Officers	7.2%	4.0%
Trainees and Apprentices	34.2%	0.0%
Total	**10.2%**	**7.9%**

Table 49 shows recruitment and separation rates for Executive Officers.

TABLE 49: RECRUITMENT AND SEPARATION RATES OF EXECUTIVE OFFICERS

Classification group	Recruitment rate	Separation rate
Executive Officers	4.0%	28.2%

For further information contact: Public Sector Management Group, Workforce Capability and Governance Division, Chief Minister and Treasury Directorate on (02) 6205 2658.

B.9 ECOLOGICALLY SUSTAINABLE DEVELOPMENT

COMMISSIONER FOR SUSTAINABILITY AND THE ENVIRONMENT

ACT Health provides the Commissioner for Sustainability and the Environment with updates on progress with the implementation of the Commissioner's recommendations from completed reports and inquiries. These updates are incorporated into the *Commissioner's annual report*.

In 2015–16, the Commissioner for Sustainability and the Environment did not investigate any activities carried out by ACT Health.

CONTRIBUTION TO ECOLOGICALLY SUSTAINABLE DEVELOPMENT

To achieve the ACT Government's target of zero net emissions by 2020, ACT Health actively:

> participates in the whole-of-government ecologically sustainable development initiatives
> continues to work towards embedding sustainability initiatives into service delivery.

In addition, ACT Health works closely with the *Environment and Planning Directorate* on sustainability activities and initiatives.

During 2015–16, ACT Health reviewed its sustainability strategy, the draft *Sustainability Strategy 2016–2020*, which incorporates the following emission reduction priorities:

> Resource Management Plan
> Buildings and Infrastructure
> the Digital Health Environment
> Our People, Partnerships
> External Service Delivery for Climate Change Adaptation and Procurement.

The strategy contains a roadmap that effectively signposts the attributes necessary for building an environmentally sustainable organisation.

ACT Health also reviewed its Resource Management Plan this financial year.

The RMP sets a clear obligation for ACT Health to demonstrate its commitment to environmental sustainability to the wider ACT Public Service (ACTPS) and the Canberra community. It provides an exciting opportunity for ACT Health to demonstrate what can be achieved in terms of sustainability.

With the guidance of the RMP, ACT Health aims to be committed to responsible and sustainable resource management through the effective and focused actions of our staff.

ACT Health used the ACT Health Environmental Principles and Guidelines – Building and Infrastructure Projects document to inform new building developments and building refurbishments.

ACT Health policies, programs and plans assist to promote Environmentally Sustainable Development (ESD), by including economic, social and environmental considerations in decision-making processes. This is required by the *Climate Change and Greenhouse Gas Reduction Act 2010* and the *Environment Protection Act 1997*.

ACT Health actively participates in the ACT Government Carbon Neutral Government Implementation Committee and Buildings and Infrastructure Subcommittee.

In 2015–16, ACT Health successfully secured approximately $3.3 million from the Carbon Neutral Government Loan Fund to:

> implement LED lighting across the Canberra Hospital campus
> erect a 500kw solar photovoltaic array on the roof of the southern, multi-storey car park (Building 26).

On completion, this project will actualise energy savings for one of ACT Health's largest energy consumption sites.

ACT Health also provided a supported framework for staff to set up Green Teams. ACT Health is required to establish Green Teams to progress the actions contained in the *ACT Government Carbon Neutrality Framework* with at key objective of reducing greenhouse gas emissions.

In addition, Property Management and Maintenance has incorporated sustainability as a topic for discussion during toolbox meetings to encourage maintenance staff to think more sustainably and provide input into strategies that will lead to greater environmental outcomes.

Energy

ACT Health continues to utilise the Enterprise Sustainability Platform (ESP) database to capture data for analysis and reporting purposes and to inform operational management of trends and potential energy usage reduction strategies.

The Sustainability Committee (the Health Infrastructure Sustainability Reference Group) continues to review the energy efficiency and whole-of-life costing of building elements for all new builds to assist in reducing carbon emissions.

The May 2015 application to the Carbon Neutral Government Fund (CNGF) has been approved. The project is underway and will:

> install solar photovoltaic (PV) panels on the roof of the multi-storey car park at Canberra Hospital
> rollout LED lighting to buildings on Canberra Hospital campus.

Initiatives incorporated into the various ACT Health new building projects, upgrades and improvements, aimed at reducing carbon emissions include:

> installing energy efficient lighting, including emergency lighting
> installing motion sensors for lighting in office areas
> trialling energy efficient window glazing, including double glazing in some areas
> installing intelligent networked lighting controls, for example the Dali lighting system, to enable ongoing lighting reviews to gain energy efficiencies
> considering sustainable procurement principles when purchasing consumables and products used in building maintenance
> implementing energy efficient chillers
> upgrading to direct digital control of heating ventilation and air conditioning
> installing variable speed drive control for ventilation fans
> converting selected large air handling systems to modulating economy cycle operation
> using the Building IQ system and building analytical software to better manage Property Management and Maintenance utilities
> analysing ACTSmart Enterprise Sustainable Platform data to help identify saving opportunities.

Water

The nature of the services delivered by ACT Health causes a heavy reliance on water, for both clinical and domestic usage, for example:

> patient showers
> theatre operations
> sterilising surgical equipment.

Efficient water initiatives incorporated into the various ACT Health new buildings, upgrades and improvements aimed at reducing water usage include:

> re-using Reverse Osmosis (RO) water from the renal process in the toilet facilities at identified community health centres
> installing flow restrictors on a range of plumbing fixtures, for example showers, hand basins and toilets
> installing motion sensors where applicable, while considering infection control issues
> using star-rated plumbing fixtures when replacing old, broken or obsolete equipment, where practical
> replacing heating pipe work and associated works at Canberra Hospital, in accordance with the preventative maintenance schedule
> continuing restrictions on the use of potable (drinkable) water for outside watering of landscapes at all ACT Health facilities, deactivating all garden sprinklers and decommissioning fountains
> using Canberra Hospital water meter data to monitor and analyse water usage, identify any anomalies and allow identified issues to be fixed immediately
> continuing to use tank water for outdoor garden watering and external washing of facilities, buildings and pavements, where tanks are installed
> analysing ACTSmart Enterprise Sustainable Platform data to help identify saving opportunities.

Waste

ACT Health recycled more than 300 tonnes of waste during the 2015–16 financial year, including paper, cardboard, plastics, cans and glass. In addition, ACT Health recycles batteries, organic matter, fluorescent light tubes and metal. ACT Health is progressing towards achieving accreditation from the ACTSmart Recycling Program for the recycling of these wastes.

In December 2015, ACT Health released a tender for the provision of cleaning and waste services management across numerous ACT Health sites. A primary objective in the tender specifications is implementing a waste management strategy that will achieve ACTSmart accreditation. The tender specifications include the requirement to identify the level of funding and resources that will be required to achieve this objective.

ACT Health continues to support the implementation of the *ACTSmart Recycling Program* across both acute and non-acute sites. In 2016, the ACTSmart Online Recycling Training continued to be made available to staff. The training provides staff with education and guidance on the impacts of and outcomes the program can deliver at ACT Health sites to improve resource recovery and reduce waste.

The ACT Health Staging and Decanting Strategy also incorporates the ACTSmart Business Recycling Programs into the refurbishment of new areas. Staff are supported to participate in the training offered to achieve maximum recycling outcomes.

Transport

ACT Health assesses replacement vehicles for efficiencies, both fuel and greenhouse gas emissions, when vehicle replacement occurs.

ACT Health increased its electric vehicles fleet to five, from three in 2014–15, and continues to explore opportunities to include additional electric vehicles. A total of 14 electric vehicle charging stations have been installed at ACT Health buildings across the Canberra region. The total fleet is 320 vehicles.

ACT Health continues to install Electronic Log Books into vehicles. This improves Fringe Benefit Tax (FBT) reporting and enhances the data used to improve fleet utilisation.

Staff are encouraged to use active travel (walk, bus or bike) for trips of less than four kilometres, instead of using motor vehicles.

FUEL USAGE DECREASED DURING THE 2015–16 FINANCIAL YEAR.

ACT Health continues to encourage car pooling among its staff and has designated car spaces at Canberra Hospital car parks for staff who take up this option.

SUSTAINABLE DEVELOPMENT PERFORMANCE

TABLE 50: ACT HEALTH OPERATIONAL CONSUMPTION OF RESOURCES

Indicator as at 30 June 2016	Unit	Current FY (2015–16)	Previous FY (2014–15)	Percentage change
Agency staff and area				
Agency staff	FTE	6,324.2	6,195.4	2%
Agency staff	Headcount	7,195	7,064	1.8%
Workplace floor area	Area (m2)	292,849	265,475[1]	10.3%
Stationary energy usage				
Electricity use	Kilowatt hours	37,810,168	36,399,242	3.8%[2]
Renewable electricity use	Kilowatt hours	-	-	-3
Natural gas use	Megajoules	109,715,318	109,252,309	0.4%
Transport fuel usage				
Total number of vehicles	Number	321	321	0%[4]
Total kilometres travelled	Kilometres	3,387,120	3,755,211	-9.8%
Fuel use – Petrol	Kilolitres	179	199	-10%
Fuel use – Diesel	Kilolitres	124	128	-3.1%
Fuel use – Liquid Petroleum Gas (LPG)	Kilolitres	-	-	-
Fuel use – Compressed Natural Gas (CNG)	Kilolitres	-	-	-
Water usage				
Water use	Kilolitres	235,901[5]	244,905	-3.6%
Resource efficiency and waste				
Reams of paper purchased	Reams	44,415	49,487	-10%
Recycled content of paper purchased	Percentage	9%	21.6%	-58%[6]
Waste to landfill	Litres	24,791,035	23,758,168	4.3%
Co-mingled material recycled	Litres	5,475,279	5,682,435	-3.6%
Paper & Cardboard recycled (incl. secure paper)	Litres	1,195,288	1,117,613	6.9%
Organic material recycled	Litres	11,984	7,262	65%
Greenhouse gas emissions				
Emissions from stationary energy use	Tonnes CO2-e	36,286	36,426[7]	-0.3%
Emissions from transport	Tonnes CO2-e	820.32	879.12	-6.6%
Total emissions	**Tonnes CO2-e**	**37,105.32**	**37,078.12**	**0.07%**

1 Error in the workplace floor area figure of 274,480 reported in 2014–15. This figure included a double up of some office accommodation.

2 The increase in electricity usage in 2015–16 may be associated with activity and infrastructure growth across all of ACT Health for example, Building 15 and the Emergency Department expansion (refer to C.4 Asset Management).

3 Not reported at Directorate level, only reported at Whole of Government level.

4 Whilst the total number of vehicles has remained the same for 2014–15 and 2015–16, the number of electric vehicles included in this figure has increased from 2 during the 2014–15 year to 5 during the 2015–16 year.

5 To ensure the data is as complete and representative of the Current FY as is practicable, the data reported here (99% complete) is for the 12 month period 1 May 2015 to 20 April 2016. For comparison purposes, the data reported in the Previous FY column is for the previous corresponding 12 month period.

6 The amount of recycled paper purchased by ACT Health decreased by 58 per cent for 2015–16 when compared to 2014–15. ACT Health encourages the use of recycled paper and is investigating the reasons for the decrease.

7 Any differences between Enterprise Sustainability Platform sourced data in the Previous FY (2014–15) and that in the original 2014–15 Report is due to updates to agency occupancy and historical consumption data.

PART C: FINANCIAL MANAGEMENT AND REPORTING

C.1 MANAGEMENT DISCUSSION & ANALYSIS FOR THE HEALTH DIRECTORATE FOR THE FINANCIAL YEAR ENDED 30 JUNE 2016

GENERAL OVERVIEW

OPERATIONS AND PRINCIPAL ACTIVITIES

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.

CHANGES IN ADMINISTRATIVE STRUCTURE

ACT Health did not gain or lose any functions in the 2015–16 financial year.

RISK MANAGEMENT

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

> abnormal rates of staff separation;
> the cost of medical malpractice indemnity;
> ability to attract and retain health professionals;
> demands on replacing systems and equipment; and
> growth in demand for services.

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

> implementation of strategies for the retention and recruitment of doctors, nurses, midwives and allied health professionals;
> strengthening our patient safety and clinical practice review framework;
> establishing the Medical School in cooperation with the Australian National University;
> enhancement of procurement processes to maximise benefits from contracting;
> a significant investment in infrastructure replacement and growth; and
> a significant investment in clinical systems and recording systems.

The above risks are monitored regularly throughout the year.

FINANCIAL PERFORMANCE

The following financial information is based on audited financial statements for 2014–15 and 2015–16, and the budget and forward estimates contained in the 2016–17 Health Directorate Budget Statements.

TOTAL NET COST OF SERVICES

	Actual	Budget	Actual	Budget	Forward Estimate	Forward Estimate	Forward Estimate
	2014–15	2015–16	2015–16	2016–17	2017–18	2018–19	2019–20
	$m	$m	$m	$m	$m	$m	$m
Total Expenditure	1,195.3	1,253.7	1,295.0	1,320.3	1,352.2	1,390.5	1,418.6
Total Own Source Revenue	898.1	942.7	960.3	987.9	1,006.6	1,031.1	1,056.8
Net Cost of Services	297.2	311.0	334.7	332.4	345.6	359.5	361.8

Comparison to Budgeted Net Cost of Services

The Directorate's net cost of services for 2015–16 of $334.7 million was $23.7 million or 7.6 per cent higher than the 2015–16 budget.

A combination of factors resulted in higher than budgeted expenses ($41.3 million). The four main higher expense variations are:

> Supplies and Services ($14.0 million) – mainly due to higher than budgeted pharmaceuticals expense due to Hepatitis C medications becoming available under the Commonwealth's 'S100 High Cost Drugs' reimbursement scheme from 1 March 2016. This increased expense is offset by an increase in revenue in User Charges;

> Employee Expenses ($11.7 million) – due to higher long service leave as a result of an increase in the rate used to estimate the present value moving from 104.2% to 114.7%;

> Grants and Purchased Services ($4.6 million) – largely due to additional elective surgery services at Calvary John James Hospital; and

> Other Expenses ($6.0 million) – largely due to expensing of various computer software projects that were discontinued in 2015–16.

The higher than budgeted expenditure was partially offset by higher than budgeted own source revenue ($17.6 million). The main higher revenue variation is:

> User Charges ($17.9 million) – largely due to increased high cost drugs reimbursements from the Commonwealth mainly due to Hepatitis C drugs becoming eligible for reimbursement under the S100 High Cost Drugs Scheme. This is offset by an increase in supplies and services expense.

Comparison to 2014–15 Net Cost of Services

There was an 12.5 per cent increase in net cost of services or $37.5 million more when compared to the 2014–15 actual cost of $297.2 million.

This increase in net cost of services was due to higher expenses ($99.7 million), partially offset by higher revenue ($62.2 million).

The three main increases in expenses are:

> Employee Expenses ($51.6 million) – largely due to:
  - an increase in staff numbers related to growth in services in acute services including emergency department and additional elective surgery, mental health, outpatient, community and primary care services and women and children's health ($6 million);
  - the impact of collective agreement pay rises ($17 million);
  - an increase in the rate used to estimate the present value of long service leave from 104.2% to 114.7% ($11.7 million);
  - leave earned exceeding leave taken ($9.7 million); and
  - the impact of pay rises on employee leave ($6.1 million).

> Supplies and Services ($36.5 million) – largely due to increased costs for:
  - pharmaceuticals due to increase in Hepatitis C medications which became available under the Commonwealth's 'S100 High Cost Drugs' reimbursement scheme from 1 March 2016.
  - contractors and consultants ($8.0 million) mainly due to costs associated with the implementation of the Directorate's new initiative to improve operational efficiency. Expensing of Information and Communication Technology contractor costs that were incorrectly accounted for as prepaid expenses in prior years has also contributed to this increase;
  - increased computer costs ($2.6 million) due to a combination of factors, including inflation, increased Microsoft licensing cost, increase in staff numbers and additional support charges for new projects such as Faster Access to ICT Systems, Intensive Care Unit Clinical System and Patient Master Index upgrade;
  - general administration ($1.9 million) due to a combination of factors including inflation, increase in staff numbers, costs related to the implementation of the comprehensive transformational reform across ACT Health and additional advertising promoting health prevention and early intervention;
  - visiting medical officers ($1.9 million) due to cover for staff specialist vacancies and an increase in elective surgeries; and
  - operating lease rental ($1.8 million) from a full year effect of the change of motor vehicle leases from finance leases to operating leases from 23 April 2015.
> Grants and Purchased Services ($11.5 million) – mainly due to new initiatives including specialised drug treatment services, community mental health services, expansion of community and home based services, end of life care at home and expanded community-based women and children's options, and an increase in elective surgery services at Calvary John James Hospital.

Total Own Source Revenue increased by $62.2 million due to higher:

> ACT Government User Charges ($51.1 million) largely due to funding for growth in activity and new initiatives, salary increases and cost escalation in supplies and services paid by the ACT Local Hospital Network Directorate; and
> Non-ACT Government User Charges ($17.0 million) due to an increase in the Commonwealth High Cost Drug reimbursements.

FUTURE TRENDS

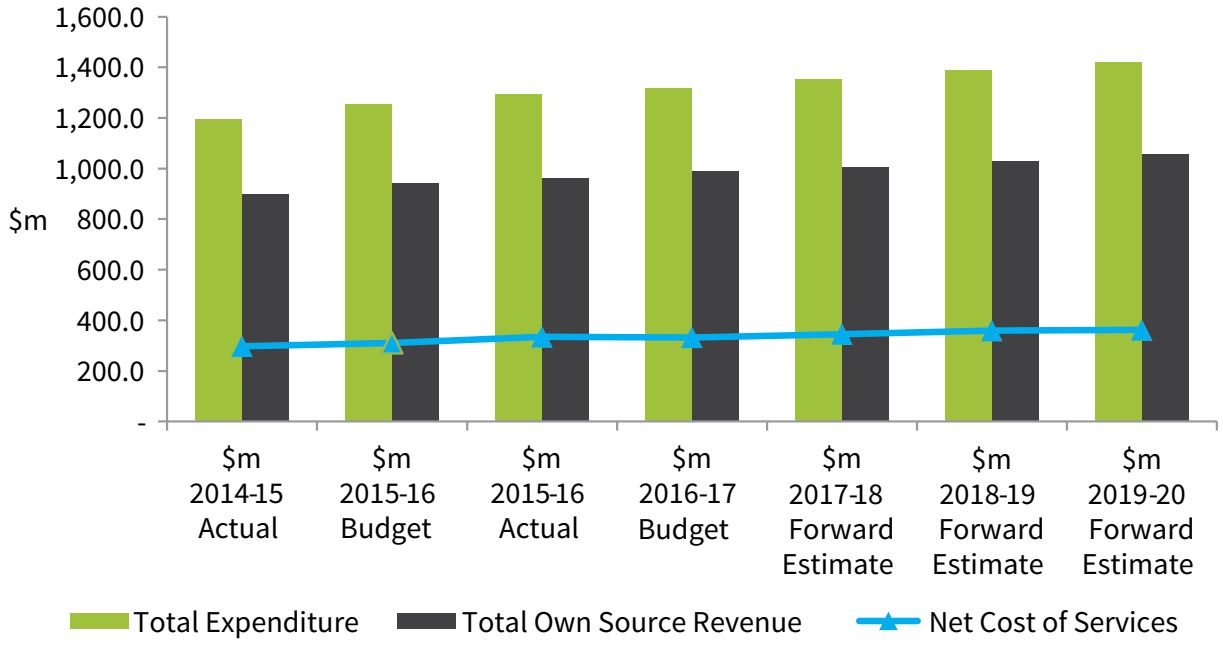


Figure 1: Net Cost of Services

Net cost of services is planned to reduce slightly in 2016–17 and then increase steadily over the future years consistent with funding provided in the 2016–17 Budget and the forward estimate years for growth in public health services including acute services, critical care, cancer services, rehabilitation, aged and community services and mental health services.

TOTAL EXPENDITURE

Components of Expenditure

Figure 2 below indicates the components of the Directorate's expenses for 2015–16. The three largest components of expense are employee expenses which represents 53.7 per cent or $694.8 million, supplies and services which represents 27.8 per cent or $360.4 million, and grants and purchased services, which represents 6.9 per cent or $89.8 million.

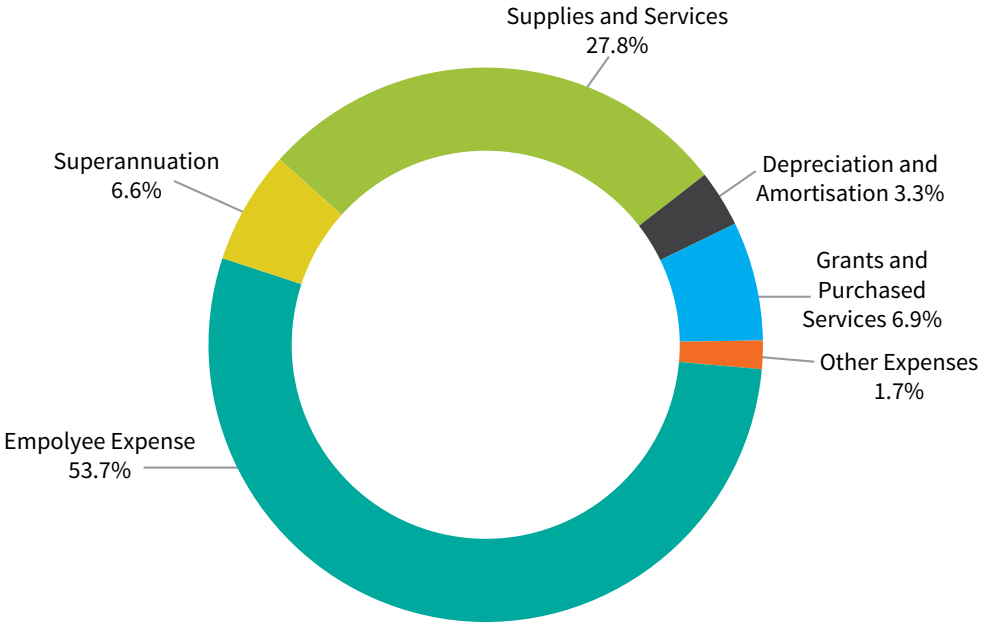


Figure 2: Components of Expenditure

Comparison to Budget

Total expenses of $1,295.0 million were $41.3 million, or 3.3 per cent higher than the original 2015–16 budget of $1,253.7 million.

Higher expenditure was due to higher:

> Supplies and Services ($14.0 million) – due to higher pharmaceuticals expense due to Hepatitis C medications becoming available on the 'S100 High Cost Drugs' reimbursement scheme from 1 March 2016;

> Employee Expenses ($11.7 million) – due to higher than budgeted long service leave largely from the increase in rate used to estimate the present value moving from 104.2% to 114.7%;

> Grants and Purchased Services ($4.6 million) – largely due to additional elective surgery services at Calvary John James Hospital;

> Other Expenses ($6.0 million) – largely due to expensing of various computer software projects that were discontinued in 2015–16;

> Superannuation ($4.1 million) – largely due to the impact of staff collective agreement pay rises and an increase in staff numbers; and

> Depreciation and Amortisation ($3.2 million) – due to additional amortisation flowing from new computer software packages introduced in 2015–16.

Comparison to 2014–15 Actual Expenses

Total expenses were $99.7 million or 8.3 per cent higher than the 2014–15 actual result. The increase was predominantly due to higher:

> Employee Expenses ($51.6 million) – largely due to:
  - an increase in staff numbers related to growth in services in acute services including emergency department and additional elective surgery, mental health, outpatient, community and primary care services and women and children's health ($6 million);
  - the impact of collective agreement pay rises ($17 million);
  - an increase in the rate used to estimate the present value of long service leave from 104.2% to 114.7% ($11.7 million);
  - leave earned exceeding leave taken ($9.7 million); and
  - the impact of pay rises on employee leave ($6.1 million).

> Supplies and Services ($36.5 million) – largely due to increased costs for:
  - pharmaceuticals ($15.7 million) due to an increase in Hepatitis C medications which became available under the Commonwealth's 'S100 High Cost Drugs' reimbursement scheme from 1 March 2016;
  - contractors and consultants ($8.0 million) mainly due to costs associated with the implementation of the Directorate's new initiative to improve operational efficiency. Expensing of Information and Communication Technology contractor costs that were incorrectly accounted for as prepaid expenses in prior years has also contributed to this increase;
  - increased computer costs ($2.6 million) due to a combination of factors, including inflation, increased Microsoft licensing cost, increase in staff numbers and additional support charges for new projects such as Faster Access to ICT Systems, Intensive Care Unit Clinical System and Patient Master Index upgrade;
  - general administration ($1.9 million) due to a combination of factors including inflation, increase in staff numbers, costs related to the implementation of the comprehensive transformational reform across ACT Health and additional advertising promoting health prevention and early intervention;
  - visiting medical officers ($1.9 million) due to cover for staff specialist vacancies and an increase in elective surgeries; and
  - operating lease rental ($1.8 million) from a full year effect of the change of motor vehicle leases from finance leases to operating leases from 23 April 2015;

> Grants and Purchased Services ($11.5 million) – mainly due to new initiatives including specialised drug treatment services, community mental health services, expansion of community and home based services, end of life care at home and expanded community-based women and children's options, and an increase in elective surgery services at Calvary John James Hospital.

> Superannuation ($4.5 million) – largely due to pay rises under collective agreements and and an increase in staff numbers.

The increase in expenditure from prior year was partially offset by reduced costs for Depreciation and Amortisation ($3.6 million) due to 2014–15 included additional depreciation for the psychiatric services unit building at the Canberra Hospital which was demolished in that year.

Future Trends

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

TOTAL OWN SOURCE REVENUE

Components of Own Source Revenue

Figure 3 below indicates that for the financial year ended 30 June 2016, the Directorate received 84.6 per cent of its total own source revenue ($812.9 million) from ACT Government user charges.

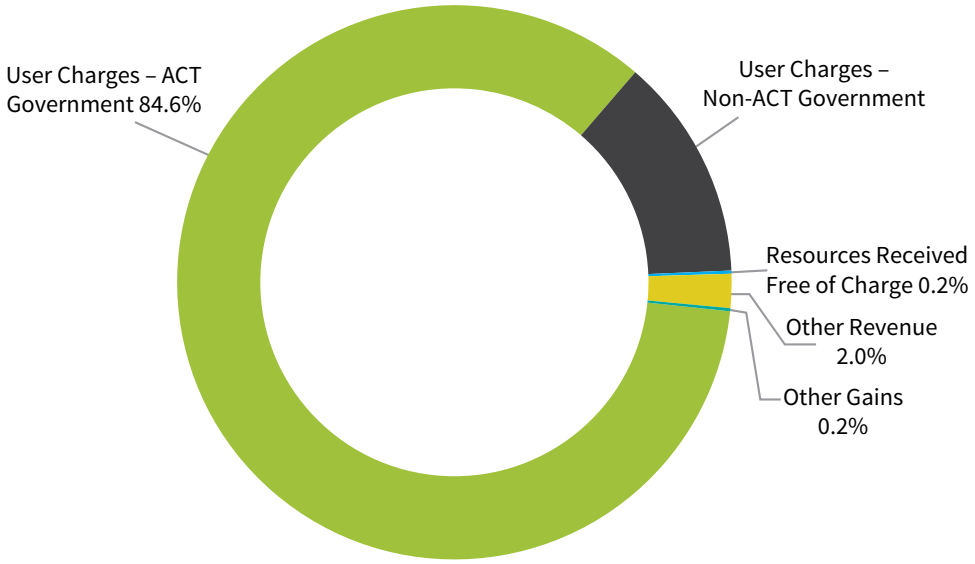


Figure 3 – Components of Own Source Revenue

Comparison to Budget

Total own source revenue of $960.3 million was $17.6 million or 1.9 per cent higher than the 2015–16 budget of $942.7 million.

This favourable variance is due to higher:

> User Charges Non-ACT Government ($17.1 million) – largely relates to higher Commonwealth reimbursements for high cost drugs due to the inclusion of additional drugs to the 'S100 High Cost Drugs' reimbursement scheme from 1 March 2016;

> User Charges ACT Government ($0.9 million) – largely due to revenue from Chief Minister Treasury and Economic Development Directorate for food inspection staff salaries; and

> Other Gains ($0.8 million) – due to higher donations than estimated.

The higher revenue variance is partially offset by underachievement against budget for:

> Other Revenue ($1.1 million) – due to lower grants revenue.

Comparison to 2014–15 Actual Revenue

Total own source revenue of $960.3 million is $62.2 million or 6.9 per cent higher than the 2014–15 actual result of $898.1 million.

The increase compared to last financial year is due to:

> ACT Government User Charges ($51.1 million) – largely due to funding for growth in activity and new initiatives, salary increases and indexation for non labour expenses paid by the ACT Local Hospital Network Directorate; and

> Non-ACT Government User Charges ($17.0 million) – largely relating to higher Commonwealth reimbursements for high cost drugs due to the inclusion of additional drugs to the 'S100 High Cost Drugs' reimbursement scheme from 1 March 2016.

The above increases in revenue were partially offset by reductions in:

> Other Gains ($5.4 million) – largely due to 2014–15 including a one off gain from de-recognition of lease vehicle liabilities; and

> Other Revenue ($0.7 million) – due to:
  - less special purpose grants for medical research;
  - lower Comcare reimbursements related to prior year; and
  - lower insurance claims revenue.

Future Trends

Total own source revenue is expected to increase steadily across the forward years consistent with funding provided to the ACT Local Hospital Network to purchase increased activity from the Canberra Hospital and Health Services in 2016–17 and the forward estimate years.

FINANCIAL POSITION

Total Assets

Components of Total Assets

Figure 4 below indicates that, for the financial year ended 30 June 2016, the Directorate held 72.5 per cent of its assets in property, plant and equipment.

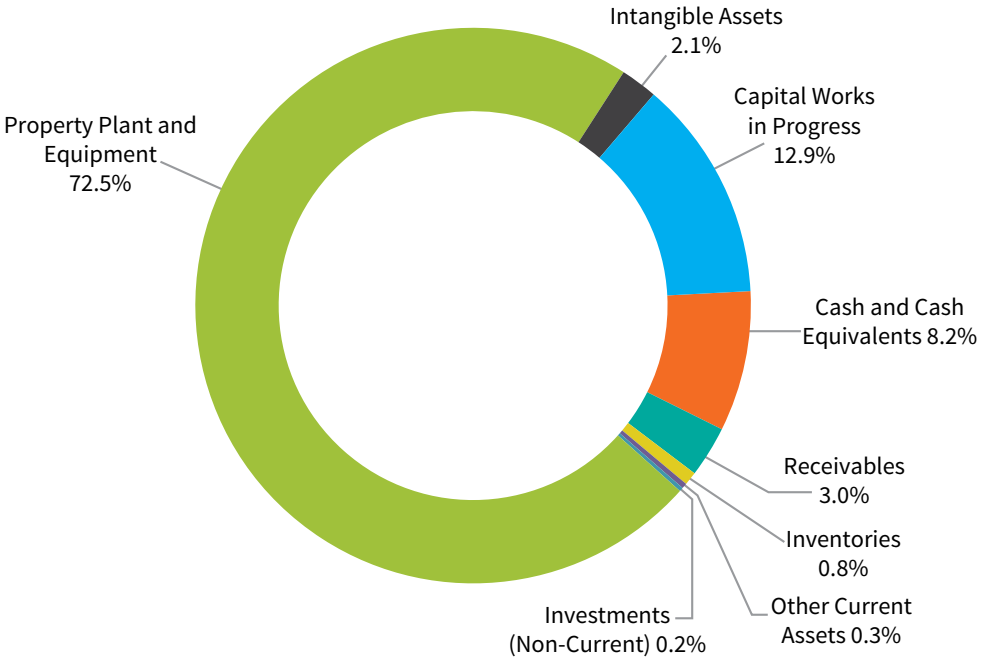


Figure 4 – Total Assets as at 30 June 2016

Comparison to Budget

The total asset position at 30 June 2016 is $1,303.5 million, $13.4 million lower than the 2015–16 budget of $1,316.9 million.

The variance reflects the timing associated with the acquisition and completion of various assets over the 2015–16 financial year resulting in lower:

> Property, Plant and Equipment ($19.2 million) – largely due to delays with current capital works projects from lengthy contract negotiations, construction delays, and a flow on effect of delays between projects;
> Capital Works in Progress ($37.8 million) – mainly due to project delays for the construction of new buildings, upgrades of current buildings and computer software development; and
> Intangible Assets ($12.5 million) – largely due to delays with computer software projects.

Partially offset by higher:

> Cash and Cash Equivalents ($45.8 million) – due to an increase in payables largely associated with delayed invoicing and payments for capital works;
> Receivables ($9.2 million) – largely due to growth in chargeable services and the level of Goods and Services Tax owing; and
> Inventories ($1.9 million) – due to the greater volume of high cost drugs held as inventory to cater for the increased demand.

Comparison to 2014–15 Actual

The Directorate's total asset position is $115.2 million higher than the 2014–15 actual result of $1,188.4 million, largely due to increases in:

> Property, Plant and Equipment ($58.6 million) – largely due to completed building capital works projects including Building 15 at the Canberra Hospital, the Canberra Hospital Emergency Department expansion and the Calvary Public Hospital Car Park; and
> Capital Works in Progress ($36.4 million) – as a result of the ongoing construction of new buildings including the Secure Mental Health Unit, the University of Canberra Public Hospital and the Ngunnawal Bush Healing Farm;
> Receivables ($11.5 million) – the increase mainly relates to a combination of factors including:
  – a new billing system implemented during 2015–16, as a result a higher level of invoices were raised towards the later part of the financial year;
  – higher medicare ineligible patient debts which takes longer to collect;
  – timing of amounts receivable from the Local Hospital Network Directorate for providing health services;
  – higher private patient debt due to some patient accounts having to be resubmitted to Medical Insurance Funds for payment as problems were encountered with the implementation of a new billing system; and
  – an increase in amounts receivable from the Commonwealth for high costs drugs reimbursement.
> Intangible Assets ($5.6 million) – The increase is due to completed internally generated operational software projects including Clinical Portal Suites, Patient Master Index, Radiology Information System Upgrade, Queue Flow Management Solution, Intensive Care Unit Metavision, new Cardiology Systems, Order Entry, Positive Patient Identification System and GP Healthnet.

Total Liabilities

Components of Total Liabilities

Figure 5 below indicates that the majority of the Directorate's liabilities relate to employee benefits 71.4 per cent and payables 28.1 per cent.

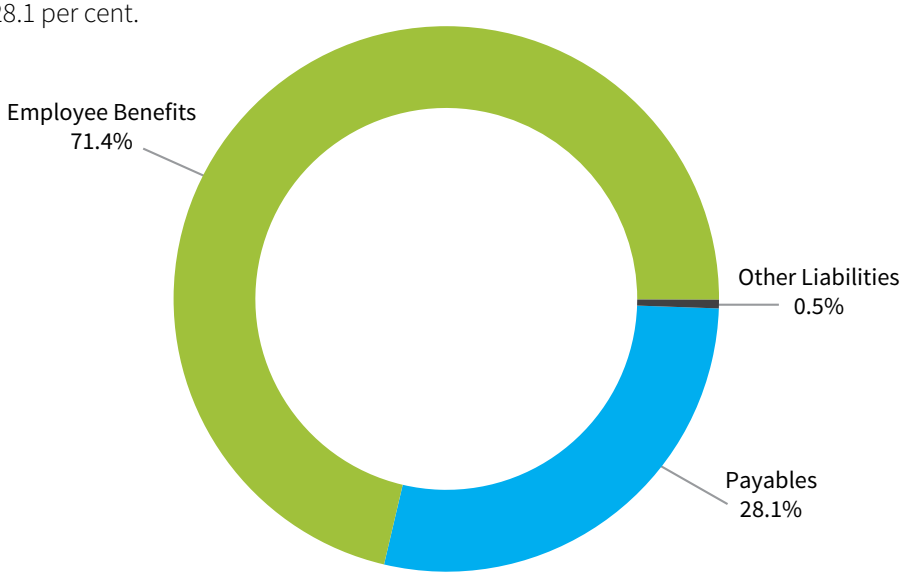


Figure 5 – Total Liabilities at 30 June 2016

Comparison to Budget

The Directorate's liabilities for the year ended 30 June 2016, of $337.7 million, is $54.9 million higher than the 2015–16 budget of $282.8 million.

This was largely due to higher:

> Payables (including Borrowings) ($51.9 million) – due to more accruals than budgeted for capital works, visiting medical officers, pharmaceuticals and medical and surgical supplies; and

> Employee Benefits ($10.2 million) – largely due to the impact of the rate used to estimate the present value of long service leave increasing from 104.2% to 114.7%.

Offset by lower:

> Finance Leases ($6.6 million) – due to a new whole-of-Government contract for motor vehicle leasing the Directorate no longer has any finance leases. All motor vehicle leases are now operating leases.

Comparison to 2014–15 Actual

Total liabilities of $337.7 million are $37.6 million higher than the actual results as at 30 June 2015 of $300.1 million. This is due to increases in:

> Payables (including Borrowings) ($40.7 million) – mainly due to an increase in payables for capital works, payment for Calvary Hospital for additional services and an increase in general accruals for other operating expenses including visiting medical officers, pharmaceuticals, medical and surgical supplies and ICT costs.

The above increases were partially offset by a decrease in:

> Employee Benefits ($3.0 million) – largely due to reductions from 2014–15 including:
  - 9 days accrued salaries compared to one day accrual in 2015–16; and
  - pay rises accrued for Medical staff whose collective agreements were finalised in 2015–16;

> Partially offset by increases in leave liabilities due to:
  - the impact of collective agreement pay rises;
  - an increase in staff numbers for growth in services in acute services including emergency department and additional elective surgery, mental health, outpatient, community and primary care services and women and children's health;
  - leave accumulated exceeding leave taken in 2015–16; and
  - The rate used to estimate the present value of future long service leave payments from 104.2% to 114.7%.

ATTACHMENT A – COMPARISON OF NET COST OF SERVICES TO BUDGET 2015–16

Description	Original Budget $'000	Plus AAO Transfers $'000	Total Funding $'000	Less Actual $'000	Variance to be Explained $'000	Variance to be Explained %
Expenses						
Employee Expense and Superannuation	764,487	-	764,487	780,307	15,820	2.1%
Supplies and Services	346,359	-	346,359	360,359	14,000	4.0%
Depreciation and Amortisation	39,794	-	39,794	42,968	3,174	8.0%
Grants and Purchased Services	85,269	-	85,269	89,823	4,554	5.3%
Other Expenses	6,572	-	6,572	12,564	5,992	91.2%
Cost of Goods Sold	11,237	-	11,237	9,000	(2,237)	-19.9%
Total Expenses	**1,253,718**	**-**	**1,253,718**	**1,295,021**	**41,303**	**3.3%**
Own Source Revenue						
User Charges	919,782	-	919,782	937,701	17,919	1.9%
Interest	191	-	191	141	(50)	-26.2%
Resources Received Free of Charge	1,708	-	1,708	1,743	35	2.0%
Gains	871	-	871	1,681	810	93.0%
Other Revenue	20,136	-	20,136	19,053	(1,083)	-5.4%
Total Own Source Revenue	**942,688**	**-**	**942,688**	**960,319**	**17,631**	**1.9%**
Total Net Cost of Services	**311,030**	**-**	**311,030**	**334,702**	**23,672**	**7.6%**

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

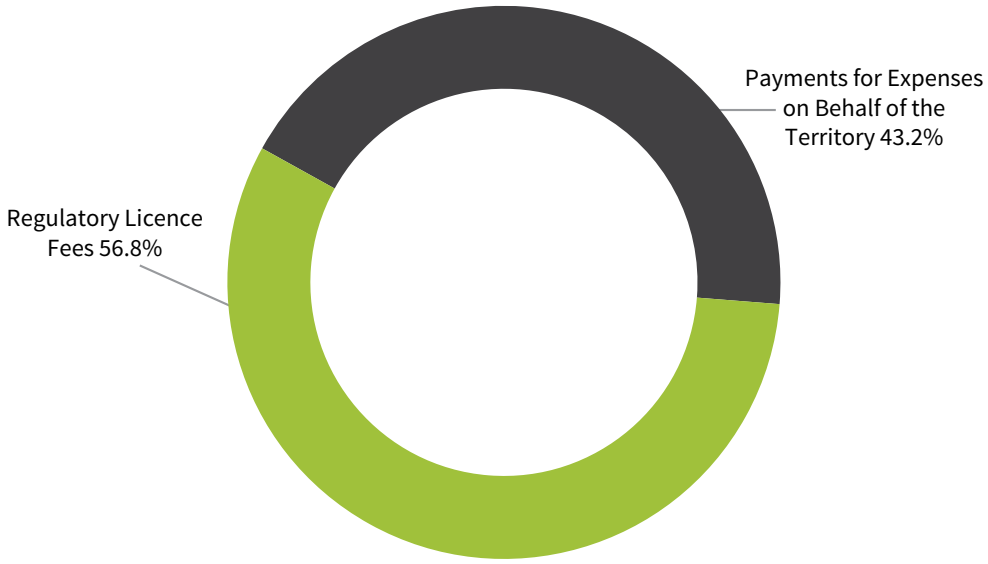


Figure 6 – Sources of Territorial Revenue

Comparison to Budget

Total Territorial income for the year ending 30 June 2016 was $2.8 million, which is $7.7 million lower than the budget figure of $10.5 million due to delays in capital works projects at Calvary Public Hospital mainly relating to operating theatre upgrades, expansion of services to enable 8 additional beds and upgrade of medical imaging equipment.

Comparison to 2014–15

Total Territorial income for 2015-16 of $2.8 million is $5.1 million lower than the 2014–15 income of $7.9 million. The main contributor to this decrease is:

> Payment for Expenses on Behalf of the Territory ($5.5 million) – this is due to delays in capital works at Calvary Public Hospital mainly relating to operating theatre upgrades, expansion of services to enable 8 additional beds and upgrade of medical imaging equipment.

Total Expenses

Figure 7 below indicates that 42.6 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 57.4 per cent being the transfer, to Government, of regulatory licence fees.

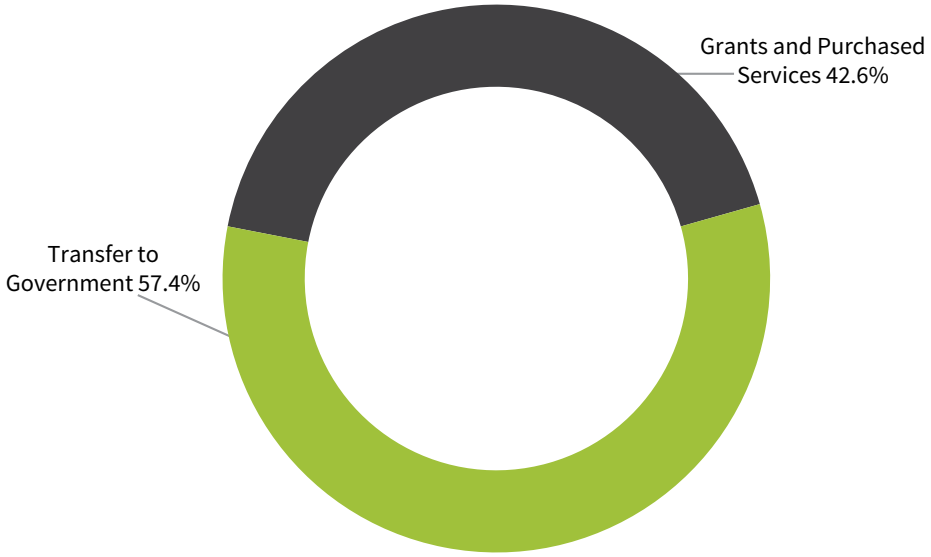


Figure 7 – Sources of Territorial Expenses

Comparison to Budget

Total expenses were $2.7 million, which was $7.8 million lower than the budget of $10.5 million due to delays in capital works at Calvary Public Hospital for the completion of operating theatre upgrades, expanded hospital services and upgrade of medical imaging equipment.

Comparison to 2014-15

Total expenses were $5.2 million lower than the 2014-15 total of $7.9 million. This is due to delays in capital works at Calvary Public Hospital mainly relating to operating theatre upgrades, expansion of services to enable 8 additional beds and upgrade of medical imaging equipment

C.2 HEALTH DIRECTORATE CONTROLLED FINANCIAL STATEMENTS

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

INDEPENDENT AUDIT REPORT

HEALTH DIRECTORATE

To the Members of the ACT Legislative Assembly

Report on the financial statements

The financial statements of the Health Directorate (the Directorate) for the year ended 30 June 2016 have been audited. These comprise the following financial statements and accompanying notes:

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

Responsibility for the financial statements

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

The auditor's responsibility

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

The audit was conducted in accordance with Australian Auditing Standards to 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.

Level 4, 11 Moore Street Canberra City ACT 2601 PO Box 275 Civic Square ACT 2608
T 02 6207 0833 F 02 6207 0826 E actauditorgeneral@act.gov.au W www.audit.act.gov.au

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

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

Electronic presentation of the audited financial statements

Those viewing an electronic presentation of these financial statements should note that the audit does not provide assurance on the integrity of information presented electronically and does not provide an opinion on any other information which may have been hyperlinked to or from these financial statements. If users of these statements are concerned with the inherent risks arising from the electronic presentation of information, then 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 2016:

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

(ii) present fairly the financial position of the Directorate at 30 June 2016 and results of its operations and cash flows for the year then ended.

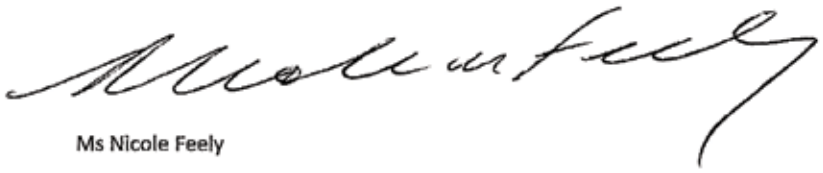
This audit opinion should be read in conjunction with other information disclosed in this report.

Dr Maxine Cooper
Auditor-General
21 September 2016

Health Directorate
Financial Statements
For the Year Ended 30 June 2016

Statement of Responsibility

In my opinion, the financial statements are in agreement with the Health Directorate's (the Directorate's) accounts and records and fairly reflect the financial operations of the Directorate for the year ended 30 June 2016 and the financial position of the Directorate on that date.



Ms Nicole Feely

Director-General

Health Directorate

19 September 2016

Health Directorate
Financial Statements
For the Year Ended 30 June 2016

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 Health Directorate's (the Directorate's) accounts and records and fairly reflect the financial operations of the Directorate for the year ended 30 June 2016 and the financial position of the Directorate on that date.

Mr Shaun Strachan
A/g Deputy Director-General, Corporate
Health Directorate
7th September 2016

HEALTH DIRECTORATE
OPERATING STATEMENT
FOR THE YEAR ENDED 30 JUNE 2016

	Note No.	Actual 2016 $'000	Original Budget 2016 $'000	Actual 2015 $'000
Income				
Revenue				
Government Payment for Outputs	4	272,366	264,857	252,617
User Charges – ACT Government	5	812,921	812,060	761,784
User Charges – Non-ACT Government	5	124,780	107,722	107,824
Interest	6	77	93	70
Distribution from Investments with the Territory Banking Account	7	64	98	97
Resources Received Free of Charge	8	1,743	1,708	1,471
Other Revenue	9	19,053	20,136	19,760
Total Revenue		**1,231,004**	**1,206,674**	**1,143,623**
Gains				
Gains on Investments	10	-	-	12
Other Gains	11	1,681	871	7,068
Total Gains		1,681	871	7,080
Total Income		**1,232,685**	**1,207,545**	**1,150,703**
Expenses				
Employee Expenses	12	694,736	683,043	643,111
Superannuation Expenses	13	85,571	81,444	81,043
Supplies and Services	14	360,359	346,359	323,871
Depreciation and Amortisation	15	42,968	39,794	46,586
Grants and Purchased Services	16	89,823	85,269	78,343
Borrowing Costs	17	44	401	305
Cost of Goods Sold	18	9,000	11,237	9,295
Other Expenses	19	12,520	6,171	12,779
Total Expenses		**1,295,021**	**1,253,718**	**1,195,333**
Operating (Deficit)		**(62,336)**	**(46,173)**	**(44,630)**
Other Comprehensive Income				
Items that will not be reclassified subsequently to profit or loss				
Increase/(Decrease) in the Asset Revaluation Surplus	36	1,604	-	(90)
Total Comprehensive (Deficit)		**(60,732)**	**(46,173)**	**(44,720)**

The above Operating Statement is to be read in conjunction with the accompanying notes. The Directorate has only one output class and as such the above Operating Statement is also the Directorate's Operating Statement for the Health and Community Care Output Class.

HEALTH DIRECTORATE
BALANCE SHEET
AT 30 JUNE 2016

	Note No.	Actual 2016 $'000	Original Budget 2016 $'000	Actual 2015 $'000
Current Assets				
Cash and Cash Equivalents	23	106,575	60,743	105,069
Investments		-	3,015	-
Receivables	24	38,761	29,591	27,232
Inventories	25	10,106	8,207	8,655
Assets Held for Sale		-	29	-
Other Assets	30	4,004	4,643	3,939
Total Current Assets		**159,446**	**106,228**	**144,895**
Non-Current Assets				
Investments	26	3,019	-	3,027
Property, Plant and Equipment	27	944,756	963,999	886,129
Intangible Assets	28	28,148	40,694	22,583
Capital Works in Progress	29	168,175	205,994	131,756
Total Non-Current Assets		**1,144,098**	**1,210,687**	**1,043,495**
Total Assets		**1,303,544**	**1,316,915**	**1,188,390**
Current Liabilities				
Payables	31	91,654	43,048	54,269
Borrowings	32	352	-	-
Finance Leases		-	2,356	-
Employee Benefits	34	224,073	212,696	229,506
Other Liabilities	35	252	923	370
Total Current Liabilities		**316,331**	**259,023**	**284,145**
Non-Current Liabilities				
Borrowings	32	2,919	-	-
Finance Leases		-	4,242	-
Employee Benefits	34	16,966	18,168	14,529
Other Provisions	33	1,462	1,375	1,418
Total Non-Current Liabilities		**21,347**	**23,785**	**15,947**
Total Liabilities		**337,678**	**282,808**	**300,092**
Net Assets		**965,866**	**1,034,107**	**888,298**
Equity				
Accumulated Funds		834,834	904,589	758,870
Asset Revaluation Surplus	36	131,032	129,518	129,428
Total Equity		**965,866**	**1,034,107**	**888,298**

The above Balance Sheet is to be read in conjunction with the accompanying notes. The Directorate has only one output class and as such the above Balance Sheet is also the Directorate's Balance Sheet for the Health and Community Care Output Class.

HEALTH DIRECTORATE
STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2016

	Note No.	Accumulated Funds Actual 2016 $'000	Asset Revaluation Surplus Actual 2016 $'000	Total Equity Actual 2016 $'000	Original Budget 2016 $'000
Balance at 1 July 2015		**758,870**	**129,428**	**888,298**	**914,133**
Comprehensive Income					
Operating (Deficit)		(62,336)	-	(62,336)	(46,173)
Increase in the Asset Revaluation Surplus	36	-	1,604	1,604	-
Total Comprehensive (Deficit)/Suplus		**(62,336)**	**1,604**	**(60,732)**	**(46,173)**
Transactions Involving Owners Affecting Accumulated Funds					
Capital Injections		138,299	-	138,299	166,147
Total Transactions Involving Owners Affecting Accumulated Funds		**138,299**	**-**	**138,299**	**166,147**
Balance at 30 June 2016		**834,834**	**131,032**	**965,866**	**1,034,107**

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

	Note No.	Accumulated Funds Actual 2015 $'000	Asset Revaluation Surplus Actual 2015 $'000	Total Equity Actual 2015 $'000
Balance at 1 July 2014		**756,459**	**129,518**	**885,977**
Comprehensive Income				
Operating (Deficit)		(44,630)	-	(44,630)
(Decrease) in the Asset Revaluation Surplus	36	-	(90)	(90)
Total Comprehensive (Deficit)		**(44,630)**	**(90)**	**(44,720)**
Transactions Involving Owners Affecting Accumulated Funds				
Capital Injections		74,041	-	74,041
Capital (Distributions)		(27,000)	-	(27,000)
Total Transactions Involving Owners Affecting Accumulated Funds		**47,041**	**-**	**47,041**
Balance at 30 June 2015		**758,870**	**129,428**	**888,298**

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 2016

	Note No.	Actual 2016 $'000	Original Budget 2016 $'000	Actual 2015 $'000
Cash Flows from Operating Activities				
Receipts				
Government Payment for Outputs		272,366	264,857	252,617
User Charges – ACT Government		807,192	812,060	760,881
User Charges – Non-ACT Government		115,766	105,000	105,233
Grants Received from the Commonwealth		3,995	3,951	4,805
Interest Received		77	93	70
Distribution from Investments with the Territory Banking Account		64	98	104
Goods and Services Tax Input Tax Credits from the Australian Taxation Office		46,843	49,100	39,346
Goods and Services Tax Collected from Customers		4,996	4,300	4,590
Other		21,429	17,036	15,573
Total Receipts from Operating Activities		**1,272,728**	**1,256,495**	**1,183,219**
Payments				
Employee		698,717	664,802	621,323
Superannuation		85,571	81,444	80,761
Supplies and Services		348,128	349,084	318,270
Grants and Purchased Services		89,823	85,269	78,343
Goods and Services Tax Paid to Suppliers		51,724	46,768	43,826
Borrowing Costs		44	401	305
Other		13,460	21,432	13,237
Total Payments from Operating Activities		**1,287,467**	**1,249,200**	**1,156,065**
Net Cash (Outflows)/Inflows from Operating Activities	**40**	**(14,739)**	**7,295**	**27,154**
Cash Flows from Investing Activities				
Receipts				
Proceeds from the Sale of Property, Plant and Equipment		64	-	1,131
Total Receipts from Investing Activities		**64**	**-**	**1,131**
Payments				
Payments for Property, Plant and Equipment		11,179	9,381	8,915
Payments for Capital Works		114,209	166,147	66,894
Total Payment from Investing Activities		**125,388**	**175,528**	**75,809**
Net Cash (Outflows) from Investing Activities		**(125,324)**	**(175,528)**	**(74,678)**

HEALTH DIRECTORATE
CASH FLOW STATEMENT (CONTINUED)
FOR THE YEAR ENDED 30 JUNE 2016

	Note No.	Actual 2016 $'000	Original Budget 2016 $'000	Actual 2015 $'000
Cash Flows from Financing Activities				
Receipts				
Capital Injections		138,299	166,147	74,041
Proceedes from Borrowings		3,319	-	-
Total Receipts from Financing Activities		**141,618**	**166,147**	**74,041**
Payments				
Repayment of Finance Lease Liabilities		-	1,452	1,703
Repayment of Borrowings		48	-	-
Capital Distributions		-	-	27,000
Total Payment from Financing Activities		**48**	**1,452**	**28,703**
Net Cash Inflows from Financing Activities		**141,570**	**164,695**	**45,338**
Net Increase/(Decrease)in Cash and Cash Equivalents		**1,506**	**(3,538)**	**(2,187)**
Cash and Cash Equivalents at the Beginning of the Reporting Period		105,069	64,281	107,256
Cash and Cash Equivalents at the End of the Reporting Period	**40**	**106,575**	**60,743**	**105,069**

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

HEALTH DIRECTORATE
CONTROLLED STATEMENT OF APPROPRIATION
FOR THE YEAR ENDED 30 JUNE 2016

	Original Budget 2016 $'000	Total Appropriated 2016 $'000	Appropriation Drawn 2016 $'000	Appropriation Drawn 2015 $'000
Controlled				
Government Payment for Outputs	264,857	277,703	272,366	252,617
Capital Injections	166,147	158,504	138,299	74,041
Total Controlled Appropriation	**431,004**	**436,207**	**410,665**	**326,658**

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 reporting period. This amount appears in the Cash Flow Statement.

Variances between 'Original Budget' and 'Total Appropriated'

Government Payment for Outputs

The difference between the Original Budget and Total Appropriated is due to a transfer of $11.9 million from Capital Injections to Government Payment for Outputs for the Directorate's new initiative to improve operational efficiency (System Innovation Program) and Commonwealth funding of $0.946 million from delayed 2014–15 programs.

Capital Injections

The difference between the Original Budget and Total Appropriated is due to a transfer of $11.9 million from Capital Injections to Government Payment for Outputs for the System Innovation Program. This is partially offset by a transfer of unspent 2014–15 funding to 2015–16 of $4.657 million relating to:

> computer software development projects;
> capital upgrade program works mainly for buildings, electrical and fire safety;
> essential infrastructure works at the Canberra Hospital campus such as replacement of generators, switchboard, electrical substation; and
> associated capital works for CT scanner replacements.

Variances between 'Total Appropriated' and 'Appropriation Drawn'

Government Payment for Outputs

The difference between the Total Appropriated and Appropriation Drawn is a result of delays to:

> the System Innovation Program ($4.101 million); and
> Commonwealth-funded programs ($1.236 million), mainly relating to the purchase of vaccines.

Capital Injections

The difference between the Total Appropriated and Appropriation Drawn is due to the delay of projects resulting in deferral of Capital Injections from 2015–16 to 2016–17, 2017–18 and 2018–19. The major delays relate to:

> construction of the Secure Mental Health Unit due to higher rainfall than average;
> computer software development projects relating to systems used in operations of the Directorate, due mainly to lengthy contract negotiations;
> infrastructure and redevelopment works across the Canberra Hospital campus; and
> ACT Health's capital upgrade program which includes building upgrades, electrical, fire and safety upgrades as well as mechanical and services infrastructure upgrades.

HEALTH DIRECTORATE
CONTROLLED NOTE INDEX
FOR THE YEAR ENDED 30 JUNE 2016

HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2016

Note 1. Objectives of the Health Directorate

Operations and Principal Activities

The Health Directorate (the Directorate) partners with the community and consumers for better health outcomes by:

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

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

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

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

Note 2. Significant Accounting Policies

(a) Basis of Preparation

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

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

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

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.

At 30 June 2016, the Directorate's current liabilities ($316.3 million) exceeded its current assets ($159.4 million) by $156.9 million. However, this is not considered to be a liquidity risk as its cash needs are funded through appropriation by the ACT Government on a cash-needs basis.

The financial statements have been prepared using the accrual basis of accounting, which recognises the effects of transactions and events when they occur. The financial statements have also been prepared according to the historical cost convention, except for assets such as those included in assets held for sale, property, plant and equipment and financial instruments which were valued at fair value in accordance with the (re)valuation policies applicable to the Directorate during the reporting period.

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

The Directorate is an individual reporting entity.

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

(c) The Reporting Period

These financial statements state the financial performance, changes in equity and cash flows of the Directorate for the year ending 30 June 2016 and the financial position of the Directorate at 30 June 2016.

(d) Comparative Figures

Budget Figures

To facilitate a comparison with the Budget Papers, as required by the *Financial Management Act 1996*, budget information for 2015–16 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 down to zero.

(f) Revenue Recognition

Revenue is recognised at the fair value of the consideration received or receivable in the Operating Statement. In addition, the following criteria must be met before revenue is recognised:

Government Payment for Outputs

Government Payment for Outputs and Payment for Expenses on Behalf of the Territory are recognised as revenue when the Directorate gains control over the funding. Control over these appropriated funds is obtained on the receipt of cash.

Note 2. Significant Accounting Policies (Continued)

(f) Revenue Recognition (Continued)

ACT Government User Charges

The Directorate receives funding from the Local Hospital Network Directorate (LHN). The funding received from the LHN is based on the historical costs of the Directorate adjusted for growth in services provided and inflation. Funding from the LHN is recognised as revenue when the Directorate gains control over the funding. Control over LHN funding is obtained on the receipt of cash.

Service Revenue

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

Inventory Sales

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

Amounts Received for Highly Specialised Drugs

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

Inpatient Fees

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

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

Facilities Fees

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

Distribution

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

Grants

Grants are non-reciprocal in nature and are recognised as revenue in the reporting period in which the Directorate obtains control over them.

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

Interest

Interest revenue is recognised using the effective interest method.

Revenue Received in Advance

Revenue received in advance is recognised as a liability if there is a present obligation to return the funds received, otherwise all are recorded as revenue.

Note 2. Significant Accounting Policies (Continued)

(g) Resources Received and Provided Free of Charge

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

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

(h) Repairs and Maintenance

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

(i) Borrowing Costs

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

(j) Waivers of Debt

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

(k) Current and Non-Current Items

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

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

(l) Impairment of Assets

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

Any resulting impairment losses, for land, buildings, and leasehold improvements, are recognised as a decrease in the Asset Revaluation Surplus relating to these classes of assets. Where the impairment loss is greater than the balance in the Asset Revaluation Surplus for the relevant class of asset, the difference is expensed in the Operating Statement.

Impairment losses for plant and equipment and intangible assets are recognised in the Operating Statement, as plant and equipment and intangibles are carried at cost. The carrying amount of the asset is reduced to its recoverable amount.

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

Note 2. Significant Accounting Policies (Continued)

(m) Cash and Cash Equivalents

Cash and cash equivalents include cash at bank, cash on hand and cash held in the Territory Banking Account. Cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and which are subject to an insignificant risk of changes in value.

(n) Receivables

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

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 recognised in the Operating Statement. The allowance for impairment losses is written off against the allowance account when the Directorate ceases action to collect the debt when the cost to recover debt is more than the debt is worth.

(o) Investments

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

(p) Inventories

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

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

(q) Assets Held for Sale

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

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

Note 2. Significant Accounting Policies (Continued)

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

Property, plant and equipment is initially recorded at cost.

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

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

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

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

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

Fair value for land and non-specialised buildings is measured using the market approach valuation technique and uses prices and other relevant information generated by market transactions involving identical or similar assets.

Fair value for specialised buildings and leasehold improvements is measured by reference to the cost of replacing the remaining future economic benefits embodied in the asset (i.e depreciated replacement cost). This is the cost approach valuation technique.

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.

(t) Intangible Assets

The Directorate's intangible assets are comprised of internally developed software. Software is recognised and capitalised when:

> it is probable that the expected future economic benefits that are attributable to the software will flow to the Directorate;
> the cost of the software can be measured reliably; and
> 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 intangible assets arising from the development phase of an internal project.

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.

Note 2. Significant Accounting Policies (Continued)

(u) Depreciation and Amortisation of Non-Current Assets

Amortisation is used in relation to intangible assets and 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 are depreciated over the estimated useful life of each asset improvement, or the unexpired period of the relevant lease, whichever is shorter.

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

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

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

Land improvements are included with buildings.

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

(v) Payables

Payables are initially recognised at fair value based on the transaction cost and subsequent to initial recognition at amortised cost, with any adjustments to the carrying amount being recorded in the Operating Statement. All amounts are normally settled within 30 days after the invoice date.

Payables include Trade Payables, Accrued Expenses and Other Payables.

(w) Leases

Finance Leases

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 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 and lease term. Assets under a finance lease are depreciated on a straight-line basis. Depreciation is calculated after first deducting any residual values which remain for each asset. 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. Significant Accounting Policies (Continued)

(w) Leases (Continued)

Motor Vehicle Leasing Arrangements

Changes were made to the whole-of-government motor vehicle leasing arrangements with SG Fleet. As a result all such leases were classified as operating leases rather than finance leases from 23 April 2015. The leased vehicles held as Property, Plant and Equipment under the previous finance lease arrangement with SG Fleet were derecognised and the associated loss on the derecognition of the motor vehicles under a finance lease reflected under Other Expenses (refer to Note 19: Other Expenses). The corresponding finance lease liability (current and non-current) was also derecognised and the associated gain from the derecognition of the liability reflected under Other Gains (refer to Note 11: Other Gains).

(x) Employee Benefits

Employee benefits include:

- short-term employee benefits such as wages and salaries, annual leave loading, and applicable on-costs, if expected to be settled wholly before twelve months after the end of the annual reporting period in which the employees render the related services;
- other long-term benefits such as long service leave and annual leave; and
- termination benefits.

On-costs include annual leave, long service leave, superannuation and other costs that are incurred when employees take annual and long service leave.

Wages and Salaries

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

Annual and Long Service Leave

Annual and long service leave including applicable on-costs that are not expected to be wholly settled before twelve months after the end of the reporting period, when the employees render the related service are measured at the present value of estimated future payments to be made in respect of services provided by employees up to the end of the reporting period. Consideration is given to the future wage and salary levels, experience of employee departures and periods of service. At the end of each reporting period, the present value of future annual leave and long service leave payments is estimated using market yields on Commonwealth Government bonds with terms to maturity that match, as closely as possible, the estimated future cash flows.

Annual leave liabilities have been estimated on the assumption that they will be wholly settled within three years. In 2015–16 the rate used to estimate the present value of future annual leave payments is 101.4% (101.0% in 2014–15).

In 2015–16, the rate used to estimate the present value of future payments for long service leave is 114.7% (104.2% in 2014–15). The use of a higher rate resulted in an increase of $11.7 million in the long service leave liability and the related expense.

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

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

Note 2. Significant Accounting Policies (Continued)

(x) Employee Benefits (Continued)

Annual leave and long service leave liabilities are classified as current liabilities in the Balance Sheet where there are no unconditional rights to defer the settlement of the liability for at least 12 months. Conditional long service leave liabilities are classified as non-current because the Directorate has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service.

(y) Superannuation

The Directorate receives funding for superannuation payments as part of the Government Payment for Outputs. The Directorate then makes payments on a fortnightly basis to the Territory Banking Account to cover the Directorate's superannuation liability for the Commonwealth Superannuation Scheme (CSS) and the Public Sector Superannuation Scheme (PSS). This payment covers the CSS/PSS employer contribution, but does not include the productivity component. The productivity component is paid directly to the Commonwealth Superannuation Corporation (CSC) 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.

The total Territory superannuation liability for the CSS, PSS, and CSC is recognised in the Chief Minister, Treasury and Economic Development Directorate's Superannuation Provision Account and the external schemes recognise the superannuation liability for the PSSAP and other schemes respectively. This superannuation liability is not recognised at individual agency level.

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

(z) Equity Contributed by the ACT Government

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

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

(aa) Insurance

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

(ab) Third Party Monies

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

Third party transactions are excluded from the Directorate's financial statements. Details of third party monies are shown at Note 42: Third Party Monies.

Note 2. Significant Accounting Policies (Continued)

(ac) Budgetary Reporting – Explanation of Major Variances between Actual Amounts and Original Budget Amounts

Explanations of major variances between the 2015–16 original budget and the 30 June 2016 actual results are discussed in Notes 43 (Controlled) and 57 (Territorial): Budgetary Reporting.

The definition of 'major variances' is provided in Note 2(ad): Significant Accounting Judgements and Estimates – Budgetary Reporting – Explanation of Major Variances between Actual Amounts and Original Budget Amounts.

(ad) Significant Accounting Judgements and Estimates

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

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

b. *Employee Benefits*: Significant judgements have been applied in estimating the liability for employee benefits. The estimated liability for annual and long service leave requires a consideration of the future wages and salary levels, experience of employee departures, probability that leave will be taken in service and periods of service. The estimate also includes an assessment of the probability that employees will meet the minimum service period required to qualify for long service leave and that oncosts will become payable.

   The significant judgements and assumptions included in the estimation of annual and long service leave liabilities include an assessment by an actuary. The Australian Government Actuary performed this assessment in May 2014. The assessment by an actuary is performed every 5 years. However it may be performed more frequently if there is a significant contextual change in the parameters underlying the 2014 report. The next actuarial review is expected to be undertaken by May 2019.

c. *Estimation of the Useful Lives of Property, Plant and Equipment (PPE)*: The Directorate has made a significant estimate in determining the useful lives of its PPE. The estimation of useful lives of PPE is based on the historical experience of similar assets and in some cases has been based on valuations provided by AON Risk Solutions. The useful lives are assessed on an annual basis and any adjustments are made when considered necessary.

   Disclosure concerning an asset's useful life can be found at Note 2(u) *Depreciation and Amortisation of Non-Current Assets*.

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. *Allowance for Impairment Losses:* The Directorate has made a significant estimate in the calculation of the allowance for impairment losses for receivables in the Directorate's Financial Statements. This significant estimate is based on a number of categorisations of receivables. These categorisations are considered by management to be appropriate and accurate, based upon the pattern demonstrated in collecting receivables in the past financial years. The categorisations are associated with accounts in bankruptcy, unpaid objections and past write-offs.

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

Note 2. Significant Accounting Policies (Continued)

(ad) Significant Accounting Judgements and Estimates (Continued)

g. *Budgetary Reporting* – Explanation of Major Variances between Actual Amounts and Original Budget Amounts: Significant judgements have been applied in determining what variances are considered as 'major variances' requiring explanations in Notes 43 (Controlled) and 57 (Territorial): Budgetary Reporting. Variances are considered to be major variances if both of the following criteria are met:

- The line item is a significant line item: the line item actual amount accounts for more than 10% of the relevant associated category (Income, Expenses and Equity totals) or sub-element (e.g. Current Liabilities and Receipts from Operating Activities totals) of the financial statements; and
- The variances (original budget to actual) are greater than plus (+) or minus (-) 10% of the budget for the financial statement line item.

Further information on this is provided in Note 2(ac): Budgetary Reporting.

(ae) Accounting Standards adopted early for the 2015–16 reporting period

AASB 2015-2 *Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 101* and AASB 2015-7 *Amendments to Australian Accounting Standards – Fair Value Disclosures of Not-For-Profit Public Sector Entities* have been early adopted for the 2015–16 reporting period, even though the standards are not required to be applied until annual reporting periods beginning on or after 1 July 2016.

AASB 2015-2 amends AASB 101 *Presentation of Financial Statements* including clarifying that agencies should not be disclosing immaterial information and that the presentation of information in notes can and should be tailored to provide users with the clearest view of an agency's financial performance and financial position.

AASB 2015-7 amends AASB 13 *Fair Value Measurement* to provide disclosure relief to not-for profit public sector agencies from certain disclosures about the fair value measurements of property, plant and equipment held for their current service potential rather than to generate net cash inflows. This includes relief from disclosures of quantitative information about the significant unobservable inputs used in fair value measurements and of the sensitivity of certain fair value measurements to changes in unobservable inputs.

(af) Impact of Accounting Standards Issued but yet to be Applied

The following new and revised accounting standards and interpretations have been issued by the Australian Accounting Standards Board but do not apply to the current reporting period. These standards and interpretations are applicable to future reporting periods. The Directorate does not intend to adopt these standards and interpretations early. Where applicable, these Australian Accounting Standards will be adopted from their application date.

> AASB 9 Financial Instruments (December 2014) (application date 1 January 2018);

This standard supersedes AASB 139 *Financial Instruments: Recognition and Measurement*. The main impact of AASB 9 is that it will change the classification, measurement and disclosures of the Directorate's financial assets. No material financial impact on the Directorate is expected.

> AASB 15 Revenue from Contracts with Customers (application date 1 January 2018);

AASB 15 is the new standard for revenue recognition. It establishes a comprehensive framework for determining whether, how much and when revenue is recognised. It replaces AASB 111 *Construction Contracts* and AASB 118 *Revenue*. The Directorate has assessed this standard and has identified that there could be potential impact on the timing of the recognition of revenue for user charges. This impact is not expected to be material.

Note 2. Significant Accounting Policies (Continued)

(af) Impact of Accounting Standards Issued but yet to be Applied (Continued)

> AASB 16 Leases (application date 1 January 2019)

AASB 16 is the new standard for leases. It introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset value is low. The Directorate has assessed this standard and has identified that there could be potential financial impact. The Directorate will make a more detailed assessment of the impact over the next 12 months.

> AASB 2015-6 Amendments to Australian Accounting Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities (application date 1 July 2016)

This standard extends the scope of AASB 124 Related Party Transactions to the not-for-profit sector and updates AASB 124 to include implementation guidance (including illustrative examples) to assist not-for-profit entities to apply the new requirements. While there is no material financial impact in implementing this standard there will be increased disclosure required by the Directorate.

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

Change in Accounting Policy and Accounting Estimates

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

Correction of Prior Period Errors

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

Note 4. Government Payment for Outputs

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

	2016 $'000	2015 $'000
Revenue from the ACT Government		
Government Payment for Outputs[a]	272,366	252,617
Total Government Payment for Outputs	**272,366**	**252,617**

a. The increase mainly relates to additional funds received for growth in acute services, including emergency and additional elective surgery, mental health, outpatient, community and primary care services and women and children's health.

Note 5. User Charges for Goods and Services

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.

	2016 $'000	2015 $'000
User Charges – ACT Government		
Local Hospital Network Funding[a]	810,999	760,262
Service Revenue*	1,922	1,522
Total User Charges – ACT Government	**812,921**	**761,784**
User Charges – Non-ACT Government		
Service Revenue*	11,711	11,232
Amounts Received for Highly Specialised Drugs[b]	34,241	16,102
Inpatient Fees	35,312	36,906
Facilities Fees	26,450	26,590
Non-inpatient Fees	1,291	1,056
Inventory Sales	12,001	12,285
Accommodation and Meals	3,774	3,653
Total User Charges – Non-ACT Government	**124,780**	**107,824**
Total User Charges	**937,701**	**869,608**

*Service Revenue ACT Government for 2014–15 has been increased by $1,190,264 with corresponding reduction to Service Revenue non-ACT Government to correct a misclassification in last year's financial statements.

a. The increase mainly relates to growth in acute services, including emergency and additional elective surgery, mental health, outpatient, community and primary care services and women and children's health.

b. The increase is mainly due to the inclusion of additional drugs under the Commonwealth High Cost Drug reimbursement scheme.

HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2016

Note 6. Interest

	2016 $'000	2015 $'000
Revenue from Non-ACT Government Entities		
Interest Revenue	77	70
Total Interest Revenue from Non-ACT Government Entities	**77**	**70**
Total Interest Revenue	**77**	**70**
Total interest revenue from financial assets not at fair value through profit and loss.	77	70

Note 7. Distribution from Investments with the Territory Banking Account

	2016 $'000	2015 $'000
Revenue from ACT Government Entities		
Distribution from Investments with the Territory Banking Account	64	97
Total Distribution from Investment with the Territory Banking Account	**64**	**97**

Note 8. Resources Received Free of Charge

	2016 $'000	2015 $'000
Revenue from ACT Government Entities		
Legal Services	1,591	1,359
Other Resources Received Free of Charge	152	112
Total Resources Received Free of Charge	**1,743**	**1,471**

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 items that are not part of the core activities of the Directorate.

	2016 $'000	2015 $'000
Revenue from Non-ACT Government Entities		
Grants	15,374	16,493
Other	3,679	3,267
Total Other Revenue from Non-ACT Government Entities	**19,053**	**19,760**
Total Other Revenue	**19,053**	**19,760**

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

	2016 $'000	2015 $'000
Contribution Analysis – Grants		
Contributions which have conditions of expenditure still required to be met:		
Contributions recognised as revenue during the current reporting period for which expenditure in manner specified had not occurred at balance date	784	3,479
Contributions recognised as revenue in previous reporting periods which were not expended in the current reporting period	12,785	7,653
Total Amount of Unexpended Contributions at Balance Date	**13,569**	**11,132**

Note 10. Gains on Investments

	2016 $'000	2015 $'000
Revenue from ACT Government Entities		
Unrealised Gains on Investments	-	12
Total Gains on Investments	**-**	**12**

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.

	2016 $'000	2015 $'000
Gains from the Sale of Assets	64	82
Assets Transferred from Other Entities	200	485
Donations[a]	1,417	1,032
Gain from De-recognition of Finance Lease Liability[b]	-	5,469
Total Other Gains	**1,681**	**7,068**

a. The increase mainly relates to higher donations received from Canberra Hospital Foundation for the purpose of purchasing equipment for the hospital.

b. The 2014–15 gain resulted from de-recognition of lease vehicles liabilities following a change to whole of government vehicle leasing arrangements, which took effect on 23 April 2015.

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

	2016 $'000	2015 $'000
Contribution Analysis – Donations		
Contributions which have conditions of expenditure still required to be met:		
Contributions recognised as revenue during the current reporting period for which expenditure in manner specified had not occurred at balance date	248	427
Contributions recognised as revenue in previous reporting periods which were not expended in the current reporting period	4,412	2,730
Total Amount of Unexpended Contributions at Balance Date	**4,660**	**3,157**

Note 12. Employee Expenses

	2016 $'000	2015 $'000
Wages and Salaries[a]	621,057	582,352
Annual Leave Expense[b]	17,374	16,523
Long Service Leave Expense[c]	26,148	14,054
Workers' Compensation Insurance Premium	19,438	20,457
Termination Expense	1,586	718
Other Employee Benefits and On-Costs	9,133	9,007
Total Employee Expenses	**694,736**	**643,111**

	No.	No.
Average full-time equivalent staff levels during the year were:	6,270	6,092

a. The increase in Wages and Salaries mainly relates to pay rises under collective agreements and increases in staff numbers related to growth in services in acute services including emergency department and additional elective surgery, mental health, outpatient, community and primary care services and women and children's health.

b. The increase is mainly due to the impact of collective agreement pay rises, an increase in staff numbers related to growth in services provided to patients and the growth in liability due to leave earned exceeding leave taken.

c. The increase in Long Service Leave is mainly due to an increase in the rate used to estimate the present value of Long Service Leave payments from 104.2% to 114.7% ($11.7 million).

Note 13. Superannuation Expenses

	2016 $'000	2015 $'000
Superannuation Contributions to the Territory Banking Account[a]	36,830	38,040
Productivity Benefit	4,699	4,976
Superannuation Payment to Commonwealth Superannuation Corporation (for the PSSAP)	3,560	3,460
Superannuation to External Providers[b]	40,482	34,567
Total Superannuation Expenses	**85,571**	**81,043**

a. The decrease is mainly due to most new employees being members of superannuation schemes managed by external providers as the defined benefits scheme is closed for new employees.

b. The increase is due to pay rises under collective agreements and an increase in staff numbers.

Note 14. Supplies and Services

	2016 $'000	2015 $'000
Audit Fees	660	454
Blood Products	8,621	8,856
Clinical Expenses/Medical Surgical Supplies*	62,005	61,543
Communications	3,743	3,617
Computer Expenses[a]	40,877	38,281
Contractors and Consultants[b]*	18,070	10,069
Domestic Services, Food and Utilities	33,943	33,509
General Administration[c]	20,132	18,194
Hire and Rental Charges	4,921	4,216
Insurance[d]	32,335	30,993
Minor Capital	3,501	4,054
Non-Contract Services	5,625	4,718
Operating Lease Rental Payments[e]	8,959	7,170
Pharmaceuticalsf	53,548	37,834
Printing and Stationery	2,381	2,529
Property and Rental Expenses	2,178	2,305
Public Relations	625	686
Publications	1,615	1,348
Repairs and Maintenance[g]	18,331	17,023
Staff Development and Recruitment	7,284	6,973
Travel and Accommodation	1,122	1,013
Vehicle Expenses[h]	696	1,207
Visiting Medical Officers[i]	29,187	27,279
Total Supplies and Services	**360,359**	**323,871**

*The contract cost for the Dialysis Centre ($3,554,808 in 2015–16, $2,491,645 in 2014–15) has been reclassified as Contractors and Consultants. This had the effect of increasing Contractors and Consultants and decreasing the Clinical Expenses/Medical Surgical Supplies.

a. The increase in computer expenses is due to a combination of factors, including inflation, increased Microsoft licensing cost, increase in staff numbers and additional support charges for new operation computer software projects such as Faster Access to ICT Systems, Intensive Care Unit Clinical System and Patient Master Index upgrade.

b. The increase in contractors and consultants is mainly due to costs associated with the implementation of the Directorate's new initiative to improve operational efficiency. Expensing of Information and Communication Technology contractor costs that were incorrectly accounted for as prepaid expenses in prior years has also contributed to this increase.

c. The increase in general administration is due to a combination of factors including inflation, increase in staff numbers and additional advertising costs for promoting health prevention and early intervention.

d. The increase in insurance expense is a result of inflation and an increase in excess payments.

e. The increase in operating lease rental payments is mainly due to the effect of new vehicle leasing arrangements.

f. The increase in pharmaceuticals is mainly due to higher demand for Hepatitis C medications as it became available on the Pharmaceutical Benefits Scheme from 1 March 2016.

g. The increase in repairs and maintenance is due to the need for repairs on ageing plant and equipment and inflation.

h. The reduction in vehicle expenses is due to the full-year effect of the change in motor vehicle lease type from finance leases to operating leases with these costs now reflected as operating lease rental payments, as well as lower fuel charges in 2015–16.

i. The increase in visiting medical officers is due to covering for staff specialist vacancies and an increase in elective surgeries.

Note 15. Depreciation and Amortisation

	2016 $'000	2015 $'000
Depreciation		
Buildings[a]	17,998	22,665
Plant and Equipment	10,434	10,643
Leasehold Improvements	1,580	3,088
Total Depreciation	**30,012**	**36,396**
Amortisation		
Intangible Assets[b]	12,956	10,190
Total Amortisation	**12,956**	**10,190**
Total Depreciation and Amortisation	**42,968**	**46,586**

a. The reduction is due to 2014–15 amount including accelerated depreciation for building 15 at the Canberra Hospital which has been demolished.

b. The increase is a result of finalised computer software projects which became new assets in 2015–16. These computer software packages relate to systems used in the operations of the Directorate and include Clinical Portal Suites, Patient Master Index, Radiology Information System Upgrade, Queue Flow Management Solution, Intensive Care Unit Metavision, new Cardiology Systems, Order Entry, Positive Patient Identification System and GP Healthnet.

Note 16. Grants and Purchased Services

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

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

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

Purchased Services from Calvary Hospital is for the provision of healthcare in the ACT.

Cross-Border Health Costs relates to costs incurred by ACT residents in interstate hospitals.

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

	2016 $'000	2015 $'000
Grants		
Grants[a]	3,139	2,161
Total Grants	**3,139**	**2,161**
Purchased Services		
Calvary Hospital[b]	8,214	4,086
Non-Government Organisations[c]	67,068	64,387
Cross-Border Health Costs	28	24
Other[d]	11,374	7,685
Total Purchased Services	**86,684**	**76,182**
Total Grants and Purchased Services	**89,823**	**78,343**

a. The increase is the result of changed funding model, from single-year projects to multi-year projects which had the effect of lower funding grants in 2014–15.

b. The increase relates to growth and funding for new beds and the Hospital in the Home Initiative.

c. The increase relates to inflation and new service initiatives such as specialised drug treatment services, community mental health services, expansion of community and home based services, end of life care at home and expanded community-based women and children's options.

d. The increase relates mainly to an increase in elective surgery services.

Note 17. Borrowing Costs

Borrowing costs are finance charges in respect of finance leases for the Directorate's fleet of vehicles and clinical equipment. Due to a change in the Whole-of-Government vehicle leasing arrangements with SG Fleet, from 23 April 2015 all such leases for the Directorate will be classified as operating leases (whose costs appear in supplies and services) rather than finance leases. There will be no borrowing costs in respect of the Directorate's fleet of vehicles in the next financial year.

	2016 $'000	2015 $'000
Finance Charges[a]	-	262
Finance Cost on Make Good	44	43
Total Borrowing Costs	**44**	**305**

a. The Directorate no longer has finance leases, due to changes in the Whole-of-Government leasing arrangements with SG Fleet.

Note 18. Cost of Goods Sold

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

	2016 $'000	2015 $'000
Cost of Goods Sold	9,000	9,295
Total Cost of Goods Sold	**9,000**	**9,295**

Note 19. Other Expenses

	2016 $'000	2015 $'000
Miscellaneous Expenses[a]	7,828	3,302
Legal Settlements	2,105	1,935
Waivers, Impairment Losses and Write-offs (see Note 20)	2,562	2,244
Loss on Sale of Assets	25	12
Loss on Derecognition of Motor Vehicles Under a Finance Lease[b]	-	5,286
Total Other Expenses	**12,520**	**12,779**

a. The increase mainly relates to expensing of some prior year operating expenses incorrectly capitalised and computer software projects that were discontinued in 2015–16, which include electronic referrals to outpatient services and real time bed management.

b. The reduction is due to recognising a loss on de-recognition of motor vehicles under a finance lease as a result of a change to motor vehicle leasing arrangements, which took effect from 23 April 2015. All leased motor vehicles are now under operating leases.

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. 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.	2016 $'000	No.	2015 $'000
Waivers				
Total Waivers	**-**	**-**	**-**	**-**
Impairment Losses				
Impairment Loss from Receivables				
Trade Receivables[a]	1,104	1,477	194	431
Total Impairment Loss from Receivables	**1,104**	**1,477**	**194**	**431**
Impairment Loss from Property, Plant and Equipment				
Plant and Equipment	42	247	19	217
Total Impairment Losses from Property, Plant and Equipment	**42**	**247**	**19**	**217**
Total Impairment Losses	**1,146**	**1,724**	**213**	**648**
Write-Offs				
Irrecoverable Debts[b]	3,412	838	2,742	1,596
Total Write-Offs	**3,412**	**838**	**2,742**	**1,596**
Total Waivers, Impairment Losses and Write-Offs	**4,558**	**2,562**	**2,955**	**2,244**

a. This increase is largely attributable to an increase in Medicare ineligible patient debts being provided for as doubtful.

b. The reduction mainly relates to high number of low value write-offs in 2016.

Note 21. Act of Grace Payments

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

The Directorate made no Act of Grace Payments during the current and prior reporting periods.

Note 22. Auditor's Remuneration

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

	2016 $'000	2015 $'000
Audit Services		
Audit Fees Paid or Payable to the ACT Audit Office	232	223
Total Audit Services	**232**	**223**

No other services were provided by the ACT Audit Office.

Note 23. Cash and Cash Equivalents

The Directorate holds a number of bank accounts, as part of the whole-of-government banking arrangements, with Westpac Banking Corporation and previously with the Commonwealth Bank. The Directorate received interest at the rate of 2.81% (3.10% in 2014–15). These funds may be withdrawn upon request.

	2016 $'000	2015 $'000
Cash on Hand	43	44
Cash at Bank	106,532	105,025
Total Cash and Cash Equivalents	**106,575**	**105,069**

Note 24. Receivables

	2016 $'000	2015 $'000
Current Receivables		
Trade Receivables	1,835	1,103
Trade Receivables – Patient Fees[a]	12,607	8,359
	14,442	**9,462**
Less: Allowance for Impairment Losses[b]	(4,141)	(2,781)
	10,301	**6,681**
Other Trade Receivables[c]	15,950	11,311
Less: Allowance for Impairment Losses	(567)	(450)
	15,383	**10,861**
Accured Revenue[d]	9,674	6,068
Sub-Total Current Receivables	**35,358**	**23,610**
Net GST Receivable	3,403	3,622
Total Receivables	**38,761**	**27,232**

a. The increase mainly relates to higher medicare ineligible patient debts which takes longer to collect. Private patient debt is also higher due to some patient accounts having to be resubmitted to Medical Insurance Funds for payment as problems were encountered with implementation of a new billing system.

b. The increase mainly relates to additional impairment allowance provided for overdue medicare ineligible patients and private patients.

c. The increase mainly relates to timing of amounts receivable from the Local Hospital Network Directorate for providing health services.

d. The increase mainly relates to an increase in revenue for chargeable patient fees due to higher patient numbers and an increase in amounts receivable from the Commonwealth for high costs drugs reimbursement.

Note 24. Receivables (Continued)

Ageing of Receivables	Not Overdue $'000	Overdue Less than 30 days $'000	Overdue 30 to 60 days $'000	Overdue Greater than 60 days $'000	Total $'000
2016					
Not Impaired					
Receivables[a]	27,887	2,915	598	7,361	38,761
Impaired					
Receivables	-	-	-	4,708	4,708
2015					
Not Impaired					
Receivables	21,050	1,811	782	3,589	27,232
Impaired					
Receivables	-	-	-	3,232	3,232

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

a. 'Not Overdue' component of Receivables largely consist of Goods and Services Input Tax receivable from the Australian Taxation Office and private patient fees accrued in June. 'Overdue – Greater than 60 Days' are mostly third party, workers' compensation or public liability transactions which have become the subject of legal claims as to responsibility for the payment. Substantial delays can therefore occur before liability for such debts is determined. This overdue amount also includes amounts receivable from Calvary Health Care for medical officers seconded from the Directorate.

	2016 $'000	2015 $'000
Reconciliation of the Allowance for Impairment Losses		
Allowance for Impairment Losses at the Beginning of the Reporting Period	3,231	2,800
Additional Allowance and Impairment Losses Recognised	1,477	431
Allowance for Impairment Losses at the End of the Reporting Period	**4,708**	**3,231**
Classification of ACT Government/Non-ACT Government Receivables		
Receivables from ACT Government Entities		
Net Trade Receivables	69	61
Net Other Trade Receivables	236	98
Net Goods and Services Tax Receivable	-	50
Total Receivables from ACT Government Entities	**305**	**209**
Receivables from Non-ACT Government Entities		
Net Trade Receivables	9,665	6,170
Net Other Trade Receivables	15,714	11,213
Net Goods and Services Tax Receivable	3,403	3,572
Accrued Revenue	9,674	6,068
Total Receivables from Non-ACT Government Entities	**38,456**	**27,023**
Total Receivables	**38,761**	**27,232**

Note 25. Inventories

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

	2016 $'000	2015 $'000
Current Inventory		
Purchased Items – Cost[a]	10,106	8,655
Total Current Inventory	**10,106**	**8,655**
Total Inventory	**10,106**	**8,655**

a. The increase mainly relates to higher drug purchases due to increased demand for 'high costs drugs'.

Note 26. Investments

Short-term investments were held with the Territory Banking Account in the Cash Enhanced Portfolio throughout the year. These funds are able to be withdrawn upon request.

The purpose of the investment in the Fixed Interest Portfolio is to hold it for a period of longer than 12 months. The total carrying amount of the Fixed Interest Portfolio investment has been measured at fair value.

	2016 $'000	2015 $'000
Non-Current Investments		
Investments with the Territory Banking Account – Cash Enhanced Portfolio at Fair Value	3,019	3,027
Total Non-Current Investments	**3,019**	**3,027**
Total Investments	**3,019**	**3,027**

Note 27. 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 multi storey car parks.

> 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.

	2016 $'000	2015 $'000
Land and Buildings		
Land at Fair Value	41,605	40,645
Total Land Assets	**41,605**	**40,645**
Buildings at Fair Value	894,516	815,234
Less: Accumulated Depreciation	(34,413)	(16,416)
Total Written Down Value of Buildings	**860,103**	**798,818**
Total Land and Written Down Value of Buildings	**901,708**	**839,463**
Leasehold Improvements		
Leasehold Improvements at Fair Value	6,786	6,527
Less: Accumulated Depreciation	(4,669)	(3,088)
Total Written Down Value of Leasehold Improvements	**2,117**	**3,439**
Plant and Equipment		
Plant and Equipment at Cost	116,172	110,130
Less: Accumulated Depreciation	(74,994)	(66,464)
Less: Accumulated Impairment Losses	(247)	(439)
Total Written Down Value of Plant and Equipment	**40,931**	**43,227**
Total Written Down Value of Property, Plant and Equipment	**944,756**	**886,129**

Note 27. Property, Plant and Equipment (Continued)

Reconciliation of Property, Plant and Equipment

The following table shows the movement of Property, Plant and Equipment during 2015–16.

	Land $'000	Buildings $'000	Leasehold Improvements $'000	Plant and Equipment $'000	Total $'000
Carrying Amount at 1 July 2015	**40,645**	**798,818**	**3,439**	**43,227**	**886,129**
Additions	200	78,461	259	8,243	87,163
Revaluation Increment	760	844	-	-	1,604
Disposals	-	(22)	-	(2,201)	(2,223)
Depreciation	-	(17,998)	(1,580)	(10,434)	(30,012)
Depreciation Write Back for Asset Disposals	-	1	-	1,904	1,905
Impairment Losses Recognised in the Operating (Deficit)	-	-	-	(247)	(247)
Reversal of Impairment Losses Recognised in the Operating (Deficit)	-	-	-	439	439
Carrying Amount at 30 June 2016	**41,605**	**860,103**	**2,117**	**40,931**	**944,756**

The following table shows the movement of Property, Plant and Equipment during 2014–15.

	Land $'000	Buildings $'000	Leasehold Improvements $'000	Plant and Equipment $'000	Total $'000
Carrying Amount at 1 July 2014	**40,250**	**771,290**	**4,811**	**42,749**	**859,100**
Additions	485	50,193	1,716	17,172	69,566
Revaluation (Decrement)	(90)	-	-	-	(90)
Disposals	-	-	-	(6,999)	(6,999)
Depreciation	-	(22,665)	(3,088)	(10,643)	(36,396)
Depreciation Write Back for Asset Disposals	-	-	-	6,143	6,143
Impairment Losses Recognised in the Operating (Deficit)	-	-	-	(217)	(217)
Reversal of Impairment Losses Recognised in the Operating (Deficit)	-	-	-	308	308
Other				(5,286)	(5,286)
Carrying Amount at 30 June 2015	**40,645**	**798,818**	**3,439**	**43,227**	**886,129**

Valuation of Non-Current Assets

The next valuation will be undertaken during 2016–17.

Fair Value Hierarchy

The Directorate is required to classify property, plant and equipment into a Fair Value Hierarchy that reflects the significance of the inputs used in determining their fair value. The Fair Value Hierarchy is made up of the following three levels:

> Level 1 – quoted prices (unadjusted) in active markets for identical assets or liabilities that the Directorate can access at the measurement date;

> Level 2 – inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly; and

> Level 3 – inputs that are unobservable for particular assets or liabilities.

Note 27. Property, Plant and Equipment (Continued)

Details of the Directorate's property, plant and equipment at fair value and information about the Fair Value Hierarchy at 30 June 2016 are as follows:

Classification According to Fair Value Hierarchy at 30 June 2016				
	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Property, Plant and Equipment at Fair Value				
Land	-	-	41,605	41,605
Buildings	-	2,758	857,345	860,103
Leasehold Improvements	-	-	2,117	2,117
	-	**2,758**	**901,067**	**903,825**

Details of the Directorate's property, plant and equipment at fair value and information about the Fair Value Hierarchy at 30 June 2015 is as follows:

Classification According to Fair Value Hierarchy at 30 June 2015				
	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Property, Plant and Equipment at Fair Value				
Land	-	-	40,645	40,645
Buildings	-	2,845	795,973	798,818
Leasehold Improvements	-	-	3,439	3,439
	-	**2,845**	**840,057**	**842,902**

Transfers between Categories

There have been no transfers between Levels 1, 2 and 3 during the current and previous reporting period.

Valuation Techniques, Inputs and Processes

Level 2 Valuation Techniques and Inputs

Valuation Technique: The valuation technique used to value land and buildings is the market approach that reflects recent transaction prices for similar properties and buildings (comparable in location and size).

Inputs: Prices and other relevant information generated by market transactions involving comparable land and buildings were considered. Regard was taken of the Crown Lease terms and tenure, the Australian Capital Territory Plan and the National Capital Plan, where applicable, as well as current zoning.

Level 3 Valuation Techniques and Inputs

Valuation Technique: Land where there is no active market or significant restrictions is valued through the market approach which values a selection of land with similar approximate utility.

Inputs: In determining the value of land with similar approximate utility, significant adjustments to market based data were required.

Valuation Technique: Buildings and Leasehold Improvements were considered specialised assets by the Valuers and measured using the cost approach that reflects the cost to a market participant to construct assets of comparable utility adjusted for obsolescence. For Buildings historical cost per square metre of floor area was also used in measuring fair value.

Inputs: In determining the value of land with similar approximate utility, significant adjustment to market based data was required.

Inputs: In determining the value of buildings and leasehold improvements regard was given to the age and condition of the assets, their estimated replacement cost and current use. This required the use of data internal to the Directorate.

There has been no change to the above valuation techniques during the reporting period.

Transfers in and out of a fair value level are recognised on the date of the event or change in circumstances that caused the transfer.

Note 27. Property, Plant and Equipment (Continued)

Fair Value Measurements using Significant Unobservable Inputs (Level 3)			
At 30 June 2016	Land $'000	Buildings $'000	Leasehold Improvements $'000
Fair Value at the Beginning of the Reporting Period	**40,645**	**798,818**	**3,439**
Additions	200	78,461	259
Revaluation Increments Recorded in Other Comprehensive Income	760	844	-
Depreciation	-	(17,998)	(1,580)
Other Movements	-	(22)	-
Fair Value at the End of the Reporting	**41,605**	**860,103**	**2,117**

At 30 June 2015	Land $'000	Buildings $'000	Leasehold Improvements $'000
Fair Value at the Beginning of the Reporting Period	**40,250**	**771,290**	**4,811**
Additions	485	50,193	1,716
Revaluation Increments Recorded in Other Comprehensive Income	(90)	-	-
Depreciation	-	(22,665)	(3,088)
Fair Value at the End of the Reporting	**40,645**	**798,818**	**3,439**

Information about Significant Unobservable Inputs (Level 3) in Fair Value Measurements			
	Fair Value at 30 June		
Item	2016 $000	2015 $000	Significant Unobservable Inputs
Valuation Technique: Market Approach			
Land	41,605	40,645	Selection of land with similar approximate utility and permissible usage
Valuation Technique: Depreciated Replacement Cost			
Buildings	860,103	798,818	Consumed physical, functional and economic obsolescence
Leasehold Improvements	2,117	3,439	Consumed physical, functional and economic obsolescence

Note 28. Intangible Assets

The Directorate has only internally generated software.

	2016 $'000	2015 $'000
Computer Software		
Internally Generated Software		
Computer Software at Cost[a]	83,348	65,797
Less: Accumulated Amortisation[b]	(55,200)	(43,214)
Total Internally Generated Software	**28,148**	**22,583**
Total Computer Software	**28,148**	**22,583**
Total Intangible Assets	**28,148**	**22,583**

a. The increase is due to completed internally generated operational software projects including Clinical Portal Suites, Patient Master Index, Radiology Information System Upgrade, Queue Flow Management Solution, Intensive Care Unit Metavision, new Cardiology Systems, Order Entry, Positive Patient Identification System and GP Healthnet.

b. The increase directly relates to amortisation of the new software applications listed above.

Reconciliation of Intangible Assets

The following table shows the movement of internally generated Intangible Assets during 2015–16. There was no externally purchased software during this reporting period.

	Internally Generated Software $'000	Total $'000
Carrying Amount at 1 July 2015	**22,583**	**22,583**
Additions	18,520	18,520
Amortisation	(12,955)	(12,955)
Carrying Amount at 30 June 2016	**28,148**	**28,148**

Reconciliation of Intangible Assets

The following table shows the movement of internally generated Intangible Assets during 2014–15. There was no externally purchased software during this reporting period.

	Internally Generated Software $'000	Total $'000
Carrying Amount at 1 July 2014	**6,933**	**6,933**
Additions	25,840	25,840
Amortisation	(10,190)	(10,190)
Carrying Amount at 30 June 2015	**22,583**	**22,583**

Note 29. 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 or development in 2015–16, include hospital buildings, software and plant and equipment.

	2016 $'000	2015 $'000
Building Works in Progress[a]	129,508	82,785
Plant and Equipment Works in Progress	-	227
Computer Software Works in Progress[b]	38,667	48,744
Total Capital Works in Progress	**168,175**	**131,756**

a. The increase in building works in progress is a result of ongoing capital projects. These include the Secure Mental Health Unit, the University of Canberra Public Hospital, the Ngunnawal Bush Healing Farm, various works throughout the Canberra Hospital campus and other capital upgrade projects.

b. The decrease in computer software works in progress is due to the completion of several operational computer software projects including Clinical Portal Suites, Patient Master Index, Radiology Information System Upgrade, Queue Flow Management Solution, Intensive Care Unit Metavision, new Cardiology Systems, Order Entry, Positive Patient Identification System and GP Healthnet.

Note 29. Capital Works in Progress (Continued)

Reconciliation of Capital Works in Progress

The following table shows the movement of Capital Works in Progress during 2015–16.

	Buildings Works in Progress $'000	Plant and Equipment Works in Progress $'000	Computer Software Works in Progress $'000	Total $'000
Carrying Amount at 1 July 2015	**82,785**	**227**	**48,744**	**131,756**
Additions	128,816	-	15,434	144,250
Capital Works in Progress Completed and Transferred to Property, Plant and Equipment and Intangible Assets	(81,477)	(222)	(19,021)	(100,720)
Capital Works Expensed	(616)	(5)	(6,490)	(7,111)
Carrying Amount at 30 June 2016	**129,508**	**-**	**38,667**	**168,175**

Reconciliation of Capital Works in Progress

The following table shows the movement of Capital Works in Progress during 2014–15.

	Buildings Works in Progress $'000	Plant and Equipment Works in Progress $'000	Computer Software Works in Progress $'000	Total $'000
Carrying Amount at 1 July 2014	**79,626**	**2,186**	**65,971**	**147,783**
Additions	55,434	8,163	8,613	72,210
Capital Works in Progress Completed and Transferred to Property, Plant and Equipment and Intangible Assets	(51,909)	(8,322)	(25,840)	(86,071)
Capital Works Expensed	(366)	(1,800)	-	(2,166)
Carrying Amount at 30 June 2015	**82,785**	**227**	**48,744**	**131,756**

Note 30. Other Assets

	2016 $'000	2015 $'000
Current Other Assets		
Prepayments	4,004	3,939
Total Current Other Assets	**4,004**	**3,939**
Total Other Assets	**4,004**	**3,939**

Note 31. Payables

	2016 $'000	2015 $'000
Current Payables		
Trade Payables[a]	23,229	3,633
Other Payables	-	24
Accrued Expenses[b]	68,425	50,612
Total Payables	**91,654**	**54,269**

a. The reason for the increase is an increase in the accrued capital works expenses ($23.0 million).

b. The increase is mainly due to payment for Calvary Hospital for additional services ($8.0 million) and an increase in general accruals for other operating expenses including visiting medical officers costs ($1.2 million), pharmaceuticals costs ($2.2 million), medical and surgical supplies ($0.8 million) and ICT costs ($3.9 million).

	2016 $'000	2015 $'000
Payables are aged as followed		
Not Overdue	91,627	53,016
Overdue for Less than 30 Days	27	1,165
Overdue for 30 to 60 Days	-	10
Overdue for More than 60 Days	-	78
Total Payables	**91,654**	**54,269**

Classification of ACT Government/Non-ACT Government Payables		
Payables with ACT Government Entities		
Other Payables	-	-
Accrued Expenses	4,938	3,607
Total Payables with ACT Government Entities	**4,938**	**3,607**
Payables with Non-ACT Government Entities		
Trade Payables	97	3,633
Other Payables	-	24
Accrued Expenses	86,619	47,005
Total Payables with Non-ACT Government Entities	**86,716**	**50,662**
Total Payables	**91,654**	**54,269**

Note 32. Borrowings

The Directorate received an interest-free loan from Environment and Planning Directorate payable over 10 years. The loan is for implementing energy and resource efficiency projects to reduce greenhouse gas emissions.

	2016 $'000	2015 $'000
Current Borrowings		
ACT Government Borrowings	352	-
Total Current Borrowings	**352**	**-**
Non-Current Borrowings		
ACT Government Borrowings	2,919	-
Total Non-Current Borrowings	**2,919**	**-**
Total Borrowings	**3,271**	**-**

Note 33. Other Provisions

Provision for Make Good

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

	2016 $'000	2015 $'000
Non-Current Other Provisions		
Provision for Make Good at the Beginning of the Reporting Period	1,418	1,375
Increase in Provision due to Unwinding of Discount	44	43
Total Other Provisions	**1,462**	**1,418**

Note 34. Employee Benefits

	2016 $'000	2015 $'000
Current Employee Benefits		
Annual Leave[a]	104,363	97,797
Long Service Leave[b]	116,236	97,218
Accrued Salaries[c]	3,436	34,281
Other Benefits	38	210
Total Current Employee Benefits	**224,073**	**229,506**
Non-Current Employee Benefits		
Long Service Leave[b]	16,966	14,529
Total Non-Current Employee Benefits	**16,966**	**14,529**
Total Employee Benefits	**241,039**	**244,035**

At 30 June 2016, the Directorate employed 6,270 full time equivalent (FTE) staff. There were 6,092 FTE staff at 30 June 2015. The increase in staff numbers is for growth in services in acute services including emergency department and additional elective surgery, mental health, outpatient, community and primary care services and women and children's health.

a. The increase is mainly due to the impact of collective agreement pay rises, an increase in staff numbers for growth in services in acute services including emergency department and additional elective surgery, mental health, outpatient, community and primary care services and women and children's health and an increase in liability as leave accumulated exceeded the leave taken in 2015–16.

b. The increase is mainly due to an increase in the rate used to estimate the present value of future long service leave payments from 104.2% to 114.7% ($11.7 million), collective agreement pay rises ($3.2 million), an increase in staff numbers and growth in liability due to the leave accumulated exceeding leave taken ($6.5 million) in 2015–16.

c. 2014–15 included 9 days accrued salaries compared to one day accrual in 2015–16. 2014–15 also included pay rises accrued for Medical staff whose collective agreements were finalised in 2015–16.

Estimate of when Leave is Payable	2016 $'000	2015 $'000
Estimated Amount Payable within 12 months		
Annual Leave	59,527	54,021
Long Service Leave	8,685	7,312
Accrued Salaries	3,436	34,281
Other Benefits	38	210
Total Employee Benefits Payable within 12 months	**71,687**	**95,824**
Estimated Amount Payable after 12 months		
Annual Leave	44,836	43,776
Long Service Leave	124,516	104,435
Total Employee Benefits Payable after 12 months	**169,352**	**148,211**
Total Employee Benefits	**241,039**	**244,035**

Note 35. Other Liabilities

	2016 $'000	2015 $'000
Current Other Liabilities		
Revenue Received in Advance	252	370
Total Current Other Liabilities	**252**	**370**
Total Other Liabilities	**252**	**370**

Note 36. Equity

Asset Revaluation Surplus

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

	2016 $'000	2015 $'000
Balance at the Beginning of the Reporting Period	**129,428**	**129,518**
Increment/(Decrement) in Land due to Revaluation	760	(90)
Increment in Buildings due to Revaluation	844	-
Total Increase/(Decrease) in the Asset Revaluation Surplus	**1,604**	**(90)**
Balance at the End of the Reporting Period	**131,032**	**129,428**

Note 37. 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: 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, therefore the Directorate is not exposed to movements in interest payable. The Directorate is, however, exposed to movements in interest rates on amounts held in Cash at Bank.

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

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

Credit Risk

Credit risk is the risk that one party to a financial instrument will fail to discharge an obligation and cause the other party to incur a financial loss. The Directorate's credit risk is limited to the amount of the financial assets it holds net of any allowance for impairment. The Directorate expects to collect all financial assets that are not past due or impaired.

Credit risk is managed by the Directorate for cash at bank by holding bank balances with the ACT Government's banker, Westpac Banking Corporation (Westpac). Westpac holds a AA-issuer credit rating with Standard and Poors. An AA-credit rating is defined as 'very strong capacity to meet financial commitments'.

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

The Directorate's receivables are predominantly from ACT Government, Commonwealth Government and insurance companies for compensable patients. As the Commonwealth Government has a AAA credit rating. It is considered that there is a very low risk of default for those receivables.

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

Liquidity Risk

Liquidity risk is the risk that the Directorate will encounter difficulties in meeting obligations associated with financial liabilities that are settled by delivering cash or other financial assets. The Directorate's financial obligations relate to the payment of grants and the purchase of supplies and services. Grants are paid on a quarterly basis and purchases of supplies and services are paid within 30 days of receiving the goods or services.

The main source of cash to pay these obligations is user charges revenue from the ACT Local Health Network Directorate and appropriation from the ACT Government which is paid on a fortnightly basis during the reporting period. 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 reporting periods and the current assessment of risk.

Note 37. Financial Instruments (Continued)

Price Risk

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

The Directorate's exposure to price risk and the management of this risk has not changed since the 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:

	Note No.	Carrying Amount 2016 $'000	Fair Value Amount 2016 $'000	Carrying Amount 2015 $'000	Fair Value Amount 2015 $'000
Financial Assets					
Cash and Cash Equivalents	23	106,575	106,575	105,069	105,069
Receivables	24	35,357	35,357	23,610	23,610
Investment with the Territory Banking Account	26	3,019	3,019	3,027	3,027
Total Financial Assets		**144,951**	**144,951**	**131,706**	**131,706**
Financial Liabilities					
Payables	31	91,654	91,654	54,269	54,269
ACT Government Borrowings	32	3,271	3,271	-	-
Total Financial Liabilities		**94,925**	**94,925**	**54,269**	**54,269**

Note 37. Financial Instruments (Continued)

Fair Value Hierarchy

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

	Classification According to the Fair Value Hierarchy			
2016	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Financial Assets				
Investment with the Territory Banking Account – Cash Enhanced Fund	-	3,019	-	3,019
Total Financial Assets	**-**	**3,019**	**-**	**3,019**

	Classification According to the Fair Value Hierarchy			
2015	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Financial Assets				
Investment with the Territory Banking Account – Cash Enhanced Fund	-	3,027	-	3,027
Total Financial Assets	**-**	**3,027**	**-**	**3,027**

Transfer Between Categories

There have been no transfers of financial assets or liabilities between Level 1 and Level 2 during the current and previous reporting periods.

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 at 30 June 2016. Except for non-current payables, financial assets and liabilities which have a floating interest rate or are non-interest bearing will mature in 1 year or less. All amounts appearing in the following maturity analysis are shown on an undiscounted cash flow basis.

				Fixed Interest Maturing In:				
	Note No.	Weighted Average Interest Rate	Floating Interest $'000	1 Year or Less $'000	Over 1 Year to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	23	-	-	-	-	-	106,575	106,575
Receivables	24	-	-	-	-	-	35,358	35,358
Investments with the Territory Banking Account	26	2.51%	3,019	-	-	-	-	3,019
Total Financial Assets		**-**	**3,019**	**-**	**-**	**-**	**141,933**	**144,952**
Financial Liabilities								
Payables	31	-	-	-	-	-	91,654	91,654
Borrowings	32	-	-	-	-	-	3,271	3,271
Total Financial Liabilities		**-**	**-**	**-**	**-**	**-**	**94,925**	**94,925**
Net Financial Assets		**-**	**3,019**	**-**	**-**	**-**	**47,008**	**50,027**

Note 37. 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 the weighted average interest rates by maturity period at 30 June 2016. Except for non-current payables, financial assets and liabilities which have a floating interest rate or are non-interest bearing will mature in 1 year or less. All amounts appearing in the following maturity analysis are shown on an undiscounted cash flow basis.

				Fixed Interest Maturing In:				
	Note No.	Weighted Average Interest Rate	Floating Interest $'000	1 Year or Less $'000	Over 1 Year to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	23	-	-	-	-	-	105,069	105,069
Receivables	24	-	-	-	-	-	23,610	23,610
Investments with the Territory Banking Account	26	3.10%	3,027	-	-	-	-	3,027
Total Financial Assets		**-**	**3,027**	**-**	**-**	**-**	**128,679**	**131,706**
Financial Liabilities								
Payables	31	-	-	-	-	-	54,269	54,269
Total Financial Liabilities		**-**	**-**	**-**	**-**	**-**	**54,269**	**54,269**
Net Financial Assets		**-**	**3,027**	**-**	**-**	**-**	**74,410**	**77,437**

Carrying Amount of Each Category of Financial Asset and Financial Liability	2016 $'000	2015 $'000
Financial Assets		
Loans and Receivables Measured at Amortised Cost	35,357	23,610
Financial Assets at Fair Value through the Profit and Loss Designated upon Initial Recognition	3,019	3,027
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	94,925	54,269

Gains/(Losses) on Each Category of Financial Asset and Financial Liability		
Gains/(Losses) on Financial Assets		
Financial Assets at Fair Value through the Profit and Loss Designated upon Initial Recognition	(8)	97

Note 38. Commitments

Capital Commitments

Capital commitments, contracted at reporting date, include the construction of new buildings such as the Secure Mental Health Unit, University of Canberra Public Hospital and Ngunnawal Bush Healing Farm, as well as infrastructure works across the Canberra Hospital campus, computer software development and upgrades to existing ACT Health assets. These have not been recognised as liabilities.

	2016 $'000	2015 $'000
Capital Commitments – Property, Plant and Equipment		
Payable:		
Within one year[a]	200,091	179,753
Later than one year but not later than five years[a]	110,815	61,455
Total Capital Commitments – Property, Plant and Equipment	**310,906**	**241,208**
Total Capital Commitments	**310,906**	**241,208**

a. The increase is due to capital works that will be continuing for 2016–17 through to 2018–19 including the construction of new buildings such as the Secure Mental Health Unit, University of Canberra Public Hospital and Ngunnawal Bush Healing Farm and various other asset upgrades and infrastructure works across the Directorate.

Operating Lease Commitments

The Directorate has several non-cancellable operating leases for buildings and computer assets.

	2016 $'000	2015 $'000
Non-cancellable operating commitments are committed as follows:		
Within one year[a]	8,147	6,940
Later than one year but not later than five years[a]	26,459	22,779
Later than five years	512	249
Total Operating Lease Commitments	**35,118**	**29,968**

a. The increase in operating commitments is due to inflation and an increase in the number of computer assets leased.

Other Commitments

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

	2016 $'000	2015 $'000
Non-cancellable other commitments are as follows:		
Within one year	43,762	49,993
Later than one year but not later than five years[b]	83,591	110
Total Other Commitments	**127,353**	**50,103**

b. The increase in other commitments is due to the renewal of contracts with non-government organisations in the areas of Aboriginal health, primary health, sexual health, women and children's health, multicultural health, and drug and alcohol for work commencing from July 2016 for a three year period.

Note 38. Commitments (Continued)

Operating Lease Commitments – Motor Vehicles

Due to a change in the Whole-of-Government car leasing arrangements with SG Fleet on 23 April 2015, all such leases for the Directorate are now classified as operating leases rather than finance leases.

	2016 $'000	2015 $'000
Non-cancellable other commitments are payable as follows:		
Within one year[c]	1,842	2,471
Later than one year but not later than five years	1,115	2,200
Total Operating Lease Commitments – Motor Vehicle	**2,957**	**4,671**

c. The reduction in motor vehicle commitments is due to a combination of factors, current year commitments is for less number of years than in 2014–15 and the Directorate has less vehicles than in previous year.

Note 39. Contingent Liabilities and Contingent Assets

Contingent Liabilities

The Directorate is subject to 143 legal actions (2015 – 137 actions). The Directorate's maximum exposure under the ACT Insurance Authority insurance policy is estimated at $5,840,705 at 30 June 2016 (30 June 2015 – $6,150,000), which has not been provided for in the accounts.

There were no contingent assets at 30 June 2016.

Note 40. 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

	2016 $'000	2015 $'000
Cash and Cash Equivalents Disclosed in the Balance Sheet	106,575	105,069
Cash and Cash Equivalents at the End of the Reporting Period as Recorded in the Cash Flow Statement	**106,575**	**105,069**

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

	2016 $'000	2015 $'000
Operating (Deficit)	(62,336)	(44,630)
Add/(Less) Non-Cash Items		
Depreciation of Property, Plant and Equipment	30,012	36,396
Amortisation of Intangibles	12,956	10,190
Bad and Doubtful Debts	2,315	2,026
Asset Book Value Written Down	6,762	837
Impairment Loss of Non-Current Assets	247	217
Assets transferred from Other ACT Government Entities	(200)	(485)
Net Gain on Disposal of Non-Current Assets	(64)	-
Unrealised Gain on Investments	-	(12)
Gain from Derecognition of Finance Lease Liability	-	(5,469)
Loss on Derecognition of Motor Vehicles under a Finance Lease	-	5,286
Cash Before Changes in Operating Assets and Liabilities	**(10,308)**	**4,356**
Changes in Operating Assets and Liabilities		
(Increase) in Receivables	(11,529)	(3,774)
(Increase) in Inventories	(1,451)	(849)
(Increase) in Other Assets	(65)	(548)
Increase in Payables	11,728	6,095
(Decrease)/Increase in Employee Benefits	(2,996)	22,027
(Decrease) in Other Liabilities	(118)	(154)
Net Changes in Operating Assets and Liabilities	**(4,431)**	**22,797**
Net Cash(Outflows)/Inflows from Operating Activities	**(14,739)**	**27,154**

c. Non-Cash Financing and Investing Activities

Due to a change in the whole of Government vehicle leasing arrangements with SG Fleet, from 23 April 2015 all such leases for the Directorate are classified as operating leases rather than finance leases.

	2016 $'000	2015 $'000
Acquisition of Plant and Equipment by means of Finance Leases	-	1,703

Note 41. Events Occurring After Balance Date

There were no events occurring after the balance date, which would affect the financial statements as at 30 June 2016, or in future reporting periods.

Note 42. Third Party Monies

The Directorate held funds in trust relating to the activities of the Health Directorate Human Research Ethics Committee.

	2016 $'000	2015 $'000
Human Research Ethics Committee Account		
Balance at the Beginning of the Reporting Period	**492**	**517**
Cash Receipts	549	855
Cash Payments	(699)	(880)
Balance at the End of the Reporting Period	**342**	**492**

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

	2016 $'000	2015 $'000
Mental Health Account		
Balance at the Beginning of the Reporting Period	43	33
Cash Receipts	91	111
Cash Payments	(99)	(101)
Balance at the End of the Reporting Period	**35**	**43**

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

	2016 $'000	2015 $'000
Private Practice Fund		
Balance at the Beginning of the Reporting Period	28,510	26,497
Cash Receipts	22,304	27,672
Cash Payments	(24,395)	(25,659)
Balance at the End of the Reporting Period	**26,419**	**28,510**

Note 43. Budgetary Reporting – Explanations of Major Variances Between Actual Amounts and Original Budget Amounts

The following are brief explanations of major line item variances between budget estimates and actual outcomes. Variances are considered to be major variances if both of the following criteria are met:

a. The line item is a significant line item: the line item actual amount accounts for more than 10% of the relevant associated category (Income, Expenses and Equity totals) or sub-element (e.g. Current Liabilities and Receipts from Operating Activities totals) of the financial statements; and

b. The variances (original budget to actual) are greater than plus (+) or minus (-) 10% of the budget for the financial statement line item.

	Actual 2015–16 $'000	Original Budget[1] 2015–16 $'000	Variance $'000	Variance %	Variance Explanations
Operating Statement Line Items					
User Charges – Non-ACT Government	124,780	107,222	17,558	16	Higher than budgeted user charges is mainly due to higher than expected Commonwealth high cost drugs reimbursements as a result of the inclusion of additional drugs that qualify for the Commonwealth reimbursements.
Increase in the Asset Revaluation Surplus	1,604	-	1,604	100	This relates to Woden Valley Childcare Centre land and building revaluation, which was recorded this year. This was not known at the time of budget setting.

[1] Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period (2015–16 Budget Statements). These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

Balance Sheet Line Items	Actual 2015–16 $'000	Original Budget[1] 2015–16 $'000	Variance $'000	Variance %	Variance Explanation
Cash and Cash Equivalents	106,575	60,743	45,832	75	Higher than budgeted cash and cash equivalents is largely due to higher than budgeted opening cash balance of $40 million which relates to cash drawn in June 15 for pay rises and accrued salaries that were settled in 2015–16. Capital works funding of $24million received in June 16 were not settled until July 16 also have contributed to this variance. These were partially offset by lower net cash flow from operating activities $19 million.
Receivables	38,761	29,591	9,170	31	Higher than budgeted receivables mainly relates to $5.5 million of activity based funding owed by the ACT Local Hospital Network Directorate and an increase in receivable associated with Commonwealth reimbursement for high cost drugs $3 million.
Capital Works in Progress	168,175	205,995	(37,820)	(18)	Lower than budgeted capital works in progress is due to project delays mainly for the following projects: • Secure Mental Health Unit construction due to higher rainfall than average; • Computer software development projects due to lengthy contract negotiations; • Infrastructure and redevelopment works across the Canberra Hospital campus; and • ACT Health's capital upgrade program which includes building upgrades, electrical, fire and safety upgrades as well as mechanical and services infrastructure upgrades.

Note 43. Budgetary Reporting – Explanations of Major Variances Between Actual Amounts and Original Budget Amounts (continued)

Balance Sheet Line Items	Actual 2015–16 $'000	Original Budget[1] 2015–16 $'000	Variance $'000	Variance %	Variance Explanation
Payables	91,654	43,048	48,606	113	Higher than budgeted payables mainly relates to higher number of invoices for capital works ($33 million) and operating expense ($16 million) received late in the year.
Statement of Changes in Equity					
These line items are covered in other financial statements					

Cash Flow Statement Line Items	Actual 2015–16 $'000	Original Budget 2015–16 $'000	Variance $'000	Variance %	Variance Explanation
User Charges – Non-ACT Government	115,766	105,000	10,766	10	Higher than budgeted user charges – non-ACT Government is mainly due to higher than expected Commonwealth high cost drugs reimbursements as a result of the introduction of additional drugs that qualify for the Pharmaceutical Benefits Scheme.
Proceeds from the Sale of Property, Plant and Equipment	64	-	64	100	This mainly relates to proceeds from the sale of motor vehicles that came off lease in June 2015 and sold at the beginning of 2015–16. As all motor vehicles are now under operating lease. No sales proceeds were anticipated, hence not budgeted.
Payments for Capital Works	114,209	166,147	(51,938)	(31)	Lower than budgeted payments for capital works was mainly due to later than expected invoice payments as large amounts were accrued at year end and project delays mainly for the following projects: • Secure Mental Health Unit construction due to higher than average rainfall; • Computer software development projects due to lengthy contract negotiations; • Infrastructure and redevelopment works across the Canberra Hospital campus; and • ACT Health's capital upgrade program which includes building upgrades, electrical, fire and safety upgrades as well as mechanical and services infrastructure upgrades.
Capital Injections	138,299	166,147	(27,848)	(17)	Capital injections were lower than the budget mainly due to delays in the projects listed above.

1 Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period (2015–16 Budget Statements). These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

HEALTH DIRECTORATE TERRITORIAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

HEALTH DIRECTORATE
STATEMENT OF INCOME AND EXPENSES ON BEHALF OF THE TERRITORY FOR THE YEAR ENDED 30 JUNE 2016

	Note No.	Actual 2016 $'000	Original Budget 2016 $'000	Actual 2015 $'000
Income				
Revenue				
Payments for Expenses on Behalf of the Territory	45	1,213	9,236	6,684
Fees	46	1,595	1,308	1,268
Total Revenue		**2,808**	**10,544**	**7,952**
Total Income		**2,808**	**10,544**	**7,952**
Expenses				
Grants and Purchased Services	47	1,176	9,236	6,684
Transfer to Government	48	1,587	1,308	1,267
Total Expenses		**2,763**	**10,544**	**7,951**
Total Comprehensive Surplus		**45**	**-**	**1**

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

The funds which 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 the Calvary Public Hospital.

HEALTH DIRECTORATE
STATEMENT OF ASSETS AND LIABILITIES ON BEHALF OF THE TERRITORY
FOR THE YEAR ENDED 30 JUNE 2016

	Note No.	Actual 2016 $'000	Original Budget 2016 $'000	Actual 2015 $'000
Current Assets				
Cash and Cash Equivalents	49	349	268	242
Receivables	50	-	35	112
Total Current Assets		**349**	**303**	**354**
Total Assets		**349**	**303**	**354**
Non-Current Liabilities				
Advance from the Territory Banking Account	51	300	300	350
Total Liabilities		**300**	**300**	**350**
Net Assets		**49**	**3**	**4**
Equity				
Accumulated Funds		49	-	4
Total Equity		**49**	**-**	**4**

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 2016

	Accumulated Funds Actual 2016 $'000	Total Equity Actual 2016 $'000	Original Budget 2016 $'000
Balance at 1 July 2015	**4**	**4**	**3**
Comprehensive Income			
Operating Surplus	45	45	-
Total Comprehensive Income	**45**	**45**	**-**
Balance at 30 June 2016	**49**	**49**	**3**

	Accumulated Funds Actual 2016 $'000	Total Equity Actual 2016 $'000	Original Budget 2016 $'000
Balance at 1 July 2014	**3**	**3**	**-**
Comprehensive Income			
Operating Surplus	1	1	-
Total Comprehensive Income	**1**	**1**	**-**
Balance at 30 June 2015	**4**	**4**	**-**

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

HEALTH DIRECTORATE
CASH FLOW STATEMENT ON BEHALF OF THE TERRITORY
FOR THE YEAR ENDED 30 JUNE 2016

	Note No.	Actual 2016 $'000	Budget 2016 $'000	Actual 2015 $'000
Cash Flows from Operating Activities				
Receipts				
Cash from Government for Expenses on Behalf of the Territory		1,213	9,236	6,684
Fees		1,595	1,308	1,268
Other Receipts		112	924	704
Total Receipts from Operating Activities		**2,920**	**11,468**	**8,656**
Payments				
Grants and Purchased Services		1,226	9,236	6,635
Transfer of Territory Receipts to the ACT Government		1,587	1,308	1,267
Other		-	924	780
Total Payments from Operating Activities		**2,813**	**11,468**	**8,682**
Net Cash Inflows/(Outflows) from Operating Activities	**52**	**107**	**-**	**(26)**
Net Increase/(Decrease) in Cash and Cash Equivalents		**107**	**-**	**(26)**
Cash and Cash Equivalents at the Beginning of the Reporting Period		242	268	268
Cash and Cash Equivalents at the End of the Reporting Period	**52**	**349**	**268**	**242**

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 2016

	Original Budget 2016 $'000	Total Appropriated 2016 $'000	Appropriation Drawn 2016 $'000	Appropriation Drawn 2015 $'000
Territorial				
Expenses on Behalf of the Territory	9,236	9,871	1,213	6,684
Total Territorial Appropriation	**9,236**	**9,871**	**1,213**	**6,684**

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 *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 reporting period. These amounts appear in the Cash Flow Statement on Behalf of the Territory.

Variances between 'Original Budget' and 'Total Appropriated'

The difference between the Original Budget and Total Appropriated mainly relates to project delays in 2014 15 capital works for the upgrade of clinical areas at Calvary Public Hospital.

Variances between 'Total Appropriated' and 'Appropriation Drawn'

The difference between Total Appropriated and Appropriation Drawn mainly relates to delays in capital works projects at Calvary Public Hospital mainly relating to operating theatre upgrades, expansion of services to enable 8 additional beds and upgrade of medical imaging equipment.

HEALTH DIRECTORATE
TERRITORIAL NOTE INDEX
FOR THE YEAR ENDED 30 JUNE 2016

HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2016

Note 44. 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)

	2016 $'000	2015 $'000
Payment for Expenses on Behalf of the Territory[a]	1,213	6,684
Total Payment for Expenses on Behalf of the Territory	**1,213**	**6,684**

a. The decrease is due to the delays in capital works program at the Calvary Public Hospital mainly relating to operating theatre upgrades, expansion of services to enable 8 additional beds and upgrade of medical imaging equipment.

Note 46. Fees – Territorial

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

	2016 $'000	2015 $'000
Fees		
Fees for Regulatory Services	1,595	1,268
Total Fees	**1,595**	**1,268**

a. The increase is mainly due to businesses using the new option to pay regulatory fees for multiple years (28% of businesses have paid for 2-3 year licences). Current receipting system does not cater for calculating how much regulatory fees were received in advance. Therefore Regulatory fees are recognised in the year the revenue is received.

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 recurrent purposes and the name or category reflects the use of the grant. The grants given are usually subject to terms and conditions set out in a contract, correspondence, or by legislation.

	2016 $'000	2015 $'000
Capital Grants to External Parties – Calvary Public Hospitala	1,176	6,684
Total Grants and Purchased Services	**1,176**	**6,684**

a. The decrease is due to the delays in capital works program at the Calvary Public Hospital mainly relating to operating theatre upgrades, expansion of services to enable 8 additional beds and upgrade of medical imaging equipment.

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.

	2016 $'000	2015 $'000
Transfers to the Territory Banking Account[a]	1,587	1,267
Total Transfer to Government	**1,587**	**1,267**

Note 49. Cash and Cash Equivalents – Territorial

The Directorate holds one Territorial bank account. Interest is not earned on cash at bank held in the Territorial Bank Account.

	2016 $'000	2015 $'000
Cash at Bank	349	242
Total Cash and Cash Equivalents	**349**	**242**

Note 50. Receivables – Territorial

	2016 $'000	2015 $'000
Current Receivables		
Net Goods and Services Tax Receivable	-	112
Less: Allowance for Impairment Losses	-	-
Total Current Receivables	**-**	**112**
Total Receivables	**-**	**112**

	Not Overdue	Overdue			
Ageing of Receivables	**$'000**	**Less than 30 Days $'000**	**30 to 60 Days $'000**	**Greater than 60 Days $'000**	**Total $'000**
2016					
Not Impaired Receivables	-	-	-	-	-
Impaired Receivables	-	-	-	-	-
2015					
Not Impaired Receivables	112	-	-	-	112
Impaired Receivables	-	-	-	-	-

Classification of Non-ACT Government Receivables	2016 $'000	2015 $'000
Receivables with Non-ACT Government Entities		
Net Goods and Services Tax Receivable	-	112
Total Receivables with Non-ACT Government Entities	**-**	**112**
Total Receivables	**-**	**112**

Note 51. Advance from the Territory Banking Account – Territorial

	2016 $'000	2015 $'000
Advance from the Territory Banking Account	300	350
Total Advance from the Territory Banking Account	**300**	**350**

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

Note 52. Cash Flow Reconciliation – Territorial

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

	2016 $'000	2015 $'000
Total Cash Disclosed on the Statement of Assets and Liabilities on Behalf of the Territory	349	242
Cash at the End of the Reporting Period as Recorded in the Cash Flow Statement on Behalf of the Territory	**349**	**242**

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

	2016 $'000	2015 $'000
Operating Surplus	45	1
Cash Before Changes in Operating Assets and Liabilities	**45**	**1**
Changes in Operating Assets and Liabilities		
Decrease/(Increase) in Receivables	112	(77)
(Decrease)/Increase in Advance from the Territory Banking Account	(50)	50
Net Changes in Operating Assets and Liabilities	**62**	**(27)**
Net Cash Inflows/(Outflows) from Operating Activities	**107**	**(26)**

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: 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 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 interest rate risk.

Therefore a sensitivity analysis has not been undertaken.

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 losses.

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

Credit risk to Cash and Cash Equivalents is managed by the Directorate by holding bank balances with the ACT Government's banker, Westpac Banking Corporation (Westpac). Westpac holds a AA-issuer credit rating with Standard and Poors.

Liquidity Risk

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

Price Risk

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

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

Note 53. Financial Instruments – Territorial (Continued)

Fair Value of Financial Assets and Liabilities

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

	Note	Carrying Amount 2016 $'000	Fair Value 2016 $'000	Carrying Amount 2015 $'000	Fair Value 2015 $'000
Financial Assets					
Cash and Cash Equivalents		349	349	242	242
Total Financial Assets	49	**349**	**349**	**242**	**242**
Financial Liabilities					
Advance from the Territory Banking Account		300	300	350	350
Total Financial Liabilities	51	**300**	**300**	**350**	**350**
Net Financial Assets/(Liabilities)		**49**	**49**	**(108)**	**(108)**

The following table sets out the Directorate's maturity analysis for financial assets and liabilities as well as the exposure to interest rates, including the weighted average interest rates by maturity period at 30 June 2016. 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 Year to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	49		-	-	-	-	349	349
Total Financial Assets			**-**	**-**	**-**	**-**	**349**	**349**
Financial Liabilities								
Advance from the Territory Banking Account	51		-	-	-	-	300	300
Total Financial Liabilities			**-**	**-**	**-**	**-**	**300**	**300**
Net Financial Assets			**-**	**-**	**-**	**-**	**49**	**49**

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 at 30 June 2015. 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.	Weighted Average Interest Rate	Floating Interest Rate $'000	1 Year or Less $'000	Over 1 Year to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	49		-	-	-	-	242	242
Total Financial Assets			**-**	**-**	**-**	**-**	**242**	**242**
Financial Liabilities								
Advance from the Territory Banking Account	51		-	-	-	-	350	350
Total Financial Liabilities			**-**	**-**	**-**	**-**	**350**	**350**
Net Financial (Liabilities)			**-**	**-**	**-**	**-**	**(108)**	**(108)**

Carrying Amount of Each Class of Financial Asset and Financial Liability	2016 $'000	2015 $'000
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	300	350

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:

	2016 $'000	2015 $'000
Capital Grant Commitments		
Within one year[a]	21,403	1,076
Total Capital Commitments	**21,403**	**1,076**
All amounts shown in the commitment note are exclusive of Goods and Services Tax (GST).		

a. The increase in capital commitments is due to the construction of a new car park for the University of Canberra Public Hospital and ongoing works at Calvary Public Hospital for operating theatre upgrade, upgrade of medical imaging equipment, expanded hospital services and capital upgrades.

Note 55. Contingent Liabilities and Contingent Assets – Territorial

There were no contingent liabilities or contingent assets at 30 June 2016, (Nil at 30 June 2015).

There were no indemnities at 30 June 2016, (Nil at 30 June 2015).

Note 56. Events Occurring After Balance Date – Territorial

There were no events occurring after the balance date, which would affect the financial statements at 30 June 2016, or in future reporting periods.

HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

Note 57. Budgetary Reporting – Territorial – Explanations of Major Variances Between Actual Amounts and Original Budget Amounts

The following are brief explanations of major line item variances between budget estimates and actual outcomes. Variances are considered to be major variances if both of the following criteria are met:

a. The line item is a significant line item: the line item actual amount accounts for more than 10% of the relevant associated category (Income, Expenses and Equity totals) or sub-element (e.g. Current Liabilities and Receipts from Operating Activities totals) of the financial statements; and

b. The variances (original budget to actual) are greater than plus (+) or minus (-) 10% of the budget for the financial statement line item.

Statement of Income and Expenses on Behalf of the Territory Line Items	Actual 2015–16 $'000	Original Budget[1] 2015–16 $'000	Variance $'000	Variance %	Variance Explanations
Payments for Expenses on Behalf of the Territory	1,213	9,236	(8,023)	(86.9)	Lower than budgeted revenue relates to delays in capital works projects at Calvary Public Hospital relating to operating theatre upgrades, expansion of services to enable 8 additional beds and upgrade of medical imaging equipment.
Fees	1,595	1,308	287	21.9	Higher than budgeted fees is mainly due to more businesses utilising the new option to pay regulatory fees for multiple years (28% of businesses have paid for 2-3 year licences).
Grants and Purchased Services	1,176	9,236	(8,060)	(87.3)	Lower than budgeted capital grants paid to Calvary Hospital relates to delayed projects for operating theatre upgrades, expansion of services to enable 8 additional beds and upgrade of medical imaging equipment.
Transfer to ACT Government	1,587	1,308	279	21.3	Higher than budgeted Transfer to ACT Government is associated with the fees revenue collected.

Statement of Assets and Liabilities on Behalf of The Territory Line Items	Actual 2015–16 $'000	Original Budget[1] 2015–16 $'000	Variance $'000	Variance %	Variance Explanation
Cash and Cash Equivalents	349	268	81	30.2	Higher than budgeted cash is due to lower than budgeted receivables and timing associated with transfer to the government.
Receivables	-	35	(35)	(100.0)	Lower than budgeted receivables is due to receipting of GST receivables earlier than budgeted.
Accumulated Funds	49	-	49	100.0	Higher than budgeted Accumulated Funds is timing associated with transfer to the government.
Statement of Changes in Equity on Behalf of the Territory					
These line items are covered in other financial statements					

1 Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period (2015–16 Budget Statements). These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

Note 57. Budgetary Reporting – Territorial – Explanations of Major Variances Between Actual Amounts and Original Budget Amounts (Continued)

Cash Flow Statement on Behalf of the Territory Line Items	Actual 2015–16 $'000	Original Budget[1] 2015–16 $'000	Variance $'000	Variance %	Variance Explanation
Cash from the ACT Government for Expenses on Behalf of the Territory	1,213	9,236	(8,023)	-86.9%	Lower than budgeted cash from ACT Government mainly relates to delays in capital works projects at Calvary Public Hospital mainly relating to operating theatre upgrades, expansion of services to enable 8 additional beds and upgrade of medical imaging equipment.
Fees	1,595	1,308	287	21.9%	Higher than budgeted fees is associated with businesses utilising the new option to pay regulatory fees for multiple years (28% of businesses have paid for 2-3 year licences).
Other Receipts	112	924	(812)	-87.9%	Lower than budgeted other receipts is due to lower GST refunds as a result of delays in capital works projects.
Grants and Purchased Services	1,226	9,236	(8,010)	-86.7%	Lower than budgeted grants and purchased services mainly relates to delays in capital works projects at Calvary Public Hospital mainly relating to operating theatre upgrades, expansion of services to enable 8 additional beds and upgrade of medical imaging equipment.
Transfer of Territory Receipts to the ACT Government	1,587	1,308	279	21.3%	Higher than budgeted transfer to Territory receipts is associated with higher Fees revenue.

1 Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period (2015–16 Budget Statements). These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

C.3 CAPITAL WORKS

INTRODUCTION/ OVERVIEW

Capital works in ACT Health occur under the leadership of the Health Planning and Infrastructure Division. The group is responsible for delivering the:

> Health Infrastructure Program, which is a significant investment in future health services for the ACT community and surrounding region
> Strategic Accommodation
> the Capital Upgrades Program.

The Health Infrastructure Program, a major capital infrastructure program, responds to a complex mix of:

> population growth and ageing
> changing technology
> changing provider and consumer expectations.

These factors contribute to a significant increase in demand for health services in the ACT and to changes in the way services are delivered.

Demand for health services is projected to increase rapidly over the next 10 years and beyond. The Health Infrastructure Program is a planned, comprehensive and structured response to these pressures. Underpinned by future health services demand projections, the Health Infrastructure Program encompasses reviewing future requirements for models of care and service delivery, technology and workforce in conjunction with a significant capital works program. This reporting year marks the eighth year of the Health Infrastructure Program.

The Capital Upgrades Program is funded annually. It aims to maintain and improve the existing infrastructure supporting the directorate. Work priorities are determined under the following categories:

> building upgrades
> electrical, fire and safety upgrades
> mechanical system upgrades
> patient and medical facility upgrades
> workplace improvement upgrades
> medical and administration office upgrades.

Completed projects

Two projects were completed under the Health Infrastructure Program in 2015–16:

> Calvary Car Park
> Staging and Decanting (S&D) Bundle Package at Canberra Hospital.

Calvary Car Park opened on 18 December 2015. The car park provides 704 parking spaces over five levels, resulting in a net increase of approximately 515 spaces.

The S&D Bundle Package at Canberra Hospital is funded through three appropriations:

> S&D–Moving to our Future (Phase 2)
> S&D–Continuity of Service (Phase 1)
> Canberra Hospital Redevelopment (Phase 3).

A number of sub-projects are now complete, including:

> Refurbishing Building 1, Level 4 at Canberra Hospital: converting the former paediatric ward into an aged care unit and rehabilitation ward. Works were completed and handed over to ACT Health in January 2016.
> Building 1, Level 8: design works were completed in May 2016.
> Building 23 Level 2 and Building 6 Level 2: the fit outs were completed in October 2015.
> Building 15: replacing the old Psychiatric Service Unit with a new demountable building for outpatient services. This was completed in October 2015.

Works in progress

Works in progress under the Health Infrastructure Program at 30 June 2016 are:

> the Emergency Department and Paediatric Streaming Expansion project
> the Adult Secure Mental Health Unit
> University of Canberra Public Hospital (UCPH)
> Ngunnawal Bush Healing Farm
> The Canberra Hospital—Continuity of Services Essential Infrastructure (COSEI)
> Canberra Hospital Essential Works – Infrastructure and Engineering (CHEWIE).

Emergency Department and Paediatric Streaming Expansion

The Emergency Department and Paediatric Streaming Expansion project will deliver:

> nine more acute treatment spaces for patients with severe conditions
> three more treatment spaces for patients with less severe problems

- three more treatment spaces in the Emergency Medicine Unit (EMU), which provides care for short-term patients
- two more paediatric treatment spaces
- two more resuscitation treatment spaces
- a new Mental HealthShort Stay Unit with two more treatment spaces and three additional ambulance bays
- a dedicated treatment space for Clinical Forensic Medicine Service.

Works commenced on 4 May 2015 and will not interfere with the day-to-day operations of the Emergency Deparment. The work is scheduled to be completed in late 2016.

The project is co-funded with a contribution from the Commonwealth Government.

Secure Mental Health Unit

Richard Crookes Constructions is the appointed Head Contractor to complete the Final Sketch Plan (FSP) design and construction of the 25-bed Secure Mental Health Unit.

Main construction works commenced in July 2015 and will be completed in late 2016.

University of Canberra Public Hospital

The University of Canberra Public Hospital (UCPH) will provide 140 inpatient beds and 75 day places. Key services will include providing:

- a neurological rehabilitation ward
- a general rehabilitation ward
- an older person's rehabilitation ward
- a slow stream rehabilitation ward
- adult mental health rehabilitation
- admitted day services.

On 20 November 2015, following a procurement process, the Design & Construct Contract and the Facility Management Contract for the project was announced. Brookfield Multiplex will design and construct the hospital, and Brookfield Global Integrated Solutions will provide ongoing facility maintenance.

Construction commencement was marked on 8 February 2016 by a sod turning ceremony and traditional smoking ceremony to cleanse the land.

The 100 per cent FSP design was completed and approved by the Health Infrastructure Program Strategic Committee in May 2016.

Ngunnawal Bush Healing Farm

Early works on the Ngunnawal Bush Healing Farm commenced in June 2015. Construction will be completed in the second half of 2016.

The Canberra Hospital—Continuity of Services Essential Infrastructure

Stage two of the Canberra Hospital—Continuity of Services Essential Infrastructure (COSEI) Project relates to Canberra Hospital's in-ground services and forms the main stage of the works package. The project commenced on 3 August 2015, with the full program scheduled for completion by end 2016.

The following activities were completed:

- On 29 February 2016, Hospital Road was opened to one-way traffic, flowing from Bateson Road to Gilmore Crescent.
- Internal signage works were undertaken in the Centenary Hospital for Women and Children (CHWC), Building 10, the Southern Car Park and will be completed in late 2016.

COSEI works include extending the covered walkway along Hospital Road connecting to the Building 15 through to the multi-storey car park. This work will be undertaken when all Hospital Road works are completed in 2016.

Canberra Hospital Essential Works—Infrastructure and Engineering

Shaw Building Group was appointed as the Head Contractor for this project in July 2015.

Works completed to date include:

- replacing fan coils in Building 1 Level 2
- ordering new lifts, which are now being manufactured.

Works underway and due for completion in 2017 include:

- mechanical upgrade of fan coil units in Building 1, Levels 1, 2, 8, 9 and 10
- replacing and upgrading fire detection systems in Building 1 and Building 10
- modernising three public lifts in Building 1
- replacing a lift in Building 5
- upgrading lift controls in Buildings 5 and 7.

CAPITAL WORKS TABLE – HEALTH DIRECTORATE

TABLE 51: ACT HEALTH CAPITAL WORKS

Project	Proposed or Actual completion date	Original project value $'000	Revised project value $'000	Prior year expenditure $'000	Current year (2015-16) expenditure $'000	Total expenditure to date $'000
New Works						
Canberra Hospital – More beds	Jun-18	2,475	2,475	0	0	0
Critical Hospital Infrastructure Systems – Enhancing patient and staff safety	Jun-17	1,646	1,646	0	303	303
Sterilising Services – Relocation and upgrade	Jun-19	17,290	17,290	0	32	32
Capital Upgrade Program Services						
Building upgrades	Apr-17	2,180	2,180	0	1,046	1,046
Electrical, fire and safety upgrades	Dec-16	938	938	0	767	767
Mechanical and services infrastructure	Dec-16	923	923	0	456	456
Works in Progress						
University of Canberra Public Hospital (construction)	Mar-18	200,000	200,000	0	13,591	13,591
Canberra Hospital Redevelopment	Jun-18	21,241	21,241	0	13,087	13,087
Canberra Hospital – Essential Infrastructure and Engineering Works	Jul-17	5,640	5,640	66	526	592
Secure Mental Health Unit	Sep-16	43,491	43,491	1,941	27,440	29,381
Health Infrastructure Program – Project Management continuation	Mar-17	27,706	27,706	8,258	10,756	19,014
Continuity of Health Services Plan – Essential Infrastructure (less previously completed Territorial works)	Dec-17	16,517	16,517	2,354	8,641	10,995
Clinical Services and Inpatient Unit Design and Infrastructure Expansion	Nov-16	40,780	28,880	5,278	15,725	21,003
Staging and Decanting – Moving to our Future	Aug-16	22,300	20,880	13,123	7,402	20,525
Staging, Decanting and Continuity of Services	Jun-18	19,430	18,430	16,882	-11	16,871
Clinical Services Redevelopment – Phase 3	Jun-17	25,700	17,790	8,908	2,466	11,374
Aboriginal Torres Strait Islander Residential Alcohol and other Drug Rehabilitation Facility	Aug-16	6,883	11,731	2,248	6,342	8,590
Clinical Services Redevelopment – Phase 2	Jun-17	15,000	8,850	8,013	235	8,248
Provision for Project Definition Planning	Jun-17	63,800	58,040	57,130	-28	57,102
Major Building Plant Replacement and Upgrade	Apr-17	5,292	5,292	3,544	1,143	4,687
An E-Healthy Future	Jun-18	90,185	90,185	62,172	9,428	71,600

Project	Proposed or Actual completion date	Original project value $'000	Revised project value $'000	Prior year expenditure $'000	Current year (2015-16) expenditure $'000	Total expenditure to date $'000
Physically but not financially completed						
Calvary Public Hospital – Car park	Dec-15	16,872	16,872	6,077	8,275	14,352
Integrated Cancer Centre – Phase 2	Jul-14	15,102	20,412	20,331	55	20,386
Replacement of CT Scanner at the Canberra Hospital	Sep-13	2,893	2,893	2,505	4	2,509
Completed Projects – physically and financially complete						
University of Canberra Public Hospital (Design)	Jun-16	8,252	8,252	614	7,638	8,252
Identity and Access Management	Jan-15	3,100	2,540	2,540	92	2,632
Tuggeranong Health Centre – Stage 2	Mar-14	14,000	14,000	13,871	12	13,883
Enhanced Community Health Centre – Belconnen	Sep-13	51,344	51,344	51,235	81	51,316
Electrical/Fire/Safety Upgrades	Jun-15	570	570	548	22	570
Women and Children's Hospital	Nov-13	90,000	113,517*	113,463	48	113,511
Building Upgrades	Oct-15	710	710	341	369	710
Electrical/Fire/Safety Upgrades	Oct-15	700	700	312	388	700
Mechanical System Upgrades	Aug-15	715	715	196	519	715
Patient and medical Facility Upgrades	Sep-15	692	692	455	237	692
Upgrade of Medical and Administrative Offices	Sep-15	530	530	79	451	530
Workplace Improvements	Sep-15	595	595	230	365	595
Building Upgrades	Oct-15	705	705	457	248	705
Medical Facilities Upgrades	Nov-15	660	660	384	286	670
Facilities Improvements to Laboratory and Outpatients Area	Aug-15	890	890	389	500	889
Heating, Ventilation and Air Conditioning System Upgrades	Aug-15	375	375	257	118	375
Upgrade of Medical and Administrative Offices	Aug-15	646	646	438	208	646

** Revised project value includes $937 thousand in donation revenue from external sources*

CAPITAL WORKS TABLE – TERRITORIAL

TABLE 52: TERRITORIAL CAPITAL WORKS

Project	Proposed or Actual completion date	Original project value $'000	Revised project value $'000	Prior year expenditure $'000	Current year (2015-16) expenditure $'000	Total expenditure to date $'000
New Works						
Calvary Public Hospital – Expanded hospital services	Jun-17	3,079	3,079	0	141	141
Calvary Public Hospital – Operating theatre upgrade	Jun-17	5,627	5,627	0	38	38
Calvary Public Hospital – Upgrade of medical imaging equipment	Jun-17	3,722	3,722	0	0	0
Works in Progress						
The Canberra Hospital Redevelopment (Grant component)	Sep-16	3,022	3,022	151	1,843	1,994
Completed Projects – physically and financially complete						
Calvary Public Hospital – Car park (Grant component)	Mar-16	2,208	2,343	431	2,047	2,478
Calvary Public Hospital – Refurbishments for more beds (Grant component)	May-16	1,605	1,470	1,144	187	1,331
Chilled water system upgrade	May-16	80	80	0	80	80
Essential power and body protection compliance upgrade	May-16	140	140	0	140	140
Ward upgrades	May-16	463	463	0	463	463
Xavier Building upgrades	Apr-16	120	120	0	120	120
Fire Safety System Upgrade	Jun-16	200	200	174	26	200

RECONCILIATION SCHEDULE

TABLE 53: ACT HEALTH RECONCILIATION SCHEDULE – CAPITAL WORKS AND CAPITAL INJECTION

Approved Capital Works Program financing to capital injection as per cash flow statement						
	Original $'000	**Section 16B $'000**	**Variation $'000**	**Deferred $'000**	**Not drawn $'000**	**Total $'000**
Capital Works	142,286	428	0	-8,356	-7,149	127,209
ICT Capital Injections	18,926	1,853	0	-7,500	-6,156	7,123
Other Capital Injections	4,935	1,976	0	0	-2,944	3,967
Total Departmental	166,147	4,257	0	-15,856	-16,249	138,299
Total Territorial	**9,236**	**635**	**0**	**-5,112**	**-3,546**	**1,213**

C.4 ASSET MANAGEMENT

INTRODUCTION/ OVERVIEW

The Directorate managed assets with a total written down value of $944.756 million at 30 June 2016.

ASSETS MANAGED

The Directorate's managed assets include:

- Built property assets $860.103 million
- Land $41.605 million
- Plant and equipment $40.931 million
- Leasehold improvements $2.117 million

The estimated replacement value of building assets was $1,128.951 million.

Table 54 lists ACT Health's property assets.

TABLE 54: ACT HEALTH'S PROPERTY ASSETS

Canberra Hospital campus	Area m²	Health facilities	Area m²
CH Building 1 – Tower Block	37,560	Belconnen Community Health Centre	11,160
CH Building 2 – Reception / Administration	5,950	Dickson Health Centre	490
CH Building 3 – Oncology / Aged Care / Rehabilitation	17,390	Gungahlin Health Centre	2,608
CH Building 3 – Radiation Oncology	1,650	Phillip Health Centre	3,676
CH Building 4 – ANU Medical School	4,115	Tuggeranong Community Health Centre	6,760
CH Building 5 – Staff Training / Accommodation	8,230	Bruce – Arcadia House	467
CH Building 6 – / Offices	4,710	Bruce – Brian Hennessy House	3,719
CH Building 7 – Alcohol and Drug	1,260	Health Protection Services – Holder	1,600
CH Building 8 – Pain Management	660	Monash – Health Protection Service Air Monitoring Station	18
CH Building 9 – Accommodation	740	Lanyon Family Care Centre	194
CH Building 10 – Pathology	10,250	Ngunnawal Family Care Centre	215
CH Building 11 – Centemary Hospital for Women and Children	19,200	Weston – Independent Living Centre	1,143
CH Building 12 – Diagnostic and Treatment (including Emergency Department / Intensive Care Unit)	20,310	Barton – Clare Holland House	1,600
CH Building 13 – Helipad Northern Car Park	7,980	Curtin – Qell Family Centre	1,120
CH Building 15	4,130	Kambah – Step Up Step Down Unit	279
CH Building 19 – Canberra Region Cancer Centre	7,980	Fadden – Karralika	534
CH Building 22 – Information Management	243	Florey – Health Protection Service Air Monitoring Station	18
CH Building 23 – Redevelopment Unit offices	1,810	Isabella Plains – Karralika	1,400
CH Building 24 – Health Administration offices	1,332	O'Connor – Mental Illness Fellowship	200
CH Building 25 – Adult Mental Health Unit	5,436	Rivett – Burrangiri Respite Care Centre	1,054
CH Building 26 – Southern Car Park	53,000	Watson Hostel	2,431
Gaunt Place Building 1 – Dialysis Unit	871	Duffy – Cancer Patient Accommodation	319
Gaunt Place Building 2 – RILU	688	Student Accommodation Phillip (3 units)	276
Gaunt Place Buildings 3, 4, 5, 6 (Health Offices)	668	Student Accommodation – Belconnen (2 units)	220
Yamba Drive Car Park (Phillip Block 7, Section 1)	N/A	Student Accommodation – Garran (1 unit0	117
Calvary Car Park	22,554	Woden Valley Child Care Centre	3,681

Assets added to the asset register

During 2015–16 the following assets was added to the agency's asset register:

- Building 15 at Canberra Hospital
- Car park at Calvary Public Hospital
- Woden Valley Child Care Centre

Assets removed from the asset register

During 2015–16 one asset was removed from the agency's asset register. This was the Egan Court Air Monitoring Station in Belconnen.

Properties not being utilised by ACT Health

On 30 June 2016, the agency had one property not being utilised by the agency or that had been identified as potentially surplus. This property is the former Belconnen Community Health Centre.

ASSETS MAINTENANCE AND UPGRADE

Asset upgrades

Works completed in 2015–16 across ACT Health sites include:

- upgrading the Fire Detection Systems in Buildings 2, 7, 8, 9 and 22 at Canberra Hospital
- upgrading Building 19 Level 3 air conditioning at Canberra Hospital
- upgrading the drainage system within the tunnel under Building 5 and 6 at Canberra Hospital
- upgrading the drainage system outside of Building 20 at Canberra Hospital
- upgrading the ambulance bays under Building 19 at Canberra Hospital
- upgrading various negative pressure room doors throughout Building 1 at Canberra Hospital
- upgrading bathrooms and kitchens in the Building 5 Residential area at Canberra Hospital
- upgrading generators at Canberra Hospital
- upgrading the Central Outpatients area in Building 1 at Canberra Hospital
- constructing a new Cryogenics facility at Canberra Hospital.

Details of the capital works program are included in section C.3, Capital works.

Property, plant and equipment are maintained to a high standard to meet health requirements. Expenditure on repairs and maintenance, excluding salaries, was $18.331 million, which represents 1.6 per cent of the replacement value.

Building audits

Thirteen building condition assessments, hazardous materials audits and fire reports were undertaken to assess buildings managed by ACT Health.

These audits are used to inform the directorate's ongoing asset management program. The condition audits assessed these properties as being in normal or good condition.

Condition of assets

The condition audits described above assessed buildings managed by ACT Health as being in normal or good condition.

Office accommodation

The agency employs 7,195 staff, of whom 1,289 occupy office-style accommodation in the sites listed in Table 55 at an average utilisation rate of 13.4 square meters (m^2) per employee. Total office-style accommodation occupied is 17,838m^2.

TABLE 55: OFFICE ACCOMODATION

Location	Property	Owned/ leased	Work points/ staff on 30 June 2016	Office area (m^2)	Utilisation rate m^2 per employee
Civic	1 Moore Street Level 3	Leased	145	1,954	13.5
Civic	11 Moore Street Level 3	Leased	75	1,161	15.5
Curtin	Carruthers Street	Leased	178	3,187	17.9
Garran	TCH Building 2	Owned	63	793	12.6
Garran	TCH Building 6	Owned	219	3,051	13.9
Garran	TCH Building 12 Medical Records	Owned	65	613	9.4
Garran	TCH Building 22	Leased	24	243	10.1
Garran	TCH Building 23	Owned	137	1,810	13.2
Garran	TCH Building 24	Owned	69	1,332	19.3
Holder	Health Protection Services	Owned	81	1,163	14.4
Phillip	Callam Offices	Leased	86	740	8.6
Woden	Bowes Place	Leased	147	1,791	12.1

A further 5,906 staff are employed in non-office environments within ACT Health's acute and non-acute facilities. Due to the clinical nature of these workplaces, the average area per employee is not applicable.

C.5 GOVERNMENT CONTRACTING

PROCUREMENT PRINCIPLES AND PROCESSES

In 2015–16, ACT Health exercised all procurement activities in accordance with the ACT Government tender thresholds and complied with procurement policies and procedures as stated in the *Government Procurement Act 2001* and the *Government Procurement Regulation 2007*.

To ensure compliance with ACT Government procurement legislation, ACT Health:

> sought advice on government procurement policies and procedures from Procurement and Capital Works (PCW)
> notified PCW of all procurements over $25,000 undertaken by ACT Health
> appropriately referred procurements requiring single, restrictive or open tender procurement processes to PCW
> referred all procurements requiring Government Procurement Board (GPB) consideration and/or approval to PCW.

In accordance with procurement legislation, ACT Health afforded the highest standard of probity and ethical behaviour towards prospective tenderers. Such behaviour included equality, impartiality, transparency and fair dealing.

A competitive procurement process is conducted wherever possible; however, due to the specialised nature of the industry, ACT Health frequently accesses single select and restricted select procurement methodologies. These procurement methodologies are justified under the following circumstances:

> The procurement needs to be compatible with existing medical equipment, both hardware and software, within the clinical setting.
> Clinical units are seeking to standardise medical equipment with existing equipment. This mitigation strategy reduces the risk of human error in the delivery of clinical practice because equipment is familiar due to established equipment operating procedures.
> A limited number of providers possess the specialised medical knowledge and/or expertise that can fulfil the ACT Health's requirements.
> Timing may preclude public tenders being called in situations that could result in disruption to medical services.

Single select and/or restricted select procurement processes are completed in accordance with the provisions of the *Government Procurement Regulations 2007* and are approved by the Director-General with a statement of justification, as required by the *Government Procurement Act 2001*.

Frequently, ACT Health relies on the NSW Department of Commerce Standing Offer Agreements for restricted select procurement. Through open tender, NSW has a selected panel of preferred suppliers/ providers from which procurement is made.

To use the buying power of the NSW Government, ACT Health frequently asks panel suppliers to offer NSW Department of Commerce pricing on tenders. This strategy:

> increases the likelihood of better value for money to the Territory in comparison to a standalone open tender
> creates a more efficient procurement process.

Social procurement is considered wherever possible. However, due to the specialised nature of its operations, ACT Health is not always able to consider utilising social enterprises. ACT Health did not undertake any social procurement in the 2015–16 year.

EXTERNAL SOURCES OF LABOUR AND SERVICES

In 2015–16, ACT Health engaged a range of external consultants and contractors to undertake services in the following areas:

> frontline clinical health services
> structural and procedural reviews of current business models
> dispute resolution services, including complaint investigation and mediation services
> capital works projects.

The following tables catalogue all procurements over $25,000 undertaken by ACT Health for contractors, consultants and Visiting Medical Officers (VMOs) for the reporting period.

Goods, services and works

Table 56 provides goods, services and works details.

TABLE 56: GOODS, SERVICES AND WORKS

Contract title	Procurement type	Exemption from quotation and tender threshold requirements	Contractor name	Contract amount	Execution date	Expiry date	Small to Medium Enterprise (SME)
The Canberra Hospital Essential Works – Infrastructure and Engineering (CHEWIE)	Works	No	Shaw Building Group Pty Ltd	$3,127,454.43	03/07/2015	22/12/2017	No
Technical Advisory Panel for Facility Management	Consultancy	No	Eco FM Pty Ltd	-	20/07/2015	15/03/2018	Yes
Technical Advisory Panel for Mechanical Building Services, Electrical Building Services, Fire Engineering Services, Independent Commissioning Agent and Facility Maintenance	Consultancy	No	A.G. Coombs Advisory Pty. Ltd.	-	22/07/2015	15/03/2018	Yes
Technical Advisory Panel for Health Infrastructure	Consultancy	No	Healthcare Equipment Planning Australia Pty Ltd	-	22/07/2015	15/03/2018	Yes
Health Future Infrastructure Taskforce – Taskforce Director	Consultancy	No	Donald Cant Watts Corke (Vic) Pty Ltd	$687,475.80	31/07/2015	30/06/2016	Yes
Health Planning And Infrastructure Project Director	Services (non-consultancy)	Yes	Law Consulting Services Pty Ltd	$275,000.00	20/08/2015	12/08/2016	Yes
Health Planning and Infrastructure Project Director	Services (non-consultancy)	No	Wombwell, Mark Christopher	$250,000.00	21/08/2015	29/02/2016	Yes
PICS Maintenance and Support Services FY15–16	Consultancy	Yes	STYGRON SYSTEMS PTY LTD	$34,221.00	03/09/2015	02/09/2016	No
Gas Chromatograph Instrument Fitted with a Flame Ionization Detector	Goods	No	AGILENT TECHNOLOGIES AUSTRALIA PTY LTD		04/09/2015	03/09/2016	No
Samsung 55 Inch 60 HZ Full HD 450CD/M2, ATDEC TH-3060-UT Slim Wall Mount	Goods	No	ETHAN GROUP PTY LTD	$38,332.80	04/09/2015	03/09/2016	No
Erosion Control and Track Works at Miowera	Works	No	Capital Hydraulics & Drains Pty Ltd	$160,459.65	13/10/2015	07/12/2016	Yes
VIP 5 Tissue Processor – Quote 00021176	Goods	Yes	Olympus Australia Pty Ltd	$121,012.32	23/10/2015	22/10/2016	No
Supply, Delivery and Installation of a BreastScreen Modality	Goods	Yes	Hologic (Australia) Pty Limited	$441,797.40	05/11/2015	04/11/2016	No

Contract title	Procurement type	Exemption from quotation and tender threshold requirements	Contractor name	Contract amount	Execution date	Expiry date	Small to Medium Enterprise (SME)
Provision of the .NET Health Manager System and Support Services	Goods	Yes	Open Office Pty Ltd	$533,544.00	09/11/2015	09/11/2018	No
The University of Canberra Hospital Design and Construct	Works	No	Brookfield Multiplex Constructions Pty Ltd	$138,594,123.00	18/11/2015	29/09/2018	No
Maintenance of the University of Canberra Hospital	Services (non-consultancy)	No	Brookfield Global Integrated Solutions Pty Ltd	$49,000,000.00	18/11/2015	18/11/2022	No
ACT Health Transformational Reform Program – Tranche Two Project Implementation	Consultancy	Yes	Kamarejo Pty Ltd trading as Healthcare Reform Consulting	$281,480.00	15/12/2015	30/06/2016	No
Bigneat Asbestos Cabinet	Goods	No	Daintree Scientific	$32,631.50	17/12/2015	16/12/2017	No
Panel for Private Contracting of Elective Surgery in the ACT	Services (non-consultancy)	No	Barton Private Hospital Rice, Jonathan George trading as Dr Jonathan G Rice	-	22/12/2015	24/12/2016	No
SMARTBARRIER TOUCH DRY ABSORBENT PAD	Goods	Yes	The Trustee for Corsal Trust trading as HAINES MEDICAL AUSTRALIA	$36,617.90	04/01/2016	03/01/2017	No
The Canberra Hospital Building 7 HVAC Upgrade	Works	No	Electaire Pty. Limited	$399,025.00	11/01/2016	18/04/2017	Yes
Gaumard 5YO Paediatric Hal Control Tablet and Software – One Year Maintenance and Service Agreement	Services (non-consultancy)	Yes	ABACUS ALS PTY LTD	$65,122.00	13/01/2016	12/01/2017	No
Executive Search and Recruitment Services	Services (non-consultancy)	No	HardyGroup International Pty Limited	$308,000.00	15/02/2016	22/04/2016	No
Auriga XL 50W Laser Console including Footpedal 2X Keys 2X Laser Safety Signs Laser Training for Theatres Staff Freight One Year Services on Parts Labour	Goods	No	BOSTON SCIENTIFIC PTY LTD	$66,000.00	23/02/2016	22/03/2017	No
Air Condition Upgrade Building 9 as per Quotation Q15-089MS	Goods	No	Canberra Air Conditioning Services Pty Limited	$229,680.00	23/02/2016	22/03/2017	No
Frima 150L Cooking Centre as per Quotation PS3006 CAN HOS	Goods	No	ALSTHE AC & R COMPANY GROUP	$48,620.00	23/02/2016	22/03/2017	No
Workstation with Camera BX 140:MM102300	Works	No	ABACUS ALS PTY LTD	$49,090.90	24/02/2016	23/03/2017	No
Zoll R Series ALS Defibrillator Monitor	Goods	No	ZOLL MEDICAL AUSTRALIA PTY LIMITED	$71,225.00	02/03/2016	01/03/2017	No

Contract title	Procurement type	Exemption from quotation and tender threshold requirements	Contractor name	Contract amount	Execution date	Expiry date	Small to Medium Enterprise (SME)
PICS Maintenance and Support Services FY15–16	Consultancy	No	STYGRON SYSTEMS PTY LTD	$35,684.00	04/03/2016	03/03/2017	No
Radiation Oncology Stormwater Rectification Works and Canberra Region Cancer Centre Ambulance Turnaround Bay	Consultancy	No	Shaw Building Group Pty Ltd	$237,930.99	15/03/2016	20/06/2017	No
Soluscope Series 3CC-PAA-BB Endoscope as per Quotation 27272/15 PZ:JB	Goods	No	The Trustee for The Nyora Trust T/A GALLAY MEDICAL & SCIENTIFIC PTY LTD	$90,574.66	16/03/2016	15/03/2017	No
GIF-HQ190 Dual Focus Gastroscope	Goods	No	OLYMPUS AUSTRALIA PTY LTD	$140,625.45	17/03/2016	16/03/2017	No
Consultation, engagement and the development of key messages	Services (non-consultancy)	No	Physical Activity Foundation Ltd	$125,000.00	18/03/2016	30/06/2018	Yes
TOTAL AWWSURANCE PLAN SERVICE MAINTENANCE PLAN FOR WATERS TQD S/N Q881189 25/3/16-24/3/2017	Services (non-consultancy)	No	WATERS AUSTRALIA PTY LTD	$32,615.00	18/03/2016	17/03/2017	No
Consultation, engagement and the development of key messages	Services (non-consultancy)	No	Coordinate Pty Ltd	$79,420.00	18/03/2016	30/07/2016	Yes
PHILIPS V60 NIV ALPINE WHITE (WITH AVAPS C-FLEX AND BATTERY) AS PER QUOTE	Services (non-consultancy)	Yes	TELEFLEX MEDICAL AUSTRALIA PTY LTD	$34,589.00	18/03/2016	17/03/2017	No
NSK DRILL MOTOR, HANDPIECES,AND ACCESORIES	Goods	Yes	NSK OCEANIA PTY LTD	$39,666.66	23/03/2016	22/03/2017	No
Panel for the Supply and Delivery of Orthotics, Prosthetics, Associated Componentry and Medical Grade Footwear	Goods	No	Otto Bock Australia Pty Ltd Medi Australia Pty Limited Othotic & Prosthetic Centre Pty. Ltd. Orthopaedic Appliances Pty. Ltd. Law Comfort Pty Ltd Ossur Australia – OA & Injury Solutions Pty Ltd Orthotic Technical Services Pty. Ltd Ossur Australia Pty Limited Patino Shoes Pty Ltd trading as Feet in Focus	-	23/03/2016	24/03/2019	No
Technical Advisory Panel for Hazardous Goods	Consultancy	No	Advitech Pty. Limited	-	23/03/2016	20/04/2018	Yes

Contract title	Procurement type	Exemption from quotation and tender threshold requirements	Contractor name	Contract amount	Execution date	Expiry date	Small to Medium Enterprise (SME)
Panel for the Supply and Delivery of Orthotics, Prosthetics, Associated Componentry and Medical Grade Footwear	Goods	No	Sole Support Pedorthic Solutions Pty Ltd	-	24/03/2016	23/03/2019	Yes
Active Streets Pilot Evaluation and Reporting	Services (non-consultancy)	No	University of New South Wales	$38,192.70	04/04/2016	17/03/2017	No
Technical Advisory Panel for Aviation	Consultancy	No	Aviation Professional Services Pty Ltd t/a Avipro	-	05/04/2016	20/04/2018	Yes
Technical Advisory Panel for Electrical Building Services	Consultancy	No	Rudds Consulting Engineers Pty Limited	-	11/04/2016	15/03/2018	Yes
Ride or Walk to School Extension Program	Services (non-consultancy)	No	Physical Activity Foundation Limited	$198,000.00	15/04/2016	30/06/2018	No
CANON DRG1100 – 110PPM, CANON 2 YEAR ADDITIONAL WARRANTY UPGRADE FOR DRG1100 SCANNER	Goods	No	ETHAN GROUP PTY LTD	$34,815.00	22/04/2016	21/04/2017	No
RFQ: DS15032016-01 ICT TRANSFORMAITON PROGRAMME MANAGER	Consultancy	No	CALLIDA RESOURCING PTY LTD	$140,250.00	29/04/2016	28/04/2017	No
Design, Construction and Maintenance of the SCPS	Consultancy	No	Solgen Energy Pty Ltd	$1,372,895.51	02/05/2016	02/05/2022	Yes
The Canberra Hospital Main Switchboards Replacement – Design Consultant	Consultancy	No	Steensen Varming (Australia) Pty Ltd	$208,130.50	03/05/2016	30/09/2017	Yes
It's Your Move Online Teacher Professional Learning	Services (non-consultancy)	No	eLearning Pty Ltd trading as Online learning Australia – A Dexler education (Australia) company	$65,890.00	17/05/2016	17/01/2017	No
Technical Advisory Panel – Various Disciplines	Consultancy	No	SMEC Australia Pty. Limited	-	06/06/2016	20/04/2018	Yes
Technical Advisory Panel for Facility Maintenance	Consultancy	No	RixStewart Pty Ltd	-	06/06/2016	15/03/2018	Yes
Technical Advisory Panel for Health Infrastructure	Consultancy	No	Cogility Pty Ltd	-	08/06/2016	15/03/2018	Yes

Visiting Medical Officers

Table 57 provides total amounts paid to Visiting Medical Officers (VMO) during 2015–16[9].

TABLE 57: VISITING MEDICAL OFFICERS

Title	Surname	First Name	Speciality	Description of contract	Date contract commences	Date contract expires	Total amount (exclusive of GST)
1.1 Acute Services							
Dr	Adendorff	Bruce	Anaesthesia	VMO	01-Apr-16	31-Mar-19	$190,531.39
Dr	Adham	Omar	O&G	VMO	28-May-14	27-May-17	$425,796.89
Dr	Albekaa	Safi	ENT Surgery	VMO	02-Nov-14	01-Nov-17	$77,856.64
Dr	Al-Sameraaii	Ahmad	Urology	VMO	01-Jun-16	31-May-19	$529,808.92
Dr	Ansary	Saidul	Respiratory & Sleep Medicine Unit	VMO	07-Feb-16	06-Feb-19	$71,886.75
Dr	Ashman	Bryan	Orthopaedic Surgery	VMO	01-Sep-15	31-Aug-18	$411,259.38
Dr	Aubin	Phil	Orthopaedic Surgery	VMO	11-Feb-14	10-Feb-17	$101,560.90
Dr	Auzins	Edwin	General Dentistry (OMFS)	VMO	02-Jul-16	01-Jul-17	$41,565.73
Dr	Bissaker	Peter	Cardiac Surgery	VMO	02-Aug-15	01-Aug-18	$467,599.85
Dr	Bradshaw	Stephen	Vascular Surgery	VMO	02-Aug-14	01-Aug-17	$381,235.20
Dr	Bromley	Jonathan	Acute General Medicine & Gastroenterology	VMO	31-Mar-15	30-Mar-18	$159,307.50
Dr	Burns	Alexander	Orthopaedic Surgery	VMO	02-Jun-15	01-Jun-18	$246,593.96
Dr	Chan	Hin Fan (Rex)	Urology	VMO	02-Nov-13	01-Nov-16	$37,836.98
Dr	Chapman	Edward Peter	ENT Surgery	VMO	01-Jun-16	31-May-17	$45,567.33
Dr	Close	Susanne	O&G	VMO	01-Aug-14	31-Jul-17	$169,721.66
Dr	Corbett	Michael	Gastroenterology	VMO	07-Feb-15	06-Feb-18	$72,408.39
Dr	Damiani	Maurizio	Orthopaedic Surgery	VMO	07-Jul-16	06-Dec-16	$326,455.55
Dr	Davies	Stephen	Anaesthesia	VMO	02-Mar-15	01-Mar-18	$45,347.69
Dr	Davis	Ian	General Surgery – Breastscreen	VMO	02-Sep-14	01-Sep-17	$190,507.72
Dr	De Freitas	Ryan	ENT Surgery	VMO	02-May-16	01-May-17	$94,418.75
Dr	Drummond	Catherine	Dermatology	VMO	01-Nov-14	31-Oct-17	$58,494.04
Dr	Duke	David	Cardiac Anaesthesia	VMO	22-Jan-15	21-Jan-18	$194,506.48
Dr	Edwards	Joanne	Paediatrics	VMO	22-Aug-13	21-Aug-16	$124,582.95
Dr	Eghtedari	Fardin	ENT Surgery	VMO	09-Nov-15	08-Nov-18	$152,491.17
Dr	Ellingham	John	Cardiac Anaesthesia	VMO	29-Nov-09	29-Nov-16	$26,649.45
Dr	Fahey	Caroline	Anaesthesia	VMO	02-Sep-14	01-Sep-17	$56,904.22
Dr	Farhadieh	Rostam	Plastic Surgery	VMO	01-Apr-13	07-Mar-18	$905,082.78
Dr	Findlay	Michael	Plastic Surgery	VMO	12-Jun-16	11-Jun-17	$417,870.35
Dr	Fletcher	Victoria	Anaesthesia	VMO	11-Feb-15	10-Feb-18	$274,261.71
Dr	Flynn	Peter	Anaesthesia	VMO	21-Jan-16	20-Jan-17	$40,128.00
Dr	Freckmann	Mary-Louise	Clinical Genetics	VMO	01-Jul-15	30-Jun-18	$95,597.38
Dr	French	James	Anaesthesia	VMO	02-Sep-15	01-Sep-18	$206,414.95
Dr	Fricker	John	OMFS – Dental Surgery	VMO	02-Jul-16	01-Jul-19	$89,904.09
Dr	Gallagher	Elizabeth	O&G	VMO	16-Jun-14	15-Jun-17	$136,015.35
Dr	Gibson	Graeme	Anaesthesia	VMO	30-Jun-16	29-Jun-17	$53,089.08
Dr	Gillmore	Colin	Anaesthesia	VMO	01-Feb-15	31-Jan-18	$77,471.76
Dr	Gross	Michael	Orthopaedic Surgery	VMO	10-Aug-13	09-Aug-16	$194,144.05

9 In some instances, payments made to a VMO in the reporting period may relate to services provided in previous reporting period(s) due to delays in submitting invoices.

Title	Surname	First Name	Speciality	Description of contract	Date contract commences	Date contract expires	Total amount (exclusive of GST)
1.1 Acute Services (continued)							
Dr	Hamid	Celine	Paediatric Surgery	VMO	23-Mar-15	22-Mar-18	$286,166.69
Dr	Hardman	David	Vascular Surgery	VMO	02-Jul-15	01-Jul-18	$378,513.54
Dr	Haxhimolla	Hodo	Urology	VMO	16-Jun-15	15-Jun-18	$110,119.17
Dr	Hayes	Deborah	Cardiology (Paediatrics)	VMO	02-Mar-15	01-Mar-18	$40,258.93
Dr	He	Yi (Mike)	General Surgery – BreastScreen	VMO	15-Apr-16	14-Apr-19	$178,786.05
Dr	Hehir	Andrew	Anaesthesia	VMO	28-Jan-15	27-Jan-18	$283,024.25
Dr	Jeans	Phil	General Surgery	VMO	12-Aug-15	11-Aug-18	$183,317.39
Dr	Joyce	Daniel	Anaesthesia	VMO	09-May-16	08-May-17	$42,958.05
Dr	Kahloon	Muhammad	Urology	VMO	08-Feb-16	07-Feb-19	$52,894.75
Dr	Kaye	Graham	Gastroenterology	VMO	31-Aug-14	30-Aug-17	$358,573.21
Dr	Kelly	Michael	General Surgery	VMO	21-Dec-15	20-Dec-16	$60,000.00
Dr	Kim	Sueng-Yeol	Oral and maxilofacial	VMO	18-Mar-16	17-Mar-17	$29,592.65
Dr	Kingsbury	David	Anaesthesia	VMO	09-May-16	03-Jan-17	$127,711.90
Dr	Kulisiewicz	Gawel	Orthopaedic Surgery	VMO	07-Aug-09	07-Aug-16	$413,725.13
Dr	Kwan	Bernard	Anaesthesia	VMO	02-Sep-14	01-Sep-17	$41,380.98
Dr	Lang	Robert	Anaesthesia	VMO	26-Jan-16	25-Jan-19	$190,366.23
Dr	Lau	Yeong Joe	Orthopaedic Surgery	VMO	08-Dec-15	07-Dec-18	$439,821.18
Dr	Lee	Elaine	Anaesthesia	VMO	11-Oct-15	10-Oct-18	$571,894.15
Dr	Lee	Tack-Tsiew	ENT Surgery	VMO	02-Jun-15	01-Jun-18	$100,563.75
Dr	Leerdam	Carolyn	Paediatric Medicine	VMO	02-Feb-15	01-Feb-18	$105,428.82
Dr	Leow	Yin Yin	Anaesthesia	VMO	29-Mar-16	28-Mar-17	$80,924.55
Dr	Lim	James	General Surgery	VMO	30-Nov-13	29-Nov-16	$87,697.06
Dr	Lipsett	Lachlan	ENT Surgery	VMO	01-Dec-15	30-Nov-16	$38,803.93
Dr	Low	Shiau Tween	O&G	VMO	01-Oct-15	30-Sep-16	$62,896.25
Dr	Lu	Don Bunnag	Anaesthesia	VMO	02-Dec-14	01-Dec-17	$29,039.73
Dr	Makeham	Timothy	ENT Surgery	VMO	14-Feb-14	13-Feb-17	$174,726.91
Dr	Malecky	George	Paediatric Surgery	VMO	01-Nov-14	31-Oct-17	$546,519.92
Dr	Malhotra	Ram	Neurology	VMO	01-Apr-14	31-Mar-17	$89,583.05
Dr	Marshall	Natalie	Anaesthesia	VMO	01-Aug-14	31-Jul-17	$580,900.55
Dr	Matthiesson	Will	Anaesthesia	VMO	01-Mar-16	28-Feb-19	$113,627.78
Dr	McCredie	Simon	Urology	VMO	02-Jul-16	01-Jul-19	$259,610.13
Dr	McDonald	Tim	Paediatrics	VMO	02-Aug-14	01-Aug-17	$509,022.22
Dr	McInerney	Carmel	Anaesthesia	VMO	02-Jun-15	01-Jun-18	$66,124.59
Dr	Meares	Nicola	Anaesthesia	VMO	31-May-16	30-May-19	$45,419.31
Dr	Miller	Andrew	Dermatology	VMO	30-Nov-13	29-Nov-16	$72,340.62
Dr	Morrissey	Phillip	Anaesthesia	VMO	02-Nov-13	01-Nov-16	$160,781.91
Dr	Muggeridge	Catherine	Anaesthesia	VMO	25-Aug-14	24-Aug-17	$73,479.40
Dr	Neilson	Wendell	Vascular Surgery	VMO	01-Jul-13	30-Jun-16	$784,619.26
Dr	O'Connor	Simon	Cardiology	VMO	01-Oct-14	30-Sep-17	$344,142.83
Dr	Oerder	Vaughn	Vascular Surgery	VMO	09-May-16	08-May-19	$32,425.44
Dr	Palnitkar	Girish	Anaesthesia	VMO	15-Nov-13	14-Nov-16	$87,912.31
Dr	Peady	Clifford	Anaesthesia	VMO	02-Aug-14	01-Aug-17	$276,163.91
Dr	Peake	Ross	Anaesthesia	VMO	23-Jul-13	22-Jul-16	$195,165.79
Dr	Pfluger	Eike	Anaesthesia	VMO	22-Feb-16	21-Feb-17	$35,572.28
Dr	Policinski	Igor	Orthopaedic Surgery	VMO	07-Dec-15	06-Dec-18	$435,968.39

Title	Surname	First Name	Speciality	Description of contract	Date contract commences	Date contract expires	Total amount (exclusive of GST)
1.1 Acute Services (continued)							
Dr	Ponniah	Senthan	Anaesthesia	VMO	24-Jan-14	23-Jan-17	$147,643.16
Dr	Powell	Suzanna	Paediatric Medicine	VMO	01-Jun-15	31-May-18	$82,206.84
Dr	Quah	Yeow Leng (Valerie)	Anaesthesia	VMO	17-Jan-14	16-Jan-17	$119,735.60
Dr	Rajapakse	Yasantha Ranjeeva	Plastic Surgery	VMO	12-Sep-15	11-Sep-16	$182,283.18
Dr	Rangiah	David	General Surgery	VMO	02-Feb-15	01-Feb-18	$187,637.45
Dr	Reddy	Rajesh	Anaesthesia	VMO	02-Nov-15	01-Nov-16	$25,341.45
Dr	Reynolds	Graham	Paediatric Medicine	VMO	15-Sep-15	14-Sep-16	$27,267.76
Dr	Riddell	James	General Medicine & Gastroenterology	VMO	01-Dec-14	30-Nov-17	$44,144.72
Dr	Roberts	Chris	Orthopaedic Surgery	VMO	02-Nov-14	01-Nov-17	$47,553.20
Dr	Robson	Stephen	O&G	VMO	01-Aug-14	31-Jul-17	$133,886.44
Dr	Rosier	Michael	Paediatric Medicine	VMO	02-Aug-14	01-Aug-17	$122,346.33
Dr	Sathasivam	Sivapirabu	Plastic Surgery	VMO	29-Jul-15	28-Jul-16	$303,692.59
Dr	Simpson	Erroll	Paediatric Surgery	VMO	01-Nov-14	31-Oct-17	$272,436.66
Dr	Skilton	Roger	Anaesthesia	VMO	01-Feb-16	31-Jan-17	$181,965.30
Dr	Smith	Damian	Orthopaedic Surgery	VMO	02-Jul-15	01-Jul-18	$329,173.73
Dr	Smith	Paul	Orthopaedic Surgery	VMO	02-Feb-14	01-Feb-17	$626,335.55
Dr	Smith	Joseph	Orthopaedic Surgery	VMO	07-Dec-15	06-Dec-18	$251,155.98
Dr	Speldewinde	Geoffrey	Anaesthesia	VMO	02-Nov-14	01-Nov-17	$39,258.57
Dr	Stone	Hilton	ENT Surgery	VMO	01-Feb-14	31-Jan-17	$70,649.20
Dr	Storey	Desmond	General Dentistry	VMO	30-Nov-13	29-Nov-16	$37,517.17
Dr	Tharion	John	Thoracic Surgery	VMO	02-Aug-15	01-Aug-18	$387,624.85
Dr	Thomson	Andrew	Gastroenterology	VMO	02-Oct-14	01-Oct-17	$352,440.65
Dr	Tsai	Nicholas	Orthopaedic Surgery	VMO	25-Aug-10	08-Apr-17	$661,417.53
Dr	Upton	Zain	Anaesthesia	VMO	10-Feb-14	09-Feb-17	$86,428.15
Dr	Vrancic	Sindy	Orthopaedic Surgery	VMO	01-Sep-09	01-Sep-16	$250,022.96
Dr	Wagner	Nils	Trauma	VMO	01-Apr-16	31-Mar-17	$140,801.68
Dr	Wilson	Michael	Anaesthesia	VMO	01-Nov-14	01-Nov-17	$84,693.13
Dr	Yeoh	Timothy Sing-Yong	Orthopaedic Surgery	VMO	11-Aug-15	10-Aug-16	$91,498.01
Dr	Young	Samuel	Orthopaedic Surgery	VMO	05-Sep-15	04-Sep-16	$101,217.65
1.2 Mental Health, Justice Health and Alcohol and Drug Services							
Dr	Adesanya	Adesina	Psychiatry	VMO	01-Sep-15	31-Aug-16	$145,925.45
Dr	Bromley	Jennifer	General Practice (Corrections Health Program)	VMO	07-Feb-14	06-Feb-17	$126,505.88
Dr	Butterfield	Ingrid	Psychiatry	VMO	19-Feb-16	18-Feb-17	$43,162.15
Dr	Eldridge	James Neil	General Practice (Corrections Health Program & Clinical Forensics ACT)	VMO	23-Dec-13	01-Feb-17	$164,620.65
Dr	Henderson	A Scott	Psychiatry	VMO	01-Nov-14	31-Oct-17	$200,494.66
Dr	Kasinathan	John	Psychiatry	VMO	02-Jul-15	02-Jul-17	$365,718.38
Dr	Matias	May	Psychiatry	VMO	20-Mar-16	19-Mar-17	$185,861.35
Dr	Mundl	Renate	Psychiatry	VMO	07-Apr-16	06-Apr-17	$141,568.80
Dr	Owen	Cathy	Psychiatry	VMO	01-Jan-15	31-Dec-16	$66,396.43

Title	Surname	First Name	Speciality	Description of contract	Date contract commences	Date contract expires	Total amount (exclusive of GST)
1.2 Mental Health, Justice Health and Alcohol and Drug Services (continued)							
Dr	Thomson	Graeme	General Practice (Corrections Health Program & Clinical Forensics ACT)	VMO	06-Jan-14	13-Jan-17	$165,947.58
Dr	Westcombe	David	Psychiatry	VMO	01-Dec-13	30-Dec-16	$182,344.79
Dr	Wurth	Peter	Psychiatry	VMO	01-Feb-15	31-Jan-18	$53,656.04
1.4 Cancer Services							
Drs	Applied Imaging Pty Ltd	Elizabeth Lim & Nigel Hunter	Radiology – BreastScreen	VMO	18-Sep-15	16-Sep-18	$96,385.45
Dr	Bell	Susanne	Radiology – BreastScreen	VMO	11-Nov-14	10-Nov-17	$150,328.84
Dr	Chen	Suet Wan	Radiology – BreastScreen	VMO	01-Nov-14	31-Oct-17	$145,530.88
Dr	Cranney	Brendan	Radiology – BreastScreen	VMO	02-Jul-14	01-Jul-17	$40,528.46
Dr	Hazan	Georges	Radiology – BreastScreen	VMO	21-Sep-15	17-Sep-18	$310,754.91
Dr	Jain	Tarun	Radiology	VMO	05-Nov-15	04-Nov-16	$158,898.42
Dr	Preda	Martina	Radiology	VMO	25-Apr-16	24-Apr-17	$34,507.62

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

REPORT OF FACTUAL FINDINGS

HEALTH DIRECTORATE

To the Members of the ACT Legislative Assembly

Report on the statement of performance

The statement of performance of the Health Directorate (the Directorate) for the year ended 30 June 2016 has been reviewed.

Responsibility for the statement of performance

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

The auditor's responsibility

Under the *Financial Management Act 1996* and *Financial Management (Statement of Performance Scrutiny) Guidelines 2016*, I am responsible for providing a report of factual findings on the statement of performance.

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

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

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

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

As disclosed in the statement of performance, in accordance with the *Financial Management (Statement of Performance Scrutiny) Guidelines 2016*, the Government Payment for Outputs and Total Cost information included in the statement of performance has not been reviewed.

Electronic presentation of the statement of performance

Those viewing an electronic presentation of this statement of performance should note that the review does not provide assurance on the integrity of information presented electronically, and does not provide an opinion on any other information which may have been hyperlinked to or from this statement of performance. If users of this statement of performance are concerned with the inherent risks arising from the electronic presentation of information, then 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 2016, 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
27 September 2016

Health Directorate
Statement of Performance
For the Year Ended 30 June 2016

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 2016 and also fairly reflects the judgements exercised in preparing it.

Nicole Feely
Director-General
Health Directorate
19 September 2016

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:

> strategies to meet performance targets for the emergency department, elective and emergency surgery; and
> continuing to increase the capacity of acute care services.

	Original Target 2015–16	Actual Result 2015–16	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	788,298	819,445	4%		
Government Payment for Outputs (GPO) ($000's)	97,404	99,985	3%		
Accountability Indicators					
a. Admitted – National Weighted Activity Units {15}	71,644	73,441	3%		1,2
b. Non-Admitted – National Weighted Activity Units {15}	27,275	28,942	6%	The annual performance result is higher than target due to higher than expected demand for services across all patient types. This service stream has been a growth area in recent years as patients with less urgent conditions are encouraged to seek medical attention in non-admitted settings.	1,3
c. Emergency Services – National Weighted Activity Units {15}	9,927	10,335	4%		1,4

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

Notes

Explanation of Accountability Indicators

1. Activity is measured in National Weighted Activity Units (NWAU) {15} as defined by the Independent Hospital Pricing Authority's National Efficient Price Determination 2015–16. National Weighted Activity Unit (NWAU) is the 'currency' that is used to express the price weights for all services that are funded on an activity basis.
2. Admitted services delivered at Canberra Hospital and Health Services, including those provided to cancer patients or rehabilitation patients, but excluding admitted mental health and subacute services.
3. Services provided to clients who were not admitted into hospital.
4. Services provided to clients in the emergency department of Canberra Hospital and Health Services.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office as this is not required by the *Financial Management (Statement of Performance Scrutiny) Guidelines 2016*.

OUTPUT CLASS 1: HEALTH AND COMMUNITY CARE (CONTINUED)

Output 1.1 Acute Services (Continued)

	Original Target 2015–16	Actual Result 2015–16	% Variance from Original Target	Explanation of Material Variances	Notes
d. Acute Admitted Mental Health Services – National Weighted Activity Units {15}	4,060	4,350	7%	Mental health services experienced higher patient volumes than expected for 2015–16, leading to a higher NWAU result compared to the target. There were 1,974 mental health episodes recorded in 2015–16 compared to 1,646 episodes the year before.	5
e. Sub Acute Services – National Weighted Activity Units {15}	4,603	7,431	61%	The higher than budgeted result is due to a change in methodology in accounting for sub acute activity which includes some activity not previously counted. This approach was agreed in February 2016 in consultation with the relevant national bodies.	6
f. Calvary Services – National Weighted Activity Units (out of scope)	1,391	1,345	-3%		7
g. Mean waiting time for clients on the dental services waiting list	6 months	6 months	-		8
h. Percentage of the Women's Health Service Intake Officer's clients who receive an intake and assessment service within 14 working days of their initial referral	100%	99%	-1%		

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

Notes

Explanation of Accountability Indicators

5. Acute Admitted Mental Health Services delivered at Canberra Hospital and Health Services. Activity is measured in National Weighted Activity Units {15} as defined by the Independent Hospital Pricing Authority's National Efficient Price Determination 2015–16. National Weighted Activity Unit (NWAU) is the 'currency' that is used to express the price weights for all services that are funded on an activity basis.
6. Sub Acute Services delivered at Canberra Hospital and Health Services. Activity is measured in National Weighted Activity Units {15} as defined by the Independent Hospital Pricing Authority's National Efficient Price Determination 2015–16.
7. All patient activity for Calvary Public Hospital that does not meet the Independent Hospital Pricing Authority's criteria for inclusion on the 'General List of In-Scope Public Hospital Services'. Activity is measured in National Weighted Activity Units {15} as defined by the Independent Hospital Pricing Authority's National Efficient Price Determination 2015–16.
8. Client mean waiting time is defined as the mean waiting period between when a client is placed on the adult dental central waiting list and the receipt of treatment.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office as this is not required by the *Financial Management (Statement of Performance Scrutiny) Guidelines 2016*.

OUTPUT CLASS 1: HEALTH AND COMMUNITY CARE (CONTINUED)

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

Description

The Health Directorate provides a range of Mental Health, Justice Health and Alcohol and Drug Services through the public and community sectors in hospitals, community health centres and other community settings, adult and youth correctional facilities and peoples' homes across the Territory. These services work to provide integrated and responsive care to a range of services, including hospital based specialist services, and therapeutic rehabilitation, counselling, supported accommodation services and other community based services.

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

This means focussing on:

> ensuring timely access to emergency mental health care;
> ensuring that public and community mental health services in the ACT provide people with appropriate assessment, treatment and care that results in improved mental health outcomes;
> providing community and hospital based alcohol and drug services;
> providing health assessments and care for people detained in corrective facilities; and
> engagement and liaison with community sector services, primary care and other government agencies providing support and shared care arrangements.

	Original Target 2015–16	Actual Result 2015–16	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	135,532	139,094	3%		
Government Payment for Outputs (GPO) ($000's)	48,299	49,698	3%		
Accountability Indicators					
a. Adult mental health program community service contacts	120,000	120,466	-		9
b. Children and youth mental health program community service contacts	65,000	71,295	10%	During 2015–16 the service introduced a new intake process referred to as the Choice and Partnership Approach (CAPA) model. The new intake model resulted in a higher than expected result.	10
c. ACT wide mental health program community service contacts	106,000	106,791	1%		11

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

Notes

Explanation of Accountability Indicators

9. Mental Health ACT Adult community occasions of services (Age group 18-64).
10. Mental Health ACT Children and Adolescents community occasions of service (Age group 0-17).
11. ACT wide mental health program community services contacts includes Aboriginal and Torres Strait Islander Services, Mobile Intensive Treatment Team (MITT) North, Mental Health Service Intellectual Disability, Neuropsychology, Mental Health Dual Diagnosis, Crisis Assessment and Treatment Team (CATT) and Older Persons Mental Health Community team.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office as this is not required by the *Financial Management (Statement of Performance Scrutiny) Guidelines 2016*.

OUTPUT CLASS 1: HEALTH AND COMMUNITY CARE (CONTINUED)

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

	Original Target 2015–16	Actual Result 2015–16	% Variance from Original Target	Explanation of Material Variances	Notes
d. Proportion of detainees at the Alexander Maconochie Centre with a completed health assessment within 24 hours of detention	100%	100%	-		12
e. Proportion of detainees in the Bimberi Youth Detention Centre with a completed health assessment within 24 hours of detention	100%	100%	-		12
f. Justice Health Services Community contacts	108,000	151,210	40%	The higher than target result is a reflection of the higher numbers of detainees in the Alexander Maconochie Centre as well as improved data capture within the service.	13
g. Percentage of current clients on opioid treatment with management plans	98%	97%	-1%		14
h. Alcohol and Drug Services community contacts	70,000	67,183	-4%		15

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

Notes

Explanation of Accountability Indicators

12. Percentage of detainees at Alexander Maconochie Centre and Bimberi who are assessed within 24 hours of arrival at the facility. For Bimberi, young detainees who are detained for a period of less than 24 hours are excluded from this indicator.
13. Community contacts are occasions of service with or about the client resulting in a dated entry in the clinical file. Contacts include both direct and indirect clinical contact, reported for all community mental health service units in the Justice Health program.
14. On presentation for opioid replacement treatment, a management plan is developed. This indicator represents the percentage of clients with management plans.
15. Direct occasions of service with a client (appointment, contact or dose).

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office as this is not required by the *Financial Management (Statement of Performance Scrutiny) Guidelines 2016*.

OUTPUT CLASS 1: HEALTH AND COMMUNITY CARE (CONTINUED)

Output 1.3 Public Health Services

Description

Improving the health status of the ACT population through interventions which promote behaviour changes to reduce susceptibility to illness, alter the ACT environment to promote the health of the population and promote interventions that remove or mitigate population health hazards. This includes programs that evaluate and report on the health status of the ACT Population, assist in identifying particular health hazards and measures to reduce the risk to the health of the public from communicable diseases, environmental hazards and the supply of medicines and poisons.

	Original Target 2015–16	Actual Result 2015–16	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	33,937	34,894	3%		
Government Payment for Outputs (GPO) ($000's)	26,077	26,765	3%		
Accountability Indicators					
a. Samples analysed	8,500	12,693	49%	The variance relates to a higher than anticipated demand for analysis of controlled substances (illicit drug samples) and microbiological testing of food and water.	16
b. Compliance of licensable, registrable and non licensable activities at the time of inspection	85%	69%	-19%	The lower than targeted result relates to food safety compliance. There was also a greater focus in the last quarter of the financial year to undertake outstanding routine inspections.	17
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%	-		18
d. Percentage of Health Protection Service's regulated businesses/ activities who have access to Multi-year licenses/registrations	75%	100%	33%	Only one of the 6,203 registrable businesses (Drinking Water Utility) does not have access to Multi-Year Licences.	19

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

Notes

Explanation of Accountability Indicators

16. Number of samples analysed during the period by the ACT Government Analytical Laboratory.
17. Percentage of inspected premises found to be compliant 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 the *Medicines, Poisons and Therapeutic Goods Act 2008*.
18. 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.
19. Relates to activities regulated under the: *Public Health Act 1997*; *Food Act 2001*; *Medicines, Poisons and Therapeutic Goods Act 2008*; and the *Radiation Protection Act 2008*.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office as this is not required by the *Financial Management (Statement of Performance Scrutiny) Guidelines 2016*.

OUTPUT CLASS 1: HEALTH AND COMMUNITY CARE (CONTINUED)

Output 1.4 Cancer Services

Description

Canberra Hospital and Health Services provides a comprehensive range of screening, assessment, diagnostic, treatment, and palliative care services. Services are provided in inpatient, outpatient, and community settings.

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

	Original Target 2015–16	Actual Result 2015–16	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	75,627	77,124	2%		
Government Payment for Outputs (GPO) ($000's)	8,212	8,975	9%	The increase in GPO relates largely to the deferral of Commonwealth funding from 2014–15 due to the late receipt of funds by the Territory.	
Accountability Indicators					
a. Total breast screens	16,500	17,869	8%	The higher than target result is primarily due to an increase in promotional activity and the opening of a new screening site in Belconnen in December 2015.	20
b. Number of breast screens for women aged 50 to 69	12,800	13,376	5%	The higher than target result is primarily due to an increase in promotional activity and the opening of a new screening site in Belconnen in December 2015.	21
c. Percentage of women who receive results of screen within 28 days	100%	100%	-		22
d. Percentage of screened patients who are assessed within 28 days	90%	82%	-9%	Timeframes for attendance at assessment were adversely impacted by the installation of a new mammography/biopsy machine in January 2016 and the need to train clinicians in its use. In addition, a significant number of women elect to delay their attendance at assessment clinics due to personal circumstances.	23

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

Notes

Explanation of Accountability Indicators

20. Total number of women screened in the period.
21. Number of women aged between 50 to 69 years screened in the period.
22. The percentage of women with a 'normal' result who receive notice of this outcome within 28 days of their screening appointment. Consistent with national methods, the end date is the date the results are produced, as it is not possible to ascertain the date a client receives a mailed document.
23. The percentage of women requiring assessment who wait 28 days or less from their breast screen appointment to their assessment appointment.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office as this is not required by the *Financial Management (Statement of Performance Scrutiny) Guidelines 2016*.

OUTPUT CLASS 1: HEALTH AND COMMUNITY CARE (CONTINUED)

Output 1.5 Rehabilitation, Aged and Community Care

Description

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

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

> ensuring that older persons in hospital wait an appropriate time for access to comprehensive assessment by the Aged Care Assessment Team. This will assist in their safe return home with appropriate support, or access to appropriately supported residential accommodation;

> improving discharge planning to minimise the likelihood of readmission or inadequate support for independent living, following completion of hospital care; and

> ensuring that access is consistent with clinical need, is timely for community based nursing and allied health services and that community based services are in place to better provide for the acute and post acute healthcare needs of the community.

	Original Target 2015–16	Actual Result 2015–16	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	133,835	133,369	-		
Government Payment for Outputs (GPO) ($000's)	45,113	46,441	3%		
Accountability Indicators					
a. Number of nursing (domiciliary and clinic based) occasions of service	84,000	91,779	9%	The higher than target result in occasions of service relates to the expansions of Belconnen, Gungahlin and Tuggeranong health centres in recent years. Improved capacity for wound care and stoma management in particular has improved access to these clinical presentations.	24
b. Number of allied health regional services (occasions of service)	25,000	31,829	27%	The higher than target result in occasions of service relates to the expansions of Belconnen, Gungahlin and Tuggeranong health centres in recent years. Changes in service models and improvements in efficiencies have also been implemented resulting in improved capacity and the number of occasions of service.	25

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

Notes

Explanation of Accountability Indicators

24. All occasions of service provided to community patients by Community Care Nurses in the following settings: home visits; ambulatory care clinics; foot care clinics; continence clinics; wound clinics; and stoma clinics.
25. All occasions of service provided to community patients by Community Care Allied Health Professionals and Allied Health Assistants for Physiotherapy, Occupational Therapy, Social Work, Podiatry and Nutrition.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office as this is not required by the *Financial Management (Statement of Performance Scrutiny) Guidelines 2016*.

OUTPUT CLASS 1: HEALTH AND COMMUNITY CARE (CONTINUED)

Output 1.6 Early Intervention and Prevention

Description

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

	Original Target 2015–16	Actual Result 2015–16	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	86,489	90,011	4%		
Government Payment for Outputs (GPO) ($000's)	39,752	40,502	2%		
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%	94%	2%		26
b. Proportion of clients attending 'Well Women's Check' within the Women's Health Service that are from culturally and linguistically diverse communities	40%	46%	15%	The higher than target result in the proportion of clients from culturally and linguistically diverse (CALD) communities is due to increased marketing of the service. Furthermore, the Women's Health Services' relationship with CALD communities has been strengthened through a targeted community development project, which has led to an increase in referrals for Well Women's Checks.	27
c. Proportion of children aged 0–14 who are entering substitute and kinship care within the ACT who attend the Child at Risk Health Unit for a health and wellbeing screen	90%	97%	8%	The higher than target result is due to the Child at Risk Health Unit (CARHU) conducing rigorous follow-up action, collaboration with staff in the Community Services Directorate as well as liaison with the carer/ guardians of children.	28

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

Notes

Explanation of Accountability Indicators

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

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office as this is not required by the *Financial Management (Statement of Performance Scrutiny) Guidelines 2016*.

PART D:
NOTICES OF NONCOMPLIANCE

D.1 DANGEROUS SUBSTANCES

In 2015–16, ACT Health received no notices of noncompliance under section 200 of the *Dangerous Substances Act 2004*.

D.2 MEDICINES, POISONS AND THERAPEUTIC GOODS

In 2015–16, ACT Health issued no notices of noncompliance under section 177 of the *Medicines, Poisons and Therapeutic Goods Act 2008*.

PART F: HEALTH

F.1 MENTAL HEALTH

See Attachments—Annexed and subsumed public authority reports—Chief Psychiatrist Annual Report 2015–16, page 239.

F.2 TOBACCO COMPLIANCE TESTING

Access Canberra has not undertaken tobacco compliance testing during the 2015–16 financial year. As a result, no contraventions to section 14 of the *Tobacco and Other Smoking Products Act 1927* (supply of smoking product to under 18-year-olds) were detected and no action was taken.

Access Canberra visited 61 licensed tobacconists and 101 venues with outdoor eating and drinking areas to ensure compliance with the Tobacco and Other Smoking Products Act 1927 and smoke-free legislative obligations. Minor administrative noncompliance was detected, which was quickly rectified with assistance from Access Canberra.

ATTACHMENTS

ANNEXED AND SUBSUMED PUBLIC AUTHORITY REPORTS

ACT CARE COORDINATOR ANNUAL REPORT 2015–16

The ACT Care Coordinator is a statutory appointment made by the Minister for Health, under Section 204 (1) of the *Mental Health Act 2015*.

This report is being submitted in accordance with Section 205 (e) of the *Mental Health Act 2015*.

The Care Coordinator is responsible for coordinating the provision of treatment, care or support for a person with a mental disorder to whom a Community Care Order (CCO) applies. The Care Coordinator is also responsible for coordinating the provision of treatment, care or support for a person for whom a Forensic Community Care Order (FCCO) is in force. CCOs and FCCOs are made by the ACT Civil and Administrative Tribunal (ACAT). The Executive Officer for the ACT Care Coordinator is located within the Public Advocate of the ACT.

From 1 July 2015 to 30 June 2016, eight people were subject to a CCO; six men and two women. There were four people for whom new CCOs were made in the reporting period. For the eight people subject to CCOs, one was referred by the courts and the remaining seven were referred by clinical services. Dementia was the reason four people were subject to CCOs, one had a neurological disorder other than dementia, and three had an intellectual disability.

No FCCOs were made during this reporting period.

Table 58 summarises the CCOs for 2015–16.

TABLE 58: COMMUNITY CARE ORDERS 1 JULY 2015–30 JUNE 2016

Category	Details
Gender	Male: 6 Female: 2 Total: 8
New CCO	4
Age	≤18 years: 0 19-29 years: 1 30-39 years: 3 40-49 years: 1 50-59 years: 1 60-69 years: 1 70-79 years: 0 80+ years: 1
Condition	Intellectual disability: 3 Dementia: 4 Neurological condition other than dementia: 1
Referring Agency	Mental Health: 3 Older Persons Mental Health Service (OPMH): 4 Courts: 1 ACT Health: 0
Restriction Orders	7

Linda Kohlhagen
ACT Care Coordinator
June 2016

CALVARY HEALTH CARE LTD ANNUAL REPORT 2015–16

Calvary Public Hospital Bruce (Calvary) is a fully accredited health service comprising 300 beds across the Bruce campus and Clare Holland House in Barton. Calvary is committed to providing contemporary and multidisciplinary team-based care, which is delivered by a dedicated, qualified and professional workforce. At both campuses the natural environment supports personal wellbeing and holistic healing.

Calvary delivers public health and hospital services on behalf of the ACT Government. The Calvary Network Agreement formalises this arrangement, with an annual Calvary Performance Plan negotiated to determine the services to be provided over the financial year. These governance arrangements are subject to ongoing review and enhancement.

As a member of the ACT Local Hospital Network with defined roles and service delineation, Calvary delivers high-quality clinical care, providing comfort and healing to ACT residents and people from surrounding communities. Calvary has formal protocols and practical working relationships that ensure patients with particular conditions and treatment requirements not available at Calvary are seamlessly transitioned or transferred to Canberra Hospital or interstate for specialty services.

Calvary is a teaching hospital associated with the Australian Catholic University, the Australian National University and the University of Canberra. In this role, and through the contribution of emerging clinical practitioners, Calvary is at the forefront of contemporary health service and acute care practices.

Services provided by Calvary include:

> a 24/7 Emergency Department
> intensive and coronary care
> medical and surgical inpatient services
> maternity services
> aged care and rehabilitation services
> voluntary psychiatric services
> specialist outpatient clinics
> Hospital in the Home service.

Calvary operates the ACT Specialist Community Palliative Care Service from Clare Holland House campus in Barton. This Service comprises:

> Clare Holland House, which is a 19-bed inpatient specialist palliative care unit
> palliative care outpatients' clinics
> community-based palliative care services
> Calvary-Australian Catholic University Palliative Care Research Centre.

The demand for palliative and end-of-life care is rising rapidly as a result of longer life expectancy, an ageing population and improved chronic diseases management. The ACT Specialist Community Palliative Care Service is a national leader in the development of interdisciplinary and multidisciplinary treatment and care plans for palliative care patients. These plans ensure that patients' care is coordinated between all their care providers including their GP, specialists, residential care supervisor and the specialist palliative care team.

ACTIVITY ACHIEVEMENTS

During 2015–16, Calvary delivered:

> 27,214 Calvary Public Hospital, Bruce admissions
> 354 Clare Holland House admissions
> 57,530 Emergency Department presentations
> 5,383 elective surgery procedures
> 1,730 emergency surgery procedures
> 1,775 babies born.

OTHER ACHIEVEMENTS

The dynamic nature of health and hospital services along with the increasing demand on those services requires Calvary to continuously review processes and procedures related to patient care. During 2015–16, this included:

> Calvary achieved unconditional accreditation against the National Safety and Quality in Health Service Standards following a survey conducted by the Australian Council on Healthcare Standards (ACHS) in 2015.
> Restructuring the organisation to establish clinical streams that foster multidisciplinary care planning and enable the more efficient planning, allocation and management of resources across the streams.
> Redefining management roles and responsibilities to support the Clinical streams model.
> Completing the development and review of the Non-Admitted Patient Model of Care and finalising the 2016–17 implementation plan for this initiative.
> Enhancing the efficient operations of the Rapid Assessment and Planning Unit, Medical Assessment and Planning Unit and Calvary Stroke Service. A National Stroke Foundation audit completed in 2015–16, found the Calvary Stroke Service to be a national leader in a number of areas of stroke diagnosis and treatment.
> Establishing a dedicated short-stay surgical ward known as 3S General. This initiative recognises the significantly different postoperative care required for various surgical procedures.
> Calvary, in partnership with SITA Environmental Solutions, expanded its waste management programs to develop 26 waste management streams (including multiple clinical waste streams) that are 'sorted at source'. This program has been

strongly supported by staff and is endorsed by the Calvary group policy on environmental stewardship. In 2015, Calvary was the 2015 ACT Government No Waste Business Award winner.

> Calvary individuals and teams were named recipients of a number of excellence awards. These include:
  - The Calvary Public Hospital Bruce Lymphoedema Senior Management and Clinical Team were named the recipients of both the 2016 Award for Allied Health Team Excellence and the 2016 Allied Health Professionals of the Year.
  - Calvary Midwife Hana Sayers was named ACT Midwife of the Year in the 2016 ACT Health Excellence Awards.
  - The Calvary Emergency Department Team was named Team of the Year in the 2016 ACT Health Excellence Awards.
  - Calvary's Christine Falez RM was awarded the Excellence In Leadership Practice in the 2016 ACT Health Excellence Awards.
  - Matt Luther NP from Calvary was awarded the Excellence In Management Practice in the 2016 ACT Health Excellence Awards.
  - Amelia Druhan RM from the Calvary Maternity Unit was named Midwife of the Year in the 2016 Australian College of Midwifery Awards.
  - The Calvary Palliative Aged Care Consultancy Team were finalists in the 2016 HESTA National Nursing Team Excellence Awards.
  - Calvary Domestic Services Manager Greg Robertson was the recipient of the Minister's Award for Leadership in the 2016 ACTSmart Business Sustainability Awards.

Improved community access

The ongoing development in the Molonglo and Gungahlin townships continues to expand the geographical and population catchments for whom Calvary is their closest acute care public hospital and health service.

The ACT Government and Calvary are committed to expanding the services to meet the needs of the growing ACT population. Over recent years, a rolling program of refurbishment and re-engineering has been formulated and implemented on the Calvary campus.

In the past 12 months this program has seen:

> a campus-wide upgrade of electrical services
> the continued upgrading of patient rooms to conform to contemporary hygiene and infection control standards
> enhancements to public areas, including toilets and the main hospital entry.

The 720 space multi-level car park on the southern side of the Calvary Bruce campus opened in December 2015. This car park provides convenient and flexible parking for patients and visitors, and features additional disability permit parking and improved disability access to Calvary Hospital entry points.

The refurbishment of a Specialist Outpatients' Clinic area in Calvary's Lewisham Building has also been completed. This purpose-built clinic area includes consultation and procedure rooms. The new area will provide an accessible and comfortable setting for Outpatient Clinic patients.

Issues and challenges

The concurrent factors of longer life expectancy, an ageing population, improved management of chronic conditions, and the consistent emergence of new and expensive health practices and technology, represent a challenge for all health services at both network and individual facility levels.

As with all Australian public health and hospital services, Calvary shares the challenge of meeting the growing needs of the community in an environment where State and Territory governments, and the Commonwealth Government, endeavour to contain growing health costs.

Calvary is wholly committed to working with ACT Health to provide economically sustainable responses to these challenges while ensuring patients and their families receive patient-centred, high-quality care and treatment.

Most importantly, Calvary remains dedicated to ensuring the community is informed and confident that in their time of need services will be available and delivered with respect and compassion by a highly trained and committed workforce.

Future directions

Imminent projects for Calvary Public Hospital are the refurbishment of a number of operating theatres, and the upgrade of medical imaging services. These projects will be undertaken with as little disruption as possible to normal services.

The operational priority for Calvary will be to further refine the clinical stream modelling across all acute services. This model, which integrates medical, nursing and allied health services into a single care team, supports:

> multidisciplinary care plans and treatment
> improved patients' outcomes
> reduced length of stay
> consistent patient flow in Calvary's acute care settings.

Construction of a new Calvary Bruce Private Hospital has commenced, with the facility expected to open in mid-2017. The 100-bed Private Hospital will include a range of clinical and hospitality features to facilitate contemporary clinical services and offer an unparalleled hospitality experience for patients.

CHIEF PSYCHIATRIST ANNUAL REPORT 2015–16

On 6 February 1995, the *Mental Health (Treatment and Care) Act 1994* was implemented in the Australian Capital Territory (ACT). This was repealed by the *Mental Health Act 2015*.

The *Mental Health Act 2015* commenced on 1 March 2016. It gives those people in the ACT living with a mental illness, or their carers and family members, greater opportunity to contribute on decisions on their treatment, care and support. The Act was developed over several years with extensive stakeholder engagement.

The objectives and principals of the Act uphold the human rights of those people with a mental illness and an acknowledgement of the place of carers is a feature throughout the Act. The Act is about empowering people in the ACT community with mental illnesses and mental disorders to make critical decisions about their treatment, care and support to the best of their ability, and with the involvement of carers, and close family and friends.

EMERGENCY APPREHENSION

Table 59 shows the number of emergency apprehensions in 2015–16, by initiator.

TABLE 59: EMERGENCY APPREHENSION

	Mental Health (Treatment and Care) Act 1994 **1 July 2015 to 29 February 2016**	***Mental Health Act 2015*** **1 March to 30 June 2016**	**Total**
Police officer	490	204	694
Mental health officer	111	51	162
Medical practitioner	90	39	129
Authorised ambulance paramedic *	0	43	43
Emergency apprehensions (total)	691	337	1028

**NB the Mental Health Act 2015 allows Authorised Ambulance Paramedics to undertake emergency apprehensions.*

EMERGENCY DETENTION

Table 60 shows the number of emergency detention notifications issued in 2015–16 in comparison to previous years. One of the major elements of the *Mental Health Act 2015* is that applications for an extension of emergency detention now allow the total period to be up to 11 days. Applications for extension of emergency detention, mental health orders and variations of mental health orders are made to the ACT Civil and Administrative Tribunal (ACAT).

TABLE 60: EMERGENCY DETENTIONS

Year	**Number of emergency detentions**
July 2012–June 2013	689
July 2013–June 2014	596
July 2014–June 2015	698
1 July 2015–29 February 2016	526
1 March–30 June 2016 *Mental Health Act 2015*	237

Outcome of those detained

Table 61 shows the outcomes for those detained in 2015–16 in comparison to previous years.

TABLE 61: OUTCOME OF THOSE DETAILED

Year	**Revocation of 72-hour detention and/or 72-hour detention being allowed to lapse**	**Applications for extension of involuntary detention**
July 2012–June 2013	363	326
July 2013–June 2014	295	299
July 2014–June 2015	387	311
1 July 2015–29 February 2016	293	233
1 March–30 June 2016 *Mental Health Act 2015*	136	101

Psychiatric treatment orders

Under both the *Mental Health (Treatment and Care) Act 1994* and the *Mental Health Act 2015*, the Chief Psychiatrist is responsible for the treatment and care of a person to whom a psychiatric treatment order (PTO) applies. The maximum duration of a PTO is six months.

Table 62 shows the PTO and Community Care Order (CCO) restriction order statistics for 2015–16 in comparison to previous years.

TABLE 62: PSYCHIATRIC TREATMENT ORDERS

Year	PTOs granted by the Tribunal	PTOs revoked	Contravention of PTO	Restriction orders made by Tribunal were all in relation to CCOs
July 2012–June 2013	924	127	82	16
July 2013–June 2014	890	167	80	15
July 2014–June 2015	921	156	90	14
1 July 2015–29 February 2016	668	126	67	44
1 March – 30 June 2016 *Mental Health Act 2015*	244	128	34	3

OTHER MATTERS

Both the *Mental Health (Treatment and Care) Act 1994 and the Mental Health Act 2015* provide for the authorisation of involuntary electro-convulsive therapy (ECT), including emergency ECT. They also have 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 an individual to Canberra Hospital for the purposes of an emergency assessment to determine whether immediate treatment and care are required.

Table 63 provides statistics for other matters in 2015–16 in comparison to previous years.

TABLE 63: OTHER MATTERS

Year	Application for ECT authorised	Application for emergency ECT authorised	Transfers to/ from NSW	Court ordered removal for assessment—s309 of the Crimes Act 1900
July 2012–June 2013	13	1	8	40
July 2013–June 2014	7	0	9	44
July 2014–June 2015	10	1	12	63
July 2015–June 2016	8	0	8	61
1 March–30 June 2016 *Mental Health Act 2015*	6	0	2	17

KEY POINTS ARISING

The following trends in key areas of activity related to the Office of the Chief Psychiatrist are noteworthy.

In 2015–16, 1,028 people were apprehended and brought to Canberra Hospital for assessment. This is a marginal increase of 0.8 per cent from the previous year, when it was 1,020. Emergency detention revocations have increased from 387 to 421, an 8 per cent increase from the previous year. This reflects the continuing efforts to provide the least restrictive care at an early opportunity, if at all possible.

Applications to extend involuntary detention increased by 7 per cent, indicating the treating team's efforts to continue to appropriately stabilise an acute episode of illness. Increasing the stability of a person's mental health during an inpatient admission provides a greater chance of successful ongoing management for that person in the community.

ACAT held 1,246 hearings during 2015–16 and granted 912 PTOs. This is a marginal increase of 1.8 per cent from 2014–15.

There are two sets of figures for PTOs revoked by the Tribunal taking into account the new *Mental Health Act 2015.* For 2015–16, 254 revocations were made, as follows:

> 126 from 1 July 2015 to 29 February 2016 under the Mental Health (Treatment and Care) Act 1994

> 128 from 1 March to 30 June 2016 under the Mental Health Act 2015.

This anomaly is due to the changes in the *Guardianship and Management of Property Act 1991* as a consequence of the *Mental Health Act 2015*, which now allows for Guardians or Health Attorneys to give consent for people with a mental illness or mental disorder who do not have decision-making capacity but show a willingness to accept treatment.

Fourteen ECT orders were authorised by the Tribunal, an increase from ten from the previous year. No applications were made to the Tribunal for emergency ECT.

Ten cross-border agreements were made between the ACT and NSW. The ACT accepted four transfers from NSW, and six transfers were made to NSW facilities.

Contraventions of PTOs increased from 90 to 101 in 2015–16. This is an increase of 12 per cent from 2014–15. Twenty-nine people were brought to Canberra Hospital for medication or assessment purposes, and 16 were admitted to hospital as a result. Community teams make every effort to anticipate and manage crises early. Often, if this is successful, a contravention is not required.

The ACT Magistrates Court made 78 referrals for assessment pursuant to section 309 of the *Crimes Act 1900*, an increase of 23 per cent from the previous year. Of these, 40 people required admission to the Adult Mental Health Unit for assessment purposes, with 38 being returned to court on the same day. The Court Assessment Liaison Service continues to provide assessment and advice to the courts at the time of the hearing, which in many circumstances means that a section 309 referral is not required.

Dr Peter Norrie
Chief Psychiatrist

HUMAN RESEARCH ETHICS COMMITTEE ANNUAL REPORT 2015–16

The ACT Health Human Research Ethics Committee (HREC) continues its work of reviewing human research proposals to ensure they meet the ethical standards set out in the *National Statement on Ethical Conduct in Human Research (2007)*, which is jointly developed by the:

> National Health and Medical Research Council (NHMRC)
> Australian Research Council
> Australian Vice-Chancellors' Committee.

During 2015–16, HREC has been an active contributor to the NHMRC consultation process on developing national reforms in research ethics administration.

The Research Ethics and Governance Office Director, August Marchesi, has continued to represent HREC and ACT Health on the Jurisdictional Working Group that is managing the National Mutual Acceptance (NMA) of ethical and scientific review for multi-centre health and medical research.

The Clinical Trials Subcommittee (CTSC) and the Social Research Subcommittee (SRSC) have continued to provide HREC with expert advice on the research merit and integrity of research proposals. The Low Risk Subcommittee (LRSC) reviews and takes decisions on more than two-thirds of all proposals received.

HREC and its subcommittees draw on the expertise available in:

> ACT Health
> the wider ACT research community
> more broadly, the ACT community.

As of June 2016 the HREC comprised:

> 10 external members
> seven internal ACT Health members.

I would like to thank the members of HREC and its subcommittees for their hard work and dedication to the enterprise of ethical review. On behalf of the committee, thanks is given to the Secretariat staff, August Marchesi, Matthew Wafer and Gillian Fox, for their tireless work in keeping the ACT Health HREC and its processes operating at the highest standards.

Louise Morauta PSM PhD
Chair

MEMBERSHIP OF THE HUMAN RESEARCH ETHICS COMMITTEE

Table 64 identifies membership of the HREC in 2015–16.

TABLE 64: HREC MEMBERSHIP

Name of member	Position
Dr Louise Morauta	Chair
A/Professor Frank van Haren	Deputy Chair Current Researcher (Intensive Care)
Professor Walter Abhayaratna	Current researcher (Cardiology)
Ms Kimberley Baillie	Lawyer member (alternate)
Ms Margaret Blood	Lay member
Professor Doug Boer	Member providing professional care (until 1 June 2016)
Dr Bianca Calabria	Current researcher (Aboriginal and Torres Strait Islander Health)
A/Professor Paul Craft	Current researcher (Oncology)
Professor Geoff Farrell	Current researcher (Hepatology)
Rev Doug Hutchinson	Member providing pastoral care (until September 2015)
Dr David Larkin	Current researcher (Nursing and midwifery) (until 30 April 2016) Member providing professional care (from 1 May 2016)
Mr David Lovegrove	Consumer member (new position from December 2015)
Professor Imogen Mitchell	Current researcher (Intensive care)
Mr John Morrissey	Lawyer member (alternate)
Dr Anna Olsen	Current researcher (Social Science)
Rev Neale Roberts	Member providing pastoral care (from October 2015)
Dr Louise Stone	Current researcher (Social Science)
A/Professor Dipti Talaulikar	Current researcher (Haematology) (until September 2015)
Ms Lyn Todd	Pharmacist
Mr Luke Williamson	Lay member

MEETINGS OF THE ETHICS COMMITTEE AND ITS SUBCOMMITTEES

The committee met 11 times from 1 July 2015 to 30 June 2016. Meetings are held monthly. Subcommittee meeting details are as follows:

> The Clinical Trials Subcommittee (CTSC), under the chairmanship of Professor Walter Abhayaratna, met nine times during the year. In each instance, recommendations were made to the subsequent HREC meeting.

- The Social Research Subcommittee (SRSC), under the chairmanship of Dr Jason Mazanov (until October 2015) and Dr Anna Olsen (from November 2015), met 10 times during the year. Again, in each instance, recommendations were made to the subsequent HREC meeting.
- The Low Risk Subcommittee (LRSC), under the chairmanship of Dr Louise Morauta, met 26 times during the year. The LRSC meets on a fortnightly cycle to enable a faster decision-making process for projects "in which the only foreseeable risk for participants is one of discomfort" (National Statement on Ethical Conduct in Human Research (2007), p. 16).

KEY POINTS ARISING

Key developments during the 2015–16 year were:

- A new rule was approved by ACT Health in December 2015, allowing research projects already approved by an NHMRC-certified HREC to be exempt from duplicate ACT Health ethics review processes. As at 30 June 2016, 13 projects had been submitted under this rule and nine approved to begin research at ACT Health.
- The Powers of Attorney Amendment Bill 2015 passed, marking a positive conclusion to two years of work for HREC and the Secretariat. This amendment will make it easier for residents of the ACT to participate in research where a Power of Attorney or guardianship order applies.
- ACT Health signed an agreement with the NSW Ministry of Health to sub-license an Information Technology (IT) system, known as AU RED, which is a critical step in facilitating the ACT to join other jurisdictions in the NMA scheme.
- The first national performance statistics for ethics committees were released and show ACT Health HREC compares very well with other NHMRC-certified HRECs.
- In 2014–15, ACT Health HREC approved 96 per cent of all proposals within the NMA benchmark of 60 calendar days (with the NMA clock-stop method applied). The comparative national figure for NMA committees for commercially sponsored trials was 82 per cent.
- In the 2015 calendar year ACT Health HREC approved 80 per cent of proposals in 34 days (clock-stop applied). The LRSC approved 80 per cent of proposals in 10 calendar days (no clock applied).

RADIATION COUNCIL ANNUAL REPORT 2015–16

CHAIR'S REVIEW

It is my pleasure to present the Annual Report of the Radiation Council (the Council) for 2015–16.

The Council has had a productive year, continuing to issue licenses, register radiation sources and consider issues that may affect the ACT community with regards to radiation safety and protection.

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* controls the safe use, storage, transportation and disposal of radioactive material and irradiating apparatus. The Council is established under Part 5 of the *Radiation Protection Act 2006*, and has the following functions:

> issuing licences
> registering regulated radiation sources
> advising the Minister on radiation protection issues
> exercising any other function given to it under the Radiation Protection Act 2006 or another territory law.

COUNCIL MEMBERSHIP

The composition of the Council is specified in section 65 of the *Radiation Protection Act 2006*. Seven members are currently appointed to the Council, as shown in Table 65.

TABLE 65: COUNCIL MEMBERS

Name	Position held	Appointed until
Elizabeth Croft	Chair	30 November 2016
Sean Geoghegan	Deputy Chair	30 September 2018
Mervyn Despois	Member	30 November 2016
Donald McLean	Member	30 November 2016
Stephen Tims	Member	30 November 2016
Ahmad Javaid	Member	30 September 2018
Fiona Jolly	Member	30 November 2016

Council meetings 2015–2016

The Council meets approximately every six weeks and met ten times during 2015–2016. Meetings were held in:

> July, September, October, November and December of 2015
> January, March, April, May and June of 2016.

Regulatory standards

The Council refers to a number of standards, codes of practice, safety guides, and recommendations when:

> considering matters relating to radiation protection
> issuing licences and approving registrations under the Radiation Protection Act 2006.

This includes documents in the Australian Radiation Protection and Nuclear Safety Agency (ARPANSA) Radiation Protection Series, which are available free of charge from *www.arpansa.gov.au*.

NATIONAL DIRECTORY FOR RADIATION PROTECTION

The National Directory for Radiation Protection (the Directory) provides the basis for achieving uniformity of radiation protection practices across Australian jurisdictions, and is an incorporated document under the *Radiation Protection Act 2006*. The Directory is designed to be regularly updated to reflect the best radiation protection practice of the time. The Directory is prepared by the ARPANSA Radiation Health Committee, and is only updated in accordance with prescribed processes.

The Council is regularly briefed on developments with regard to the work of the ARPANSA Radiation Health Committee. ACT Health has a jurisdictional representative appointed to the committee.

COUNCIL ACTIVITIES

Approvals and decisions

Licences

The Council issued 195 new licences during the 2015–16 year, bringing the total number of active licences in the ACT to 1,196. Overall, this represents a 4.7 per cent increase (54 licences) on the 2014–15 total of 1,142 licences.

Registrations

The Council registered 82 new radiation sources during the 2015–16 year, bringing the total number of registered radiation sources in the ACT to 658. Overall, this represents a 9.3 per cent increase (56 sources) on the 2014–15 total of 602 registered sources.

Radiation incidents

Two radiation incidents, summarised in Table 66, were reported to the Council during the year and underwent further investigation.

TABLE 66: RADIATION INCIDENTS

Incident type	No. incidents	Details
Accidental Exposure	1*	One incident involved radiotherapy medical equipment.
Other Incident	1	One incident involved a patient who had undergone a therapeutic nuclear medicine procedure becoming ill after they were discharged.

In line with the ACT Health Risk Management Guidelines, both 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.

Following investigation, one of these incidents (marked with an asterisk *) was reported to ARPANSA for inclusion on the Australian Radiation Incident Register. The incident was reported to ARPANSA as a 'near-miss' which had a potential to be of minor consequence.

Enforcement and remedial actions by the Council

No investigations or legal proceedings were commenced in 2015–2016.

CONTACT DETAILS

All correspondence should be addressed to:

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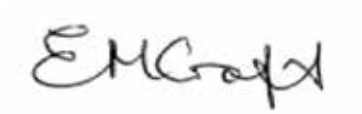
Radiation Council
C/- Health Protection Service
Locked Bag 5005
WESTON CREEK ACT 2611

Phone: (02) 6205-1700
Email: *hps@act.gov.au*
Website: *www.health.act.gov.au\radiationsafety*



Elizabeth Croft
Chair
01 July 2016

ACT LOCAL HOSPITAL NETWORK DIRECTORATE ANNUAL REPORT 2015–16

MANAGEMENT DISCUSSION AND ANALYSIS FOR THE ACT LOCAL HOSPITAL NETWORK DIRECTORATE, FOR THE YEAR ENDED 30 JUNE 2016

GENERAL OVERVIEW

Purpose

The ACT Local Hospital Network Directorate (ACT LHN) was established under the *Health Act 1993* (the Act), and is administered by the Director-General of the Health Directorate and supported by staff from the Health Directorate.

The ACT LHN receives Activity Based Funding from the Commonwealth and ACT Governments, and block funding for teaching, training and research. It purchases public hospital services from four ACT public hospital providers:

> Canberra Hospital and Health Services;
> Calvary Public Hospital;
> Clare Holland House; and
> Queen Elizabeth II Family Centre.

RISK MANAGEMENT

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

Actual public hospital activity (inpatient and outpatient services) delivered by entities in the ACT Local Hospital Network is lower than the budgeted activity resulting in a reduction of funding from the Commonwealth Government.

The Commonwealth Government funded 45 per cent of the growth in public hospital activity from 2015–16 and the ACT Government and the Directorate will agree on the process for managing fluctuation in activity and costs from 2015–16.

The above risk is monitored regularly throughout the year.

FINANCIAL PERFORMANCE

The following financial information is based on audited financial statements for 2014–15 and 2015–16, and the forward estimates contained in the 2016–17 ACT LHN Budget Statements.

Total Net Cost of Services

	Actual 2014–15 $m	Budget 2015–16 $m	Actual 2015–16 $m	Budget 2016–17 $m	Forward Estimate 2017–18 $m	Forward Estimate 2018–19 $m	Forward Estimate 2019–20 $m
Total Expenses	966.0	1,019.6	1,025.5	1,064.7	1,103.5	1,130.0	1,156.8
Total Own Source Revenue	402.9	414.5	421.7	431.2	459.8	481.0	503.2
Total Net Cost of Services	563.1	605.1	603.8	633.5	643.7	649.0	653.6

Comparison to Budget

The Directorate's net cost of services for 2015–16 of $603.8 million was within $1.3 million or 0.2 per cent of the 2015–16 budget.

Comparison to 2014–15 Actual Expenses

There was an increase of $40.7 million or 7.2 per cent compared to the 2014–15 net cost of service of $563.1 million. This is due to higher expenses of $59.5 million mainly relating to growth in acute services including emergency and additional elective surgery, mental health, outpatient, community and primary care services and women and children's health.

Higher expenses are partially offset by an increase in own source revenue of $18.8 million mainly due to:

> growth in activity for public hospital services funded through the National Health Reform Agreement including emergency and additional elective surgery, mental health, outpatient, community and primary care services and women and children's health; and

> a higher number of interstate patients, in particular New South Wales residents, being treated in ACT public hospitals.

Future Trends

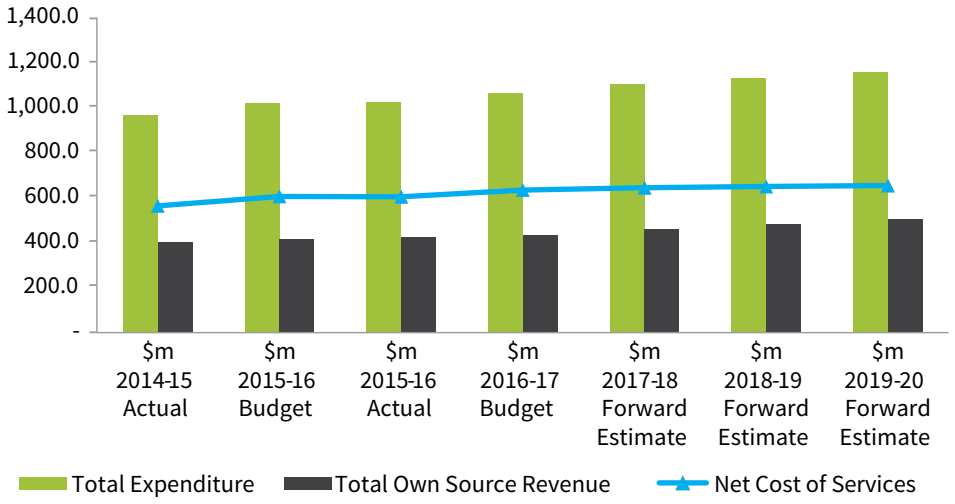


Figure 1: Net Cost of Services

As shown above in Figure 1, net cost of services is expected to increase across the forward years.

Total Expenditure

Components of Expenditure

Figure 2 below shows that for the financial year ended 30 June 2016, 99.4 per cent of total expenditure ($1,025.5 million) relates to grants and purchased services.

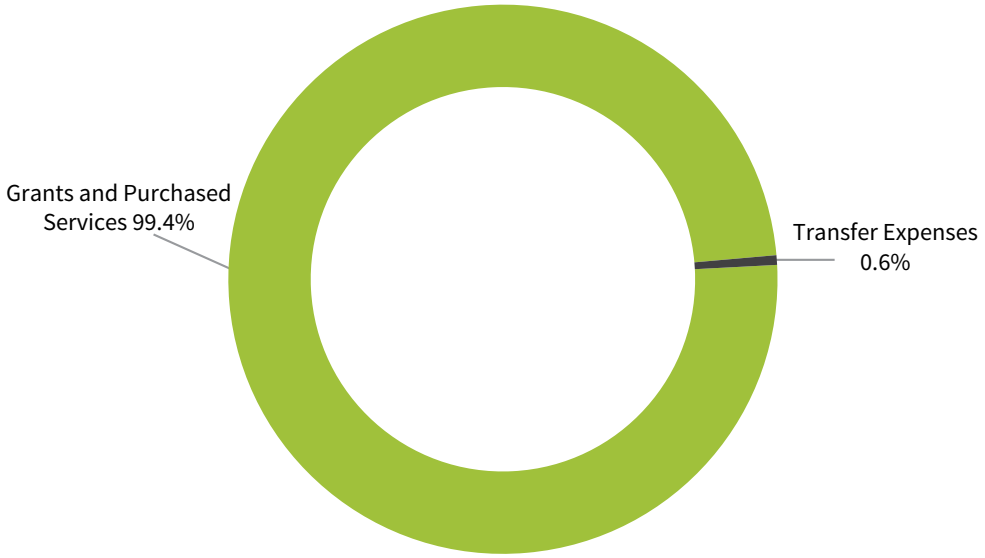


Figure 2 – Components of Expenditure

Comparison to Budget

Total expenses of $1,025.5 million was within $5.9 million, or 0.6 per cent of the original 2015–16 budget of $1,019.6 million.

Comparison to 2014–15 Actual Expenses

Total expenses were $59.5 million or 6.2 per cent higher than the 2014–15 actual result of $966.0 million. This was due to growth in public hospital services funded through the National Health Reform Agreement including emergency and additional elective surgery, mental health, outpatient, community and primary care services and women and children's health.

Future Trends

Expenses are budgeted to steadily increase across the forward estimate years.

Total Own Source Revenue

Components of Own Source Revenue

Figure 3 below indicates that for the financial year ended 30 June 2016, the Directorate received 77.0 per cent of its total own source revenue of $421.7 million from Grants from the Commonwealth ($324.7 million) and the remaining 23.0 per cent from Cross Border User Charges ($97.0 million)

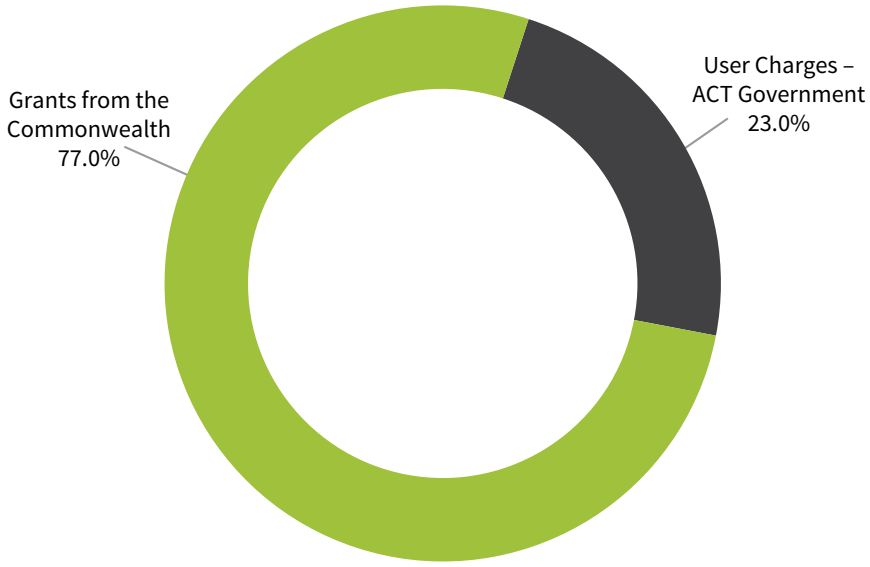


Figure 3 – Components of Own Source Revenue

Comparison to Budget

Own source revenue for the year ending 30 June 2016 was $421.7 million, which was $7.2 million or 1.7 per cent higher the 2015–16 budget of $414.5 million. The higher own source revenue is due to higher activity based funding and cross border revenue from higher patient numbers than estimated in the budget.

Comparison to 2014–15 Actual Own Source Revenue

Own source revenue was $18.8 million or 4.7 per cent higher than the 2014–15 result of $402.9 million. The increase is mainly due to growth in public hospital activity including acute services, mental health services and cancer services funded through the National Health Reform Agreement.

Future Trends

Total own source revenue is expected to increase steadily.

Financial Position

Total Assets

Components of Total Assets

Figure 4 below indicates that, at 30 June 2016, the Directorate held total assets of $23.0 million with 86.3 per cent of its assets in receivables and 13.7 per cent in cash and cash equivalents.

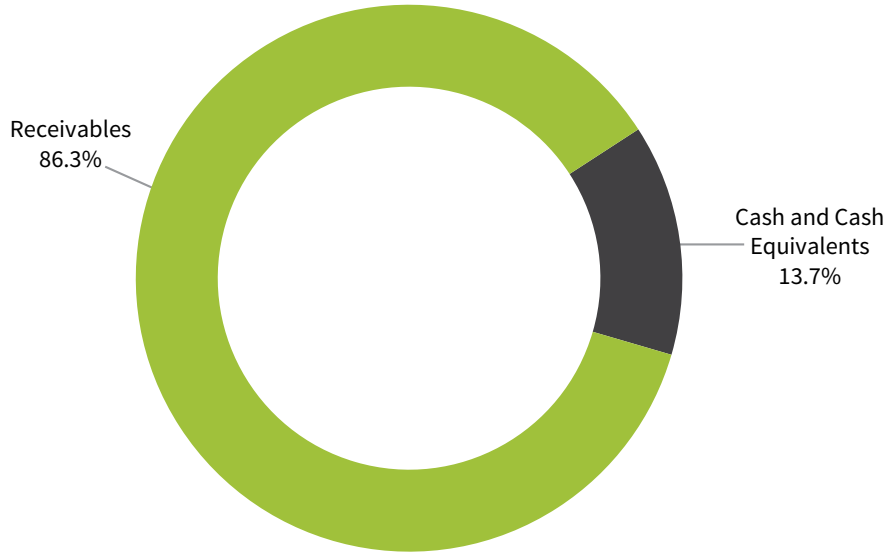


Figure 4 – Total Assets at 30 June 2016

Comparison to Budget

The total asset position at 30 June 2016 is $23.0 million, which is lower than the 2015–16 budget of $25.2 million by $2.2 million.

The variance reflects an increase in:

> Receivables ($2.4 million) – which relates to outstanding cross border health receipts, mainly from New South Wales for the treatment of their residents in ACT hospitals; offset by a decrease in

> Cash and Cash Equivalents ($4.6 million) – relates to the abovementioned increase in receivables and a lower than anticipated result from the finalisation of 2014–15 cross border activity.

Comparison to 2014–15 Actual

The Directorate's total asset position at 30 June 2016 is $23.0 million, which is $5.4 million higher than the 2014–15 actual result of $17.6 million. This mainly relates to outstanding cross border health receipts, mainly from New South Wales for the treatment of their residents in ACT hospitals.

Total Liabilities

Components of Total Liabilities

100 per cent of the Directorate's liabilities relates to payables.

Comparison to Budget

The Directorate's liabilities at 30 June 2016, was $14.0 million, which is higher than the 2015–16 budget of $9.3 million by $4.7 million. This is mainly due to an outstanding payment to the Health Directorate for providing health services.

Comparison to 2014–15 Actual

Total liabilities were $7.4 million higher than the actual results as at 30 June 2015 of $6.6 million.

The higher level of payables in 2015–16 is mainly due to an outstanding payment to the Health Directorate for providing health services and cross border health payments mainly in connection with New South Wales.

Net Assets

The Directorate's net assets at 30 June 2016 were $6.8 million lower than the $15.8 million budgeted. This is due to the combined impact of the reasons listed above.

ATTACHMENT A – COMPARISON OF NET COST OF SERVICES TO BUDGET 2015–16

Description	Original Budget $'000	Plus AAO Transfers $'000	Total Funding $'000	Less Actual $'000	Variance to be Explained $'000	Variance to be Explained %
Expenses						
Purchased Services	1,013,732	-	1,013,732	1,019,664	(5,932)	-0.6%
Transfer Expenses	5,910	-	5,910	5,803	107	1.8%
Total Expenses	**1,019,642**	**-**	**1,019,642**	**1,025,467**	**(5,825)**	**-0.6%**
Own Source Revenue						
User Charges	93,053	-	93,053	97,005	(3,952)	-4.2%
Grants from Commonwealth	321,427	-	321,427	324,704	(3,277)	-1.0%
Total Own Source Revenue	**414,480**	**-**	**414,480**	**421,709**	**(7,229)**	**-1.7%**
Total Net Cost of Services	**605,162**	**-**	**605,162**	**603,758**	**1,404**	**0.2%**

FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2016
ACT LOCAL HOSPITAL NETWORK DIRECTORATE

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

INDEPENDENT AUDIT REPORT

ACT LOCAL HOSPITAL NETWORK DIRECTORATE

To the Members of the ACT Legislative Assembly

Report on the financial statements

The financial statements of the ACT Local Hospital Network Directorate (the Directorate) for the year ended 30 June 2016 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.

The auditor's responsibility

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

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

I formed the audit opinion following the use of audit procedures to obtain evidence about the amounts and disclosures in the financial statements. As these procedures are influenced by the use of professional judgement, selective testing of evidence supporting the amounts and other disclosures in the financial statements, inherent limitations of internal control and the availability of persuasive rather than conclusive evidence, an audit cannot guarantee that all material misstatements have been detected.

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

Level 4, 11 Moore Street Canberra City ACT 2601 PO Box 275 Civic Square ACT 2608
T 02 6207 0833 F 02 6207 0826 E actauditorgeneral@act.gov.au W www.audit.act.gov.au

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

Electronic presentation of the audited financial statements

Those viewing an electronic presentation of these financial statements should note that the audit does not provide assurance on the integrity of information presented electronically and does not provide an opinion on any other information which may have been hyperlinked to or from these financial statements. If users of these statements are concerned with the inherent risks arising from the electronic presentation of information, then 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 2016:

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

(ii) present fairly the financial position of the Directorate at 30 June 2016 and the results of its operations and cash flows for the year then ended.

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

M. Cooper

Dr Maxine Cooper
Auditor-General
21 September 2016

ACT Local Hospital Network Directorate
Financial Statements
For the Year Ended 30 June 2016

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 2016 and the financial position of the Directorate on that date.

Ms Nicole Feely
Director-General
Health Directorate
19 September 2016

ACT Local Hospital Network Directorate
Financial Statements
For the Year Ended 30 June 2016

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 2016 and the financial position of the Directorate on that date.

Mr Shaun Strachan
A/g Deputy Director-General, Corporate
Health Directorate
21 September 2016

ACT LOCAL HOSPITAL NETWORK DIRECTORATE OPERATING STATEMENT FOR THE YEAR ENDED 30 JUNE 2016

	Note No.	Actual 2016 $'000	Original Budget 2016 $'000	Actual 2015 $'000
Income				
Revenue				
Government Payment for Outputs	3	601,790	605,162	567,279
User Charges – Non-ACT Government	4	97,005	93,053	91,906
Grants from the Commonwealth	5	324,704	321,427	310,958
Total Revenue		**1,023,499**	**1,019,642**	**970,143**
Total Income		**1,023,499**	**1,019,642**	**970,143**
Expenses				
Grants and Purchased Services	6	1,019,664	1,013,732	960,497
Transfer Expenses	7	5,803	5,910	5,542
Total Expenses		**1,025,467**	**1,019,642**	**966,039**
Operating (Deficit)/Surplus		**(1,968)**	**-**	**4,104**
Total Comprehensive (Deficit)/Income		**(1,968)**	**-**	**4,104**

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.

The ACT Local Hospital Network Directorate receives Activity Based Funding from the Commonwealth and ACT Governments, and block funding for teaching, training and research. It purchases 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.

ACT LOCAL HOSPITAL NETWORK DIRECTORATE
BALANCE SHEET
AT 30 JUNE 2016

	Note No.	Actual 2016 $'000	Original Budget 2016 $'000	Actual 2015 $'000
Current Assets				
Cash and Cash Equivalents	11	3,146	7,695	4,902
Receivables	12	19,842	17,489	12,650
Total Current Assets		**22,988**	**25,184**	**17,552**
Total Assets		**22,988**	**25,184**	**17,552**
Current Liabilities				
Payables	13	14,009	9,339	6,605
Total Current Liabilities		**14,009**	**9,339**	**6,605**
Total Liabilities		**14,009**	**9,339**	**6,605**
Net Assets		**8,979**	**15,845**	**10,947**
Equity				
Accumulated Funds		8,979	15,845	10,947
Total Equity		**8,979**	**15,845**	**10,947**

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.

ACT LOCAL HOSPITAL NETWORK DIRECTORATE
STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2016

	Accumulated Funds Actual 2016 $'000	Total Equity Actual 2016 $'000	Original Budget 2016 $'000
Balance at 1 July 2015	**10,947**	**10,947**	**15,845**
Comprehensive Income			
Operating (Deficit)	(1,968)	(1,968)	-
Total Comprehensive (Deficit)	**(1,968)**	**(1,968)**	**-**
Transactions Involving Owners Affecting Accumulated Funds			
Capital (Distributions)	-	-	-
Total Transactions Involving Owners Affecting Accumulated Funds	**-**	**-**	**-**
Balance at 30 June 2016	**8,979**	**8,979**	**15,845**

	Accumulated Funds Actual 2015 $'000	Total Equity Actual 2015 $'000
Balance at 1 July 2014	**26,843**	**26,843**
Comprehensive Income		
Operating Surplus	4,104	4,104
Total Comprehensive Income	**4,104**	**4,104**
Transactions Involving Owners Affecting Accumulated Funds		
Capital (Distributions)	(20,000)	(20,000)
Total Transactions Involving Owners Affecting Accumulated Funds	**(20,000)**	**(20,000)**
Balance at 30 June 2015	**10,947**	**10,947**

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 2016

	Note No.	Actual 2016 $'000	Original Budget 2016 $'000	Actual 2015 $'000
Cash Flows from Operating Activities				
Receipts				
Government Payment for Outputs		601,790	605,162	567,279
User Charges		97,005	93,053	103,152
Grants Received from Commonwealth		316,915	321,427	310,958
Goods and Services Tax Input Tax Credits from the Australian Taxation Office		21,978	19,324	18,681
Total Receipts from Operating Activities		**1,037,688**	**1,038,966**	**1,000,070**
Payments				
Grants and Purchased Services		1,018,062	1,019,642	968,697
Goods and Services Tax Paid to Suppliers		21,382	-	18,748
Other		-	19,324	-
Total Payments from Operating Activities		**1,039,444**	**1,038,966**	**987,445**
Net Cash (Outflows)/Inflows from Operating Activities	**17**	**(1,756)**	**-**	**12,625**
Cash Flows from Investing Activities				
Payments				
Distribution to Government		-	-	(20,000)
Total Payments from Investing Activities		**-**	**-**	**(20,000)**
Net Cash (Outflows) from Investing Activities		**-**	**-**	**(20,000)**
Net (Decrease) in Cash and Cash Equivalents		**(1,756)**	**-**	**(7,375)**
Cash and Cash Equivalents at the Beginning of the Reporting Period		4,902	7,695	12,277
Cash and Cash Equivalents at the End of the Reporting Period		**3,146**	**7,695**	**4,902**

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

ACT LOCAL HOSPITAL NETWORK DIRECTORATE CONTROLLED STATEMENT OF APPROPRIATION FOR THE YEAR ENDED 30 JUNE 2016

	Original Budget 2016 $'000	Total Appropriated 2016 $'000	Appropriation Drawn 2016 $'000	Appropriation Drawn 2015 $'000
Controlled				
Government Payment for Outputs	605,162	605,162	601,790	567,279
Total Controlled Appropriation	**605,162**	**605,162**	**601,790**	**567,279**

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 reporting period. This amount appears in the Cash Flow Statement.

Variance between 'Total Appropriated' and 'Appropriation Drawn'

Government Payment for Outputs

The difference between the Total Appropriated and the Appropriation Drawn is due to the Directorate receiving higher than anticipated cross-border (interstate) health revenue therefore not withdrawing the total appropriated amount. This is in line with ACT Government cash management arrangements, where the Directorate receives enough cash to meet its immediate cash needs.

ACT LOCAL HOSPITAL NETWORK DIRECTORATE
NOTE INDEX
FOR THE YEAR ENDED 30 JUNE 2016

ACT LOCAL HOSPITAL NETWORK DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2016

Note 1. Objectives of The ACT Local Hospital Network Directorate

Operations and Principal Activities

The ACT Local Hospital Network Directorate (the Directorate) was established under the Health Act 1953 (the Act), and is administered by the Director-General of the Health Directorate and supported by staff from the Health Directorate.

The 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. Significant Accounting Policies

(a) Basis of Preparation

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

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

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

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

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

The financial statements have been prepared using the accrual basis of accounting, which recognises the effects of transactions and events when they occur. The financial statements have also been prepared according to the historical cost convention.

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

The Directorate is an individual reporting entity.

Note 2. Significant Accounting Policies (Continued)

(b) Controlled and Territorial Items

The Directorate produces Controlled financial statements. The Controlled financial statements include income, expenses, assets and liabilities over which the Directorate has control.

The Directorate does not produce Territorial financial statements because it does not administer any resources on behalf of the Territory.

(c) The Reporting Period

These financial statements state the financial performance, changes in equity and cash flows of the Directorate for the year ending 30 June 2016 and the financial position of the Directorate at 30 June 2016.

(d) Comparative Figures

Budget Figures

To facilitate a comparison with the Budget Papers, as required by the *Financial Management Act 1996*, budget information for 2015–16 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 down to zero.

(f) Revenue Recognition

Revenue is recognised at the fair value of the consideration received or receivable in the Operating Statement. In addition, the following criteria must be met before revenue is recognised:

Government Payment for Outputs

Government Payment for Outputs is recognised as revenue when the Directorate gains control over the funding. Control over appropriated funds is obtained upon the receipt of cash.

Note 2. Significant Accounting Policies (Continued)

(f) Revenue Recognition (Continued)

Cross-Border (Interstate) Health Revenue

Revenue for cross border (interstate) health services is recognised when the number of patients and complexities of treatments provided can be measured reliably using the price payable for the service. The price payable for services is determined by the Independent Hospital Pricing Authority. Actual patient numbers and services are settled following an acquittal process undertaken in subsequent years and variations to the revenue recognised are accounted for in the year of settlement.

The National Health Reform Agreement specifies that each jurisdiction will make funding contributions through the National Health Funding Pool for services provided by other jurisdictions to its residents either on an ad hoc basis reflecting actual activity, or on a regular basis as scheduled through a Cross Border agreement. For 2015–16 the ACT has a Cross Border Agreement in place with the New South Wales Ministry of Health.

Commonwealth Grants

Commonwealth Grants relate to Activity Based Funding and Block Funding under the National Health Reforms. They also include the Commonwealth funding component of cross border health costs for interstate residents treated in ACT public hospitals.

Activity based funding (ABF) refers to a national system for funding public hospital services using national classifications, national price weights and a national efficient price (NEP). It is predicated on the Independent Hospital Pricing Authority (IHPA) pricing model which has set weights and pricing adjustments based on patient characteristics, that together give rise to a total payment amount for a hospital patient service. ABF covers all admitted, non-admitted and emergency department services that meet the IHPA criteria for inclusion on the 'General List of In-Scope Public Hospital Services'.

For 2015–16, ABF was paid at a rate of 45% of the NEP for activity above last year's baseline, with base activity payment paid at last year's rate plus price indexation.

Block funding is provided to support public hospital functions that are recognised by the Independent Hospital Pricing Authority as services acceptable to be funded on this basis and that conform to the Independent Hospital Pricing Authority's national pricing model.

Commonwealth Grants is calculated and paid using estimates. The estimate is based on expected number of patients treated during the year. Further information on the basis of the estimate is provided in Note 2 (O): Significant Accounting Judgements and Estimates.

Commonwealth Grants are recognised as revenue upon the receipt of cash.

Revenue Received in Advance

Revenue received in advance is recognised as a liability if there is a present obligation to return the funds received, otherwise all are recorded as revenue.

(g) Waivers of Debt

Debts that are waived under Section 131 of the FMA are expensed 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.

Note 2. Significant Accounting Policies (Continued)

(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 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

Cash includes cash at bank and cash on hand. Directorate money held in the Territory Banking Account Cash Fund is classified as a Cash Equivalent. The 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 (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.

Accrued Cross Border revenue relates to the estimated number of interstate patients treated in ACT public hospitals. Under the National Health Reform Agreement, States and Territories are required to pay for Cross Border activity using the price payable for services. The price payable for services is determined by the Independent Hospital Pricing Authority. The actual level of revenue will be subject to an acquittal process to be completed in subsequent years.

The allowance for impairment losses represents the amount of 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 is written off against the allowance account when the Directorate ceases action to collect the debt when the cost to recover debt is more than the debt is worth.

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

(k) Payables

Payables are initially recognised at fair value based on the transaction cost and subsequent to initial recognition at amortised cost, with any adjustments to the carrying amount being recorded in the Operating Statement. All amounts are normally settled within 30 days after the invoice date.

Payables consist of Accrued Expenses.

Note 2. Significant Accounting Policies (Continued)

(l) Employee Benefits

The Directorate does not employ any staff. All staff providing administrative support are employed by the Health Directorate. Therefore, the Directorate does not incur employee costs and does not have 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) Budgetary Reporting – Explanation of Major Variances between Actual Amounts and Original Budget Amounts

Explanations of major variances between the 2015–16 original budget and 30 June 2016 actual results are discussed in Note 19 (Controlled): Budgetary Reporting.

The definition of 'major variances' is provided in Note 2(o): Significant Accounting Judgements and Estimates – Budgetary Reporting – Explanation of Major Variances between Actual Amounts and Original Budget Amounts.

(o) Significant Accounting Judgements and Estimates

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

Cross-Border (Interstate) Health Receivables: is an estimate based on the number of interstate patients converted into a National Weighted Activity Unit and paid at the price determined by the Independent Hospital Pricing Authority. Interstate patient numbers for the current year is an estimation based on actual patient numbers for the nine months to 30 April 2016. Actual patient numbers and services are settled following an acquittal process undertaken in subsequent years and variations to the revenue recognised are accounted for in the year of settlement.

Commonwealth Grants: is an estimate based on the expected number of patients converted into a National Weighted Activity Unit and paid at the price determined by the Independent Hospital Pricing Authority. Actual National Weighted Activity Units is settled following an acquittal process undertaken in the following financial year and variations to the revenue recognised are accounted for in the year of settlement.

a. *Budgetary Reporting – Explanation of Major Variances between Actual Amounts and Original Budget Amounts:* Significant judgements have been applied in determining what variances are considered as 'major variances' requiring explanations in Note 19 (Controlled): Budgetary Reporting. Variances are considered to be major variances if both of the following criteria are met:
   - The line item is a significant line item: the line item actual amount accounts for more than 10% of the relevant associated category (Income, Expenses and Equity totals) or sub-element (e.g. Current Liabilities and Receipts from Operating Activities totals) of the financial statements; and
   - The variances (original budget to actual) are greater than plus (+) or minus (-) 10% of the budget for the financial statement line item.

Further information on this is provided in Note 2(n): Budgetary Reporting.

Note 2. Significant Accounting Policies (Continued)

(p) Impact of Accounting Standards Issued but yet to be Applied

Accounting Standards early adopted

AASB 2015-2 *Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 101* has been early adopted for the 2015–16 reporting period, even though the standard is not required to be applied until annual reporting periods beginning on or after 1 July 2016.

AASB 2015-2 amends AASB 101 *Presentation of Financial Statements* including clarifying that reporting agencies should not be disclosing immaterial information and that the presentation of information in notes can and should be tailored to provide users with the clearest view of a reporting agency's financial performance and financial position.

Accounting Standards yet to be applied

The following new and revised accounting standards and interpretations have been issued by the Australian Accounting Standards Board but do not apply to the current reporting period. These standards and interpretations are applicable to future reporting periods. The Directorate does not intend to adopt these standards and interpretations early. Where applicable, these Australian Accounting Standards will be adopted from their application date.

> AASB 9 Financial Instruments (December 2014) (application date 1 January 2018);

This standard supersedes AASB 139 *Financial Instruments: Recognition and Measurement*. The main impact of AASB 9 is that it will change the classification, measurement and disclosures of the Department's financial assets. At this stage the Directorate is not able to estimate the impact of this new standard on its financial statements. The Directorate will make a more detailed assessment of the impact over the next 12 months.

> AASB 15 Revenue from Contracts with Customers (application date 1 January 2018);

AASB 15 is the new standard for revenue recognition. It establishes a comprehensive framework for determining whether, how much and when revenue is recognised. It replaces AASB 111 *Construction Contracts* and AASB 118 *Revenue*. At this stage the Directorate is not able to estimate the impact of this new standard on its financial statements. The Directorate will make a more detailed assessment of the impact over the next 12 months.

> AASB 2016-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107 (application date 1 January 2017)

This standard amends AASB 107 *Statement of Cash Flows* to require agencies preparing financial statements in accordance with Tier 1 reporting requirements to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes.

This standard affects disclosures only and there is no material financial impact on the Directorate.

Note 3. Government Payment for Outputs

Government Payment for Outputs (GPO) is revenue received from the ACT Government for the purchase of hospital services from ACT public hospitals. The ACT Government pays GPO appropriation on a fortnightly basis.

	2016 $'000	2015 $'000
Revenue from the ACT Government		
Government Payment for Outputs[a]	601,790	567,279
Total Government Payment for Outputs	**601,790**	**567,279**

a. The increase mainly relates to growth in services in acute services including emergency and additional elective surgery, mental health, outpatient, community and primary care services and women and children's health.

Note 4. User Charges for Goods and Services

User charge revenue is derived by providing public hospital services to interstate residents. User charge revenue is not part of ACT Government appropriation and is paid by other state or territory governments. This revenue is driven by demand for health services from interstate patients and is not for profit in nature.

	2016 $'000	2015 $'000
User Charges – Non-ACT Government		
Cross Border (Interstate) Health Revenue[a]	97,005	91,906
Total User Charges – Non-ACT Government	**97,005**	**91,906**

a. The increase is mainly due to higher number of interstate patients, in particular New South Wales residents, being treated 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.

	2016 $'000	2015 $'000
Grants from the Commonwealth		
Grants[a]	324,704	310,958
Total Grants from the Commonwealth	**324,704**	**310,958**

a. The increase is mainly due to growth in activity for public hospital services funded through the National Health Reform Agreement including emergency and additional elective surgery, mental health, outpatient, community and primary care services and women and children's health.

Note 6. Grants and Purchased Services

Grants and Purchased Services reflect public hospital payments to the Canberra Hospital and Health Services, Calvary Public Hospital, Clare Holland House, Queen Elizabeth II Hospital, and States and the Northern Territory for cross border patient services.

	2016 $'000	2015 $'000
Purchased Services		
Payments to Service Providers[a]		
– Canberra Hospital and Health Services	805,196	754,745
– Calvary Public Hospital	185,037	178,557
– Clare Holland House	5,267	5,114
– Queen Elizabeth II Hospital	3,176	2,534
Cross Border (Interstate) Health Costs	20,988	19,547
Total Grants and Purchased Services	**1,019,664**	**960,497**

a. The increase mainly relates to growth in services in acute services including emergency and additional elective surgery, mental health, outpatient, community and primary care services and women and children's health.

Note 7. Transfer Expenses

Transfer Expenses relate to the passing on of the Commonwealth's contribution to public health funding to the Health Directorate.

	2016 $'000	2015 $'000
Transfer Expenses	5,803	5,542
Total Transfer Expenses	**5,803**	**5,542**

Note 8. Auditor's Remuneration

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

	2016 $'000	2015 $'000
Audit Services		
Audit Fees Paid or Payable to the ACT Audit Office	69	45
Total Audit Services	**69**	**45**

No other services were provided by the ACT Audit Office.

The increase in audit fee is due to the recovery of the estimated cost of engaging an expert to review the accuracy of clinical coding of activity data recorded by the Health Directorate.

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

The Directorate had no waivers, impairment losses or write-offs in 2015–16 (nil, in 2014–15).

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 2015–16 (nil, in 2014–15).

Note 11. Cash and Cash Equivalents

The Directorate holds a number of bank accounts with the Westpac Bank as part of the whole-of-government banking arrangements. As part of these arrangements, the Directorate does not receive any interest on these accounts.

	2016 $'000	2015 $'000
Cash at Bank	3,146	4,902
Total Cash and Cash Equivalents	**3,146**	**4,902**

Note 12. Receivables

	2016 $'000	2015 $'000
Current Receivables		
Accrued Revenue[a]	19,106	11,318
Net GST Receivable[b]	736	1,332
Total Current Receivables	**19,842**	**12,650**
Total Receivables	**19,842**	**12,650**

a. The increase relates to outstanding cross-border health receipts, mainly related to New South Wales residents.

b. The reduction is due to reduced Goods and Services Tax owing from the Australian Taxation Office.

		Overdue			
Ageing of Receivables	**Not Overdue $'000**	**Less than 30 Days $'000**	**30 to 60 Days $'000**	**Greater than 60 Days $'000**	**Total $'000**
2016					
Not Impaired Receivables[a]	19,842	-	-	-	19,842
2015					
Not Impaired Receivables	12,650	-	-	-	12,650

a. This mainly relates to cross-border receivable for admitted and non-admitted patient services provided to residents of the States and Northern Territory. This is categorised as 'not overdue' as the funding arrangement 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.

Classification of ACT Government/Non-ACT Government Receivables	2016 $'000	2015 $'000
Receivables from Non-ACT Government Entities		
Other Receivables	19,106	11,318
Net Goods and Services Tax Receivables	736	1,332
Total Receivables from Non-ACT Government Entities	**19,842**	**12,650**
Total Receivables	**19,842**	**12,650**

Note 13. Payables

	2016 $'000	2015 $'000
Current Payables		
Accrued Expenses[a]	14,009	6,605
Total Current Payables	**14,009**	**6,605**
Total Payables	**14,009**	**6,605**

a. The increase is due to:
   - a higher number of ACT residents accessing health services in other states and the Northern Territory; and
   - an outstanding amount of $5.585 million payable to the Health Directorate for providing health services.

	2016 $'000	2015 $'000
Payables are aged as followed		
Not Overdue	14,009	6,605
Total Payables	**14,009**	**6,605**

Classification of Non-ACT Government Payables		
Payables with ACT Government Entities		
Accrued Expenses[a]	5,585	-
Total Payables with ACT Government Entities	**5,585**	**-**
Payables with Non-ACT Government Entities		
Accrued Expenses[b]	8,424	6,605
Total Payables with Non-ACT Government Entities	**8,424**	**6,605**
Total Payables	**14,009**	**6,605**

a. This relates to an outstanding amount of $5.585 million payable to Canberra Hospital and Health Services for providing health services.

b. The increase is due to a higher number of ACT residents accessing health services in other states and the Northern Territory.

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 has no exposure to interest rate risk, as its cash and cash equivalents, receivables and payables are non-interest bearing.

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

Note 14. Financial Instruments (Continued)

Credit Risk

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

The Directorate's financial assets consist of cash and cash equivalents and receivables.

Cash and cash equivalents are held with the Westpac Banking Corporation, a high credit, quality financial institution, in accordance with whole of ACT Government banking arrangements.

The Directorate's receivables mainly consist of amounts owed from the New South Wales Ministry of Health and the Department of Health and Human Services in Victoria. As the New South Wales and Victorian Governments both have a AAA credit rating, it is considered that there is a very low risk of default for these receivables. Any credit risk for receivables with New South Wales Ministry of Health and Department of Health and Human Services in Victoria is managed by having an agreement in place providing required activity data in a timely manner.

Liquidity Risk

Liquidity risk is the risk that the Directorate will encounter difficulties in meeting obligations associated with financial liabilities that are settled by delivering cash or another financial asset.

The main source of cash to pay these obligations is appropriation from the ACT Government and Grants from the Commonwealth. Appropriation is paid on a fortnightly basis and the Commonwealth Grants on a monthly basis during the year. The Directorate manages its liquidity risk through forecasting appropriation drawdown requirements to enable payment of anticipated obligations.

Price Risk

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

The Directorate holds no financial instruments that are subject to price risk and as a result, is not considered to have any price risk. Accordingly, a sensitivity analysis has not been undertaken.

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:

	Note	Carrying Amount 2016 $'000	Fair Value 2016 $'000	Carrying Amount 2015 $'000	Fair Value 2015 $'000
Financial Assets					
Cash and Cash Equivalents	11	3,146	3,146	4,902	4,902
Receivables	12	19,106	19,106	11,318	11,318
Total Financial Assets		**22,252**	**22,252**	**16,220**	**16,220**
Financial Liabilities					
Payables	13	14,009	14,009	6,605	6,605
Total Financial Liabilities		**14,009**	**14,009**	**6,605**	**6,605**

Note 14. 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 the weighted average interest rates by maturity period as at 30 June 2016. Except for non-current payables, financial assets and liabilities which have a floating interest rate or are non-interest bearing will mature in 1 year or less. All amounts appearing in the following maturity analysis are shown on an undiscounted cash flow basis.

	Note No.	Weighted Average Interest Rate	Floating Interest Rate $'000	Fixed Interest Maturing In: 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		-	-	-	-	3,146	3,146
Receivables	12		-	-	-	-	19,106	19,106
Total Financial Assets			**-**	**-**	**-**	**-**	**22,252**	**22,252**
Financial Liabilities								
Payables	13		-	-	-	-	14,009	14,009
Total Financial Liabilities			**-**	**-**	**-**	**-**	**14,009**	**14,009**
Net Financial Assets			**-**	**-**	**-**	**-**	**8,243**	**8,243**

The following table sets out the Directorate's maturity analysis for financial assets and liabilities as well as the exposure to interest rates, including the weighted average interest rates by maturity period as at 30 June 2015. Except for non-current payables, financial assets and liabilities which have a floating interest rate or are non-interest bearing will mature in 1 year or less. All amounts appearing in the following maturity analysis are shown on an undiscounted cash flow basis.

	Note No.	Weighted Average Interest Rate	Floating Interest Rate $'000	Fixed Interest Maturing In: 1 Year or Less $'000	Over 1 to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	11		-	-	-	-	4,902	4,902
Receivables	12		-	-	-	-	11,318	11,318
Total Financial Assets			**-**	**-**	**-**	**-**	**16,220**	**16,220**
Financial Liabilities								
Payables	13		-	-	-	-	6,605	6,605
Total Financial Liabilities			**-**	**-**	**-**	**-**	**6,605**	**6,605**
Net Financial Assets			**-**	**-**	**-**	**-**	**9,615**	**9,615**

Note 14. Financial Instruments (Continued)

Carrying Amount of Each Category of Financial Asset and Financial Liability	2016 $'000	2015 $'000
Financial Assets		
Loans and Receivables Measured at Amortised Cost	19,106	11,318
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	14,009	6,605

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 a commitment with QEII hospital that has not been recognised as a liability.

	2016 $'000	2015 $'000
Commitments		
Payable:		
Within One Year[a]	880	2,748
Total Commitments	**880**	**2,748**

All amounts shown in the commitment note are inclusive of Goods and Services Tax.

a. The reduction in commitment is due to the funding agreement with Queen Elizabeth II Family Centre finishing in June 2016. There has been a three-month extension to the agreement to allow for contract negotiations.

Note 16. Events Occurring After Balance Date

There were no events occurring after the balance date, which would affect the financial statements as at 30 June 2016, or in future reporting periods.

Note 17. 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

	2016 $'000	2015 $'000
The Cash and Cash Equivalents Recorded in the Balance Sheet	3,146	4,902
Cash and Cash Equivalents at the End of the Reporting Period as Recorded in the Cash Flow Statement	**3,146**	**4,902**

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

	2016 $'000	2015 $'000
Operating (Deficit)/Suplus	(1,968)	4,104
Cash Before Changes in Operating Assets and Liabilities	**(1,968)**	**4,104**
Changes in Operating Assets and Liabilities		
(Increase)/Decrease in Receivables	(7,193)	11,177
Decrease in Other Assets	-	79
Increase/(Decrease) in Payables	7,405	(2,735)
Net Changes in Operating Assets and Liabilities	**212**	**8,521**
Net Cash (Outflows)/Inflows from Operating Activities	**(1,756)**	**12,625**

Note 18. Service Concession Asset

The Directorate has entered into an agreement with Calvary Health Care ACT Ltd for the provision of hospital and associated services. The original agreement was entered into by the Commonwealth on 22 October 1971 and does not stipulate an 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 are 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. These arrangements have remained unchanged during the reporting period.

The Agreement may be terminated by Calvary Health Care ACT Ltd or the Health Directorate if there are material breaches of the Agreement or the Crown Lease is terminated. In the event the Agreement is terminated, the management of the Calvary Public Hospital will transfer to the Health Directorate.

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

Service concession arrangement has been accounted for in accordance with the whole of government policy on *Public Private Partnerships Financed by the Operator with the Assets being Territory Assets at the end of the Arrangement*.

Note 19. Budgetary Reporting – Explanations of Major Variances Between Actual Amounts and Original Budget Amounts

The following are brief explanations of major line item variances between budget estimates and actual outcomes. Variances are considered to be major variances if both of the following criteria are met:

a. The line item is a significant line item: the line item actual amount accounts for more than 10% of the relevant associated category (Income, Expenses and Equity totals) or sub-element (e.g. Current Liabilities and Receipts from Operating Activities totals) of the financial statements; and

b. The variances (original budget to actual) are greater than plus (+) or minus (-) 10% of the budget for the financial statement line item.

Balance Sheet Line Items	Actual 2015–16 $'000	Original Budget[1] 2015–16 $'000	Variance $'000	Variance %	Variance Explanation
Cash and Cash Equivalents	3,146	7,695	(4,549)	(59.1)	Lower than budgeted cash and cash equivalents is largely due to net cash outflow from operating activities of $1.7 million due to timing of payables and receivables and lower opening cash balance of $2.7 million.
Receivables	19,842	17,489	2,353	13.5	Higher than budgeted receivables is mainly due to higher than budgeted cross-border revenue from higher than expected interstate patients being treated in ACT public hospitals.
Payables	14,009	9,339	4,670	50.0	Higher than budgeted payables is mainly due to an outstanding unbudgeted amount of $5.585 million payable to Canberra Hospital and Health Services for providing health services.

1 Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period (2015–16 Budget Statements). These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

Balance Sheet Line Items (Continued)	Actual 2015–16 $'000	Original Budget[1] 2015–16 $'000	Variance $'000	Variance %	Variance Explanation
Accumulated Funds	8,979	15,845	(6,866)	(43.3)	Lower than budgeted Accumulated Funds is largely due to combined effect of a lower opening balance of $4.8 million and an operating deficit of $1.9 million incurred compared to break even in the budget.
Statement of Changes in Equity					
These line items are covered in other financial statements					

1 Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period (2015–16 Budget Statements). These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

REPORT OF FACTUAL FINDINGS

ACT LOCAL HOSPITAL NETWORK DIRECTORATE

To the Members of the ACT Legislative Assembly

Report on the statement of performance

The statement of performance of the ACT Local Hospital Network Directorate (the Directorate) for the year ended 30 June 2016 has been reviewed.

Responsibility for the statement of performance

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

The auditor's responsibility

Under the *Financial Management Act 1996* and *Financial Management (Statement of Performance Scrutiny) Guidelines 2016*, I am responsible for providing a report of factual findings on the statement of performance.

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

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

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

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

As disclosed in the statement of performance, in accordance with the *Financial Management (Statement of Performance Scrutiny) Guidelines 2016*, the Government Payment for Outputs and Total Cost information included in the statement of performance has not been reviewed.

Electronic presentation of the statement of performance

Those viewing an electronic presentation of this statement of performance should note that the review does not provide assurance on the integrity of information presented electronically, and does not provide an opinion on any other information which may have been hyperlinked to or from this statement of performance. If users of this statement of performance are concerned with the inherent risks arising from the electronic presentation of information, then 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 2016, are not fairly presented in accordance with the *Financial Management Act 1996*.

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

M. Cooper.

Dr Maxine Cooper
Auditor-General
23 September 2016

ACT Local Hospital Network Directorate
Statement of Performance
For the Year Ended 30 June 2016

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 2016 and also fairly reflects the judgements exercised in preparing it.

Nicole Feely
Director-General
Health Directorate
9 September 2016

OUTPUT CLASS 1: ACT LOCAL HOSPITAL NETWORK

Description

The ACT Local Hospital Network will receive funding under the National Health Reform Agreement and purchase public hospital services from the Canberra Hospital and Health Services, Calvary Public Hospital, Clare Holland House and Queen Elizabeth II Family Centre.

	Original Target 2015–16	Actual Result 2015–16	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	1,019,642	1,025,467	1%		
Government Payment for Outputs (GPO) ($000's)	605,162	601,790	-1%		
Accountability Indicators					
a. Admitted Services – NWAU {15}	89,032	90,951	2%		1,2
b. Non-Admitted Services – NWAU {15}	17,759	17,283	-3%		1,3
c. Emergency Services – NWAU {15}	16,099	16,750	4%		1
d. Acute Mental Health Services – NWAU {15}	6,611	7,025	6%	Mental health services experienced higher patient volumes than expected for 2015–16, leading to a higher NWAU result compared to the target. There were 2,726 patient episodes in 2015–16 compared to 2,371 episodes the year before (a 15% increase).	1,4
e. Sub Acute Services – NWAU {15}	6,946	10,557	52%	The higher than target result is due to a change in methodology in accounting for sub acute activity which includes some activity not previously counted. This approach was agreed in February 2016 in consultation with the relevant national bodies.	1
f. Total in scope – NWAU {15}	136,447	142,566	4%		1

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

Notes

Explanation of Accountability Indicators

1. Activity purchased by the ACT Local Hospital Network is consistent with the criteria in the National Health Reform Agreement. Activity is measured in National Weighted Activity Units (NWAU) {15} as defined by the Independent Hospital Pricing Authority's National Efficient Price Determination 2015–16. National Weighted Activity Unit (NWAU) is the 'currency' that is used to express the price weights for all services that are funded on an activity basis. These indicators combine the results for Canberra Hospital and Calvary Public Hospital for services that meet the Independent Hospital Pricing Authority's criteria for inclusion on the 'General List of In-Scope Public Hospital Services'.
2. Excludes mental health and sub-acute services.
3. Excludes community mental health services.
4. Acute admitted mental health services only.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office as this was not required by the *Financial Management (Statement of Performance Scrutiny) Guidelines 2016*.

OUTPUT CLASS 1: ACT LOCAL HOSPITAL NETWORK (CONTINUED)

	Original Target 2015–16	Actual Result 2015–16	% Variance from Original Target	Explanation of Material Variances	Notes
g. Percentage of mental health clients with outcome measures completed	>65%	<65%	-100%	64% of mental health clients had outcome measures completed.	5
h. Proportion of mental health clients contacted by a Health Directorate community facility within 7 days post discharge from inpatient services	75%	76%	1%		6

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

Notes

Explanation of Accountability Indicators

5. Proportion of eligible mental health registered clients receiving ongoing mental health care having clinical outcome measures completed. These measures were completed three-monthly. Service settings included are inpatient, community and residential care. All age groups included. Eligible clients are people receiving mental health services on an ongoing basis, have a case manager assigned and are in contact with mental health services in the reference period.
6. The proportion of clients admitted to a public mental health acute inpatient facility within the ACT Local Hospital Network and having direct contact with mental health services within seven days post discharge. Day of discharge is not included as part of the seven days. Same day admissions are excluded.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996*. The Total Cost and Government Payment for Outputs measures were not examined by the ACT Audit Office as this was not required by the *Financial Management (Statement of Performance Scrutiny) Guidelines 2016*.

APPENDIX A COMPLIANCE STATEMENT

The ACT Health Annual Report must comply with the 2015 Annual Report Directions (the Directions). The Directions are found at the ACT Legislation Register.

http://www.legislation.act.gov.au/ni/annual/2015.asp

The Compliance Statement indicates the subsections, under the five Parts of the Directions, that are applicable to ACT Health and the location of information that satisfies these requirements:

PART 1 DIRECTIONS OVERVIEW

The requirements under Part 1 of the 2015 Directions relate to the purpose, timing and distribution, and records keeping of annual reports. The ACT Health Annual Report 2015–16 complies with all subsections of Part 1 under the Directions.

In compliance with section 13 Feedback, Part 1 of the Directions, contact details for ACT Health are provided within the ACT Health Annual Report 2015–16 to provide readers with the opportunity to provide feedback.

PART 2 AGENCY ANNUAL REPORT REQUIREMENTS

The requirements within Part 2 of the Directions are mandatory for all agencies and ACT Health complies with all subsections. The information that satisfies the requirements of Part 2 is found in the ACT Health Annual Report 2015–16 as follows:

PART 3 REPORTING BY EXCEPTION

ACT Health has nil information to report by exception under Part 3 of the Directions for the 2015–16 reporting period. This is explicitly stated in the following sections:

PART 4 AGENCY SPECIFIC ANNUAL REPORT REQUIREMENTS

The following subsections of Part 4 of the 2015 Directions are applicable to ACT Health and can be found within the ACT Health Annual Report 2015–16:

PART 5 WHOLE-OF-GOVERNMENT ANNUAL REPORTING

All subsections of Part 5 of the Directions apply to ACT Health. Consistent with the Directions, the information satisfying these requirements is reported in the one place for all ACT Public Service Directorates

ACT Public Service Directorate annual reports are found at the following web address:

http://www.cmd.act.gov.au/open_government/report/annual_reports

APPENDIX B INDEX

A

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W

Y