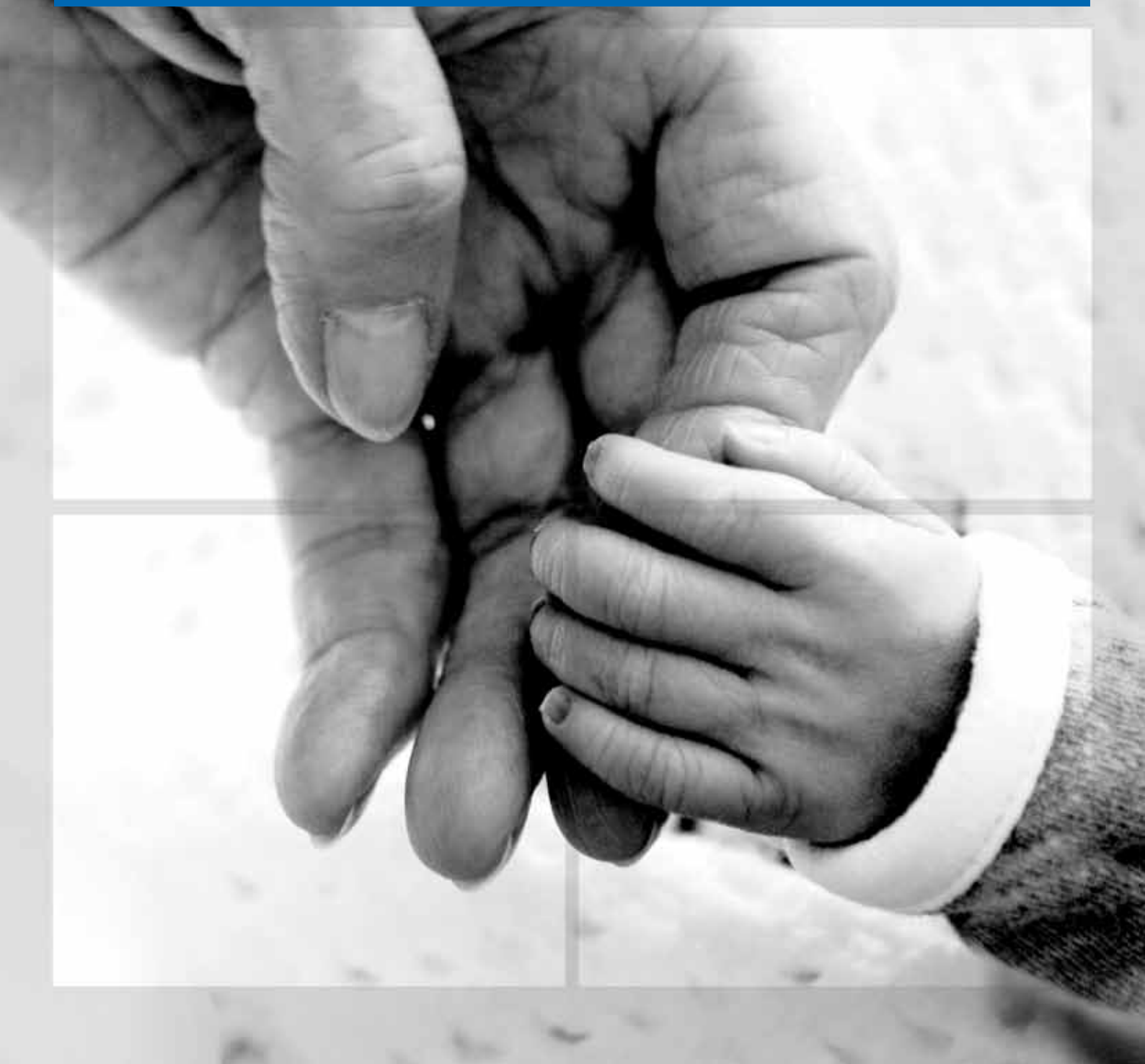
ACT Government
Health

ANNUAL REPORT 2010–11



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Contents

Transmittal Certificate

ACT Government
Health

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

Dear Minister

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

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

I hereby certify that the attached Annual Report is an honest and accurate account and that all material information on the operations of the Health Directorate during the period 1 July 2010 to 30 June 2011 has been included and that it complies with the Chief Minister's Annual Report Directions.

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

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

Yours sincerely

Dr Peggy Brown
Director-General

16 September 2011

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Aids to Access

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

Abbreviations and acronyms

AAMHIU	Adult Acute Mental Health Inpatient Unit
ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACHS	Australian Council on Healthcare Standards
ACRS	Aged Care and Rehabilitation Service
ACTGS	ACT Government Solicitor
ACTHEIM	ACT Health Enterprise Information Management
ACTPS	ACT Public Service
AHPRA	Australian Health Practitioner Regulation Agency
AIDS	Acquired Immune Deficiency Syndrome
AIHW	Australian Institute of Health and Welfare
AIP	Access Improvement Program
AMC	Alexander Machonochie Centre
ANU	Australian National University
ATODA	Alcohol, Tobacco and Other Drug Association ACT
AVA	Australian Veterinary Association
AVBC	Australasian Veterinary Boards Council
AWA	Australian Workplace Agreement
BJOG	National Breastfeeding Jurisdictional Senior Officials Group
CADP	Capital Asset Development Plan
CALD	Culturally and Linguistically Diverse
CAPAC	Community Acute and Post-Acute Care
CCP	Chronic Care Program
CCPCR	Calvary Centre for Palliative Care Research
CDC	Communicable Disease Centre
CDMR	Chronic Disease Management Register
CDMU	Chronic Disease Management Unit
CDN/Ms	Clinical Development Nurses and Midwives
CET	Consumer Engagement Team
CFET	Consumer Feedback and Engagement Team
CFMS	Clinical and Forensic & Medical Service
CFR	Community Funding Round
CHC ACT	Calvary Health Care ACT
CIMS	Cancer Information Management System
CIT	Canberra Institute of Technology
COAG	Council of Australian Governments
COPD	Chronic Obstructive Pulmonary Disease
CPAP	Continuous Positive Airway Pressure
CPD	Continuing Professional Development
CPOE	Computerised Physician Order Entry
CPP	Community Partners Program

CRCS	Capital Region Cancer Service
CSS	Commonwealth Superannuation Scheme
DDG	Deputy Director-General
DG	Director-General
DHCS	Disability, Housing and Community Services
DHP	Dental Health Program
DJACS	Department of Justice and Community Safety
DMFT	Decayed, missing or filled teeth
ECT5	Electro-convulsive therapy
ED	Emergency Department
EHR	Electronic Health Record
ELS	Equipment Loan Service
EMR	Electronic Medical Record
EMMS	Electronic Medicines Management System
EN	Enrolled Nurse
ESD	Ecologically Sustainable Development/Environmentally Sustainable Design
ETS	EmergoTrain System
FMA	Financial Management Act 1996
FOI	Freedom of Information
FTE	Full-time equivalent
GAAP	Generally Accepted Accounting Principles
GM	Genetically modified
GP	General practitioner/general practice
GPO	Government Payments for Outputs General Post Office
HACC	Home and Community Care
HCCA	Health Care Consumers' Association of the ACT
HH	Hand hygiene
HITH	Hospital in the Home
HIV	Human Immunodeficiency Virus
HPS	Health Protection Service
HREC	Human Research Ethics Committee
HWA	Health Workforce Australia
ICU	Intensive care unit
IM&IT	Information management and information technology
IMPACT	Program Integrated Multi-agencies for Parents and Children Together
IPC	Infection Prevention and Control
IPCU	Infection Prevention and Control Unit
IPTAS	Interstate Patient Travel Assistance Scheme
IRCTN	Integrated Regional Clinical Training Network
LCMHC	Little Company of Mary Health Care
MA	Moderate Achievement
MACH	Maternal and Child Health
MAPU	Medical Assessment and Planning Unit
MET	Medical Emergency Team
MOU	Memorandum of understanding
MRI	Magnetic resonance imaging
NEAT	National Emergency Access Target
NEST	National Elective Surgery Target

NGO	Non-government organisation
NHMRC	National Health & Medical Research Council
NICU	Neonatal Intensive Care Unit
NPA	National Partnership Agreement on Essential Vaccines
NRAS	National Registration and Accreditation Scheme
OH&S	Occupational health and safety
OPMHIU	Older Persons Mental Health Inpatient Unit
OPMHS	Older persons mental health services
OSCAR	Online System for Comprehensive Activity Reporting
PatCH	Paediatrics at the Canberra Hospital
PBS	Pharmaceutical Benefits Scheme
PCEHR	Personally Controlled Electronic Health Records
PEPA	Program of Experience in the Palliative Approach
PET/CT	Positron Emission Tomograph/Computerised Tomography
PHD	Population Health Division
PICAC	Partners in Culturally Appropriate Care
PID	Public interest disclosure
PII	Professional indemnity insurance
PPDP	Positive Professional Development Pathway
PPEI	Promotion, prevention and early intervention
PSP	Professional Standards Panel
PSQU	Patient Safety and Quality Unit
PSS	Public Sector Superannuation Scheme
PSSAP	Public Sector Superannuation Scheme Accumulation Plan
PSU	Psychiatric Services Unit
PTO	Psychiatric treatment order
QI	Quality improvement
RADAR	Rapid Assessment of the Deteriorating and At-Risk
RED	Respect, Equity, Diversity
RILU	Rehabilitation Independent Living Unit
RT	Radiation therapists RT
SAPU	Surgical Assessment Planning Unit
SCPU	Student Clinical Placement Unit
SEA	Special Employment Arrangement
STEPS	Sustainability, Training, Education, Participation, Skills
STI	Sexually transmissible infection
TCH	(the) Canberra Hospital
TCH&HS	Canberra Hospital & Health Services
TTCP	Transitional Therapy and Care Program
UNSW	University of New South Wales
VMO	Visiting Medical Officer
WHO	World Health Organisation
WHS	Women’s Health Service
WiC	Walk-in Centre
WYC	The Women, Youth & Children Division

Glossary of technical terms

Access Improvement Program	A major change program initiated in early 2005 aimed at redesigning the way we provide health services by focusing on patient journeys through our health system.
Acute care	An episode of acute care for an admitted patient is one in which the principal clinical intent is to provide short-term hospital admission focused on the treatment of emergency conditions or the conduct of an elective procedure.
Ambulatory care	Care provided in a non-inpatient setting such as outpatients, home-based care, office-based care or community health centre-based care.
Australian Health Care Agreements	Agreements made between the Australian Government and each State and Territory Government every five years which provide the basis for federal funding for public hospital services.
Benchmarking	The process of assessing the performance of an organisation of entity within an organisation by comparing it to the performance of a similar entity, a national average, or the best performing entity within the same field in order to assess performance and determine opportunities for improvement.
Chlamydia	Chlamydia is Australia's most common sexually transmitted disease. It is caused by the bacteria Chlamydia trachomatis.
Community-based organisations	Not-for-profit organisations within the community that have specialist skills in the management of certain health issues. These organisations provide services such as health services for disadvantaged young people, drug and alcohol rehabilitation, Aboriginal and Torres Strait Islander health services and supported accommodation for people with mental illness.
Cost weight	A cost weight is a form of measurement for the use of health services that provides an indication of the relative resource use. It provides an indication as to the complexity of an admission or an occasion of service.
Healthpact	A former statutory authority of the ACT Government with responsibility for promoting good health and well-being in the ACT community.
Hepatitis C	Hepatitis is inflammation of the liver. Hepatitis C is a viral form that is transferred by blood-to-blood contact.
Length of stay	The number of days (or part thereof) that each admitted patient stays in hospital. Patients who are admitted and discharged on the same day have a length of stay of one day.
Pandemic	An epidemic that strikes a very wide area, usually hemisphere-wide or worldwide. It can last for several or more years. Influenza (the flu) can be pandemic, since it has the ability to rapidly spread around the entire world.
Patient-centred care	Refocusing the delivery of health care around the needs of the patient rather than other stakeholders such as providers.
Patient journey	A patient's experience of travelling or moving through the health system at pre-hospital to hospital and to community care.

Primary healthcare service	Primary healthcare services are those which focus on first contact health services provided predominantly by GPs, but also by practice nurses, primary/ community health care nurses, early childhood nurses and community pharmacists, allied health professionals and other health workers such as multicultural health workers and Indigenous health workers, health education/promotion and community development workers.
Public health officers	Public health officers provide a range of services to the community, including communicable disease control, pharmaceutical services, environmental health and scientific services, and have certain powers enshrined in legislation.
Public hospital outpatients	Services provided by public hospitals in a clinic environment. Outpatient services are generally provided prior to or following an inpatient episode. Occasion of service A measure of services provided to patients—usually used in the outpatient or community health setting. Sub-acute Intermediate care provided between acute care and community-based care. Sub-acute care includes services such as rehabilitation that can be provided in a less invasive environment than an acute hospital environment.
Tertiary services	Tertiary services are generally those provided in a complex, highly specialised hospital environment.

Other sources of information

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

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

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

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Additional publications relating to health status and health services in the ACT are:

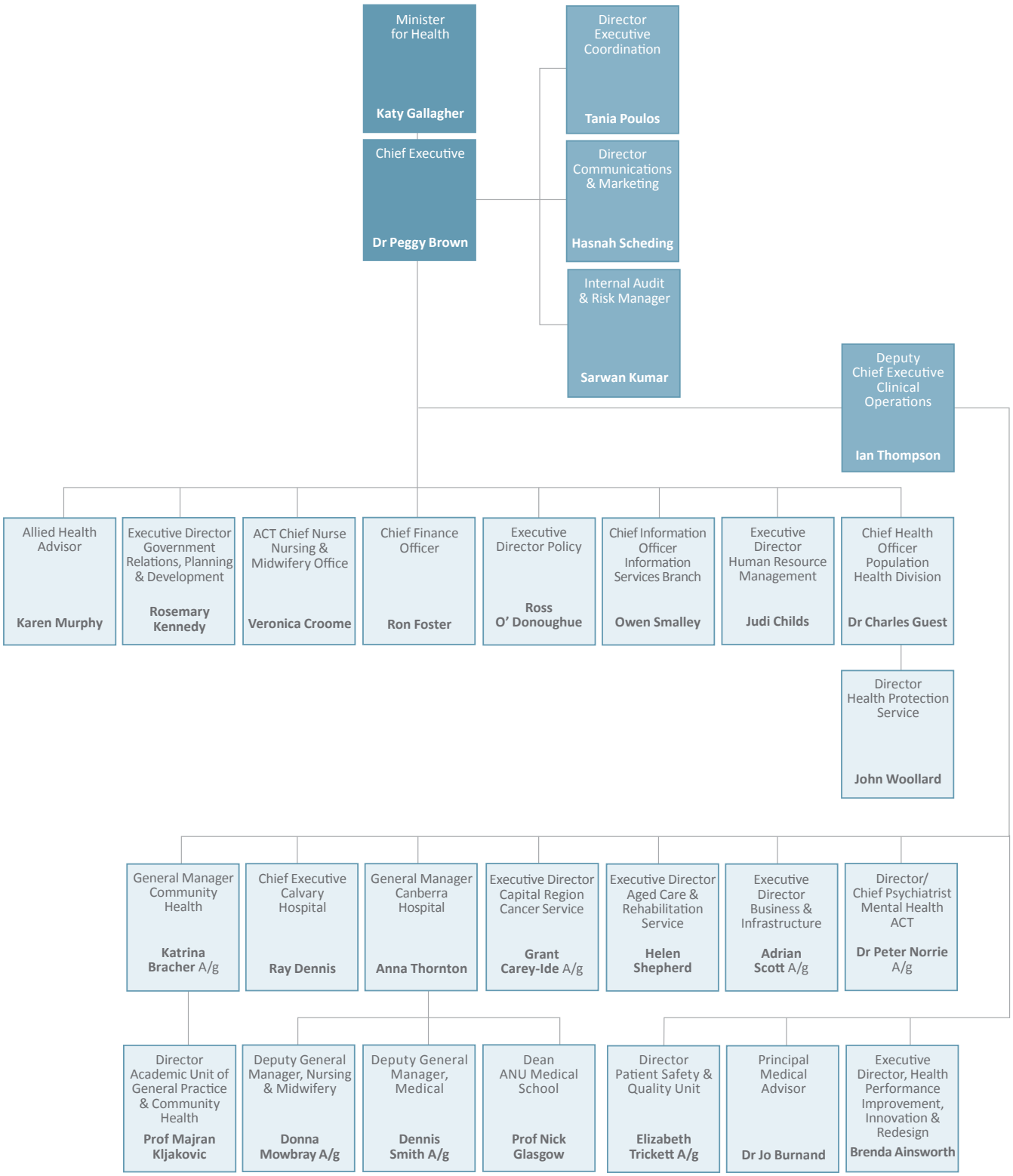
ACT Chief Health Officer's Report 2010
ACT Human Rights Commissioner—Annual Report 2010–11
Australian Institute of Health and Welfare—Australia's Health 2010

Compliance index

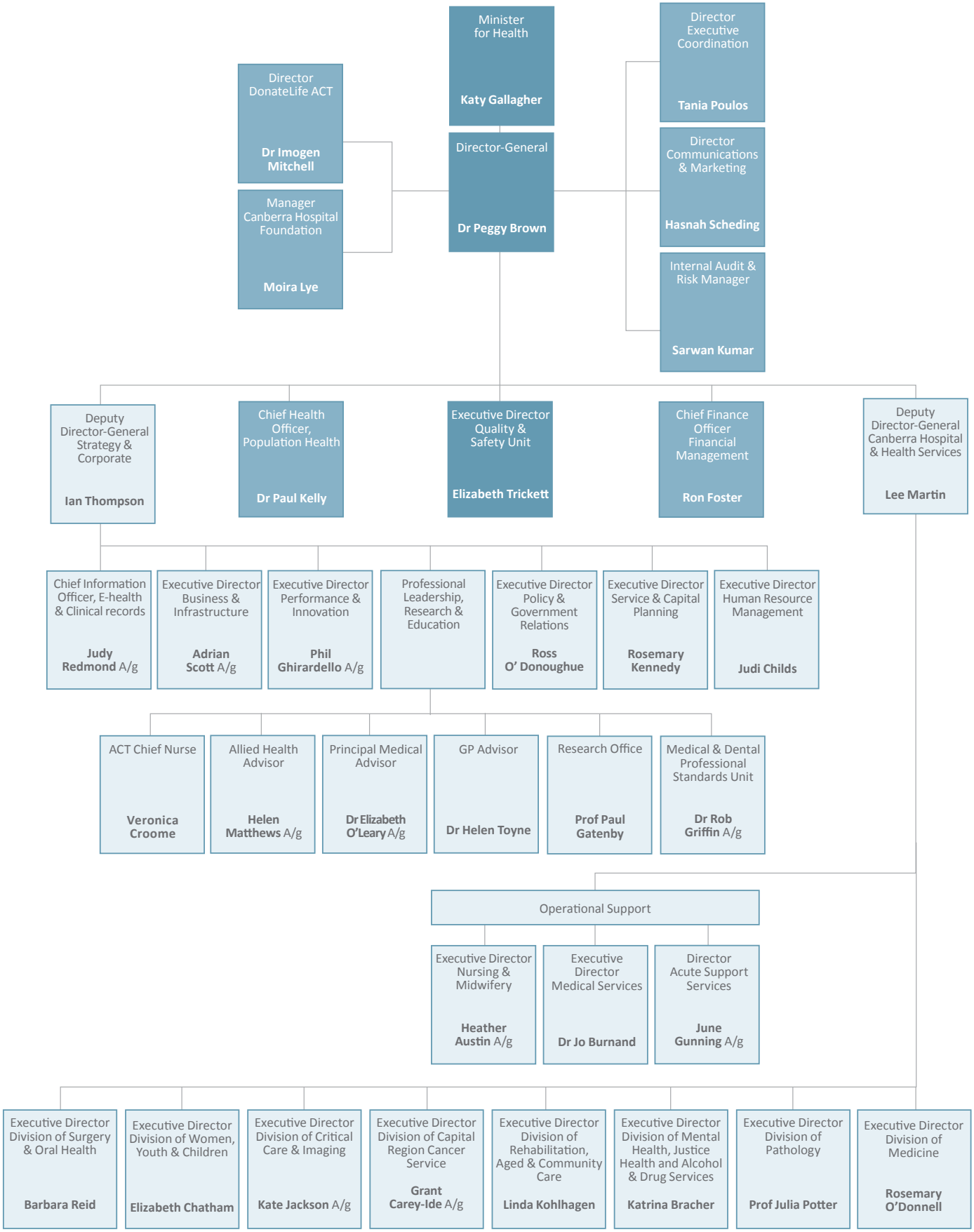
Section A

Performance and financial reporting

ACT Health organisational structure
1 January 2011



Health Directorate organisational structure
30 June 2011



A.1
The organisation

Vision and values

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

- Care
- Excellence
- Collaboration
- Integrity.

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

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

Objectives

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

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

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

Organisational structure

Two organisation charts are provided on the preceding pages (pp. 2 and 3).

In March 2011, the organisation was restructured and its governance arrangements revised. The organisation charts provide an overview of the organisation at 1 January 2011 and, following restructure, on 30 June 2011.

The restructure was undertaken to meet the challenges of an increasing demand for services, the desire to deliver service excellence, the need to prepare for and implement changes arising under the National Health Reform Agreement, as a large and diverse organisation, and implementation of the Capital Asset Development Plan. The aim was to enhance the organisation's operations and strengthen its governance.

A consultation process occurred in two stages, with active engagement of staff and stakeholders. Over the consultation process more than 500 submissions were received. These submissions, and feedback received during staff forums, informed the final structure and arrangements for the organisation.

At the highest level, the Health Directorate is structured into groups and operational areas which report directly to the Director-General. The two groups—Canberra Hospital & Health Services and Strategy & Corporate—are led by Deputy Directors-General and are divided into clinical service divisions and strategic and corporate support branches. Canberra Hospital & Health Services (TCH&HS) employs the majority of staff working within the Health Directorate and provides acute, sub-acute, primary and community-based health services to the ACT and surrounding region. The Little Company of Mary provides public hospital services (Calvary Public Hospital) under a contractual agreement with the Health Directorate. The Strategy and Corporate group employs a smaller number of staff. These staff provide infrastructure, policy, funding and strategic planning support to clinical service areas as well as plan for workforce and health service needs into the future. Operational areas which report directly to the Director-General provide a range of corporate support and organisation-wide services such as quality and safety initiatives and financial management. Population Health Division provides a range of public and environmental health services as well as health protection and promotion services.

As part of the organisational restructure, the organisation's governance arrangements were reviewed and strengthened. This is outlined more fully in section C.5, Internal accountability.

In May 2011 the Health Directorate made further changes, predominantly relating to nomenclature and branding, in line with the formation of the single ACT Public Service arising from the Hawke Review.

The Health Directorate, other agencies and external stakeholders

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

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

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

A.2 & A.3
Overview & highlights for 2010–11

In 2010–11 the Health Directorate continued to deliver high-quality services in a complex and challenging environment, achieving significant improvements in performance while continuing to grow and mature as an organisation. It is particularly pleasing that, while engaging with and adopting changes arising from an internal restructure, a review of the broader ACT Public Service and initiatives arising from the National Health Reform process, the organisation maintained a focus on its service objectives and is able to report a significant number of achievements against them.

With overarching direction from the Corporate Plan 2010–2012, a continued emphasis on improving the performance of our services in relation to quality, safety and timely access has ensured that achievements of prior years have been maintained, and areas of need improved. Acknowledging the complex environment and challenges that all health care organisations experience in the delivery of services, the Health Directorate continues to closely monitor all areas of performance and implement strategies where necessary to address issues and to identify areas for improvement.

The Health Directorate was pleased to deliver an overall reduction in the elective surgery waiting list. Given the increasing demand for elective surgery, this was a significant achievement, with the waiting list at 30 June at 4267—the lowest it has been since March 2003. An elective surgery program targeting long-wait elective surgery patients was implemented in 2010–11, and this saw the number of patients waiting longer than clinically recommended timeframes reduced from 2200 in June 2010 to 1431 in June 2011. As a result of the increased capacity at Canberra Hospital and Calvary Hospital, along with the use of the private sector, which was contracted to perform a number of operations, the total number of elective surgery operations in 2010–11 was a record 11,336.

A 16-bed Surgical Assessment Planning Unit (SAPU) was commissioned in September 2010 at the Canberra Hospital (TCH). The SAPU model of care focuses on facilitating rapid decision-making and access to definitive care for acute surgical patients. Hospital capacity continued to increase, with the overall capacity of the public health system growing to 926 beds, a 36 per cent increase over the past six years (from 679 beds in 2004–05). While this has assisted us in addressing waiting times for elective and emergency care, bed occupancy levels increased to 89 per cent. This remains lower than the 97 per cent bed occupancy experienced in 2005–06, but it is an increase of 3 per cent from the last reporting year.

Our focus on timely access to care continued, with timeliness for emergency department presentations at or above the national benchmarks for categories 1 and 5. Challenges were experienced in meeting the national target for categories 2, 3 and 4. The 5 per cent increase in presentations compounded over each reporting year has contributed to the challenge of meeting these targets. Work occurring both within the emergency department and more broadly across the Health Directorate as part of the National Health Reform process is expected to produce improvements in these results.

Australia's first public, nurse-led Walk-in Centre was opened in May 2010 and managed over 17,114 presentations to the end of June 2011. The Walk-in Centre has continued to receive an exceptional amount of positive consumer feedback about the service it provides, in addition to meeting an increasing demand for services. The Walk-in Centre was also recognised formally by the Australian Institute for Project Management, winning three national awards in relation to the planning and establishment of the program.

A purpose-built neurosurgery operating theatre opened at the Canberra Hospital in September 2010, and is currently the only one if its kind in Australia. Containing an intra-operative magnetic resonance imaging (MRI) machine, the suite enables complex procedures to be undertaken. The ability to perform this imaging procedure while the patient is anaesthetised as a part of the surgical process significantly improves patient outcomes and reduces the rate of patients having to return for surgery for additional procedures.

With monies allocated in 2009–10 for the purchase and installation of a positron emission tomography/computerised tomography (PET/CT) scanner, the PET/CT service began operating in November 2010. Prior to its installation, ACT residents needed to travel interstate for this service. During the reporting year, a number of patients continued to seek this service interstate but with in excess of 1000 patients in the ACT and surrounding region anticipated to benefit from this service, a significant increase in utilisation is anticipated in 2011–12.

A significant improvement was experienced in the waiting times for radiotherapy. Despite the increased demand, in 2001–11 nearly 100 per cent of patients receiving care received radiotherapy within standard timeframes, compared with 85 per cent in 2009–10 and 78 per cent the previous year. In addition, the fit-out of the housing for a fourth linear accelerator was completed in August 2010. This bunker will enable the installation of a new linear accelerator within the coming year and then the seamless replacement of the original one.

Our rehabilitation services based at the Canberra Hospital achieved a number of outcomes higher than national benchmarks for measures of both quality and efficiency. These include being 8 per cent above the Australian Rehabilitation Outcomes Centre benchmark for discharge of post-stroke patients back to a private residence, 9 per cent above the benchmark for discharge of amputee patients back to a private residence, and the average length of stay for patients requiring rehabilitation after multi-trauma being 36.5 days, compared with the benchmark of 45.6 days. In addition to these positive outcomes, the appointment of a rehabilitation specialist in March 2011 enabled additional clinics to be provided by the rehabilitation team, lowering waiting times.

Consistent with an increase in demand for hospital-based services, our community-based nursing services met an increased demand for services delivered through home visits or health centre appointments. Efforts to assist ACT residents to remain at home safely were assisted by a 40 per cent reduction in the waiting times for non-urgent community-based occupational therapy assessments and interventions, and an increase of 19 per cent of people receiving falls injury prevention services (a total of 486 in 2010–11, up from 412 in 2009–10). In addition, a range of innovative programs were developed and delivered, improving access to pre- and post-surgical nursing and allied health support to the ACT community. These include pre-prostatectomy group education, post-operative knee replacement physiotherapy groups, and the opening of a southside ambulatory clinic on the weekends, improving consumer access to nursing care and complementing the existing weekend clinic located northside.

Our excellent performance in the delivery of timely emergency and planned restorative dental care was maintained this year. One hundred per cent of clients requiring emergency dental services were seen within 24 hours, while the mean waiting time target of 12 months for restorative dental treatment continued to be the best outcome for any public dental service in Australia. It was also pleasing to see that a collaborative program between the Dental Health Program, the Salvation Army, Communities at Work and a pro-bono dentist, called Dental Care for the Homeless and Low Income clients in the ACT, was recognised by being awarded the ACT Quality in Healthcare Award for Access and Efficiency.

In line with improving consumer experience and access to care, over 396 sleep studies have been performed in the 12 months that the Sleep Laboratory at TCH has been open, with multiple sleep latency testing commencing in May 2011. Some of these studies have been performed in the client's home, while others occur on the Canberra Hospital campus. A significant proportion of hospital-based sleep studies are complex in nature, and these tests were previously unavailable in the ACT.

Similarly, implementation of the NICUCAM website, which provides a video streaming service for parents of up to eight infants in the Centre for Newborn Care Neonatal Intensive Care Unit (NICU) at any one time, has helped parents who may not be able to visit the centre as regularly as they would like to stay in touch with the care and wellbeing of their child. With a secure password and login provided to families, this service promotes access to and bonding with the baby. The website has received over 20,000 hits, and been accessed from 17 countries.

A joint initiative between Mental Health and Ward Services to reduce aggression and consumer distress has introduced an Early Support and Intervention Team at the Canberra Hospital Psychiatric Services Unit. By training staff, the initiative focuses on engagement and de-escalation. With continued monitoring and review of all episodes of seclusion and restraint, the initiative has resulted in a significant reduction in seclusion within the Psychiatric Services Unit. The first formal mental health consumer-led research is now examining this project and its effect on staff, consumers and carers. In addition, Mental Health has focused on following up with clients admitted to the Psychiatric Services Unit within seven days of discharge. It achieved a rate of 75 per cent in 2010–11 (up from 72 per cent in 2009–10)—the best in Australia.

Access to health care services for detainees was streamlined at the Alexander Maconochie Centre during the reporting year, with the introduction of a new health induction process that reduces duplication and refers to other services when there is an assessed need for further specialised care. The introduction of a GP liaison triage nurse has also assisted patient access and flow to Justice Health clinics within the centre.

The need to deliver sustainable, quality services into the future has driven the establishment of a range of initiatives. The launch of the Aboriginal and Torres Strait Islander portal (http://health.act.gov.au/health-services/aboriginal-torres-strait-islander) has enabled greater access to relevant health and health service information for Aboriginal and Torres Strait islander people within the community. A Home Telemonitoring Program and a Chronic Disease Telephone Coaching Service to assist individuals in self-managing their chronic condition were also established. A memorandum of understanding with the Southern Local Health Network for the provision of renal services in Goulburn and surrounding regions has also led to input into the implementation of a new self-care dialysis unit at West Wyalong in NSW, and design and planning of a new dialysis unit at Queanbeyan. These initiatives meet the objectives of the Renal Services Plan 2010–15 to deliver an integrated, quality service to the ACT and surrounding region.

Our efforts towards early intervention and prevention of health problems continue to deliver effective strategies and outcomes.

The Australian Institute of Health and Welfare identifies the ACT as being within the top three jurisdictions for participation in the Cervical Screening Program, with a rate of 58.86 per cent. We similarly continue to achieve high childhood immunisation coverage in the general population, with rates for 12-month-old children in 2010–11 above the 90 per cent national target. Also achieving above-target outcomes were the ‘well women’ health checks of women from culturally and linguistically diverse communities and referrals of children in substitute and kinship care to the Out-of-Home Care clinic. A range of health promotion grants and social marketing strategies were also introduced. Building on national programs, these strategies encourage us all to increase our activity levels, improve our nutrition and make lifestyle changes that will assist our health outcomes.

As well as the significant number of service achievements, the Capital Asset Development Plan (CADP) continued in 2010–11. This plan combines the delivery of capital works and e-health initiatives with a review of the model of care for each project, ensuring that all health services will be aligned with the objectives of the organisation and consistent with contemporary standards in health care. Key achievements in 2010–11 include the installation and opening of the Neurosurgery Operating Suite, the Surgical Assessment and Planning Unit and the PET/CT scanner as identified earlier. In addition, construction commenced on the new Women’s and Children’s Hospital and the Adult Acute Mental Health Inpatient Unit on the Canberra Hospital campus, the new southern multi-storey car park on the campus was opened and demountable administration buildings were completed, with hospital-based executives moving in and freeing up clinical space within TCH. A new 16-bed critical care unit and an additional operating theatre further enhanced the capacity of Calvary Public Hospital. Designs were completed for the new Gungahlin Community Health Centre and were commenced for the Capital Region Cancer Centre.

Aligned activity in e-health saw the implementation of Meta-Vision, an electronic clinical information system within the Intensive Care Unit of the Canberra Hospital which supports improved clinical outcomes and reporting by integrating all data relating to a patient's stay in intensive care within a secure system. The Equipment Loan Service implemented a new application that streamlines information in relation to equipment tracking, cleaning, delivery and maintenance. The Digital Health Enterprise consultancy was completed, providing the Digital Health Enterprise Technology Strategy, which outlines how technology will support the Health Directorate, with the key goals of improving access, efficiency and reliability. Another 17 e-health projects continued during the year, and four major projects commenced. These include a nurse-call system and electronic entry of radiology and pathology requests.

Recognition of the positive work being undertaken across the Health Directorate was provided by the accreditation of the organisation by the Australian Council on Healthcare Standards. The accreditation was maintained for a period of four years, the maximum period that can be granted. The Periodic Review survey in February 2011 reviewed the 14 mandatory criteria which are required to be met at the Moderate Achievement (MA) or higher level for accreditation to be maintained. The Health Directorate achieved an Extensive Acheivement on four criteria and an MA rating on 10.

On the legislation front, a significant number of the Health Directorate clinical staff who were previously registered with local health professions boards came under the jurisdiction of the relevant national board, under the auspices of the Australian Health Practitioner Regulation Agency, on 1 July 2010. To accommodate this change, sections of the *Health Professionals Act 2004* were repealed and the Health Practitioner Regulation National Law (ACT) Act 2010 was enacted. During the reporting period, the *Smoking (Prohibition in Enclosed Public Places) Act 2003* was re-named the *Smoke-Free Public Places Act 2003*. The name change was necessary to reflect the Act's expanded purpose.

Our staff continues to be our greatest asset, with formal recognition of this coming from both external and internal sources. Over 90 per cent of the compliments received from our consumers and patients relate to and reflect on the positive conduct of our staff. More formally, a number of staff were recognised for their significant contribution to the organisation through a range of internal recognition programs throughout the reporting year. The awards included recognition of outstanding clinical performance and contributions, contributions to the organisation through excellence in administrative work practices, safety initiatives and specific quality projects aimed at improving work practice. These internal award programs are highly regarded within the organisation and, as a result, very competitive. Nominees and award winners are to be congratulated.

As well as internal processes, a number of our staff were recognised at the territory and national level. Awards and recognition provided to staff include Bronwyn Robinson being named the Barnardos ACT Mother of the Year 2011; recognition by the Governor-General, Ms Quentin Bryce AC, of Dr Ross Peake and Dr Carmel McInerney for their exceptional service and contribution to the South Care Helicopter Service; Sasha Berryman becoming a joint winner in the ACT Workplace Health and Safety Awards, and being nominated for the national awards; and recognition of a joint initiative between a range of teams within the Health Directorate and the ACT Ambulance Service, called the Acute Coronary Syndrome Project, winning a 2010 Australian Safer Communities Award for the ACT. The highly contested Australian Institute of Project Management (ACT) awards recognised the Asset Management Business Systems Improvement Project as the winner of the ACT Systems Support category and named Susan Hayward as Project Manager of the Year. At the national level, the Walk-in Centre received three awards—for National Project Manager of the Year, National Project of the Year and National Product Development. These are only some examples of the formal recognition received by staff for their ongoing commitment to the ACT community, their work and the organisation. All are to be commended.

In 2010–11 we significantly increased alignment of our clinical service delivery with teaching, education and research efforts. In late 2009 ACT Health initiated the Clinical Training Subsidies Executive Management Group, which brought together executive members of all the largest health and education service providers in the ACT and Southern NSW region to work collaboratively on Health Workforce Australia initiatives. The work of this group has resulted in subsidies from Health Workforce Australia being gained in 2010–11 to support delivery of additional clinical training places across the Health Directorate, Calvary Public Hospital, Calvary John James Hospital and Murrumbidgee and Southern NSW local health districts. Additional funding has also been secured to improve and expand student accommodation and training infrastructure across the region, support improvements in supervision and develop simulated learning facilities in the ACT. The Clinical Training Subsidies Executive Management Group will form the basis of the new Integrated Regional Clinical Training Network commencing in September 2011, which will have an expanded membership, with all health service stakeholders in the ACT region invited to take part.

The maturing and evolving culture of the organisation, to which all staff contribute, was most obviously demonstrated during the restructuring of both organisational and governance arrangements. All involved in this process, from officers coordinating the process to staff who provided feedback during consultation, were actively engaged in a positive and constructive manner. The restructure project team received more than 500 submissions, and further information was obtained at staff forums. This valuable information highlighted areas not adequately addressed, expressed concern with some of the proposed changes and indicated strong support for others. The final proposed structure, and the decision-making that occurred, reflected much of this feedback. I believe that, as a result of this commitment and engagement, the Health Directorate is now in a much better position to meet the current and future health care demands.

Our staff are to be commended for their continued commitment to the delivery of high-quality services and the active demonstration of the values of the organisation in their day-to-day work. With the significant changes of the restructure and the National Health Care Reform, in addition to ongoing day-to-day demands, all have worked hard to ensure that changes have been adopted and integrated into their work, while continuing to meet, and at times exceed, service targets.

A.4
Outlook for 2011–12

The coming year will again be a challenging but rewarding one for the Health Directorate. We look forward to maintaining a high standard of clinical services while continuing to improve upon our consumer's experience of and access to services.

Areas of focus for 2011–12 include:

- continuing to embed the Health Directorate values of care, excellence, collaboration and integrity within all aspects of our operations as an organisation, and delivering against the seven key performance areas within the Corporate Plan. Maintaining a focus on the values and objectives are essential for us to deliver high quality care while retaining our skilled and valued workforce
- continuing to implement work arising from the National Health Reform Agreement, including establishment of the ACT Local Hospital Network and strategies to meet performance targets for the emergency department and elective and emergency surgery
- implementing the National Safety and Quality Health Service standards across all services within the organisation. This work is anticipated to further improve our performance in a range of key performance areas, including consumer engagement, health-associated infections, falls prevention and medication safety
- progressing new models of care for traditionally hospital-based services to enable provision of these within the community, improving the timeliness, access to and experience of these services. This includes an expansion of telemonitoring to assist self-management of chronic disease and commencing consultation on the provision of renal services at the planned enhanced community health centres
- continuing the Capital Asset Development Plan, with commissioning and opening of the Women and Children's Hospital, the Adult Mental Health Unit, and a new Ophthalmology Clinic, procurement of two new linear accelerators, and progressing design plans and the model of care for a new sub-acute hospital on the north side of Canberra, a major new clinical services block at the Canberra Hospital, and the Capital Regional Cancer Centre
- implementing a number of e-health projects as part of the Government's $900 million Health-e Future Program
- developing a new Clinical Services Plan to guide the development of health services across the ACT
- evaluating the operation of both the governance and organisational arrangements of the Health Directorate following the internal restructure.

A.5
Management discussion and analysis

General overview

Change of name

On 17 May 2011 as a result of Administrative Arrangement 2011 (No.1), the agency changed its name from ACT Health to the Health Directorate.

Operations and principal activities

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

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

- community and consumers
- safety and quality of care
- partnerships
- accountability and internal systems, and
- the Directorate's staff.

Changes in administrative structure

The Directorate did not gain or lose any functions in the 2010–11 year.

Risk management

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

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

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

- implementation of strategies for the retention and recruitment of doctors, nurses, midwives and allied health professionals
- strengthening our patient safety and clinical practice review framework
- establishing the Medical School in cooperation with the Australian National University
- enhancement of procurement processes to maximise benefits from contracting
- a significant investment in infrastructure replacement and growth

- a significant investment in clinical systems and recording systems, and
- the Government introducing growth funding into the Health Budget in 2006–07. This was based on activity projected through clinical services planning.

These risks are monitored regularly throughout the year.

Financial performance

The following financial information is based on audited financial statements for 2009–10 and 2010–11, and the forward estimates contained in the 2011–12 Budget Paper Number 4.

Total net cost of services

	Actual 2009–10 $m	Budget 2010–11 $m	Actual 2010–11 $m	Forward Estimate 2011–12 $m	Forward Estimate 2012–13 $m	Forward Estimate 2013–14 $m
Total expenses	990.4	1,068.6	**1,077.6**	1,146.3	1,188.4	1,276.3
Total own source revenue	205.8	216.0	**225.3**	222.1	228.0	234.1
Net cost of services	784.6	852.6	**852.3**	924.2	960.4	1,042.2

Comparison to budget

The Directorate's net cost of services for 2010–11 of $852.3 million was only $0.3 million, or 0.04 per cent higher than the 2010–11 budget (refer to Attachment A). However, this reflects a combination of factors comprising:

- an increase in expenses ($9.0 million or 0.8 per cent), largely due to higher payments to non-government organisations ($10.6 million or 5.3 per cent) and other expenses ($7.0 million or 26.9 per cent) and higher employee expenses and superannuation ($0.5 million or 0.09 per cent), offset by lower supplies & services ($8.3 million or 3.0 per cent) and lower depreciation and amortisation ($0.8 million or 3.0 per cent). These higher payments through grants and purchased services are due to a targeted reduction in elective surgery for long-wait patients, and cost pressures at Calvary Public Hospital. The increase in other expenses is largely due to the transfer of the Narrabundah Health Centre from the control of the Directorate to the Winnunga Nimmityjah Aboriginal Health Service. The reduced expense for supplies and services is largely due to the finalisation, after the budget was set, of where the targeted elective surgery would be delivered. See the reference above to higher payments to non-government organisations.
- offset by higher revenue ($9.3 million or 4.0 per cent), largely due to higher other revenue (12.5 million or 106 per cent) and higher gains ($1.1 million or 78 per cent), due to contributions of assets and donations offset by lower revenue ($4.1 million or 2 per cent), largely resulting from lower than expected user charges, and decreases in resources received free of charge ($0.2 million or 26 per cent).

Comparison to 2009–10 actual expenses

Total net cost of services was $67.7 million, or 8.6 per cent higher than the 2009–10 actual cost, due to increased expenses ($87.2 million or 8.8 per cent), offset by increased non-appropriated revenue ($19.5 million or 9.5 per cent).

Future Trends

Figure 1—Net Cost of services

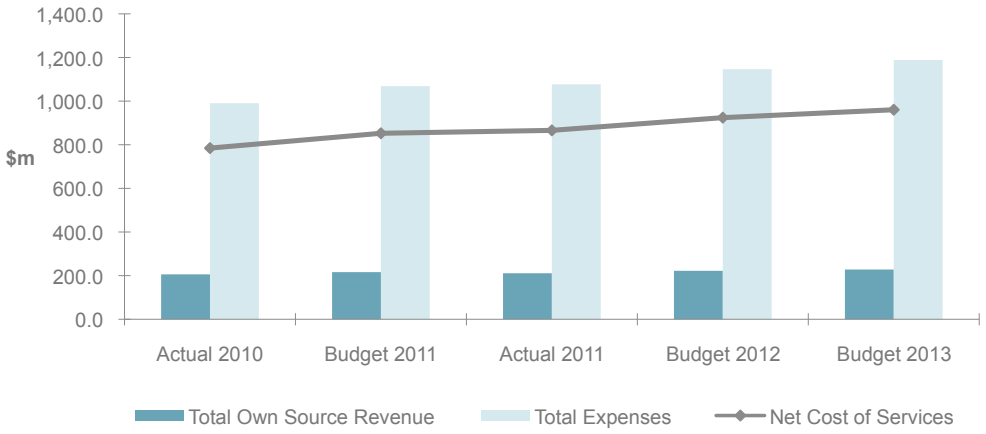


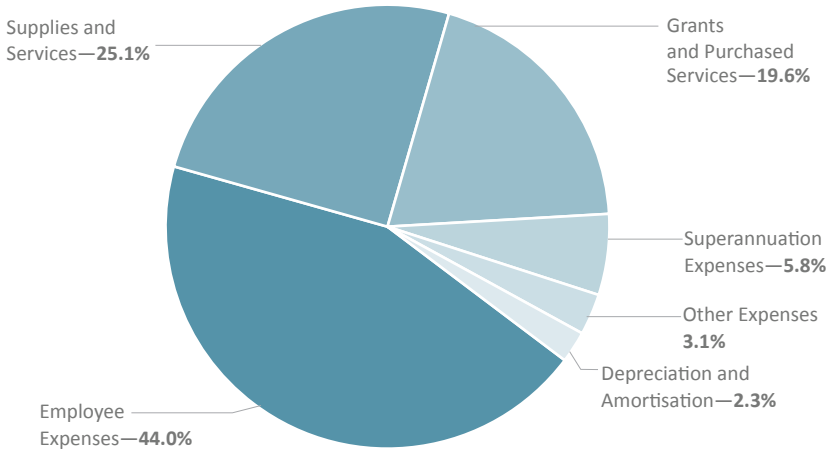
Figure 1 indicates that from 2010 the Directorate is anticipating a gradual trend of increasing expenses and net cost of services.

Total expenditure

1. Components of expenditure

Figure 2 below indicates the components of the Directorate's total expenses for 2010–11, with the largest components being employee expenses (excluding superannuation), which represent 44.0 per cent or $474.5 million; supplies and services, which represent 25.1 per cent or $270.2 million; and grants and purchased services, which represent 19.6 per cent or $211.1 million.

Figure 2—Components of expenditure



2. Comparison to budget

Total expenses of $1,077.6 million were $9.0 million, or 0.8 per cent higher than the original 2010–11 budget of $1,068.6 million.

This variation was predominantly due to:

- grants and purchased services higher by $10.6 million, or 5.3 per cent—resulting from higher than anticipated elective surgery activity delivered through the non-government sector and cost pressures, and

- other expenses of $7.0 million, or 20 per cent higher, mainly resulting from expensing Narrabundah Health Centre land and building that were transferred to the Winnunga Nimmityjah Aboriginal Health Service.

The above higher expenses were partially offset by lower supplies and services ($8.3 million or 3.0 per cent). The reduction was mainly due to the expensing of elective surgery delivered by Calvary Public Hospital through grants and purchased services.

3. Comparison to 2009–10 actual expenses

Total expenses were $87.2 million, or 8.8 per cent higher than the 2009–10 actual result. The increase reflects a combination of factors, including increased expenditure in:

- employee costs (excluding superannuation) $36.1 million or 8 per cent—due to salary and wage increases, growth in a wide range of services and growth in services in Mental Health, Critical Care, Cancer Services, Home and Community Care Services, Obstetrics and Gynaecology, increased elective surgery throughput and National Health Reform initiatives
- superannuation of $3.0 million or 5 per cent—due to the increased number of contributors as the workforce grew at a faster rate than planned and the number of contributors in the CSS and PSS remained at similar levels to previous years
- supplies and services of $17.7 million or 7 per cent—resulting from indexation and growth in services
- grants and purchased services of $25.2 million or 13 per cent—mainly resulting from increased payments to Calvary Public Hospital for salary increases, other indexation, and additional activity and payments to non-government organisations for growth and indexation and workforce and healthy futures initiatives, and
- other expenses of $8.0 million or 32 per cent—due to expensing of Narrabundah Health Centre land and building, which were transferred to the Winnunga Nimmityjah Aboriginal Health Service and higher costs for the National Blood Supply Agreement.

This was offset by reduced depreciation ($2.8 million or 10 per cent) due to the prior year impact of the accelerated depreciation of a multistorey car park at Canberra Hospital, which was demolished.

4. Future trends

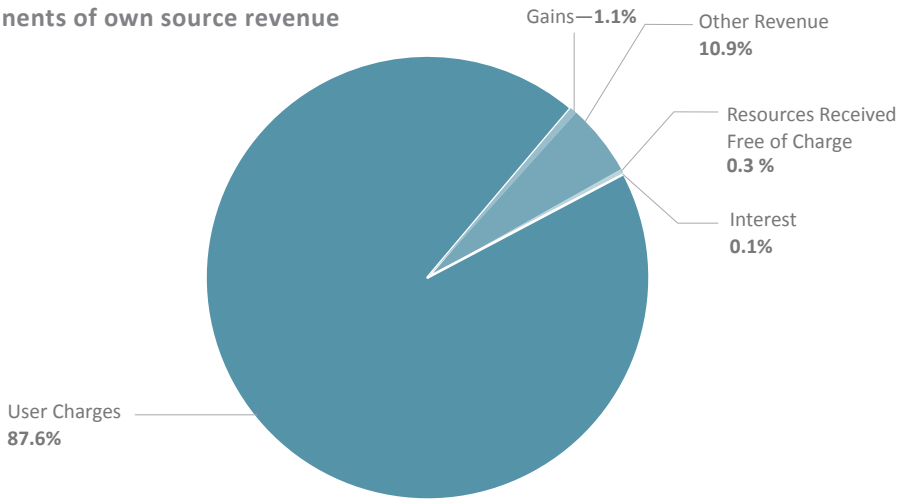
Expenses are budgeted to increase in 2011–12 by $68.7 million or 6 per cent and continue to trend upwards across the forward years.

Total own source revenue

1. Components of own source revenue

Figure 3 below indicates that for the financial year ended 30 June 2011 the Directorate received 87.6 per cent of its total own source revenue of $225.3 million from user charges.

Figure 3—Components of own source revenue



2. Comparison to budget

Revenue

Non-appropriated revenue for the year ending 30 June 2011 was $225.3 million, which was $9.3 million higher than the 2010–11 budget of $216.0 million. This favourable variance is due to higher other revenue ($12.5 million) and other gains ($1.1 million), offset by a reduction in user charges ($4.2 million) and resources received free of charge ($0.2 million).

3. Comparison to 2009–10 actual income

Revenue

Non-appropriated revenue was $19.5 million, or 9.5 per cent higher than the 2009–10 actual result of $205.8 million. The result reflects an increase in user charges ($2.6 million or 1 per cent), other revenue ($15.3 million or 168 per cent) and other gains ($1.5 million or 136 per cent), offset by a reduction in resources received free of charge revenue ($0.2 million or 22 per cent).

4. Future trends

Total own source revenue is expected to decrease slightly in 2011–12 and then to slowly trend upwards across the forward years.

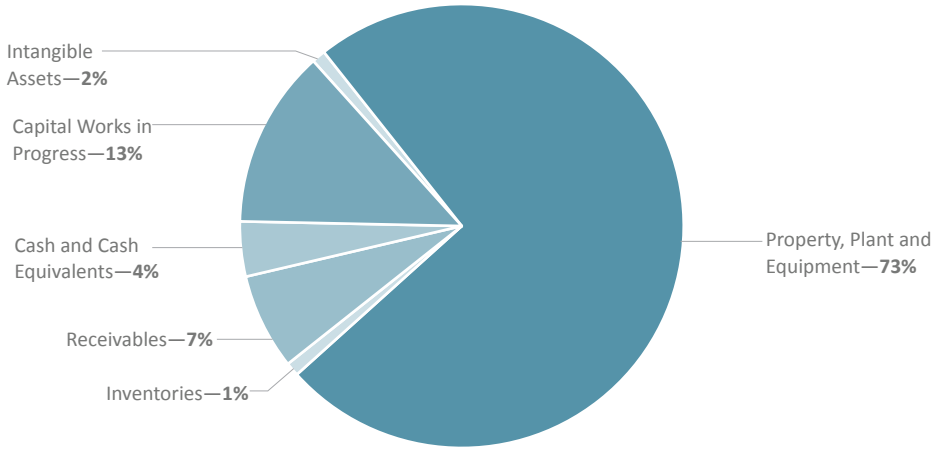
Financial position

Total assets

1. Components of total assets

Figure 4 below indicates that for the financial year ended 30 June 2011 the Directorate held 73 per cent of its assets in property, plant and equipment.

Figure 4—Total assets as at 30 June 2011



2. Comparison to budget

The total asset position as at 30 June 2011 is $806.6 million, $73.3 million lower than the 2010–11 budget of $879.9 million.

The variance reflects the timing associated with the acquisition and completion of various assets over the 2010–11 financial year, including intangibles ($31.4 million), capital works in progress ($46.3 million), property, plant and equipment ($24.5 million) and receivables ($4.8 million), offset by increases in cash and cash equivalents ($30.1 million) due to receipt on 30 June 2011 of monies from NSW Health for prior years' cross-border activity, inventories ($2.4 million) and other assets ($1.2 million).

3. Comparison to 2009–10 actuals

The Directorate's total asset position is $117.5 million or 17 per cent higher than the 2009–10 actual result of $689.1 million largely due to increases in:

- cash and cash equivalents ($25.3 million or 478 per cent)
- inventories ($1.6 million or 26 per cent)
- property, plant and equipment, including assets held for sale ($84.9 million or 17 per cent), as a result of buildings completed as part of the Capital Asset Development Plan and a revaluation of land, buildings and leasehold improvements
- intangibles ($1.4 million or 12 per cent), and
- capital works in progress ($16.1 million or 17 per cent).

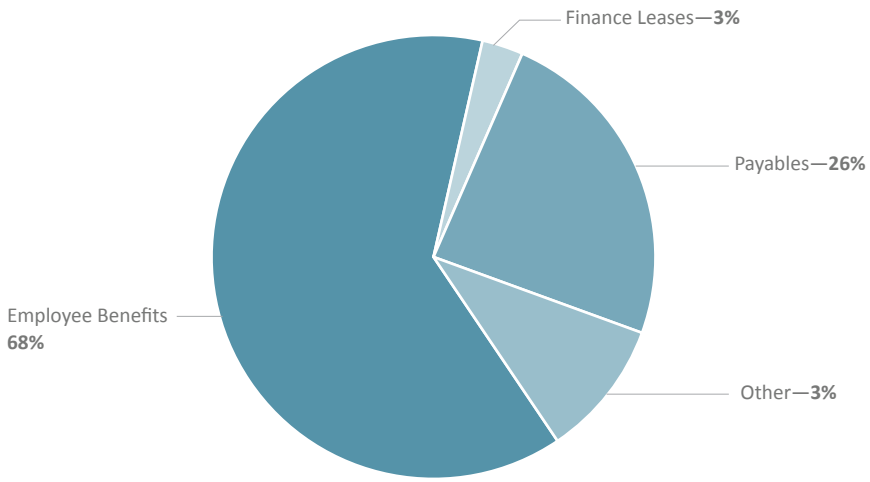
The above increases were partially offset by a reduction in receivables ($11.3 million or 20 per cent) and other assets ($0.7 million or 1 per cent).

Total liabilities

1. Components of total liabilities

Figure 5 below indicates that the majority of the Directorate's liabilities relate to employee benefits (68 per cent) and payables (26 per cent).

Figure 5—Total liabilities as at 30 June 2011



2. Comparison to budget

The Directorate's liabilities for the year ended 30 June 2011 of $221.1 million are $26.1 million or 13 per cent higher than the 2010–11 budget figure of $195.0 million. This was largely due to increased employee benefits ($5.4 million), payables ($22.2 million) and finance leases ($0.6 million), offset by a reduction in other liabilities and provisions ($2.1 million).

3. Comparison to 2009–10 actuals

Total liabilities are $15.2 million higher than the actual results for the same period last year of $205.9 million, largely due to increases in payables ($14.7 million), employee benefits ($10.7 million) and finance leases ($0.1 million), offset by a reduction in other liabilities ($10.3 million).

Territorial statement of revenues and expenses

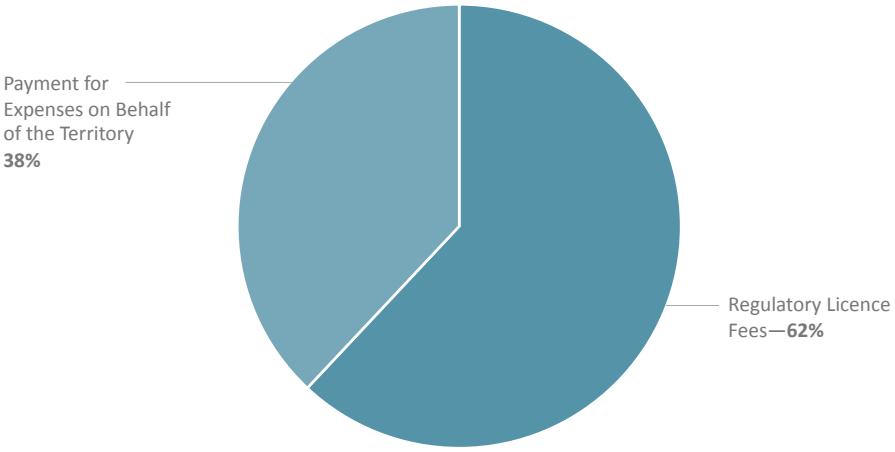
The activities whose funds flow through the Directorate's territorial accounts are:

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

Total income

Figure 6 indicates that 62 per cent of territorial income is regulatory licence fees, with the balance being the receipt, for on-passing, of monies for capital works at the Calvary Public Hospital (expenses on behalf of the territory).

Figure 6—Sources of territorial revenue



Total territorial income for the year ending 30 June 2011 was $1.2 million, which was lower ($0.2 million) than the budget figure of $1.4 million.

Total income was $8.5 million lower than for the same period last year, due to a reduced level of building activity at the Calvary Public Hospital.

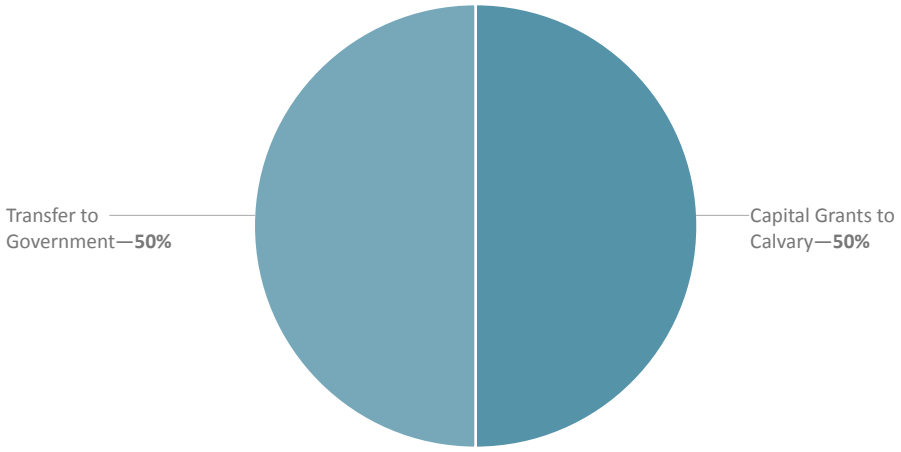
Grants from the Commonwealth

All Commonwealth grant monies are now paid directly to the Treasury Directorate rather than through the Directorate's territorial accounts.

Total expenses

Figure 7 indicates that 50 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 50 per cent being the transfer to government of regulatory licence fees.

Figure 7—Sources of territorial expenses



Total expenses were $1.4 million, which was equal to the budget for the period.

Total expenses were $8.3 million lower than for the same period last year, due to a reduced level of building activity at Calvary Public Hospital.

Attachment A—Comparison of net cost of services to budget 2010–11

Description	Original Budget	Plus AAO Transfers	Total Funding	Less Actual	Variance to be Explained	
	$'000	$'000	$'000	$'000	$'000	%
Expenses						
Employee and superannuation	537,029	—	537,029	537,492	–463	–0.09%
Supplies and services	278,561	—	278,561	270,237	8,324	3.00%
Depreciation and amortisation	26,038	—	26,038	25,271	767	2.95%
Grants and purchased services	200,456	—	200,456	211,107	–10,651	–5.31%
Other expenses	26,467	—	26,467	33,475	–7,008	–26.47%
Total expenses	**1,068,551**	—	**1,068,551**	1,077,582	–9,031	–0.85%
Own source revenue						
User charges	201,481	—	201,481	197,318	–4,163	–2.07%
Interest	278	—	278	247	–31	–11.15%
Resources free of charge	956	—	956	709	–247	–25.84%
Gains	1,469	—	1,469	2,608	1,139	77.54%
Other revenue	11,838	—	11,838	24,373	12,535	105.89%
Total own source revenue	**216,022**	—	**216,022**	225,255	9,233	4.3%
Total net cost of services	**852,529**	—	**852,529**	852,327	202	0.02%

A.6
Financial report

ACT AUDITOR-GENERAL'S OFFICE

INDEPENDENT AUDIT REPORT

HEALTH DIRECTORATE

To the Members of the ACT Legislative Assembly

Report on the financial statements

The financial statements of the Health Directorate (the Directorate) for the year ended 30 June 2011 have been audited. These comprise the following financial statements and accompanying notes:

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

Responsibility for the financial statements

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

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

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

I formed the audit opinion following the use of audit procedures to obtain evidence about the amounts and disclosures in the financial statements. As these procedures are influenced by the use of professional judgement, selective testing of evidence supporting the amounts and other disclosures in the financial statements, inherent limitations of internal control and the availability of persuasive rather than 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
Telephone: 02 6207 0833 | Facsimile: 02 6207 0826 | Email: actauditorgeneral@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 the financial statements should note that the audit does not provide assurance on the integrity of information presented electronically, and does not provide an opinion on any other information which may have been hyperlinked to or from the financial statements. If users of the financial statements are concerned with the inherent risks arising from the electronic presentation of information, they are advised to refer to the printed copy of the audited financial statements to confirm the accuracy of this electronically presented information.

Independence

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

Audit opinion

In my opinion, the financial statements of the Directorate for the year ended 30 June 2011:

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

(ii) present fairly the financial position of the Directorate as at 30 June 2011 and the results of its operations and cash flows for the year then ended.

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

M. Cooper

Dr Maxine Cooper
Auditor-General
16 September 2011

Health Directorate
Financial Statements
For the Year Ended 30 June 2011

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 2011 and the financial position of the Directorate on that date.

Dr Peggy Brown
Director – General
Health Directorate

14 September 2011

Health Directorate
Financial Statements
For the Year Ended 30 June 2011

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 2011 and the financial position of the Directorate on that date.

Mr Ron Foster
Chief Finance Officer
Health Directorate

14 September 2011

Health Directorate Departmental Financial Statements for the Year Ended 30 June 2011

Health Directorate Operating Statement for the Year Ended 30 June 2011

	Note No.	Actual 2011 $'000	Original Budget 2011 $'000	Actual 2010 $'000
Income				
Revenue				
Government Payment for Outputs	4	834,520	826,910	753,617
User Charges—ACT Government	5	788	862	805
User Charges—Non-ACT Government	5	196,530	200,619	193,948
Interest and Distributions	6	247	278	259
Commonwealth Government Grants	7	—	—	(324)
Resources Received Free of Charge	8	709	956	948
Other Revenue	9	24,373	11,838	9,096
Total Revenue		**1,057,167**	**1,041,463**	**958,349**
Other Gains	10	2,608	1,469	1,059
Total Gains		2,608	1,469	1,059
Total Income		**1,059,775**	**1,042,932**	**959,408**
Expenses				
Employee Expenses	11	474,457	476,461	438,390
Superannuation Expenses	12	63,036	60,568	59,984
Supplies and Services	13	270,237	278,561	252,545
Depreciation and Amortisation	14	25,271	26,038	28,113
Grants and Purchased Services	15	211,107	200,456	185,926
Borrowing Costs	16	441	401	406
Other Expenses	17	33,034	26,066	25,016
Total Expenses		**1,077,582**	**1,068,551**	**990,380**
Operating (Deficit)		**(17,807)**	**(25,619)**	**(30,972)**
Other Comprehensive Income				

Health Directorate Operating Statement for the Year Ended 30 June 2011 *—continued*

	Note No.	Actual 2011 $'000	Original Budget 2011 $'000	Actual 2010 $'000
Increase in the Asset Revaluation Surpluses	34	9,607	—	—
Total Comprehensive (Deficit)		**(8,200)**	**(25,619)**	**(30,972)**

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

Health Directorate Balance Sheet As at 30 June 2011

	Note No.	Actual 2011 $'000	Original Budget 2011 $'000	Actual 2010 $'000
Current Assets				
Cash and Cash Equivalents	20	30,598	505	5,272
Receivables	21	46,469	53,356	57,722
Inventory	22	7,866	5,433	6,242
Assets Held for Sale	23	127	—	234
Other Assets	28	2,414	1,348	2,981
Total Current Assets		**87,474**	**60,642**	**72,451**
Non-Current Assets				
Receivables	21	2,135	—	2,154
Investments	24	3,000	3,000	3,000
Property, Plant and Equipment	25	592,600	617,090	507,677
Intangible Assets	26	12,827	44,228	11,394
Capital Works in Progress	27	108,578	154,890	92,447
Total Non-Current Assets		**719,141**	**819,208**	**616,673**
Total Assets		**806,615**	**879,850**	**689,123**

Health Directorate Balance Sheet As at 30 June 2011 *—continued*

	Note No.	Actual 2011 $'000	Original Budget 2011 $'000	Actual 2010 $'000
Current Liabilities				
Payables	29	57,197	35,010	42,453
Finance Leases	30	2,423	3,250	1,471
Employee Benefits	31	136,193	131,129	127,732
Other Liabilities	33	5,262	8,834	17,066
Total Current Liabilities		**201,075**	**178,223**	**188,723**
Non-Current Liabilities				
Finance Leases	30	3,575	2,109	4,401
Employee Benefits	31	14,962	14,621	12,757
Other Provisions	32	1,503	—	—
Total Non-Current Liabilities		**20,040**	**16,730**	**17,158**
Total Liabilities		**221,115**	**194,953**	**205,881**
Net Assets		**585,500**	**684,897**	**483,243**
Equity				
Accumulated Funds	34	440,499	549,503	347,849
Asset Revaluation Surplus	34	145,001	135,394	135,394
Total Equity		**585,500**	**684,897**	**483,243**

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

Health Directorate Statement of Changes in Equity For the Year Ended 30 June 2011

	Accumulated Funds Acutal 2011 $'000	Asset Revaluation Surplus Actual 2011 $'000	Total Equity Actual 2011 $'000	Original Budget 2011 $'000
Balance at the Beginning of the Reporting Period	**347,849**	**135,394**	**483,243**	**513,535**
Comprehensive Income				
Operating (Deficit)	(17,807)	—	(17,807)	(25,619)
Increase in the Asset Revaluation Surplus	—	9,607	9,607	—
Total Comprehensive Income	**(17,807)**	**9,607**	**(8,200)**	**(25,619)**
Transactions Involving Owners Affecting Accumulated Funds				
Capital Injections	106,284	—	106,284	196,981
Movements in Retained Earnings				
Transferred from Asset Revaluation Surplus	4,173	—	4,173	—
Total Transactions Involving Owners Affecting Accumulated Funds	**110,457**	**—**	**110,457**	**196,981**
Balance at the End of the Reporting Period	**440,499**	**145,001**	**585,501**	**684,897**

	Accumulated Funds Acutal 2010 $'000	Asset Revaluation Surplus Actual 2010 $'000	Total Equity Actual 2010 $'000	Original Budget 2010 $'000
Balance at the Beginning of the Reporting Period	**317,022**	**135,394**	**452,416**	**494,326**
Comprehensive Income				
Operating (Deficit)	(30,972)	—	(30,972)	(18,384)
Total Comprehensive Income	**(30,972)**		**(30,972)**	**(18,384)**
Transactions Involving Owners Affecting Accumulated Funds				
Capital Injections	61,799	—	61,799	117,309
Total Transactions Involving Owners Affecting Accumulated Funds	**61,799**	**—**	**61,799**	**117,309**
Balance at the End of the Reporting Period	**347,849**	**135,394**	**483,243**	**593,251**

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 2011

	Note No.	Actual 2011 $'000	Original Budget 2011 $'000	Actual 2010 $'000
Cash Flows from Operating Activities				
Receipts				
Government Payment for Outputs		831,953	826,910	755,321
User Charges—ACT Government		800	844	1,095
User Charges—Non-ACT Government		208,546	200,638	192,074
Interest and Distributors		250	278	253
Goods and Services Tax Input Tax Credits from the Australian Taxation Office		55,202	45,195	45,811
Goods and Services Tax Collected from Customers		4,248	4,288	3,714
Other		18,188	12,721	12,329
Total Receipts from Operating Activities		**1,119,187**	**1,090,874**	**1,010,597**
Payments				
Employee		461,434	468,010	426,175
Superannuation		62,722	60,568	59,675
Supplies and Services		256,130	280,799	249,922
Grants and Purchased Services		211,107	197,684	185,926
Goods and Services Tax Paid to Suppliers		60,562	51,768	50,671
Other		27,356	23,389	23,973
Borrowing Costs		441	401	406
Total Payments from Operating Activities		**1,079,752**	**1,082,619**	**996,749**
Net Cash Inflows from Operating Activities	**38**	**39,435**	**8,255**	**13,848**
Cash Flows from Investing Activities				
Receipts				
Proceeds from Sale of Property, Plant and Equipment		679	—	1,840
Total Receipts from Investing Activities		**679**	**—**	**1,840**

Health Directorate Cash Flow Statement For the Year Ended 30 June 2011—*continued*

	Note No.	Actual 2011 $'000	Original Budget 2011 $'000	Actual 2010 $'000
Payments				
Purchase of Property, Plant and Equipment		29,090	28,696	13,313
Payments for Capital Works		90,034	182,756	64,036
Total Payments from Investing Activities		**119,124**	**211,452**	**77,349**
Net Cash (Outflows) from Investing Activities		**(118,445)**	**(211,452)**	**(75,509)**
Cash Flows from Financing Activities				
Receipts				
Capital Injections		106,284	196,981	61,799
Total Receipts from Financing Activities		**106,284**	**196,981**	**61,799**
Payments				
Repayment of Finance Leases		1,948	1,452	3,882
Total Payments from Financing Activities		**1,948**	**1,452**	**3,882**
Net Cash Inflows from Financing Activities		**104,336**	**195,529**	**57,917**
Net Increase / (Decrease) in Cash and Cash Equivalents Held		**25,326**	**(7,668)**	**(3,744)**
Cash and Cash Equivalents at the Beginning of the Reporting Period		5,272	8,173	9,016
Cash and Cash Equivalents at the End of the Reporting Period	**38**	**30,598**	**505**	**5,272**

Non-cash financing activities are disclosed in Note 38: Cash Flow Reconciliation.
The above Cash Flow Statement should be read in conjunction with the accompanying notes.

Health Directorate Departmental Statement of Appropriation For the Year Ended 30 June 2011

	Original Budget 2011 $'000	Total Appropriated 2011 $'000	Appropriation Drawn 2011 $'000	Appropriation Drawn 2010 $'000
Departmental				
Government Payment for Outputs	826,910	840,782	831,953	755,321
Capital Injections	196,981	219,551	106,284	61,799
Total Departmental Appropriation	**1,023,891**	**1,060,333**	**938,237**	**817,120**

The above Departmental 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 these financial statements, in the Cash Flow Statement of the Directorate.

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

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

Variances between 'Original Budget' and 'Total Appropriated'

Government Payment for Outputs

The difference between the Original Budget and the Total Appropriated to the Directorate was the provision of appropriation for Treasurer's Advance and Commonwealth funding. The increased funding was provided to cover shortfalls in user charges and non-achievement of savings targets.

Capital Injections

The difference between the Original Budget to the Directorate and the Total Appropriated is due to deferred capital works projects from 2009–10 that had not been commenced due to site selection issues and planning delays.

Variances between 'Total Appropriated' and 'Appropriation Drawn'

Government Payment for Outputs

The difference between the *Total Appropriated* and the *Appropriation Drawn* is due to rollover of funding from the Commonwealth and new initiatives for 'A Healthy Future' and 'Workforce' programs. Commonwealth funding phasing was determined by the Commonwealth health department, and will be adjusted to more adequately reflect the implementation of the National Reform projects. The implementation of the 'A Healthy Future' and 'Workforce' programs was delayed due to procurement and development activity.

Capital Injections

The difference between the Total Appropriated to the Directorate and the Appropriation drawn is largely due to rollover of delayed capital works programs. The delays mainly related to site selection issues and recruitment of project directors. In addition, there were delays from development and building application approvals, agreement on Models of Care and inclement weather.

Health Directorate Departmental Note Index

Note 1. Objectives of the Health Directorate

Change of Name

On 17 May 2011 as a result of Administrative Arrangement 2011 (No.1), the Department changed its name from ACT Health to the Health Directorate.

Operations and Principal Activities

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

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

- community and consumers;
- safety and quality of care;
- partnerships;
- accountability and internal systems; and
- the Directorate's staff.

Note 2 Summary of significant accounting policies

(a) Basis of Accounting

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

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

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

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

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

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

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

The Directorate is an individual reporting entity.

Note 2. Summary of significant accounting policies—*continued*

(b) Departmental and Territorial Items

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

The basis of accounting described in paragraph (a) above applies to both Departmental 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 2011 together with the financial position of the Directorate as at 30 June 2011.

(d) Comparative Figures

Budget Figures

To facilitate a comparison with Budget Papers, as required by the *Financial Management Act 1996*, budget information for 2010-11 has been presented in the financial statements. Budget numbers in the financial statements are the original budget numbers that appear in the Budget Papers.

Prior Year Comparatives

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

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

(e) Rounding

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

(f) Revenue Recognition

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

Cross Border (Interstate) Health Revenue

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

Note 2. Summary of significant accounting policies—*continued*

(f) Revenue Recognition—continued

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

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

Facilities Fees

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

Interest

Interest revenue is recognised using the effective interest method, a method of calculating the interest income/expense on a financial instrument over the reporting period. The effective interest rate is the rate that represents a constant yield to maturity on the outstanding balance of the transaction.

(g) Revenue Received in Advance

Revenue Received in Advance is recognised when monies are received for the provision of goods or services prior to the goods or services being provided.

(h) Resources Received and Provided Free of Charge

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

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

(i) Repairs and Maintenance

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

Note 2. Summary of significant accounting policies—*continued*

(j) Borrowing Costs

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

(k) Waivers of Debt

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

(l) Current and Non-Current Items

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

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

(m) Impairment of Assets

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

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

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

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

(n) Cash and Cash Equivalents

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

Note 2. Summary of significant accounting policies—*continued*

(0) Receivables

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

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

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

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

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

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

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

(p) Investments

The Directorate holds one long-term investment. It is held with Territory Banking Account in the Cash Enhanced Portfolio. Investments are measured at fair value with any adjustments to the carrying amount recorded in the operating statement. Fair value is based on an underlying pool of investments which have quoted market prices as at the reporting date.

(q) Inventory

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

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

Note 2. Summary of significant accounting policies—*continued*

(r) Assets held for Sale

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

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

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

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

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

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

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

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

Property, plant and equipment is valued using the cost or revaluation model of valuation.

Land, buildings and leasehold improvements are measured at fair value.

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

Fair value for land and buildings is measured using current prices in a market for similar properties in a similar location and condition.

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

The Directorate measures its plant and equipment at cost.

(u) Intangible Assets

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

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

Note 2. Summary of significant accounting policies—*continued*

(u) Intangible Assets—continued

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

Intangible Assets are measured at cost.

(v) Depreciation and Amortisation of Non-Current Assets

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

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

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

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

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

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

The useful lives of Buildings and Leasehold Improvements are reassessed as part of the triennial revaluation of these assets.

(w) Payables

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

Payables include Trade Payables, Accrued Expenses and Other Payables.

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

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

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

Note 2. Summary of significant accounting policies—*continued*

(x) Leases

The Directorate has entered into finance leases and operating leases.

Finance Leases

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

Operating Leases

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

(y) Employee Benefits

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

Wages and Salaries

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

Annual and Long Service Leave

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

Annual and long service leave including applicable on-costs that do not fall due within the next 12 months is measured at the present value of estimated future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given to the future wage and salary levels, experience of employee departures and periods of service. At each reporting period, the estimated future payments are discounted using market yields on Commonwealth Government bonds with terms to maturity that match, as closely as possible, the estimated future cash flows. In 2010-11, the discount factor used to calculate the present value of these future payments is 92.2% (92.9% in 2009-10).

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

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

Note 2. Summary of significant accounting policies—*continued*

(y) 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. However, where there is an unconditional right to defer settlement of the liability for at least 12 months, annual leave and long service leave have been classified as a non-current liability in the Balance Sheet.

(z) Superannuation

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

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

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

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

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

(aa) Equity Contributed by the ACT Government

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

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

(ab) Insurance

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

Note 2. Summary of significant accounting policies—*continued*

(ac) Third Party Monies

The Directorate holds third party monies in a trustee capacity for the Health Professional Registration Boards, the Health Directorate Human Research Ethics Committee, residents of its Mental Health facilities and by assisting in the administration of funds whose revenue is principally derived from patients treated by salaried specialists. Accordingly, third party transactions are excluded from the Directorate's financial statements. Details of third party monies are shown at Note 40: 'Third Party Monies'.

(ad) Significant Accounting Judgements and Estimates

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

a. ***Fair Value of Assets:*** The Directorate has made a significant judgement regarding the fair value of its Assets. Land and Buildings have been recorded at the market value of similar properties as determined by an independent valuer. In some circumstances, buildings that are purpose built may in fact realise more or less in the market.

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

c. ***Contingent Liabilities:*** the Directorate has made a significant judgement in disclosing the contingent liabilities amount based on an estimation provided by the ACT Government Solicitor. The ACT Government Solicitor's estimation of contingent liability is an estimate of the likely liability for legal claims against the Directorate.

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

e. ***Depreciation:*** 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 AON Risk Solutions.

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

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

Note 2. Summary of significant accounting policies—*continued*

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

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

- AASB 1 First-time Adoption of Australian Accounting Standards (application date 1 January 2011);
- AASB 5 Non-current Assets Held for Sale and Discontinued Operations (application date 1 January 2011);
- AASB 7 Financial Instruments: Disclosures (application date 1 January vary 2011);
- AASB 9 Financial Instruments (application date 1 January 2013);
- AASB 101 Presentation of Financial Statements (application date 1 January 2011);
- AASB 107 Statement of Cash Flows (application date 1 January 2011);
- AASB 108 Accounting Policies, Changes in Accounting Estimates and Errors (application date 1 January 2011);
- AASB 110 Events after the Reporting Period (application date 1 January 2011);
- AASB 118 Revenue (application date 1 January 2011);
- AASB 119 Employee Benefits (application date 1 January 2011);
- AASB 132 Financial Instruments: Presentation (application date 1 January 2011)
- AASB 137 Provisions, Contingent Liabilities and Contingent Assets (application date 1 January 2011);
- AASB 139 Financial Instruments: Recognition and Measurement (application date 1 January 2011);
- AASB 140 Investment Property (application date 1 January 2011);
- AASB 1031 Materiality (application date 1 January 2011);
- AASB 1053 Application of Tiers of Australian Accounting Standards (application date 1 July 2013);
- AASB 2009-11 Amendments to Australian Accounting Standards arising from AASB 9 [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 121, 127, 128, 131, 132, 136, 139, 1023 & 1038 and Interpretations 10 & 12] (application date 1 January 2013);
- AASB 2010-2 Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements [AASB 1, 2, 3, 5, 7, 8, 101, 102, 107, 108, 110, 111, 112, 116, 117, 119, 121, 123, 124, 127, 128, 131, 133, 134, 136, 137, 138, 140, 141, 1050 & 1052 and Interpretations 2, 4, 5, 15, 17, 127, 129 & 1052] (application date 1 January 2013);
- AASB 2010-6 Amendments to Australian Accounting Standards — Disclosures on Transfers of Financial Assets [AASB 1 & AASB 7] (application date 1 July 2011);
- AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Interpretations 2, 5, 10, 12, 19 & 127] (application date 1 January 2013);
- AASB Interpretation 4 Determining whether an Arrangement contains a lease (application date 1 January 2011);
- AASB Interpretation 14 AASB 119—The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction (application date 1 January 2011);
- AASB 4 Insurance Contracts (application date 1 January 2011);
- AASB 124 Related Party Disclosures (application date 1 January 2011); and
- AASB 1023 General Insurance Contracts (application date 1 January 2011).

Note 3. Change in accounting policy and accounting estimates, and correction of a prior period error

Change in Accounting Policy

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

Change in Accounting Estimate

Revision of the Employee benefit Discount Rate

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

Last financial year the discount rate was 92.9%, however, due to a change in the government bond rate the rate is now 92.2%.

As such, the estimate of the long service leave has changed.

This change has resulted in a decrease to the estimate of the long service leave liability and expense in the current reporting period of $888,973.

Correction of Prior Period Errors

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

Note 4. Government Payment for Outputs

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

	2011 $'000	2010 $'000
Revenue from the ACT Government		
Government Payment for Outputs	834,520	753,617
Government Payment for Outputs	**834,520**	**753,617**
Total Government Payment for Outputs	**834,520**	**753,617**

This increase relates to funding for the growth in services in Mental Health, Critical Care, Cancer Services, Home and Community Care Services, Obstetrics and Gynaecology, increased elective surgery throughput, National Health Reform initiatives and salary increases and indexation.

Note 5. User Charges

	2011 $'000	2010 $'000
User Charges – ACT Government		
Justice and Community Safety Directorate	670	687
Environment and Sustainable Development Directorate	—	8
ACTION	1	—
Disability, Housing and Community Services Directorate	40	37
Territory and Municipal Services Directorate	21	22
Canberra Institute of Technology	15	11
ACTEW Corporation Limited	41	40
Total User Charges – ACT Government	**788**	**805**
User Charges – Non-ACT Government		
Service Revenue (Non-ACT Government) [a]	13,892	17,931
Amounts Received for Highly Specialised Drugs	15,479	16,111
Cross Border (Interstate) Health Receipts [b]	96,310	91,339
Inpatient Fees	27,285	26,559
Facilities Fees	20,571	20,038
Non-inpatient Fees	615	603
Inventory Sales	19,002	18,316
Accommodation and Meals	3,376	3,051
Total User Charges—Non-ACT Government	**196,530**	**193,948**
Total User Charges	**197,317**	**194,753**

a. *The reduction mainly relates to non-renewal of contract to supply pharmaceuticals to National Capital Private Hospital.*

b. *Cross Border (Interstate) Health Revenue—the increase relates to growth in inpatient activity provided to residents of New South Wales.*

	2011 $'000	2010 $'000
Revenue from ACT Government Entities		
Realised Gains on Investments	160	181
Total Interest Revenue from ACT Government Entities	**160**	**181**
Revenue from Non-ACT Government Entities		
Other Interest Revenue	87	78
Total Interest Revenue from Non-ACT Government Entities	**87**	**78**
Total Interest Revenue	**247**	**259**
Total Interest Revenue from Financial Assets not at Fair Value through profit and loss	247	259

Note 6. Interest and Distributions

	2011 $'000	2010 $'000
Revenue from ACT Government Entities		
Distributions on Investments	160	181
Total Interest and Distribution Revenue from ACT Government Entities	**160**	**181**
Revenue from Non-ACT Government Entities		
Interest Revenue	87	78
Total Interest and Distribution Revenue from Non-ACT Government Entities	**87**	**78**
Total Interest Distributions	**247**	**259**
Total Interest Revenue from Financial Assets not at Fair Value through profit and loss.	87	78

Note 7. Commonwealth Government Grants

	2011 $'000	2010 $'000
Commonwealth Government Grants		
Australian Immunisation Program	—	(324)
Total Commonwealth Government Grants	—	(324)

Australian Immunisation Program has been funded through Government Payment for Output since 2010, therefore no amount is shown in 2011.

Note 8. Resources Received Free of Charge

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

	2011 $'000	2010 $'000
Revenue from within the ACT Government		
Legal Services	709	948
Total Resources Received Free of Charge	709	948

The reduction reflects lower level of legal services received from the ACT Government Solicitor.

Note 9. Other Revenue

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

	2011 $'000	2010 $'000
Revenue from Other Sources		
Grants [a]	15,895	2,862
Research Grants [a]	4,436	4,201
Specific Purpose Grants [a]	1,201	1,030
Other [b]	2,841	1,003
Total Revenue from Other Sources	**24,373**	**9,096**
Total Other Revenue	**24,373**	**9,096**

a. *The variations reflect funding decisions taken by third parties for specific grants, initiatives and research that vary from year to year and bringing to account revenue that was previously treated as 'revenue received in advance' to comply with AASB 1004: Contributions.*

b. *The increase is mainly due to reimbursements for seconded staff and higher workers' compensation reimbursements that relate to prior years and bringing to account revenue that was previously treated as 'revenue received in advance' to comply with AASB 1004: Contributions.*

Contribution Analysis		
Contributions which have conditions of expenditure still required to be met.		
Grants	5,629	5,602
Research Grants	517	751
Specific Purpose Grants	150	854
Total Contributions	**6,296**	7,207

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

Note 10. Other Gains

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

	2011 $'000	2010 $'000
Profit on Sale of Assets —General [a]	93	544
Donations [b]	2,515	515
Total Other Gains	**2,608**	**1,059**

a. *This mainly relates to the sales of motor vehicles for which the lease term ended during the year. The reduction reflects lower number of finance leases due for termination than in the previous year.*
b. *Donations are unpredictable and fluctuate from year to year, however the increase in 2011 is mainly due to bringing to account revenue that was previously treated as 'revenue received in advance' to comply with AASB 1004: Contributions.*

Contributions Analysis		
Contributions which have conditions of expenditure still required to be met	224	1,272

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

Note 11. Employee Expenses

	2011 $'000	2010 $'000
Wages and Salaries [a]	438,687	403,773
Annual Leave [b]	8,452	5,748
Long Service Leave [c]	5,712	6,247
Workers' Compensation Premium [d]	13,541	12,357
Termination Payments	828	624
Other Employee Benefits and On-Costs [e]	7,236	9,642
Total Employee Expenses	**474,456**	**438,390**

	No.	No.
Average Full-time equivalent staff levels during the year were:	5,039	4,778

a. *The increased Wages and Salaries mainly relates to payrises under collective agreements and staff increases related to growth in services in Mental Health, Critical Care, Cancer Services, Home and Community Care Services, Obstetrics and Gynaecology, increased elective surgery throughput and National Health Reform initiatives.*
b. *The increase in Annual Leave largely relates to impact of payrises and an increase in staff numbers in 2011. The 2010 figure includes one-off gain from leave audits.*
c. *The decrease in Long Service Leave is mainly due to an increase in the discount rate used for present value calculations.*
d. *The increase relates to labour costs, as the Workers' Compensation Premium is affected by increased salaries and wages.*
e. *2010 included a one-off $650 sign-on bonus for two collective agreements.*

Note 12. Superannuation Expenses

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 for its portion of the Territory's CSS and PSS superannuation liability. The productivity benefit for these schemes is paid directly to Comsuper.

Superannuation payments have been made direct to Comsuper to cover the superannuation liability for employees that are in the Public Sector Superannuation Scheme Accumulation Plan (PSSAP).

Superannuation payments are also made to external providers as part of the employee fund of choice arrangements, and to employment agencies for the superannuation contribution the Directorate is required to make for the contract staff it employs.

	2011 $'000	2010 $'000
Superannuation Contributions to the Territory Banking Account	36,345	36,353
Productivity Benefit	5,290	5,231
Superannuation Payment to Comsuper (for the PSSAP)	3,582	3,691
Superannuation to External Providers [a]	17,819	14,709
Total Superannuation Expenses	**63,036**	**59,984**

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

Note 13. Supplies and Services

	2011 $'000	2010 $'000
Audit Expenses	486	413
Clinical Expenses/Medical Surgical Supplies [a]	54,949	48,588
Communications [b]	3,647	3,075
Computer Expenses [c]	25,110	22,974
Contractors and Consultants	6,183	5,923
Domestic Services, Food and Utilities [d]	26,793	24,957
General Administration [e]	15,240	16,783
Hire and Rental Charges	4,349	4,639
Operating Lease Rental Payments	5,736	5,349
Insurance	25,698	25,234
Minor Capital [f]	3,595	3,195
Non-Contract Services [g]	9,019	7,081
Pharmaceuticals [h]	35,826	36,855
Printing and Stationery	2,513	2,447
Property and Rental Expenses	2,546	2,468
Public Relations	878	849
Publications	1,231	1,280
Repairs and Maintenance [i]	9,809	7,543
Staff Development and Recruitment	6,007	6,539
Travel and Accommodation	1,561	1,601
Vehicle Expenses	1,373	1,377
Visiting Medical Officers [j]	27,688	23,374
Total Supplies and Services	**270,237**	**252,545**

a. *This increase is due to price increases linked to consumer price index and higher activity in Pathology and increased cost of implants.*
b. *This increase mainly relates telephone expenses reflecting an increase in staff numbers and an increase in high-tech equipment.*
c. *The increase mainly relates to recurrent costs related to new systems, price increases for services by IT providers and IT costs related to new staff.*
d. *The increase is mainly due to utilities and cleaning contract price rises and an increase in floor space.*
e. *The reduction relates to lower call centre and interstate ambulance charges and a reduction in various minor miscellaneous expenses.*
f. *The increase mainly relates to an increase in the number of plant and equipment purchases that fell below the capitalisation threshold of $5,000.*
g. *This increase reflects usage of agency staff to cover for vacancies and unplanned leave.*
h. *The reduction mainly relates to the non renewal of a contract to supply pharmaceuticals to National Capital Private Hospital, that offset indexation increases for pharmaceuticals.*
i. *This is mainly attributable to increased expenditure on preventative and reactive maintenance of ageing infrastructure and an increase in the number of facilities, an increase in breakdown repairs of medical equipment and a new service contract for the maintenance of new medical equipment.*
j. *The increase is mainly due to use of visiting medical officers to fill vacancies, indexation and growth in services.*

Note 14. Depreciation and Amortisation

	2011 $'000	2010 $'000
Depreciation		
Buildings [a]	10,496	14,663
Plant and Equipment [b]	10,183	8,971
Leasehold Improvements [c]	818	517
Total Depreciation	**21,497**	**24,151**
Amortisation		
Intangible Assets	3,774	3,962
Total Amortisation	**3,774**	**3,962**
Total Depreciation and Amortisation	**25,271**	**28,113**

a. 2010 included accelerated depreciation of a multistorey car park that was demolished and subsequently replaced by a new larger car park.
b. The increase mainly relates to the increasing plant and equipment base, including new equipment for the Intensive Care Unit at the Calvary Hospital.
c. The increase is attributable to depreciation related to make good increment for 1 & 11 Moore Street and Swanson Plaza. The lease agreements require the Health Directorate to make good any leasehold improvements installed on these premises at the end the lease and provision had been made to reflect this liability.

Note 15. Grants and Purchased Services

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 the contract, correspondence, or by legislation.

	2011 $'000	2010 $'000
Payments to Service Providers		
- Calvary Hospital [a]	141,174	124,450
- Other [b]	69,933	61,476
Total Grants and Purchased Services	**211,107**	**185,926**

a. *The increased payment to Calvary Hospital is mainly due to the provision of funding for salary increases, indexation, and targeted elective surgery for long wait patients.*
b. *Expenditure to Other Service Providers is for organisations who 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. It also includes Health Promotion Grants. The increase relates to annual indexation, growth in services, including Home and Community Care, Mental Health and other initiatives for Healthy Future and GP workforce.*

Note 16. Borrowing Costs

	2011 $'000	2010 $'000
Finance Charges	441	406
Total Borrowing Costs	**441**	**406**

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

Note 17. Other Expenses

	2011 $'000	2010 $'000
Cost of Goods Sold	15,637	15,397
Cross Border (Interstate) Health Costs [a]	2	121
Miscellaneous Expenses [b]	8,205	6,350
Legal Settlements	1,510	1,677
Waivers, Impairment Losses and Write-offs (see Note 18)	2,135	957
Loss on Disposal of Assets [c]	5,545	514
Total Other Expenses	**33,034**	**25,016**

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

a. *The decrease reflects impact of less ACT residents using state public health systems compared to residents of states using the ACT public health system.*
b. *The increase is largely due to higher National Blood Plan Authority payments for the supply of blood and other blood products due to growth in demand and annual indexation.*
c. *This relates to the transfer of the Narrabundah Health Centre to the Winnunga Nimmityjah Aboriginal Health Service.*

Note 18. Waivers, Impairment Losses and Write-Offs

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

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

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

	No.	2011 $'000	No.	2010 $'000
Waivers				
Waivers				
Waiver of Debt	—	—	—	—
Total Waivers	—	—	—	—
Impairment Losses				
Impairment loss from Receivables				
Trade Receivables	—	315	—	—
Other Trade Receivables	—	—	—	—
Total Impairment loss from Receivables	—	315	—	—
Impairment Loss from Property, Plant and Equipment				
Property, Plant and Equipment	6	538	—	—
Total Impairment loss from Property, Plant and Equipment	6	538	—	—
Total Impairment Losses	**6**	**853**		—
Write-offs				
Irrecoverable Debts	1,879	1,281	2,749	957
Obsolete Stock	—	—	—	—
Total Write-offs	1,879	1,281	2,749	957
Total Waivers, Impairment Losses and Write-offs	**1,885**	**2,134**	**2,749**	**957**

Note 19. Auditor's Remuneration

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

	2011 $'000	2010 $'000
Audit Services		
Audit Fees Paid to the ACT Auditor-General's Office	215	168
Total Audit Fees	**215**	**168**

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

Note 20. Cash and Cash Equivalents

The Directorate holds a number of bank accounts with the Commonwealth Bank as part of the whole-of-government banking arrangements. As part of these arrangements, the Directorate receives interest at the rate of 6.71% (5.78% in 2010) on some of these accounts. These funds are able to be withdrawn upon request.

	2011 $'000	2010 $'000
Cash on Hand	49	47
Cash at Bank	30,549	5,225
Total Cash and Cash Equivalents	**30,598**	**5,272**

The increase in cash at bank is mainly due to timing differences between receiving capital funding and the payments for capital works and a reduction in cross border debt for the provision of health services to interstate patients.

Note 21. Receivables

	2011 $'000	2010 $'000
Current Receivables		
Trade Receivables [a]	8,928	12,508
Less: Allowance for Impairment Losses	—	—
	8,928	12,508
Other Trade Receivables [b]	13,096	11,561
Less: Allowance for Impairment Losses	(1,601)	(1,250)
	11,495	10,311
Accrued Revenue	9,619	9,739
Accrued Revenue —Cross Border [c]	16,427	25,162
	26,046	**34,901**
Total Current Receivables	**46,469**	**57,722**
Non-Current Receivables		
Accrued Revenue	2,135	2,154
Total Non-Current Receivables	**2,135**	**2,154**
Total Receivables	**48,604**	**59,876**

a. *The decrease is mainly attributable to timing of receipts.*
b. *The increase is mainly attributable to accrued debtors for insurance refunds and increase in receivables for pathology services to other hospitals.*
c. *The reduction reflects higher provisional payments, received from New South Wales for services provided to its residents in the ACT.*

Note 21. Receivables—*continued*

Ageing of Receivables					
	Not Overdue[d]	Past Due			Total
		Less Than 30 days	30 to 60 Days	Greater Than 60 days[e]	
	$'000	$'000	$'000	$'000	$'000
2011 Not Impaired Receivables	40,617	2,352	715	4,920	48,604
Impaired Receivables	—	—	—	1,120	1,120
2010 Not Impaired Receivables	50,845	2,540	890	5,600	59,876
Impaired Receivables	—	—	—	**1,250**	**1,250**

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

d. A large component of the debtors in the category 'Not overdue' are for the funding, from New South Wales, for admitted and non-admitted patient services provided to residents of New South Wales. This is categorised as not overdue since the funding agreement does not mandate a timeframe for payment prior to final acquittal of activity numbers for each period and the final acquittals are yet to occur.

e. Most debtors in the category 'Overdue more than 60 days' are 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.

	2011 $'000	2010 $'000
Reconciliation of the Allowance for Impairment Losses		
Allowance for Impairment Losses at the Beginning of the Reporting Period	1,250	1,902
Additional Allowance and Impairment Losses Recognised	315	—
Reduction in Allowance Resulting from a Write-Back against the Receivables	(445)	(652)
Allowance for Impairment Losses at the End of the Reporting Period	**1,120**	**1,250**

The carrying amount of financial assets that are past due or impaired, whose terms have been renegotiated is $0.

Note 21. Receivables—*continued*

	2011 $'000	2010 $'000
Classification of ACT Government/Non-ACT Government Receivables		
Receivables with ACT Government Agencies		
Net Trade Receivables	39	940
Net Other Trade Receivables	1,387	—
Accrued Revenue	12	14
Other Receivables		
Total Receivables with Other ACT Government Agencies	**1,438**	**954**
Receivables with Non ACT Government Entities		
Net Trade Receivables	8,889	11,568
Net Other Trade Receivables	10,108	10,311
Accrued Revenue	28,169	37,042
Net Other Trade Receivables		
Total Receivables with Non ACT Government Entities	**47,166**	**58,922**
Total Receivables	**48,604**	**59,876**

Note 22. Inventories

	2011 $'000	2010 $'000
Current Inventories		
Purchased Items—Cost	7,866	6,242
Total Current Inventories	7,866	6,242
Total Inventories	**7,866**	**6,242**

The increase mainly relates to pharmaceuticals.

Note 23. Assets Held for Sale

The Directorate has 13 motor vehicles which have been returned to SG Fleet and are expected to be sold in July 2011. The residual and all lease payments have been paid. As such, these vehicles have been classified as plant and equipment held for sale.

	2011 $'000	2010 $'000
Plant and Equipment held for Sale	127	234
Total Assets held for Sale	**127**	**234**

Note 24. Investments

The total carrying amount below has been measured at fair value.

	2011 $'000	2010 $'000
Non-Current Investments		
Investments with the Territory Banking Account —Cash Enhanced Portfolio	3,000	3,000
Total Non-Current Investments	**3,000**	**3,000**
Total Investments	**3,000**	**3,000**

Note 25. 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 office buildings.

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

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

Note 25. Property, Plant and Equipment—*continued*

	2011 $'000	2010 $'000
Land and Buildings		
Land at Fair Value [a]	36,820	35,580
Total Land Assets	**36,820**	**35,580**
Buildings at Fair Value [a]	501,245	445,538
Less Accumulated Depreciation [b]	—	(19,662)
Total Written Down Value of Buildings	**501,245**	**425,876**
Total Land and Written Down Value of Buildings	**538,065**	**461,456**
Leasehold Improvements		
Leasehold Improvements at Fair Value [c]	8,314	4,488
Less Accumulated Depreciation [b]	(300)	(1,078)
Total Written Down Value of Leasehold Improvement	**8,014**	**3,410**
Plant and Equipment		
Plant and Equipment at Cost [d]	89,769	79,394
Less: Accumulated Depreciation [d]	(43,248)	(36,583)
Total Written Down Value of Plant and Equipment	46,521	42,811
Total Written Down Value of Property, Plant and Equipment	**592,600**	**507,677**

Assets Under a Finance Lease

Assets under a finance lease are included in the asset class to which they relate in the above disclosure. Assets under a finance lease are also required to be seperately disclosed as outlined below.

Note 25. Property, Plant and Equipment—*continued*

	2011 $'000	2010 $'000
Carrying Amount of Assets Under a Finance Lease		
Plant and Equipment Under a Finance Lease	8,151	7,333
Accumulated Depreciation of Plant and Equipment Under a Finance Lease	(2,309)	(1,392)
Total Written Down	**5,842**	**5,941**
Total Written Down Value of Assets under a Finance Lease	**5,842**	**5,941**

a. *The increase is mainly due to revaluation of Land, Buildings and Leasehold improvements.*
b. *The decrease is mainly due to write back of accumulated depreciation as a result of revaluation of Land, Buildings and Leasehold improvements.*
c. *The increase is partly due to revaluation of Land, Buildings and Leasehold improvements and partly due to accounting for make good provision. Make good provision is the cost to be incurred at the end of the lease to restore the accommodation to the state it was prior to occupation.*
d. *The increase is due to purchases of new plant and equipment.*

Reconciliation of Property, Plant and Equipment

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

	Land $'000	Buildings $'000	Leasehold Improvements $'000	Plant and Equipment $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	35,580	425,876	3,411	42,811	507,678
Additions [a]	—	82,490	1,503	15,529	99,522
Revaluation Increment	5,700	4,163	3,917	—	13,780
Assets classified as Held for Sale	—	—	—	(127)	(127)
Disposals	(4,460)	(788)	—	(1,508)	(6,756)
Depreciation	—	(10,496)	(817)	(10,184)	(21,497)
Carrying Amount at the End of the Reporting Period	**36,820**	**501,245**	**8,014**	**46,521**	**592,600**

e. The additions include Multistorey Carpark, Walk-in Centre, Neurosurgery Operating Theatre, Surgical Assessment and Planning Unit, Neonatal ICU, Building 23, Fire Systems upgrade, PET Scanner and Linear Accelerator building works and various minor capital upgrades.

Note 25. Property, Plant and Equipment—*continued*

The following table shows the movement of Property, Plant and Equipment during 2009–10.

	Land $'000	Buildings $'000	Leasehold Improvements $'000	Plant and Equipment $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	35,580	434,421	3,928	42,419	516,348
Additions	—	6,168	—	12,473	18,641
Revaluation Increment /Decrement	—	—	—	—	—
Assets classified as Held for Sale	—	—	—	(234)	(234)
Disposals	—	(5,154)	—	(2,876)	(8,030)
Depreciation	—	(9,559)	(517)	(8,971)	(19,047)
Carrying Amount at the End of the Reporting Period	**35,580**	**425,876**	**3,411**	**42,811**	**507,677**

Valuation of Non-Current Assets

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

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

The next valuation will be carried out as at 30 June 2014.

Note 26. Intangible Assets

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

	2011 $'000	2010 $'000
Computer Software		
Internally Generated Software	29,681	24,445
Less: Accumulated Amortisation	(16,854)	(13,247)
Total Internally Generated Software	12,827	11,198
Externally Purchased Software		
Computer Software at Cost	2,373	2,373
Less: Accumulated Amortisation	(2,373)	(2,177)
Total Externally Purchased Software	—	196
Total Computer Software	**12,827**	**11,394**
Total Intangible Assets	**12,827**	**11,394**

Note 26. Intangible Assets—*continued*

Reconciliation of Intangible Assets

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

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

The following table shows the movement of each class of Intangible Asset distinguishing between internally generated and externally purchased intangibles from the beginning to the end of 2009-10.

	Internally Generated Software $'000	Externally Purchased Software $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	14,748	608	15,356
Additions	—	—	—
Amortisation	(3,550)	(412)	(3,962)
Carrying Amount at the End of the Reporting Period	**11,198**	**196**	**11,394**

Note 27. Capital Works in Progress

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

Assets, which are under construction, include buildings and computer software.

	2011 $'000	2010 $'000
Building Works in Progress [a]	85,189	77,085
Plant and Equipment Works in Progress	98	260
Computer Software Works in Progress [b]	23,138	14,903
Other Works in Progress	153	200
Total Capital Works in Progress	**108,578**	**92,447**

a. *Building works in progress comprised of Women's and Children's Hospital, Adult Mental Health Acute Inpatient Facility, Clinical Services Redevelopment, Integrated Cancer Centre, New Gungahlin Health Centre, Enhanced Community Health Centre in Belconnen, Tuggeranong Health Centre, Feasibility Studies and Forward Design and various capital upgrades.*

b. *Computer software works in progress mainly comprised of Patient Administration System for Calvary Hospital, Intensive Care Unit project, Electronic Health Care Record Project, e-Referral and other e-Health projects.*

Reconciliation of Capital Works in Progress

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

	Building Works in Progress $'000	Computer Software Works in Progress $'000	Other Works in Progress $'000	P&E Works in Progress $'000	Total $'000
Carrying Amount at the Beginning of the reporting period	77,085	14,904	199	260	92,447
Additions	90,594	13,443	—	—	104,037
Capital Works in Progress Completed and Transferred to Property, Plant and Equipment and Intangible Assets	(82,490)	(5,207)	(46)	(162)	(87,905)
Capital Works Expensed	—	—	—	—	—
Carrying Amount at the End of the Reporting Period	**85,189**	**23,138**	**153**	**98**	**108,578**

Note 27. Capital Works in Progress—*continued*

Reconciliation of Capital Works in Progress

The following table shows the movement of Capital works in Progress during 2009-10. .

	Building Works in Progress $'000	Computer Software Works in Progress $'000	Other Works in Progress $'000	P&E Works in Progress $'000	Total $'000
Carrying Amount at the Beginning of the reporting period period	25,616	3,269	148	—	29,033
Additions	57,580	11,635	51	260	69,526
Capital Works in Progress Completed and Transferred to Property, Plant and Equipment and Intangible Assets	(6,111)	—	—	—	(6,111)
Carrying Amount at the End of the Reporting Period	**77,085**	**14,904**	**199**	**260**	**92,447**

Note 28. Other Assets

	2011 $'000	2010 $'000
Current Other Assets		
Prepayments	2,414	2,981
Total Current Other Assets	**2,414**	**2,981**
Total Other Assets	**2,414**	**2,981**

Note 29. Payables

	2011 $'000	2010 $'000
Current Payables		
Trade Payables [a]	19,546	7,894
Other Payables	50	49
Accrued Expenses [b]	37,123	34,040
GST Payable	478	470
Total Current Payables	**57,197**	**42,453**
Non-Current Payables		
Other Payables	—	—
Total Non-Current Payables	—	—
Total Payables	**57,197**	**42,453**
Payables are aged as follows:		
Not Overdue	43,153	40,941
Overdue for Less than 30 Days[a]	9,226	1,091
Overdue for 30 to 60 Days	97	165
Overdue for More than 60 Days[c]	4,721	256
Total Payables	**57,197**	**42,453**

a. *Increase in trade payables mainly relates to capital works invoices received in late June.*
b. *The increase is consistent with the growth in Supplies and Services expenses.*
c. *The increase in overdue amount compared to last year is due to invoices for capital works received late in June.*

Classification of ACT Government/Non-ACT Government Payables		
Payables with ACT Government Entities		
Trade Payables	—	—
Accrued Expenses	6,051	13,615
GST Payable	3	1
Total Payables with ACT Government Entities	**6,054**	**13,616**
Payables with Non-ACT Government Entities		
Trade Payables	19,547	7,894
Other Payables	50	49
Accrued Expenses	31,071	20,425
GST Payable	475	469
Total Payables with Non-ACT Government Entities	**51,143**	**28,837**
Total Payables	**57,197**	**42,453**

Note 30. Finance Leases

The Directorate has 317 finance leases, which have been taken up as a finance lease liability and an asset under a finance lease. These leases are for motor vehicles. The interest rates implicit in these leases vary from 6.8% to 7.9% and the terms vary from 1 year to 3 years. These leases allow for extensions, but have no terms of renewal or purchase options and escalation clauses.

	2011 $'000	2010 $'000
Current Finance Leases		
Secured		
Finance Leases Liability	2,423	1,471
Total Current Finance Leases	**2,423**	**1,471**
Non-Current Finance Leases		
Secured		
Finance Leases Liability	3,575	4,401
Total Non-Current Finance Leases	**3,575**	**4,401**
Total Finance Leases	**5,998**	**5,872**

Secured Liability

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

	2011 $'000	2010 $'000
Finance lease commitments are payable as follows:		
Within one year	2,765	1,827
Later than one year but not later than five years	3,758	4,707
Minimum Lease Payments	**6,523**	**6,534**
Less: Future Finance Lease Charges	(525)	(662)
Amount Recognised as a Liability	5,998	5,872
Add: Lease incentive involved with non-cancellable operating lease	—	—
Total Present Value of Minimum Lease payments	**5,998**	**5,872**

The present values of the minimum lease payments are as follows:		
Within one year	2,423	1,471
Later than one year but not later than five years	3,575	4,401
Total Present Value of Minimum Lease payments	**5,998**	**5,872**
The future minimum lease payments for non-cancellable financing sub-leases expected to be received.	—	—

Note 30. Finance Leases—*continued*

	2011 $'000	2010 $'000
Classification on the Balance Sheet		
Finance Leases		
Finance Leases—Current	2,423	1,471
Finance Leaseson—Non-Current	3,575	4,401
Total Finance Leases	**5,998**	**5,872**

Note 31. Employee Benefits

	2011 $'000	2010 $'000
Current Employee Benefits		
Annual Leave [a]	67,924	61,848
Long Service Leave [a]	55,084	51,527
Accrued Salaries [b]	12,506	10,013
Other Benefits [c]	679	4,345
Total Current Employee Benefits	**136,193**	**127,732**
Non-Current Employee Benefits		
Long Service Leave	14,962	12,757
Total Non-Current Employee Benefits	**14,962**	**12,757**
Total Employee Benefits	**151,155**	**140,489**

a. *The increase is mainly due to the impact of collective agreement payrises and an increase in staff numbers for growth in services and new initiatives.*
b. *The increase is due to an additional unpaid working day in June 2011.*
c. *2010 included a $650 sign-on bonus for two collective agreements.*

Note 31. Employee Benefits—*continued*

	2011 $'000	2010 $'000
Estimated Amount Payable within 12 Months		
Annual Leave	67,923	61,848
Long Service Leave	6,331	5,786
Accrued Salaries	12,506	10,013
Other Benefits	679	4,345
Total Employee Benefits Payable within 12 Months	**87,439**	**81,991**
Estimated Amount Payable after 12 Months		
Long Service Leave	63,716	58,498
Total Employee Benefits Payable after 12 Months	**63,716**	**58,498**
Total Employee Benefits	**151,155**	**140,489**

Note 32. Other Provisions

	2011 $'000	2010 $'000
Non-current Other Provisions		
Provision for Make Good	1,503	—
Total Other Provisions	**1,503**	—

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.

The Directorate also erected leasehold improvements in the buildings which are valued at $14.163m as at 30 June 2011. On that date the estimated costs to make good those improvements was $1.627m . The present value of $1.627m, using the 5 year Government bond rate as at 30 June 2011 of 4.96%, is approximately $1.503m.

Note 33. Other Liabilities

	2011 $'000	2010 $'000
Current Other Liabilities		
Revenue Received in Advance	5,262	17,066
Total Current Other Liabilities	**5,262**	**17,066**
Total Other Liabilities	**5,262**	**17,066**

Revenue Received in Advance is monies received for which goods or services are yet to be provided for and the control of these monies has not passed to the Directorate.

The reduction is mainly the result of complying with accounting standard AASB 1004: Contributions, which resulted in bringing to account contributions and grants as revenue even though no expenditure in relation to the relevant grant/funding agreements had occured.

Note 34. Equity

	2011 $'000	2010 $'000
Total Equity at the End of the Reporting Period		
Accumulated Funds	440,499	347,849
Asset Revaluation Surplus	145,001	135,394
Total Equity	**585,500**	**483,243**
Accumulated Funds		
Balance at the Beginning of the Reporting Period	347,849	317,022
Capital Injection	106,284	61,799
Transferred from Asset Revaluation Surplus to Accumulated Funds	4,173	—
Operating (deficit)	(17,807)	(30,972)
Balance at the End of the Reporting Period	**440,499**	**347,849**
Asset Revaluation Surplus		
The Asset Revaluation Reserve is used to record the increments and decrements in the value of property, plant and equipment.		
Balance at the Beginning of the Reporting Period	135,394	135,394
Increment in Land due to Revaluation	5,700	—
Decrement in Land due to Disposal	(4,040)	—
Increment in Building due to Revaluation	4,163	—
Increment in Leasehold Improvements due to Revaluation	3,917	—
Decrement in Building due to disposal	(133)	—
Increase in the Asset Revaluation	9,607	—
Balance at the End of the Reporting Period	**145,001**	**135,394**

Note 35. Financial Instruments

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

Interest Rate Risk

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

The Directorate does not hold any financial liabilities with floating interest rates, the Directorate is therefore not exposed to movements in interest payable. The Directorate is, however, exposed to movements in interest rates on amounts held in Cash at Bank. Interest rates increased during the year ended 30 June 2011 and, as such, have resulted in an increase in the amount of interest received.

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

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

Credit Risk

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

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

The Directorate's receivables are predominantly from insurance companies, ACT Government and State (mainly NSW) and the Federal Governments. As the Federal Government has an AAA credit rating it is considered that there is a very low risk of default for those receivables. Credit Risk for receivables with the NSW Government, which are for provision of services to patients who reside in NSW, is managed by ongoing assessment of movement in the level of the receivables and seeking, and receiving, payments to keep them at a manageable level.

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

Liquidity Risk

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

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

The Directorate has an ageing workforce with significant levels of accumulated and unpaid leave. As staff resign or retire and these obligations fall due, the Directorate has been able to meet these obligations from current level of appropriation. With anticipated higher levels of staff retiring in coming years, it is possible that in future years the Directorate may need additional appropriation from Government to be able to meet payment of these obligations.

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

Note 35. 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 instruments or its issuers, or factors affecting all similar financial instruments traded in the market. The only price risk the Directorate is exposed to results from its investment in the Cash Enhanced Portfolio. The Directorate has units in the Cash Enhanced Portfolio that fluctuate in value. The price fluctuation in the units of the portfolio is causedn by movements in the underlying investments of the portfolio. The underlying investments are managed by an external fund manager who invests in a variety of different securities, including bonds issued by the Commonwealth Government, the State Government guaranteed treasury corporations and semi-government authorities, as well as investment-grade corporate issues.

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

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

Fair Value of Financial Assets and Liabilities

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

	Carrying Amount 2011 $'000	Net Fair Value 2011 $'000	Carrying Amount 2010 $'000	Net Fair Value 2010 $'000
Financial Assets				
Cash and Cash Equivalents	30,598	30,598	5,272	5,272
Receivables	48,604	48,604	59,876	59,876
Investments with the Territory Banking Account	3,000	3,000	3,000	3,000
Total Financial Assets	**82,202**	**82,202**	**68,148**	**68,148**
Financial Liabilities				
Payables	57,197	57,197	42,453	42,453
Finance Leases	5,998	5,998	5,872	5,872
Total Financial Liabilities	**63,195**	**63,195**	**48,325**	**48,325**

Fair Value Hierarchy

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

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

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

Note 35. Financial Instruments—*continued*

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

Transfer Between Categories

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

2010	Classification According to Fair Value Hierarchy			
	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total
Financial Assets				
Investment with the Territory Banking - Cash Advanced Portfolio	—	3,000	—	3,000
	—	**3,000**	—	**3,000**

Transfer Between Categories

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

Note 35. Financial Instruments—*continued*

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

		Floating Interest Rate	Fixed Interest maturing in:			Non - Interest Bearing	
	Note No.		1 Year or Less	Over 1 to 5 Years	Over 5 Years		Total
		$'000	$'000	$'000	$'000	$'000	$'000
Financial Instruments							
Financial Assets							
Cash and Cash Equivalents	20	30,549	—	—	—	49	30,598
Receivables	21	—	—	—	—	48,604	48,604
Investments with the Territory Banking Account	24	—	—	—	—	3,000	3,000
Total Financial Assets		**30,549**	—	—	—	**51,653**	**82,202**
Weighted Average Interest Rate		6.71%	—	—	—		
Financial Liabilities							
Payables	29	—	—	—	—	57,197	57,197
Finance Leases	30	—	2,765	3,758	—	—	6,523
Total Financial Liabilities	—	—	**2,765**	3,758	—	**57,197**	**63,720**
					—		
Weighted Average Interest Rate	—	—	7.35%	7.35%			
Net Financial Assets/(Liabilities)		**30,549**	**(2,765)**	**(3,758)**	—	**(5,544)**	**18,483**

Note 35. Financial Instruments—*continued*

The following table sets out the Directorate 's maturity analysis for financial assets and liabilities as well as the exposure to interest rates, including average weighted interest rates by maturity period as at 30 June 2010. All financial assets and liabilities which have a floating interest rate or are non-interest bearing will mature in 1 year or less. All amounts appearing in the following maturity analysis are shown on an undiscounted cash flow basis.

		Floating Interest Rate	Fixed Interest maturing in:			Non - Interest Bearing	
	Note No.		1 Year or Less	Over 1 to 5 Years	Over 5 Years		Total
		$'000	$'000	$'000	$'000	$'000	$'000
Financial Instruments							
Financial Assets							
Cash and Cash Equivalents	20	5,225	—	—	—	47	5,272
Receivables	21	—	—	—	—	59,876	59,876
Investments with the Territory Banking Account	24	—	—	—	—	3,000	3,000
Total Financial Assets		**5,225**	—	—	—	**62,923**	**68,148**
Weighted Average Interest Rate		5.78%	—	—	—		
Financial Liabilities							
Payables	29	—	—	—	—	42,453	42,453
Finance Leases	30	—	1,827	4,707	—	—	6,534
Total Financial Liabilities		—	**1,827**	**4,707**	—	**42,453**	**48,987**
			6.69%	6.69%	—		
Weighted Average Interest Rate							
Net Financial Assets/(Liabilities)		**5,225**	**(1,827)**	**(4,707)**	—	**20,470**	**19.161**

Note 35. Financial Instruments—*continued*

	2011 $'000	2010 $'000
Carrying Amount of Each Category of Financial Asset and Financial Liability		
Financial Assets		
Loans and Receivables	48,604	59,876
Financial assets at fair value through the Profit and Loss designated upon initial recognition	3,000	3,000
Financial Liabilities		
Financial Liabilities measured at Amortised Cost	63,195	48,325

Gains on Each Category of Financial Asset and Financial Liability		
Gains on Financial Assets		
Loans and Receivables	—	—
Gains on Financial Liabilities		
Financial Liabilities measured at Amortised Cost	—	—

Note 36. Commitments

Capital Commitments

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

	2011 $'000	2010 $'000
Capital Commitments—Property, Plant and Equipment		
Payable:		
Within one year	283,466	120,197
Later than one year and not later than five years	212,921	42,698
Later than five years	—	—
Total Capital Commitments—Property, Plant and Equipment	496,387	162,895
Total Capital Commitments	**496,387**	**162,895**

The increase reflects capital works activity related to redevelopment of the Canberra Hospital as well as Community Health Centres.

Note 36. Commitments—*continued*

Operating Lease Commitments

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

	2011 $'000	2010 $'000
Non-cancellable operating lease commitments are payable as follows:		
Within one year	5,006	4,415
Later than one year and not later than five years	12,523	11,706
Later than five years	4,366	5,391
Total Operating Lease Commitments	**21,895**	**21,512**

Other Commitments

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

	2011 $'000	2010 $'000
Non-cancellable other commitments are payable as follows:		
Within one year	69,219	63,507
Later than one year and not later than five years	39,881	63,260
Later than five years	—	154
Total Operating Lease Commitments	**109,100**	**126,921**

The decrease is due to delays in executing contracts.

Finance Lease Commitments

Finance lease commitments are disclosed in Note 30: Finance Leases.

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

Note 37. Contingent Liabilities

Contingent Liabilities

The Directorate is currently defending 159 actions (2010 - 127 actions). These actions have an estimated net liability of $11,515,000 (2010 - $5,983,000), which has not been provided for in the accounts. The estimated liability has been calculated net of the amounts covered under the Directorate's insurance policy.

Note 38. 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.**

	2011 $'000	2010 $'000
Cash and Cash Equivalents Recorded in the Balance Sheet	30,598	5,272
Total Cash and Cash Equivalents at the end of the reporting period as recorded in the Cash Flow Statement	**30,598**	**5,272**

b. **Reconciliation of Net Cash Inflows / Outflows from Operating Activities to the operating deficit.**

	2011 $'000	2010 $'000
Operating (Deficit)	(17,807)	(30,972)
Add/(Less) Non-Cash Items		
Depreciation of Property, Plant and Equipment	21,497	24,151
Amortisation of Intangibles	3,774	3,962
Bad and Doubtful Debts	1,281	957
Asset book value written down	6,105	—
(Less) Items Classified as Investing or Financing		
Gain on Disposal of Assets	(114)	(29)
Cash Before Changes in Operating Assets and Liabilities	**14,736**	**(1,931)**
Changes in Operating Assets and Liabilities		
Decrease/(Increase) in Receivables	11,272	(2,582)
(Increase) in Inventories	(1,624)	(809)
Decrease/(Increase) in Other Assets	567	(1,634)
Increase in Payables	14,121	5,646
Increase in Provision	12,169	10,831
(Decrease)/Increase in Other Liabilities	(11,804)	4,327
Net Changes in Operating Assets and Liabilities	**24,701**	**15,779**
Net Cash Inflows from Operating Activities	**39,435**	**13,848**

c. **Non - Cash Financing and Investing Activities**

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

	2011 $'000	2010 $'000
Acquisition of Motor Vehicles by means of a Finance Lease	1,528	4,563

Note 39. Events Occurring after Balance Date

There were no events occuring after Balance Date.

Note 40. Third Party Monies

	2011 $'000	2010 $'000
The Directorate held funds in trust relating to the activities of the Health Professional Registration Boards and the Health Directorate Human Research Ethics Committee.		
Ethics Committee and Registration Boards Trust Account		
Balance at the Beginning of the Reporting Period	2,430	2,841
Cash Receipts	4,628	1,529
Cash Payments	(6,620)	(1,940)
Balance at the End of the Reporting Period	**438**	**2,430**
The Directorate held funds in trust relating to residents of its Mental Health facilities.		
Mental Health Trust Account		
Balance at the Beginning of the Reporting Period	25	22
Cash Receipts	82	87
Cash Payments	(85)	(84)
Balance at the End of the Reporting Period	**22**	**25**
The Directorate held funds relating to the activities of Salaried Specialists.		
Private Practice Hospital Account		
Balance at the Beginning of the Reporting Period	18,960	17,349
Cash Receipts	20,688	15,281
Cash Payments	(17,946)	(13,670)
Balance at the End of the Reporting Period	**21,702**	**18,960**

Note 41. Service Concession Assets

The Directorate has entered into an agreement with Calvary Health Care ACT Ltd for the provision of hospital and associated services. The original agreement was entered into by the Commonwealth on 22 October 1971 and does not stipulate any expiry date. This was subsequently amended in 1979 to include the Directorate (named at the time as Capital Territory Health Commission) with any duties or functions of the Commonwealth being transferred to the Directorate. The Agreement was for the facility to be used for a public hospital. This was varied, in 1988, by the Calvary Private Agreement to allow Calvary Health Care ACT 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. There have been no changes in these arrangements during the reporting period.

Under the agreement, Calvary Health Care ACT Ltd is required to provide hospital services and make these services available to all persons irrespective of creed or individual ability to pay and is to charge patients fees only in accordance with the scale of fees applicable at Health Directorate hospitals for comparable services. The agreement does not obligate the Directorate to provide funding for capital purchases, however the Directorate may do so. In the event that the agreement ceases, all land is to be returned to the Territory. The level of services that is required to be provided in a financial year, for the amount of funding provided is stipulated in a Performance Plan agreed between the Directorate and Calvary Health Care ACT Ltd for each year.

The amount of funding provided for in the 2010-11 financial year was $141.196m in recruitment funding, recognised in the Directorate's grants and purchased services expenditure, and $0.710m for capital upgrades of assets subject to these service concession arrangements. This is recognised as Territorial grants expenditure.

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

Note 42. Act of Grace Payments

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

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

Health Directorate Territorial Financial Statements for the Year Ended 30 June 2011

Health Directorate Statement of Income and Expenses on Behalf of the Territory for the Year Ended 30 June 2011

	Note	Actual 2011 $'000	Original Budget 2011 $'000	Actual 2010 $'000
Income				
Revenue				
Payment for Expenses on Behalf of the Territory	43	451	710	9,102
Fees	44	721	650	606
Total Revenue		1,172	1,360	9,708
Total Income		**1,172**	**1,360**	**9,708**
Expenses				
Grants and Purchased Services	45	710	710	9,102
Transfer to the ACT Government	46	721	650	606
Total Expenses		**1,431**	**1,360**	**9,708**
Operating (Deficit)		**(259)**	—	—
Total Comprehensive (Deficit)		**(259)**	—	—

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

Health Directorate Statement of Assets and Liabilities on Behalf of the Territory as at 30 June 2011

	Note	Actual 2011 $'000	Original Budget 2011 $'000	Actual 2010 $'000
Current Assets				
Cash and Cash Equivalents	47	36	259	177
Receivables	48	5	42	123
Total Current Assets		**41**	**301**	**300**
Total Assets		**41**	**301**	**300**
Current Liabilities				
Non Current Liabilities				
Advance from Territory Banking Account	49	300	301	300
Total Liabilities		**300**	**301**	**300**
Net (Liabilities)		**(259)**	—	—
Equity				
Accumulated Funds		(259)	—	—
Total Equity		**(259)**	—	—

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

Health Directorate Statement of Changes in Equity on Behalf of the Territory for the Year Ended 30 June 2011

	Accumulated Funds 2011 $'000	Total Equity 2011 $'000	Original Budget 2011 $'000
Balance at the Beginning of the Reporting Period	—	—	—
Comprehensive Income			
Operating (Deficit)	(259)	(259)	—
Total Comprehensive Income	**(259)**	**(259)**	—
Transactions Involving Owners Affecting Accumulated Funds			
Capital Injection	—	—	—
Capital (Distribution)	—	—	—
Transferred in as part of Net Assets due to Administrative Restructure	—	—	—
Total Transactions Involving Owners Affecting Accumulated Funds	—	—	—
Balance at the End of the Reporting Period	**(259)**	**(259)**	—

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

	Accumulated Funds 2010 $'000	Total Equity 2010 $'000
Balance at the Beginning of the Reporting Period	—	—
Comprehensive Income		
Operating Surplus/(Deficit)	—	—
Total Comprehensive Income	—	—
Transactions Involving Owners Affecting Accumulated Funds		
Capital Injection	—	—
Capital (Distribution)	—	—
Transferred in as part of Net Assets due to Administrative Restructure	—	—
Total Transactions Involving Owners Affecting Accumulated Funds	—	—
Balance at the End of the Reporting Period	—	—

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

Health Directorate Cash Flow Statement on Behalf of the Territory for the Year Ended 30 June 2011

	Note	Actual 2011 $'000	Original Budget 2011 $'000	Actual 2010 $'000
Cash Flows from Operating Activities				
Receipts				
Cash from Government for Expenses on Behalf of the Territory		451	710	9,102
Fees		721	650	606
Other Receipts		**71**	**71**	**828**
Total Receipts from Operating Activities		**1,243**	**1,431**	**10,536**
Payments				
Grants and Purchased Services		710	710	9,102
Transfer of Territory Receipts to the ACT Government		721	650	606
Other		(47)	71	910
Total Payments from Operating Activities		**1,384**	**1,431**	**10,618**
Net Cash (Outflows) From Operating Activities		(141)	—	(82)
Net (Decrease) in Cash Held	50	(141)	—	**(82)**
Cash and Cash Equivalents at the Beginning of the Reporting Period		177	259	259
Cash and Cash Equivalents at the End of the Reporting Period	**50**	**36**	**259**	**177**

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

Health Directorate Territorial Statment of Appropriation for the year ended 30 June 2011

	Original Budget 2011 $'000	Total Appropriated 2011 $'000	Appropriation Drawn 2011 $'000	Appropriation Drawn 2010 $'000
Territorial				
Expenses on Behalf of the Territory	710	451	451	9,102
Total Territorial Appropriation	710	451	451	9,102

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

Column Heading Explanations

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

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

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

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

Expenses on Behalf of the Territory

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

The Appropriation Drawn 2010 includes capital works funding for the Intensive Care Unit at Calvary Public Hospital.

Territorial Notes Index

Note 42. Summary of Significant Accounting Policies—Territorial

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

Note 43. Payment For Expenses On Behalf Of The Territory—Territorial

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

(See Note 45: 'Grants and Purchased Services—Territorial')

	2011 $'000	2010 $'000
Payment for Expenses on Behalf of the Territory[a]	451	9,102
Total Payment for Expenses on Behalf of the Territory	**451**	**9,102**

a. This relates to capital works at Calvary Hospital. The reduction reflects the level of capital works approved in the budget.

Note 44. Fees—Territorial

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

	2011 $'000	2010 $'000
Fees		
Fees for Regulatory Services	721	606
Total Fees	**721**	**606**

Note 45. 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.

	2011 $'000	2010 $'000
Fees		
Capital Grants to External Parties—Calvary Hospital[a]	710	9,102
Total Grants and Purchased Services	710	9,102

a. This relates to payments for capital works at Calvary Hospital. The reduction reflects the level of capital works approved in the budget.

Note 46. 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 licences fees collected.

	2011 $'000	2010 $'000
Payments to the Territory Bank Account	721	606
Total Transfer to Government	**721**	**606**

Note 47. Cash and Cash Equivalents—Territorial

	2011 $'000	2010 $'000
Cash at Bank	36	177
Total Cash	**36**	**177**

Note 48. Receivables—Territorial

	2011 $'000	2010 $'000
Current Receivables		
Goods and Services Tax Receivable	5	123
Less: Allowance for Doubtful Debts	—	—
Total Current Receivables	**5**	**123**
Total Non-Current Receivables	**—**	**—**
Total Receivables	**5**	**123**

Ageing Receivables	Not Overdue	Past Due			Total
		Less Than 30 days	30 to 60 days	Greater Than 60 days	
	$'000	$'000	$'000	$'000	$'000
2011					
Not Impaired Receivables	—	5	—	—	5
Impaired Receivables	—	—	—	—	—
2010					
Not Impaired Receivables	—	123	—	—	123
Impaired Receivables	—	—	—	—	—

Note 48. Receivables—Territorial—*continued*

	2011 $'000	2010 $'000
Classification of ACT Government/Non-ACT Government Receivables		
Receivables with Non-ACT Government Entities		
Net Goods and Services Tax Receivable	5	123
Total Receivables with Non-ACT Government Entities	5	123
Total Receivables	**5**	**123**

Note 49. Advance from Territory Banking Account—Territorial

	2011 $'000	2010 $'000
Advance from Territory Banking Account	300	300
Total Advance from Territory Banking Account	**300**	**300**

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

Note 50. Cash Flow Reconciliation—Territorial

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

	2011 $'000	2010 $'000
Total Cash Disclosed in the Statement of Assets and Liabilities on Behalf of the Territory	36	177
Cash at the End of the Reporting Period as recorded in the Cash Flow Statement	**36**	**177**

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

	2011 $'000	2010 $'000
Changes in Operating Assets and Liabilities		
(Increase) in Receivables	(141)	(82)
Net Changes in Operating Assets and Liabilities	**(141)**	**(82)**
Net Cash (Outflows) from Operating Activities	**(141)**	**(82)**

Note 51. 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 42:* 'Summary of Significant Accounting Policies—Territorial'.

Interest Rate Risk

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

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

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

Credit Risk

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

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

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

Liquidity Risk

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

Price Risk

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

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

Fair Value of Financial Assets and Liabilities

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

	Carrying Amount 2011 $'000	Fair Value 2011 $'000	Carrying Amount 2010 $'000	Fair Value 2010 $'000
Financial Assets				
Cash and Cash Equivalents	36	36	177	177
Total Financial Assets	**36**	**36**	**177**	**177**
Financial Liabilities				
Advance from Treasury Banking Account	300	300	300	**300**
Total Financial Liabilities	**300**	**300**	**300**	**300**
Net Financial (Liabilities)	**(264)**	**(264)**	**(123)**	**(123)**

Note 51. Financial Instruments—Territorial—*continued*

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

		Floating Interest Rate	Fixed Interest maturing in:			Non - Interest Bearing	
	Note		1 Year or Less	Over 1 to 5 Years	Over 5 Years		Total
		$'000	$'000	$'000	$'000	$'000	$'000
Financial Instruments							
Financial Assets							
Cash and Cash Equivalents	47	—	—	—	—	36	36
Total Financial Assets		—	—	—	—	**36**	**36**
Financial Liabilities							
Advance from Territory Banking Account	49	—	—	—	—	300	300
Total Financial Liabilities		—	—	—	—	**300**	**300**
Net Financial (Liabilities)		—	—	—	—	**(264)**	**(264)**

Note 51. Financial Instruments—Territorial—*continued*

The following table sets out the Directorate's maturity analysis for financial assets and liabilities as well as the exposure to interest rates, including the weighted average interest rates by maturity period as at 30 June 2010. All financial assets and liabilities which are non-interest bearing will mature in 1 year or less. All amounts appearing in the following maturity analysis are shown on an undiscounted cash flow basis.

		Floating Interest Rate	Fixed Interest maturing in:			Non - Interest Bearing	
	Note		1 Year or Less	Over 1 to 5 Years	Over 5 Years		Total
		$'000	$'000	$'000	$'000	$'000	$'000
Financial Instruments							
Financial Assets							
Cash and Cash Equivalents	47	—	—	—	—	177	177
Total Financial Assets		—	—	—	—	**177**	**177**
Financial Liabilities							
Advance from Territory Banking Account	49	—	—	—	—	300	300
Total Financial Liabilities		—	—	—	—	**300**	**300**
Net Financial (Liabilities)		—	—	—	—	**(123)**	**(123)**

Note 51. Financial Instruments—Territorial—*continued*

	2011 $'000	2010 $'000
Carrying Amount of Each Class of Financial Asset and Financial Liability		
Financial Assets		
Loans and Receivables	5	123
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	300	300
Fair Value Hierarchy		

The Directorate Territorial does not have any financial assets or financial liabilities at fair value. As such no fair value hierarchy disclosures have been made.

Note 52. Commitments—Territorial

Capital Commitments	2011 $'000	2010 $'000
Capital Commitments at reporting date that have not been recognised as liabilities are as follows:		
Capital Grant Commitments		
Within one year	727	710
Later than one year and not later than five years	—	—
Total Capital Commitments	**727**	**710**

All amounts shown in the commitment note are exclusive of GST

Note 53. Contingent Liabilities and Contingent Assets—Territorial

There were no contingent liabilities or contingent assets as at 30 June 2011.
There were no Indemnities as at 30 June 2011.

Note 54. Events occuring after Balance Date—Territorial

There were no events occurring after the balance date, which would affect the financial statements as at 30 June 2011.

A.7
Statement of performance

ACT AUDITOR-GENERAL'S OFFICE

REPORT OF FACTUAL FINDINGS

HEALTH DIRECTORATE

To the Members of the ACT Legislative Assembly

Report on the statement of performance

The statement of performance of the Health Directorate for the year ended 30 June 2011 has been reviewed.

Responsibility for the statement of performance

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

The auditor's responsibility

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

This review was conducted in accordance with Australian Auditing Standards applicable to review engagements, to provide assurance that the results of the performance 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 Health 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 performance indicators reported in the statement of performance or the related performance targets.

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

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

Electronic presentation of the statement of performance

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

Independence

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

Review opinion

Based on the review procedures, no matters have come to my attention which indicate that the results of the performance indicators, reported in the statement of performance of the Health Directorate for the year ended 30 June 2011, 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
15 September 2011

Health Directorate
Statement of Performance
For the Year Ended 30 June 2011

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 2011 and also fairly reflects the judgements exercised in preparing it.

Dr Peggy Brown
Director-General
Health Directorate
14 September 2011

Output Class 1 Health and Community Care

Output 1.1 Acute Services

Description

The ACT Government provides public hospital services at the Canberra Hospital and Calvary Public Hospital. These public hospitals provide a comprehensive range of acute care, including inpatient, outpatient and emergency department services.

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

This means focussing on:

- reducing waiting times for admission to a hospital bed through emergency departments, with a specific emphasis on older patients who might otherwise experience long waits due to the complexity of their conditions;
- achieving national benchmark performance standards for waiting times for access to elective surgery for category one patients; and
- achieving bed occupancy rates of approximately 85 per cent over time. Occupancy levels of around 85 per cent contribute positively to patient safety, reduce access block, ensure efficient workflows and minimise disruptions to elective surgery.

	Original Target 2010-11	Actual Result 2010-11	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	717,400	725,177	1%	The increase in total cost relates to cost pressures as well as non-achievement of savings targets.	
Government Payment for Outputs (GPO) ($000's)	506,182	514,365	2%	The increase in GPO relates to supplementation for the above mentioned cost pressures and non-achievement of savings and revenue targets.	
Accountability Indicators *Patient activity*					
a. Cost weighted patient separations	86,340	85,179	(1%)		1
b. Non-admitted occasions of service	291,490	305,781	5%	The variance relates to an increase in demand for a range of services provided by Surgical and Medical outpatient clinics. These include Thoracic Medicine, Gastroenterology, Canberra Sexual Health Centre, Fracture Clinic/ Orthopaedics and Ophthalmology outpatient clinics.	2
c. Percentage of category one elective surgery patients who receive surgery within 30 days of listing	95%	90%	(5%)	Following on from the Auditor-General's Report into elective surgery, the Health Directorate has changed processes and is implementing additional initiatives to improve access to elective surgery for all patients, particularly category one patients. This includes closer monitoring of category one patients to avoid extended waiting times.	3

	Original Target 2010-11	Actual Result 2010-11	% Variance from Original Target	Explanation of Material Variances	Notes
d. Number of allied health care services provided for acute care patients in ACT public hospitals	98,460	99,550	1%		4

Notes:

1. Cost weighted separations for all hospital episodes, excluding those reported elsewhere (Mental Health, Cancer Service and Aged Care and Rehabilitation Service) and unqualified neonates (well babies, who are counted as part of their mother's admission). Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of activity performed.
2. Non-admitted patient services provided in ACT public hospitals, excluding those services provided by Mental Health ACT, Cancer Service and the Aged Care and Rehabilitation Service.
3. Category one patients are those assessed by the treating medical officer as the highest priority for elective surgery requiring surgery within 30 days of assessment by a surgeon.
4. The number of allied health services to inpatients within the Canberra Hospital.

Output 1.2 Mental Health Services

Description

The Health Directorate provides a range of mental health services in hospitals, community health centres and in the broader community across the Territory. Mental Health ACT works with its community partners to provide integrated and responsive mental health services, including hospital-based specialist services, supported accommodation services and community-based service responses.

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

- ensuring timely access to emergency mental health care by reducing waiting times for urgent admissions to acute psychiatric units; and
- ensuring that the Health Directorate mental health services provide consumers with appropriate assessment, treatment, support and care which results in improved mental health outcomes.

	Original Target 2010-11	Actual Result 2010-11	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	74,381	75,414	1%		
Government Payment for Outputs (GPO) ($000's)	71,594	71,653	—		
Accountability Indicators *Patient activity*					
a. Cost weighted separations	3,760	3,678	(2%)		5
b. Admitted patient separations	1,340	1,312	(2%)		6
c. Adult services (18-64 years)	175,100	174,551	—		7

		Original Target 2010-11	Actual Result 2010-11	% Variance from Original Target	Explanation of Material Variances	Notes
d.	Children and youth services (0-17 years)	51,500	51,207	(1%)		8
e.	Older persons' services (65+ years)	20,600	17,120	(17%)	The variance relates to a refinement in reporting occasions of care that were previously duplicated. This duplication has been rectified as part of the ongoing improvement in data reporting.	9
f.	Psychogeriatric services bed days	4,530	5,195	15%	The variance is due to a gradual increase in beds from 13 to 15 based on staff availability, which has been sustained over the last nine months.	10
g.	Psychogeriatric inpatient episodes of care	113	143	27%	The variance is due to a gradual increase in beds from 13 to 15 based on staff availability, which has been sustained over the last nine months.	11
h.	Supported accommodation bed occupancy rate	95%	89%	(6%)	The variance relates to consumers preferring to wait for 'single' accommodation rather than be accommodated in 'group housing'.	12
i.	The proportion of clients seen at an ACT Health community facility during the 7 days post discharge from the inpatient services	75%	75%	—		13
j.	Percentage of clients with outcome measures completed	65%	63%	(3%)		14

Notes:

5. Cost weighted separations for mental health relate to the Psychiatric Services Unit (PSU) at the Canberra Hospital, Ward 2N at Calvary and the Older Persons' Mental Health Inpatient Unit at Calvary (OPMHIU). Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation.
6. Raw separations from the PSU and Calvary Ward 2N. Raw separations count the number of inpatient hospital episodes.
7. Mental Health ACT Adult community occasions of service (Age group 18 - 64).
8. Mental Health ACT Children and Adolescents community occasions of service (Age group 0 - 17).
9. Mental Health ACT older persons' community occasions of service (Age group 65+).
10. The actual number of Occupied Bed Days at Calvary older persons' mental health inpatient unit.
11. This indicator provides a count of the number of admitted clients treated by Mental Health ACT during the financial year within the Older Persons' Mental Health Inpatient Unit.
12. Actual occupancy expressed as a percentage of the total supported accommodation places provided by the following Community Service providers: Richmond Fellowship, Centacare, ACT Mental Health Foundation and Inanna.
13. The proportion of clients admitted to a mental health inpatient unit and contacted by Mental Health ACT Community Services during the 7 days post discharge from the Mental Health Inpatient Units (not all inpatients are referred to Mental Health ACT community mental health but may be seen by their GP or private psychiatrist). Consistent with national standards for reporting this performance indicator, both face-to-face and telephone contacts are counted in this result. The outcome excluding telephone contacts was 68%.
14. Percentage of Mental Health ACT registered clients with mandatory outcome measures completed each three months. The purpose of measuring clinical outcomes is to see whether consumers of public mental health services are getting better as a result of the services they receive.

Output 1.3 Community Health Services

Description

Community Health provides a range of community based health services in a number of settings across the ACT, including health promotion and clinical programs such as maternal and child health services, immunisation, youth health services, women's health services, alcohol and drug services, dental services, corrections health and Aboriginal liaison and interpreter services. There is a wide range of allied health, nursing and medical services that meet the needs of many people with post acute and chronic conditions.

The key strategic priorities for community health include early intervention, improved access to community health care and better integration between acute, primary and community based care. This includes:

- ensuring timely access to public dental health care in cases of emergency need;
- providing health care assessments for people detained in corrective facilities;
- improving accessibility to, and the appropriateness of, services for women of culturally and linguistically diverse backgrounds;
- providing timely access to counselling services within the ACT Women's Health Service;
- ensuring that access consistent with clinical need, is timely for community-based nursing and allied health services; and
- ensuring that community-based services are in place to better provide for the acute and post-acute health care needs of the community.

	Original Target 2010-11	Actual Result 2010-11	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	101,494	102,254	1%		
Government Payment for Outputs (GPO) ($000's)	93,636	93,488	—		
Accountability Indicators					
a. Percentage of opioid treatment clients with management plans	90%	99%	10%	The favourable variance reflect vigilant monitoring and compliance by clinical staff.	15
b. Mean waiting time for clients on the dental services waiting list	12 months	12 months	—		16
d. Proportion of offenders and detainees at the Alexander Maconachie Centre with a completed health care assessment within 24 hours of detention	100%	100%	—		17

		Original Target 2010-11	Actual Result 2010-11	% Variance from Original Target	Explanation of Material Variances	Notes
e.	Proportion of offenders and detainees in Bimberi Youth Detention Centre with a completed health care assessment within 24 hours of detention	100%	85%	(15%)	The variance is attributed to high level of offenders and detainees during the first quarter when the Bimberi nurse position was part time. Following a return to normal levels of client access and the appointment of a full time nurse in January 2011, the outcome improved over the remainder of the financial year (100% was achieved in the fourth quarter).	17
f.	Number of nursing (domiciliary and clinic based) occasions of service	80,000	83,446	4%		18
g.	Number of allied health regional services (occasions of service)	22,000	23,474	7%	The favourable variance is due to a change in service delivery model resulting in increased phone contacts.	19
h.	Percentage of the Women's Health Service Intake Officer's clients who receive an intake and assessment service within 14 working days of their initial referral	100%	100%	—		20

Notes:

15. On presentation for opioid replacement treatment, a management plan is developed. This indicator represents the percentage of clients with management plans.
16. Client mean waiting time is defined as the mean waiting period between when a client is placed on the adult dental central waiting list and the receipt of treatment by a public dentist.
17. Percentage of detainees inducted into Bimberi and Alexander Maconachie Centre who are assessed within 24 hours of arrival at the facility. In respect of Bimberi, youth detainees who are detained for a period of less than 24 hours will be excluded from this measure.
18. All occasions of service provided to community patients by Continuing Care Nurses in the following settings: home visits; ambulatory care clinics; foot care clinics; continence clinics; wound clinics; and stoma clinics.
19. All occasions of service provided to community patients by Continuing Care Allied Health Professionals and Technical Officers for Physiotherapy, Occupational Therapy, Social Work, Podiatry, and Nutrition.
20. This performance indicator provides an indication of the availability of services.

Output 1.4 Public Health Services

Description

Public Health Services provides high quality health and community services to the ACT and surrounding region. The key strategic priorities for Public Health Services include the monitoring of prevention, early intervention and integrated care services to ensure that the ACT maintains its position as the healthiest jurisdiction in Australia. This includes:

- maintaining the ACT's position as the jurisdiction with the greatest life expectancy in Australia;
- reducing the incidence of cardiovascular disease in the community; and
- ensuring that the rate of hip fractures declines over the long term.

	Original Target 2010-11	Actual Result 2010-11	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	29,041	28,662	(1%)		
Government Payment for Outputs (GPO) ($000's)	27,146	27,106	—		
Accountability Indicators					
a. Samples analysed	7,000	7,597	9%	The variance is due to increased analysis of asbestos, water, food and road transport authority samples. These are largely driven by public demand for testing.	21
b. Inspection compliance of licensable, registrable and non-licensable activities	85%	84%	(1%)		22
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%	—		23

Notes:

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

Output 1.5 Cancer Services

Description

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

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

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

	Original Target 2010-11	Actual Result 2010-11	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	38,543	39,582	3%	The increase in total costs relates to cost pressures flowing-on from the 2009-10 financial year and activity funded from third party revenue. Third party revenue refers to patient and other revenue received from parties other than the ACT Government.	
Government Payment for Outputs (GPO) ($000's)	31,751	31,826	—		
Accountability Indicators *Patient activity*					
a. Cost weighted admitted patient separations	4,710	4,779	1%		24
b. Non-admitted occasions of service	55,620	55,637	—		25
Breast Screening					
c. Total breast screens	12,000	11,666	(3%)		26
d. Number of breast screens for women aged 50-69	10,500	9,826	(6%)	The variance is due primarily to radiographer staff shortages. Recruitment of new staff, along with additional strategies such as increased screening appointment numbers with targeted education and awareness strategies for women aged 50-69 are currently being implemented.	27
e. Percentage of women who receive results of screen within 28 days	100%	99%	(1%)		28

		Original Target 2010-11	Actual Result 2010-11	% Variance from Original Target	Explanation of Material Variances	Notes
f.	Percentage of screened who are assessed within 28 days	90%	76%	(16%)	The performance against this target was impacted by issues resulting from the implementation of digital mammography, such as delays in the electronic transfer of images. The variance is also the result of staffing shortages in the areas of radiography, radiology and administration, all of which have recruitment strategies in place.	29

Notes:

24. Inpatient cost weighted activity for patients of the Capital Region Cancer Service. Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of activity performed.
25. Medical oncology (including chemotherapy), radiation oncology and haematology outpatient services.
26. Total number of women screened in the period.
27. Number of women aged between 50 to 69 years screened in the period. This age group is the target population for the breast screen program.
28. The percentage of women with a 'normal' result who receive notice of this outcome within 28 days of their screening appointment.
29. The percentage of women seeking an appointment who wait 28 days or less from the making of an appointment to the actual appointment.

Output 1.6 Aged Care and Rehabilitation Services

Description

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

The key strategic priorities for Aged Care and Rehabilitation Services are:

- reducing waiting times for admission to a hospital bed through emergency departments;
- ensuring that older persons in hospital wait the least possible time for access to comprehensive assessment by the Aged Care Assessment Team. This will assist in their safe return home with appropriate support, or access to appropriately supported residential accommodation;
- improving discharge planning to minimise the likelihood of readmission or inadequate support for independent living, following completion of hospital care; and
- ensuring that people with rehabilitation care needs receive the care at the right time and in the right place.

	Original Target 2010-11	Actual Result 2010-11	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	47,234	47,139	—		
Government Payment for Outputs (GPO) ($000's)	40,594	41,403	2%		
Accountability Indicators *Patient activity*					
a. Cost weighted admitted patient separations	5,140	4,569	(11%)	Target not met due to reduction in Geriatric Evaluation Medicine Services at Calvary Public Hospital because of inability to recruit Geriatricians. There has also been a reduction of services at the Rehabilitation and Independent Living Unit due to staff shortages and lower numbers on the waiting list for inpatient therapy.	30
b. Non-admitted occasions of service	2,230	2,027	(9%)	Actual occasions of service for Geriatrics have been falling steadily since September 2010, mostly due to extended leave and consultant resignations — a number of these positions remain unfilled. This is partly offset by an increase in activity from the Health Directorate RADAR service.	31
c. Sub acute service– episodes of care	1,640	1,556	(5%)	The full year target was not met due to temporarily ceasing admission to Geriatric Evaluation and Management services at Calvary Public Hospital due to Geriatrician shortages.	32

	Original Target 2010-11	Actual Result 2010-11	% Variance from Original Target	Explanation of Material Variances	Notes
d. Sub acute service—occupied bed days	22,660	21,573	(5%)	The Rehabilitation and Independent Living Unit had a prolonged period of closure due to staffing issues. Admissions to Geriatric Evaluation and Management beds closed temporarily in February 2011 due to Geriatrician shortages. Recruitment is in progress.	33
e. Number of people assessed in falls clinics	420	486	16%	The favourable outcome reflects the implementation of various strategies including the introduction of a third clinic, reminder phone calls for clinic clients, development and distribution of a monthly newsletter to Health Directorate staff and external organisations, involvement in Seniors week and relevant expos, and in-service presentations to promote the services to the ACT community.	34

Notes:

30. Inpatient cost weighted activity for patients of the Aged Care and Rehabilitation Service. Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of activity performed.
31. Geriatric and rehabilitation outpatient services.
32. The total number of persons separated from the sub and non-acute service at Calvary Public Hospital.
33. Total number of occupied bed days used for persons separated from the sub and non-acute service at Calvary Public Hospital.
34. Data is for the Falls Clinic taken from 'Integrated Health Care Partnership Central Regional Team'. The 'Integrated Health Care Partnership Assessors' contacts have been excluded as this relates to 'non-clinic time' intervention by staff member.

Output 1.7 Early Intervention and Prevention

Description

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

The key strategic priorities for intervention and prevention are:

- reducing the level of youth smoking in the ACT; and
- maintaining immunisation rates for children above 90 per cent.

	Original Target 2010-11	Actual Result 2010-11	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	60,458	59,354	(2%)	The reduction in total cost relates largely to the rollover of Commonwealth vaccine and 'A Healthy Future' funding.	
Government Payment for Outputs (GPO) ($000's)	56,007	54,679	(2%)	The reduction in GPO relates to the rollover of Commonwealth vaccine and 'A Healthy Future' funding.	
Accountability Indicators *Immunisation*					
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%		35
Community Health					
a. Proportion of clients attending 'Well Women's Check' within the Women's Health Service that are from culturally and linguistically diverse communities	30%	32%	7%	The favourable outcome reflects targeting of services towards women from culturally and linguistically diverse communities.	36
b. Proportion of children aged 0–14 who are entering substitute and kinship care within the ACT who attend to the Child at Risk Health Unit for a health and wellbeing screen	80%	88%	10%		37

Notes:

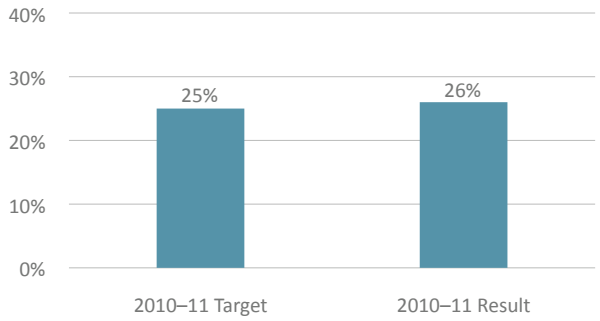
35. Percentage of 12 month old children who have been fully immunised in accordance with the Australian Childhood Immunisation Register.
36. This indicator measures the percentage of women who are from culturally and linguistically diverse communities accessing a 'Well Women's Check'.
37. This indicator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

A.8
Strategic indicators

Strategic indicator 1 Emergency department access block

Acute Care Services

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



In 2010–11 emergency department access block increased by 3 per cent to 26 per cent from the rate of 23 per cent reported in 2009-10. Admissions to ACT public hospitals via the emergency department for 2010-11 were 5 per cent more than reported for last year.

Strategic indicator 2 Maximising the quality of hospital services

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

Data for these indicators is extrapolated from data for the period July 2010 to May 2011. The determination of these figures requires detailed analysis of medical records; as a result, data for June 2011 was not available at the time of preparing this report.

1 Rate of unplanned return to the operating theatre

The proportion of people who undergo a surgical operation and who require an unplanned return to the operating theatre within a single episode of care due to complications of their condition. This provides an indication of the quality of theatre and post-operative care.

	2010–11 target	2010–11 result
The Canberra Hospital	<1.0%	0.46%
Calvary Public Hospital	<0.5%	0.23%

Counting in relation to this measure is currently under review. New counting methodology will be available for future reports.

2 Rate of unplanned hospital re-admission

The proportion of people separated from hospital, who are re-admitted to hospital within 28 days of their separation due to complications of their condition (where the re-admission was unforeseen at the time of separation). This provides an indication of the effectiveness of hospital-based and community services in the ACT in the treatment of persons who receive hospital-based care.

	2010–11 target	2010–11 result
The Canberra Hospital	<2.0%	1.45%
Calvary Public Hospital	<1.0%	1.07%

3 Hospital acquired infection rate (bacteraemia)

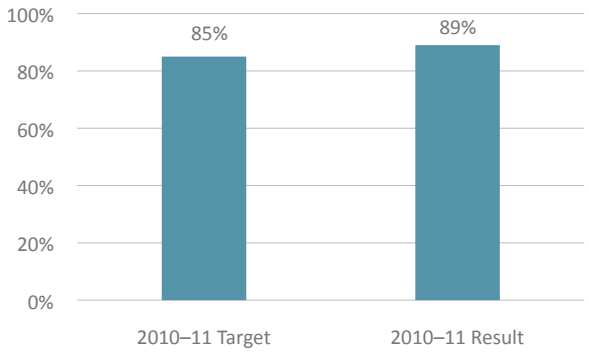
The number of people admitted to hospital per 10,000 occupied bed days who acquire a bacteraemial infection during their stay. This provides an indication of the safety of hospital-based services.

	2010–11 target	2010–11 result
The Canberra Hospital	<7 per 10,000	6.71
Calvary Public Hospital	<3 per 10,000	2.03

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

Bed occupancy

The mean percentage of adult overnight acute medical and surgical hospital beds in use. This provides an indication of the efficient use of resources available for hospital services.



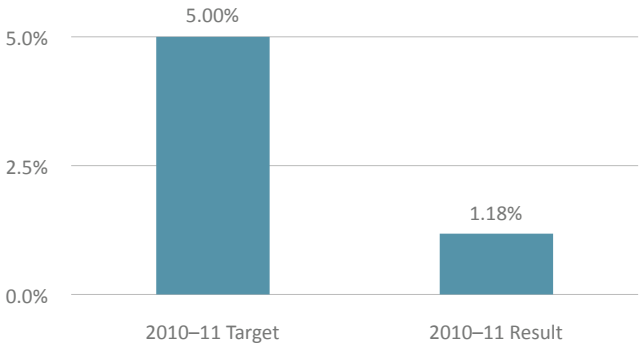
The major cause for the increase in bed occupancy rates has been the increase in demand for services in 2010–11.

Strategic indicator 4 Reducing the usage of seclusion

Seclusion rate

The proportion of clients of Mental Health ACT who are subject to seclusion during an inpatient episode. This measures the effectiveness of care provided by Mental Health ACT over time in providing services that minimise the need for seclusion.

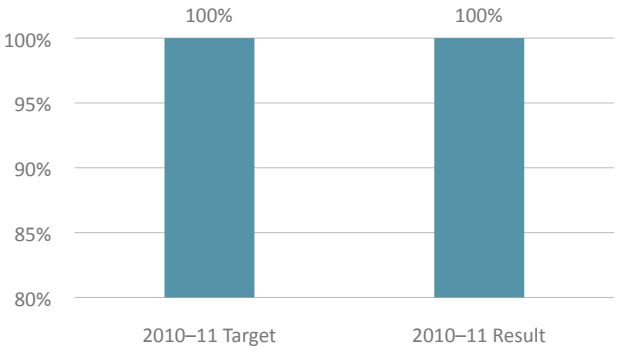
Mental Health ACT has implemented a number of initiatives to reduce the level of clients secluded during an inpatient episode. These initiatives were very successful, with the rate of seclusion decreasing from 2.3 per cent in 2009–10 to 1.18 per cent in 2010–11.



Strategic indicator 5 Maintaining consumer and carer participation

Consumer and carer representation on relevant mental health committees

The proportion of Mental Health ACT committees in which consumers and carers are represented. This measure ensures that the committees that monitor the delivery and planning of our mental health services have effective input from mental health consumers.



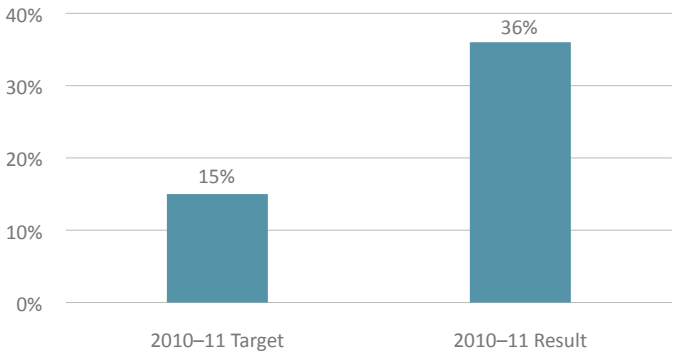
Strategic indicator 6 Mental health—emergency department access block

Mental health acute care

The proportion of mental health clients admitted to hospital from the emergency department who wait more than eight hours from the time of commencement of treatment to the time of transfer to a ward.

The unfavourable result is directly related to bedding down the new model of care following the establishment of the new Mental Health and Assessment Unit within the Canberra Hospital Emergency Department in 2009–10. This new unit is part of the emergency department and it is not an inpatient unit. Mental Health Services will continue to monitor the use of this new service as part of the overall patient journey through Mental Health Services to minimise the time people spend in the Emergency Department.

This indicator covers only a small number of people, with an average of about two patients per day transferred from the Emergency Department to mental health inpatient services. As such, small changes in access to care can result in relatively large movements in access block results for this group of patients.



Strategic indicator 7 Mental health—return to hospital

Return to ACT Health Mental Health Inpatient Unit

The proportion of clients who return to hospital within 28 days of discharge from an ACT Health mental health inpatient unit. The measure provides an indication of the quality of support provided to Mental Health clients being discharged, so as to avoid unnecessary returns to hospital.

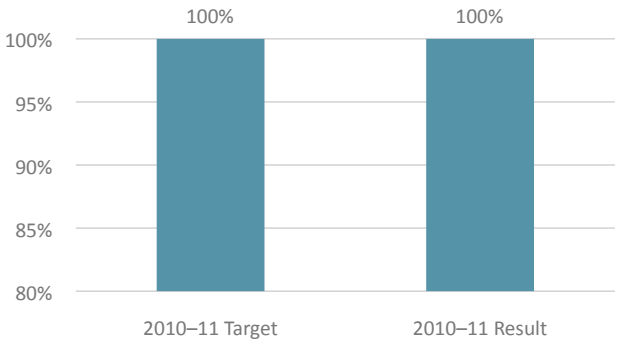
	2010–11 target	2010–11 result
Proportion of clients who return to hospital within 28 days of discharge from an ACT Health mental health inpatient unit	<10%	5.5%

The ACT rate in 2010–11 was significantly better than the most current national rate, for 2007–08, which was 10 per cent.

Strategic indicator 8 No waiting for access to emergency dental health services

Oral health

Percentage of assessed emergency clients seen within 24 hours. This provides an indication of the responsiveness of the dental service to emergency clients.



Strategic indicator 9 Access to radiotherapy services

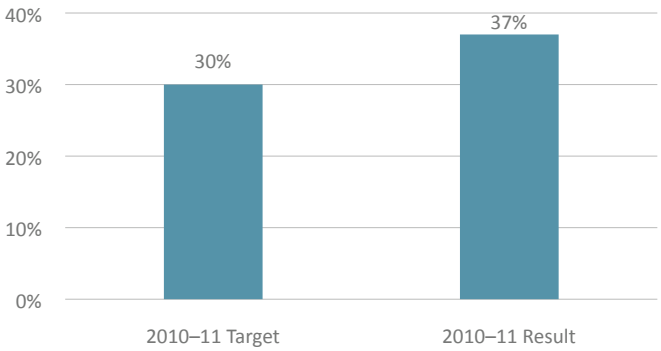
Percentage of urgent radiotherapy patients who commence treatment within standard time frames.

Category	2010–11 target	2010–11 result
Urgent—treatment starts within 48 hours	100%	100%
Semi-Urgent—treatment starts within 4 weeks	95%	100%
Non-Urgent Category A—treatment starts within 4 weeks	85%	99.5%
Non-Urgent Category B—treatment starts within 6 weeks	95%	100%

Strategic indicator 10 Improving hospital access times for older persons

Improving hospital access times for persons aged over 75 years

The percentage of admissions via Emergency Department (ED) by persons 75 years or more who wait more than eight hours from commencement of treatment in the ED to admission to a ward.

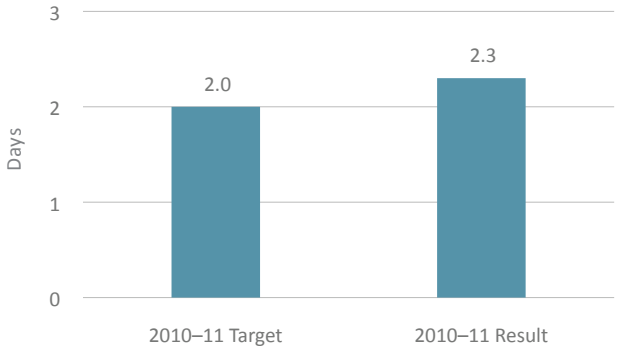


Access block for older persons was above the target in 2010-11 at 37 per cent, this was 4 per cent above the rate of 33 per cent reported in 2009-10. There has been an overall growth in presentations to the emergency department of 5 per cent and an 8 per cent increase in admissions of older persons into ACT public hospitals. The 2011-12 budget provides additional funding to improve the management of the health needs of older people.

Strategic indicator 11 Maintain the waiting times for in-hospital assessments by the Aged Care Assessment Team

Aged Care Assessment Team

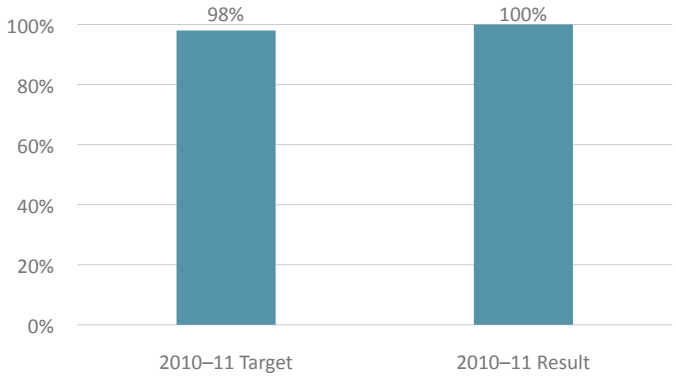
This is measured by the mean waiting time in working days between the request for, and provision of, assessment by the Aged Care Assessment Team (ACAT) for patients in public hospitals. This provides an indication of the responsiveness of the ACAT team in assessing the needs of clients.



Strategic indicator 12 Increasing the rate of discharge planning

Discharge planning

Proportion of aged care clients under the management of the Aged Care & Rehabilitation Division who are discharged with a comprehensive discharge plan. This provides an indication of the effectiveness of services in planning and organising the needs of clients following their hospital episode and the level of integration of hospital and community-based care.



Strategic indicator 13 Two-year participation rate in the cervical screening program

Cervical screening program

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

	ACT rate	National rate
Two-year participation rate	58.86%	58.5%

Cervical Screening in Australia 2008–09 (Australian Institute of Health and Welfare, May 2010).

There has been a change in how the population is calculated so that it reflects the current trend of fewer hysterectomies being performed. As a result, the ACT screening population figure rose by 2 per cent, causing a corresponding drop in participation.

Strategic indicator 14 Emergency department timelines

Waiting times for treatment of triage category

The proportion of Emergency Department presentations that are treated within clinically appropriate timeframes.

Triage category	2010–11 target	2010–11 result
One (resuscitation seen immediately)	100%	100%
Two (emergency seen within 10 mins)	80%	78%
Three (urgent seen within 30 mins)	75%	48%
Four (semi-urgent seen within 60 mins)	70%	48%
Five (non-urgent seen within 120 mins)	70%	75%
All Presentations	70%	55%

Waiting times for category one and five patients either met or exceeded the national standard waiting times in 2010-11. The below-target result for category two, three and four patients are related to continuing increases in demand for emergency department services in the ACT, with presentations up 5 per cent compared to the same period last year.

A number of new initiatives have been funded to improve patient flow from the emergency departments to more appropriate health settings. These included:

- employment of three new emergency department physicians at TCH, and
- redesigning how the emergency departments work and how the rest of the hospital can work to improve the way patients move through the emergency departments as part of a hospital episode.

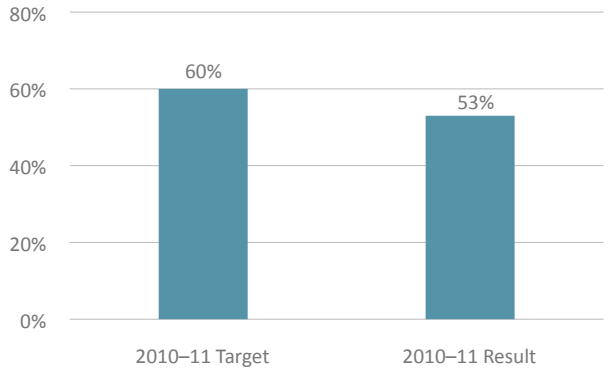
These initiatives will supplement the additional services funded by the Government over recent years to improve patient flow from the emergency department to more appropriate health settings, such as the establishment of the Medical Assessment and Planning Unit and the Surgical Assessment and Planning Unit, which provides the capacity for emergency department clinicians to transfer people to specialist assessment and treatment services.

Strategic indicator 15 Breast screen participation rate for women aged 50–69 years

Breast screening

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

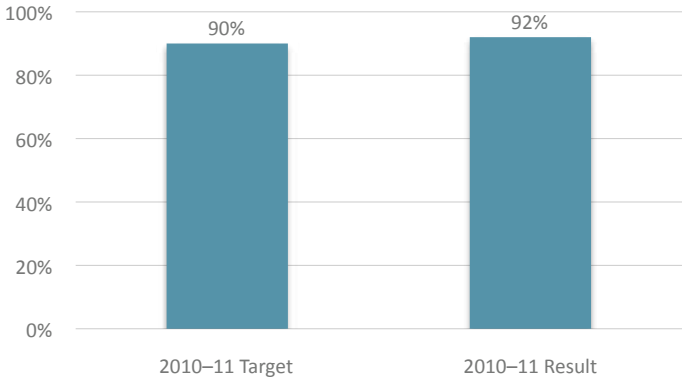
The participation rate fluctuates from year to year. This year's result is consistent with that for 2009–10. The ACT's performance against this indicator is also consistent with that of other jurisdictions, in that none acheives a 60 per cent participation rate.



Strategic indicator 16 The proportion of patients with a length of stay greater than 30 days who have a comprehensive discharge plan

Discharge plans—long-stay patients

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



‘Monitoring our health’ strategic indicators

Strategic indicator 17 Achieve lower than the Australian average in the decayed, missing or filled teeth (DMFT) Index

	ACT rate	National rate
Dental Health — Decay, Missing or Filled Teeth (DMFT)		
dmft index at 6 years	1.6	2
DMFT index at 12 years	1.1	1.1

Source: Water fluoridation and children’s dental health. The Child Dental Health Survey 2005 (AIHW, Australian Research Centre for Population)

The mean number of teeth with dental decay, missing or filled teeth at ages 6 and 12. This gives an indication of the effectiveness of prevention, early intervention and treatment services in the ACT. The aim for the ACT is to better the Australian average.

On the basis of the latest figures available, the ACT has the second lowest rate of dmft index at 6 years in Australia. Western Australia has the lowest rate at 1.5.

Strategic indicator 18 Maintenance of the highest life expectancy at birth in Australia

Maintenance of the highest life expectancy at birth in Australia	ACT Rate	National Rate
Females	84.3	83.9
Males	80.5	79.3

Source: Deaths Australia, 2009 (Australian Bureau of Statistics)

Life expectancy at birth provides an indication of the general health of the population and reflects a range of issues other than the provision of health services, such as economic and environmental factors. On the basis of the latest data available, the ACT has the highest life expectancy of any jurisdiction in Australia and the Government aims to maintain this result. Life expectancy for ACT females increased by 0.3 years and for ACT males by 0.5 years from 2007 to 2009.

Strategic indicator 19 Prevalence of circulatory disease

Circulatory disease

The proportion of the ACT population with some form of circulatory disease.

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

Source: National Health Survey 2007–08 (Australian Bureau of Statistics)

The prevalence of cardiovascular disease is an important indicator of general population health, as it is a major cause of mortality and morbidity. The ACT is committed to prevention and early intervention efforts to assist in achieving a decline in the prevalence of this disease. In 2007–08 (the latest figures available), the proportion of ACT residents with a long-term cardiovascular condition was slightly lower than that for the whole of Australia. There was also an encouraging decrease from 2004–05, when the proportion was 18.9 per cent in the ACT.

Strategic indicator 20
Prevalence of diabetes

Diabetes

The proportion of the ACT population diagnosed with some form of diabetes. This provides an indication of the success of prevention and early intervention initiatives. Prevalence rates may increase in the short term as a result of early intervention and detection campaigns. This would be a positive result, as experts estimate that only half of those with diabetes are aware of their condition, and this lack of awareness can have significant adverse impacts on their long-term health. Significant positive impacts for long-term health can be gained from lifestyle modification and early intervention programs and treatment.

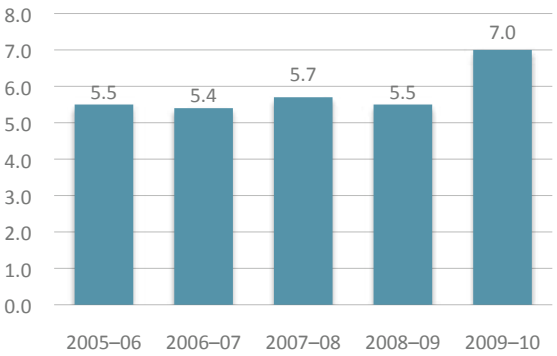
Diabetes	ACT Rate	National Rate
Prevalence of diabetes in the ACT	3.1%	4.0%

Source: National Health Survey 2007–08 (ABS)

Strategic indicator 21
Reduction in the rate of broken hips (fractured neck of femur)

Reducing the risk of fractured femurs in ACT residents aged over 75 years

The reduction or maintenance of the rate of fractured femurs for ACT residents aged over 75 years. This provides an indication of the success of public and community health initiatives to prevent hip fractures. In 2009–10 (the latest year for which data is available), the rate for ACT residents was 7.0 fractures per 1000 for ACT residents aged over 75 years—up from 5.5 in 2008–09. Fluctuations in the annual rate of fractured neck of femurs are expected in the ACT due to the small number of people aged 75 and over. However, the rate of fractured femurs should be monitored over time to ensure that the upward trend does not continue. The ageing of the population will significantly increase the number of people in this group.

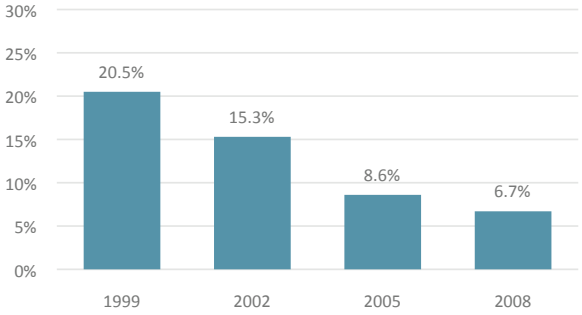


Source: Health Directorate, Admitted Patient Care files, 2005–2010

Strategic indicator 22
Reduction in the youth smoking rate

Percentage of persons aged 12–17 years who smoke regularly

The ACT rate dropped significantly between 1999 (20.5 per cent) and 2008 (6.7 per cent). Anti-smoking campaigns and legislative measures have contributed to reductions in smoking in the ACT. The government aims to continue to reduce youth smoking rate, with the objective of reaching 5 per cent in the longer term.



Source: Health Directorate, Australian Secondary School Alcohol and Drug Survey, confidential unit record file, 1999–2008

A.9
Analysis of agency performance

Public hospital services

Output 1.1 Acute Services

The Government provides public hospital services at the Canberra Hospital and Calvary Public Hospital. These public hospitals provide a comprehensive range of acute care, including inpatient, outpatient and emergency department services.

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

This means focusing on:

- reducing waiting times for admission to a hospital bed through emergency departments, with a specific emphasis on older patients who might otherwise experience long waits due to the complexity of their conditions;
- achieving national benchmark performance standards for waiting times for access to elective surgery for category one patients; and
- achieving bed occupancy rates of approximately 85 per cent over time. Occupancy levels of around 85 per cent contribute positively to patient safety, reduce access block, ensure efficient workflows and minimise disruptions to elective surgery.

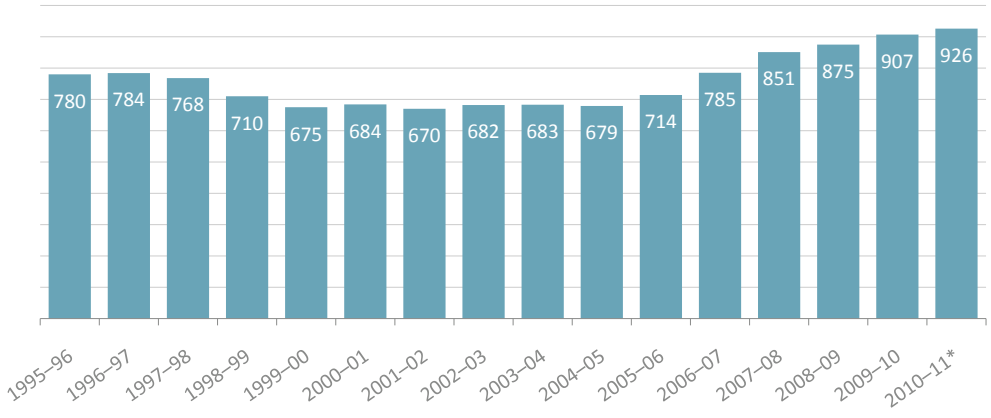
Increasing the Capacity of the ACT Public Health Services

More beds to manage increasing demand for hospital services

The Australian Institute of Health and Welfare (AIHW) reported that in 2009–10 ACT public hospitals provided an average of 907 beds. In the 2010–11 Budget an additional 19 beds were funded, providing a capacity of 926 beds. This is 256 extra beds since 2001–02.

In addition, a considerable expansion to the Hospital in the Home service provided another 25 bed equivalents for the service in 2010. Four sub-acute beds were also added in 2010–11 as part of the Australian Government's National Health Reform Program.

ACT Public Hospitals



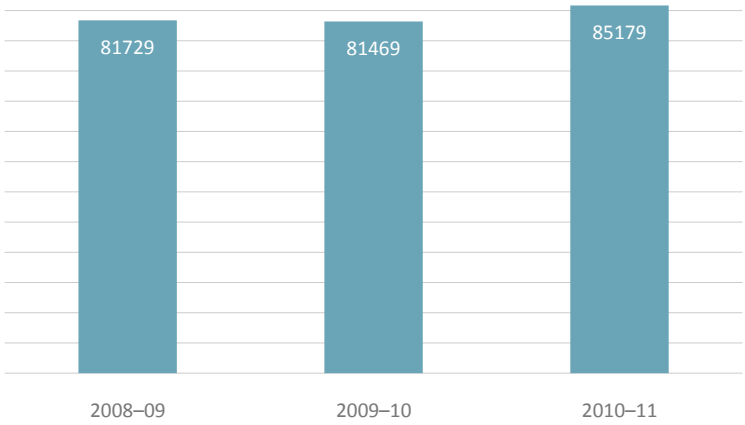
*2010–11 figure provides estimated impact of government in additional capacity.
Source: Australian Hospital Statistics, AIWH, 1995–96 to 2009–10 publications

2010–11 (estimate, not published until May 2012)

The ACT Government is committed to continuing to add bed capacity to the public hospital system to meet growing demand for care and to reduce bed occupancy to optimum levels.

In 2010–11, the territory's public hospitals provided 85,179 cost-weighted separations within Acute Care Services (which includes general hospital services but excludes hospital services provided by Mental Health ACT, the Capital Region Cancer Service and the Aged Care and Rehabilitation Service). This is a 5 per cent increase in cost-weighted separations activity in 2010–11 compared to 2009–10.

ACT Public Hospitals
Inpatient Admitted Patient cost-weighed separations (round 12 National cost weight, AR-DRG Version 5.1)

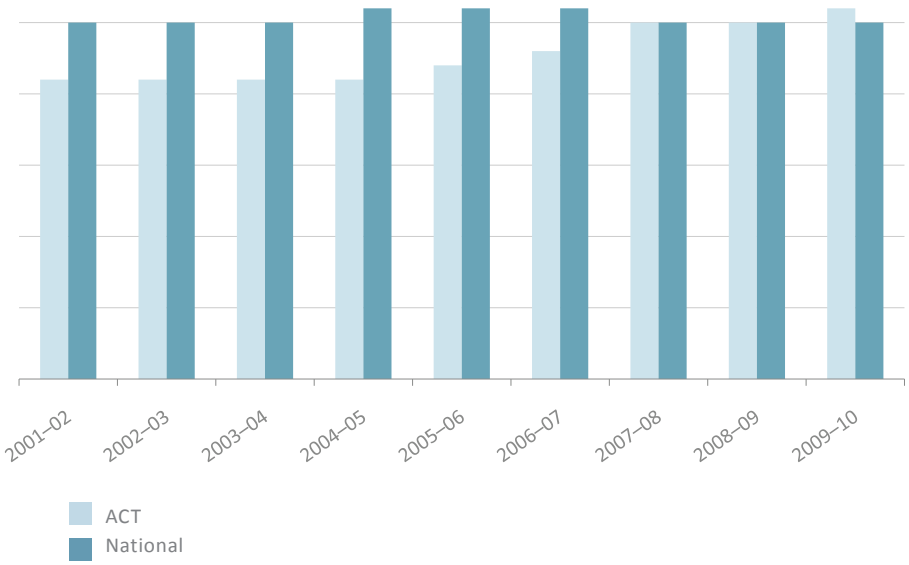


Preliminary
Source: Admitted patient care data set

Over the reporting year, our public hospitals provided more than 256,888 overnight hospital bed days of care, 6 per cent up on the total of 241,573 provided the previous year.

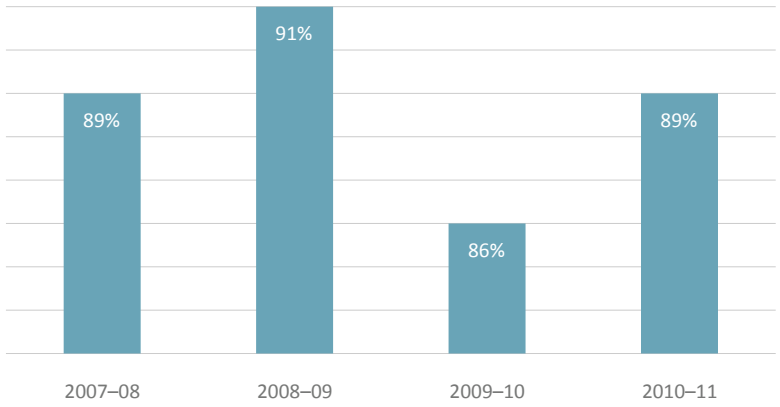
The Australian Hospital Statistics Report for 2009–10 issued by the Australian Institute of Health and Welfare in May 2011 showed that the ACT had achieved the national average in public hospital bed availability for the second time in the almost 21 years of reporting by the institute. We reached 2.6 public hospital beds per 1000 people—which is 0.1 above the Australian national average.

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



The bed occupancy rate for overnight adult medical and surgical beds in 2010–11 was 89 per cent, up from 86 per cent the previous year. The Government's long-term target is to maintain bed occupancy levels at around 85 per cent, which is considered the best level for best patient outcomes and to achieve maximum efficiency. This increase in bed occupancy rate resulted from an increase in demand for services in 2010–11.

ACT Public Hospitals
Bed Occupancy Rate

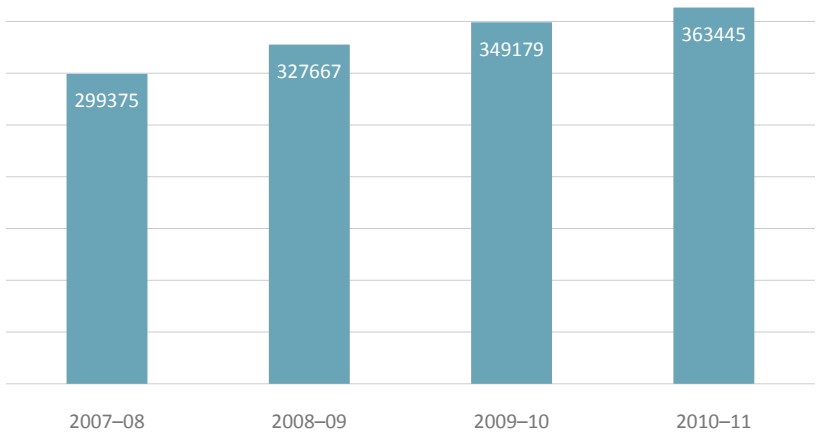


Year-To-Date June
Source: ACT Public Hospitals

Our public hospitals reported a continuation of the strong increase in demand for outpatient services. They reported a 4 per cent growth in the number of outpatient services in 2009–10, rising from 349,179 in 2009–10 to 363,445.

The business processes for outpatient services are being reviewed to improve their efficiency and to improve access to services for consumers.

ACT Public Hospitals
Non-admitted (outpatient) occasions of service

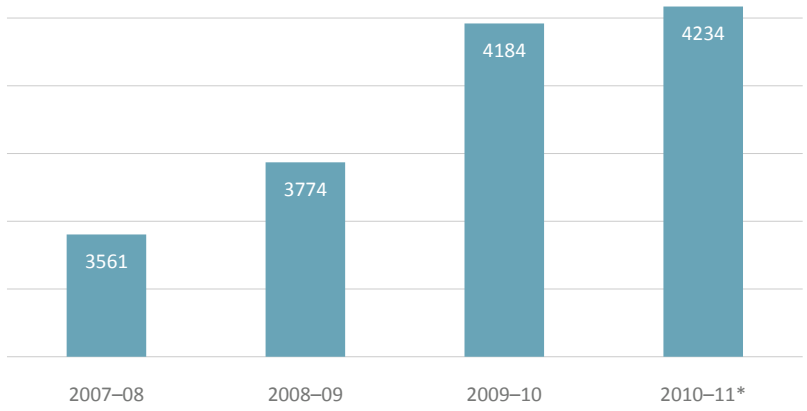


Year-To-Date June
Source: ACT Public Hospitals

Births

Births in ACT public hospitals steadied at 4236 over 2010–11 with an increase of 1 per cent above the 4184 reported for 2009–10.

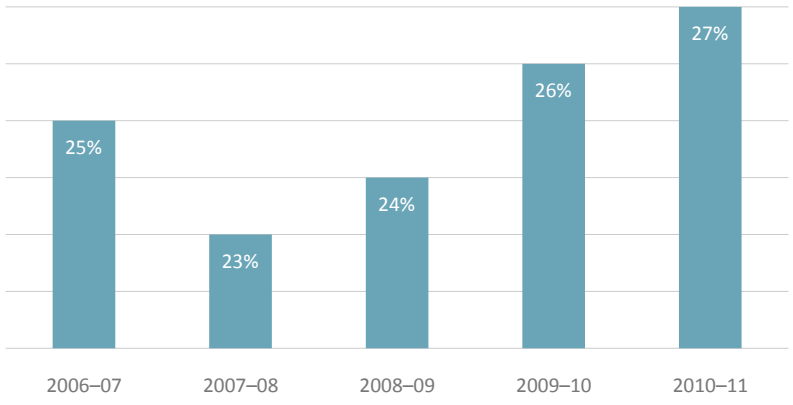
ACT Public Hospitals
BIrths by Year



*Preliminary
Source: Admitted patient care data set

The number of births by caesarean section increased to 27 per cent of all births in 2010–11, slightly up from the 26 per cent reported in 2009–10 and the 24 per cent reported the year before.

ACT Public Hospitals
% Caesarean Procedures by Year



*Preliminary
Source: Admitted patient care data set

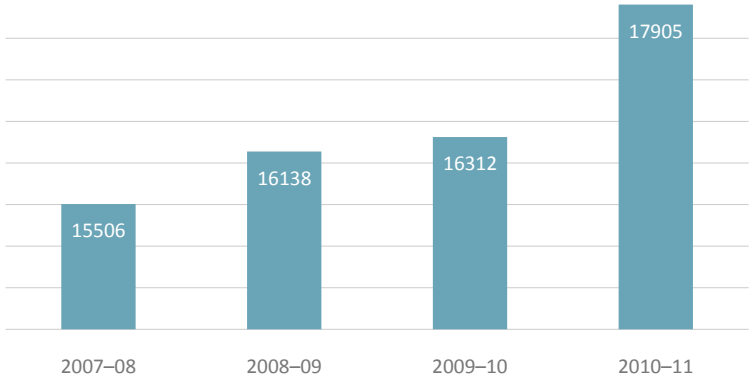
Caesarean rates have been steadily rising since 2001 both in the ACT and nationally. The ACT rate of 27 per cent in 2010–11 is equal to the most recent national figures published by the Australian Institute of Health and Welfare, 2007–08. ACT public hospitals continue to have a low caesarean rate compared to benchmarking hospitals. The most recent Australian hospitals data on women, for 2009–10, shows that the Canberra Hospital's caesarean rate is well below those of peer hospitals. There are a number of measures in place to help reduce and reverse the trend of increased caesarean rates in ACT public hospitals. These include actively promoting vaginal birth after caesarean as an option for women and increasing the availability of continuing midwifery care models.

The ACT Government has also provided an additional $2 million in 2010–11 and $1.5 million in 2011–12 to enhance obstetric and gynaecological services and neonatal services.

Operations in ACT public hospitals

Over the past three years, the number of surgical operations performed at our public hospitals has jumped by 15 per cent, from 15,506 in 2007–08 to 17,905 (preliminary) reported for 2010–11. Around 30 per cent of the emergency and elective surgical operations are performed on people from New South Wales.

ACT Public Hospitals
Total Surgical Operations (Emergency and Elective)



*Preliminary
Source: Admitted patient care data set

A new Surgical Assessment Planning Unit was opened in December 2010. This unit is designed to streamline the admission process for non-critically ill surgical patients, allowing for increased throughput and rapid turnaround for short-stay surgical patients.

Access to elective surgery

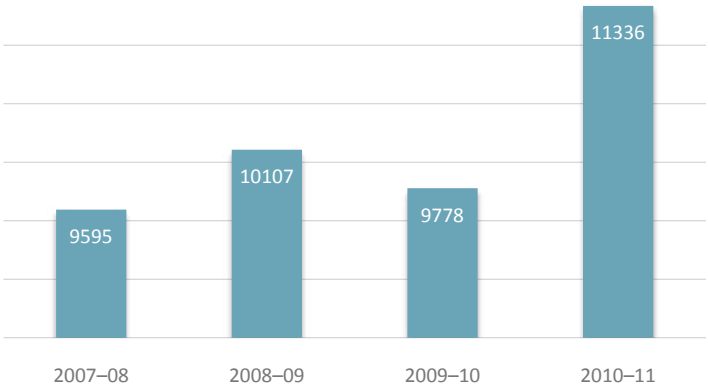
The number of people who had elective surgery at ACT public hospitals in 2010–11 (11,336) was 16 per cent above the 9778 reported for 2009–10. This result was made possible by more than $7 million extra being provided for elective surgery in 2010–11.

This additional activity, together with the Government's giving priority to people who had waited the longest for their surgery, has seen a decrease in the number of people waiting longer than one year from 831 people in June 2010 to 457 in 2011.

At 30 June 2011, there were 4267 people on the ACT public hospitals elective surgery waiting list. This was 19 per cent below the 5327 waiting at the same time the previous year.

Over the past four years there has been a 12 per cent decrease in the total number of people on the ACT elective surgery waiting list. At the same time, the number of people on the list who are waiting longer than the recommended waiting time has been reduced by 27 per cent.

ACT Public Hospitals
Elective surgery waiting list—Number of people removed from the list for surgery



Source: Elective surgery dataset

The ACT Government also reports surgeons' waiting times and operating sessions for the ACT's public hospitals. The Health Directorate's website provides information on average waiting times for elective surgery for either a particular doctor or a clinical speciality. It shows the number of operating sessions a doctor has at either of the two public hospitals in the ACT. This information can be found www.health.act.gov.au/waitinglists.

Median waiting time to surgery for ACT public hospitals

				Year to June
	2007–08	2008–09	2009–10	2010–11
Category 1	14 days	14 days	13 days	15 days
Category 2	98 days	101 days	106 days	103 days
Category 3	203 days	172 days	220 days	225 days
Total ACT	72 days	75 days	73 days	77 days

The ACT median waiting time for all elective surgery was 77 days at June 2011. This is higher than the national average and it resulted from the recent increases in elective surgery providing surgery for people who have waited longer than recommended waiting times.

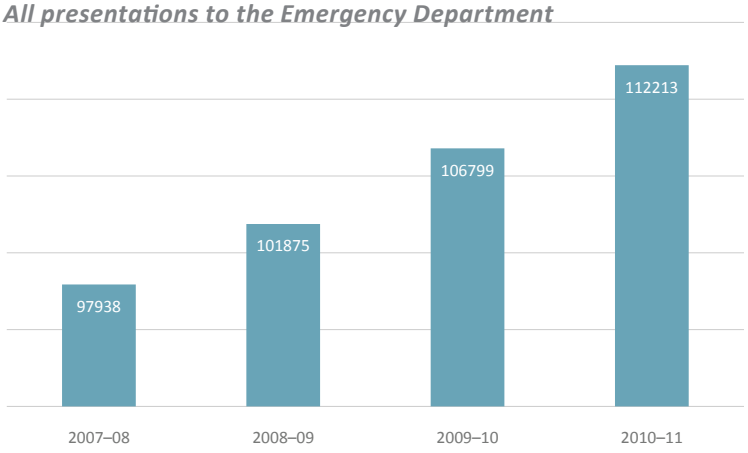
Additional information on the ACT elective surgery waiting list can be found in the ACT Public Health Services Quarterly Performance Report. This report can be found at http://health.act.gov.au/publications/reports/act-public-health-services-quarterly-performance-report.

Access to acute services

The proportion of patients who wait longer than eight hours between the start of treatment in an emergency department and their admission to a ward during 2010-11 was 26 per cent. This is a 3 per cent increase from the rate of 23 per cent reported in 2009-10. Although there has been a small increase in access block in 2010-11, the access block result has been improved over the last five years, falling from 40.7 per cent in 2004–05.

At the same time, emergency department presentations increased by 5 per cent in 2010–11 compared to the same period the previous year. There has been a 15 per cent increase in presentations to the emergency departments since 2007–08.

ACT Public Hospitals
All presentations to the Emergency Department



*Preliminary
Source: Emergency Department Information System

Waiting time for emergency treatment

Waiting times for category 1 and 5 patients either met or exceeded national standard waiting times during 2010–11. The below target results for category 2, 3 and 4 patients are related to continuing increases in demand for emergency department services in the ACT, with presentations up 5 per cent to the same period last year. Category 2 presentations (emergency) increased by 13 per cent in 2010–11.

Over recent years the Government has funded new initiatives to improve patient flow from the emergency departments to a more appropriate health setting, including providing three new Emergency Department physicians. Work is underway to look at how our emergency departments work and how the rest of the hospital can work to improve the way patients move through the emergency department as part of a hospital episode.

Triage category	2010–11 target	2010–11 result
One (resuscitation—seen immediately)	100%	100%
Two (emergency—seen within 10 mins)	80%	78%
Three (urgent—seen within 30 mins)	75%	48%
Four (semi-urgent—seen within 60 mins)	70%	48%
Five (non-urgent—seen within 120 mins)	70%	75%
All Presentations	70%	55%

Triage category	2008-09	2009-10	2010-11	% Var on 2009–10[1]
One (resuscitation seen immediately)	100%	100%	100%	0%
Two (emergency seen within 10 mins)	86%	83%	78%	5%
Three (urgent seen within 30 mins)	53%	57%	48%	9%
Four (semi-urgent seen within 60 mins)	53%	56%	48%	–8%
Five (non-urgent seen within 120 mins)	79%	77%	75%	–2%
Total Presentations	60%	62%	55%	7%

[1] Variances have been rounded to nearest percentage point.

There has been a 13 per cent increase in category 2 emergency department presentations. This is equal to 1248 additional people. At the same time, there has been an increase in low acuity patients, which is partly due to the lack of general practitioner services in the ACT, and the lowest bulk billing rates in Australia.

Australia's first Walk-in-Centre

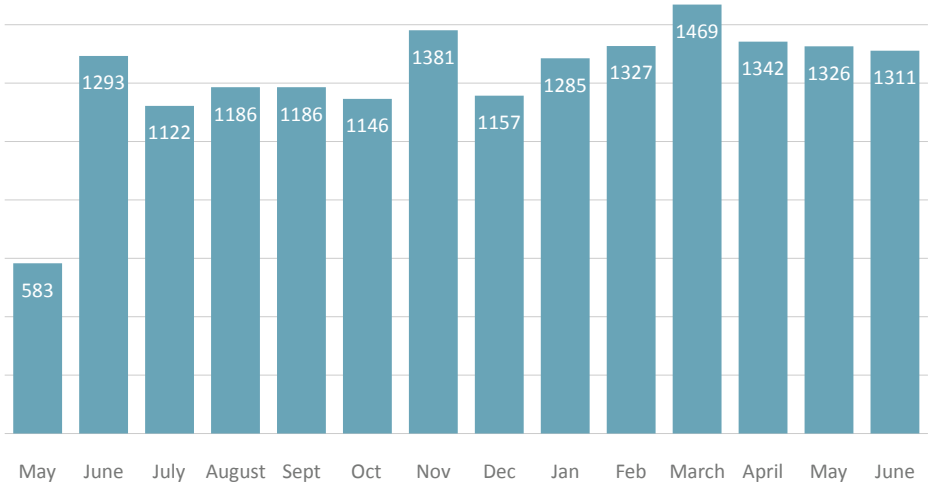
The Walk-in Centre, located on the campus of the Canberra Hospital at Garran, provides free treatment for people with minor illnesses or injuries. The Centre has been funded by the ACT and Commonwealth governments.

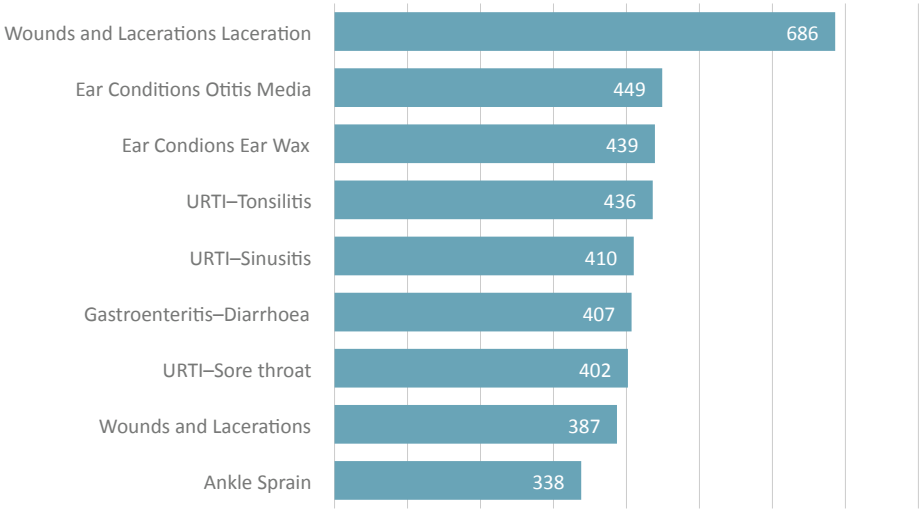
The Walk-in Centre is designed to help people get fast, free, one-off treatment for minor illnesses and injuries. The people of Canberra will be able to see a specialist nurse for advice, assessment and treatment for conditions such as cuts and bruises, minor infections, strains, sprains, skin complaints,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

Australia's first public, nurse-led Walk-in Centre was opened in May 2010 and has managed over 17,114 presentations to the end of June 2011.

Health Directorate

Walk-in-Centre—Total Presentations

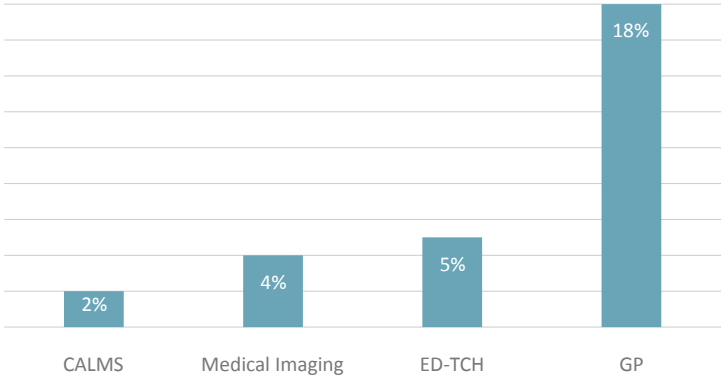




If necessary, people are redirected to more appropriate services, such as their general practitioner (GP) or the Emergency Department. To the end of 2010–11, of the 16,352 patients assessed by a nurse, 11,547 were treated by the nurse. Eighteen per cent of patients assessed were redirected to their GP and 5 per cent were told to present to the Canberra Hospital Emergency Department.

Walk-in-Centre

Patient redirection following assessment by nurse since commencing operation



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

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

The Walk-in Centre is a major new service for the people of the ACT and fulfils a commitment the Government made at the last election.

People in the community now have access to a wide range of primary health services, including their GPs, emergency departments, community health services, pharmacists and now the Walk-in Centre.

The Walk-in Centre was evaluated after its first 12 months of operation and feedback from the evaluation will inform the future directions of the centre.

National Partnership Agreement on Improving Public Hospital Services

The Commonwealth will deliver an additional $67 million to the ACT under the National Partnership Agreement on Improving Public Hospital Services for emergency department, elective surgery and sub-acute services.

This National Partnership Agreement is designed to drive improvements in how elective surgery, emergency department (ED), and sub-acute services are delivered. Central to the agreement are national elective surgery and ED targets.

A National Elective Surgery Target (NEST) will require 100 per cent of patients to be treated within clinically recommended time across all urgency categories by the year 2016.

Similarly, a National Emergency Access Target (NEAT) will be implemented, and will set a target of 90 per cent of all patients leaving the ED within four hours of presentation—whether by admission, transfer to another hospital, or discharge (rather than targets by urgency category), by 2015.

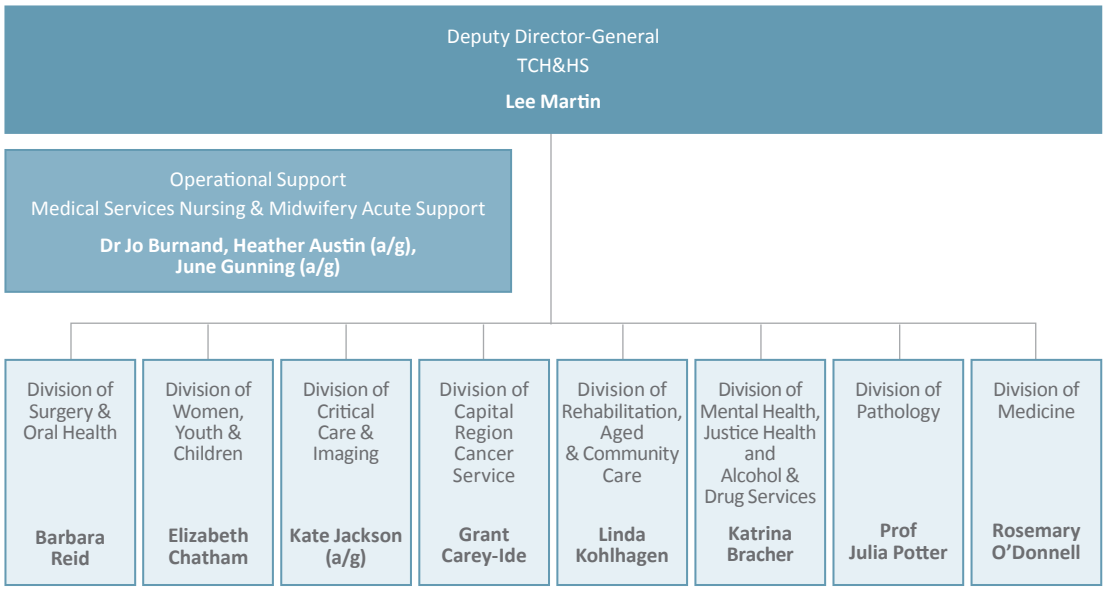
Both the NEST and NEAT targets will be gradually implemented between now and 2016. The ACT Health Directorate has already put in place programs designed to set a foundation upon which the NEST and NEAT targets can be achieved.

Canberra Hospital & Health Services

Introduction

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

TCH&HS consists of nine divisions: Surgery & Oral Health; Women, Youth & Children; Critical Care & Imaging; Capital Region Cancer Service; Rehabilitation, Aged & Community Care; Mental Health, Justice Health and Alcohol & Drug Services; Pathology; Medicine; and Operational Support.



A comprehensive range of services are delivered from the Canberra Hospital campus, including acute inpatient and day services, outpatient and pathology services. Community-based services include early childhood, youth and women's health; dental services, rehabilitation and community care; mental health and alcohol and drug services. In addition, justice health services are provided within the territory's detention facilities.

Strong links exist between hospital and community-based services, as many of the operational divisions deliver services across the continuum of care to ensure continuity of patient care.

TCH&HS liaises closely with Calvary Public Hospital to ensure effective coordination of services across the territory and delivery of required outputs. A number of TCH&HS's divisions provide services within Calvary Public Hospital facilities and many of the community-based services liaise closely to ensure a seamless service is provided.

The performance of TCH&HS is monitored at organisational and divisional level against accountability indicators and strategic objectives. These are outlined in the Corporate Plan 2010–12.

Achievements

- The Canberra Hospital elective surgery baseline target for 2010–11 was 5685 and an additional 162 procedures were funded under the National Health Reform Program, making a total target of 5847. Canberra Hospital exceeded this target by 272 cases, achieving a total of 6119 elective surgery cases for the year.
- The Canberra Hospital opened a purpose-built neurosurgery operating theatre in September 2010, in which complex neurosurgical procedures can be performed. The suite contains an intra-operative magnetic resonance imaging (MRI) machine, which can be transported into the operating theatre to perform an MRI while the patient is anaesthetised. The ability to perform intra-operative MRI significantly improves patient outcomes and reduces the rate of patients having to return to theatre for additional procedures. This is currently the only neurosurgical suite of its kind in Australia.
- The ACT Government allocated $4.5 million in the 2009–10 budget for the purchase and installation of a positron emission tomography/computerised tomography (PET/CT) scanner, which began operating in mid-November 2010. Many of the patients previously referred interstate for this service now have the option of using the PET service at Canberra Hospital.
- The ACT Breastfeeding Strategic Framework was launched in November 2010. Its aim is to increase the number of infants being exclusively breastfed from birth to six months, and to encourage ongoing breastfeeding with complementary foods until at least 12 months of age in line with National Health and Medical Research Council recommendations.
- The Emergency Department continued to meet the national target for triage category 1 and 5 patients.
- The 16-bed Surgical Assessment Planning Unit was commissioned in September 2010. The model of care focuses on facilitating rapid decision-making and access to definitive care for acute surgical patients. The unit has improved access for emergency surgical patients and reduced the time to emergency surgical intervention.
- The fourth linear accelerator bunker was completed in August 2010 in preparation for installation of the new accelerator.
- The Medical Oncology Ward 14B opened four new beds in February 2011, enabling greater access for patients requiring inpatient services.
- BreastScreen ACT & SE NSW has been working towards the transfer of responsibility for provision of screening and assessment of NSW women from BreastScreen ACT to the SE Murrumbidgee Local Health Network of NSW. This has involved the transfer of records and data and development of joint communication strategies. The target date for completion of 30 June 2011 was met.
- The establishment of the Cancer Outpatient Treatment clinic has facilitated early follow-up of patients in an outpatient setting. This has resulted in earlier discharge planning and has improved continuity of care.
- There has been a 40 per cent reduction in the time clients wait for non-urgent community-based occupational therapy assessment and intervention in 2010–11 in comparison to 2009–10. This has helped ACT residents stay safer in their homes.
- An additional four sub-acute care beds on the aged care Ward 11A at the Canberra Hospital became operational in January 2011, greatly aiding access to the aged care service.
- Another rehabilitation staff specialist position was appointed and commenced in March 2011. This has allowed the rehabilitation team to provide additional clinics, including a multidisciplinary spasticity clinic and spinal medicine clinic. The waiting time for new appointments in all clinics is now less than two weeks.
- Pathology works in close collaboration with many areas of the Health Directorate to provide access to timely results and facilitate decision-making, thereby helping them to achieve their outputs. There has been a 5 per cent increase in the number of pathology requests received for hospital patients.

- The Mental Health Community Policing Initiative was developed after a review of ACT Policing mental health practices and procedures in 2010. The initiative promotes and upholds key principles of the Fourth National Mental Health Plan—safety, least restrictive care, dignity, access and coordination between agencies. It also aligns with the national standards for mental health and relevant legislation. A pilot was commenced in April 2011 and the initiative was launched officially in June 2011.
- Mental Health Services adopted a 'no wrong door' philosophy to improve the responsiveness of its service to all people who make contact. The Mental Health Services Referral Response/ Screen Guidelines support clinicians in referring people to facilitate their access to optimal appropriate care. Mental Health Services provides care coordination and liaison to general practitioners and community agencies. General practitioners have timely access to consultant psychiatrists for consultation. Specific training has been provided to increase awareness of this expectation among clinical and administrative staff across all areas of the service.
- A new model of care for Diabetes Services in the ACT has progressed during 2010–11. Tertiary level services will be provided through a single multidisciplinary team including medical, nursing and allied health staff and at multiple sites in the ACT, bringing traditionally hospital-based services closer to people in community health centres. Infrastructure to support the new organisational structure and the enhancement and coordination of services is currently being developed. Strategies are also being developed to increase the primary care, health promotion and disease prevention support for people who are at high risk of developing type 2 diabetes.

Issues and analysis

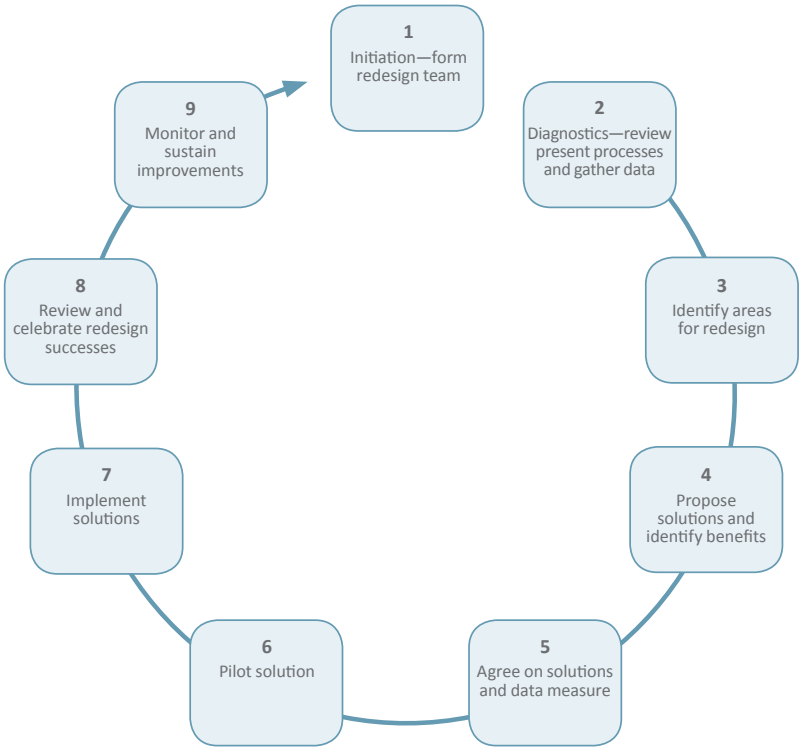
- 2010–11 presented a number of significant governance and operational changes for TCH&HS. The Health Directorate underwent a wide-ranging restructure, which included revised reporting lines and redevelopment of governance arrangements. This brought together the directorate's many clinical services, both acute and community-based, under one reporting structure. This restructure has allowed TCH&HS to improve service delivery across the continuum of care.
- TCH did not achieve the Commonwealth target of 95 per cent of category 1 patients receiving surgery in the required timeframe. The Surgery & Oral Health Division continues to take measures to improve this and continues to achieve targets set by the Commonwealth for category 2 and 3 patients.
- The Emergency Department did not reach the national target for category 2, 3 and 4 patients. The 5 per cent increase in presentations compounded year on year has contributed to the Emergency Department not meeting these targets. It is anticipated that work both within the Emergency Department and across the organisation as part of the National Health Reform will contribute to improving results against this indicator over the next 12 months.
- Mental health services nationally and internationally continue to face shortages of clinical staff. In the ACT, these shortages are mostly across the acute and community settings, with resultant impact on service delivery. Recruitment through the Mental Health Nursing Post Graduate Diploma in Mental Health Nursing scholarship program has shown a gradual improvement and has enhanced the partnership with the University of Canberra. This has also strengthened links to the undergraduate nursing program by identifying undergraduate nurses' interest in the mental health field.
- Mental Health Services has developed a local workforce strategy and a planning and development framework. Mental Health Services has five intern psychologist positions to promote attraction and retention of psychologists.

Future directions

- As a major provider of healthcare to patients of the ACT and the surrounding area, TCH&HS faces an exciting year. With a new structure that brings together all clinical divisions, a major redevelopment plan and innovations in e-health, the focus will be on embedding the new structure and strengthening the management and partnerships between management and medical and nursing staff.
- A redesign program will be implemented to support clinical staff in delivering quality care and improving access.

Redesign Cycle

This simple improvement process will assist front line staff to complete redesign activities and develop skills in theories that support improvement.



- Recruitment and retention plans will be improved through providing even more ways to support TCH&HS staff to deliver excellence in care and a new process for recruiting clinical staff to the Canberra region.
- The following National Safety and Quality Health Service standards will be implemented across all services within TCH&HS:

    1. ***Governance for Safety and Quality in Health Service Organisations*** (TCH&HS Executive Lead, Lee Martin)—provides the framework for health service organisations as they implement safe systems.

    2. ***Partnering for Consumer Engagement*** (TCH&HS Executive Lead, Katrina Bracher/Denise Lamb)—describes a consumer-centred health system by including consumers in the design and delivery of health care.

    3. ***Healthcare Associated Infection*** (TCH&HS Executive Lead, Rosemary O'Donnell)—describes the standard expected to prevent infection of patients with the healthcare system and to manage infections effectively when they occur, to minimise their consequences.

    4. ***Medication Safety*** (TCH&HS Executive Lead, Rosemary O'Donnell)—describes the standard expected to ensure clinicians prescribe, dispense and administer appropriate and safe medication to informed patients.

    5. ***Patient Identification and Procedure Matching*** (TCH&HS Executive Lead, Barbara Reid)—specifies the expected processes for identification of patients and correctly matching their identity with the correct treatment.

    6. ***Clinical Handover*** (TCH&HS Executive Lead, Dr Jo Burnand)—describes the requirement for effective clinical communication whenever accountability and responsibility for a patients' care is transferred.

    7. ***Blood and Blood-product Safety*** (TCH&HS Executive Lead, Professor Julia Potter)—sets the standard to ensure that the patients who receive blood and blood products are safe.

    8. ***Prevention and Management of Pressure Ulcers*** (TCH&HS Executive Lead, Heather Austin)—specifies the expected standard to prevent patients developing pressure ulcers and for best practice management when pressure ulcers occur.

    9. ***Recognising and Responding to Clinical Deterioration in Acute Health Care*** (TCH&HS Executive Lead, Heather Austin/Kate Jackson)—describes the systems required by health services responding to patients when their clinical condition deteriorates.

    10. ***Preventing Falls and Harm from Falls*** (TCH&HS Executive Lead, Linda Kohlhagen)—describes the standards for reducing the incidence of patient falls in health service organisations.

- The Canberra Hospital Foundation will be launched. The foundation will raise funds for services and research promoting the health and wellbeing of residents of the Australian Capital Territory and surrounding region.
- The new Women's and Children's Hospital and Adult Mental Health Unit will be commissioned and opened.
- Plans to improve TCH&HS campus entrances and waiting areas will be further developed and implemented.
- The Surgical Improvement Plan will be implemented to meet the demand for elective and emergency surgery while improving access to care for patients to reach National Access program targets.
- A new custom-built ophthalmology clinic is under construction and will open for business in 2011. The Ophthalmology Department's move to this facility, along with the commencement of a second retinal specialist in 2011, will increased its capacity for new patients with age-related macular degeneration.

- The new Women and Children's Hospital is making rapid progress. The construction will be in two stages. Stage 1 will involve an extension to the existing maternity building and is expected to be completed in March 2012. Stage 2 will involve a major refurbishment of the existing maternity building and is expected to be completed in early 2013. The new hospital will bring together a range of women and children's services that are currently dispersed across the Canberra Hospital. This will include the relocation of the Paediatric Unit and co-location on the Canberra Hospital campus of Maternity Services, the Neonatal Intensive Care Unit, Gynaecology, Fetal Medicine and specialised outpatient services/ambulatory care.
- The Commonwealth Government is providing a grant of $27.9 million from the Health and Hospital Fund for the ACT Capital Region Cancer Centre. This fund is set up to invest in high priority health infrastructure across the country. The ACT Government has provided additional funding of $15.4 million to enable the completion of the Capital Region Cancer Centre in early 2013. The ACT was successful in obtaining an additional grant of $1.8 million from the Commonwealth Government for cancer patient accommodation in its 2010–11 budget. The Capital Region Cancer Centre will be run by the Capital Region Cancer Service. The design process is nearing completion and work on the stage three model of care will commence in September 2011. The building will be a five-storey construction with a treatment floor, a consultation floor, clinical office space and resource areas for consumers. Education and meeting rooms will be provided for tumour-specific support groups. Final sketch plans are due to be signed off by the users groups in August 2011.
- The Capital Region Cancer Service will procure two new linear accelerators. The existing one will be replaced and another one acquired to further expand treatment capacity. The new linear accelerator will have stereotactic capability to treat brain cancers, increasing the range of services available for patients and reducing the need for patients to travel interstate for treatment. The additional accelerator will commence operation in early 2012.
- Additional funding in 2011–12 will mean that critical care capacity in the Intensive Care Unit and High Dependency Unit will increase by two beds.
- The Perinatal Mental Health Consultation Service provides specialist opinion and treatment planning for pregnant and postnatal women (up to 12 months postpartum) who present with diagnosed mental health disorders or the potential to require intensive support before and/or after the delivery of their child. Since its inception, service demand has increased considerably and the program currently has approximately 65 registered clients. A budget enhancement will allow for the implementation of a group program for women with high levels of emotional 'stress/distress' in the antenatal period. The group will be co-facilitated with the Child & Family Centre staff. The provision of an outreach mental health assessment service to the antenatal clinic at the Canberra Hospital will also be implemented as part of this project.
- A pilot project to include volunteers within the multidisciplinary team to provide practical and or emotional support to patients, families and their carers has been developed by the Canberra Hospital Emergency Department. The project has been developed by clinicians, consumers and volunteer managers from the Health Directorate. Volunteers will interact with our patients to complement and enhance the clinical support and care already provided to our patients. The volunteer model has been successfully introduced in emergency departments in other jurisdictions, with patients and their families reporting a high level of satisfaction. The pilot will commence in August 2011 and will operate seven days a week for three months, with shifts between the hours of 3pm and 6pm or 6pm and 9pm. Volunteers will work together, with two rostered on each of the shifts.

Division of Surgery & Oral Health

Introduction

The Division of Surgery & Oral Health is responsible for delivering inpatient and outpatient surgical services and prevention and treatment dental health programs for children and targeted youth and adults of the ACT community and surrounding region. The aim is to provide timely access to elective and emergency surgery, with a focus on quality patient-centred care, supported by evidence-based practice. The division includes the Surgical Bookings & Pre-admission Clinic, Anaesthesia & Pain Management, operating theatres, Post-anaesthetic Care Unit, Day Surgery Unit, Admissions/Extended Day Surgery Unit, various specialty surgical ward areas, Outpatient Department, Pain Management Unit, Shock Trauma Service, Trauma Orthopaedic Research Unit and the ACT Dental Health Program.

Achievements

- The Canberra Hospital elective surgery baseline target for 2010–11 was 5685 and an additional 162 procedures were funded under the National Health Reform Program, making a total target of 5847. Canberra Hospital exceeded this target by 272 cases, achieving a total of 6119 elective surgery cases for the year.
- The Canberra Hospital opened a purpose-built neurosurgery operating theatre in September 2010, in which complex neurosurgical procedures can be performed. The suite contains an intra-operative magnetic resonance imaging (MRI) machine, which can be transported into the operating theatre to perform an MRI while the patient is anaesthetised.
- The ability to perform intra-operative MRI significantly improves patient outcomes and reduces the rate of patients having to return to theatre for additional procedures. This is currently the only neurosurgical suite of its kind in Australia.
- The ACT Government allocated $4.5 million in the 2009–10 budget for the purchase and installation of a positron emission tomography/computerised tomography (PET/CT) scanner. The PET/CT scanner began operating in mid-November 2010. Many of the patients previously referred interstate for this service now have the option of using the PET service at Canberra Hospital.
- One hundred per cent of clients triaged as a dental emergency were seen within 24 hours.
- The mean waiting time target of twelve months for restorative dental treatment was achieved.
- The mean waiting time target of twelve months for clients on the dental services waiting list was achieved.
- In 2010–11, the dentist workforce skills shortage was addressed by the recruitment of dental officers to all vacant positions.
- The ACT Dental Health Program (DHP) won the 2010 ACT Quality in Healthcare Award in the Access and Efficiency category for Dental Care for the Homeless and Low Income clients in the ACT. This is a collaborative program with the Salvation Army, Communities at Work and a pro-bono dentist which entitles clients whom the Salvation Army considers to have no financial means to receive timely and affordable dental care. At June 2011, 58 clients were receiving treatment or had completed their course of care under this program—an achievement of 93 per cent above the target.
- Memorandums of understanding (MOUs) with two additional external agencies were agreed upon and implemented with the DHP during 2010–11, increasing to 13 the number of agreements for clients with special needs and medical conditions.
- Dentistry clinical training placements in the ACT have increased and further expansion is planned following the DHP's successful grant application through Health Workforce Australia for a Clinical Training Initiative to support the expansion of clinical training for health.
- A poster abstract was presented by the DHP at the Australian and New Zealand Association for Health Professional Educators Annual Conference in 2011 highlighting the achievements of the Health Directorate's first dental student placements in 2010, showcasing innovative approaches to student education.

Issues and analysis

- TCH did not achieve the Commonwealth target of 95 per cent of category 1 patients receiving surgery in the required timeframe. The division continues to take measures to improve this result and achieved targets set by the Commonwealth for category 2 and 3 patients.
- The recruitment to vacant dentist positions has made more appointments available and helped meet the target of a mean waiting time for treatment of 12 months.
- In 2011–12 the DHP will finalise honorary contracts for an additional four dentists who have agreed to work pro bono with the Salvation Army memorandum of understanding and the Dental Care for the Homeless and Low Income clients in the ACT program. This will further increase the number of clients who receive care from this initiative, improving the oral health of many vulnerable ACT residents.
- Winnunga Nimmityjah and Pilgrim House signed MOUs with the DHP, providing for improved access and waiting times for clients and exemptions of fees and charges for those referred by these external agencies for dental treatment.
- The Health Directorate's figures for decayed, missing or filled teeth index (DMFT) in 2010–11 1.54 at six years and 0.69 at twelve years. This is an improvement on the 2009–10 figures, which were 1.63 at six years and 0.81 at twelve years.

Future directions

- The Surgical Improvement Plan is being implemented with the aim of meeting the demand for elective and emergency surgery while improving access to care for patients, and thereby meet National Access Program targets.
- A new custom-built Ophthalmology Clinic is under construction, and will open for business in October 2011. The Ophthalmology Department's move to this facility, along with the commencement of a second retinal specialist in August 2011, will allow this service to be expanded for new patients with age-related macular degeneration.
- The DHP will participate in the National Child Dental Health Survey in collaboration with the Australian Research Centre for Population Health. The study will combine an oral and epidemiological examination and a social survey of dental service use, service mix received and other determinants of oral health.
- The DHP will actively contribute to the development of the models of care for the new community health centres.
- The number of pro bono dentists working through the Dental Care for the Homeless and Low Income Clients in the ACT program will be increased so that more clients can be treated.
- Dentistry clinical training placements in the ACT will be further expanded to increase the level of tertiary training in the profession.
- Models of oral health care will be reviewed and developed, with a focus on prevention. This will entail benchmarking with public dental services in other states and territories on the utilisation of the entire oral health professional team, and the commencement and evaluation of a trial of dental hygiene treatments.
- Consumer engagement, consultation and evaluation related to the delivery of dental services will be strengthened.

Division of Women, Youth & Children

Introduction

The Women, Youth & Children Division (WYC) provides a broad range of primary, secondary and tertiary health care services. The provision of services is based on a family-centred, multidisciplinary approach to care, in partnership with the consumer and other service providers. Services are provided at the Canberra Hospital, community health centres and in community-based settings, including clients' homes, schools and child and family centres. Some services are provided within other agency facilities.

The division's services comprise:

- maternity, including Midcall and the Canberra Midwifery Program
- women's health, including screening, gynaecology and programs dealing with violence against women
- neonatology, including the Neonatal Intensive Care Unit, Special Care Nursery, specialist clinics, newborn hearing screening and ACT Newborn Retrieval Service
- paediatric, including inpatient care, specialist clinics, community paediatricians and genetics
- maternal and child health, including a universal home visit following birth, support for breastfeeding and parenting, immunisation and referral
- services that support children and their families with complex care needs, such as
    - the Community Asthma Support Service
    - Caring for Kids Program (care in the home for children with complex needs)
    - Child at Risk Health Unit (care for children affected by violence and abuse)
    - IMPACT, which coordinates care for women with complex care needs who are pregnant and/or have young children
    - child protection training for clinicians
- school-based nursing services, including immunisation, kindergarten health checks, school youth health checks and special school nurses
- nurse audiometry, providing hearing assessments to children and adults.

Achievements

Budget priorities

The division was responsible for three key strategic priorities during 2010–11:

Output 1.3 Community Health Services

The key strategic priorities for community health include early intervention, improved access to community health care and better integration between acute, primary and community based care.

1. ***Accountability indicator h***—Percentage of Women's Health Service Intake Officer's clients who received an intake and assessment service within 14 working days of their initial referral. This measure provides an indication of the availability of services.

   Target—100 per cent.
   Achievement—100 per cent.

Output 1.7 Early Intervention and Prevention

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

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

   Target—30 per cent.
   Achievement—The Women's Health Service achieved 32 per cent of women from culturally and linguistically diverse communities accessing 'Well Women's Checks'.

3. ***(Accountability indicator 1.7 b***—Proportion of children aged 0– 4 who are entering substitute and kinship care within the ACT who attend the Child at Risk Health Unit for a health and wellbeing screen. ACT Health relies on referrals from the Community Services Directorate to provide these services.

   Target—80 per cent.
   Achievement—88 per cent. All referrals from Care and Protection were seen by the unit.

ACT Breastfeeding Strategic Framework

The ACT Breastfeeding Strategic Framework was launched on 10 November 2010. Its aim is to increase the number of infants being exclusively breastfed from birth to six months, and to encourage ongoing breastfeeding with complementary foods until at least 12 months of age in line with National Health and Medical Research Council recommendations. Research is underway to explore transitional Maternal and Child Health (MACH) services that protect, promote and support breastfeeding in the ACT. There has been substantial education of health professionals and extensive liaison throughout the ACT community, including government and non-government organisations.

Women's Health Service

The Women's Health Service (WHS) Review recommendations concerning the target groups and the model of care were endorsed by the Minister for Health in July 2010. An implementation plan was developed to outline short and longer term activities to enhance the Women's Health Service. Recruitment to key positions has been completed. A Women's Health Service Medical Officer commenced in April 2011 and a Nurse Practitioner with primary health care speciality commenced in February 2011. These positions work collaboratively in conjunction with the counselling and nursing team to provide comprehensive care to the priority population groups

School Youth Health Nurse Program

The School Youth Health Nurse Program aims to promote positive health outcomes for young people and their families through the delivery of accessible, acceptable, appropriate and culturally respectful primary health care services in the school setting. It also provides the opportunity for young people, their parents and members of the school community to access a health professional in the school setting. This can be for matters relating to health and well-being and can also include acting as a curriculum resource for staff. The program is coming to the end of its pilot phase and it is anticipated that an external evaluation will take place during 2011–12.

Maternal and Child Health nursing partnership with Canberra College

This partnership with Canberra College provides MACH services to pregnant young women and young parents who are continuing their education, allowing them to bring their child to this unique school setting. The partnership continues to develop, with more than 100 young parents using these services and an increased number of sessions provided.

Centre for Newborn Care—Neonatal Intensive Care Unit Webcam

In the 2008–09 Budget, ACT Health allocated $200,000 to develop and implement a video streaming service for parents of infants at the Centre for Newborn Care Neonatal Intensive Care Unit (NICU). The NICUCAM website provides general information on the services provided by the Centre for Newborn Care and can be accessed by the public. From this site parents can access the secure password-protected portal to view their own babies daily between 6.00am and 10.00am and between 6.00pm and 10.00pm, through a webcam installed above the baby's cot in the Centre for Newborn Care. Parents may provide the password and login to family members in Australia and overseas, which promotes bonding with the new baby.

Up to eight babies can be on the webcam site at the same time. The maximum so far has been six. The website has received over 20,000 hits and has been accessed from 17 countries as far afield as the United Kingdom, Canada, France, Italy, Hungary and India.

Review of ACT Public Maternity Services—April 2010

A review of service delivery and clinical outcomes at public maternity units in the Australian Capital Territory was undertaken by an expert panel and tabled in April 2010. The review found that, in terms of clinical outcomes, the Canberra Hospital is performing consistently with comparable hospitals in Australia and New Zealand. However a number of recommendations were made by the reviewers that will improve services and processes surrounding maternity services.

A committee was established from across all ACT Public Maternity Services to oversee the implementation of these recommendations. The Committee is chaired by Dr Peggy Brown and includes representatives from the Canberra Hospital, Calvary Health Care, and professional and consumer representatives. To date a number of these recommendations have been completed, and some remain in progress.

Paediatric and Adolescent Health Services

The implementation of a Paediatric Nurse-Led Ambulatory care service has seen improvements in reduced waiting times and staff and customer satisfaction. The service is led by experienced nurse clinicians with a broadened scope of practice. The initiative has enhanced the services ability to care for children and young people in a contemporary, timely, and effective manner.

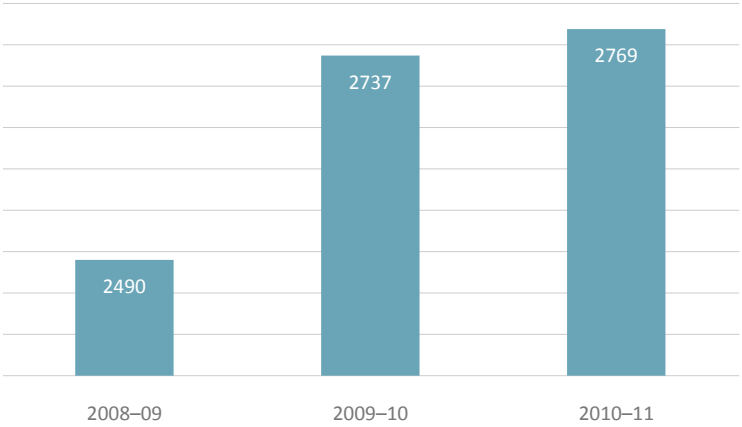
The review of the Paediatric and Adolescent Health services Ambulatory Care Service has seen a revision of the overall model of care, focusing on customer service and the patient journey. Consideration of workforce numbers, education and training, process review, and infrastructure has led to initial improvements in time-to-referral performance, ‘Did-not-attend’ rates and staff and customer satisfaction.

The implementation of a Paediatric Early Warning System for management of deteriorating patients and the installation of the Paediatric High-Dependency Unit cardiac monitoring system have led to improvements in safety and quality of care. These initiatives have allowed for improved identification of patients who demonstrate signs of rapid clinical deterioration and monitoring of cardiac conditions. This has resulted in an increase in the appropriate use of specialist services, such as the MET service and intervention by clinical staff when required. Overall, this has reduced the adverse outcome events for patients and resulted in greater levels of confidence in safety systems being expressed by members of the clinical teams.

The Australian Commission for Quality and Safety clinical handover practices have been implemented within Paediatric and Adolescent Services. This change in practice has led to enhanced communication between members of the multidisciplinary team, thereby complementing safety and quality of care.

Births

Births at the Canberra Hospital



In 2010–11, the number of births at the Canberra Hospital steadied, with only a slight increase from the prior year.

Future directions

Midwifery Caseload Program—

- ***Midwifery Caseload Program—***Canberra Hospital has expanded the opportunities for women to access continuing midwifery care through their pregnancy, birth and postnatal period. The caseload program will care for women of all risk levels who access their pregnancy care through the antenatal clinic and who plan to give birth in the Delivery Suite. It will complement the existing Canberra Midwifery Program, which caters for women of low risk who are planning a low intervention birth in a birth centre. A pilot program is proposed to trial the new model during the later part of 2011, with the initial establishment of two teams. Approximately 280 women currently accessing maternity services at the Canberra Hospital will be drawn from all stages of pregnancy. This will reduce the load on all areas of the service.
- ***New Women's & Children's Hospital—***The new Women's and Children's Hospital is making rapid progress. Leighton Constructions Pty Limited was engaged as the Construction Project Manager and construction commenced mid-July 2010. The project is scheduled for completion in 2012. The construction will be in two stages. Stage 1 involves an extension to the existing Maternity building and is expected to be completed in early 2012. Stage 2 involves a major refurbishment of the existing Maternity building and is expected to be completed in early 2013.

  The new hospital will bring together a range of women and children's services that are currently dispersed across the Canberra Hospital. It will entail the relocation of the Paediatric Unit and co-location of Maternity Services, Neonatal Intensive Care Unit (NICU) Gynaecology, Fetal Medicine and specialised outpatient services/ambulatory care on the Canberra Hospital campus.

  The new hospital will provide 146 inpatient beds, an increase of 35 on the number currently available at the Canberra Hospital. This includes an additional six delivery suites. The Canberra Birth Centre will continue to be a key feature of the new hospital, and Birth Centre birthing rooms will increase from three to five. There will also be a family accommodation service. It will be a family-focused and friendly environment with a 12-bed family accommodation unit for parents. There will also be a family resource centre in the building and family space on each floor. A playground and café have also been included.

Consultation with the community about the new hospital is ongoing. One example of a successful consumer consultation forum is the NICU Redevelopment Parent Discussion Forum. The Department of Neonatology User Group wished to encourage participation from other groups in the community such as young mothers and fathers and people living outside Canberra.

A web-based discussion forum has been developed to encourage these groups to participate in the planning decision. This is a secure site and members are required to register to be provided with a log-in and password. This is a unique opportunity for the Centre for Newborn Care to involve consumers in important decisions regarding the new hospital.

- ***Increased demand for obstetrics and gynaecology services at the Canberra Hospital—*** This initiative provides capacity to meet increased service demand in obstetrics and gynaecology services at the Canberra Hospital. It also provides for additional medical and nursing resources to adequately manage the increasing level of demand for these services. Additional resources have been recruited under the program, including more visiting medical officer sessions, an additional registrar, recruitment of midwives, more staff specialists, increased administrative support, and additional allied health support.
- ***Service agreement with Sydney Children's Hospital Network—***A service agreement between the ACT Health Directorate and the Sydney Children's Hospital Network to provide specialist paediatric services to the ACT Health Directorate is currently being negotiated. Specialist medical officers from the Sydney Children's Hospital Network will conduct clinics at the Canberra Hospital on a regular basis.

Division of Critical Care & Imaging

Introduction

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

Achievements

- The Emergency Department continues to meet or exceed the national target for category 1 and 5 patients.
- The 16-bed Surgical Assessment Planning Unit (SAPU) was commissioned in September 2010. The model of care focuses on facilitating rapid decision making and access to definitive care for acute surgical patients. The SAPU has improved access for emergency surgical patients and reduced the time to emergency surgical intervention.
- In March 2011, Canberra Hospital & Health Services implemented a dedicated Medical Emergency Team (MET) service. The MET service provides specialised assistance to patients that clinical staff identify as having rapidly deteriorating clinical symptoms. Previously, the MET service was offered on the basis of staff in specialist areas having to respond as part of other duties. With more MET requests in 2010–11 than in previous years, this dedicated team both responds to MET calls and provides an outreach critical care review in the ward setting. This provides early intervention and improved management of unwell patients outside the Intensive Care Unit (ICU).
- Meta-vision was implemented in the Intensive Care Unit. The system enables a secure and fully integrated solution for the electronic management of a patient's clinical record during their stay in the ICU. This entails the creation, editing and management of electronic clinical documents such as flowcharts, progress notes, medication management and various other clinical observation charts.

This system:

1. improves clinical outcomes through timely access to the whole spectrum of available ICU patient data
2. improves ICU management reporting, through accurate and timely reporting
3. reduces the length of stay in the ICU and improve clinical outcomes through the early management of clinical emergencies and timely documentation and discharge preparedness
4. improves clinical outcomes for critically ill patients by eliminating repetitive documentation for the bedside nurse.

Issues and analysis

- The Emergency Department did not reach the national target for category 2, 3 and 4 patients. The 5 per cent increase in presentations compounded year on year has contributed to the Emergency Department's not meeting this target. It is anticipated that work both within the Emergency Department and across the organisation as part of the National Health Reform will improve performance against this indicator over the next 12 months.
- The $3.4 million Meta-vision project was implemented as part of the ACT Government's commitment to improve patient safety through e-health projects.

Future directions

- The division will implement the Emergency Care redesign project to improve patient access to emergency care in line with the national health and hospital reform.
- As part of the National Health Reform, the Council of Australian Governments (COAG) has applied a national access target for emergency department patients to be admitted, discharged or transferred from the emergency department within four hours of presentation. The aim is to improve the timeliness of treatment in emergency departments as well as improving access to care. The Canberra Hospital Emergency Department has commenced process redesign work to help meet the COAG target.
- The division will further develop models of care between the Emergency Department and Diversion Services to enhance their ability to provide inpatient services within four hours of presenting to the Emergency Department.
- With additional funding in 2011–12, critical care capacity within the Intensive Care Unit and High Dependency Unit will increase by two beds.
- The Canberra Hospital Emergency Department had developed a pilot project to include volunteers within the multidisciplinary team to provide practical and/or emotional support to patients, families and their carers. The project has been developed by clinicians, consumers and ACT Health volunteer managers. Volunteers will interact with patients to complement and enhance the clinical support and care provided. The volunteer model has been successfully introduced in emergency departments in other jurisdictions, with patients and their families reporting a high level of satisfaction. The pilot will commence in August 2011 and will operate seven days a week for three months with shifts between 3pm and 6pm or 6pm and 9pm. Volunteers will work together, with two rostered on each of the shifts.
- The division will implement an emergency care communication campaign to 'Keep emergency for emergency patients' to assist in directing patients to the most appropriate care for their needs.

Division of Capital Region Cancer Service

Introduction

The Capital Region Cancer Service (CRCS) Division is responsible for the provision of oncology, clinical haematology, BreastScreen and immunology services to the ACT and surrounding region. Services are offered as screening, inpatient and outpatient services and community-based psycho-social support services. The division also manages and coordinates clinical outpatient administrative support, health centre administration, Community Health Intake and transcription services.

The clinical services of CRCS integrate existing cancer services across the ACT and surrounding region, to ensure a continuum of care for consumers ranging from prevention and screening through to diagnosis, treatment, rehabilitation and palliative care. Services are provided on an area-wide basis and delivered at a number of locations, including hospital and community settings and the patient's home.

Achievements

- The fourth linear accelerator bunker was completed in August 2010 in preparation for installation of the new accelerator.
- The Division of Capital Region Cancer Service provided care for 1229 new radiotherapy patients in 2010–11. This is a 2.5 per cent increase on the 1199 patients who began radiotherapy services in the same period the previous year.

Percentage of radiotherapy patients who commence treatment within standard time frames

	Year-to-June			
	2007–08	2008–09	2009–10	2010–11
Urgent—within 48 hours	100%	100%	98%	100%
Semi Urgent—within 28 days	83%	90%	93%	100%
Non Urgent Category A—within 28 days	65%	67%	75%	99.5%
Non Urgent Category B—within 42 days	59%	68%	86%	100%
Total—All Radiotherapy Patients	73%	78%	84%	99.8%

Despite the increase in demand for services, waiting times for radiotherapy services improved, with nearly 100 per cent of all patients receiving care within standard timeframes in 2010–11, compared with 84 per cent for the same period in 2009–10, and 78 per cent the previous year.

- A new Prostate High Dose Rate Brachytherapy program started treating patients in August 2010, allowing the provision of a highly focused treatment option to a specific group of prostate cancer patients.
- The Medical Oncology Ward 14B opened four new beds in February 2011, enabling greater access for patients requiring inpatient services.
- The CRCS Immunology Department established a dedicated allergy clinic.
- BreastScreen ACT & SE NSW has been working towards the transfer of responsibility for provision of screening and assessment of NSW women from BreastScreen ACT to the SE Murrumbidgee Local Health Network of NSW. This has involved the transfer of records and data and development of joint communication strategies. The target date for completion of 30 June 2011 was met.
- The Haematology Clinical Trials Unit has continued to increase its participation in national and international studies, including several trials investigating new therapies.

- The establishment of the Cancer Outpatient Treatment Clinic has facilitated the process of early follow-up of patients in an outpatient setting. This has resulted in earlier discharge planning and has improved continuity of care.
- The appointment of a senior nurse as leader and coordinator in Clinical Haematology will facilitate improved patient care. This will enable a dedicated group of nurses to work closely with the haematology consultants and registrars in the management of a broad spectrum of haematology patients.
- Members of the clinical haematology unit have continued to publish in peer-reviewed journals and have produced poster presentations, which were presented at the Haematology Society of Australia and New Zealand Annual General Meeting in October 2010.
- The CRCS Head and Neck Nurse Care Coordinator was awarded a fellowship award from the Winston Churchill Memorial Trust for her research in the field of cancer.
- CRCS introduced a new model of care for the delivery of outreach services in February 2011. This has enabled greater access for patients requiring cancer services in the community.
- CRCS secured funding from the Commonwealth for the Cancer Network (CanNET) project for the period from July 2010 to June 2012. The project has commenced and it aims to strengthen the quality and coordination of cancer care in the ACT region and improve access to best practice multidisciplinary care.
- As part of the federal Youth Cancer Networks Program, CRCS has obtained Commonwealth funding to participate in the Adolescents and Young Adults with Cancer project. The project aims to develop clinical expertise in relation to this age group, with a focus on multidisciplinary and coordinated care, centralised resource development and clinical trial capacity to improve patient outcomes.
- The Palliative Care Nurse practitioner is a newly established position with a focus on preventing unnecessary admissions to the Canberra Hospital. The Nurse Practitioner covers Emergency and all outpatient areas.

Issues and analysis

The increased demand for service has continued to challenge CRCS to provide timely access and quality care to all clients.

The development of the new Cancer Information System continues to be a complex process, with challenges in the areas of technical development, resourcing and change management. The project team continues to work with the new system supplier and clinicians to align the technology with clinical requirements.

The CRCS continues to find the recruitment and retention of staff across all disciplines a challenge. This reflects national workforce shortages. The division is working with professional bodies and Human Resources Branch on strategies to develop a sustainable workforce.

Future directions

Capital Region Cancer Centre

The Commonwealth Government is supporting the ACT with a grant of $27.9 million from the Health and Hospital Fund for the ACT Capital Region Cancer Centre. This fund is set up to invest in high-priority health infrastructure across the country. The ACT Government has provided additional funding of $15.4 million to enable the completion of the Capital Region Cancer Centre in early 2013. The ACT was successful in obtaining an additional grant of $1.8 million dollars from the Commonwealth Government for cancer patient accommodation in the 2010–11 budget.

The Capital Region Cancer Centre will be run by the Capital Region Cancer Service and will be built around the recently expanded and refurbished Radiation Oncology Department at the Canberra Hospital. The centre will provide:

- dedicated cancer centre facilities and patient information services
- co-located outpatient services providing formal multidisciplinary clinics, allowing patients to have their treatment program planned in one visit
- radiation oncology
- coordinated care through multidisciplinary team meetings, which will include surgical services
- clinical offices
- services for inpatients across the Canberra Hospital campus
- teaching and research facilities, and
- a service delivery hub for rural and regional outreach and locally delivered cancer support services.

The design process is nearing completion and work on the stage three model of care will commence in September 2011. The building is a five-storey construction providing a treatment floor, consultation floor, clinical office space and resource areas for consumers. Education and meeting rooms will be provided for tumour-specific support groups. Final sketch plans are due to be signed off by the users groups in August 2011.

- The Haematology Unit continues to attract high-calibre advanced trainees in haematology, two of whom are undertaking postgraduate examinations in 2011. One of the registrars has been accepted for ongoing training as a Fellow in Haematology at the Vancouver General Hospital in Canada in 2012.
- The recruitment process for an Academic Head of Clinical Haematology to provide leadership in research and undergraduate teaching is underway. This appointment is expected to enhance research within the department, with the aim of creating a centre of excellence in haematology in the ACT.
- CRCS will procure two new linear accelerators at a cost of approximately $6.4 million. This provides for replacement of one linear accelerator and purchase of a new one to further expand treatment capacity. The new linear accelerator will have stereotactic capability to treat brain cancers, increasing the range of services available for patients and reducing the need for patients to travel interstate for treatment. The new accelerator will commence operation in early 2012.
- A new CT simulator has been procured and recurrent budget approved for a further five radiation therapists (RTs), a further 2.5 full-time equivalent positions for RTs in 2012–13, and an additional radiation oncologist to support the department's becoming a four-linear accelerator facility.
- The electronic Cancer Information Management System (CIMS) is expected to be delivered in two phases during 2011–12. The first phase of implementation will include the departments of Medical Oncology, Haematology and Immunology, with implementation expected in late 2011. The second phase is planned to implement the CIMS within Radiation Oncology by early 2012, subject to the development of system software by the vendor.
- BreastScreen ACT will launch as a new service from July 2011 after 18 years as a combined ACT and south-east NSW service. This change in scope occurred following the transfer of south-east NSW screening services to the Greater Southern Area Health Service. BreastScreen ACT provides state-of-the-art digital screening services to women in the ACT and it is hoped that this change in scope will see an increase in participation of ACT women in the target age group.

Division of Rehabilitation, Aged & Community Care

Introduction

The Rehabilitation, Aged & Community Care (RACC) Division integrates the public health system rehabilitation, aged, community and primary care services across the ACT. The division aims to improve the quality and accessibility of services to clients. RACC promotes a continuum of care ranging across prevention, assessment, diagnosis, treatment, support, rehabilitation and maintenance.

RACC adopts a sector-wide approach to client-centred care. To this end, RACC works closely with others to improve the communication between primary, acute, sub-acute and community healthcare, as well as fostering professional development and promoting best practice in rehabilitation, aged and community care.

RACC services are delivered across a broad range of locations throughout the ACT, including hospital, community health centres and patients' homes. They include health care and support for people with acute, post-acute, long-term and terminal illnesses, at community health centres and dementia-specific day care.

Services include:

- hospital-based inpatient and outpatient geriatric and rehabilitation medicine services, including ortho-geriatrics, at both the Canberra Hospital and Calvary Public Hospital and outpatient geriatric medicine and rehabilitation medicine services to regional New South Wales
- the Rapid Assessment of the Deteriorating and At-Risk Aged (RADAR) Service provides service to older people in their own homes, including to residents of aged care facilities upon referral from a general practitioner
- aged care client assessment services, residential aged care liaison and the Partners in Culturally Appropriate Care Program
- Community nursing and allied health services, such as podiatry, social work, nutrition and weight management, physiotherapy, continence services, occupational therapy and training in self-management of chronic conditions
- the Transitional Therapy and Care Program, supporting clients in the post-hospital discharge period, either in a residential setting or in their own homes
- the falls injury prevention service, including falls assessment clinics, the 'Stepping on' program and health promotion activities
- transitional rehabilitation at the Rehabilitation Independent Living Unit
- multidisciplinary community-based rehabilitation services
- services provided by exercise physiologists, including programs for gym rehabilitation, cardiac rehabilitation and hydrotherapy
- vocational assessment and rehabilitation and driver assessment and rehabilitation services
- equipment loan, supply and support services, including ACT Equipment Subsidy Scheme, Equipment Loan Service, Domiciliary Oxygen & Respiratory Support Scheme, ACT Continence Support Service, Clinical Technology Services and Specialised Wheelchair and Posture Seating service
- prosthetics and orthotics services
- information and advice on assistive technologies by the Independent Living Centre.

Achievements

- In Community Care, Community Nursing experienced and met an increase in demand in 2010–11 for providing services to clients in the community through home visits or health centre appointments.
- Community Care Program Allied Health Services exceeded its target for providing services to clients in the community through home visits or health centre appointments.

- There has been a focus on supporting clients to 'self-manage' their chronic conditions in the community. In 2010–11, 108 participants completed the Living a Healthy Life with Long-Term Conditions program.
- The Community Care Program has delivered weekly community-based physiotherapy group sessions in post-operative knee replacement across two sites.
- In 2010–11 Community Nursing established a pre-prostatectomy group education initiative. Evaluation shows that this education has resulted in all clients being seen in a timely manner and that client feedback has been positive.
- Community Nursing implemented a weekend Ambulatory Clinic in 2010, which has improved access to services for southside residents. This clinic complements the weekend clinic operating in the north of Canberra.
- In 2010–11 there was a 40 per cent reduction in the time clients wait for non-urgent occupational therapy assessment and intervention compared to 2009–10. The significant reduction in waiting times for services has assisted ACT residents staying safer in their homes.
- Under a Commonwealth-funded project—the Healthy Communities Initiative—two programs were delivered in 2010–2011 by Community Care. Mini Health checks were conducted by allied health and nursing staff across four sites, targeting disadvantaged persons. Forty-three people attended the checks and 42 of them received influenza vaccinations. The nutrition service ran an Adult Healthy Weight Program across multiple sites and 115 people attended the courses.
- An additional four sub-acute care beds on ward 11A at the Canberra Hospital became operational in January 2011, greatly aiding access to the aged care service.
- Falls injury prevention services were provided to 486 people in 2010–11. This is an increase of 19 per cent on the 2009–10 result.
- Another Rehabilitation Staff Specialist was appointed and commenced in March 2011. This has allowed the rehabilitation team to provide additional clinics, including a multidisciplinary spasticity clinic and spinal medicine clinic. The waiting time for new appointments in all clinics is now less than two weeks.
- RACC Canberra Hospital-based rehabilitation services achieved better than the Australian Rehabilitation Outcomes Centre benchmarks for:
    - discharge of post-stroke patients back to a private residence (8 per cent higher than the benchmark)
    - discharge of amputee patients back to a private residence (9 per cent higher than the benchmark)
    - average length of stay for patients requiring rehabilitation after a spinal cord injury (36.3 days against a benchmark of 69.0 days)
    - average length of stay for patients requiring rehabilitation after multi-trauma (36.5 days against a benchmark of 45.6 days)
- RACC's learning, research and development activities in 2010–11 included:
    - providing student placements for nursing, medical and allied health staff from educational tertiary institutions, including the Canberra Institute of Technology, the University of Canberra, ANU, Charles Sturt University, University of Sydney, Australian Catholic University and Canberra Institute of Technology
    - presenting at local, national and international conferences. Staff received an award for a poster presentation at the 2011 ASM of the Canadian Geriatrics Society in Toronto
    - the Department of Geriatric Medicine obtaining a research grant from the TCH Private Practice Fund to investigate the effect of vitamin D supplementation in residents of aged care facilities in the ACT
    - a physiotherapy educator authoring an article titled 'Video Peer Review Project' which was accepted for publication in the Australian and New Zealand Association for Health Professional Educators journal. This was also presented at the 2010 ANZAPHE conference.
    - RACC Physiotherapy staff participating in a multi-centre trial for Parkinson's disease research.

- A number of RACC Allied Health staff commenced participation in the Allied Health Assistant Traineeship Program, whereby a trainee is employed to undertake the Certificate IV training at Canberra Institute of Technology to become an allied health assistant. The staff attending are from various teams, such as the Independent Living Unit, Community Rehabilitation Team and Speech Pathology.
- Projects undertaken at the Rehabilitation Independent Living Unit (RILU) resulted in significant improvements being made to its physical presentation. These included purchase of new beds, mattresses and bedside lockers, new floor coverings and repairs and maintenance to bathrooms.
- ACT Health Australia Day team awards were presented to both the Clinical Technology Services Manager of Client Support Services and Community Rehabilitation Team for demonstrating significant innovations that improved access and clinical outcomes for clients.
- RACC Allied Health staff, in conjunction with University of Canberra students, were winners in the ACT Quality in Healthcare Awards student category, for their therapeutic use of a Nintendo Wii project.
- RACC Allied Health staff were finalists in the ACT Quality in Healthcare Awards for:
    - the establishment of multidisciplinary Parkinson's Disease Groups in the Community Rehabilitation Team
    - the development and implementation of multidisciplinary team assessment clinics in community rehabilitation teams
    - the Evidence-Based Practice Education Project for physiotherapists, and
    - development of a peer review program for physiotherapy.
- RACC Allied Health staff were winners of two ACT Health Better Practice Awards for an Evidence Based Practice Education Project in physiotherapy and the establishment of a Dysphagia Clinic in speech pathology.
- The custom-designed Village Creek Centre was established in November 2010 to accommodate a range of community-based services. This included the relocation of the Equipment Loan Service (ELS) from the Canberra Hospital to the Village Creek Centre in Kambah.
  The relocation has provided the ability to increase the range of equipment items to better meet client needs. The service has also commenced weekend operation.
- The ACT Equipment Scheme introduced a new policy in August 2010, which included implementation of recommendations related to increasing access and equity and included fully funding all equipment provided (the previous scheme was a subsidy scheme and only partly funded equipment), making all children under 16 years eligible regardless of parental income, and increasing the equipment and some allocations provided through the scheme. In 2009–10 the ACT Equipment Subsidy Scheme provided subsidised funding to 60 high-cost (over $2000) applications. In 2010–11, the ACT Equipment Scheme fulfilled 107 high-cost applications.
- The ACT Continence Scheme provides full funding of continence products to eligible clients and established a home delivery service of these in April 2011.
- The Walk-in Centre (WIC) at the Canberra Hospital experienced consistent and growing use across the reporting year. Between May 2010 and the end of June 2011, it managed more than 17,114 presentations. If necessary, people are redirected to more appropriate services, such as their general practitioner (GP) or the Emergency Department. Of the 16,352 patients assessed by a nurse over this period, 11,547 were treated by the nurse. Eighteen per cent of patients assessed were redirected to their GP and 5 per cent were told to present to the Canberra Hospital Emergency Department. The Walk-in Centre has received an exceptional amount of positive consumer feedback on the service it provides and the WIC's Nurse Practitioner received the ACT Nursing and Midwifery Award for Clinical Excellence 2011.
- RACC successfully changed its hospital-based administration model to a centralised administration, improving its ability to organise staff and provide better support across the range of services and sites.
- The Acute Care of the Elderly Ward (11A) continues to develop a volunteer program designed to enhance the lived experience of patients admitted to it. Trained volunteers have been successful in helping patients maintain their sense of quality of life.

Issues and analysis

- The commencement of the allied health assistant trainee at the Independent Living Centre has led to some changes in staff roles, particularly in regard to display management and health promotion. As this role is still developing, there are expected to be further changes to help streamline the service and allow clinicians more time for complex clients and appointments.
- The Health Workforce Australia Workforce Innovation and Reform project 'Caring for Older People Program' was undertaken to develop and test a workforce solution to ensure the safe, effective and sustained transition of older adults from an acute setting to the community. The final report, with recommendations, is due in August 2011.
- Expansion of the Transitional Therapy and Care Program (TTCP) with nine new community places increased total availability (residential and community) to 49 places. The TTCP Access Project commenced to improve entry into the service. Recommendations will be implemented in 2011–12.
- Pressures arising from professional allied health vacancies remain a barrier to fully implementing proposed best-practice models. Strategies to recruit and retain staff, as well as provide innovative models of care, continue to be developed. Geriatric Medicine also experienced significant workforce shortages in 2010–11.

Future directions

- The Community Care Program's Community Nursing service will be commencing a new stomal-therapy clinic operating from the Belconnen Health Centre, in an expansion of services for this client group.
- The Community Care Program's nutrition service will begin a Healthy Eating and Lifestyle Program in 2011 that will combine diet and exercise. It is envisaged that four courses will be conducted over 2011 and 2012.
- Geriatric Medicine outpatient services will be reviewed, particularly with a view to providing specialty clinics for falls and memory disorders. This will complement the development and implementation of a specialised community-based multidisciplinary geriatric clinic that focuses on assessment and intervention for clients with neuro-degenerative diseases such as dementia. The Acute Care of the Elderly Ward (11A) will participate in the Clinical Audit program through the Research Centre for Nursing and Midwifery Practice. As the research centre is now an approved affiliate of the Johanna Briggs Institute at the University of Adelaide, it is also recognised as the Australian Capital Regional Centre for Evidence Based Nursing and Midwifery Research.
- The division will implement the recommendations of the HWA project on using allied health assistants to support vulnerable older adults in the discharge processes from acute settings to their home in the community.
- The Transitional Therapy and Care Program (TTCP) will continue to expand, having increased its community places by nine.
- Community-based rehabilitation services will be expanded through the establishment of specialised clinics. The Driver Assessment and Rehabilitation service will also be expanded.
- RACC will participate in the formal evaluation of the Speech Pathology Allied Health Assistant Trainee program, in partnership with the Office of the Allied Health Advisor and an academic consortium.

Division of Mental Health, Justice Health and Drug & Alcohol Services

Introduction

The Mental Health, Justice Health and Alcohol & Drug Services Division provides health services directly and through partnerships with community organisations. The services provided range from prevention and treatment to recovery and maintenance. Consumer and carer participation is encouraged in all aspects of service planning and delivery. The division works in partnership with consumers, carers and a range of government and non-government service providers to ensure the best possible outcomes for clients.

The division delivers services at a number of locations and in varied environments, including hospital inpatient and outpatient settings, community health centres, detention centres, other community settings and the consumer's home. These services include:

Mental Health

- Child & Adolescent Mental Health Services
- Mental Health Rehabilitation & Speciality Services
- Access and acute Mental Health
- Mental Health & sector development
- Academic Unit of Psychological Medicine

Justice Health

- Alexander Maconochie Centre
- Bimberi Centre
- Symonston Periodic Detention Centre
- ACT Court Cells

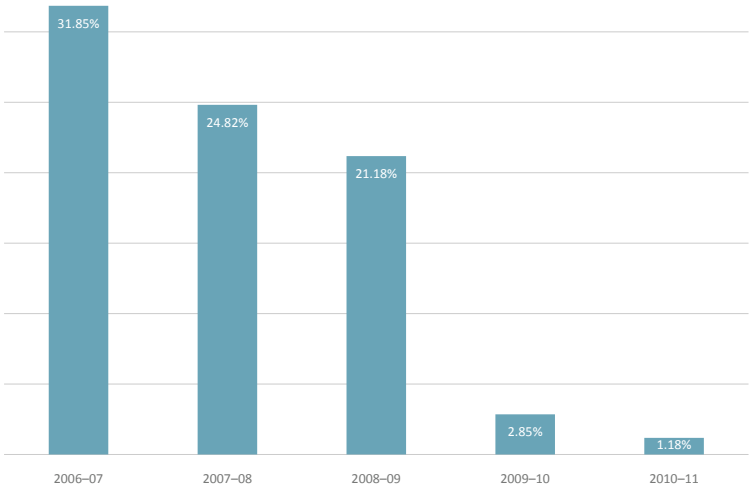
Alcohol & Drug Services

- Medical Services
- Consultation, Liaison, Co-Morbidity & Impact Team
- Opioid Treatment Service
- Withdrawal Service
- Counselling Treatment Service
- Diversion Service

Achievements

- Mental Health Services adopted a 'no wrong door' philosophy to improve the responsiveness of its service to all people who make contact with the service. The Mental Health Services Referral Response/Screen Guidelines support clinicians in their referral of people to facilitate their access to optimal appropriate care. Mental Health Services provides care coordination and liaison to general practitioners and community agencies. General practitioners have timely access to consultant psychiatrists for consultation. Specific training has been provided to increase awareness of this expectation among clinical and administrative staff across all areas of the service.
- Mental Health participated in the National Mental Health Seclusion and Restraint Project in 2009. Mental Health Services continues to monitor and review all episodes of seclusion and restraint. A further development has been the introduction of the Early Support and Intervention Team in the Psychiatric Services Unit. This initiative was introduced in partnership with Ward Services to reduce aggression and consumer distress. A training package has been developed collaboratively with Ward Services that focuses on engagement and de-escalation. A second development in the reporting year was the first formal mental health consumer-led research into the seclusion and restraint project and its effects on staff, consumers and carers.

Use of seclusion in Mental Health—Health Directorate
(seclusion Episodes as % of Admission Episodes)



- The Mental Health Community Policing Initiative was developed after a review of ACT Policing mental health practices and procedures in 2010. The initiative promotes and upholds key principles of the Fourth National Mental Health Plan—safety, least restrictive care, dignity, access and coordination between agencies. It also aligns with the national standards for mental health and relevant legislation. A pilot was commenced in April 2011, with an official launch in June 2011.The three main components of the initiative are:
    1. Two clinicians are embedded within the Police Operations Centre, from Thursday through to Sunday. These clinicians are a dedicated resource for the police. They have access to Mental Health's electronic clinical record, MHAGIC, and can provide information relevant to situations/individuals.
    2. A four-day training program is delivered monthly to ACT police. Lecturers will be drawn from Mental Health Services, ACT Policing, the community sector and experts from interstate.
    3. A third mental health worker has been seconded to work with ACT police on a full-time basis. This clinician works closely with both agencies to address increasing pressures on the system and to promote greater mental health awareness and acceptance within the ACT Community.
- The Mental Health Assessment Unit began operations on 4 May 2010. It has a six-room psychiatric assessment suite co-located with the Emergency Department of the Canberra Hospital. The unit provides the opportunity for consumers with mental health issues to receive assessment, treatment and support within the Emergency Department. Following an assessment, the consumer may undergo a period of observation and further assessment, be referred to services within the community for appropriate follow-up or admitted to an inpatient unit. There were approximately 2200 mental health presentations from the unit's commencement to 30 June 2011.
- 2010–11 saw the implementation of the consumer scholarships program funded in the 2009–10 budget. The scholarships provide an opportunity for mental health consumers to gain qualifications in human services. The CIT is providing training and support for a Certificate IV of Mental Health, and ongoing care and tutorial support for students going on to study Alcohol and Other Drugs, Community Development, Youth Work or Community Services Work. This initiative will enhance opportunities for employment in the community sector, including peer support roles.

- Consumer and carer participation has remained a priority for Mental Health Services, which now employs a total of 4.9 full-time equivalent consumer consultant staff. This includes two consumer consultants, a quality improvement consumer consultant and a coordinator of consumer and carer participation. Their roles have been reviewed to further address and enhance activities that promote a cultural shift in Mental Health Services staff, particularly in regard to recovery and consumer empowerment. Other roles include systems advocacy for consumers, involvement in the review of the *Mental Health (Treatment and Care) Act 1994*, implementation of the recovery model, development and implementation of Advance Agreements, Consumer Companions and staff training. The division also maintains full representation of consumers and carers on all relevant governance committees.
- Over the past five years Mental Health ACT has adopted a recovery approach to service delivery. In a recovery-oriented service, clinicians encourage a collaborative relationship with the consumer. The consumer brings their expertise and perspective to the relationship—offering insight into their experience and successful strategies they have used and identifying the supports, motivations and aspirations to promote their recovery journey. Clinical staff offer their expertise and professional skills to provide specialist assessment help to identify needs and goals, assess risks and develop strategies to manage them, share their knowledge, assist the consumer to develop the skills they require to fulfil their roles and responsibilities and ensure access to appropriate treatment and therapeutic interventions.
- In March 2011, Mental Health ran a week-long Recovery Showcase to present recovery stories, highlight examples of excellence and provide an opportunity for discussion and networking for consumers, carers and mental health workers. 123 people attended. Discussions have commenced on planning the 2012 event, with a theme of recovery for consumers with a combination of alcohol or other drug issues and mental illness. In May 2011 training was provided for managers and leaders in mental health recovery. The course was open to staff from NSW and the ACT across the sector and explored the concept of recovery and what it means for those in management and leadership roles.
- Forensic Services has recruited a specialist forensic consultant with expertise in sex offending behaviours. The Consultant Forensic Psychiatrist provides ongoing training and expertise to support clinicians and forms part of the assessment team for consumers referred to Mental Health Services.
- The Forensic Court Liaison Service has expanded to provide mental health assessments and court liaison services within the ACT Children's Court, the ACT Magistrates Court and the Supreme Court of the ACT. Assessments are conducted on a daily basis in the court cells for both the ACT Children's Court and the ACT Magistrates Court. This service assessed approximately 300 individuals prior to their court appearances. Representatives of the service also attended court for approximately 50 mental health consumers per month.
- Justice Health Services has recruited a designated GP liaison triage nurse. This position triages patient access and flow to Justice Health Services clinics within the Alexander Maconochie Centre. The GP Liaison Nurse works in conjunction with the rostered medical officer and coordinates follow-up care with other members of the treating team.
- A more streamlined induction process has been developed for prisoners at the Alexander Maconochie Centre. It reduces duplication and refers people to other services when it is assessed that there is a need for further specialised care.
- A group program has been implemented at the Bimberi Youth Justice Centre focusing on mental health awareness and anger management.
- Alcohol & Drug Services has focused on young people, introducing two new initiatives:
    1. a specialised counselling program for young people who have complex alcohol and/or drug dependency issues to empower them to make clear and healthy decisions about their own life
    2. the Early Intervention Pilot Project under the National Binge Drinking Campaign, which is a coordinated response between the Australian Federal Police and Alcohol and Drug Diversion Service. Activities undertaken through the project produced a large number of referrals, with successful outcomes in education and referral for young people and their families.

- The Opiate Treatment Service has established opportunistic health clinics, which provide women's health checks, baby clinics and hepatitis screening and immunisation.
- Alcohol & Drug Services has coordinated planning and delivery from the Opiate Treatment Service of monthly health promotion activities with the consumer group Canberra Alliance for Harm Minimisation and Advocacy.
- Alcohol & Drug Services has successfully delivered pharmacist and GP training to support tier 2 and 3 Opiate Treatment Service clients.
- Alcohol & Drug Services has implemented a referral pathway for Youth Justice to request assessment and referral to treatment by the Council for Alcohol and Drug Abuse Services.
- Pharmacy Services at the Alexander Maconochie Centre and at the Bimberi Youth Justice Centre now provide specialist services for the entire population of those two facilities, covering both general health and mental health prescribing needs.
- During 2010–11, the ACT continued to host a project on behalf of the Mental Health Standing Committee's Safety and Quality Partnership Subcommittee revising the National Standards for Mental Health Services. In September 2010, her Excellency the NSW Governor Marie Bashir, AC CVO, launched the revised National Standards for Mental Health Services at the Mental Health Services Conference. The new standards reflect a recovery-based approach to treatment, and supporting implementation guidelines cover public and private mental health services, non-government providers of community services and office-based mental health services. The ACT finalised its part of supporting the standards revision project in March 2011.

Issues and analysis

Mental health services nationally and internationally continue to face shortages of clinical staff. In the ACT, these shortages are mostly across the acute and community settings, with resulting impact on service delivery. Recruitment through the Mental Health Nursing Post Graduate Diploma in Mental Health Nursing scholarship program has shown a gradual improvement and has enhanced the partnership with the University of Canberra. This has also strengthened links to the undergraduate nursing program by identifying undergraduate nurses' interest in the mental health field. Mental Health Services has developed a local workforce strategy and a planning and development framework. Mental Health Services has five intern psychologist positions to promote attraction and retention of psychologists.

Mental Health Services has funded a pilot of having a senior mental health nurse work with the Winnunga Nimmityjah Aboriginal Health Service to enhance access to and improve mental health problem identification, treatment and follow-up. An evaluation of the pilot will be undertaken to identify the support required for the Aboriginal and Torres Strait Islander community and its dedicated medical service.

Mental Health Services has continued to improve its electronic clinical record, MHAGIC. Mental Health Services worked closely with the vendor to upgrade the product to the latest version in September 2010. This version of MHAGIC had considerable improvements built in, as well as operating on a different and better platform.

In May 2010 the Auditor-General advised that, under the *Auditor General Act 1996*, it would conduct a performance audit of ACT Mental Health Services. The objective of the audit was to provide an independent opinion to the Legislative Assembly on the efficiency and effectiveness of the delivery of older persons mental health services (OPMHS) to the ACT community. The Auditor undertook fieldwork and conducted focus groups with relevant stakeholders in July and August 2010. The audit focused on ACT Health's ability and capacity to meet mental health needs of older persons and its administrative, operational and governance arrangements. The audit made 16 key recommendations. ACT Health accepted all the recommendations. Some of the improvements made as a result of the audit were:

- provision of refresher training on the mental health electronic record
- establishment of a registered nurse position as part of the workforce plan to increase the capacity of the OPMHS Community Team
- development of an OPMHS-specific session, Suicide Assessment (Introduction and Advanced), to increase awareness on the part of older persons mental health clinicians that suicide risk assessments need to be conducted consistently and that the relevant risk ratings should be allocated accordingly, with regular monitoring of the implementation of the suicide risk assessments

- initiating a shared approach to training between the residential aged care facilities, agencies such as Alzheimer's ACT and the OPMHS.

The review of the *Mental Health (Treatment and Care) Act 1994* continues. The review aims to ensure that the Act remains consistent with contemporary mental health policy and service delivery. Working groups are currently working on detailed aspects of the Act's content. After the revised legislation is drafted, there will be a double exposure draft process, and the Bill to revise the Act is scheduled for consideration by the ACT Legislative Assembly in mid-2013.

Future directions

- Funding has been provided for a carer consultant position, which will provide expert input from a range of carer perspectives to policy development, service provision, service reform and strategic direction for Mental Health Services. It is anticipated the appointee to this position will work closely with Carers ACT to ensure that advice provided is gained from mental health carer constituents.
- The employment of a registered nurse in the Dual Disability Service will improve response times for specialised dual disability services and provide opportunities to promote upskilling of mental health clinicians in this field. Mental illness is around five times more prevalent in the disability consumer group than in the general population. This enhancement will promote earlier identification of illness and access to treatment for a marginalised consumer group whose mental health symptoms can easily be misinterpreted.
- The Perinatal Mental Health Consultation Service provides specialist opinion and treatment planning for pregnant and postnatal women (up to 12 months postpartum) who present with diagnosed mental health disorders or the potential to require intensive support prior to and/or after the delivery of their child. Since its inception, service demand has increased considerably and the program currently has approximately 65 registered clients. A budget enhancement will allow for the implementation of a group program for women with high levels of emotional 'stress/distress' in the antenatal period. The group will be co-facilitated with the Child & Family Centre staff. The provision of an outreach mental health assessment service to the antenatal clinic at the Canberra Hospital will also be implemented as part of this project.
- A budget enhancement in 2011–12 will enable the Mental Health Community Policing Initiative to continue.
- New mental health initiatives funded in 2010–11 include a youth health and wellbeing program for 'at risk' youth, operated by Gugan Gulwan Youth Aboriginal Corporation, and a new adult step-up step-down outreach program provided by Woden Community Service.
- The Review of the ACT Community Sector of Mental Health Services was completed and presented to the Legislative Assembly in June 2011. Chief Minister and Minister for Health, Ms Katy Gallagher MLA, cited the review as a document 'to grow and strengthen mental health services in the ACT'. Twenty-seven organisations delivering services in the community mental health sector were reviewed and contributed to the development of the recommendations, which will see 14 key actions undertaken through an action framework. The framework includes recommendations for more integrated service planning between government and community agencies; better outcome measurement; quality benchmarking; leadership development in the sector; measures which will give agencies capacity to consolidate as more sustainable organisations; and implementing and monitoring the ACT Mental Health Services Plan 2009–2014.
- A pain management clinic has been established to service the clients of Justice Health Services who have chronic pain conditions. Links with the tertiary pain services will continue.
- A similar streamlined induction process to the one established at the Alexander Maconochie Centre will be introduced at the Bimberi Youth Detention Centre. The streamlined process entails reducing duplication and engaging specialist services only when they are assessed as clinically required.

Division of Pathology

Introduction

The Division of Pathology is the provider of public pathology for the ACT providing specialist pathology services to the medical practitioners of the ACT and surrounding region. This includes pathology testing while patients are in hospital and when they return to their homes.

Services are provided in the acute setting at Canberra and Calvary Hospitals and the National Capital Private Hospital and in the community through collection centres across the ACT. A home collection service for patients who are frail or unwell and who cannot attend these collection centres is also provided. Analysis of collected samples is undertaken at the two ACT laboratories within the ACT, the main one at the Canberra Hospital and its branch laboratory located at Calvary Hospital.

Pathology is a medical specialty looking at disease processes and their cause. Body tissue, blood and other bodily fluids are analysed to assist medical practitioners in identifying the cause and severity of disease, and to monitor treatment. The Division of Pathology is made up of a range of clinical specialities—Anatomical Pathology, Chemical Pathology, Haematology, Cytogenetics, Immunology, Microbiology and Molecular Pathology.

Achievements

- Pathology holds accreditation for medical postgraduate pathology training in all the major specialisations of pathology and has a sound track record of success.
- Pathology is working in collaboration with the University of Canberra to redevelop the undergraduate Medical Laboratory science course and develop postgraduate courses. A number of scientific staff prepare and provide lectures for these courses. Twenty students undertook professional practice in pathology in 2010–11. This is a substantial increase over previous years. This initiative will provide new graduates who are more workforce-ready than in previous years.
- The contribution of scientific staff from cytogenetics to the development of the University of Canberra course has allowed postgraduate cytogenetic studies to be offered, potentially the only such course in Australia.
- Pathology is working in collaboration with Canberra Institute of Technology (CIT) to develop and deliver courses in histology, blood transfusion, clinical chemistry, immunology, laboratory operations and phlebotomy.
- Pathology is working in collaboration with private pathology in the provision of one rotation in anatomical pathology, the funding provided by the Commonwealth Department of Health and Ageing.
- Investments in research: pathology is a scientific discipline with research as a cornerstone. Many of the pathologists and scientists are actively involved in their own research or work collaboratively with others. This demonstrates the important role of research in teaching and Pathology's increasing link and contribution to the Australian National University Medical School.
    - At the recent Royal College of Pathology of Australasia scientific meeting, four staff members were made foundation members of the Faculty of Science.
    - During 2010–11 Pathology staff were co-authors of 26 peer-reviewed publications, and numerous other presentations at scientific and professional meetings.
- Social inclusion: Pathology has undertaken a project to include Aboriginal identification on its pathology testing. This information is then available to feed through to health databases such as the Pap smear register, notifiable diseases and cancer cases, and should enable better health policy planning.
- Pathology works in close collaboration with many areas of Health to provide access to timely results and facilitate decision making and assist them in achieving their outputs.

- Pathology has seen an overall increase in the number of pathology requests received for hospital patients, as shown in the table below.

Location	Number of requests 2009–10	Number of requests 2010–11	% increase in requests
Canberra Hospital	305420	320439	5%
Calvary Hospital	80565	83515	4%

- Each request generates the analysis of multiple tests, as shown below.

Location	Number of tests	Number of requests 2010–11	% increase in requests
2009–10	Number of tests	1226230	7.8%
2010–11	% increase in requests	307470	7.8%

- Emergency department: pathology gives priority to tests requested by the emergency departments of both Calvary and Canberra hospitals. These results are critical for decision-making about treatment, discharge or admission of patients.
    - The increases in the numbers of tests requested by the emergency departments at Canberra and Calvary hospitals are shown below.

Location	Number of tests	Number of requests 2010–11	% increase in requests
Canberra ED	180503	204465	13%
Calvary ED	132113	136041	3%

- Breast screening: Pathology provided diagnostic services to Breast Screening ACT and NSW, with a turnaround time of two to three days for reporting.
- Infection Prevention and Control Unit (IPCU): The relationship that Infection Prevention and Control (IPC) has with the pathology department remains strong, which is extremely important to the unit's functioning as it provides the following services:
    - timely results for all potentially transmissible microorganisms, including multi-resistant organisms, tuberculosis and, Clostridium difficile, which allow the early isolation of patients. In addition, microbiology helps with identification of disease clusters and works closely with the IPCU when there is an increased number of cases with gastroenteritis and Influenza
    - serology, which has an important role in gaining timely results for contact tracing when a patient is identified with, for example, chickenpox or measles and this relationship extends to the Occupational Medicine Unit
    - air sampling and identification of fungi, which are essential to the immuno compromised patient and undertaken regularly
    - microbiology testing of scopes that are multi-chanelled. Under the Gastroenterological Nurses College of Australia guidelines, areas of the hospital that have scopes that are multi-channelled must undertake microbiology testing. This has allowed timely follow-up when a scope is identified as contaminated.

Testing notified to IPC is shown in the table below:

	Total for 2009–10	Notified in 2009–10	Total for 2010–11	Notified in 2010–11
Endoscope testing (IC)	2009–10	Notified in	616	—
Surveillance swabs	2009–10	Total for	15059	—
MRSA positive (IC)	2010–11	Notified in	—	771
VRE positive (IC)	2010–11	296	—	393
RSV positive (IC)	—	202	—	161

- Public Health: microbiology plays a key role in early recognition of outbreaks of disease within the hospital and in the community allowing the Communicable Disease Centre (CDC) to begin investigation and prevention as soon as possible. Testing notified in 2010–11 is shown in the table below.

	Total for 2009–10	Notified in 2009–10	Total for 2010–11	Notified in 2010–11
Faeces requests	7063		7548	
Campylobacter (CDC)	—	211	—	222
Salmonella (CDC)	—	134	—	180
Shigella (CDC)	—	8	—	12
Cryptosporidium (CDC)	—	16	—	13
Giardia (CDC)	—	39	—	32
Other parasites (CDC)	—	77	—	101
Gonococcus (CDC)	—	40	—	59
Meningococcus (CDC)	—	1	—	4
Invasive pneumococcus (CDC)	—	34	—	28
Respiratory virus requests	2174		962	
Influenza A positive (CDC)	—	136	—	11
Influenza B (CDC)	—	3	—	1
Mycobacterium requests	1656	—	1632	—
Mycobacterium notified (CDC)	—	128	—	116

Issues and analysis

The work load in pathology is increasing significantly, reflecting the increased patient load and complexity in the hospital. This increase is being experienced across all parts of Pathology. Pathology is aware of the workforce situation and challenge of an ageing population, both in potential recruitment and retirement. The need to respond to new diagnostic requirements and provide rapid results also presents an increasing challenge. Pathology plans to address some of this through improved technology, as well as the ongoing investments in recruitment, education and training.

Future directions

- Research that promotes evidence-based practice: New assays for cardiac troponin offer the potential for earlier diagnosis and commencement of treatment. A trial designed and undertaken by chemical pathology will use the new assay on patients presenting to the emergency department with chest pain. One of the aims of this trial will be to decrease the time a patient spends in the emergency department waiting for a definitive diagnosis of myocardial infarction.
- Chronic disease management: After many years of discussion there is now international agreement that the reporting of HbA1c in diabetes mellitus will be modified, and adopted by all laboratories. This paves the way for standardised reporting in all laboratories and in all countries, thus improving the management and understanding for doctors and patients.
- Improved patient safety and quality of care: Pathology is working to introduce Computerised Physician Order Entry (CPOE). This system will improve completion of mandatory information required for pathology testing, improve legibility and thus accuracy of request information, and provide decision-making support information to the requesting doctor. In conjunction with the CPOE, a pathology collection system providing positive patient identification for the collection of blood samples will be introduced. The introduction of both CPOE and PPID is expected to reduce pre-analytical errors that occur before the sample is presented to the laboratory for analysis. This will significantly improve patient safety.

Division of Medicine

Introduction

The Division of Medicine provides a range of medical specialties, providing inpatient, outpatient and outreach services to the Canberra community. The inclusion within the division of the Pharmacy Department and the Chronic Disease Management Unit as part of the Health Directorate restructure will further enhance the services the division provides to the community for people with chronic diseases and in medication management. A strong emphasis is placed across all sections on accessible, timely and integrated care, delivered to a high standard of safety and quality. This is underpinned by the division's commitment to research and training.

The division works in partnership with professional colleagues, consumers, and a range of government and non-government service providers to ensure the best possible outcomes for patients.

Services are predominantly provided at the Canberra Hospital, but may also be provided in community settings or the patient's home, such as Renal Outreach Services and Hospital in the Home. With the development of the community health centres under the Capital Asset Development Plan, future services provided by the division are planned to be available to the community in these centres. Plans are well underway to have the diabetes service provided in the Enhanced Community Health Centre in Belconnen.

Achievements

Endocrinology and diabetes service

A new model of care for diabetes services in the ACT has progressed during 2010–11. Tertiary-level services will be provided through a single multidisciplinary team including medical, nursing and allied health staff and at multiple sites in the ACT, bringing traditionally hospital-based services closer to people, in community health centres. Infrastructure requirements to support the new organisational structure and the enhancement and coordination of services are currently being addressed. Planning will also address strategies to increase the primary care, health promotion and disease prevention support for people who are at high risk of developing type 2 diabetes.

The Endocrinology and Diabetes Department at the Canberra Hospital is involved in investigator led and pharmaceutical industry sponsored clinical research. The Department also has a very active basic research laboratory that focuses on pancreatic islet biology with projects relevant to both Type 1 and Type 2 diabetes as well as diabetes in pregnancy. There is a strong focus on research training of both medical students and postgraduate research students. The Endocrinology and Diabetes Department collaborates widely in research across the Canberra Hospital campus, the Australian National University and research groups, both interstate and internationally.

Cardiology services

In May 2011 specialist cardiology services have been provided to Calvary Hospital by Canberra Hospital specialists undertaking on-call and clinical services at Calvary, thereby enhancing services across both campuses.

Renal services

- All the achievements outlined for renal services are consistent with stated objectives in the Renal Services Plan 2010–2015, which was developed in consultation with clinical and community stakeholders in 2010–11.
- ACT Health signed a memorandum of understanding (MOU) with the Southern Local Health Network (LHN) to undertake provision of renal service delivery at Goulburn and in the surrounding region. This includes clinical governance of the dialysis facility at Goulburn and also provision of outpatient services locally.

- The renal service at Canberra Hospital & Health Services was involved in the design and planning of a new dialysis unit at Queanbeyan. The facility is expected to commence operations in September 2011 and, when fully operational, it will be able to dialyse 24 patients. The clinical governance for the service will be provided by the renal service within the Division of Medicine.
- The tender process and contract negotiation were completed for procurement of the renal electronic medical record. The renal electronic medical records are vital to achieving a connected service delivery within the community—a key objective of the Renal Services Plan 2010–2015. Additionally, it will allow for real-time communication between members of the renal team and enable quality assurance activities to be performed simultaneously with clinical service delivery.

Chronic disease management

The Chronic Disease Management Unit (CDMU) is a multidisciplinary team created in January 2010. Its focus on improving the management of ACT residents with diabetes, chronic lung disease and chronic heart failure through supporting evidence-based practice, secondary prevention through consulting with other units, and providing clinical services.

The unit achieved the following in 2010–11:

- implementation of the Home Telemonitoring Program for patients, where daily monitoring at home can assist with self-management and stabilisation of their condition.
- development and implementation of the Chronic Disease Telephone Coaching Service to help people improve their ability to self-manage their chronic condition
    - maintenance of the Chronic Disease Management Register (CDMR) to track the care of patients with chronic disease and identify gaps in their care. There are currently 5200 patients on the CDMR and a variety of reports and research projects are being developed from this data
    - establishment of a consulting service to other units working in the management of chronic disease as well as organisations external to the Health Directorate
    - development of service expansions for people with heart failure and obesity
    - collaboration with local research institutions and community organisations to contribute to the community education package titled 'Training group leaders how to include people with chronic disease in community activities'.

Chronic Care Program

The Chronic Care Program (CCP) provides education, clinical support and care coordination in the acute care sector for patients with chronic heart failure or chronic obstructive pulmonary disease. The service is provided by nurse specialists and clinical care coordinators who focus on self-management strategies, education and clinical support.

The relocation of CCP to sit within Chronic Disease Management as part of the Division of Medicine has allowed for a more cohesive and collegiate relationship within the program. A service review project was undertaken throughout 2010 to assist in streamlining services within CCP for a more efficient, coordinated and streamlined process, which has lead to an increase in referrals to the service.

Respiratory and sleep services

The Sleep Laboratory has been open for 12 months and it is currently performing 14 sleep studies per week. Multiple sleep latency testing commenced in May 2011. In the first 12 months of operation, the laboratory performed 396 sleep studies (169 hospital-based and 227 home-based) and three multiple sleep latency tests. This included 22 current hospital inpatients. A significant proportion of the hospital based sleep studies performed on both an inpatient and outpatient basis are complex in nature, involving assessment of respiratory failure and efficacy of non-invasive positive pressure ventilation therapy. Complex sleep laboratory-based testing on these patients was previously unavailable in the ACT. The Sleep Disorders Unit also operates a continuous positive airway pressure (CPAP) acclimatisation program for patients diagnosed to have sleep disordered breathing and the service had 613 patient visits in the reporting year, including 61 current hospital inpatients.

A recent audit performed in the unit demonstrated a CPAP uptake rate of 83.8 per cent for patients with newly diagnosed obstructive sleep apnoea undergoing the acclimatisation program. Patients participating in this program are 4.84 times more likely to take up CPAP therapy compared to traditional CPAP acclimatisation undertaken by commercial vendors.

Clinical and Forensic & Medical Service

The Clinical and Forensic & Medical Service (CFMS) successfully tendered for a contract with the Australian Federal Police for the provision of clinical forensic and medical services, including a model for nurses providing services to the ACT City Watch house.

Canberra Sexual Health Centre

The Canberra Sexual Health Centre continues to conduct epidemiological, clinical and laboratory research with a focus on chlamydia screening and head lice management.

The Stamp Out Chlamydia research project, which was funded for five years (2009–2013) by the Health Directorate, is aimed at screening various subpopulations of young people 'in the field', including those employed on worksites and in offices as well as disadvantaged youth. In 2010–11 resources were developed for index cases with chlamydia to support contact tracing and documented improvement in the recording of chlamydia contact tracing.

Pharmacy

The Canberra Hospital commenced Antibiotic Stewardship in March 2011. This was established to optimise and rationalise antibiotic prescribing, reduce hospital-acquired infection, and provide education of medical, nursing and other clinical staff. It is a joint initiative with the Infectious Diseases and Infection Control departments.

Gastroenterology and Hepatology Unit

The Gastroenterology and Hepatology Unit continues to provide endoscopy services for patients referred as part of the National Bowel Cancer Screening Project and has ongoing Commonwealth funding for this service.

Infectious Diseases and Infection Control

There has been a continued reduction in the number of blood stream infections from intravenous catheters. At the time of reporting it was about 30 episodes per year, which is one of the lowest numbers recorded. This is a 200 per cent reduction from the baseline in 1998, when there were about 115 episodes per year. Reduction in blood stream infections can be interpreted as representing a potential five fewer deaths per year, plus major savings in patient morbidity and otherwise prolonged hospital stays for those that survive.

The Infectious Diseases Unit continues to have extensive research publications including international liaisons, and continues to work with the World Health Organisation (WHO) on antimicrobial resistance. Professor Peter Collignon from the Health Directorate is on one of WHO's international expert committees—the Advisory Group on Integrated Surveillance of Antimicrobial Resistance.

The Canberra Hospital continues to be involved with the National Hand Hygiene Initiative and has implemented the program. This program raises the profile of hand hygiene for staff and the public, and includes education, monitoring of compliance and measuring infection rates. Hand Hygiene compliance rates have increased from 49 per cent in July 2009 to 72 per cent in March 2011, above the national average of 68.7 per cent.

Future directions

Renal services

- Roll out of the Renal EMR (Electronic Medical Record).
- Commencement of consultation for clinical service provision at the enhanced community health centres as part of the Capital Asset Development Plan.
- Further development and expansion of self-care community dialysis centres, including developing a centre within the ACT, planned for Weston.
- Development of new dialysis service at Queanbeyan.

Chronic Disease Management Unit

- Increase the profile of chronic disease management within the Health Directorate and primary health and community organisations.
- Expansion of the Home Telemonitoring and Heart Failure Service.

Chronic Care Program

- Expansion of program to include Parkinson's disease, including the appointment of a Registered Nurse Level 3 and a Registered Nurse Level 2/Health Professional Level 3 for care coordination of this group of clients. The model of care will be based on the current model of care that exists with the heart failure and chronic obstructive pulmonary disease (COPD) program.
- Inclusion of a Smoking Cessation Clinic, scheduled to commence in August 2011, which will be led by the COPD Nurse Coordinator.
- The development of a territory-wide COPD booklet for patients, which is currently in draft format.

Neurology

The Neurology Department will be working closely with the Chronic Disease Management Unit in setting up a service for people with Parkinson's disease, funded as a budget Initiative in the 2011–12 financial year.

Clinical and Forensic & Medical Service

The service will continue liaising with the AFP on the establishment of new services. These include traffic medicine, and those medical and nursing services required by the amendments to the road traffic legislation and drug driving issues. The service has an increasing role with the AFP's Coroner's Officer and the investigation of unexpected deaths.

Pharmacy

The Canberra Hospital is setting up a tender specifications committee to procure a closed system transfer device for Oncology Pharmacy, for increased safety of oncology pharmacy staff and patients.

The Pharmacy Project Officer has been involved in electronic medicines management, including EMMS (Electronic Medicines Management System) and eMed Rec (electronic medication reconciliation), and the Cancer Information Management System Project. Also, recruitment has been undertaken to a Clinical Information Systems Pharmacist position to oversee all these projects and their implementation.

Pharmacy has been involved in extended scope projects for many allied health areas, as well as internally for the technical officers.

Discussions are underway to collaborate with the University of Canberra to consider a joint Academic Director of Pharmacy with the Canberra Hospital and Health Service within the Division of Medicine.

Gastroenterology & Hepatology Unit

In 2010 the Health Technology Assessment Committee supported acquiring the equipment to introduce an advanced endoscopic ultrasound service and the recruitment of an endoscopy specialist to provide the service is planned for late 2011.

General Medicine Unit

The General Medical Unit proposed in 2010–11 will commence operation in 2011–12.

Cardiac Services

Work will commence on scoping and developing a cardiac centre model for cardiac services during 2011–12. This will include the clinical model of service delivery and integration of health promotion and prevention through TCH&HS services, with strong links to the Heart Foundation.

Public health services

Introduction

Public health services in the ACT are provided largely through the Population Health Division (PHD). PHD is headed by the Chief Health Officer, who is appointed under the *Public Health Act 1997* and reports to the Director-General of the Health Directorate. The Chief Health Officer is also required to report biennially on the health of the ACT population on specific health-related topics, which is done through the ACT Chief Health Officer's Report.

The Population Health Division has primary responsibility for the management of population health issues within the Health Directorate. The division undertakes the core functions of prevention, assessment, policy development and assurance, and contributes to local and national policy, program delivery and protocols on population health issues. The division has four branches:

- The Policy Support Office (formerly Population Health Executive Office) is responsible for the development and implementation of policy on a range of public health issues, including sexual and reproductive health, blood and blood products, organ and tissue donation, healthcare facility licensing and gene technology.
- The Health Promotion Branch is responsible for policy and program delivery in the areas of health promotion and prevention. Health promotion activities aim to strengthen the skills and capabilities of individuals, as well as influence the social, environmental and economic conditions that impact on public and individual health.
- The Epidemiology Branch collects, analyses and disseminates information on the health status and health-related behaviours of the ACT population. This information is used to monitor, evaluate and guide health planning and policy. It provides advice and assistance for research and evaluation activities across the health portfolio and broader research community. The cervical cytology register is a sub-unit of the Epidemiology Branch. The register is a central and confidential list of ACT women's Pap test results. The register, through the cervical screening program, seeks to reduce morbidity and mortality from cervical cancer.
- The Health Protection Service manages risks and implements strategies for the prevention of, and timely response to, public health events. This is achieved through a range of regulatory and policy activities relating to areas such as food safety, communicable disease control, environmental health, emergency management, pharmaceutical products, tobacco control, and analytical services.

Achievements

- The Population Health Division maintained significant activity to address the issue of the increasing number of chlamydia notifications in the ACT. In line with a 2009 ACT Government budget initiative PHD has continued to fund the 'Stamp Out Chlamydia' project, and a range of other outreach-based activities that promote and provides readily accessible sexual health screening 'events' for identified high-risk populations. These activities are delivered through a partnership comprising PHD, the Canberra Sexual Health Centre, Sexual Health and Family Planning ACT, the ANU Medical School and a number of community organisations. These activities operate under the banner of the 'Partnership Approach to Comprehensive Testing' . The effectiveness of these activities was recognised when the Partnership Approach to Comprehensive Testing project won the 2010 ACT Quality in Health Care Award in the consumer participation category.
- PHD supported the Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases in providing ACT input into the implementation of the National HIV, Hepatitis and STI policies, a review of the ACT Prostitution Act 1992, and provision of advice in relation to public health matters at the Alexander Maconochie centre. PHD facilitated a number of stakeholder forums—attended by 45 representatives from 20 organisations in the sexual health and blood-borne virus sector—and proposed a range of ideas to be fed into the national drafting process.

- PHD has also been involved in the sponsorship and organisation of the 2011 Australasian Sexual Health Conference and Australasian Society of HIV Medicine Conferences, which are to be held back-to-back at the National Convention Centre in September 2011. Up to 1000 delegates are expected to attend the two conferences.
- PHD remains responsible for policy relating to blood and blood products and several of its officers represent the ACT on national committees, including the the Jurisdictional Blood Committee, (a subcommittee of the Clinical, Technical and Ethical Principal Committee of the Australian Health Ministers' Advisory Committee) and the Haemovigilance Advisory Committee . The Australian Haemovigilance Report 2010 was published in August 2010, with a PHD staff member part of the writing group.
- The consolidation of the ACT and NSW Red Cross Blood Service at a single principal site at Mascot in Sydney took place in April 2011. Collaboration between PHD, the ACT Laboratory Providers and the ACT and NSW Red Cross Blood Service resulted in a seamless transition of production and distribution services for the ACT blood sector. The ACT and NSW Red Cross Blood Service remains committed to the timely and efficient delivery of blood and blood products across the ACT.
- PHD collaborates across the ACT to support National Blood Donor Week. This annual acknowledgement of blood donors is a national initiative by the Blood Service, held during the third week of July. The week recognises and thanks blood donors, and also raises awareness in the wider Australian community about the continued need for blood.
- PHD has been involved in implementing the $151.1 million National Reform Package on Organ and Tissue Donation for Transplantation announced by former Prime Minister Kevin Rudd MP in July 2008. The ACT continued to meet requirements against the nine measures of the Reform Package as outlined by the Australian Organ and Tissue Authority. PHD represents the Health Directorate on the Jurisdictional Working Group of the authority and has coordinated the negotiation of funding agreements with the authority on behalf of the Health Directorate. PHD was involved in guiding the establishment of a new volunteer model for DonateLife ACT, which coordinates all organ and tissue donor activities across the ACT and surrounding region, and progressing new plans for its governance arrangements. From January to December 2010, there were 10 multi-organ donors in the ACT compared with eight in the 2009 calendar year.

The Health Directorate sponsored the 12th Australian Transplant Games, hosted by Transplant Australia in October 2010. This provided a great opportunity for the life-saving gift of organ and tissue donation to be celebrated and the lives of donors honoured and their families thanked.

- The ACT maintained its position as the jurisdiction with the highest life expectancy. Projections suggest that life expectancy in the ACT will continue to increase over coming years. By 2015, life expectancy at birth in the ACT is projected to be 83.1 years for males (up 2.4 years from 2007) and 86.5 for females (up 2.5 years from 2007). Cancer, mental disorders and cardiovascular disease are the leading contributors to the total burden of disease in the ACT, contributing nearly half of the total disease burden.
- PHD fulfilled its statutory and national reporting requirements for 2010–2011. These included the collection of data for and maintenance of the ACT cancer registry and maternal and perinatal data collection and the publication of the ACT Chief Health Officer's Report 2010. PHD also published reports on maternal and perinatal health, breast cancer in ACT women, secondary students' health risk behaviours and youth health. PHD fulfilled national reporting requirements on public health expenditure, cancer incidence and mortality and perinatal statistics for the ACT.
- In 2010–11 PHD focused on strengthening quality systems in population health data collection and reporting. This included commencing the 2011 ACT Secondary Students Alcohol and Drug Survey; developing systems to facilitate electronic transmission of maternal and perinatal data in the ACT; developing systems for reporting on new national and local health indicators; and building local capacity in data linkage between key population health data collections.
- In partnership with the ANU, PHD commissioned a key report on the mental health characteristics of people living in the ACT, which was released in July 2011.

- PHD continued to fund and distribute a combination vaccine that includes protection against pertussis for new parents and grandparents as part of a 'Targeted Adult Pertussis Vaccination Program' to minimise the incidence of this disease in infants. An evaluation of the program was undertaken in October 2010 to determine the effects of the program on disease incidence. The evaluation found that there was a small decrease in the number of notifications for children 12 months and under. However, it was noted that the full benefits of this program may not be fully evident until it has been running for a longer period. Implementation of the program has been efficient, using existing Health Directorate processes and infrastructure for vaccine delivery.
- In response to an increased number of bat bites in the ACT, in early 2011 HPS raised awareness of the risk of Australian bat lyssavirus through media releases and web updates and provided post-exposure treatment through the emergency departments and medical practices as requested.
- The Health Directorate undertook a community education campaign aimed at reducing the transmission of influenza in the ACT community after the H1N1 influenza pandemic in 2009. The campaign included a number of promotional activities, including radio advertising and print media promoting influenza immunisation and the provision of advice on hygiene measures to minimise the transmission of influenza.
- The H1N1 influenza immunisation program continued until December 2010. In total, PHD delivered nearly 129,000 doses of vaccine since the commencement of the program on 30 September 2009.
- An evaluation of the Health Directorate's response to influenza was conducted in late 2010. The review acknowledged that overall the Health Directorate conducted a strong and well coordinated response to the H1N1 pandemic and to the 2010 influenza season. The 2010 evaluation made a number of recommendations in relation to the ongoing management of influenza. The majority of the recommendations from an evaluation of the 2009 pandemic were implemented during 2010.
- A case of hepatitis E virus infection in a food handler was investigated. Following extensive risk assessment a decision was made to issue a public health alert naming the restaurant, thereby enabling patrons who may have been exposed to seek early medical treatment should they become symptomatic. No secondary cases were identified. This is likely to be the first recognised instance of hepatitis E infection in a food handler in Australia.
- An increase in the number of pertussis (whooping cough) notifications was observed in the ACT from October 2010, with an increase of more than 200 per cent in notifications from September to October 2010. Notifications started to decline in March 2011, although numbers remained elevated compared with previous years. Public health officers from PHD investigated all confirmed cases to provide information on limiting transmission, especially to contacts that are more susceptible to severe infection, such as infants aged less than 12 months. Information regarding pertussis was also provided to general practitioners and schools, and a health alert was placed on the Health Directorate website.
- PHD developed and coordinated an EmergoTrain System (ETS) exercise, named 'Formicidae', which was conducted on 12 November 2010 and involved staff from the Canberra Hospital, Population Health, Calvary Health Care ACT and the ACT Ambulance Service. ETS exercises are used to test and refine pre-hospital and hospital emergency response and coordination arrangements across the health sector. ETS Exercise Formicidae aimed to evaluate the capacity of the health system within the ACT to deal with more than 500 casualties requiring decontamination. Funding for the exercise was sourced through the National Counter-Terrorism Committee drill-style exercise program. A report detailing the outcomes and recommendations arising from ETS Exercise Formicidae was being finalised at the time of reporting.
- The Australian Government passed legislation in 2010 to allow midwives to prescribe medicines under the Pharmaceutical Benefits Scheme (PBS). A subsequent amendment was successfully passed under the ACT medicines law to allow eligible midwives to prescribe medicines listed on the PBS in order to align with these PBS changes.

- The National Registration and Accreditation Scheme for health professionals was implemented in July 2010, following which certain pharmacy ownership provisions and pharmacy premises standards under the Health Professionals Act 2004 were repealed. A temporary modification was made to the Health Act 1993 to ensure that pharmacy ownership remains restricted to pharmacists and that pharmacy premises standards are maintained.

Issues and analysis

- The Pacific Island community expressed concerns about restrictions on kava supply under Commonwealth and ACT medicines law, particularly in relation to restricted supply at the 2011 National Multicultural Festival. The Health Directorate and the Office of Multicultural, Aboriginal and Torres Strait Islander Affairs have been engaging with the Pacific Island community on this matter. At the time of reporting, the Health Directorate was working on a submission to the national medicines scheduling committee in an attempt to amend restrictions on kava under Commonwealth law, which are adopted in the ACT by reference.
- An increase in the number of gonorrhoea notifications in the ACT was also noted in early 2011. Some of the increase in notifications may be attributed to the introduction at the Canberra Sexual Health Centre of a more sensitive test. However, this change in diagnostic method does not explain the full extent of the increase in notifications seen in the ACT. A letter from the Chief Health Officer was sent to all ACT general practitioners, providing them with information on managing cases of gonorrhoea. Staff from PHD have also liaised with relevant community groups and the Canberra Sexual Health Centre in developing education programs targeting high-risk groups.
- In April 2011 a particular batch of the vaccine Pneumovax 23 was withdrawn following an increase in national adverse events following immunisations. Pneumovax vaccine is used to prevent a potentially life-threatening bacterial infection that can cause meningitis, pneumonia, sepsis and death. The Therapeutic Goods Administration subsequently issued precautionary advice to doctors not to give patients a second dose of the vaccine Pneumovax 23 pending completion of an investigation into an increased rate of adverse events in people receiving the vaccine for the second time. Pneumovax vaccine is provided free under the Australian Government's National Immunisation Program for people over 65 years old, Aboriginal and Torres Strait Islander people over 50 years old, Aboriginal and Torres Strait Islander peoples aged 15 to 49 years old who are tobacco smokers or who have certain medical conditions, and some children at high risk of invasive pneumococcal disease.
- Since July 2009, PHD has served 74 improvement notices and 28 prohibition orders on food businesses, which represents an increase compared to previous years. Some of this increase can be attributed to the implementation of a more formalised approach to enforcement. Previously, food businesses found to be non-compliant with legislation were issued with a copy of the inspection report indicating issues to be rectified. The new approach involves providing a business owner with a copy of the inspection report and issuing formal written advice in the form of an improvement notice. Improvement notices are issued for less serious breaches of the Food Safety Standards. Prohibition orders are issued for serious breaches of food safety legislation and, in accordance with the Health Directorate's policy, require the immediate commencement of formal investigations with a view to prosecuting.
- PHD analysed inspectorial data and confirmed a trend in issuing prohibition orders attributed to food businesses that prepare and serve specific types of foods. In response, the Health Directorate began a targeted inspection campaign, which has resulted in a spike in the number of
notices issued, but has also improved the understanding of requirements and compliance in this sector.
- In the past year, overcrowding of houses in the ACT emerged as a significant public health issue. Public health officers from PHD detected a number of houses that were seriously overcrowded, placing occupants at risk because of insanitary conditions. As a result of the actions by the public health officers, more than 100 people were provided with emergency accommodation. At the time of reporting, PHD was continuing to investigate possible breaches of the Public Health Act arising from overcrowding.

Future directions

- PHD has formed a useful collaborative partnership with the Education and Training Directorate with the intention of better integrating the delivery of sexual health and sexuality education for young people. This is in line with expressed priorities in the National Sexually Transmissible Infections Strategy 2010 and it is hoped it will have a positive effect in reducing the burden of sexually transmissible infections in this group.
- The ACT will continue to work with the Australian Organ and Tissue Authority to implement national plans and programs such as the National Protocol for Donation after Cardiac Death and the Australian Paired Kidney Exchange Program.
- PHD will continue to explore and develop responses to the health impacts of climate change within the context of the proposed Health Directorate Sustainability Strategy being developed by the Business and Infrastructure Division. PHD will also contribute to the development of a new action plan aligned with the ACT Government Climate Change Strategy, which will include mitigation and adaptation strategies.
- An ACT Emergency Blood Management (EMB) Plan is being developed. This local EBM plan has been designed to align with the National Blood Supply Contingency Plan to coordinate a rapid response in the event of a domestic threat or disaster that affects the provision of safe and adequate blood supply in ACT. The EBM will ensure that overall blood usage is minimised; blood is available to all patients for essential transfusions; and the most urgent cases receive the appropriate available supply.
- Progress on the National Reform Package on Organ and Tissue Donation for Transplantation will continue into 2011–12 as the Health Directorate continues to work to implement the reform package in the ACT. PHD will also continue to work with the NSW Health Department and the Queensland Heart Valve Bank to ensure seamless provision of services in relation to organ and tissue donation.
- Prevenar 13, a new vaccine that protects against more strains of pneumococcal disease, is expected to replace Prevenar 7 on the National Immunisation Program from 1 July 2011. This vaccine is effective in serotype 19A, which has caused an increasing proportion of pneumococcal disease seen in Australia in recent years.
- A new system for the recording and monitoring of controlled medicines in the ACT will be implemented within PHD in mid-2012. This system will enhance PHD's capacity to monitor supplies of controlled medicines in the ACT and address issues relating to dependence on and diversion of these medicines.
- The Health Directorate has scheduled the conduct of a large-scale emergency management simulation exercise in November 2011. Both public and private hospitals and the ACT Ambulance Service will be participating in the exercise. The exercise will test:
    - the ability of the health sector within the ACT to manage mass casualties
    - control, command and coordination functions of the health sector through the recently revised Health Emergency Plan, and
    - the response capabilities and arrangements of participating agencies.
- PHD is reviewing its enforcement approach and legal powers under the Food Act 2001. One of the changes being considered is a requirement for every food business to have a trained food safety supervisor. PHD is also considering providing more transparency in food regulation, including a proposal that the names of food businesses convicted of an offence against the Food Act be placed on a register and a requirement for a food business that has received a prohibition order to display the closure notice at the business for the public to see. A proposal for a food business rating scheme (often called 'scores on doors') requiring each business to display an annual food safety rating for the public to see is also being considered. Consultation will be undertaken with the community and food businesses before any proposals are considered.
- A significant amount of work is being done locally and nationally with a view to introducing legislative amendments that would require certain types of food businesses, primarily chains and franchises, to display nutritional information at the point of sale, such as on menu boards.

- The PHD is currently developing a research strategy for the division in liaison with the Health Directorate Research Office and other stakeholders. The strategy will provide a framework for PHD to maximise its use of existing knowledge to improve the health and wellbeing of the ACT population and reduce health inequities. The strategy will help in prioritising areas for research and outline how knowledge transfer will occur and how research capacity will be enhanced. It aims to develop a research culture within the existing budget.
- The completion of a revised Code of Practice for Public Swimming Pools (the Code) was delayed due to resources reallocated to priority public health issues. These priority issues included overcrowded boarding houses, increased food safety regulatory activity and work on proposed improvements to food regulation transparency. The Code is proposed to be completed by June 2012, following consultation with the relevant stakeholders

Early intervention and prevention

Introduction

The Health Directorate conducts several activities to help prevent, or provide early intervention for, health conditions that result in major acute or chronic health care burdens on the community.

Early intervention includes the Health Directorate screening programs—such as BreastScreen, cervical and bowel screening, and newborn hearing screening—and immunisation programs.

The directorate's programs and projects in this area aim to improve the health of the ACT population through health promotion and disease prevention actions that target individuals and population groups that have the potential for the greatest health gains.

Achievements

There were three key accountability indicators relating to early intervention and prevention during 2010–11:

- ***Output 1.7 Immunisation (a)*** Immunisation coverage for the primary immunisation schedule measured at 1 year of age, in accordance with the Australian Childhood Immunisation Register—Target: 92 per cent The ACT continued to achieve high childhood immunisation coverage in the general population. Coverage rates for children in all three cohorts were consistently above the national average. In 2010–11, ACT childhood immunisation coverage rates remained above the national target of 90 per cent for 12-month-old children. Coverage rates for children in all three cohorts was consistently above the national average. The ACT Health Directorate's target of 92 per cent of one-year-old children being fully immunised was exceeded in all quarters (94.2%, 93.9%, 93.6% and 92.6%).

- ***Output 1.7 Community Health (a)*** Proportion of clients attending 'Well Women's Check' within the Women's Health Service that are from culturally and linguistically diverse communities—Target: 30 per cent
  Well Women's Checks were provided to 32 per cent of women from culturally and linguistically diverse communities. This was above the target of 30 per cent, and an increase of 3 per cent on the 2009–10 result.

- ***Output 1.7 Community Health (b)*** 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—Target: 80 per cent

  Eighty-eight 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 was above the target of 80 per cent, and an increase of 18 per cent on the 2009–10 result.

Further achievements are listed below.

- PHD participated in and provided support for Phase 2 of the Australian Government's Measure Up national social marketing campaign. Phase 1 of Measure Up was an awareness-raising campaign focusing on the lifestyle risk factors for chronic disease. Phase 2 moves to how to make changes. 'Swap it' is a key message—swapping less healthy behaviours for healthier ones. In line with the move to support Canberrans to make behavioural changes, funding was provided to pilot the Get Healthy Information and Coaching Service®. This s ervice provides information and telephone coaching support and has now received recurrent funding.
- Social research was undertaken with the Aboriginal and Torres Strait Islander community about the elements of an effective communication strategy to further support the Measure Up campaign as well as the national tobacco cessation social marketing campaign. Findings from this will be used to develop and implement a tobacco cessation and healthy lifestyle social marketing campaign.
- Find 30—It's not a big exercise® was promoted in partnership with the Territory and Municipal Services Directorate with the introduction of new bike parking facilities on major bus routes. 'Bike, Park and Ride' was promoted as an 'easy way of finding your thirty'. It was also a message in the Grants Sponsorship funding round in which community agencies can seek funding in exchange for promoting the campaign message and implementing policies that further embed the message in agency workplace practices and policies.
- Go for 2 and 5® was a health-promoting message within the grants sponsorship funding round. A pilot 'point of sale' promotion is under development with Nutrition Australia at selected IGA stores. It is also promoted in conjunction with other messages through the Kids@Play initiative, and the Healthy Communities initiative, which targets adults on government income support.
- Tap into Water® was introduced in 2010. This promotes tap water as the drink of choice. Resources such as water bottles were distributed. It was also introduced as a new health message in the grants sponsorship funding round for 2010–11 and included as a health message in Kids@Play initiative.
- Unplug and Play® was introduced to the ACT. This encourages parents to restrict screen time for children to two hours a day. An active campaign was rolled out using media and school-based promotion. Media included press, ACTION bus advertising, cinema advertising, shopping centre advertising, radio and school newsletters.
- Social research was conducted on developing an overarching and integrated social marketing campaign addressing both mental and physical wellbeing. This has met with a very positive response from the Canberra community. It has five key messages: connect, give, be curious, eat well, and be active. A marketing campaign is being developed.
- Partnerships are operating with PHD, the ACT Government Education and Training Directorate, the Community Services Directorate's Child and Family Centres, the Economic Development Directorate's Sport and Recreation Services, the Heart Foundation ACT and Nutrition Australia to progress programs to:
  - encourage healthy eating and physical activity for children and young people by providing training for school canteen managers to improve capacity to meet National School Canteen Guidelines
  - evaluate Phase 1 and implement Phase 2 of the Kids@Play initiative, which supports healthy eating and physical activity for early childhood settings
  - initiate a Healthy Sporting Canteens project,. Lifestyle Triple P (Positive Parenting Program) and an Active Travel to Schools project.
  - PHD supported Smart Start for Kids—1402 children were screened across 14 primary schools and 69 students participated in a targeted healthy lifestyle program.

- PHD supported the Sustainability, Training, Education, Participation, Skills (STEPS) program delivered by the YWCA, which targets vulnerable young parents.

- PHD hosted the Health Promotion Awards in November 2010. The Health Promotion Awards are held to recognise a variety of innovative and best practice health promotion projects delivered in the ACT, and include categories such as Outstanding Achievement to Promote Health and Wellbeing in Settings, Outstanding Achievement to Address Chronic Disease Risk Factors, Outstanding Achievement in the Delivery of Health Promotion Messages to Identified Target Groups, Outstanding Achievement in Health Promotion Evaluation or Research, Australian Health Promotion Australia (ACT Branch) Award for Outstanding Contribution by an Individual to Health Promotion Practice, and the ACT Health Award to an Outstanding Organisation for its Innovation and Achievement in Health Promotion.
- PHD continued to develop and support the implementation of evidence-based falls prevention programs in the community and residential aged care environments, aimed at reducing the risk of injury and avoidable hospitalisation in this population group. A stakeholder forum was held in December 2010 to promote best practice in falls prevention in line with the outcome of the review of grants funding rounds.
- PHD conducted the Healthy Young People feasibility study to examine potential models of delivery for youth health initiatives, particularly from an early intervention and prevention perspective. The findings of the study will be used to formulate recommendations to the ACT Government on actions to improve the health and wellbeing of young people aged between 12 and 25 years living in the ACT.
- 'my health', the Health Directorate's new staff health and wellbeing program, was launched in May 2011 by the Health Promotion Branch of the Population Health Division. my health provides Health Directorate employees with increased access to information and programs that support healthy lifestyle change in areas such as physical activity, nutrition, smoking and emotional health and wellbeing. It also helps the Health Directorate, as an employer, to build its capacity to provide a supportive environment for employees in regard to healthy living. Initiatives included an online employee staff health and wellbeing survey, the launch of an intranet site and the establishment of a number of walking groups across the Health Directorate. The analysis of the survey data will inform the development of future my health initiatives.
- The Cervical Screening Program captures and reports data over a two-year period as recommended by the National Cervical Screening Program. At 30 June 2011, the ACT participation rate was 58.86 per cent. The Australian Institute of Health and Welfare report Cervical Screening in Australia 2007–2008 put the ACT in the top three jurisdictions in Australia for participation in cervical screening. A health promotion officer was recently recruited to develop and progress recruitment activities for the ACT program.
- BreastScreen ACT & SE NSW is part of a national population breast screening program that aims to reduce deaths from breast cancer through early detection. Further information can be found under the Capital Region Cancer Service on page (140) of this report.
- Endoscopy services for patients referred as part of the National Bowel Cancer Screening Project, and funded by the Commonwealth, continued to be provided by the Division of Medicine, Canberra Hospital & Health Services. In July 2009 the National Partnership Agreement on Essential Vaccines (NPA) was implemented. The objective of this NPA is to improve the health and wellbeing of Australians through the cost-effective delivery of the National Immunisation Program. The NPA sets out performance benchmarks that must be achieved for the ACT to be eligible for an incentive payment. The performance benchmarks associated with the essential vaccines NPA are:

  1. Maintaining or increasing vaccine coverage for Indigenous Australians
  2. Maintaining or increasing coverage in agreed areas of low immunisation coverage
  3. Maintaining or decreasing wastage and leakage
  4. Maintaining or increasing vaccination coverage for four-year-olds.

  Early indications are that for 2010–11 the ACT will achieve three of the four performance benchmarks. As the ACT does not have any identified areas of low immunisation coverage, performance against benchmark 2 cannot be assessed.

For the period from 1 April 2010 to 31 March 2011 the mean immunisation coverage rates for Aboriginal and Torres Strait Islander children in the ACT were:

- 12–15 months—89 per cent
- 24–27 months—97.9 per cent, and
- 60–63 months—86.3 per cent.

For the period from 1 April 2010 to 31 March 2011 the mean immunisation coverage for four-year-old children in the ACT was 90.6 per cent.

- The ACT Immunisation Strategy 2007–2010 has been evaluated. Some key achievements of the strategy were:
  - ACT childhood immunisation rates consistently above the national average and often the highest, or among the highest, of all states and territories in Australia
  - implementation of the Human Papilloma Virus (HPV) Vaccination Program, the Rotavirus vaccination program, the H1N1 Panvax vaccination program and the seasonal new at-risk cohort program in the ACT
  - placement of Indigenous identification on the ACT Childhood Immunisation Record
  - development of a health care worker screening and immunisation policy
  - drafting of detailed cold chain policies/procedures for internal use by Health Directorate staff
  - increased provision of immunisation through general practice. In June 2010 general practices administered 57 per cent of childhood vaccine compared to 35 per cent in January 2005
  - introduction of a professional development program for immunisation providers, consisting of several presentations discussing immunisation issues
  - development and production of promotional materials for, and implementation of, outbreak control measures for pandemic influenza.
- An objective of the ACT Immunisation Strategy 2007–2010 was to 'enhance the quality of immunisation information in the ACT available to service providers'. To achieve this, PHD funded a professional development program for immunisation providers. An evaluation of this development program was in progress at the time of reporting. Data indicates that more than 560 people attended the education programs, with the majority stating that their learning needs were entirely met.

Future directions

- A new 2011–2015 Immunisation Strategy is being developed and is expected to go out for community consultation before being launched in late 2011.
- PHD will continue to take a lead role in implementing the National Partnership Agreement on Preventative Health. As part of the federal government health reforms, the agreement seeks to address the rising prevalence of lifestyle-related chronic disease by laying the foundations for healthy behaviours in the daily lives of Australians through such settings as communities, early childhood education and care environments, schools and workplaces, supported by national social marketing campaigns.

Quality and Safety Unit

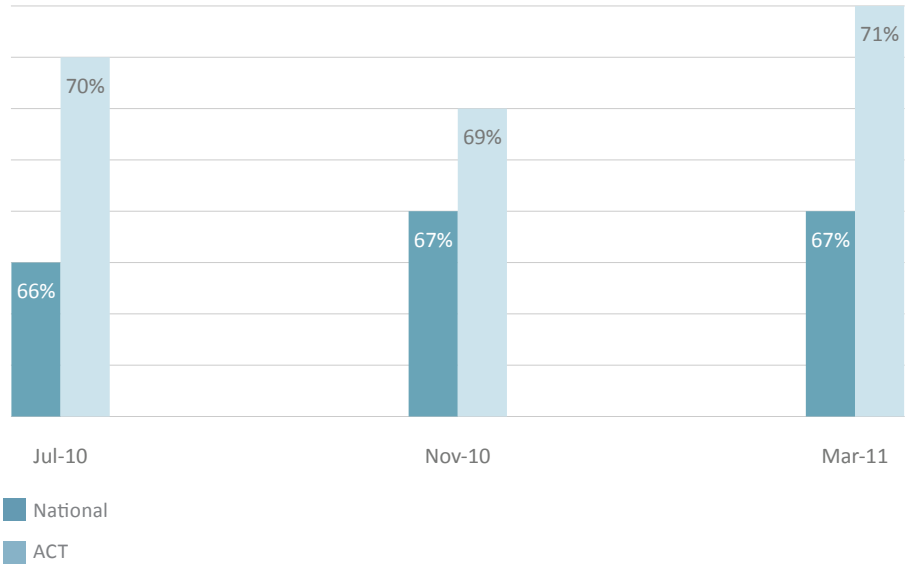
Introduction

Safety and quality of care are key elements in the provision of health services. The Quality and Safety Unit (QSU) takes a lead role in planning, managing and evaluating patient safety and quality for the Health Directorate. QSU focuses on quality improvement, evaluation and review, clinical management systems and measurement, consumer engagement, clinical performance related to patient safety and quality, and clinical risk management. QSU is committed to advancing the national agenda on patient safety and is working closely with the Australian Commission on Safety and Quality in Health Care to progress the ten national priority standards. The Workplace Safety section within QSU has overarching responsibility for keeping our staff healthy and safe.

Achievements

- Developed the Quality and Safety Framework 2010–2015 for the Health Directorate. This document describes a vision and direction to improve safety and quality in the Health Directorate and sets out the key activities that will be happening throughout the organisation to improve the safety and the quality of the service we provide for our consumers.
- Supported the Health Directorate through the Australian Council on Healthcare Standards (ACHS) Periodic Review of its accreditation status. The Health Directorate retained its accreditation and was recognised for its achievements in a range of areas.
- Helped clinicians evaluate clinical performance and developed organisational knowledge through clinical audit activities. These include the Health Directorate Clinical Indicator Program and the procedural audit program, which reviews all cases of unplanned return to theatre at the Canberra Hospital.
- Completed a pilot research project into clinical handover in collaboration with the University of Technology Sydney, NSW Health and WA Health. This project included observation of clinical handovers of patient information in the Canberra Hospital's Medical Assessment and Planning Unit and examined the usefulness and effectiveness of clinical handover tools.
- Implemented the Charter of Health Rights across the organisation by embedding it into existing systems and processes, educating and training staff, and working with the Health Care Consumers Association of the ACT to raise awareness of the charter among consumers. This included developing an e-learning package.
- Convened a workshop on patient and family-centred care in November 2010 in collaboration with the Health Care Consumers Association of the ACT, with consumer representatives and healthcare workers. The outcomes of the workshop formed the basis of the ACT Government Health Directorate submission to the Australian Commission on Safety and Quality in Health Care consultation on patient-centred care.
- Implemented the Open Disclosure Policy and Standard Operating Procedures in collaboration with clinical areas, to support timely provision of information to patients and families when issues arise in their health care.
- Supported the Health Directorate to meet key performance indicators for consumer feedback management and consumer and carer feedback.
- Trialled and implemented the World Health Organisation Surgical Safety Checklist at the Canberra Hospital.
- Continued the project to reduce health care-associated infections. This project continued the work with clinical areas to improve hand hygiene among health care workers. Good hand hygiene (HH) is the best way to reduce the number of infections that consumers acquire in the health system. The project educates healthcare workers on good HH practices and conducts audits three times a year to see how well they wash their hands. The graph below shows healthcare worker compliance rates for three recent audits. The data shows that since the project began in May 2009 there has been a 23 per cent increase in overall HH compliancerates across the Health Directorate, gradually increasing to above the national average. This information helps the project to target its education efforts for 2011–12.

ACT and National compliance rates



Issues and analysis

- The Riskman incident management system is being upgraded to include a quality improvement (QI) function, Riskman Q, which will integrate QI, accreditation and risk functions. The upgrade will enable more useful reporting on incident and risk data.
- The Safety Management System document will be amended to clarify changes to manager responsibilities for staff safety in their work area which take effect from 1 January 2012.
- Information gained from review of incidents, together with consumer feedback, will inform the direction for future work and priorities for QSU and the directorate.

Future directions

- Support the Health Directorate preparations for the next ACHS accreditation assessment in 2011 and site visit in 2012. Also work with the Health Directorate to implement the newly endorsed National Safety and Quality Health Service Standards throughout the organisation.
- Improve the use of existing health care data to monitor safety and quality of health care provided by the Health Directorate.
- Work with clinical areas to implement the National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines to assist health care professionals identify the correct medicines and/or fluid at all times (container) and the correct route of administration of the injectable medicines (conduit).
- Further improve the capacity of Riskman to support the work of Health Directorate.
- Improve the way information is provided to consumers and carers on changes that have been made at the Health Directorate as a result of their feedback.
- Future planning and development are underway for the Safety Management System to meet national legislative requirements, which come into effect on 1 January 2012.

Calvary Health Care ACT

Introduction

Calvary Hospital is the second major public hospital in the ACT. It is operated by Calvary Health Care ACT (CHC ACT), a subsidiary of Little Company of Mary Health Care (LCMHC).

Funding for the operation of Calvary Hospital is provided by the territory. Each year a performance plan is signed between the ACT Health Directorate and CHC ACT. This Plan specifies the level of activity to be performed by Calvary Hospital, the funding available to cover that activity, and the reporting and other requirements concerning activity and funding. Monthly performance meetings are convened between the directorate and CHC ACT.

Supporting the performance plan are other formal and informal protocols and processes that relate to Calvary's role in the provision of networked acute and sub-acute hospital and health services for the community. These arrangements address issues ranging from high-level matters such as service and role delineation through to individual patient issues such as transfers between the two facilities.

As well as the requirements of the performance plan, CHC ACT sets out its annual objectives and values in the Calvary Hospital annual strategic plan. Calvary Hospital rigorously assesses its annual performance against both the territory's requirements and its own objectives.

Achievements

- Commencing intensive and coronary care services in the new Critical Care Unit and implementing new models of care for critically ill patients. A highlight in this area has been the commencement of the Calvary Cardiology Service.
- Developing, implementing and evaluating the Calvary Patient Access Improvement Program (AIP) in partnership with the Health Directorate. This initiative has streamlined and formalised activity management across Calvary's clinical areas. The AIP involves all clinical areas to provide real-time reporting on patient status and treatment plans, which in turn enables coordinated and timely treatment and progress for patients. The incidence of delays to treatment and discharge processes has been markedly reduced.
- Remodelling Emergency Department (ED) processes. While the formal review of ED procedures is scheduled for the second half of 2011, patient streaming processes commenced in the reporting year. These processes have significantly reduced both the waiting times for non-life threatened patients and the number of patients leaving ED before being seen by a doctor.
- Meeting the allied health requirements for maternity, aged care and mental health service patients.
- Achieving record elective and emergency surgery levels. Calvary Hospital was supported by its surgical, medical, nursing and allied health cohort to develop an innovative surgery program targeting long-wait elective surgery patients. Considered scheduling of surgery and accurate activity management enabled Calvary to achieve its agreed elective surgery level and to undertake additional surgery for more than 1000 people classified as long-wait surgery patients.
- Reducing the number of elective surgery patients on Calvary Hospital's waiting list compared with the previous year's.
- Reducing the number of people on the endoscopy waiting list to within national benchmarks.
- Establishing the Calvary Centre for Palliative Care Research (CCPCR). A collaborative agreement was enacted between CHC ACT and the Australian Catholic University to establish the CCPCR at Clare Holland House. The CCPCR will promote optimal health in the community in relation to issues of death and dying, and advance palliative and end-of-life care through innovative, collaborative programs of interdisciplinary, nursing-led research.
- Continuing the Calvary Refugee Mentoring Program to provide workplace placements and learning for refugees, thereby assisting their capacity to pursue employment and other opportunities in their new place of residence and to assimilate with their community.

- Expanding the Calvary volunteer program to provide training and support for volunteers to assist in administration and patient and visitor support programs across the Calvary campus.
- Providing Calvary's second and third artist-in-residence placements, and formalising arrangements with the Belconnen Arts Centre for the artists to exhibit their works as a part of the centre's exhibition programs.
- Commencing an expanded community engagement program with the Community Open Day in March 2011. An estimated 2000 people visited Calvary to take a 'behind the scenes' tour of clinical areas that are traditionally not accessible to the public.
- Appointing the Calvary Community Advisory Board to provide additional opportunities for the community to contribute to service delivery and enhancement across the Calvary campus.
- Building strong and productive relationships with Calvary's Bruce Precinct neighbours, including the University of Canberra, Canberra Institute of Technology and Radford College, and further developing partnerships with the wider Catholic community through networks with the Australian Catholic University and Daramalan College.
- Being confirmed as an e-Health lead implementation site under the Commonwealth Government's Personally Controlled Electronic Health Records (PCEHR) program. Calvary was announced as one of nine second wave e-Health lead implementation sites in March 2011, with final agreements executed in June 2011.
- Pursuing excellence in research and development.
    - The CHC ACT Hospital Research and Ethics Committee approved a total of 27 research projects. These included four nurse-led research projects being awarded ACT Health Directorate Practice Development Grants, and two that were subsequently implemented into direct nursing practice.
    - Calvary's Nutrition Department is a leader in its professional field, with clinical audits driving the implementation of the EQUiP5 accreditation criterion, improving nutrition risk screening and implementing education for nursing staff.
    - The Critical Care Unit/Intensive Care Unit continued to engage in pharmaceutical and cardiac clinical trials, with seven trials in progress at the time of reporting.
    - The 'Sedation Practices in Intensive Care in Australia and New Zealand' guideline was approved at Calvary.

Issues and analysis

The reporting period presented a number of significant governance and operational challenges for CHC ACT.

At the commencement of the reporting period negotiations continued between the territory and LCMHC regarding the purchase of Calvary Hospital by the territory. During the first quarter of the reporting period these negotiations ceased, with the parties unable to finalise an arrangement for a change of ownership.

In the second quarter of the reporting period the ACT Legislative Assembly referred to the Standing Committee on Health, Community and Social Services four options for future ownership and management arrangements of Calvary Hospital.

Early in 2011 the territory also opened to public consultation the future options for Calvary Hospital and the consideration of a third acute care hospital for Canberra.

Late in the reporting period the territory announced that acute care services would continue from Calvary Hospital and that future planning for ACT public hospital services would include an increase in capacity and service from Calvary. This decision has set the scene for enhancement of the Calvary site and for the establishment of long-term formal service network agreements and productive role delineation arrangements between Calvary Hospital and the Canberra Hospital.

Despite a degree of uncertainty around Calvary's long-term future, the organisation embarked on a program of increased surgical throughput to target elective surgery waiting lists. This program was extremely successful in respect of ophthalmology and some specialty orthopaedic and urology surgery.

Communication continued to be an issue that adversely affects the satisfaction of a small proportion of Calvary patients. Occasions still arise where patients and their support group feel uninformed of imminent and longer term elements of the intended patient journey. Calvary operates a program titled 'Simply Better Care' that provides all staff with a suite of simple strategies that greatly improve communications between patients and clinicians. This program will be strengthened in 2011–12.

Future directions

With the long-term future of Calvary Hospital as an acute care facility assured and clarified through formal service network agreements, Calvary can focus on the following directions:

- commencing planning the development of Calvary's Bruce site
- advancing planning for improved car parking services and the refurbishment of Calvary's Emergency Department
- formalising long-term service and role delineation between Calvary and other primary health care service providers and establishing contemporary agreements for these activities
- strengthening CHC ACT's links with the community through partnerships embracing education and learning, clinical enhancement, community service and good citizenship
- continually scrutinising existing models of care and rigorously assessing, trialling and evaluating alternative models of care and improved practices
- maintaining the commitment to achieving national benchmarks for the costs of delivering services
- embedding the Access Improvement Project principles and processes and improving interdisciplinary collaboration and cooperation
- improving admission and information processes for both scheduled and emergency patients to clearly establish the rights of patients and their obligations while at Calvary Hospital
- continuing to develop and implement innovative and effective strategies concerning the five areas of preventable harm
- leading the consortium of clinical and technical partners in the development of a patient-controlled electronic health record as a part of the Department of Health and Ageing and National e-Health Transition Authority transformation of collecting and securing health information
- enhancing the 'hospitality' Calvary provides for patients through new patient entertainment services
- reviewing and revising directional signage across the Calvary campus.

A.10
Triple bottom line report

	INDICATOR	2009–10 Result	2010–11 Result	% Change
ECONOMIC	Employee Expenses			
	- Number of staff employed (head count)	5,594	5,953	6.4%
	- Total employee expenditure	$438,390,000	$474,456,000	8.2%
	Operating Statement			
	- Total expenditure	$990,380,000	$1,077,582,000	8.8%
	- Total own source revenue	$205,791,000	$225,254,000	9.0%
	- Total net cost of services	$784,589,000	$852,328,000	8.6%
	Economic Viability			
	- Total assets	$689,123,000	$806,615,000	17.0%
	- Total liabilities	$205,881,000	221,14,000	7.4%
	Transport			
	- Total number of fleet vehicles	314	320	1.9%
	- Total transport fuel used (kilolitres)	365	358	-1.9%
	- Total direct greenhouse emissions) of the fleet (tonnes of $CO2_e$)	972	968	-0.4%
ENVIRONMENTAL	Energy Use			
	- Total office energy use (megajoules)[1]	4,223,628[2]	10,474,606	148%
	- Office energy use per person (megajoules)	10,829[3]	26,789	147.4%
	- Office energy use per m^2 (megajoules)	731[4]	1,647	125.3%
	Greenhouse Emissions			
	- Total office greenhouse emissions - direct and indirect (tonnes of $CO2_e$)	1,472.2	2,507[8]	70.3%
	- Total office greenhouse emissions per person (tonnes of $CO2_e$)[5]	107[6]	4.20	N/A
	- Total office greenhouse emissions per m^2 (tonnes of $CO2_e$)	7.25[7]	0.25	N/A
	Water Consumption			
	- Total water use (kilolitres)	160,249	152,278	3.6%
	- Office water use per person (kilolitres)[9]	28.82[10]	N/A[11]	N/A
	- Office water use per m^2 (kilolitres)	0.97	N/A[12]	N/A
	Resource Efficiency and Waste			
	- Total co-mingled office waste per Headcount (litres)	514	142.97[13]	72.0%
	- Total paper recycled (litres)	1,991,288	1,312,855 [14]	34.0%
	- Total paper used (by reams) per Headcount	9.15 reams	7.75 reams	15.0%
	- Percentage of paper recycled (%)	N/A	N/A	N/A

	INDICATOR	2009–10 Result	2010–11 Result	% Change
SOCIAL	The Diversity of Our Workforce			
	- Women (Female FTEs as a percentage of the total workforce)	77.46%	76.63%	1.1%
	- People with a disability (as a percentage of the total workforce)	1.77%	1.93%	9.0%
	- Aboriginal and Torres Strait Islander people (as a percentage of the total workforce)	0.63%	0.84%	33.3%
	- Staff with English as a second language (as a percentage of the total workforce)	15.37%	16.93%	10.1%
	Staff Health and Wellbeing			
	- OH&S Incident Reports	1,431	1,219	-14.8%
	- Accepted claims for compensation (as at 31 August 2011)	94	72	
	- Staff receiving influenza vaccinations	2,788	2,793	0.2%
	- Workstation assessments requested	Not collected	128	N/A

1. Per FTE.
2. Office only required to be reported in 2009–10. See L7 in C21 report. Figure for total in 2009–10 for total energy use should be 9,495,911.
3. This amount was only partially reported in 2009–10. It relates to the figure in L7 in section C.21 and should be 24,348.
4. This amount was only partially reported in 2009–10. It relates to the figure in L7 in section C.21 and should be 1,644.
5. Per FTE.
6. This amount was only partially reported in 2009–10 and should be 3.7.
7. This amount was only partially reported in 2009–10 and should be 0.25.
8. Report criteria in C.21 refer to total stationary greenhouse gas emissions.
9. Per FTE.
10. Not reported in 2009–10. Figure in this report relates to the 2008–09 reported amount. 2009–10 and 2010–11 not reported as tenanted office spaces in 1 and 11 Moore Streets are not sub-metered.
11. Not sub-metered.
12. Not sub-metered.
13. The figure of 142.97 is a significant reduction against the 2009–10 figures, which also included a cardboard (in litres) figure. Co- mingled office waste refers to plastics, cans and glass only.
14. The figure of 1,312,855 is a significant reduction against the 2009–10 figures, which included an additional (extra) secure paper waste figure of 557,538 litres. An adjusted 2009–10 figure of 1,433,750 (– 557,538 litres) represents a change of 8% when compared to the 2010–11 figure of 1,312,855, and this is due to a reduction in the use of secure paper services.

Section B

Consultation and scrutiny reporting

B.1
Community engagement

The Health Directorate has actively engaged with the community on a range of matters, as indicated in the table below.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
E-Health and Clinical Records					
E-Health and Clinical Records	E-Health project steering committees	Participation of a consumer representative on all steering committees, where relevant.	A consumer representative on steering committees.	A consumer representative on steering committees.	E-Health and Clinical Records.
E-Health and Clinical Records	Implementation of Health Services Directory	Involvement in the development of the web-enabled consumer search and access to be used for the ACT Health Services Directory.	Health Care Consumers' Association.	10–15	E-Health and Clinical Records.
Service and Capital Planning					
Health Services Planning Unit	Ambulatory Health Services Framework	Consumer representatives on the plan's Steering Committee.	Consumer representatives on Steering Committee, ACT Division of General Practice, Health Care Consumers' Association.	1 representative from each group.	Framework under development.
Health Services Planning Unit	Rehabilitation and Aged Care Plan	Consumer representatives on the plan's Steering Committee.	Consumer representatives on Steering Committee, ACT Division of General Practice, Health Care Consumers' Association, ACT Council on the Ageing.	1 representative from each group.	Plan under development.
Health Services Planning Unit	Cancer Services Plan	Consumer representatives on the plan's Steering Committee.	Consumer representative on Steering Committee.	1 consumer representative.	Plan under development.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Service and Capital Planning	Health Directorate Redevelopment Committee	Consumer representatives on the committee.	Health Care Consumers' Association.	2 consumer representatives.	Committee continues to meet monthly.
Service and Capital Planning	Gungahlin Community Health Centre preliminary sketch plans	Detailed communication and consultation strategy. The primary tools were a display in the Gungahlin Marketplace, a dedicated page in the Health Directorate website, and displays of the artist's impressions. Other tools included: • media announcements and media coverage • press advertisements • posters • emails to all Health Directorate staff and key stakeholders • staff newsletters • whole-of-government messages • and a presentation to the Gungahlin Community Council.	ACT community, Health Directorate staff.	More than 1000.	There was overwhelming community support for the new health centre in Gungahlin. Comments and suggestions on the preliminary sketch plans informed the development of final sketch plans.
Service and Capital Planning	Belconnen Community Health Centre preliminary sketch plans	Detailed communication and consultation strategy. The primary tools were information sessions in the Belconnen Library, a dedicated page in the Health Directorate website, and displays of the artist's impressions. Other tools included: • media announcements and coverage • press advertisements • posters • emails to all Health Directorate staff and key stakeholders • staff newsletters • and whole-of-government messages.	ACT community, Health Directorate staff.	More than 1000.	Although community engagement in this project was limited, those that did provide comment were very supportive. Comments and suggestions on the preliminary sketch plans informed the development of final sketch plans.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Service and Capital Planning	Tuggeranong Community Health Centre preliminary sketch plans	Detailed communication and consultation strategy. The primary tools were a display in the Tuggeranong Hyperdome, information sessions in the Tuggeranong Library, a dedicated page in the Health Directorate website, and displays of the artist's impressions. Other tools included: • media announcements and coverage • press advertisements • posters • emails to all Health Directorate staff and key stakeholders • staff newsletters • whole-of-government messages • a presentation to the Tuggeranong Community Council • an article in the Tuggeranong Community Council newsletter *Valley Voice*.	ACT community, Health Directorate staff.	More than 1100.	There was significant community engagement and support for the Tuggeranong Community Health Centre and the refurbishment design plans. Comments and suggestions on the preliminary sketch plans informed the development of final sketch plans.
Service and Capital Planning	Capital Region Cancer Centre preliminary sketch plans	A detailed communication and consultation strategy was implemented across the ACT community and surrounding NSW region. The primary tools were displays in the Westfield Woden and Westfield Belconnen shopping centres, an information session at Canberra Hospital, a dedicated page in the Health Directorate website, and displays of the plans in the public waiting area of the Radiation Oncology building at Canberra Hospital. Other tools included: • media announcements and coverage • press advertisements, both locally and in regional press;	ACT community, Health Directorate staff, Cancer support groups, South-east NSW community —primarily those living within the catchment area of the Capital Region Cancer Service.	More than 1200.	There was significant community engagement and support for the Capital Region Cancer Centre and its design plans. Comments and suggestions on the preliminary sketch plans informed the development of final sketch plans.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Service and Capital Planning *—continued*		• posters • emails to all Health Directorate staff and key stakeholders • flyers provided to cancer support groups staff for further distribution through their networks; • flyers provided to the Southern NSW Local Health District for distribution to cancer support groups in south-east NSW • a contribution to the Cancer Council ACT newsletter • whole-of-government messages • a postcard delivered to approximately 2500 local households surrounding the Canberra Hospital campus.			
Service and Capital Planning	Community Health Project Control Group (PCG)	Consumer representatives on committee	Health Care Consumers' Association	2 consumer representatives	Advice and endorsement of CADP projects. In 2011–12 this group will be in the combined Health Directorate PCG
Service and Capital Planning	Mental Health Project Control Group (PCG)	Consumer representatives on committee	Mental Health Consumers	3 consumer representatives	Advice and endorsement of CADP projects. In 2011–12 this group will be in the combined Health Directorate PCG
Service and Capital Planning	Canberra Hospital Campus Project Control Group (PCG)	Consumer representatives on committee	Health Care Consumers' Association	2 consumer representatives	Advice and endorsement of CADP projects. In 2011–12 this group will be in the combined Health Directorate PCG

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Human Resource Management Branch					
Workforce Policy and Planning Unit	Programs under the GP Workforce Program Education Infrastructure Support Grant Payment (EISGP) Health Directorate —ANU GP Scholarships	GP Workforce Working Group (GPWWG).	Key general practice stakeholders.	Representatives from key ACT/federal government and medical organisations as per the Terms of Reference. Special Subgroups formed under the group's work plan requirements.	Ongoing: Providing input into development/enhancements of current programs, including reviewing the GP Scholarships Program. Providing expert advice on general practice workforce issues.
Workforce Policy and Planning Unit	Revision of the Health Workforce Plan (ACT) — in progress	Website presence on Health Directorate website. Targeted emails to key stakeholder organisations seeking input. Discussion paper to be released imminently.	ACT-wide health professionals, health service organisations in the ACT, relevant industrial and professional bodies, NGO, healthcare consumers and Health Directorate staff and managers.	72 external organisations/ individuals consulted, 39 ACT Health Directorate services/ individuals consulted. Input from 23 external organisations/individuals and 20 Health Directorate services /individuals.	Will inform the revision of the local health workforce plan.
Nursing and Midwifery Office					
Nursing and Midwifery Office	Mechanisms to engage the professions of nursing and midwifery and the community	Nursing and Midwifery website.	Available on the internet.	5000+	Open communication, timely promulgation of nursing and midwifery news.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Nursing and Midwifery Office	Mechanisms to engage the professions of nursing and midwifery and the community	Nursing and Midwifery Newsletter.	Aged care sector, tertiary education sector, nurses and midwives, community members, professional organisations, private and public institutions.	600	Informed workforce and community.
Nursing and Midwifery Office	Australian War Memorial Remembrance Ceremony	Memorial service held during International Nurses and Midwives Week of celebrations.	Veterans, nurses and midwives, defence force personnel, community members.	200	Respect and honour to members of the defence forces who have served our country.
Nursing and Midwifery Office	Community representation	Community representation on the Council for Nurses and Midwives ACT, the peak nursing and midwifery forum for nurses and midwives from all sectors across the ACT.	Consumer Health Forum.	Healthcare consumer representation (x 2).	Strategic workforce issues and professional matters conveyed to Council for Nurses and Midwives, community representative participates in decision making.
Policy and Government Relations Branch					
Aboriginal and Torres Strait Islander Health Unit	Aboriginal and Torres Strait Islander Residential Rehabilitation Service—Ngunnawal Bush Healing Farm (NBHF).	Consultation undertaken with the Advisory Board that includes representation from the ACT Aboriginal and Torres Strait Islander communities. Regular quarterly meetings are held. Newsletters that provide an update on progress are distributed to the ACT Rural Landholders. Members have attended meetings of the Advisory Board. Karabena Consulting Pty Ltd consulted widely with the ACT Aboriginal and Torres Strait Islander communities on the development of a model of care. Thinc Health developed a Health Planning Unit Brief and Schedule of Accommodation.	The Advisory Board includes individuals from the Aboriginal and Torres Strait Islander communities, representatives from non-government community organisations, ACT Government Health Directorate and the Australian Government Department of Health and Ageing (ACT/NSW office).	A total of 23 people (including Advisory Board members) are involved in regular consultations.	The NBHF service aims to improve health outcomes for Aboriginal and Torres Strait Islander peoples in the ACT and surrounding region by addressing the complex issues that relate to drug and alcohol abuse.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Aged and Community Care Policy	Home and Community Care (HACC) /Disability Network	Monthly meetings	Comprising HACC and disability service providers from the ACT community sector and relevant areas of the ACT and Australian Governments.	Approximately 30 members per monthly meeting.	Ongoing consultation and communication regarding issues and activities affecting the ACT HACC/disability sector.
Aged and Community Care Policy	HACC Sector Planning Day	Annual event	The HACC Sector Planning Day is an annual event bringing together executives, senior managers and coordinators from ACT HACC-funded agencies and government.	There are between 60 and 80 attendees per year.	Future strategies and issues around a theme, pre-determined by the HACC-Disability Working Group, are discussed and planned.
Alcohol and Other Drug Policy Unit	The Macfarlane Burnet Institute for Medical Research and Public Health—External Component of the Evaluation of Drug Policies and Services and their Subsequent Effects on Prisoners and Staff within the Alexander Maconochie Centre.	Workshops, group and individual interviews.	Prison management and staff, community-based service providers, prisoners and ex-prisoners in the ACT.	Community-based service providers and other stakeholders: n = 29 Prisoners: n=19 Ex-prisoners: n= 9	Supported recommendations from the report to be implemented.
Chronic and Primary Health Policy Unit	The ACT Primary Health and Chronic Disease Strategy Committee oversees implementation of the ACT Primary Health Care Strategy 2006–2009, the ACT Chronic Disease Strategy 2008–2011 and other chronic disease and primary health initiatives.	Committee membership.	Consumers and community organisations are represented on this committee by representatives of the Health Care Consumers' Association, Winnunga Nimmityjah Aboriginal Health Service, ACT Division of General Practice, Pharmacy Guild ACT, ANU Medical School, Heart Foundation ACT and Diabetes ACT.	Seven non-government organisations representing community members are consulted.	Ongoing. The committee responds as appropriate to issues raised by consumer and community organisation representatives.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Chronic and Primary Health Policy Unit	The ACT Palliative Care Strategy Implementation Steering Committee is responsible for implementing the ACT Palliative Care Strategy 2007–2011.	Committee membership.	Consumers and community organisations are represented on this committee by representatives of the Health Care Consumers' Association, Winnunga Nimmityjah Aboriginal Health Service, Carers ACT and ACT Palliative Care Society.	Four non-government organisations representing community members are consulted.	Ongoing. The committee responds as appropriate to issues raised by consumer and community organisation representatives.
Chronic and Primary Health Policy Unit	The Diabetes Services Strategic Plan Transition Team is responsible for implementing the Diabetes Services Strategic Plan in a staged approach through the development of a transition plan.	Committee membership.	Consumers and community organisations are represented on this committee by representatives of the Health Care Consumers' Association, Diabetes ACT and ACT Division of General Practice (ACTDGP).	Three non-government organisations representing community members are consulted.	Ongoing. The committee responds as appropriate to issues raised by consumer and community organisation representatives.
Chronic and Primary Health Policy Unit	Development of the ACT Primary Health Care Strategy 2011–14	The development of the new ACT Primary Health Care Strategy has involved wide community consultation. Two consultation forums were held in November 2010: a consumer, carers and community members forum; and a GPs and service providers forum. The draft strategy was released for public consultation between 11 March and 22 April 2011. A final consultation forum was held in March 2011.	Written submissions were received from Carers ACT, Cancer Council ACT, Royal Australian College of General Practitioners, ACT Mental Health Consumer Network, Women's Centre for Health Matters, University of Canberra, Royal College of Nursing Australia, Pharmacy Guild of Australia ACT Branch, Heart Foundation ACT, Health Care Consumers' Association ACT and a member of the public.	Written submissions were received from 11 community organisations, and approximately 45 people attended the public forums.	Feedback received from the first two public forums was utilised to develop the draft Primary Health Care Strategy. This draft was then refined through the release of the draft strategy for public consultation and the final community forum. The finalised strategy more accurately reflects the thinking of the ACT community with regard to primary health care.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Chronic and Primary Health Policy Unit—*continued*		*—continued*	Palliative Care Society, Epilepsy ACT, the ACT Division of General Practice and a large number of individual consumers. In addition to those listed above, the consultation forums were attended by representatives of the Australian Physiotherapy Association, CatholicCare, ACT Australian Nursing Federation, Neurospace, Companion House, Chiropractors Association,	*—continued*	*—continued*
Mental Health Policy Unit	Community education sessions	The Mental Health Community Development and Education Officer continues to provide community education sessions as requested in the ACT community. Sessions are conducted within and outside the mental health sector for government and community groups. Community education sessions are delivered in partnership with mental health consumers or carers.	26+ community education sessions held.	500+	Community education responds to community requests.
Mental Health Policy Unit	Mental Health Promotion Prevention and Early Intervention (PPEI) Working Group	The evaluation and implementation working group oversees the implementation and evaluation of *Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009–2014.*	The evaluation and implementation working group has met bi-monthly with representation from the community mental health sector, consumers, carers, Health Directorate, ACT Education and Training Directorate, Justice and Community Safety Directorate, Community Services Directorate and the Australian National University.	Four meetings with 14 participants.	Ongoing implementation and evaluation of *Building a Strong Foundation: A framework for Promoting Mental Health and Wellbeing in the ACT 2009–2014.*

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Mental Health Policy Unit	ACT Suicide Prevention Implementation and Evaluation Working Group (SPIEWG)	The evaluation and implementation working group continues to oversee the implementation and evaluation of *Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009–2014.*	The evaluation and implementation working group has met bi-monthly with representation from Lifeline Canberra, Lifeline Australia, OzHelp Foundation, Carers ACT, Supportlink, MensLink, Australian National University, ACT Mental Health Consumer Network, Mental Health ACT, Education and Training Directorate, Justice and Community Safety Directorate, ACT Policing and ACT Division of General Practice.	Five meetings with 16 participants.	Ongoing implementation and evaluation of *Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009–2014.*
Mental Health Policy Unit	Review of the *Mental Health (Treatment and Care) Act 1994.* A review team has been appointed to carry out the review with oversight by a Review Policy Management Team and Review Advisory Committee.	Broad stakeholder representation on Review Advisory Committee meetings and workshops. Policy Management Team and Review Advisory Committee meetings and workshops.	Members of the Review Advisory Committee include government and non-government mental health services, ACT Youth Coalition, ACT Division of General Practice, ACT Mental Health Consumer Network, Mental Health Community Coalition of the ACT, Carers ACT, Community Services Directorate, Justice and Community Safety Directorate and ACT Policing.	Thirty-six members of the Policy Management Team and Review Advisory Committee.	Agreement on recommendations for the framework of the revised Mental Health (Treatment and Care) Act.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Women, Youth and Child Health Policy Unit	Women's Health Advisory Network. Monitors implementation of women's access to health services and implementation of the Strategic Framework 2010–2015.	Advisory Committee	Health Care Consumers' Association, Women's Centre for Health Matters, Greater Southern Area Health Service South-East NSW, Women With Disabilities ACT, QEII Family Centre, Pregnancy Support Service, Ministerial Advisory Committee for Women, Office for Women, Health Directorate Staff.	20	Meets quarterly, ongoing.
Population Health					
Health Protection Service	Kava supply in the ACT	In April 2011, a joint community statement was released to the Pacific Island community by the ACT Health and Office of Multicultural, Aboriginal and Torres Strait Islander Affairs (OMATSIA). Forum held on 11 May 2011, in collaboration with OMATSIA, in which Pacific Island community leaders were invited to express their views.	Pacific Island community.	Broad community base as distributed by OMATSIA. Approximately 50 invitations were sent; approximately 20 attended.	Ongoing.
Health Protection Service	*Smoke-Free Public Places Act 2003* campaign	Industry presentations on the S*moke-Free Public Places Act 2003* were held in September 2010. Handouts were supplied to community groups regarding legislative changes.	Licensed premises in the ACT.	80+	Prepared industry for new legislative requirements. Comments used in the development of future consultative forums.
Health Protection Service	Ongoing management of influenza in the ACT	Key stakeholder meetings conducted throughout 2010.	Various groups, including ACTDGP, Child Youth and Women's Health Program, Department of Education and Training.	Approximately 10 participants from various organisations.	Ongoing.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Population Health Executive Office	Local implementation of national reforms of the organ and tissue donation sector	Community representation on ACT organ and tissue donation governance committees gained through EOI in *Canberra Times*.	There is community representation on the DonateLife Principal Advisory Committee, whose Chair and Deputy Chair are community/ consumer representatives.	3 participants (representing NGOs,Kidney Health and Gift of Life). 3 other consumer representatives who are organ recipients, family of organ donors, carers of recipients or those on organ donor waiting lists.	Ongoing input into policy and strategic directions for organ and tissue donation in the ACT.
Population Health Executive Office	Review of HIV/AIDS, *Hepatitis C and Sexually Transmissible Infections: A Strategic Framework for the ACT 2007–2012*	The review gathered input from a range of sources, including the feedback gathered from a SHAHRD stakeholder forum in July 2010. The forum was an opportunity for stakeholders to express local views, particularly in the context of the release of the national strategies.	The forum was well attended, with 32 participants, representing 17 different agencies in the sexual health and blood-borne virus sector.	32 participants, representing 17 different agencies.	Forum proposed a range of ideas, which were fed into the final review endorsed by the ACT Health Minister.
Epidemiology	Cervical Program Management Committee	Participation in quarterly meetings.	Consumer representatives from Health Care Consumers' Association, Cancer Council and Women with Disabilities ACT.	3	Ongoing. Consumer input into Cervical Program direction.
Health Promotion Branch	Healthy Workplaces Advisory Group	Stakeholder representation on advisory group established to guide the development and delivery of the ACT Workplace Health Promotion Program.	Representatives from government directorates and NGOs.	7 non-government representatives.	Ongoing advice to the ACT Workplace Health Promotion Program.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Health Promotion Branch	Healthy Workplaces Workplace Capacity-Building Grants Round	Community and industry representation on the assessment panel.	Representatives from government directorates and NGOs.	2 non-government representatives.	Assessment of grant applications and input into the allocation of grants to workplace capacity building for service providers.
Health Promotion Branch	Healthy Communities Initiative pilot project based in inner north Canberra	Stakeholder representation on advisory group established to guide the development and delivery of the Healthy Communities Initiative.	Representatives from government directorates and NGOs.	6 non-government representatives.	Ongoing advice to the Healthy Communities Initiative.
Health Promotion Branch	Healthy Communities Initiative pilot project based in inner north Canberra	Four community focus groups held to guide the nature and scale of interventions to be provided.	Residents and community representatives from the inner north target population.	50 participants.	Ongoing advice to inform the nature of the Healthy Communities Initiative and to provide feedback.
Health Promotion Branch	Integrated mental and physical wellbeing social marketing campaign	14 focus group discussions with ACT residents covering a large range of socio-demographic segments; and 40 in-depth interviews, plus one focus group with sporting and community organisations.	Focus groups with culturally and linguistically diverse (CALD) people, Aboriginal and Torres Strait Islanders, general population, parents with young children, young people, young adults, people with chronic health conditions. Interviews and focus groups with ACT sporting and community organisations.	112 ACT residents Approximately 40 sporting and community organisations.	ACT community supported an integrated mental and physical wellbeing social marketing campaign. Messages were tested and refined resulting in five key concepts: connect, give, be curious, be active, eat well. This will inform the development of a social marketing campaign.
Health Promotion Branch (in partnership with the Aboriginal and Torres Strait Islander Health Unit)	Social research for the combined social marketing campaign regarding tobacco and healthy lifestyle behaviours of the local Aboriginal and Torres Strait Islander community	9 focus discussion groups.	Focus groups with representatives from the Aboriginal and Torres Strait Islander community–young people; pregnant young women; people with an existing chronic disease (over and above 35 years of age);	47 community members and 4 health professionals consulted.	Recommendations for a communication/social marketing strategy made. This will inform the development of a social marketing campaign.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Health Promotion Branch (in partnership with the Aboriginal and Torres Strait Islander Health Unit) *—continued*	(levering off the national Measure Up and tobacco campaigns)		service providers from Winnunga Nimmityjah Aboriginal Health Service and Gugan Gulwan Youth Aboriginal Corporation.		
Health Promotion Branch	Healthy Young People Feasibility Study	A broad stakeholder consultation strategy was undertaken to inform this study. The consultation process included: individual and group face-to-face meetings and telephone interviews; online feedback and surveys; paper-based surveys; and youth week live feedback forum.	Feedback and input was sought from: a range of organisations and individuals who have links to young people's health; service providers and other organisations or individuals with links to young people; young people (12–25 years); and parents and carers of young people.	Almost 1000 participants were actively engaged in the consultation process, comprising: 600 young people; 22 school students; 200 parents and carers; and 100 contacts who, through work, have links to young people's health.	The information provided to the consultants was used to inform the compilation of the ACT healthy young people feasibility study final report.
Health Promotion Branch	Preparation of the information paper *'ACT Healthy Children's Initiative: A proposed approach 2010–11 – 2014–15*	An information paper was prepared to inform the development of the ACT Healthy Children's Implementation Plan under the National Partnership Agreement on Preventive Health. The paper was electronically circulated to key stakeholders.	Organisations involved in the provision of services to children were provided with the information paper.	30 organisations.	Awareness was raised among key stakeholders of the initiatives planned by the Health Directorate to improve the health and wellbeing of children aged 0–12 in the coming years, to ensure effective engagement, cooperation and collaboration.
Health Promotion Branch	Health Promotion Grants Program	Community representation within four funding round assessment panels.	Representatives from the community and non-government organisations.	4 participants.	Assessment of grant applications and input into the allocation of grants to community-based projects.
Health Promotion Branch	Healthy Workplaces Advisory Group	Stakeholder representation on advisory group established to guide the development and delivery of the ACT Workplace Health Promotion program.	Representatives from government directorates and NGOs.	7 non-government representatives.	Ongoing advice to the ACT Workplace Health Promotion Program.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Health Promotion Branch	Healthy Workplaces Workplace Capacity Building Grants Round	Community and industry representation on the assessment panel.	Representatives from government directorates and NGOs.	2 non-government representatives.	Assessment of grant applications and input into the allocation of grants to workplace capacity-building for service providers.
Health Promotion Branch	Healthy Communities Initiative pilot project based in inner north Canberra	Stakeholder representation on advisory group established to guide the development and delivery of the Healthy Communities Initiative.	Representatives from government directorates and NGOs.	6 non-government representatives.	Ongoing advice to the Healthy Communities Initiative.
Health Promotion Branch	Healthy Communities Initiative pilot project based in inner north Canberra	Four community focus groups held to guide the nature and scale of interventions to be provided.	Residents and community representatives from the inner north target population.	50 participants.	Ongoing advice to inform the nature of the Healthy Communities Initiative and to provide feedback.
Canberra Hospital and Health Services					
Rehabilitation, Aged and Community Care	Community Rehabilitation Team—SPICE Programs (Parkinson's and stroke)	Seek feedback via a survey.	Participants of the program.	25 and carers.	Changes to format delivery and frequency of programs.
Aged Care and Rehabilitation Service	Clinical Governance Committee	Committee membership.	Consumer representative from HCCA.	HCCA.	Consumer input into development, implementation and evaluation of quality and safety initiatives, risk management and policy development.
Aged Care and Rehabilitation Service	ACT Equipment Subsidy Scheme Advisory Committee	Committee membership.	HCCA representative. PWD (People with Disabilities) representative.	2	Representatives continue to provide advice to committee regarding approval of high-cost applications and future service development.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Aged Care and Rehabilitation Service	Domiciliary Oxygen and Respiratory Support Scheme Advisory Committee	Committee membership.	ACT Sleep Apnoea Association representative. HCCA Lung Life representative. ACT DonateLife representative.	3	Representatives provide advice to committee regarding approval of extraordinary applications and future service development.
Rehabilitation, Aged and Community Care	Village Creek Centre Steering Committee (pre-relocation)	Committee membership and consumer workshops.	Consumer representatives, including HCCA, People with Disabilities ACT, Disability ACT, COTA, Women with Disabilities, plus some individual consumers involved in consumer workshops.	15–20 plus combined feedback from organisations.	A coordinated direction for working groups and direct feedback to Aged Care and Rehabilitation Service executive. Development of consumer evaluation indicators for ongoing evaluation post-relocation.
Rehabilitation, Aged and Community Care	Village Creek Centre Steering Committee (post-relocation)				Ongoing feedback to consumer groups every six to 12 months based on consumer evaluation indicators. Steering Committee finalised on completion of stage 1. Steering Committee will be re-established for stage 2 if required.
Rehabilitation, Aged and Community Care	Village Creek Centre	Village Creek Project Working groups to develop a model of care.	HCCA representatives.	4	Development of models of care and client service pathways. Equipment and technology requirements to meet best practice. Storage and space requirements to achieve service efficiencies. Working groups completed on relocation.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Aged Care and Rehabilitation Service	Village Creek Centre	HCCA, PWD and ACRS hosted two consumer forums and two site visits.	ACT Council on the Ageing, People with Disabilities, Women with Disabilities, HCCA.	16	To inform and gain feedback on aspects of the transition e.g. access issues and solutions, proposed models of care, fit-outs etc. and seek feedback.
Rehabilitation, Aged and Community Care	Village Creek Centre	Official Opening and Community Open Day.	HCCA, PWD, general consumers, local community.	100	To inform and gain feedback on the refurbished centre and relocated services.
Rehabilitation, Aged and Community Care	Health Workforce Australia (HWA)—Care of the older person project.	Committee membership.	HCCA and HACC provider representatives.	2	Committee to provide input into a HWA workforce initiative and processes to ensure initiative integrates current clinical pathways.
Rehabilitation, Aged and Community Care	Walk-in Centre Clinical Advisory Group	Consumer representative.	Representation from the HCCA .	2	Consumers have provided advice for ongoing policy and protocol development in the new Walk-in Centre model of care.
Rehabilitation, Aged and Community Care	Volunteer Program	Consumer representative.	The Canberra Hospital Volunteer Program credentialed volunteers.	2	New service being developed.
Aged Care and Rehabilitation Service	Partners In Culturally Appropriate Care (PICAC)—Information on Cultural Competency	Cultural competency training to staff from residential aged care facilities and community-based service providers.	Aged care facilities and community-based service providers across the ACAT region.	Approximately 60 attendees.	Improve the capacity for service providers to provide culturally appropriate care to clients.
Canberra Hospital	Clinical Board	Board consultation and the use of the ACT Health Consumer Representative Program through the Health Directorate Consumer Engagement Team.	HCCA.	HCCA.	Appointment of one consumer representative through the ACT Health Consumer Representative Program to ensure consumer input into development, implementation and evaluation of quality and safety initiatives.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Canberra Hospital	Clinical Review Committee	Committee consultation and the use of the ACT Health Consumer Representative Program through the ACT Health Consumer Engagement Team.	Health Care Consumers' Association consulted.	Health Care Consumers' Association.	Appointment of three consumers (rotating position) through the ACT Health Consumer Representative Program to ensure consumer input into development, implementation and evaluation of quality and safety initiatives. The committee is convened weekly with the consumers.
Canberra Hospital	Clinical Ethics Committee	Committee consultation and the use of the ACT Health Consumer Representative Program through the ACT Health Consumer Engagement Team.	HCCA.	HCCA.	Appointment of two consumer representatives through the Consumer Representative Program. Committee convened bi-monthly. Consumers support healthcare professionals in considering ethical issues and decisions related to clinical practice and help patients, relatives and advocates resolve concerns about ethical aspects of clinical practice.
Canberra Hospital	Medication Safety Working Group	Clinical Board consultation and the use of the ACT Health Consumer Representative Program through the ACT Health Consumer Engagement Team. Emails and letters of invitation.	HCCA.	HCCA.	Appointment of consumer representative through the ACT Health Consumer Representative Program to support healthcare professionals in the consideration of medication safety issues and decisions relating to safe medication management during hospitalisation and on patient's discharge.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Women's, Youth and Children Division	Your Health, Our Priority Stage 1 and Stage 2—New Women's and Children's Hospital	User groups quarterly newsletter mail-outs, public meetings/consumer consultation for final sketch plans of stage 1 of the project and preliminary sketch plans of stage 2.	Women and Babies User Group, Paediatric User Group, NICU User Group, Friends of the Birthing Centre, Australian Breastfeeding Association, residents of suburbs adjacent to the Canberra Hospital, Kidsafe, Starlight Foundation, Ronald McDonald House, other ACT agencies.	50	That input, feedback and decisions reflect the needs and requirements of all stakeholders who will use the new hospital.
Canberra Hospital, Women, Youth and Children	New Women's and Children's Hospital child and adolescent consultation regarding the interior design of the hospital.	Consultation at schools and in adolescent community areas to obtain input on the interior design of the new hospital.	Schools (Burgmann Anglican School and Monash Primary School) and Youth Drop-in Centre and CYCLOPS.	100	That input, feedback and decisions reflect the needs and requirements of all stakeholders who will use the new hospital.
Women's, Youth and Children Division	Family Advisory Network Paediatrics at the Canberra Hospital (PatCH) Consumer Network of Paediatrics	Public fundraising activities. Newspaper articles, advertisements in local newspapers and newsletters. Re-forming the Paediatric Consumer Consultative committee into the PatCH. Family Advisory Network being more representative of both the community and consumer expectations.	Major commercial organisations, consumers, parents/relatives of current and former patients, members of the community dedicated to paediatrics at Canberra Hospital.	5–10 people on a regular quarterly basis.	Improved community awareness and support of PatCH with common vision, goals and problem-solving capacity.
Women's, Youth and Children Division	Department of Neonatology—	The current user group, which meets face to face, wished to encourage participation by a larger cohort of stakeholders. Letters were mailed out to individuals requesting their participation.	Members of the User Group of the Centre for Newborn Care, young mothers and fathers in the ACT, parents outside the ACT and various other stakeholders.	130	To involve more consumers in the important decisions regarding the development of the Centre for Newborn Care within the CADP.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Women's, Youth and Children Division *—continued*	Development of web-based parent discussion forum for parents of former patients to be involved in the redevelopment of the Centre for Newborn Care within the CADP.				
Women's, Youth and Children Division	ACT Breastfeeding Initiative Steering Group. Implementation of ACT Breastfeeding Strategic Framework.	Consumer representative in ongoing advisory role.	Health Care Consumers' Association, Australian Breastfeeding Association, QEII Family Centre, lactation consultant, Winnunga, Health Directorate staff.	8	Ongoing.
Division of Medicine	Renal Advisory Committee	Regular monthly meeting with community engagement.	Patients, doctors, nurses and consumer representatives.	50	To involve consumers in decisions regarding renal services.
Capital Region Cancer Service	Cancer support groups	Participation in meetings about specific issues.	Leukaemia Foundation, prostate support group, brain tumour group.	10	Ongoing meetings to communicate with cancer support groups.
Capital Region Cancer Service	Information Management and Information Technology (IM&IT)	Participation in monthly meetings.	Representative from the HCCA.	1	Ongoing. Consumer viewpoint on the management of IT systems from an operational point of view.
Capital Region Cancer Service	Cancer Information Management System (CIMS)	Participation in monthly steering committee meeting.	Representative from the HCCA.	1	Ongoing. Consumer input into the governance of the information system.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Capital Region Cancer Service	Capital Region Cancer Centre	Committee membership.	Consumer representatives from Health Care Consumers' Association.	2	Ongoing. Consumer input in the planning phase of the Integrated Cancer Centre.
Capital Region Cancer Service	Radiation Oncology Major Equipment Procurement Project (ROMEPP)	Participation in monthly meetings.	The HCCA has been contacted to provide a consumer representative. To date, none have been available to attend.	HCCA representative not available.	Consumer representative requested to give input into the procurement of equipment.
Capital Region Cancer Service	Cancer Network Project (CanNET)	Committee meeting.	A consumer representative that is a member of both HCCA and Cancer Voices ACT.	1	Ongoing. Consumer input into the CanNET project direction.
Capital Region Cancer Service	BreastScreen Program Advisory Group	Participation in quarterly meetings.	Consumer representatives from Breast Cancer Network Australia, Cancer Council and Bosom Buddies.	2	Ongoing. Consumer input into BreastScreen direction.
Capital Region Cancer Service	Breast and Cervical Programs Community Reference Group	Participation in biannual meetings.	Representatives from Council on the Ageing, Cancer Council, YWCA, CWA, Migrant Youth Advocacy, Canberra Multicultural Community Forum, Bosom Buddies, Winnunga Nimmitjah AMS, HCCA ACT, Women with Disabilities ACT.	10	Ongoing. Consumer ideas and feedback on resources, and events to increase participation in the programs.
Women's, Youth and Children Division	Implementation of ACT Breastfeeding Strategic Framework	Focus groups, phone interviews, and consumer representatives on Project Steering Committee.	Focus groups and phone interviews for parents of infants.	100	Inform development of specific implementation strategies as identified in the strategic framework.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Division of Surgery and Oral Health	Dental Health Forum	Consultation forum.	20 members of the Health Care Consumers' Association attended a Dental Health Forum presented by two senior DHP managers.	20	This forum provided information related to available dental services and access to these services. Consumers were encouraged to provide their feedback related to dental services and access and their own personal satisfaction of public dental services. A follow-up information session was held with the DHP and a Health Care Consumers' Association representative, who is actively involved in the ACT Health e-Health reference group in relation to dental information systems. An article related to dental services is also being developed for inclusion in the August 2012 edition of the Superannuated Commonwealth Officers Association newsletter.
Mental Health Services	Trans-Cultural Mental Health Network	The Health Directorate provides ongoing secretariat support for this community network, which includes producing a bi-monthly e-bulletin and is involved in supporting the Transforming Perceptions fortnightly radio show. Mental Health ACT supports the ACT TCMHN in coordinating stalls at various community events.	There are more than 130 individuals and organisations on the network's distribution list. Up to 20 members attend regular network meetings.	130 regularly through network distribution. 50 registered for state consultation.	Ongoing.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Mental Health Services	Community education sessions	The Mental Health Community Development and Education Officer continues to provide community education sessions as requested in the ACT community. Sessions are conducted within and outside the mental health sector for government and community groups. Community education sessions are normally delivered in partnership with mental health consumers.	26+ community education sessions held.	500+	Community education responds to community requests.
Mental Health Services	Community consultation on the discussion paper for the development of the Fourth National Mental Health Plan	Consultation forums for Mental Health ACT staff and for the general community.	Three community consultations and two Mental Health ACT staff forums.	Five consultations with a total of 19 participants.	Feedback from the forums was compiled and submitted to the Australian Government.
Mental Health Services	Community consultation	A presentation, combined with Q&A opportunities, was conducted on the implementation phase of the Model of Care for the new Adult Acute Mental Health Inpatient Unit.	Separate presentations with Q&A opportunities were delivered to the Mental Health Consumer Network, the ACT Mental Health Community Coalition and Carers ACT.	Three presentations were delivered with a combined attendance of 32 members of these three organisations.	Productive feedback was provided at all sessions.
Mental Health Services	Community consultation	Workshops were conducted in support of the development of the values and operating philosophy to be adopted in the implementation of the Model of Care for the new Adult Acute Mental Health Inpatient Unit.	Separate workshops were held with the Mental Health Consumer Network, the ACT Mental Health Community Coalition and Carers ACT.	Three workshops were conducted with a combined attendance of 28 members of these three organisations.	Productive feedback was provided at all sessions.
Justice Health Services	2011 ACT Inmate Health Survey	In May 2010 Justice Health Services surveyed, by questionnaire, clients of the service.	Clients from all accommodation areas of the Alexander Maconochie Centre were consulted.	134	Publication of survey results is expected shortly.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Justice Health Services *—continued*		Included a consumer representative on the coordination team and the surveyors included a master's student from the Australian National University.	*—continued*	*—continued*	Will contribute to a greater understanding of the health issues facing prisoners and improving health outcomes for clients in custody and future planning of services.
Justice Health Services	Health Services at the Hume Health Centre—Pamphlet	A draft was developed by Justice Health Services and then distributed widely for comment, feedback and input.	Client (prisoner groups), ACT Corrective Services, ACT Health Alcohol and Drug Program, Mental Health ACT, Prisoners Aid and Directions ACT.	20	A pamphlet that meets the needs of the clients who will access it.
Alcohol and Drug Services	Monthly health promotion events in collaboration with Canberra Alliance for Harm Minimisation Association (CAHMA)	Monthly meetings with consumer representatives from CAHMA.	Consumer representatives from CAHMA.	5	Monthly health promotion events addressing changing themes (dental health, nutrition, hepatitis and immunisation) held in OTS achieving opportunistic engagement of OTS clients.
Mental Health Services	Satisfaction Survey at Brian Hennessy Rehabilitation Centre	Satisfaction Survey sent to all staff, consumers and their carers.	Staff, consumers and their carers.	100 To be repeated every six months. Next due November 2011.	50 per cent return rate with many issues identified. Progressively making the required changes to improve overall staff, consumer and carer satisfaction. Surveys to be done every six months.
Mental Health Services	Education sessions at residential aged care facilities (RACFs) as part of the National Partnership Agreement	Staff from the Older Persons Mental Health Community Team provide in-service education to residential aged care facilities on the management of mental health conditions/issues.	Various RACFs within Canberra.	Approximately four sessions per quarter.	Quarterly report provided to the Australian Government. Positive responses from participants.

Line area	Project	Consultation process (tools used)	Groups/individuals consulted	Approximate number consulted	Outcome
Mental Health Services	Older Persons Mental Health Service and community stakeholder meetings	Originating from OPMHS Planning Day in November 2010, follow-up meetings have occurred to consider issues of relevance to aged care sector and ACT Mental Health e.g. education, communication processes.	Residential aged care facilities, ACT Division of GPs, RADAR, DBMAS, Aged Care and Rehabilitation Service TCH and others.	Two meetings held since November 2010. Next meeting scheduled in coming weeks.	Increased awareness of older persons' mental health/aged care in provision of services. Improved networking of stakeholders in this sector.
Acute Support Services, Operational Support	Review of the Migrant Health Unit	Community forums, one-on-one consultations, membership on the project Steering Committee.	Canberra Multicultural Community Forum, CALD Women's Network, Arabic Women's Group, Diversity Health Network, Current and past staff of the Migrant Health Unit, Health Directorate.	55 individuals.	Feedback received from the community and staff will be incorporated into a discussion paper, which will offer models for future service provision and will be circulated for broad community consultation.

B.2
Internal and external scrutiny

Reports

The following table summarises reports during the reporting year on aspects on the Health Directorate's operations.

Name of agency	Nature of inquiry/report title	Recommendations/outcome of inquiry	Response to the outcome of inquiry
Pricewaterhouse-Coopers	Review of the Management of Scheduled Drugs	**Eight recommendations were made relating to:** • develop a service-wide drugs disposal policy • fully implement the Controlled Medicines Register • develop policies and procedures for the management of scheduled drugs within Community Mental Health • review specific drug management practices and develop a uniform approach • review the Medicines Regulations and update policy and procedures • record calibrations performed and enable requests for drugs during medication rounds • revise current detainee medication management practices.	Health Directorate agreed to 7 recommendations and agreed in part to one. *The recommendation that was agreed in part related to the development of policies and procedures for drug borrowing, as this practice is not supported.*
Pricewaterhouse-Coopers	Review of VMO Arrangement in Breastscreen ACT/SE NSW	**Six recommendations were made relating to:** • the development of policies and procedures for the payment of invoices, records and late claims follow-up • compliance of claims with terms and conditions of relevant contracts • monitoring and benchmarks productivity and performance • re-negotiation of Breastscreen ACT and SE NSW VMO contracts • reviewing of the approach for allocation of third reads to VMOs and ACT patient reads to NSW.	Health Directorate agreed to all the recommendations made in the report.
Pricewaterhouse-Coopers	Review of VMO Payment	**Thirteen recommendations were made relating to:** • education and awareness to highlight the timely submission of claims • review of process of VMO invoices • awareness of rates and contractual terms • review of budgeting processes and establishment of individual budgets where practicable	Health Directorate agreed to 11 recommendations, noted one and partly agreed to one. *The recommendation that was partly agreed to related to the establishment of budgets for all individual VMOs.*

Name of agency	Nature of inquiry/report title	Recommendations/outcome of inquiry	Response to the outcome of inquiry
Pricewaterhouse-Coopers *—continued*		• revision of the standard claim template, guidance material and minimum requirements • the names of all staff involved in a surgical procedure to be entered into ACTPAS • theatre reports to include surgeon and assistant surgeon details before recording in ACTPAS • review system for verifying hours claimed • review system for verifying claims submitted and a centralised register of claims paid • second officer review of all draft contracts • clarification of claims for non-eligible patients, and claim eligibility guidelines for administration of transitional allowances • Executive review and approval of transitional allowance payments.	
Pricewaterhouse-Coopers	Review of Staff Grievances	**Nine recommendations were made relating to:** • implement the Health Directorate Anti-Discrimination Harassment and Bullying Policy and staff awareness • provide consistent messages and approaches to staff • engage profession boards for health professional complaints • develop a communication strategy to manage staff grievance process expectations • develop key performance indicators to measure the effectiveness and efficiency of services and a single database for grievance information • improve the guide to the type of information kept by supervisors and managers and associated recording requirements • implement a service model assigning senior HR as the first point of contact • provide targeted training.	Health Directorate agreed to 8 recommendations and noted one.
Auditor-General's Office	Final Audit Management Report at June 2009	**Five recommendations were made relating to:** • investigate, independently review and resolve variances • review the completeness and accuracy of coding to the private practice accounts • document third-party monies and review accounting arrangements for these accounts • review the financial report and preparation procedures • disclosures note of the financial report • review the resolution of matters identified.	Health Directorate agreed to all the recommendations made in the report.

Name of agency	Nature of inquiry/report title	Recommendations/outcome of inquiry	Response to the outcome of inquiry
Auditor-General's Office	Waiting Lists for Elective Surgery and Medical Treatment (Report No.1/2011) Tabled in the Legislative Assembly on 17 January 2011	**Eleven recommendations were made relating to:** • develop a single waiting list by integrating databases • review and standardise the hospitals' forms • implement and monitor regular clerical reviews of surgical booking processes • develop a comprehensive procedural manual for surgical bookings and provide training • enhance authorised doctor-based reclassifications, controls and procedures in recording reclassifications • reassess clinical review of elective surgery waiting list criteria and complete regular reviews within set timeframes • implement policy strategies to meet clinical timeframes • develop and implement systems to improve leave management • monitor and manage 'avoidable' factors to minimise postponements and cancellations of surgery • implement routine data audits of waiting lists • develop a framework to monitor and review the implementation of agreed recommendations from the Review of the Canberra Hospital Outpatients Service Redesign Project.	Health Directorate agreed to nine recommendations, agreed to one in principle, and agreed to one in part. *The recommendation that was agreed to in part was to 'conduct regular clinical reviews of patients on elective surgery waiting lists within the recommended timeframes'.*
Auditor-General's Office	Mental Health (Report No. 1/2011) Tabled in the Legislative Assembly on 17 January 2011	**Sixteen recommendations were made relating to:** • develop entry and exit criteria guidelines for Older Persons Mental Health Services • communicate with external stakeholders in relation to dementia-related illnesses that can (or cannot) be assessed and treated by the Older Persons Mental Health Services • develop orientation and procedure manuals for Older Persons Mental Health Services consistent with relevant policies and provide clear directives on referrals, prioritisation, definitions and acceptable ratios • develop a feedback mechanism and privacy information • strengthen general awareness of Older Persons Mental Health Services programs • develop reporting arrangements to report the number of consumers awaiting Older Persons Mental Health Services, and formalise the 'annual performance review' process to include analysis of mental health diagnosis, prevalence, impact and 'unmet needs' • manage delayed response to Older Persons Mental Health Services or at-risk group needs are not met • improve regular external stakeholder consultation and collaboration	Health Directorate agreed to all the recommendations made in the report.

Name of agency	Nature of inquiry/report title	Recommendations/outcome of inquiry	Response to the outcome of inquiry
Auditor-General's Office—*continued*		• regularly analyse and evaluate staffing data • plan to include provision of specialised training in mental health of older persons, and provide good access to information regarding current developments in the assessment and treatment of older persons with mental health problems • monitor the requirements of the use of mental health data collection systems and highlight the importance of updating information • maintain a consistent approach to 'referring on' consumers • consistently apply suicide risk assessments and protocols across Older Persons Mental Health Services • analyse the impact of admission blocks on staffing requirements and other Older Persons Mental Health Inpatient Unit • conduct three-monthly reviews for long-term Older Persons Mental Health Services consumers • implement measures to report mental health outcomes.	

Consumer participation and feedback

The Consumer Feedback and Engagement Team (CFET) is an integrated function within the Quality and Safety Unit. The team is responsible for the leadership and coordination of consumer feedback and consumer engagement activities, including:

- healthcare surveys across the Health Directorate
- Australian Charter of Healthcare Rights
- 10 Tips for Safer Health Care
- assistance with consumer publications and fact sheets
- consumer feedback management
- coordination of family meetings
- coordination of open disclosure/open communication meetings
- of Respecting Patient Choices Program.

The Health Directorate values all consumer feedback (comprising compliments, complaints and comments or suggestions) as a service improvement tool. The CFET is responsible for ensuring timely, fair and effective consumer and carer feedback management across all divisions and service areas and facilitates processes to ensure that consumer and carer voices are heard.

The Consumer Feedback module of the RiskMan database system has been customised to allow the CFET to record, manage and report against all feedback received across the Health Directorate.

Implementation of the Consumer Feedback Management policy has improved the quality and timeliness of feedback handling across the Health Directorate and highlights potential trigger improvements in the quality and safety of services.

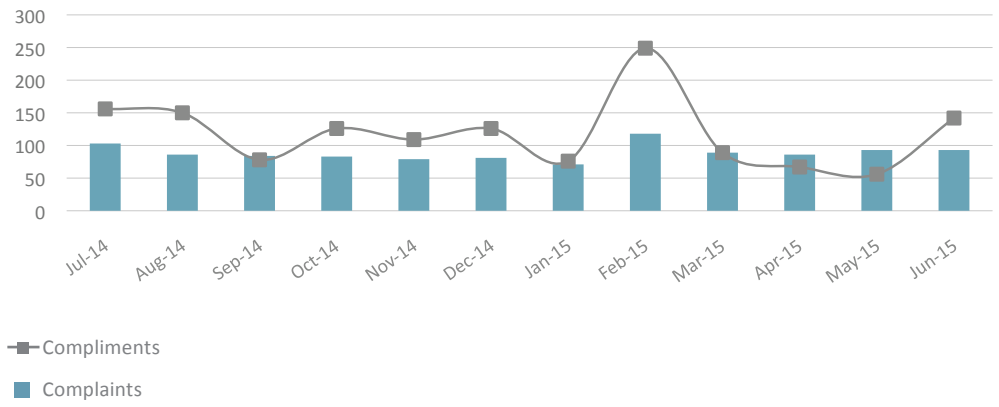
The Health Directorate has contracted with Ultra Feedback, a research company based in Victoria, to undertake Health Directorate-wide consumer satisfaction monitoring.

The Health Directorate's Consumer Participation/Engagement Framework is being developed in collaboration with consumer and carer groups of the ACT and is nearing completion. The framework will facilitate appropriate, effective and sustainable consumer and carer participation in a range of settings.

Consumer feedback in 2010—11

From 1 July 2010 to 30 June 2011, the Health Directorate received 1424 compliments, 973 complaints and 169 comments–a total of 2659 pieces of feedback.

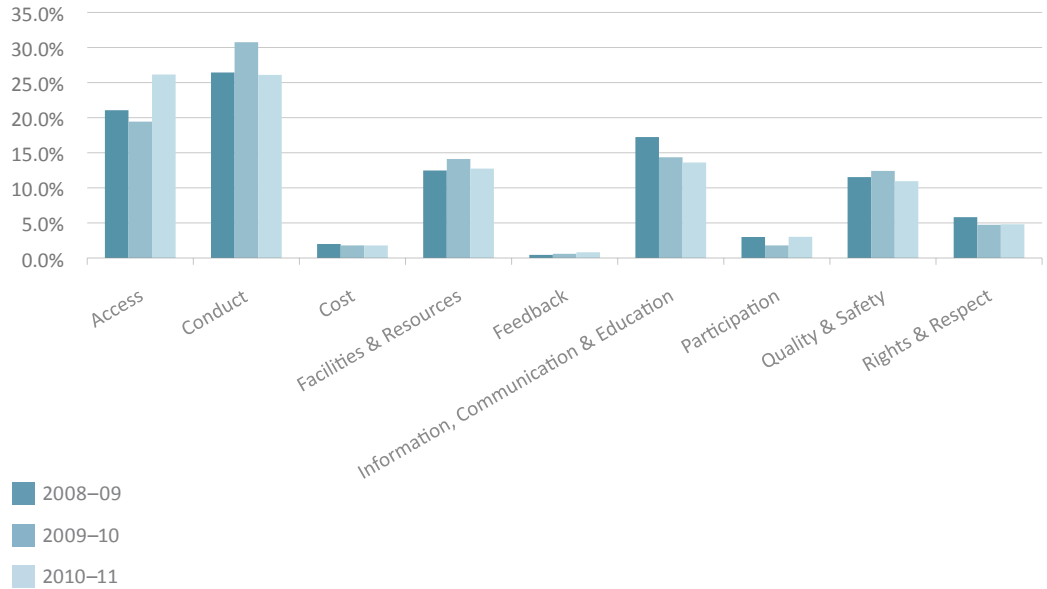
Consumer Feedback (compliments and complaints) received by month



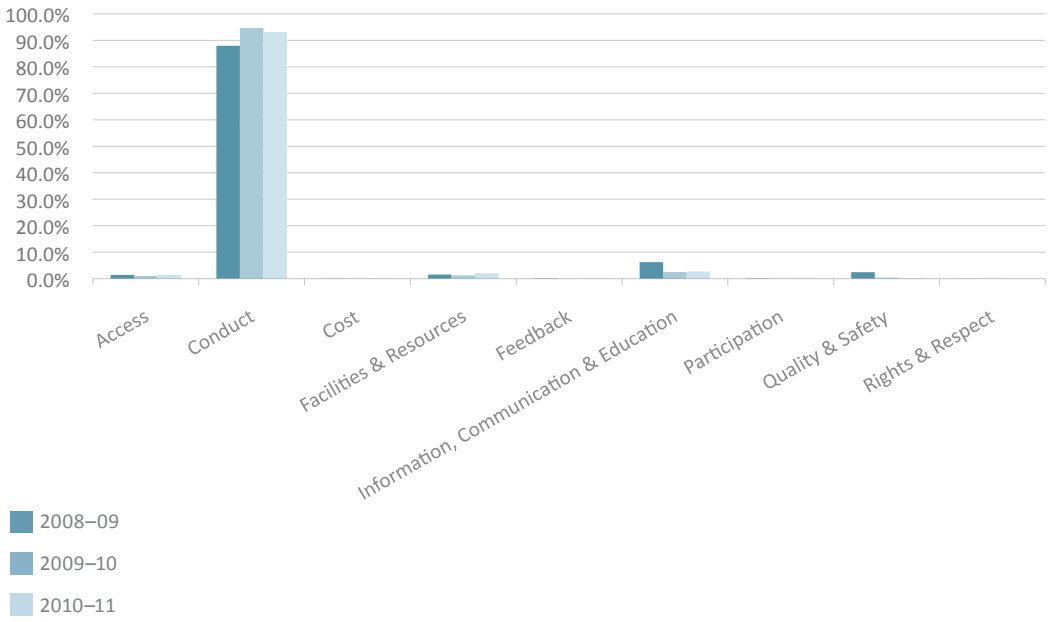
The issues highlighted by consumer feedback received by the divisions and services of the Health Directorate are classified according to the following categories, which have been developed based on classifications used by the Australian Institute of Health and Welfare, the Picker Institute, clinical review classifications and classifications used in other Australian states:

- access
- conduct
- cost
- resources/facilities
- feedback
- participation
- quality and safety
- information/communication/education
- rights and respect.

Issues Highlighted by Consumer Feedback (Complaints)



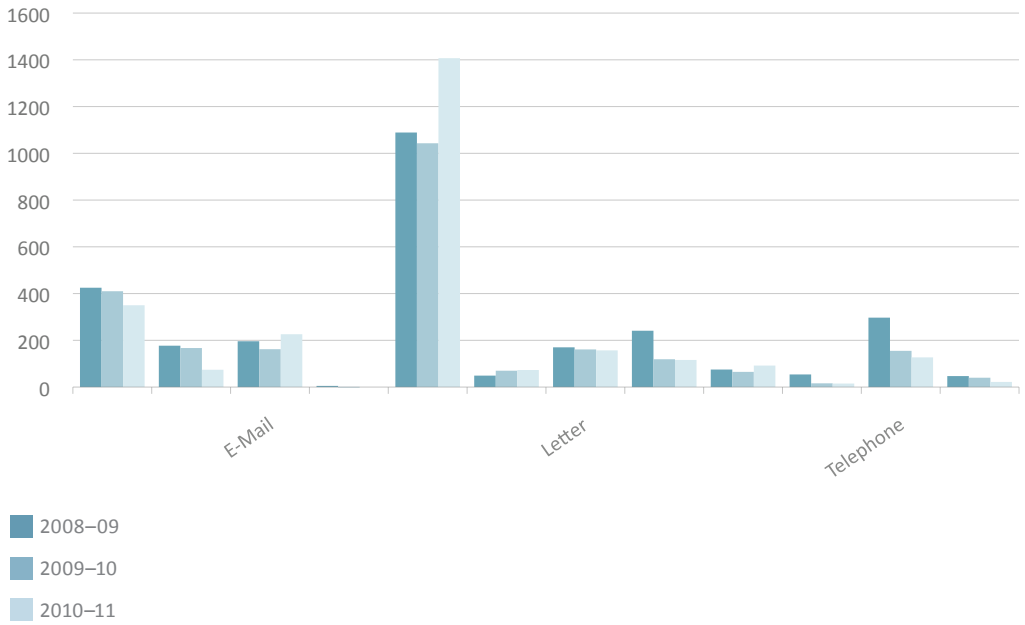
Issues Highlighted by Consumer Feedback (Compliments)



It should be noted that a consumer may mention a number of issues in one piece of feedback. Conduct, access and information/communication/education were the most important issues identified through complaints received from consumers.

A number of quality improvement projects have commenced as a result of consumer feedback, including the review of consumer information materials and resources.

Consumer Feedback by Mode Received



Consumer feedback drop boxes are installed at over 80 sites across the Health Directorate. The feedback boxes and posters provide information for consumers and carers about how to lodge feedback with the Health Directorate. Forms are provided at each drop box which can be taken away and posted without charge into any Australia Post box in Australia. Feedback forms account for about 53 per cent of the feedback received by the Health Directorate.

The Health Directorate utilises key performance indicators (KPI) to monitor the outcomes of our consumer feedback processes. Performance against these indicators is shown in the table below.

KPI	2010–11	Target achved
100% of feedback is acknowledged within 5 working days as appropriate	100%	Yes
80% of consumer complaints are resolved within 35 calendar days	70.5%	No

Regular reports with trended data are provided to all divisions and service areas of the Health Directorate. The data is presented to quality and safety committees for consideration and action as appropriate to the area.

This year, as a result of consumer feedback, program areas have undertaken improvements which include:

- policy reviews and ongoing policy development
- assistance with consumer surveying, focus groups and consultations
- highlighting of specific issues raised within complaints received with relevant staff
- improvements to patient information brochures and questionnaires, as recommended through consumer feedback
- input into the content of consumer and carer education materials
- consumer representatives reimbursement policy review
- consumer representatives appreciation awards
- implementation of the Australian Charter of Healthcare Rights
- advice to Health Directorate staff and committees on how to increase engagement of consumers and carers in the delivery of their services to improve the safety and quality of their services
- family meetings to facilitate the resolution of complaints
- liaison with peak consumer and carer groups and the ACT Human Rights Commission.

B.3
Legislative Assembly committee inquiries and reports

Standing Committee on Health, Community and Social Services

Report No.	Title	Date presented
2	Access to Primary Health Care Services	February 2010

Recommendation	Government response	Directorate implementation
1 The Committee recommends that the ACT Government work with the ACT Division of General Practice to develop ways of raising the profile of general practitioners in the community.	**Agreed**—The ACT Government will continue to work with the ACT Division of General Practice to address GP workforce shortages in the ACT. The ACT Government and the ACT Division of General Practice commenced a nationwide advertising campaign in 2008 showcasing the lifestyle benefits of living and working in Canberra as a GP, which also included a call to action to potential applicants to investigate GP employment opportunities in Canberra. In 2009 this campaign was expanded to include a direct mail-out to approximately 4000 GPs in inner Sydney and Melbourne locations and to target overseas locations, including New Zealand and the United Kingdom. 2010 will see the continuation of the national and international campaigns and include linkages with Live in Canberra for the promotion of GP vacancies.	To attract and retain GPs to the Canberra region, the Health Directorate has funded a part-time marketing and support adviser to work in partnership with the ACT Division of General Practice (now ACT Medicare Local) to address GP workforce shortages. Together linkages have been developed with the Economic Directorate's Live in Canberra team as well as with a number of medical recruitment agencies to target and promote the benefits of living and working in the ACT. Methods actively being used to recruit GPs both in Australia and overseas have involved primarily an advertising campaign directing interested applicants to a central list of positions vacant. This includes national and international advertising, online and print media, brochures, flyers and attendance at employment expos. Working closely with Live in Canberra has resulted in representation at a number of expos which would otherwise be inaccessible. Factsheets for international medical graduate employers and employees and promotion activities at medical conferences are some other methods being utilised. The GP Workforce Program has been well supported by key stakeholders, with positive results across several areas.

Recommendation		Government response	Directorate implementation
1			Support from ACT Medicare Local and the Health Directorate for the GP Workforce Program has contributed to positive results in this time of widespread GP shortage and to date the program has been successful in maintaining the overall numbers of GPs, despite a number of practice closures and GPs either retiring or leaving the ACT. Between May 2008 and the end of June 2011, the GP Workforce Program has so far successfully recruited 32 GPs. Another four have been confirmed to commence in the next six months and up to five others may arrive in Canberra by the end of the year.
2	The Committee recommends that the ACT Government extend their marketing strategy for GPs over the age of 55 to include attracting and re-engaging recently retired GPs from across Australia, with particular attention to NSW and Victoria.	**Noted**—There is an ongoing shortage of general practitioners in Australia and a particularly severe shortage in the ACT. As noted in the response to recommendation 1, the ACT Government continues to progress a nationwide advertising campaign that included GPs in NSW and Victoria. The ACT GP Marketing and Support Officer will also continue to undertake generic marketing for general practice. This will encompass all general practitioners eligible for registration regardless of age. The ACT Government has also agreed to recommendation 8 of the GP Taskforce to increase the GP Marketing and Support Officer role to full time. The GP Taskforce Final Report noted that many GPs see the ACT as an ideal environment to work across a portfolio of professional activities, offering diverse and interesting career prospects. The promotional campaign endeavours to leverage this strength and highlight the variety of employment opportunities and structures (such as part-time work) available to GPs in the ACT.	Marketing opportunities for all GPs continue to be progressed by the GP Marketing and Support Officer and ACT Medicare Local. 2011–12 will continue to see a concerted effort to target GPs both nationally and internationally.
3	The Committee recommends that ACT Health collect and publish data on the number of overseas trained doctors recruited to the ACT, including their country of origin, the length of stay and whether they return to their country of origin.	**Not agreed**—This information is not collected by the Health Directorate or the ACT Medical Board. It is not clear what the benefits of collecting such data would be. Furthermore, the collection of this information is likely to present privacy and confidentiality challenges in part due to the small sample size in the ACT.	No action.

Recommendation		Government response	Directorate implementation
4	The Committee recommends that the ACT Government conduct a feasibility study on employing salaried general practitioners in community health centres.	**Noted**—The ACT Government will continue to explore new models of primary health care delivery, of which salaried general practitioners in community health centres may be a component. It would not be feasible, however, for the Health Directorate to consider recommendations in this area until negotiations have been finalised surrounding the Commonwealth's National Health Reform Plan, as contained in the *A National Health and Hospitals Network: Further Investments in Australia's Health paper, released on 12 April 2010.*	Pending completion of Council of Australian Government (COAG) negotiations in 2011, it is anticipated that a revised COAG National Health Reform Agreement will be agreed to by all states and territories soon. The ACT Government confirmed its support on 15 July 2011. It is expected this will include the Commonwealth, states and territories working together on system-wide policy and state-wide planning for GP and primary health care.
5	The Committee recommends that the ACT Government examine the provision of financial and other incentives to small suburban general practices in identified areas of need and to new general practices wishing to establish in those areas.	**Agreed in principle**—The Australian Government already provides incentives to general practice in districts of workforce shortage, which corresponds with outer metropolitan provisions. The ACT Minister for Health has repeatedly asked for these provisions to be extended to the whole of Canberra and the Australian Government has declined to do so. The ACT Government has established the GP Workforce Program, an initiative available to all Canberra GPs. The GP Workforce Program will provide a total of $12 million over the next four years to support and grow general practice support in the ACT. Included in this funding is an initiative called the ACT GP Development Fund. Under this initiative, ACT GPs, including those in small suburban general practices, will be able to apply for funds under a number of different categories.	The GP Development Fund provides $4 million over four years to support GPs. Funding is available for education and training, attraction and retention, innovation and infrastructure.
6	The Committee recommends that the Minister for Health propose that the consideration of increased Medicare item numbers for allied health professionals be included for discussion at the next Australian Health Ministers' Conference.	**Noted**—Increased Medicare item numbers for allied health professionals are a matter for the Commonwealth. The ACT Minister for Health will write to the Commonwealth Minister for Health communicating the committee's recommendation regarding this issue.	The ACT Minister for Health wrote to the Australian Government Minister for Health. Minister Roxon replied in November 2010 advising of the Medicare item application method.
7	The Committee recommends that the ACT Government consider ways of expanding health options for consumers by enhancing the provision of services provided by registered and accredited allied health professionals under the National Registration and Accreditation Scheme in community health centres in the ACT.	**Agreed in principle**—The Health Directorate has actively pursued pathways for new roles to become part of the health workforce, such as nurse practitioners and allied health assistants. The Health Directorate has also extended the scope of professional practice in a number of areas.	Nurse practitioner opportunities are being discussed at the ACT Nursing and Midwifery Council. A dedicated resource is available in the Nursing and Midwifery Office to assist with development of the nurse practitioner roles and models of care.

Recommendation		Government response	Directorate implementation
7		For example, enrolled nurses who have undertaken additional training can administer medications, and physiotherapists are now working in the emergency department to help with the management of musculoskeletal injuries. *The Health Directorate Workforce Plan 2005–2010* sets the agenda for workforce redesign to ensure a sustainable health workforce into the future. Work aligned to the plan, such as establishing nurse practitioner roles within the ACT, has already expanded health options for consumers and been incorporated within the legislative framework of the ACT. Significantly, on 16 March 2010, the ACT Legislative Assembly passed the Health Practitioner Regulation National Law Bill 2009 to enable the ACT to join the National Registration and Accreditation Scheme. The national scheme, which currently involves 10 health professions–chiropractors, dental care practitioners, medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists–will help health professionals move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable Australian health workforce.	The GP Workforce Working Group has formed a Nurse Practitioners Sub-Working Group. This group last met in May 2011. The multidisciplinary outpatients orthopaedic clinic trialling an extended role for physiotherapists is working well. Work is under way on the next Health Workforce Plan for the ACT. Members of 10 health professions, including medicine, became registered under the National Registration and Accreditation Scheme, from 1 July 2010. Another four professions will join the scheme in 2012. They are Chinese medicine practitioners, occupational therapists, medical radiation practitioners, and Aboriginal and Torres Strait Islander healthcare workers.
8	The Committee recommends that the ACT Minister for Health enlist the assistance of all ACT federal members to lobby on behalf of the ACT for the whole of the ACT to be considered a district of workforce shortage for GP services.	**Noted**—The ACT Minister for Health has written to and lobbied the Commonwealth Minister for Health on numerous occasions regarding this matter. While the Commonwealth has confirmed that the criteria regarding districts of workforce shortage for GP services will not be changed for the ACT, the ACT Government will continue to avail itself of every opportunity to outline to the Australian Government the reasons why all of Canberra should be considered a district of workforce shortage in relation to general practice until the supply meets the average number of GPs for a similar urban population.	Ongoing—This issue continues to be raised with the Commonwealth.

Recommendation		Government response	Directorate implementation
9	The Committee recommends that the ACT Government consider the provision of financial assistance to small general practices to employ a practice nurse that demonstrate a need for a practice nurse but are unable to employ one.	**Noted**—The Australian Government already provides incentives to general practice in outer metropolitan areas to support practices to employ a practice nurse. The ACT Division of General Practice also provides support to all general practices to assist with the engagement of a practice nurse. In addition, the ACT Division of General Practice provides a nursing in general practice officer who is available to support all Canberra general practices. As noted in the response to recommendation 5, the ACT Government has also put in place a GP Workforce Program that will provide a total of $12 million over the next four years to support and grow general practice support in the ACT. The ACT Minister for Health will write to the Commonwealth Minister for Health regarding these issues.	The Minister has written a number of letters to the Commonwealth minister regarding these issues. No further action is being taken.
10	The Committee recommends that the ACT Government commission an independent evaluation of the walk-in centre at the Canberra Hospital, after 12 months of operation, to examine the viability of establishing similar clinics in areas of greatest need.	**Agreed**—The ACT Government has in place a governance model for new initiatives such as the Walk-In Centre (WIC) that includes a cycle of review and improvement. The Health Directorate Centre for Nursing and Midwifery Research, in conjunction with the Australian Primary Health Care Research Institute, is undertaking an evaluation of the WIC. This will be done in the first year of operation.	The ANU Australian Primary Health Care Research Institute has undertaken an independent evaluation of the WIC, which was submitted to the Health Directorate on 30 June 2011. The Health Directorate is considering the report.
11	The Committee recommends that ACT Health engage with the Pharmacy Guild to explore ways of better utilising the pharmacies in the ACT in the provision of primary healthcare services.	**Agreed in principle**—The ACT Government will continue to explore new models of primary healthcare delivery and will continue to explore ways of improving access to health services by working closely with stakeholders, including the Pharmacy Guild. The Health Directorate intends to commence work with stakeholders once negotiations surrounding the National Health Reform Plan are finalised and the consequences for the ACT are fully understood.	To be considered in the context of COAG reforms. Note progress of the COAG reforms in recommendation 4 above.

Recommendation		Government response	Directorate implementation
12	The Committee recommends that the ACT Government monitor the progress of the West Belconnen Health Cooperative and, if it proves to be successful, provide information and support to community groups interested in establishing a health cooperative, or a similar model, in their local community.	**Noted**—The ACT Government does not routinely monitor the progress of private organisations. The ACT Government will continue to work with West Belconnen Health Cooperative to support this model as well as explore new models of primary healthcare delivery. It should be noted, however, that the outcomes of negotiations surrounding the National Health Reform Plan could influence how primary health services are delivered at a community level in the future.	Monitoring only at this stage.
13	The Committee recommends that the ACT Government conduct a community education campaign informing people about access points for healthcare needs, including general practitioners, allied health professionals and pharmacists.	**Agreed in principle**—The ACT Government is in the process of developing a service provider directory. Once established, the directory will provide a platform to improve awareness of services. The Walk-In Centre campaign will also include clear public messages about where members of the community can go for particular levels of health care.	Work continues on the development of the Health Services Directory, which will provide comprehensive and current information about health services in the ACT. The Health Services Directory will be launched in 2011, with completion anticipated in 2012. The project team is loading all ACT GP practice localities into the directory. The team has developed prototype consumer-friendly search and result display views for integration into the Health Directorate website. These will be reviewed internally by the Health Directorate and externally by healthcare consumer groups in early August 2011. The project team is working towards a public release of the Health Services Directory, which is anticipated to occur in late August 2011. The project team continues to gather service information from remaining Canberra Hospital services and allied health services. The team will begin adding non-government health services following the public launch.
14	The Committee recommends that the ACT Government trial a temporary shuttle bus service from Woden Town Centre and the Woden Interchange to the Canberra Hospital and from an appropriate place at the Belconnen Town Centre to the Calvary Hospital, until such time as the Sustainable Transport Action Plan is implemented and public transport access to the hospitals is improved.	**Noted**—The ACTION bus network already offers regular services from Woden Town Centre and the Woden Interchange to the Canberra Hospital, as well as from Belconnen Town Centre to Calvary Hospital. In total, there are 15 services to the Canberra Hospital: routes 3, 5, 6, 21, 22, 23, 24, 66, 67, 76, 77, 267, 720, 934 and 938, and four services to Calvary Hospital: routes 3, 73/74 and 900.	No action.

Recommendation		Government response	Directorate implementation
14		Additionally, there are six ACT Regional Community Bus Services, which provide flexible transportation for residents who are isolated because of a lack of viable transport options. This community transport services residents in Belconnen, Gungahlin, the northside (Dickson and surrounding areas), the southside (Narrabundah and surrounding areas), Tuggeranong, and Woden. A shuttle bus could not offer round trips any faster than the current ACTION network and would serve only as an expensive duplication of the ACTION service coverage. The current utilisation of ACTION buses going to these hospitals is unknown, and further research may be warranted. The Health Directorate will endeavour to work with ACTION to increase consumer awareness of the available services.	
15	The Committee recommends that ACT Health promote the use of interpreters to general practitioners and the broader primary healthcare sector to provide people for whom English is not a first language with greater choice in accessing medical services and to reduce the burden on services that cater specifically for this population group.	**Noted**—The Australian Government is responsible for both general practice and interpreter services. The Australian Government, through the Department of Immigration and Citizenship, provides the Translating and Interpreting Service National for people who do not speak English and for English speakers who need to communicate with them. The ACT Division of General Practice is most appropriately positioned to promote this service to GPs and the broader primary healthcare sector. ACT Health will bring the standing committee's recommendation to the attention of the ACT Division of General Practice for consideration.	The Health Directorate has written to the Chief Executive Officer of the ACT Division of General Practice.

Recommendation		Government response	Directorate implementation
16	The Committee recommends that the ACT Government investigate ways of providing an in-hours locum service to cover general practitioners working in community-run health services that receive funding from the ACT Government, such as the in-hours GP Aged Day Service.	**Noted**—The ACT Government, through ACT Health, provides funding to community-run health services such as the Junction Youth Health Service and Companion House to provide specific services. Locum availability is a GP workforce issue. As noted in the response to recommendation 5, the ACT Government has put in place a GP Workforce Program that will provide a total of $12 million over the next four years to support and grow general practice support in the ACT. The ACT GP Aged Day Service, which has recently gone out to tender, will provide GPs with emergency support for providing medical care to consumers who are house-bound and residents of residential aged care facilities. This service will provide in-hours locum cover to a clearly defined scope of clients.	A GP Aged Day Service has been implemented. It provides an in-hours locum service to support people who are home-bound or in residential aged care facilities when their GP is unable to make house calls. The service supports ACT GPs and reduces the load on hospitals by providing care to patients who need prompt attention and might otherwise end up in hospital. The Health Directorate holds a service funding agreement with the ACT Division of General Practice until 30 June 2013 to establish and deliver the in-hours locum service. The service commenced on 21 March 2011 and ACT GPs are actively referring to the service.
17	The Committee recommends that the ACT Government investigate the feasibility of establishing a pilot project for residents living in residential aged care facilities in the ACT, such as the Proactive Aged Care program proposed by Healthcube, or a similar model.	**Not agreed**—While residential aged care is the responsibility of the Australian Government, the ACT Government is tendering for an ACT GP Aged Day Service to provide GPs with emergency support for providing medical care to consumers who are house-bound and residents of residential aged care facilities. This service will provide in-hours locum cover to a defined scope of clients. It would not be appropriate to consider modifying the model at this stage, or running an alternative program in parallel, until the GP Aged Day Service is established and evaluated.	No action.
18	The Committee recommends that ACT Health negotiate a cross-border agreement with the NSW Government for health services provided by Winnunga Nimmityjah Aboriginal Health Service to NSW residents.	**Noted**—Winnunga Nimmityjah Aboriginal Health Service (Winnunga) is a non-government organisation which receives funding from the Health Directorate for the delivery of a range of allied health programs. The ACT Government is not responsible for the funding of general practice at Winnunga; this is a Commonwealth responsibility.	Winnunga has been contacted and advice has been received that Winnunga has yet to develop a cross-border agreement. The Health Directorate has indicated its willingness to support Winnunga with representations to the NSW and Commonwealth Governments.

Recommendation		Government response	Directorate implementation
18		The Australian Healthcare Agreement provides the framework allowing for cross-border arrangements between government agencies of jurisdictions on hospital services. However, there is no mechanism that allows for bilateral arrangements on primary healthcare services provided by government agencies, or between non-government organisations of one jurisdiction and government agencies of another. For example, services provided by ACT Community Health are not subject to any cross-border payment by NSW. While it would be inappropriate for the ACT Government to negotiate a cross-border agreement with the NSW Government on behalf of a non-government organisation, the Health Directorate will endeavour to contact Winnunga to clarify the issues and explore alternative options.	
19	The Committee recommends that the ACT Government provide funding to Winnunga Nimmityjah Aboriginal Health Service to enable the employment of at least one full-time general practitioner position.	**Not agreed**—This is a Commonwealth issue. The Australian Government, through the Department of Health and Ageing, is responsible for the funding of general practice. The Health Directorate funded Winnunga Nimmityjah Aboriginal Health Service with approximately $1.34 million (2009–10) to deliver a range of allied health programs, including: the Aboriginal Midwifery Access Program, Hearing Health, Dental Health, Mental Health, Dual Diagnosis, Youth Detoxification Support Service, the Opiate Program, and Correctional Health Services.	No action.
20	The Committee recommends that the ACT Government extend the Better General Health Program to general practitioners that provide 'continuity of care' to elderly patients and those with chronic and complex conditions to ensure they are financially agreed for the provision of that service.	**Noted**—The ACT Government will continue to explore new models of primary healthcare delivery and will consider expanding the Better Health Program, formerly known as the Better General Health Program in its pilot phase, to cater for targeted populations in the ACT. The ACT Government notes that the Better Health Program had a budget of $275,000 in 2008–09.	The Better General Health Program is being evaluated. Other models of care are being reviewed and considered.
21	The Committee recommends that the ACT Government conduct appropriate consultation with all relevant stakeholders in the development of its e-health strategy.	**Agreed**—The ACT Government recognises the value of effective community engagement and strives to draw on the diverse range of skills, experiences and knowledge from within the community when developing policy and programs.	The Project Manager (PM) position for development of the EHR is being recruited to.

Recommendation	Government response	Directorate implementation
21	Central to the ACT Government e-health strategy is the development of an Electronic Health Record (EHR). In developing the e-health strategy, ACT Health conducted an implementation planning study (IPS) into a clinical repository, which is a necessary pre-requisite to the development of an EHR. ACT Health consulted with a broad range of stakeholders during the IPS. These groups included: • all divisions within ACT Health • the ACT Division of General Practice • the Southern General Practice Network • a sample group of ACT GPs • the ACT Division of General Practice Aged Care Focus Group • the Health Care Consumers' Association ACT • Capital Pathology • Canberra Imaging Group • the National E-Health Transition Authority. A key outcome of the IPS recommended that ACT Health broaden its governance arrangements of both the development and ongoing management of the EHR to include a wider range of stakeholders (public, private and consumers). ACT Health has adopted this recommendation and is considering the possible structural arrangements for the governance of the EHR. Other strategies focused on garnering stakeholder engagement in the e-health strategy include: • a monthly e-health meeting between ACT Health E Health and Clinical Records Branch and the Health Care Consumers' Association • representation by consumers and the ACT Division of General Practice on the ACT Health Portfolio Information and Communications Technology Committee • the employment of a full-time GP e-health liaison position • consumer representation on key e-health project steering committees • regular meetings with the ACT Division of General Practice and the Southern General Practice Network.	On commencement of the PM's employment, the Health Directorate will undertake an independent review of the IT infrastructure to look for opportunities for reuse in the EHR and identification of the components still required. The Health Directorate has been working on the development of the fundamental building blocks of an EHR, including the following: • individual healthcare identifiers • e-discharge summaries • e-referrals • medication management (in development) • atomic pathology results • electronic radiology reports.

Recommendation		Government response	Directorate implementation
22	The Committee recommends that ACT Health widely promote the services of Healthdirect throughout the community.	**Agreed in principle**—It is anticipated that the Healthdirect Australia service will be a fully national service by 2011. Given the national status of the service, any unplanned increase in call volume resulting from promotional activity in one jurisdiction has the potential to adversely affect service levels nationally. Consequently, promotional activities need to be undertaken in consultation with the operator of the service (National Health Call Centre Ltd) so that the service provider has time to employ and train any extra staff required to maintain contracted service levels. An intensive promotional campaign accompanied the launch of the service in the ACT in May 2001. Promotions, including newspaper and television advertising and the distribution of flyers and fridge magnets, were undertaken. The promotional activity continued intermittently for the next year. When call volumes reached the anticipated target level of 10 per cent of the population (i.e. around 30,000 calls per year) promotional activity ceased (though it should be noted that call volumes continued to increase well beyond national and international averages for such services, consistently remaining at around 13 per cent of the population, or more than 40,000 calls per annum). Recent promotional activities have included display ads on the side of ACTION buses (mid-2009 and display advertising in the Blue Book, which is a resource distributed to the parents of newborn children in the ACT. Materials targeted at Aboriginal and Torres Strait Islander communities have been produced and will shortly be distributed to Aboriginal and Torres Strait Islander health services.	Ongoing. Materials targeted at Aboriginal and Torres Strait Islander communities have been produced and have been distributed to 10 Aboriginal and Torres Strait Islander health services. Healthdirect is widely promoted in digital form on the Health Directorate website under Health Services and in the quick links. Any search on health.act.gov.au also reveals the Healthdirect link. Healthdirect is promoted by the Health Directorate as an alternative source of advice and support by facilities such as the Walk-In Centre and the Emergency Department. The Health Directorate is planning to promote Healthdirect on TV and radio as part of a broader awareness campaign about alternatives to presenting to the Emergency Department. The Commonwealth Department of Health and Ageing will also implement a national communication strategy between July and December 2011 to promote the after hours GP Helpline, which will operate from the Healthdirect infrastructure. This campaign will see advertisements and promotional material appear in all forms of media, including non-English speaking background and Indigenous press.
23	The Committee recommends that ACT Health report on Healthdirect activity, including generic information about the number and nature of calls and action taken, as part of ACT Health's quarterly performance reports.	**Agreed in principle**—Healthdirect Australia publishes both quarterly and annual reports on its website: http://healthdirect.org.au/go/publications.	Discussion has commenced with the Health Performance Unit. The request for inclusion of Healthdirect data is to be considered in the review of Quarterly Performance Report content for the 2011–12 reporting cycle.

Recommendation		Government response	Directorate implementation
23	The Committee further recommends that the ACT Government examine the Western Australian Healthdirect reporting model, with a view to its introduction in the ACT, if deemed appropriate.	These reports are publicly available and provide the number of calls, the nature of calls and action taken. More detailed reports are provided to each participating jurisdiction, and the ACT Government will consider the feasibility of including this data in the Health Directorate's quarterly performance reports.	
		Not agreed—The Healthdirect Australia service is a national service and provides regular reports via its website. The Western Australian Government has not provided a report since the second quarter of 2008 and instead provides a link to the Healthdirect Australia website, where, for example, the most recent Healthdirect Australia report (third quarter, 2009) can be found.	No action.
24	The Committee recommends that the ACT Government continue to monitor the innovations in primary healthcare delivery being trialled across Australia and overseas.	**Agreed**—The ACT Government will continue to monitor innovations in primary health care and will continue to actively engage in the national health reform process.	The Health Directorate and ACT Government continue to monitor innovations in primary health care and actively engage in the national health reform process. The ACT Walk-In Centre was established in 2010 and has undergone an independent evaluation as per recommendation 10 above.

Standing Committee on Health, Community and Social Services

Report No.	Title	Date presented
3	Report on Annual and Financial Reports 2008–09	June 2010

Recommendation		Government response	Directorate implementation
7	The Committee recommends that ACT Health enhance the RADAR program for the elderly to reduce the number of presentations to the emergency departments and to ease the stress on elderly patients by avoiding an unnecessary emergency department presentation.	**Noted**—The RADAR (Rapid Assessment of the Deteriorating At Risk) Older Person Service received significant staff enhancement in the 2009–10 financial year. This included the addition of enhanced Specialist Geriatrician staffing, an additional Registered Nurse, a Social Worker and an Occupational Therapist.	Referral numbers have slightly decreased in the last financial year. Referrals for the year 2010–11 were 239. Complexity of the client profile continues to increase, resulting in an increase in occasions of service and an increase in length of stay.

Recommendation		Government response	Directorate implementation
7		RADAR, while still achieving excellent outcomes for referred patients in preventing avoidable hospital admissions, is not receiving the number of referrals that would support further staffing enhancements at this time. RADAR are working with the Division of General Practice to enhance referral numbers, as well as developing pathways for increased involvement in the TCH Emergency Department. RADAR are also working with Community Health's CAPAC (Community Acute and Post-Acute Care) program and TCH's HITH (Hospital in the Home) program to identify ways in which the three programs can better work together to provide services for older people that avoid an acute admission or reduce the length of stay for an acute admission. It is envisaged that this work will lead to a greater availability of the service to older people in their homes, including residential aged care facilities, without a current need for enhanced staffing.	Forty-six of the clients referred to RADAR were deceased within six months of the referral. This in part reflects the frailty and complexity of the clients referred. Despite this, RADAR still maintains a less than 20 per cent admission rate into the hospital system, therefore maintaining more than 80 per cent of people in their place of residence. The clients admitted into hospital were admitted directly into the Medical Assessment and Planning Unit (MAPU) or into the private hospital system. Only 2 per cent were admitted through the Emergency Department and these admissions occurred after hours or on the weekend, when RADAR does not operate. RADAR is slowly moving towards increased co-management of clients with HITH. To date, three clients have been co-managed. The addition of the social worker has allowed RADAR to deal with more complex guardianship and other social issues. Unfortunately there were periods in the last financial year when RADAR was without a social worker due to maternity leave and difficulty recruiting to the position. The occupational therapy position has allowed the immediate equipment and modification needs of the clients to be addressed in timely manner. Again, this position was vacant for periods due to maternity leave. To maintain promotion of RADAR to the GPs, we have representation on the ACT Division of GPs Aged Care Panel. RADAR was involved in the training and support for the GPs in the new GPAD service.
8	The Committee recommends that ACT Health, in the 'external scrutiny' section of its Annual Report, provide more accurate reporting on relevant inquiries by Legislative Assembly Committees concerning the operation of the agency, and information on the implementation of Assembly committee recommendations that have been accepted by the Government of the day.	**Noted**—ACT Health will monitor closely the recommendations made by standing committees of the Legislative Assembly and provide comment on each recommendation that relates to the operation of the agency. This will include information relating to the recommendations that have been accepted by the government.	The Health Directorate provides annual report information in line with the Chief Minister's 2010–11 Annual Report Directions and continues to monitor recommendations relating to this directorate.

Standing Committee on Health, Community and Social Services

Report No.	Title	Date presented
4	Love has its limits—Respite care services in the ACT	December 2010

Recommendation		Government response	Directorate implementation
19	The Committee recommends that the ACT Government expand its funding program to enable a greater number of government and non-government workers to complete the Certificate IV in Disability Work and to include Certificate III in Community Studies for mental health workers.	**Noted**—The commitment to a professional and stable workforce across the government and community providers is supported in both policy and operation. The Workforce Directions 2010–2014 strategy for the disability sector was developed by the Disability Workforce Working Group to position the ACT disability sector well into the future by ensuring a developed and sustainable, skilled, valued and committed workforce. Disability ACT either funds or supports a range of workforce development activities, including: • Funding five community sector employees each year to undertake the Certificate IV in Disability Studies along with a number of places for Disability ACT support workers (seven were funded to attend in 2010). Each place costs $1887. • Reimbursing community agencies' costs to backfill their workers' attendance on the course throughout the year. In 2010 Disability ACT spent $43,700 on community agency backfill. • Engaging the Council of Quality and Leadership to enhance approaches towards individual planning. Disability ACT will pilot a personal outcome measures framework developed by the Council on Quality and Leadership.	The ACT Government provided funding in the 2011–12 ACT Health budget to support the community sector mental health workers to attain the required minimum standard of Certificate IV in Community Studies. The Health Directorate is working with the Mental Health Community Coalition ACT to assist the sector to implement the minimum standard in 2011–12 and will vary the community sector contracts to include workers who have or are working towards the minimum qualifications from 2012–13 onwards. Further information can be found in the Community Services Directorate Annual Report 2010–11, section 4.4.

Recommendation		Government response	Directorate implementation
19		• Supporting the Disability Professional Learning Network to provide disability support workers in the ACT with opportunities to meet, learn from and support one another. This network also promotes the profile of disability support work as a profession of choice. Workshops for government and community agency support workers are held on various topics (i.e. mental health first aid, working with families, disability and sexuality, and staff self-care) to improve the quality of care for people with disability • Supporting the Annual ACT Disability Support Worker Awards, which recognise the achievements and acknowledge the valued role of disability support workers in the ACT. In relation to mental health workers, the minimum standard will be the Certificate IV in Community Studies (in Mental Health, Drug and Alcohol, Youth Health or Aged Care). ACT Health will work with the Mental Health Community Coalition ACT to assist the sector to implement the minimum standard in 2011–12. ACT Health is working in collaboration with the Mental Health Community Coalition ACT, which is the mental health sector community peak body, to enable a greater number of community mental health sector workers to meet minimum mandatory qualifications. ACT Health-funded community organisations are required through the service funding agreements to meet responsibilities for quality assurance and staff development activities.	
23	The Committee recommends that DHCS work with ACT Health to extend its disability marketing and communication plan to promote information access points in the community sector to people with a mental illness and the frail aged and their carers.	**Agreed**—Disability ACT will add links to ACT Health service information portals on its information pages. ACT Health will include links to DHCS on the ACT Health internet page.	The additional internet links have been operationalised. Further information can be found in the Community Services Directorate Annual Report 2010–11, section 4.4.

	Recommendation	Government response	Directorate implementation
25	The Committee recommends that the ACT Government examine the community partnership model developed by Dr Leanne Craze as part of the Building Capacity in Community Mental Health Family Support and Carer Recognition project with a view to supporting its implementation across government and non-government service providers.	The ACT Government will consider the community partnership model developed by Dr Leanne Craze in the context of the Implementation Plan 2010–14 Future Directions: Towards Challenge 2014 under Strategic Priority 5, 'I want to tell my story once', and will report on its findings to the Strategic Governance Group. Since publication of the report on the Building Capacity in Community Mental Health Family Support and Carer Recognition project in 2001, the ACT Government has increased spending across Mental Health Services by 183 per cent, from $27.4 million in 2001–02 to $77.8 million in 2010–11. The Mental Health Community Coalition's submission to the Standing Committee on Health, Community and Social Services included the issues that were highlighted in the report on Building Capacity in Community Mental Health Family Support and Carer Recognition regarding respite services. The ACT Government is committed to work incrementally with the community sector mental health services to address mental health issues including but not limited to: quality of service, housing, supported accommodation options, respite, vocational and employment support, and education.	The Health Directorate undertook a review of community sector mental health services during 2010–11. ConNetica Consultants undertook the sector consultations and assisted the Advisory Group in finalising the report and reviewing actions. The review report was tabled in the Legislative Assembly by the Minister for Health, Ms Katy Gallagher, on 30 June 2011. The community sector peak body, the Mental Health Community Coalition, and the Health Directorate will work in partnership with the sector providers in implementing the review actions from 2011–12. The review actions address issues such as: quality of service, outcome measurement, workforce standards and research. Further information can be found in the Community Services Directorate Annual Report 2010–11, section 4.4.
26	The Committee recommends that the Minister for Health table in the Assembly, by the last sitting day in March 2011, the results of the community sector mental health services review.	**Agreed**—The progress of the review of community sector mental health services is drawing to a conclusion. ACT Health supports the tabling of the report in the Legislative Assembly by the Minister for Health, Ms Katy Gallagher, when it is finalised.	The report was tabled in the Legislative Assembly by the Minister for Health, Ms Katy Gallagher, on 30 June 2011.
27	The Committee recommends that the ACT Government ensure that the development of the 'no wrong door' model of service delivery is well planned and fully resourced and extends across the disability and mental health sectors.	**Noted**—The ACT Government supports a 'no wrong door' approach to service delivery in the mental health and the disability sector.	Mental Health Services is progressing the implementation of the Referral Response/ Screening Guidelines.

Recommendation	Government response	Directorate implementation
27	Mental Health ACT aims to support all people making contact with Mental Health ACT services. To meet this expectation, any contact will be responded to as an opportunity to assist the individual either by providing a response or a service directly or by linking them to another service deemed better suited to the person's needs. Mental Health ACT is in the final stages of developing a screening guideline to identify the most appropriate services to support consumers who access services. The 'no wrong door' approach is also in line with Disability ACT's strategic priority 5 in *Future Directions: Towards Challenge 2014—'I want to tell my story once'.* In November 2010, Disability ACT released a draft concept paper No wrong door, which is available at www.dhcs.act.gov.au/disability act/sgg. The 'no wrong door' approach is about building a commitment across all formal services in the ACT to provide people with the right information at the right time and at the right place. It understands that, even in a city as small as Canberra, finding formal supports and services when you do not know what you are looking for presents challenges. The concept paper notes that there is a need to develop resources in the areas of information resources, an agency helpdesk function, agency education and information, and potentially the development of an information-sharing network. In addition, the need to better resource people with disabilities themselves and their families is included in the concept paper by identifying strategies to assist them to find information, manage their own information and to advocate for their own needs. It is noted that funded agencies have also been working to promote and centralise their intake mechanisms to make access more streamlined for service users. This their families is included in the work is iterative but reflects the commitment across ACT human service agencies to make sure that service access is simplified and streamlined. By way of example, Housing ACT has developed a centralised intake system and Therapy ACT has a centralised intake line.	Mental Health Services adopted a 'no wrong door' philosophy to improve the responsiveness of its service to all people who make contact with the service. The Mental Health Services Referral Response/Screening Guidelines support clinicians in the referral of persons to facilitate their access to optimal appropriate care. Mental Health Services provides care coordination and liaison to general practitioners and community agencies. General practitioners have timely access to consultant psychiatrists for consultation. Specific training has been provided to increase awareness of this expectation among clinical and administrative staff across all areas of the service. Further information can be found in the Community Services Directorate Annual Report 2010–11, section 4.4.

Standing Committee on Health, Community and Social Services

Report No.	Title	Date presented
5	Calvary Public Hospital Options	31 March 2011

	Recommendation	Government response	Directorate implementation
1	The Committee recommends that the ACT Government provide to the Assembly the evidence demonstrating the efficiencies to be gained by having a fully networked and specialised hospital system for ACT public hospitals.	Government response yet to be determined.	No action taken.
2	The Committee recommends that, in the event that the ACT Government and Little Company of Mary Health Care are unable to reach agreement, an independent arbitrator be appointed to assist the parties to reach a mutually beneficial contractual arrangement.	Government response yet to be determined.	No action taken.
3	The Committee recommends that any future agreement between the ACT Government and Little Company of Mary Health Care seek to establish the requirement for Calvary Health Care to provide an annual and financial report for the Legislative Assembly and the people of Canberra.	Government response yet to be determined.	No action taken.
4	The Committee recommends that the ACT Government report to the Assembly the steps taken to address the concerns raised by the Auditor-General in relation to cross-charging arrangements between Calvary Public Hospital and Calvary Private Hospital.	Government response yet to be determined.	No action taken.
5	The Committee recommends that the ACT Government consider the merits of a public–private partnership for the construction of a new public hospital, should it proceed with this option.	Government response yet to be determined.	No action taken.
6	The Committee recommends that the ACT Government does not proceed with Option C that would result in three acute hospitals and Option B that would result in TCH becoming a 'super hospital', as proposed in the Government discussion paper released on 25 February 2011.	Government response yet to be determined.	No action taken.
7	The Committee recommends that the ACT Government proceed with developing a fully networked and specialised hospital system as proposed in Options D and E in the Government discussion paper released on 25 February 2011.	Government response yet to be determined.	No action taken.

Standing Committee on Health, Community and Social Services

Report No.	Title	Date presented
6	Report on Annual and Financial Reports 2009–10	April 2011

	Recommendation	Government response	Directorate implementation
1	The Committee recommends that ACT Health include information regarding elective surgery waiting lists in its annual report or include a reference to where the information can be found.	Government response yet to be determined.	No action taken.
2	The Committee recommends that any new infection of Hepatitis C confirmed while a person is detained at the Alexander Maconochie Centre be further investigated to determine where the infection was acquired, if possible.	Government response yet to be determined.	No action taken.
3	The Committee recommends that the Minister for Health tables in the Assembly the results of the evaluation of the nurse-led walk-in clinic when completed.	Government response yet to be determined.	No action taken.

Standing Committee on Justice and Community Safety

Report No.	Title	Date presented
4	Report on Annual and Financial Reports 2009–10	February 2010

	Recommendation	Government response	Directorate implementation
28	That ACT Health examines the feasibility of incorporating information about persons authorised to exercise substituted decision-making powers on relevant electronic files being created for national and ACT e-health initiatives.	**Agreed**—As a component of the health-e future program, funded in 2009–10, ACT Health has committed to the development of an electronic health record (EHR) to support patients seeking health treatment within the ACT. The purpose of the EHR would be to support higher quality and safety healthcare decision-making, enabling providers' access to a more complete view of their patient, drawn from as many sources of clinical data as possible. It is intended that consumers will also be provided with access to this data.	The ACT electronic health record is still in the planning phases. The Concept of Operations for the national Personally Controlled Electronic Health Record (PCEHR), to be introduced in July 2012, provides for the concept of an authorised representative to have access to an individual's PCEHR record. Consideration is being given to provide a person who is authorised by the law of any jurisdiction to act on the behalf of an individual for healthcare purposes with recognition by the PCEHR system as an authorised representative.

Recommendation	Government response	Directorate implementation
28	Enduring powers of attorney will be considered for inclusion in the ACT EHR. It is anticipated that a process will be established whereby a carer, with an enduring power of attorney, will be able to apply to be registered to have access to and control over an individual's EHR, where they have been legally deemed the person responsible for making decisions about that individual's health care. The information in relation to the enduring power of attorney should also be made available to the patient's providers, where they have access to the EHR.	The PCEHR system would need to verify the legal authority; therefore, a person would need to present to the PCEHR system operator appropriate documentary evidence of their authority. An authorised representative would have the ability to decide whether to create a PCEHR for the individual they represent and to complete the registration process for that individual. The legislation that underpins this, and a number of other PCEHR concepts, was released by the Department of Health and Ageing for public consultation.

Select Committee on Estimates 2010–11

Report No.	Title	Date presented
1	Inquiry into the Appropriation Bill 2010–11	June 2010

Recommendation		Government response	Directorate implementation
14	The Committee recommends that the Minister for Health provide the Assembly with quarterly updates about the National Health and Hospitals Network negotiations with the Australian Government.	**Agreed**—Noting the level of detail provided will be governed by the usual expectations of confidentiality surrounding intergovernmental negotiations.	The process of finalising a new National Health Reform Agreement, National Partnership Agreement on Improving Public Hospital Services and National Health Agreement, with negotiation between the ACT and the Commonwealth Governments, is nearly completed.
15	The Committee recommends that the ACT Government build growth funding into the formula for mental health funding which is consistent with the reported growth in national mental health demand.	**Agreed in principle**—This government has a strong track record in increasing funding for mental health. The government has demonstrated responsiveness to demand and will continue to do so. While having medium- to longer-term objectives in relation to mental health as a percentage of total health expenditure and the proportion of that expenditure delivered in the community sector, the experience is that a fixed annual increase is not the most appropriate approach. While the growth in national mental health demand is a useful reference, the government makes annual decisions based on local need and priority and will continue to do so.	In 2010–11 the ACT Government mental health budget grew by 6.7 per cent on the 2009–10 Budget to the estimated outcome for the year of $81,102,900. New mental health initiatives in 2010–11 included services for Aboriginal and Torres Strait Islander young people, increased individual advocacy services, increased respite services, the short-term intensive step-up step-down outreach service, consumer consultants, improved training and supervision for forensic mental health clinicians and therapies for people with personality disorders.

Recommendation		Government response	Directorate implementation
15		It should be noted that this government has made strong commitments to mental health expenditure, including community sector agencies, purpose-built facilities such as the secure mental health service, the mental health assessment unit at TCH, the young adult mental health service and the new adult mental health inpatient unit, all of which are articulated in the ACT Strategic Plan for Mental Health Services.	
16	The Committee recommends that the percentage of overall mental health funding allocated to community organisations be reported in the annual Budget Papers.	**Agreed**	The estimated outcome for the overall percentage of mental health funding allocated to community organisations through the Health Directorate budget was 13.4 per cent. The percentage was not reported in the 2011–12 Budget papers but will be reported from the 2012–13 papers onwards.
17	The Committee recommends that the next ACT Government review of the interstate patient travel scheme is approached with a view to meeting real costs and providing an appropriate level of assistance where required.	**Noted**—The Commonwealth Government is working collaboratively with all states and territories towards a harmonisation of the schemes to ensure equity in access for all Australians. ACT reimbursement rates are equivalent to, or above, those paid by most other states or territories under similar schemes. The Commonwealth Government provides policy principles for states and territories. Administrative Principle 1 states that the schemes should provide a subsidy for travel and accommodation expenses to assist with access to specialist medical care. A ceiling against real cost recovery will always be required to ensure the government funds are being appropriately expended. The ACT Interstate Patient Travel Assistance Scheme (IPTAS) annually reviews the guidelines, eligibility criteria and the levels of reimbursement payable under the scheme. From 1 July 2010, CPI indexation will be applied to all reimbursement rates.	A paper has been prepared for presentation to the Health Policy Priorities Principal Committee (HPPPC) meeting. From 1 July 2010, CPI indexation has been applied to all reimbursement rates.

B.4
Legislation report

The following is a list of all legislation that the ACT Health Directorate was responsible for during the reporting period:

- Blood Donation (Transmittable Diseases) Act 1985
- Drugs of Dependence Act 1989
- Epidemiological Studies (Confidentiality) Act 1992
- Food Act 2001
- Gene Technology Act 2003
- Gene Technology (GM Crop Moratorium) Act 2004
- Health Act 1993
- Health Practitioner Regulation National Law (ACT) Act 2010
- Health Professionals Act 2004
- Health Professionals (Special Events Exemptions) Act 2000
- Health Records (Privacy and Access) Act 1997
- Human Cloning and Embryo Research Act 2004
- Intoxicated People (Care and Protection) Act 1994
- Medicines, Poisons and Therapeutic Goods Act 2008
- Mental Health (Treatment and Care) Act 1994, except parts 8 and 9 and sections 141, 142 and 143
- Public Health Act 1997
- Radiation Protection Act 2006
- Smoke-Free Public Places Act 2003
- Supervised Injecting Place Trial Act 1999, except sections 7, 8 and 13
- Tobacco Act 1927
- Transplantation and Anatomy Act 1978.

The following legislation was enacted during the reporting period:

1. Health Practitioner Regulation National Law (ACT) Act 2010
2. Health Amendment Act 2011 (repealed).

During the reporting period, the Smoking (Prohibition in Enclosed Public Places) Act 2003 was re-named the Smoke-Free Public Places Act 2003. The name change was necessary to reflect the Act's expanded purpose.

Section C

Legislative and policy-based reporting

C.1
Risk management and internal audit

The Health Directorate Audit and Risk Management Committee Charter governs the operation of the Audit and Risk Management Committee. The Audit and Risk Management Committee plays an essential role by providing assurance to the Director-General on directorate governance and oversight in relation to risk management, internal systems and legislative compliance.

The committee's ability to consider the internal control environment, governance and risk management activities objectively is facilitated by the mix of internal and external members and supported by the Health Directorate Internal Audit and Risk Manager.

The committee consists of five members: an independent chair, three senior executives from within the Health Directorate and one external member. Observers from the Health Directorate and the ACT Auditor-General's Office also attend the meetings. Two committee members (the chair and an internal member) were appointed during 2010–11. The committee held four meetings in 2010–11.

The committee's attendances are set out in the table below.

Name of member attended	Position	Duration	Meetings
Mr Geoff Knuckey	Independent Chair (appointed in May 2011)	recently appointed	1 meeting
Mr Ian Thompson	Deputy Chair	4.5 years	4 meetings
Mr Lee Martin	Member (appointed in June 2011)	recently appointed	1 meeting
Ms Judi Childs	Member	4 years	4 meetings
Mr Bruce Jones	External Member	5 years	4 meetings

The Internal Audit and Risk Management Branch promotes and improves the Health Directorate's corporate governance by conducting audits and investigations and making recommendations for improvements. The Health Directorate Strategic Internal Audit Program for the period from 1 July 2010 to 31 December 2011 is designed to closely align the directorate's strategic priorities and risks. The program is reviewed regularly to ensure that it continues to be effective.

In 2010–11, the Internal Audit and Risk Management Branch finalised four audits (signed reports) under the Annual Audit Program. Five special review and external audits were also commissioned in response to issues of concern identified during the year. Audit findings and recommendations are rated in line with the Health Directorate Integrated Risk Management Guidelines. Throughout the year, the Internal Audit and Risk Manager reported to the Audit and Risk Management Committee on progress against the Strategic Internal Audit Program and on the implementation of audit recommendations.

The Audit and Risk Management Committee is also kept informed of progress in implementing recommendations from the ACT Auditor-General's Office where they apply to the Health Directorate.

Managing risk in the Health Directorate involves implementing effective treatments to reduce the risks identified. All business units in the Health Directorate conduct risk management activities in accordance with the Health Directorate Integrated Risk Management Policy and Procedures and Guidelines.

The former ACT Health Risk Management Committee became part of the Audit and Risk Management Committee from June 2011. The Risk Management Committee was chaired by the Director General and it guided strategic risk management across the Health Directorate.

Pending establishment of the Audit and Risk Management Committee in 2010–11, the Risk Management Committee:

- provided leadership and advice on improving the Health Directorate Risk Management Framework and Policy and integrating business planning activities with the assessment and treatment of risk
- ensured that risk management processes were implemented throughout the Health Directorate and promoted the Health Directorate's risk management philosophy, appetite and culture.
- ensured that the Health Directorate risk management processes aligned with its risk management direction
- ensured that key risks facing the Health Directorate, including financial risks and emerging risks, were documented and prioritised, and
- ensured that appropriate resources and responsibility for expeditious, effective treatment were assigned.

Currently, the Audit and Risk Management Committee monitors risk management developments and the operation and performance of risk management in the Health Directorate. The Audit and Risk Management Committee receives reports on these matters at each quarterly meeting.

The Health Directorate is conducting an Integrated Risk Management Project, whose deliverables and their status are shown in the table below.

Project deliverables	Status
A review of the Directorate's enterprise risk register that includes operational and strategic risks.	In progress
The development of a risk management training package that is aligned with the revised risk management framework and guidelines	In progress

The Health Directorate has developed the Divisional Risk Management framework to support the Directorate's Risk Management Policy and Procedures and Guidelines. The framework, policy, procedures and guidelines aim to integrate risk management activities across all business units of the Health Directorate and to further standardise the risk management methodology and reporting process across the agency.

Each business unit is charged with the responsibility of developing its own risk management plan and divisional risk register. Extreme and significantly high operational risks are reported to the Audit and Risk Management Committee for oversight.

C.2
Fraud prevention

The Health Directorate has a comprehensive fraud control policy and framework in place. The framework was reviewed in April 2009 in accordance with the Risk Management Standard (AS/NZS 4360-2004) and the ACT Public Service Integrity Policy. An updated action plan was developed and endorsed by the Portfolio Executive as part of the review. Risk assessments are undertaken across the agency to identify fraud risks. Mitigating controls are in place to address these fraud risks. Executive Directors are vested with responsibility for the management of all risks. Continuous processes are in place to identify, record and mitigate risks in line with documented procedures. Effective reporting and mitigation is monitored by the Directorate's Audit and Risk Management Committee and other financial reporting mechanisms.

Staff are given fraud control and prevention training during orientation. Managers are provided with further information and training during the managers orientation program. This is reinforced by distributing targeted information.

No cases of alleged fraud were reported during 2010–11.

C.3
Public interest disclosure

Public interest disclosure is managed in the Health Directorate in accordance with the *Public Interest Disclosure Act 1994* (PID Act). Procedures for actioning public interest disclosures are carried out according to the Chief Minister and Cabinet Directorate guidelines. The Health Directorate's public interest disclosure policy and procedures are available to all staff and the community on the Health website. The Senior Executive Responsible for Business Integrity Risk receives disclosures and determines the appropriate action in accordance with the Act.

Three matters referred for investigation in 2009–10 were finalised in 2010–11. Of these, two were found not proven and one resulted in the development of a comprehensive action plan implemented during 2010–11.

Five disclosures relating to disclosable conduct were received during 2010–11. Four were investigated and finalised in 2010–11, with no supporting evidence of misconduct found. One matter, currently under preliminary investigation, is yet to be finalised.

C.4
Freedom of information

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

Section 7 statement

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

Organisation

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

Powers

The Health Directorate holds a wide variety of statutory powers relating to health services in the ACT. A comprehensive list of legislation under which the Health Directorate exercises statutory powers can be found in section B.4, Legislation report.

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

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

The Health Records (Privacy and Access) Act 1997 assists clients of health services to gain access to their personal records without having to apply under the Freedom of Information Act 1989.

The Health Services Commissioner holds power under the Human Rights Commission Act 2005 to investigate and conciliate complaints about providers of health services. Clients can contact the Commissioner's office by telephoning 6205 2222 or calling in person at Level 2, 12 Moore Street, Canberra City, 2601.

Categories of documents

The directorate holds several basic categories of documents:

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

The Health Directorate's Freedom of Information Officer coordinates requests on behalf of the agency.

Documents available on request

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

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

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

The portfolio holds medical and client records at many of its functional units. These include inpatient and outpatient records at the Canberra Hospital and health centres' medical records and dental records. Access to these records can be gained under the Health Records *(Privacy and Access) Act 1997.*

The portfolio also produces a number of pamphlets and brochures, for public distribution, relating to health matters in the ACT and surrounding region. Many other documents are often made available free of charge.

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

FOI procedures and initial contact points

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

Processing guidelines

A copy of the portfolio's FOI processing guidelines is forwarded to decision makers as they are requested to process FOI applications. The FOI officer is able to assist decision makers in all aspects of processing applications in accordance with the Act.

Section 8 statement

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

Section 79 statement

The following tables summarise the results of FOI requests across the portfolio and the time taken to determine requests. No application fees were charged.

Description	Number
Initial applications lodged	45
Partial access	17
Access refused	0
Full release	5
Technical Refusal	19
Withdrawn	0
Transferred	1
Reviews lodged (under s59)	6
Number upheld	2
Number overturned	4
Applications to ACT Civil and Administrative Tribunal	0
Requests to amend records	0
Time taken to determine requests	
Less than 31 days	15
31–45 days	3
46–60 days (third party consultation)	8
61–90 days	4
More than 90 days	0

At the time of reporting there were three applications that were not yet finalised.

C.5
Internal accountability

Senior executive and responsibilities

The organisational charts on pages 2 and 3 show the structure of the Health Directorate at 1 January 2011 and on 30 June 2011, following an internal restructure which took effect on 21 March 2011. These charts include the names of the senior executive responsible for each of the organisation's output areas, and the latter chart shows the titles of new divisions and branches.

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.

Substantial senior executive and organisational changes

As mentioned in sections A.1 to A.4, the Health Directorate underwent an internal restructure during 2010–11. This was undertaken to meet the challenges of an increasing demand for services, the large and increasing size of the organisation, the implementation of the Capital Asset Development Program, the desire to deliver service excellence, and preparing and implementing changes arising under the National Health Care Reform program. The aim was to enhance the operations of the organisation and strengthen its governance.

The Health Directorate is organised into groups and operational areas which report directly to the Director-General. The two groups—Canberra Hospital & Health Services, and Strategy and Corporate—are led by Deputy Directors-General and are divided into direct clinical service divisions and strategic and corporate support branches. Canberra Hospital & Health Services employs the majority of staff working in the Health Directorate.

As well as this internal restructure, the Health Directorate underwent changes in line with the formation of the single ACT Public Service comprising nine directorates, with key leadership from the Head of Service, located in the Chief Minister and Cabinet Directorate. The aim of this structure is to present the community with one public service, and one public service face, so that it can serve its customers—the ACT's citizens—in the best possible way and meet their demands.

Senior executive positions across the organisation are as follows:

• Dr Peggy Brown	Director-General (DG)
• Ian Thompson	Deputy Director-General (DDG), Strategy and Corporate
• Lee Martin	Deputy Director-General (DDG), Canberra Hospital and Health Services
• Tania Poulos	Director, Executive Coordination Unit
• Hasnah Scheding	Director, Communications and Marketing Unit
• Sarwan Kumar	Manager, Internal Audit and Risk
• Dr Imogen Mitchell	Director, DonateLife ACT
• Moira Lye	Manager, Canberra Hospital Foundation
• Dr Paul Kelly	Chief Health Officer, Population Health Division
• Elizabeth Trickett	Executive Director, Quality and Safety Unit
• Ron Foster	Chief Finance Officer, Financial Management
• Judy Redmond (A/g)	Chief Information Officer, E-health and Clinical Records Branch
• Phil Ghirardello (A/g)	Executive Director, Performance and Innovation Branch
• Adrian Scott (A/g)	Executive Director, Business and Infrastructure Branch
• Ross O'Donoughue	Executive Director, Policy and Government Relations Branch

• Rosemary Kennedy	Executive Director, Service and Capital Planning Branch
• Judi Childs	Executive Director, Human Resource Management Branch
• Veronica Croome	Chief Nurse
• Helen Matthews (A/g)	Allied Health Advisor
• Dr Elizabeth O'Leary (A/g)	Principal Medical Advisor
• Dr Helen Toyne	GP Advisor
• Dr Rob Griffin (A/g)	Director, Medical and Dental Professional Standards Unit
• Prof. Paul Gatenby AM	Director of Research
• Barbara Reid	Executive Director, Division of Surgery and Oral Health
• Elizabeth Chatham	Executive Director, Division of Women, Youth and Children
• Kate Jackson (A/g)	Executive Director, Division of Critical Care and Imaging
• Grant Carey-Ide(A/g)	Executive Director, Division of Capital Region Cancer Service
• Linda Kohlhagen	Executive Director, Division of Rehabilitation, Aged & Community Care
• Katrina Bracher	Executive Director, Division of Mental Health, Justice Health and Alcohol & Drug Services
• Prof. Julia Potter	Executive Director, Division of Pathology
• Rosemary O'Donnell	Executive Director, Division of Medicine
• Dr Jo Burnand	Executive Director, Medical Services
• Heather Austin (A/g)	Executive Director, Nursing and Midwifery
• June Gunning (A/g)	Director, Acute Support Services

Senior management committees, roles and membership

Governance arrangements of the Health Directorate were also considered as part of the internal restructure. Two consultation periods were held, the first focusing on the top-level executive structure and the second focusing on the functions and units within each division and branch, as well as tier one governance structures. Senior management committees were mapped across to the new governance model.

Committees within the Health Directorate are established against the following levels:

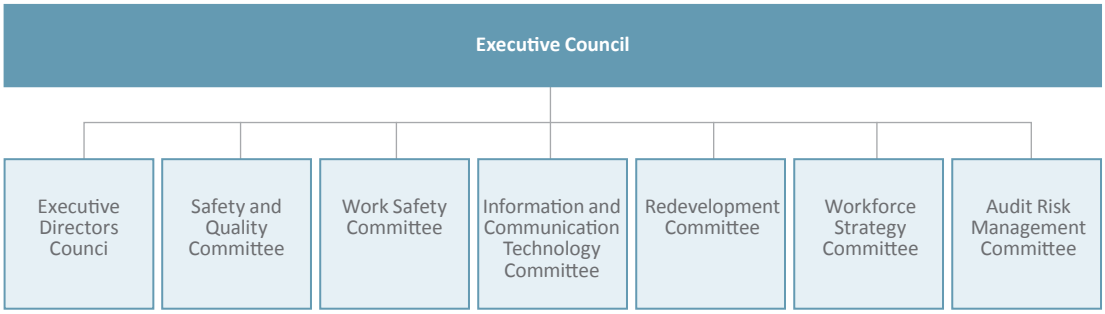
Tier One—directorate level

Tier Two—division/branch level and Tier One subcommittees

Tier Three—unit/team level

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

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



Name of committee	Role of committee	Membership
Executive Council	At the centre of the Health Directorate's governance model is the Executive Council. The role of this peak council is to: • support the Director-General to meet responsibilities outlined in the *Health Act 1993* and other relevant legislation • make recommendations on the strategic direction, priorities and objectives of the organisation and endorse plans and actions to achieve the objectives • oversight finance, performance and human resources • set an example for the corporate culture throughout the organisation Executive Council is chaired by the Director-General of the Health Directorate and meets twice monthly; one of these meetings each month is focused on finance and performance, with other matters discussed at the alternate meeting. A number of subcommittees report to Executive Council, each dealing with different key areas of accountability across the directorate.	Director-General (Chair) Deputy Director-General, Canberra Hospital & Health Services Deputy Director-General, Strategy & Corporate Chief Finance Officer Chief Health Officer Executive Director, Quality & Safety
Executive Directors Council	This council provides an opportunity for all Executive members to communicate and collaboratively work in partnership with other areas of the Health Directorate to deliver patient-focused, high-quality care through influencing policy and strategic direction, managing policy governance and risk, and maximising operational effectiveness. The Executive Directors Council meets monthly and reports to Executive Council, informing Executive Council on strategic operational matters and risk management. Subcommittees of the Executive Directors Council include: • divisional/branch Executive meetings • National Access Plan Committee/Executive subcommittee • Medical Staff Council • Nursing and Midwifery Council • Allied Health Council • Surgical Services Taskforce • Emergency Care Taskforce • Critical Care Taskforce • Plant and Equipment Committee • Southern Local Health Network ACT Health Directorate Clinical Governance Committee • ACT Health Directorate Nursing and Midwifery Reasonable Workload Committee	Director-General Deputy Director-General, Strategy & Corporate Deputy Director-General, Canberra Hospital & Health Services Director, Executive Coordination Unit Director, Communications and Marketing Manager, Internal Audit and Risk Allied Health Advisor ACT Chief Nurse Principal Medical Advisor Chief Finance Officer Chief Health Officer Chief Information Officer Executive Director, Service and Capital Planning Executive Director, Policy and Government Relations Branch Executive Director, Human Resource Management Branch Executive Director, Quality and Safety Unit Executive Director, Business and Infrastructure Branch Executive Director, Performance and Innovation Branch Executive Director, Division of Capital Region Cancer Service Executive Director, Division of Mental Health, Justice Health and Alcohol & Drug Services Executive Director, Division of Rehabilitation, Aged & Community Care Executive Director, Division of Critical Care and Imaging

Name of committee	Role of committee	Membership
Executive Directors Council *—continued*		Executive Director, Division of Medicine Executive Director, Division of Women, Youth and Children Executive Director, Division of Surgery and Oral Health Executive Director, Division of Pathology
Safety and Quality Committee	This committee comprises executive and professional advisor positions and academic and consumer representatives. Its role is to: • set strategic directions, priorities and objectives in quality and safety • oversight clinical practice improvement, quality improvement, accreditation, clinical governance matters (including sentinel events), consumer engagement and clinical policy • monitor research committee Subcommittees: • Medical and Dental Appointments Committee • Clinical Privileges Committee • Southern LHN ACT Health Clinical Governance Committee • Ethics Committee • Hand Hygiene Committee • Medication Management Committee • Falls Committee • Pressure Injury Prevention Management Reference Group • Infection Control Committee • Wound Management Committee • Clinical Handover Reference Group • Clinical review committees • Resuscitation Committee • Sterilising Management Committee	Director-General Deputy Director-General, Corporate and Strategy Deputy Director-General, Canberra Hospital & Health Services Executive Director, Quality and Safety Unit Chief Information Officer Chief Health Officer Executive Director, Performance & Innovation Branch Executive Director, Business & Infrastructure Branch Executive Director, Service & Capital Planning Branch Executive Director, Policy and Government Relations Branch Executive Director, Human Resource Management Branch Chief Nurse Principal Medical Advisor Principal Allied Health Advisor Executive Director, Surgery and Oral Health Executive Director, Division of Critical Care and Imaging Executive Director, Division of Women, Youth & Children Executive Director, Division of Medicine Executive Director, Division of Rehabilitation, Aged & Community Care Executive Director, Division of Capital Region Cancer Service Executive Director, Division of Mental Health, Justice Health and Alcohol & Drug Services Executive Director, Division of Pathology Manager, Internal Audit & Risk Management Unit Academic representative, ANU Academic representative, University of Canberra Consumer and carer representatives

Name of committee	Role of committee	Membership
Work Safety Committee	This committee provides a strategic overview of the agency's approach to workplace safety, provides advice and makes recommendations to the Director-General about policies, strategies, allocation of resources and legislative arrangements for workplace health and safety and addresses whole-of-agency workplace safety issues that are unable to be resolved at division or branch Level. The Work Safety Committee meets quarterly and reports to Executive Council. Subcommittees: • Dangerous Substances Committee • Tier 2 workplace safety committees • Radiation Safety Committee • Security Committee • Violence and Aggression Working Group	Director-General (Chair) Deputy Director-General, Canberra Hospital & Health Services Deputy Director-General, Strategy and Corporate Chief Health Officer Chief Finance Officer Executive Director, Quality and Safety Unit Director, Injury Prevention and Management 2 Representatives from each Division/Branch (Tier 2) OH&S Committee, including: • 1 Manager • 1 Health and Safety Representative (chairs of divisional committees)
Audit and Risk Management Committee	This committee is established to provide assurance and assistance to the Director-General on the agency's risk, control and compliance frameworks and external accountability responsibilities, as prescribed in the *Financial Management Act 1996t*. The committee contributes to management and delivery of health services through oversight of financial statements, internal control, internal audit, external audit and compliance. The membership provides strategic advice to the Director-General on organisation-wide risk management and facilitates the prevention of fraud risk. The Audit and Risk Management Committee meets quarterly and reports to the Director-General.	External Chairperson—Chair of the committee must be independent and external to the Health Directorate Manager, Internal Audit & Risk Management Deputy Director-General, Strategy & Corporate Deputy Director-General , Canberra Hospital & Health Services External member with expertise in internal audit and/or risk management Executive Director, Human Resource Management Branch Director-General (observer)
Workforce Strategy Committee	This committee is to: • give strategic context and direction for the development of the Health Directorate workforce, including a focus on workforce planning; recruitment and retention strategies; organisational development, workplace culture and leadership; human resource management, including employee relations and industrial matters; training and education, including essential education, academic linkages and research • ensure all associated strategies are coordinated, integrated and aligned to the broader Health Directorate strategic objectives • strategically oversight the impact of organisational re-design on the workforce profile and on workplace health and safety The committee comprises members of the Executive, strategic and operational professional advisors and Directors of Human Resource Management Branch sections. The Workforce Strategy Committee meets quarterly and reports to Executive Council.	Deputy Director-General, Strategy and Corporate (Chair) Deputy Director-General, Canberra Hospital & Health Services Executive Director, Human Resource Management Branch Executive Director, Performance & Innovation Branch Executive Director, Quality & Safety Unit Executive Director, Business & Infrastructure Branch (representing support services) Director, Executive Coordination Unit (representing administrative staff) Chief Nurse Principal Medical Advisor Principal Allied Health Advisor Executive Director of Nursing & Midwifery Executive Director of Medical Services Executive Director, Service & Capital Planning Branch Director, Acute Support Services

Name of committee	Role of committee	Membership
Workforce Strategy Committee *—continued*	Subcommittees: • Workforce Planning Subcommittee	Director, Workforce Policy and Planning Unit Director, Staff Development Unit Director, Organisational Development
Information Communication and Technology Committee	This committee focuses on strategic planning of cross-directorate E-health and Information Communication and technology (ICT). It provides a forum for: • setting strategic ICT direction, priorities and objectives • endorsing plans and actions to achieve the directorate's objectives • optimising returns on ICT investment, and • ensuring continual alignment of ICT strategic planning with the strategic goals of the ACT Health Directorate. The Committee meets monthly and reports to Executive Council. Subcommittees: • Tier 2 ICT committees • Breast Screening and Digital Mammography Steering Committee • Calvary ACTPAS Steering committee • CADP health-e future PCG • Cancer Information Management System Steering Committee • Community Clinical Record Project Steering Committee • Electronic Discharge Summary and Referral Project Steering Committee • Electronic Medication Management Steering Committee • Integrated Food Services Management System Steering Committee • Intensive Care Unit Steering Committee • PMI Steering Committee • Renal EMR Steering Committee	Director-General—Health Directorate (Chair) Deputy Director-General, Strategy and Corporate Deputy Director-General, Canberra Hospital & Health Services Chief Information Officer Executive Director, Quality & Safety Unit Executive Director, Policy and Government Relations Branch Executive Director, Service & Capital Planning Branch Executive Director, Business and Infrastructure Branch Executive Director, Human Resources Management Branch Chief Health Officer Chief Nurse Principal Medical Advisor Principal Allied Health Advisor General Manager, InTACT Director Operations, InTACT Director Health ICT, InTACT Chief Executive Officer, ACT Division of General Practice Chief Executive, Calvary Public Hospital Health Care Consumer Representative
Redevelopment Committee	The Redevelopment Committee is the chief decision-making body for the Health Directorate Capital Asset Development Program (CADP). It is responsible for providing advice, monitoring progress and monitoring the risks of the CADP. The committee provides strategic advice and recommendations to ensure that the capital works and infrastructure align with the strategic and endorsed service planning directions of the Health Directorate. The committee includes membership external to the Directorate, including representatives from the Chief Minister and Cabinet Directorate, ACT Government Solicitor, Treasury Directorate, Shared Services Procurement, Shared Services ICT, and Thinc Health Australia (Project Director).	Director-General (Chair) Deputy Director-General, Strategy & Corporate Deputy Director-General, Canberra Hospital & Health Services Deputy Director-General, Chief Minister and Cabinet Executive Director, Policy Coordination & Development , Treasury Executive Director, Shared Services Procurement Director Health ICT, Shared Services ICT General Manager, Shared Services ICT Executive Director, Service and Capital Planning Executive Officer, Service and Capital Planning Executive Director, Business and Infrastructure

Name of committee	Role of committee	Membership
Redevelopment Committee *—continued*	The Redevelopment Committee meets monthly and reports to Executive Council. Subcommittees: • Strategic Implementation Group • All project control groups • All executive reference groups • CADP Budget Committee • CADP Directors-General Steering Committee	Executive Director, Performance and Innovation Executive Director, Human Resource Management Project Director, Thinc Health Australia Deputy Project Director, Thinc Health Australia Chief Finance Officer Chief Information Officer Principal Solicitor, ACT Government Solicitor Chief Executive, Calvary Public Hospital Consumer representative (x2)
Management Advisory Council	The broad membership reflects the role of the council, which is to promote engagement with staff across the organisation, facilitate information sharing and discussion on government priorities and key strategic and operational issues, and to provide advice to Executive Council. Management Council is chaired by the Director-General, and meets quarterly for half a day, reporting to Executive Council. There are no sub-committees.	The membership council comprises the members of the Executive Directors Council along with key professional positions within divisions and representatives of stakeholder groups, including consumers and professional staff across the organisation comprise the Management Advisory Council. Director-General (Chair) DDG, Strategy and Corporate DDG, Canberra Hospital &and Health Services Executive Officer, Strategy and Corporate Executive Officer, Canberra Hospital &and Health Services Director, Executive Coordination Manager, Communications & Marketing Manager, Internal Audit and Risk Chief Finance Officer Chief Health Officer Executive Director, Quality & Safety Chief Nurse Principal Medical Advisor Principal Allied Health Advisor, Director, GP Liaison Unit Executive Director of Nursing and Midwifery Executive Director of Medical Services Senior Business Analyst Director, Acute Support Services Chief Information Officer Executive Director, Performance & Innovation Executive Director, Business and Infrastructure (Plus additional PD reps as required) Executive Director, Service & Capital Planning Executive Director, Policy & Government Relations GP Advisor Executive Director, Human Resource Management Executive Members, Surgery and Oral Health (i.e. ED, Clinical Directors, DON, Academic Head, Manager Allied Health)

Name of committee	Role of committee	Membership
Management Advisory Council *—continued*		Executive Members, Critical Care and Diagnostics (i.e. ED, Clinical Directors, DON Academic Head, Manager Allied Health) Executive Members, Women, Youth and & Children (i.e. ED, Clinical Directors, DON s, Academic Head, Manager— Allied Health) Executive Members, Medicine (i.e. ED, Clinical Director, DON, Academic Head, Manager Allied Health) Executive Members, Rehabilitation, Aged & Community Care (i.e. ED, Clinical Directors, DONs, Academic Heads, Manager —Allied Health) Executive Members, Capital Region Cancer Service (i.e. ED, Clinical Director, DON, Academic Head, Manager— Allied Health) Executive Members, Mental Health, Justice Health & Alcohol and Drug Services (i.e. ED, Clinical Director, DON, Academic Head, Manager —Allied Health) Executive Members, Pathology (i.e. ED, Operational Manager) Consumer and carer representatives x 2 RMO representatives x 2 Registrar representatives x 2 Nursing representatives x 2 Allied health representatives x2 Non-clinical staff representatives x 2 Administrative staff representatives x 2 Scientific staff representatives x 2
Clinical Senate	The role of this group is to provide a forum for advice to the Director-General by clinicians on matters relating to: • the coordination and development of clinical planning • clinical and resource decision- making • other relevant clinical issues in health service delivery in the ACT • issues of key concern to the Director-General. Through regular meetings, information dissemination and coordination, the Clinical Senate provides a means for medical practitioners, nurses and allied health professionals to assume a leadership role in advising and leading clinical and system-wide reform. Clinical Senate meets quarterly for three hours and reports to Executive Council.	Deputy Director-General, TCH & Health Services (Chair) DDG, Strategy & Corporate Executive Director of Medical Services Executive Director of Nursing and Midwifery Director, Acute Support Services Chief Nurse Principal Medical Advisor Principal Allied Health Advisor GP Advisor Chair, Medical Staff Council All Divisional Clinical Directors All Divisional Directors of Nursing All Divisional Allied Health representatives Executive Director, Quality and Safety Consumer and carer representatives Relevant others, based on issue(s) to be considered

Name of committee	Role of committee	Membership
Clinical Senate		*The membership is not a fixed membership and will comprise up to 40 non-representative medical practitioners, nurses, allied health professionals, therapeutic, scientific and diagnostic members as well as consumers and carers. Membership for each Senate meeting will be determined on the basis of the matters being discussed.

In addition to the Tier One committees, two committees established as a result of the review of governance were progressed. These committees provide advice and recommendations directly to the Executive Council. The Clinical Senate met for the first time in June 2011, and the establishment of the Management Advisory Council was progressed, with the first meeting scheduled for July 2011.

Clinical Senate		Deputy Director-General, TCH & Health Services (Chair) Deputy Director-General, Strategy & Corporate Executive Director of Medical Services Executive Director of Nursing and Midwifery Director, Acute Support Services Chief Nurse Principal Medical Advisor Principal Allied Health Advisor GP Advisor Chair, Medical Staff Council All Divisional Clinical Directors All Divisional Directors of Nursing All Divisional Allied Health representatives Executive Director, Quality and Safety Unit Consumer and carer representatives x 2
Management Advisory Council	The broad membership reflects the role of the council, which is to promote engagement with staff across the organisation, facilitate information sharing and discussion on government priorities and key strategic and operational issues, and provide advice to Executive Council. Management Council is chaired by the Director-General, and meets quarterly for half a day, reporting to Executive Council. There are no subcommittees.	'Executive Members' of each division are usually the Executive Director, Clinical Unit Directors, Academic Head, Director of Nursing and Allied Health Director or Manager. Director-General (Chair) Deputy Director-General, Strategy and Corporate Deputy Director-General, Canberra Hospital & Health Services Executive Officer, Strategy and Corporate Executive Officer, Canberra Hospital & Health Services Director, Executive Coordination Unit Manager, Communications & Marketing Unit Manager, Internal Audit and Risk Unit Chief Finance Officer Chief Health Officer Executive Director, Quality & Safety Unit Chief Nurse Principal Medical Advisor

Name of committee	Role of committee	Membership
Management Advisory Council *—continued*		Principal Allied Health Advisor GP Advisor Director, GP Liaison Unit Executive Director of Nursing and Midwifery Executive Director of Medical Services Senior Business Analyst, TCH&HS Director, Acute Support Services Chief Information Officer Executive Director, Performance & Innovation Branch Executive Director, Business and Infrastructure Branch Executive Director, Service & Capital Planning Branch Executive Director, Policy & Government Relations Branch Executive Director, Human Resource Management Branch Executive Members, Division of Surgery and Oral Health Executive Members, Division of Critical Care and Imaging Executive Members, Division of Women, Youth & Children (i.e.) Executive Members, Division of Medicine Executive Members, Division of Rehabilitation, Aged & Community Care Executive Members, Division of Capital Region Cancer Service Executive Members, Division of Mental Health, Justice Health and Alcohol & Drug Services Executive Members, Division of Pathology Consumer and carer representatives x 2 Resident Medical Officer representatives x 2 Registrar representatives x 2 Nursing representatives x 2 Allied health representatives x2 Non-clinical staff representatives x 2 Administrative staff representatives x 2 Scientific staff representatives x 2

As well as these committees, governance meetings are established at the Tier Two level within the Strategy and Corporate group and the Canberra Hospital & Health Services group, as well as within clinical divisions and corporate branches. Senior staff from divisions and branches are involved in these meetings and key information will be cascaded down from the Tier One level via groups, divisions and branches to unit level across the directorate.

A range of forums is also being established that will add to existing forums and provide the opportunity for stakeholder input. These include:

- Local Hospital Network Council (bimonthly)—commencing after 1 July 2011
- Medical Staff Council (monthly)—underway
- Nursing and Midwifery Leaders meeting (monthly)—underway
- Allied Health forum (monthly)—underway
- Director-General Forums (6-weekly)—underway
- Leadership Network (x 3/year)—underway
- Integrated Regional Clinical Training Network—to commence July 2011
- Tertiary Education Liaison Committee (quarterly)—underway
- Private Hospitals Liaison Committee (quarterly)—underway
- Healthcare Consumers Liaison Committee (quarterly)—underway
- GP Liaison Network (quarterly)—underway
- ACT Division of General Practice/ ACT Health Executive Committee (quarterly)—underway (will be modified when ACT Medicare Local commences after 1/7/11)
- Southern LHN Liaison Committee—to be advised
- Health Directorate/Community Services Directorate Liaison committee (quarterly)—underway
- Health Directorate/Human Rights Commission (annual)—underway

Corporate and operational plans (and associated reporting and review)

access health

access health is a future directions document developed by the ACT Minister for Health. access health is about ensuring people have access to the right care when they need it. The ACT Government is committed to maintaining the high standard of health enjoyed by people living in the Canberra region and has identified key priority areas in which to concentrate its efforts.

These are:

- timely access to care
- aged care
- mental health
- chronic disease management
- Aboriginal and Torres Strait Islander health, and
- early childhood and vulnerable families.

Corporate Plan 2010–2012

The Health Directorate has implemented its Corporate Plan, which covers the period 2010–2012. The Plan describes the Health Directorate's vision, values and key objectives. Its priorities are described under seven key performance areas, as set out below.

Consumer experience

- Provide timely access to care based on clinical priority
- Encourage patient-centred models of care that provide needed services in appropriate settings and target disadvantaged groups

- Develop clinical pathways for key conditions (chronic and complex) and implement and monitor across the health system
- Provide an individual health record and accurate, online information on health services with capacity to be customised to individual health needs to support self-management
- Uphold rights and responsibilities of patients and their carers, including those with mental health needs
- Improve patient safety and quality

Sustainability

- Improve service delivery through investment in appropriate physical and technological infrastructure
- Identify collaborative actions to reduce our ecological footprint, with a particular focus on energy consumption and transport
- Invest in research that promotes evidence-based practice and innovation
- Support workforce role redesign and collaborate on action to meet immediate health workforce shortages
- Build and sustain an adaptive, learning, innovative and change-enabling organisation
- Prepare and implement organisational changes for new Local Hospital Network and Medicare Locals
- Provide a safe and healthy working environment for all employees
- Provide appropriate stewardship over public funds
- Provide timely and quality advice to minister and government
- Form effective partnerships with key stakeholders

Hospital and related care

- Ensure 95 per cent of all elective surgery patients will be treated within clinically recommended time
- All people presenting to an emergency department will be admitted, referred for treatment or discharged within four hours of presentation, as clinically appropriate
- Increase technical efficiency of public hospital services
- Provide more effective assessment and support of patients before admission and on discharge

Prevention

- Increase the focus on prevention, particularly for children and at-risk groups
- Encourage public and private investments in initiatives that support prevention
- Improve risk factor and evidence surveillance
- Raise self-awareness and personal responsibility

Social inclusion and Indigenous health

- Reduce gaps in health outcomes from disparities in socioeconomic status
- Develop innovative evidence-based models of care for Indigenous Australians
- Improve services for disadvantaged populations
- Link health interventions to broader activities, including cross-agency support for vulnerable families.

Community-based health

- Encourage patient-centred models of primary and community care
- Better connect hospitals, primary and community care to meet patient needs, improve continuity of care and reduce demand on hospitals
- Use e-health to link providers and improve quality of care

Aged care

- Expand appropriate care options in line with needs and aspirations of ageing population
- Provide continuity of care across hospitals, community and aged care to smooth patient transitions
- Develop care options for older people with dementia and mental health issues, including aggressive behaviours

Health Directorate develops an annual business plan, which targets priority key performance measures from the Corporate Plan. Quarterly reports on performance against the 2010–11 Business Plan were provided to the Finance and Performance Committee for review and monitoring of progress against the Health Directorate's key objectives. Each division and branch of the Health Directorate develops an annual divisional branch plan under the Health Directorate Business Plan.

Clinical Services Plan 2005–2017

Planning is underway for the new Clinical Services Plan 2012–2017, which will update the current plan. The Clinical Services Plan 2005–2011 provides a strategic framework for the delivery of ACT public hospital and health services. It is an internal document which outlines initiatives for population groups, hospitals and ambulatory care services. It lists service expansion initiatives and improved service performance targets that will be implemented under the plan.
In implementing the initiatives under the plan, it was recognised that the Health Directorate needed to create additional capital and human resource capacity to meet future demand and that a longer-term plan had to be developed to prepare for projected population growth and changes in illness presentation, management and prevention. The Capital Asset Development Plan was subsequently developed. Infrastructure development planning has been underpinned by a series of health services plans and strategies to support clinical services that have been completed or are under development. Each plan addresses information management and technology impacts, recurrent funding and workforce requirements. The principles used for all planning exercises are: patient-centred, aligned with agreed priorities for the future, provided in an integrated multidisciplinary and multi-agency setting, safe and high-quality, equitable, innovative and evidence-based, integrated, affordable and flexible.

2010–11 saw the completion of the planning document *Improving Women's Access to Healthcare Services and Information—a Strategic Framework 2010–2015* and the completion of consultation on the Rehabilitation and Aged Care Plan 2011–2016.

Work continued on a number of other clinical services planning projects and the facility planning component of the Capital Asset Development Program.

Capital Asset Development Plan

The ACT Health Capital Asset Development Plan (CADP) is a comprehensive and structured response to the pressures of growing demand for health services in the ACT. Also referred to as *Your health—our priority*, it represents a program for redeveloping the ACT public health infrastructure that incorporates the total health system, including new models of care aimed at better managing chronic disease and reducing the need for people to be admitted to hospital. Aligned with these new models are workforce initiatives that will create a sustainable workforce for the future. Forward planning also includes better use of technology and different ways of providing care, such as community-based post-hospitalisation support or other step-up/step-down facilities.

To date the ACT Government has committed more than $600 million to the CADP.

Main strategic directions (goals)

The main strategic directions are as follows:

- The Canberra Hospital campus will be transformed through new building and refurbishment to provide additional beds, a new Women's and Children's Hospital, an Integrated Cancer Care Centre, additional theatres and a skills development centre.
- Both Calvary Public Hospital and Canberra Hospital will have enhancements to emergency department treatment areas.
- Mental health infrastructure will be improved through a new Adult Acute Mental Health Inpatient Unit, and a new Adolescent and Young Adult Mental Health Inpatient Unit at Canberra Hospital.
- Community-based services will be strengthened through new community health centres at Gungahlin and Belconnen. Tuggeranong Community Health Centre will be refurbished to provide a broader range of health services.
- Planning has commenced for the new northside sub and non-acute hospital

Strategies/actions implemented or commenced during 2010–11

Significant progress has been achieved on CADP during 2010–11:

- The new Neurosurgery Operating Theatre was officially opened on 17 September 2010, with equipment that is the first of its type to be used in Australia.
- A new 16-bed Surgical Assessment and Planning Unit, in close proximity to the Canberra Hospital Emergency Department, is now operational. This assists to streamline the admission process for non-critically ill surgical patients, allowing for increased throughput and rapid turnaround of short-stay surgical patients.
- The interim Walk-in-Centre at the Canberra Hospital is complete and operational.
- Calvary Public Hospital capacity has been enhanced by the completion of a new 16-bed critical care unit and an additional operating theatre.
- The new Southern Car Park delivered 1720 car spaces on the Canberra Hospital campus.

Digital Health Enterprise Technology Strategy

The Digital Health Enterprise (DHE) technology strategy outlines how technology will support the Health Directorate's transformation program (Your health—our priority). The transformation program is developing new service delivery methods and models so the Health Directorate can continue providing quality health services in an environment of rapidly rising demand. The transformation program encompasses new models of care, new and refurbished facilities, workforce planning and enhanced technology capabilities.

In order to deliver the *Your health—our priority* benefits and goals, technology must provide three key capabilities:

Access—providing health care professionals and patients with timely access to trusted information

- New level of access to information for health care professionals both within and beyond the hospital, enabling the delivery of care from other facilities such as community health centres
- Higher level of access for patients and consumers, supporting prevention and early intervention activities and enabling patients to be more involved in their health care

Efficiency—integrating systems to improve communication, enable collaboration, increase automation and reduce the unit cost of services

- Real-time collaboration and more effective communications, enabling multidisciplinary clinical teams to deliver more integrated care
- More efficient communication processes, supporting new models of care that are more efficient and less resource-intensive

Reliability—providing trusted systems supported by a robust technical infrastructure

- Increased system availability and responsiveness to develop strong trust in new and existing technology, supporting change management efforts for clinicians (buy-in and speed of uptake) and improving the patient experience.

The DHE enables an integrated approach to the delivery of health care across a broad range of clinical services by integrating Information communication technology (ICT) and medical equipment, including clinical systems, communication systems, clinical devices, controls over the physical facilities, imaging services and information management. Integration extends across all services in the hospitals, community health, mental health, cancer services and aged care and rehabilitation services, including the provision of home-based and remote monitoring and the use of technologies to support mobile health workers.

A key aim of the DHE is to make the right information available to the right person when required and wherever that person may be located. The establishment of a DHE is a critical enabler for the level of organisational transformation that the Health Directorate will be undertaking through the Your health—our priority program.

A key belief underpinning the strategy is that technology will inevitably continue advancing and will play an increasing role in the delivery of health care, just as it is in other industries.

Health care will become increasingly digital due to the nature and direction of the health services industry. The aim of the strategy is to manage the introduction of new technologies in a controlled way so as to maximise the benefits for patients, staff and the overall enterprise.

The DHE is made up of a number of integrated building blocks. Together they provide the access, efficiency and reliability capabilities required to support new models of health care delivery. These building blocks fall into three groupings:

- the functional capabilities required by stakeholders (systems and devices, building management, unified communications and collaboration)
- the enabling technologies that underpin the applications, systems and devices (identity and access management, enterprise integration, medical grade network and data centre)
- the governance and services that are required to maintain the health of the DHE and provide the information required (governance, service management).

The systematic development and integration of these building blocks will enable the Health Directorate to leverage the convergence of information, medical, communication, building and logistics technologies. This convergence plays a critical role in providing the access, efficiency and reliability capabilities required to meet the goals and objectives of *Your health—our priority.*

Major projects implemented/completed in 2010–11

- Digital Intensive Care Unit at the Canberra Hospital
- Equipment Loans Service Application for ACT Equipment Services
- Digital Health Enterprise consultancy that produced the DHE Strategy and Implementation Plan.

Major projects continuing in 2010–11

- Digital Intensive Care Unit at Calvary Hospital
- eReferrals from GPs—focusing on rehabilitation, aged care and community health services
- Digital mammography—Breast Screening Information System
- Clinical Portal enhancements to improve access to a range of applications by clinicians
- Community-Based Services System
- Cancer Information System
- Renal Medicine System
- Electronic Medication Management
- Identity and Access Management
- Wireless Connectivity into Clinical Areas
- Centralised eRostering
- Integrated Patient Meal System
- Patient Access Project
- Calvary Patient Administration System
- Patient Master Index
- Real-time Bed Management
- EDIS—TCH Upgrade and Calvary Implementation

Major projects commenced in 2010–11

- Integrated Nurse Call system
- Integrated security system
- Integrated building management system
- Electronic order entry of radiology and pathology requests

ACT Children's Plan

Overview

The ACT Children's Plan was launched in June 2010 to provide an aspirational whole-of-government and whole of community vision to make Canberra a great and safe place for children, and to ensure their needs are a priority for government and community.

Timeframe of plan

The ACT Children's Plan is operational from 2010 to 2014.

Main strategic directions (goals)

The aim of the ACT Children's Plan is that Canberra is a child and youth-friendly city that supports all children and young people to reach their potential, make a contribution, and share the benefits of our community.

The plan proposes six building blocks to build Canberra as a child-friendly city:

- opportunities for children to influence decisions about their lives and their community, and to actively participate in their communities
- advocacy, promotion and protection of children's rights
- processes to assess the impact of law, policy and practice on children
- regular monitoring of the state of children's health, well-being, learning and development
- services, programs and environments that support children's optimal development and enhance parental, family and community capacity, and
- effective governance mechanisms across government and community.

Strategies/actions/projects fully implemented as at the end of June 2011

There are none to report for 2010–11

Major goals/projects implemented/completed in 2010–11

There are none to report for 2010–11

Major goals/projects commenced in 2010–11

- Implementation of the Charter on the Rights of Children and Young People in Healthcare Services in Australia has commenced under the auspices of Australian Charter of Healthcare Rights Implementation Committee.
- Health Directorate has contributed to the development of A Picture of ACT Children, which will be the first report on children's health, wellbeing, development and learning indicators.
- Health Directorate is participating in the three strategic priority working groups under the *ACT Children and Young People's Taskforce* to
    - implement an ACT children outcomes-based data monitoring system
    - embed mechanisms for across-government actions to advance the needs of children, within the new governance structures of the single ACT public service, and
    - create a comprehensive and coordinated system for early identification and provision of supports for vulnerable children, families and their communities.

Mental Health Services Plan 2009–2014

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

The guiding vision for mental health services in the ACT is that by 2020 the mental health needs of the ACT community will be met by a comprehensive network of complementary and integrated mental health services that:

- enhance knowledge and understanding
- intervene and provide support early and for as long as is necessary, and
- as far as possible, address mental health issues within community settings, working with and developing natural systems of support.

Consumer and carer participation will be richly woven through all aspects of service planning, delivery, research, teaching and evaluation, while peer support and advocacy services will be available as required to support consumers along their journey of recovery.

The plan aligns services with four developmental stages that, rather than promoting service delivery along age lines alone, will focus on developmental and life milestones to determine .the most appropriate point of service.

During 2010–11 at a national level the ACT's mental health direction was informed by the Council of Australian Governments National Action Plan for Mental Health 2006–2011 and the National Mental Health Plans and other documents of the National Mental Health Strategy. These included the Fourth National Mental Health Plan 2009–2014 and the revised National Standards for Mental Health Services.

Strategic directions

The plan sets goals for change and improvements in the mental health sector. To achieve these goals, the plan follows four priorities:

- Reinforcing capacity in the mental health sector
- Extending the mental health service system
- Innovation in the mental health service system
- Planned implementation of change

Timelines for implementing these actions were indicated throughout the five-year life of the plan. Oversight of the implementation process was allocated to the Strategic Oversight Group (SOG). Led by the Health Directorate, the SOG includes key consumer, carer, community, education, and primary care representatives, with participation from ACT and Australian Government agencies. The SOG released its first Annual Report in 2010. The activities of the SOG in its first year of operation focused on the development of understanding of the complex and dynamic environment that constitutes mental health services in the ACT, and the issues faced.

Strategies/actions fully implemented at the end of June 2011

- The Review of the ACT Community Sector of Mental Health Services was completed. The review was undertaken to identify gaps in workforce and organisational capacity and recommend actions to grow and strengthen mental health services in the ACT.
- Shared Care Guidelines for GPs were developed.
- A survey of consumers' perceptions of care was undertaken with focus groups developed specifically for carers.

Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009 - 2014

Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009-2014 aims to guide the implementation and development of activities to promote mental health and wellbeing, prevent mental illness and, where this is not possible, intervene early to detect and treat mental disorders.

Main strategic directions

The framework has the following three priorities:

- promoting mental health and wellbeing is everybody's business
- preventing mental illness is a shared responsibility
- early intervention requires strong inter-sectoral cooperation.

Timelines for implementing these activities were indicated throughout the five-year life of the plan. Oversight of this process is undertaken by the Mental Health Promotion, Prevention and Early Intervention Implementation and Evaluation Working Group, which includes key consumer, carer, community, education, primary care and directorate representation.

The 2009–2010 evaluation report *Building a Strong Foundation: Evaluation Findings 2009–2010* was finalised in 2011. This report summarises the implementation findings from the first-year evaluation of the framework.

Major goals implemented/ completed:

- participation in workplace mental health literacy training by more than 3000 individuals from government and community agencies
- expansion of MindMatters and KidsMatter across ACT schools, with 14 primary schools participating in KidsMatter and 18 secondary schools and colleges participating in MindMatters
- successful implementation of the Housing and Accommodation Support Initiative, providing tenancy for 10 people with serious mental illness
- allocation of 67 properties through the Housing *ACT Housing for Young People* project.

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

Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009–2014 provides a service development framework to guide an integrated, whole-of-community approach to suicide prevention across the lifespan in the ACT.

Main strategic directions

- Reduce rates of suicide and self-harm in the ACT.
- Increase resilience, coping skills and connectedness.
- Improve awareness of and access to suicide prevention training, education and information.
- Increase collaboration and partnerships between organisations providing suicide prevention and postvention services in the ACT.

The 2009–2010 evaluation report: Managing the Risk of Suicide: Evaluation Findings 2009–2010 was finalised in 2011. This report summarises the implementation findings from the first-year evaluation of the strategy.

Major goals implemented/completed

- provision of a mental health risk assessment to all new detainees at both Bimberi Youth Justice Centre and the Alexander Maconochie Centre on admission
- provision of support through SupportLink and Carers ACT to 333 Canberrans bereaved by suicide
- development of a service level agreement between the Australian Federal Police, ACT Corrective Services, ACT Courts Administration and Mental Health ACT outlining the responsibilities of staff within each organisation in relation to the care of people with a mental illness.

The Health Directorate is leading the way nationally in having developed the first whole-of-government mental health promotion, prevention and early intervention framework. The Health Directorate, in conjunction with the Centre for Mental Health Research at the Australian National University, is evaluating the outcomes of implementation and identifying the factors that affect implementation of both *Building a Strong Foundation and Managing the Risk of Suicide.*

Outcome and process evaluation data, collected from agencies identified with responsibility for implementing actions, is collated and the findings from the surveys used to compile an annual report to the Legislative Assembly.

Council of Australian Governments (COAG) National Action Plan on Mental Health 2006–2011

The National Action Plan on Mental Health 2006 – 2011 aims to increase the pace of reform in mental health with new priorities and new funding for mental health from the Australian Government and jurisdictions.

ACT Implementation Plan

The ACT Implementation Plan details the commitment made by the ACT Government to achieve these aims. Implementation is monitored by the ACT COAG Mental Health Group, chaired by the Chief Minister and Cabinet Directorate. All initiatives in the ACT Implementation Plan were fully implemented two years ago.

The main priorities are:

- increased activity in mental health promotion, prevention and early intervention
- integrating and improving the care system
- more stable accommodation and more support available for social integration, rehabilitation, vocational training and employment for those people with recurrent and enduring mental illness, and
- better coordinated care.

The Fourth National Mental Health Plan

The *Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009–2014* was launched at the Australian Health Ministers' Conference held on 13 November 2009. It demonstrated a commitment to ongoing national mental health reform and identified key actions to advance the vision of the National Mental Health Policy 2008.

While led by health ministers, the plan takes a whole-of-government approach through involving sectors other than just health. The plan provides a basis for governments to advance mental health activities within the various portfolio areas in a more integrated way, recognising that many sectors can contribute to better outcomes for people living with mental illness.

The plan has five priority areas for government action in mental health:

- social inclusion and recovery
- prevention and early intervention
- service access, coordination and continuity of care
- quality improvement and innovation and
- accountability—measuring and reporting progress.

The plan is ambitious in its approach and includes a robust accountability framework. Each year, governments report progress on implementation of the plan to the Council of Australian Governments. The plan includes indicators for monitoring change in the way the mental health system is working for people living with mental illness as well as their families and carers. Health ministers agreed to develop targets and data sources for each of the indicators in the first 12 months of the plan's operation.

Implementation

A comprehensive implementation plan has been developed. It has 36 elements, and various jurisdictions have the lead to establish small committees and develop action plans for the coming five years. The Australian Government has the lead for 12 of the 36 elements, and the ACT is participating on six of the implementation committees.

‘A New Way’—Aboriginal and Torres Strait Islander Health & Wellbeing Plan 2006–2011

‘A New Way’ is the ACT’s response to the requirement in the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013 that each jurisdiction develop its own implementation plan.

The plan was developed as a six-year plan (2006–2011) to engage the health and health-related sectors in collaborative action to measurably improve the health and wellbeing of Aboriginal and Torres Strait Islander communities in the ACT.

Main strategic directions (goals)

‘A New Way’ takes a holistic and family-centred approach and is focused on the following health and wellbeing priorities and their interdependencies: building family resilience; maternal and child health; social health, including mental health and substance abuse; chronic disease prevention and management; and frail aged and people with disabilities.

Strategies/actions/projects fully implemented at the end of June 2011

There are 30 strategies included in ‘A New Way’ that the Health Directorate has responsibility for implementing. Of these, 17 have been completed or implemented and six have been partially implemented. The seven strategies that have not been implemented relate to the conduct of research to determine unmet need. However, during the scoping of projects it was recognised that there was insufficient data available to commence these projects. The Health Directorate is therefore undertaking activities to improve data collection.

Major goals/projects implemented/completed in 2010–11

The Health Directorate has:

- developed an Aboriginal and Torres Strait Islander Health Portal that is accessible on the Health Directorate’s website and intranet, which provides a range of information on Aboriginal and Torres Strait Islander health, health services and organisations, policies and research publications, including related links
- ensured that the design of the main clinical buildings for the new Canberra Hospital included a plan for an Aboriginal and Torres Strait Islander Family Resource Centre to cater to the needs of clients and their extended families, and
- contributed to the Aboriginal and Torres Strait Islander Health Worker Project that aims to define the role in relation to the delivery of care to the Aboriginal and Torres Strait Islander populations.

Major goals/projects commenced in 2010–11

- Engaged a consultant to design a model of care for the Aboriginal and Torres Strait Islander Residential Rehabilitation Service (Ngunnawal Bush Healing Farm) and progressed to the development of a Health Planning Unit brief and schedule of accommodation for the service. Commenced the process of engaging a principal consultant to design the service buildings.
- Commenced addressing options for the development of an Aboriginal and Torres Strait Islander employment and retention plan.
- Developed and launched a Reconciliation Action Plan 2011–-2012 that commits to building relationships and strengthening partnerships to resolve health issues for Aboriginal and Torres Strait Islander peoples in the ACT and surrounding region.
- Implemented strategies to improve data collection around the identifier for Aboriginal and Torres Strait status. ACT Pathology request forms have been amended to include an Aboriginal and Torres Strait Islander identifier and a strategy to improve data collection has now been fully implemented. An information and support project is currently in place to improve collection in clinical areas of the Canberra and Calvary Hospital Maternity units, as well as with Community Health staff. Information sessions are offered as part of regular professional development sessions using the Australian Institute of Health and Welfare’s ‘One Simple Question’ posters and pamphlets.

Health Workforce Plan 2005–2010

Overview

The ACT Health Workforce Plan 2005–2010 sets out the issues, evidence and strategies required to deliver a sustainable ACT Health Workforce capable of continuing to deliver high-quality health care to the people of the ACT and the surrounding region to 2010.

Timeframe of plan

The ACT Health Workforce Plan was current until the end of 2010. A new, expanded plan is in development. This will be titled the Workforce Plan for the ACT Health Sector 2011–2015. This will include:

- consideration of the issues impacting on health workforces across the ACT
- non-clinical staff as well as the clinical health workforce in Health Directorate
- alignment with national activity on health workforce planning and reform, and
- collaboration with national workforce initiatives being progressed by Health Workforce Australia.

Main strategic directions (goals)

1. A workforce profile—Health Directorate requires access to replicable and reliable data to effectively analyse the workforce and permit future workforce planning.
2. A responsive workforce—to develop and maintain a responsive workforce, we need the correct mix of competencies and skills, and new job roles to support existing ones.
3. Education and training—Health Directorate requires access to a labour pool of health professionals that are workplace ready.
4. Effective linkages—Health Directorate participates in and contributes to comprehensive policy discourse within a system of national health committees that include all sectors of government and other stakeholders in Australia and New Zealand.

Strategies/actions/projects fully implemented at the end of June 2011

The strategies in the workforce plan are by their nature ongoing. Major progress has been made against all goals and these feed into the overarching strategic direction for the Health Directorate.

Major goals/projects implemented/completed in 2010–11

Since the last reporting period of 2009–10, the Health Directorate has achieved the following against the goals of the Workforce Plan:

1. ***A workforce profile***
    - Routine reports have been provided in the following areas:
    - Monthly Health Minister Workforce Update
    - Monthly Chief Minister Workforce Update
    - Quarterly Workforce Report to Minister
    - Quarterly reports to ACT Division of General Practice
    - Monthly reports to the ACT Health Finance and Performance Committee.

The workforce data integration project is ongoing. This project uses the newly available functionality provided by the ACT Health Enterprise Information Management (ACTHEIM). This project is integrating data collection, entry, validation, storage and reporting functions with information management systems for the ACTHEIM environment. An outcome of this work will be improved employee data quality for human resource and workforce reporting and planning activities.

2. ***A responsive workforce***

The Health Workforce Development program is an $8.2 million package over four years that aims to expand the roles of allied health professionals, as well as nursing and medical roles.

The following occurred in 2010–11:

- A trial of an extended scope physiotherapy position commenced in the orthopaedic unit at Canberra Hospital, with promising outcomes. An additional trial in the Emergency Department will commence shortly.
- Recruitment was completed for clinical training and development roles for four enrolled nurses and five allied health positions.
- The Caring for Older People Program, funded by Health Workforce Australia, commenced to develop and test the role of allied health assistants in ensuring safe, effective and sustained transition of older adults from an acute setting to the community.
- The GP Workforce Program, a $12 million package over four years, operated to grow and support the local GP workforce.

The following initiatives are all ongoing:

- the Prevocational General Practice Placement Program—provides rotations into general practice for junior medical officers
- the GP Development Fund—a flexible bi-annual grant fund, which supports Canberra GPs by providing one-off incentive payments to GP practices
- the GP Bonded Scholarship Scheme—to encourage ANU Medical School graduates to choose a career in general practice and continue working in Canberra for three years following completion of a fellowship in general practice.

These initiatives commenced in 2010–11:

- the GP Aged Day Service, which ensures that elderly people (such as residents of aged care facilities) have access to a business-hours GP locum service
- the Education Infrastructure Support Grant Payment (formerly titled Teaching Incentive Program), which provides sessional funding to support ACT GPs who provide teaching to third-year medical students studying at the Australian National University.

3. ***Education and training***
   The ACT Health Directorate led a regional network bid that was successful in gaining funding from Health Workforce Australia (HWA) for growth in student clinical placements. The following initiatives have been funded and are about to commence:

   - Health Directorate has been selected as the host organisation for the Integrated Regional Clinical Training Network (IRCTN) for the ACT Region and has been allocated $910,000 in funding. Recruitment is commencing for staff to coordinate the network and meet HWA data reporting requirements and an upgrade of the student database will commence in 2011 to enable better inter-organisational data base compatibility and improve clinical training placement data management.
   - As part of the network bid, Health Directorate was allocated a subsidy of $123,403 by HWA to help support an additional 1718 student placement days across nursing, midwifery, physiotherapy, dentistry and psychology in 2011. Additional funding has been provided for growth in2012–13.
   - Funding of $3,300,000 was allocated for student accommodation and $534,000 for dental infrastructure.

4. ***Effective linkages***
   - Linkages have been maintained with national health workforce committees.
   - Strong intra-agency and intragovernmental partnerships have been formed to progress collaborative HWA initiatives.

ACT Chronic Disease Strategy 2008–2011

The *ACT Chronic Disease Strategy 2008–2011* provides strategic direction for the prevention, detection and management of chronic disease in the ACT. It provides the overarching framework for the provision of programs and supports to address the increasing prevalence of people at risk of, or living with, chronic disease in our community.

Main strategic directions (goals)

The strategy incorporates the four action areas identified in the National Chronic Disease Strategy as core components in the prevention, detection and management of chronic disease, and one additional action area focused on research and surveillance.

The action areas are:

- prevention and risk reduction across the continuum
- early detection and early treatment
- integration and continuity of prevention and care
- self-management
- research and surveillance.

Major goals/strategies implemented, completed or begun in 2010–11

In 2010–11 progress was made in the following areas:

- The *ACT Breastfeeding Strategic Framework 2010–2015* was launched in November 2010. The aim of this strategy is to increase the number of infants being exclusively breastfed from birth to six months, and to encourage ongoing breastfeeding with complementary foods until at least 12 months of age in line with National Health and Medical Research Council recommendations. This is outlined more fully below.
- The *Get Healthy Information and Coaching Service* was implemented from 1 July 2010. Get Healthy (www.gethealthy.act.gov.au/) is a free and confidential telephone-based service that provides information and ongoing coaching support to ACT adults who would like to eat healthier, be more active, or achieve and maintain a healthy weight. The service targets ACT adults who are at risk of developing chronic disease due to having one or more of the following risk factors: not meeting healthy eating guidelines; lack of physical activity; and being overweight. The service is provided by Medibank Health Solutions with funding provided by Health Directorate. Evaluation is to be undertaken by the Prevention Research Collaboration at the University of Sydney.
- The *Aboriginal and Torres Strait Islander Tobacco Control Strategy* was finalised, and a steering committee established to guide its implementation. Smoking cessation programs are being delivered by Winnunga Nimmityjah Aboriginal Health Service and Gugan Gulwan Youth Aboriginal Corporation through three-year service funding agreements, 2010–13. The Aboriginal and Torres Strait Islander Health Unit, in partnership with Health Promotion Branch, has engaged a consultant to undertake social research with the local Aboriginal and Torres Strait community to identify local champions, effective communication strategies and messages tailored to the local community which will complement two national social marketing campaigns: tobacco cessation as well as the 'Swap it. Don't stop it' (Measure Up) campaigns. Both of these have been promoted in 2011. An agreement has been entered into with the University of Canberra to fund a full-time three year PhD scholarship to evaluate the strategy.

- Health Promotion Branch continued implementation of the ACT Government's three year $11 million *Healthy Future: Preventive Health Program*. This program is aligned with the National Partnership Agreement for Preventive Health and consists of a range of health promotion campaigns. These include:
    - ***Healthy kids, healthy future'—***early childhood and school settings, consisting of the *Kids at Play Active Play and Eating Well Early Childhood* project (www.kidsatplay.act.gov.au); SmartStart for Kids (SSK) program (www.smartstart.com.au); *Sustainability, Training, Education, Participation, Skills program* (STEPS) (www.ywca-canberra.org.au); *Healthy Transitions* (in four public primary schools, Year 6 focused program); *Lifestyle Triple P (Positive Parenting Program); Healthy Sporting Canteens; Healthy School Canteens; It's Your Move; ACT Healthy Schools Audit; Active Travel to School project; Food Skills project; Go for 2&5* campaign (www.gofor2and5.com.au); *Unplug and Play* social marketing campaign (www.unplugandplay.act.gov.au); *Tap into Water* social marketing campaign promoting water as the drink of choice; *Integrated Wellbeing Campaign* (promote physical and mental wellbeing with a focus on families with young children); and a Youth Health feasibility study.
    - ***'Healthy at work program'—workplace settings,*** consisting of the *ACT Healthy@ Work Pilot; Workplace Health Promotion Capacity Building Funding Round*; and the Health Directorate Staff Health and Wellbeing Program, Myhealth.
- The Health Directorate continued to deliver its *Self-Management of Chronic Conditions* program in 2010–11 (www.health.act.gov.au/health-services/chronic-disease management). The program aims to enhance the capacity of individuals to self-manage their chronic disease, and provides education for clients and clinicians on the self-management of long-term conditions. The program is conducted in partnership with Arthritis ACT and SHOUT Inc, and courses are delivered in community centres across Canberra to clients, carers and families. The focus is on optimal self-care (physical, emotional and social) and active participation by people in their own health care, including health promotion, risk reduction, decision-making, care planning, medication management and working with health care providers. Fourteen 'Living a Healthy Life with Long-Term Conditions' courses were offered in 2010–11 with 108 participants completing the program.
- A *Home Tele-monitoring Service* was established by the Chronic Disease Management Unit to provide remote monitoring of patients where daily monitoring at home can assist with stabilisation of their condition. Eligible patients include those with chronic heart failure, chronic obstructive pulmonary disease (COPD) or diabetes. The service is now operational and currently has five patients undergoing monitoring. The system has the capacity to accept 10 patients and an expansion of the program is planned.
- The *Chronic Care Program* (previously known as Improving Coordination in *Chronic Disease Care Program)* continued to be supported. The program uses a coordinated care approach to improve the health of people who regularly attend emergency departments with a chronic illness.The Chronic Care team operated well in 2010–11, with 211 patients receiving care for chronic illness, mainly for heart failure or chronic obstructive pulmonary disease. This included 60 patients receiving care coordination.
- The Chronic Disease Management Unit established a register of people who have chronic health conditions. The Chronic Disease Management Register, which is a component of the directorate's medical records, tracks the care coordination and preventative health care of patients with chronic heart failure, chronic obstructive pulmonary disease and diabetes as well as the patients of a number of chronic disease care units within the Health Directorate. The register provides health professionals with a central picture of the treatment and care needs of clients, helping to ensure that care provided to people with chronic disease is coordinated. This also allows the care of patients to be followed over time and reminders about treatment are provided to care providers. The register has progressed through the development and testing stage, and reports are now being produced each month for a wide range of chronic disease services. Currently there are 5200 patients on the *Chronic Disease Management Register.*

- The *Chronic Disease Telephone Coaching Service* was implemented. This service aims to assist people with less complex chronic diseases by providing them with regular contact for health and lifestyle advice and support. People enrolled in the program receive regular phone calls from a registered nurse to discuss their condition and work towards achieving their personal health goals. The service is tailored to patients with specific conditions, including heart failure, coronary artery disease, chronic obstructive pulmonary disease or diabetes. The service is operated by Medibank Health Solutions with funding provided by the Health Directorate. 250 patients have been referred to this service.
- The Health Directorate secured funding for a three-year pilot project which aims to improve the detection of people at risk of cardiovascular disease and to ensure they get the management they need to decrease their risk. *The Better Outcomes for People at Risk of Cardiovascular Disease* project will be implemented and evaluated by the Heart Foundation ACT, ACT Division of General Practice and the University of Canberra. The project will work with general practices to help them identify patients between the ages of 45 and 74 years who are at risk of cardiovascular disease. Once identified, clients can be supported with information and referral to appropriate services.

ACT Breastfeeding Strategic Framework 2010–2015

The ACT Breastfeeding Strategic Framework 2010–2015 was launched on 10 November 2010. The strategy sets the context for the protection, promotion and support of breastfeeding in the ACT for the next five years, and beyond. The ACT Breastfeeding Initiative is funded through the Health Directorate's Population Health Division 'Healthy Future' budget and is a joint initiative of the Health Promotion Branch and the Child, Youth and Women's Health Program.

Main strategic directions (goals)

The aim of the Strategy is to increase the number of infants being exclusively breastfed from birth to six months, and to encourage ongoing breastfeeding with complementary foods until at least 12 months of age in line with National Health and Medical Research Council recommendations.

Major goals/strategies implemented, completed or begun in 2010–11

The implementation plan for the strategy was endorsed by the Breastfeeding Initiative Steering Committee on 18 November 2010. Work on the implementation of the strategy continued in 2010–11, with the following noteworthy activities:

- representation on the National Breastfeeding Jurisdictional Senior Officials Group (BJOG), which is implementing the Australian Breastfeeding Strategic Framework 2010–2015. Work will initially focus on milk banks, priority groups, legislation and data collection
- as a leader on the BJOG working group, instigation of a revisiting of the potential for expansion of Australia's Marketing of Infant Formula agreement to align further with the World Health Organisation code on the marketing of breastmilk substitutes
- attendance at the National Breastfeeding Indicators Workshop on 8 December 2010, conducted by the Australian Institute of Health and Welfare. At this meeting a nationally agreed set of data indicators was developed and endorsed
- the development of an enhanced breastfeeding data collection system through the ACT Patient Administration System database, while ensuring collaboration and consistency with the national approach
- the commissioning of further research in response to initial research undertaken during the development phase of the strategy. This research project was approved by three ACT human research ethics committees and commenced in May 2011. This research project is entitled 'Exploring transitional Maternal and Child Health Services which protect, promote and support breastfeeding in the ACT' and responds to the recommendation that there was a need for 'more intensive at-home support and guidance'. The aim of this research is to identify realistic, achievable and sustainable breastfeeding support services for ACT parents in the first 6–8 weeks after the birth of their baby and is anticipated to be complete in early September 2011

- extensive liaison with government and non-government stakeholders to progress activities pertinent to their organisation
- ongoing education of health professionals, key stakeholders and members of the ACT community on the key components of the Strategy;
- support for professional development, with 25 health professionals supported to attend an Australian Breastfeeding Association seminar in March and a further 25 health professionals supported to undertake the necessary education to obtain the International Board of Certified Lactation Consultants accreditation, and
- the active pursuit of Breastfeeding Friendly Workplace accreditation for the Health Directorate. This process was endorsed by Executive Council in mid-June and is progressing with input from representatives from each Division.

The overall strategy will be evaluated for effectiveness and ongoing need over the fourth and fifth year of implementation. The steering committee will develop an agreed process for measuring the strategy's impact on breastfeeding rates and duration, while ensuring consistency with the national approach.

ACT Palliative Care Strategy 2007–2011

The *ACT Palliative Care Strategy 2007–2011* sets the strategic direction for the delivery of palliative care services in the ACT. It was developed in the context of Palliative Care Australia's national palliative care standards, and commits the ACT to delivering services in accordance with these standards.

Main strategic directions (goals)

The *ACT Palliative Care Strategy* aims to improve the palliative care services available to the ACT community by:

- improving community education, awareness and participation
- further developing a comprehensive ACT palliative care service
- strengthening provision of primary care through the palliative approach
- strengthening specialist palliative care services
- further developing a skilled workforce
- improving information management and data collection.

Major goals/strategies implemented, completed or begun in 2010–11

In 2010–11 progress was made in the following areas:

- A Clinical Handover Working Group continued to meet in 2010–11 to progress referral and discharge processes to and from Clare Holland House and the Home-Based Palliative Care Service. The Clinical Handover Working Group includes representatives from Clare Holland House, home-based palliative care, general practice, Rehabilitation, Aged and Community Care and the Canberra Hospital. This group has progressed issues such as referral criteria for home-based palliative care patients; clarification of roles of Commonwealth-funded palliative care Nurse Practitioners and development of clear strategies for integration between the Canberra Hospital, Calvary Public Hospital, and Clare Holland House; review of discharge process from hospital for patients returning home; and timeliness of Aged Care Assessment Team assessments for palliative care patients.
- A Paediatric Palliative Care Working Group, a subcommittee of the Clinical Handover Working Group, was formed in October 2010 and is progressing a number of issues in paediatric palliative care. The working group includes representatives from Paediatrics at the Canberra Hospital (PatCH), Department of Social Work at the Canberra Hospital, Clare Holland House, general practice, and the Clinical Nurse Consultant for Patient Transfer/ Coordination at the Canberra Hospital. The group is focusing on the following key areas:
    - incorporating the *NSW Paediatric Palliative Care Planning Framework 2010–13*
    - drafting a referral pathway for paediatrics with palliative care needs
    - developing a single entry point for paediatric palliative care referrals
    - developing a single referral form into paediatric palliative care

- establishing regular case conferencing/client database
- engaging stakeholders, and
- undertaking a quality improvement project.

Additionally, links with NSW paediatric palliative care services were established through professional development visits to Sydney in 2010 (supported through a Commonwealth-funded project). Ten delegates from Health Directorate (paediatrics, social work and palliative care staff) visited the Westmead Children's Hospital, Bear Cottage and Sydney Children's Hospital with the aim of developing closer relationships with other professional colleagues, gaining information on palliative care services available in NSW, improving coordination of care and identifying cross-border issues between NSW and the ACT. These relationships have continued to be maintained and formal processes for referral and information sharing are being developed through the Paediatric Palliative Care Working Group.

- Opportunities for primary health care providers to participate in education on provision of palliative care and the palliative approach continue to be provided through the Commonwealth-funded *Program of Experience in the Palliative Approach (PEPA)*. PEPA has been established in the ACT since 2004 and is consistently well-subscribed and receives good feedback. Twenty-two placements were provided in 2010–11, including five 'Reverse PEPA'. Reverse PEPA engages a specialist palliative care nurse to provide experiential learning and mentoring within the participant's own work environment in the aged care sector. This contrasts with the usual placement of PEPA participants whereby they attend the host site for a one-week placement. Feedback from Reverse PEPA has been very positive. Reverse PEPA enables participants to develop knowledge and expertise in direct relation to their patient population group. While not eligible for PEPA placements in the ACT, personal care workers can participate in experiential learning through Reverse PEPA, providing opportunity for the palliative approach to be more widely adopted in a workplace. In 2010–11 PEPA also held five general workshops (with 76 participants), two GP workshops, two post-placement workshops, eight post-placement in-service courses and bi-monthly post-placement support meetings.

In 2010–11 Clare Holland House appointed a Director of Palliative Care Research, who, in consultation with key stakeholders is developing a palliative care research program.

ACT Primary Health Care Strategy 2011–2014

In 2010–11 the ACT Government Health Directorate developed a new ACT Primary Health Care Strategy which will build on the work of the *ACT Primary Health Care Strategy 2006–2009* and set the strategic direction for primary health care into the future. The ACT Primary Health Care Strategy 2011–14 is a high-level, visionary document that reflects the thinking of the ACT community in relation to their needs and priorities for primary health care.

The strategy was developed and finalised within the context of the National Health and Hospitals Network Agreement, the outcomes of the Council of Australian Governments deliberations, and a range of health-related strategies and plans already in existence. It is envisaged that the strategy will aid the development of the proposed ACT Medicare Local.

The strategy was developed in consultation with health care providers and community members. Two public forums were held in late 2010 to gather input prior to drafting the document. The draft strategy was then released for six weeks public consultation in March–April 2011, and a final public consultation forum was held during this period. At 30 June the strategy was awaiting endorsement of the Health Directorate Executive Council in July 2011.

Main strategic directions (goals)

The strategy identifies seven priority areas for action. The first four priorities focus on improving outcomes and addressing the shortcomings of current arrangements. The last three priority areas focus on providing enablers or building blocks that are essential to achieve improvement.

The key priorities are based on those identified in the *National Primary Health Care Strategy*:

- improving access and reducing inequity
- improving continuity and coordination of care, especially for people with chronic conditions
- increasing the focus on health promotion, prevention, early intervention and consumer empowerment
- improving quality, safety, performance and accountability
- information management
- workforce
- infrastructure.

ACT Alcohol, Tobacco and Other Drug Strategy 2010–2014

Implementation of the ACT Alcohol, Tobacco and Other Drug Strategy 2010–2014 commenced in July 2010.

Highlights during the first 12 months of implementation are set out below.

- New liquor laws came into effect on 1 December 2010. They allow for:
  - the implementation of a risk-based licensing system that measures the amount of risk posed to the community based on opening hours
  - the provision for lockouts at licensed venues in the future
  - the introduction of mandatory responsible service of alcohol training for all staff including licensees
  - the collection and reporting of sales data annually from all licensees
- An ACT Early Intervention Pilot Project was begun, a joint ACT Policing and ACT Health initiative focusing on underage drinking. Police who have contact with young people under the age of 18 years who are either intoxicated or in possession of alcohol contact parents/guardians of the young person to disclose what has occurred, ensure the safety and welfare of the young person and provide information about the option of participating in the information and education session.
- An Evaluation of Drug Policies and Services in the Alexander Maconochie Centre was completed. The government has tabled its response to the evaluation, which included plans for implementation of supported recommendations.
- Workers in the mental health, youth and alcohol and other drug sectors participated in a Workplace Tobacco Management project. The project aims were to increase awareness, and support the implementation, of workplace tobacco management policies and reduce the impact of smoking behaviours for the staff in nine services. The project was a collaboration of the Alcohol, Tobacco and Other Drug Association ACT (ATODA) (as the lead agency for the project), the Mental Health Community Coalition ACT and the Youth Coalition of the ACT.

Sustainability Strategy

Overview

The ACT is likely to experience increases in extreme weather events due to climate change, with the potential health impacts and associated social implications that may affect the territory.

Work has begun to identify the population health impacts of climate change and explore potential responses, with the likelihood for collaborative work across all areas of Health and the ACT Government.

The Health Directorate continues to demonstrate its commitment to the principles of ecologically sustainable development and enhancement of health service delivery by closely monitoring its use of resources, integrating economic, social and environmental considerations into decision-making and implementing measures to minimise the impact of agency activities on the environment.

To achieve the goals, the agency adopted a strong and ambitious plan to develop a Sustainability Strategy. Four workshops were conducted, which engaged a broad range of Health staff and stakeholders. The workshops enabled a collaborative and robust process for the development of Health's Sustainability Strategy designed to:

- activate the benefits of sustainability
- optimise lifestyle costs
- deliver a platform for stakeholder engagement
- develop repeatable capacity within the agency for tackling future strategic challenges
- embed environmental sustainability as an important factor in planning for future health services and clinical operational activities
- incorporate sustainability into Health's corporate plan and align with the ACT Canberra Plan and the ACT Climate Change Strategy: 'Weathering the Change'

Health's Sustainability Strategy provides a roadmap for a collaborative sustainable future by encapsulating a total picture of where the Health Directorate wants to be in 30 years time and takes into account all elements contributing to a sustainable and dynamic future.

The Health Directorate will accomplish its vision by aligning seven key focus areas: models of care, building and infrastructure, the digital health environment, transport, regulator environment, workforce, partnership and external service delivery. It will do this by:

- improving service delivery through investment in appropriate physical and technological infrastructure
- identifying collaborative actions to reduce our ecological footprint with a particular focus on energy consumption and transport
- investing in research that promotes evidence-based practice and innovation
- supporting workforce role redesign and collaborate on action to meet immediate health workforce shortages
- building and sustaining an adaptive, learning, innovative and change—enabling organisation
- implementing organisational change for new local hospital networks
- providing a safe and healthy working environment for all employees
- providing appropriate stewardship over public funds
- providing timely and quality advice to the minister and government
- leveraging off the existing seven organisational focus areas for ongoing development of actions to address climate change and create an environmentally and economically sustainable future for health services across the territory.

The strategy contains actions for each of the seven focus groups.

Major goal completed in 2010–11

The first phase of the sustainability strategy has been completed and a Draft Sustainability Action Plan, which consists of short, medium and long-term actions, has been developed and is in the process of staff and consumer consultation and engagement.

Once the Sustainability Action Plan has been endorsed, the agency will be on track to achieving its vision.

Quality and Safety Framework 2010–2015

The Quality and Safety Framework 2010–2015 for the Health Directorate describes a vision and direction to improve safety and quality in the Health Directorate and sets out the key activities that will be happening throughout the organisation to improve the safety and the quality of the directorate's services for its consumers. The document is broken into four parts:

- summary of safety and quality systems in the Health Directorate
- outline of safety and quality governance in the Health Directorate
- education to support safety and quality
- plan outlining specific areas that the Health Directorate will focus on to improve safety and quality, as we move towards 2015.

The plan includes a set of actions divided into three themes, which align with those of the Australian Commission on Safety and Quality in Health Care in its framework for a vision for safe and high-quality health care for Australia. These themes are that care will be:

- consumer-centred
- driven by information, and
- organised for safety.

This plan will form the basis of the plans for each of the service areas. Each service area will develop activity and result indicators and report against these annually.

C.6
HR performance

In 2010–11, the Human Resource Management Branch in the Health Directorate focused on supporting the organisation through significant challenges, such as the development and implementation of a new organisational structure and the implementation of the Capital Asset Development Program (CADP). The core work of the branch continued to be guided by the four themes in the Human Resources Strategy 2008–2012:

- Talented Workforce
- Supportive Systems and Processes
- Challenging and Rewarding Employment
- Engaging Organisational Culture.

Central to these themes are strategies to improve employee retention, engagement and performance through continued professional development; improvements to the quality of management, leadership and organisational culture; and specific strategies for the creation of an efficient and effective employment and industrial environment.

The establishment of the new Commonwealth Government agency Health Workforce Australia (HWA) has created considerable opportunity through its development of a range of initiatives and projects. Human Resource Management Branch has been involved in supporting a range of important regional initiatives and projects initiated by HWA, including the development of a preliminary regional network that has overseen and coordinated HWA initiatives and developed successful funding applications to provide support for:

- increased student clinical placements in the region through new student accommodation and infrastructure and additional funding to support placements
- the development of a comprehensive simulated learning package over 2011–12
- new simulated learning equipment in 2011 to support students and staff in the ACT region
- an expansion of the virtual world environment by CIT and the University of Canberra
- mapping of clinical supervision needs in the ACT region, and
- upgrading of student clinical placement data collection infrastructure to improve compatibility across key student databases and provide the basis for regional data collection.

This preliminary network includes members from large health and tertiary education providers across the ACT region, including representatives from Southern Area Local Health Network and Murrumbidgee Local Health Network. The Integrated Regional Clinical Training Network for the ACT Region will formally commence in September 2011 with an expanded membership.

Work has continued on developing a new Workforce Plan for the Health Workforce of the ACT (2011–2015). A comprehensive discussion paper has been developed based on literature analysis and submissions from within the ACT Health Directorate and from external stakeholders. This discussion paper will be released shortly. The main focus of the new plan will be on health professionals and health support workers employed by ACT Health but many of the strategies are expected to be relevant to other parts of the ACT's health system. The workforce plan will be completed and released in 2011.

Key achievements in 2010–11 are set out below.

Delivering for the future

- The Capital Asset Development Program included dedicated support for change management and workforce development across the full range of projects, including the new Women's & Children's Hospital, the Adult Acute Mental Health Inpatient Unit, the Community Health Centres and the Capital Region Cancer Centre.

- The Health Leadership Network was created and commenced operation, with more than 100 leaders from across the directorate. The major objectives are to break down silos and create opportunities to build collaborative relationships and partnerships; draw on the capabilities, corporate and business knowledge and experience of our leaders at all levels; generate solutions to meet organisational needs; further develop and refresh members' leadership skills; and promote and support learning organisation principles including systemic thinking, integration and dialogue.
- An Electronic Learning and Achievement Planning system was developed, with transition commencing from the old paper-based performance management process. The system helps to ensure a clear relationship between individual staff performance objectives and the directorate's overarching goals.

Strengthening organisational resilience

- The Health Directorate's management orientation program continued, ensuring that managers have the knowledge, skills and organisational contacts to manage staff and services in a sustainable and effective way.
- As part of the directorate's commitment to the Respect, Equity, Diversity Framework, mandatory training for managers and all staff on managing and preventing bullying and harassment commenced, along with the selection and upskilling of contact officers.

Sustaining community confidence

- The ACT Government Health Directorate Secondary Student Work Experience Program commenced in June 2011, accepting 58 school students from government, Catholic and independent high schools and colleges who are planning to take up careers in the health professions.
- In 2010–11 the Health Directorate supported 94 graduate registered nurses, 13 enrolled nurses and 12 graduate midwives.
- Human Resources has administered the GP Workforce program, a four-year, $12 million program to grow and support the local GP workforce. It included the following initiatives: the Education Infrastructure Support Grant Payment to support GPs teaching undergraduate medical students; the GP Prevocational Placement Program, enabling newly trained doctors to gain clinical experience in general practice; and the GP Trainee Scholarships, providing incentives to choose training in general practice.
- A marketing partnership with the ACT Division of General Practice saw 11 GPs recruited in 2010–11 through the GP Marketing and Support program and more than 100 genuine calls of interest received.
- Close stakeholder relationships were formed with the (then) ACT Chief Minister's Department Live in Canberra Team and the ACT Division of General Practice in order to promote awareness of and address Canberra's GP shortages both nationally and internationally.

Working collaboratively

- Managers and team leaders continued to seek specialist advice and support from the Human Resource Management Branch to support employees' individual needs in the workplace and to facilitate significant change activities associated with new models of care and redevelopment of the health service.
- Many work areas and teams undertook development workshops in 2010–11 to enhance workplace interactions and teamwork; identify and progress sustainable business planning and improvement initiatives; increase employee engagement; ensure a commitment to positive values-based behaviour. These workshops focused on providing quality patient care and services to the ACT and surrounding community.

Enhancing skills and capabilities

- The continued commitment to ongoing development and enhancement of the workforce through a comprehensive and rigorous learning and development strategy delivered significant rewards in terms of qualifications and traineeships, as described in section C.8, Learning and development.
- In 2011–12, the Human Resource Management Branch will continue to partner with the organisation's executive and business units to refine and develop these strategies and plans. A major focus continues to be on refining human resources service delivery to internal business units following the implementation of the new structure, and supporting the organisation's redevelopment and capital investment program.

C.7
Staffing profile

At the end of June 2011, the Health Directorate (excluding Calvary Public Hospital) had 5953 staff. Of these:

- 76.63 per cent were female and 23.37 per cent were male
- 76.3 per cent were permanent, 17.69 per cent were temporary and 6.01 per cent were casual.

All staff are employed under the *Public Sector Management Act 1994*.
Further details are included in the tables below.

Full-time equivalent (FTE) and headcount

	Female	Male
FTE by gender	3883.74	1282.92
Headcount by gender	4562	1391
% of workforce (headcount)	**76.63%**	**23.37%**

Classifications

Classification group	Female	Male	Total
Administrative Officers	736	136	872
Dental	13	3	16
Executive Officers	10	8	18
General Service Officers & equivalent	186	258	444
Health Assistants	58	6	64
Health Professional Officers	719	193	912
Information Technology Officers	0	2	2
Medical Officers	302	388	690

Classification group	Female	Male	Total
Nursing Staff	2163	228	2391
Professional Officers	12	3	15
Senior Officers	221	108	329
Teachers	1	0	1
Technical Officers	137	54	191
Trainees and Apprentices	4	4	8
TOTAL	**4562**	**1391**	**5953**

Employment category by gender

Employment category	Female	Male	Total
Casual	275	83	358
Permanent full-time	2153	808	2961
Permanent part-time	1467	114	1581
Temporary full-time	521	350	871
Temporary part-time	146	36	182
TOTAL	**4562**	**1391**	**5953**

Average length of service by age group by gender

Average length of service	Pre-Baby Boomers		Baby Boomers		Generation X		Generation Y		Total	
	F	M	F	M	F	M	F	M	F	M
0–2	2	5	252	70	412	202	610	199	1276	476
2–4	6	3	231	69	298	129	289	61	824	262
4–6	7	0	172	42	256	81	102	23	537	146
6–8	6	3	176	50	183	68	56	12	421	133
8–10	5	3	181	45	132	37	24	5	342	90
10–12	4	1	106	29	89	24	9	0	208	54
12–14	0	1	82	23	68	12	1	0	151	36
14+ years	17	6	604	144	182	44	0	0	803	194

Generation	Year span
Pre-Baby Boomers	Born prior to 1946
Baby Boomers	Born 1946 to 1964 inclusive
Generation X	Born 1965 to 1979 inclusive
Generation Y	Born from 1980 and onwards

Total average length of service by gender

Gender	Average length of service
Female	7.4
Male	6.3
Total	7.2

Age profile

Age group	Female	Male	Total
<20	31	15	46
20–24	284	94	378
25–29	588	139	727
30–34	527	179	706
35–39	555	224	779
40–44	583	179	762
45–49	583	177	760
50–54	656	164	820
55–59	465	123	588
60–64	232	70	302
65–69	51	22	73
70+	7	5	12

Agency profile

Branch/Division	FTE	Headcount
Strategy & Corporate	694.98	750
Canberra Hospital & Health Service	4161.76	4867
Director-General	291.36	313
Special Purpose Account	18.56	23
Total	**5166.66**	**5953**

Agency profile by employment type

Branch/Division	Permanent	Temporary	Casual
Strategy & Corporate	626	88	36
Canberra Hospital & Health Services	3643	904	320
Director-General	267	45	1
Special Purpose Account	6	16	1
Total	**4542**	**1053**	**358**

Equity and workplace diversity

	A	B	C		
	Aboriginal and/or Torres Strait Islander employment	Culturally & Linguistically Diverse (CALD) employment	Employment of people with a disability	Number of employees who identify in any of the equity & diversity categories (A, B, C)	Women
Headcount	50	1008	115	1159	4562
% of total staff	0.84%	16.93%	1.93%	19.47%	76.63%

The statistics above exclude board members, staff not paid by the ACT Public Service and people on leave without pay. Staff members who had separated from the ACT Public Service but received a payment were included.

C.8
Learning and development

Learning and development programs and activities

Learning and development programs and activities in the Health Directorate are delivered to enhance staff capabilities in key output areas and to support tertiary students who are studying in health-related disciplines. Learning and development is important in health to ensure a competent workforce and compliance with legislation. Many clinical education programs facilitate credentialing and expanding the scope of practice for professions.

The Health Directorate provides a calendar of learning and development, which includes management and leadership development, essential training, clinical programs, workplace skills development, nationally accredited training and comprehensive staff orientation programs.

Registered Training Organisation

The Health Directorate is a Registered Training Organisation and offers two nationally recognised programs to staff. Fifty-eight staff participated in the Certificate IV in Training and Assessment, which provides professional development for staff across the organisation engaged in work-based training and education initiatives, student and graduate support, and competency assessment to support the provision of safe, quality health care. The Diabetes Mellitus accredited course provides clinicians and health professionals with information and underpinning knowledge of diabetes for management in the clinical and community environment. In 2010–11, 20 staff completed this program.

Education Activity Register

An education activity register database describes all programs entered on the training management system (Capabiliti) and provides information about revision dates and references. The register was endorsed by Portfolio Executive as a Health Directorate-wide education database. As part of this initiative, an electronic data template has been developed.

Essential Education

The Health Directorate Essential Education policy was introduced in June 2010 and describes the education and training staff are required to complete based on their job role. An Essential Education Coordinator was appointed to the Staff Development Unit in September 2010 to implement the policy and coordinate the development of any new learning programs associated with the policy.

Education and training were developed and implemented as face-to-face, e-Learning training or blended learning courses that addressed the Essential Education Policy requirements. Adjustments to the Essential Education policy were made to further clarify training requirements.

A project team within the Staff Development Unit mapped the training requirements and requested managers to assign a training group or groups to each position number (i.e. All Staff, Managers, Clinical, and Clinical Support categories). This was linked to existing human resource data already loaded into Capabiliti. A Capabiliti upgrade in June 2011 provided new information on training requirements for individuals, easier course bookings and management, easier course searches, automatic identification of Essential Education requirements for individuals, automated email reminders for when essential education modules expire, and improved reporting functionality.

Orientation

The Staff Development Unit provides the Health Directorate Orientation Program for one half-day on the first Monday of each month. This session covers important organisational information relevant to employees. In 2010–11, 792 participants attended the Health Directorate Orientation Program. Participants were new staff, staff returning for an update and volunteers.

Managers Orientation

The Health Directorate Managers Orientation program is a two-day course for new managers and supervisors and provides an introduction to the responsibilities and challenges of managing staff. In 2010–11, 59 people attended the Health Directorate Managers Orientation program.

Human Rights Act training for managers

This education has been identified as essential for managers in the Health Directorate under the Essential Education policy. Eighty-one people participated in this program. Staff who are not managers may also attend.

Leadership programs

In 2010–11, the Health Directorate provided leadership and management development opportunities with the central elements of promoting emotional intelligence, managing change and uncertainty, and dealing effectively with difficult issues and challenging interactions. These programs are offered in addition to the whole-of-government opportunities offered through the Chief Minister and Cabinet Directorate.

Programs for senior leader level, manager level and team leader/supervisor level staff are provided under the ACT Public Service (ACTPS) Training and Development Panel arrangement through the ACT Government Shared Services Centre. Participants who attend these programs form part of an ongoing, coordinated Health Directorate Leadership Network, which drives collaboration across the organisation as well as developing individual and collective leadership capability.

Training for clinical supervisors

The Health Directorate supports health staff to be trained and skilled in clinical supervision and awarded five scholarships in 2010–11 to health practitioner staff to undertake a Graduate Certificate in Higher Education at the University of Canberra. The scholarships are part of a collaborative scheme between the Health Directorate and the University of Canberra to support health staff with a high teaching load to gain tertiary qualifications in adult education.
A total of 25 staff have been awarded scholarships since 2008.

The Health Directorate Preceptorship course has been revised and is now called the Clinical Support and Supervision Essentials course. The aim of this program is to provide education for staff supervising other staff and students in the workplace. Changes to this program were made to promote interdisciplinary learning. As a result, allied health staff have increased their participation and now comprise 25 per cent of all attendees. In 2010–11, 112 people undertook this course.

Clinical Development Nurse/Midwifery Professional Development Program

Clinical Development Nurses and Midwives (CDN/Ms) are employed by the clinical areas to provide workplace learning and support for nursing and midwifery staff. Learning and development and professional support are provided to CDN/Ms through bimonthly half-day professional development programs and monthly meetings. In 2010–11, five professional development programs were conducted and attended by 65 CDN/Ms.
Additionally, 99 CDN/Ms attended the professional development meetings.

Managing and preventing bullying and harassment

In 2010–11, the Health Directorate developed and commenced a rollout of essential training to managers and all staff on managing and preventing bullying and harassment. This is one of the key elements of the Territory's Respect, Equity, Diversity (RED) Framework.

The comprehensive training has the following key objectives:

- familiarise staff with the revised Health Directorate Anti-Discrimination, Bullying and Harassment Policy and Procedures
- define the roles and responsibilities of staff and managers
- inform staff of the RED Framework
- define and describe unacceptable behaviour
- discuss the consequences of inaction for the individual, the Health Directorate and the supervisor, manager or executive
- provide information on additional supports or resources available to assist staff to manage and prevent discrimination, harassment and bullying.

Safety education: manual handling and PART

In March 2011, the manual handling education team joined the Staff Development Unit. The team is responsible for providing training and coaching on the safe performance of manual tasks for a wide range of work groups to support adherence to the Work Safety Act 2008. In 2010–11 the team conducted 133 face-to-face courses with 2010 participants and provided additional on-the-job training to specific work areas. A total of 2391 staff also completed e-learning programs on manual handling.

The PART (Predict, Assess and Respond to Challenging/Aggressive Behaviour) program provides training for staff in high-risk areas to respond to challenging client behaviour safely and effectively to minimise the risk of harm to both clients and staff. In 2010–11 a total of 18 PART courses and refresher courses were provided, with 167 participants. To meet demand for this program, a team of five additional trainers were accredited in 2011 and the program was moved in order to be centrally managed in the Staff Development Unit.

Chemotherapy Safe Handling Program

This program provides evidenced-based education to meet best practice requirements of enrolled and registered nurses, midwives and medical officers working with patients receiving chemotherapy. Nurses working in private medical practices also attend. In 2010–11, seven programs were conducted through the Staff Development Unit.

Student Clinical Placement Unit

The Health Directorate Student Clinical Placement Unit (SCPU) was established in 2008 and has three staff members. Staff members now report via the Nursing and Midwifery Office, Allied Health Adviser's office and the Principal Medical Adviser's office, all within the newly formed Professional Leadership, Research and Education branch.

The SCPU continues to support students and educators via a coordinated, standardised approach to student placement requirements and planning for nursing, medical and allied health disciplines. Student placements numbered more than 3600 in 2010–11. The Student Placement Database provides a central collection point for data on student placements across the Health Directorate. Significant change to the funding of student placements across Australia occurred in 2010–11, and the SCPU provided and verified data with Health Workforce Australia regarding ACT region student placements in 2010 and 2011.

Work Experience Program

The Health Directorate Secondary Student Work Experience Program has been designed in partnership with the ACT Government Education and Training Directorate to encourage Year 10, 11 and 12 students from government, Catholic and independent high schools and colleges in the ACT to take up careers in the health professions. Placements may be offered in both clinical and non-clinical areas of the Health Directorate.

The program began accepting students in June 2011. To date 58 students are registered with the Staff Development Unit to undertake work experience placements in the Health Directorate.

Feedback from school coordinators, students and Health Directorate staff has been very positive. The school coordinators and students state they have a better understanding of the broad range of careers available in health and the subjects they need to select to gain entry to those careers. Health Directorate staff have provided positive feedback about the maturity and enthusiasm of the students attending placement.

Night Duty Program

Nurses working at night are provided with an education program offered once or twice a month, depending on learning priorities. Twenty-five to 45 participants attend each session. The night duty program covers essential learning and clinical or professional topics.

Initiatives in allied health

Clinical educator positions in occupational therapy and social work were established in 2010 to help improve workforce capacity through student placements, and support for new graduates and other staff. In 2010–11 these positions developed and implemented orientation support and supervision programs for new graduates and clinical supervisors in their disciplines.

Nineteen occupational therapy students (3708 placement hours) and six social work students (2748 placement hours) undertook clinical placements in the Health Directorate as part of their study program during 2010–11.

The evaluation of the Designated Clinical Educator Model in Allied Health has been completed. This clinical education model was found to have enhanced the quality of clinical education while supporting productivity in the Health Directorate. A proposal for an allied health clinical supervision policy is under development.

Child protection training

Training is provided for three categories of staff according to the extent of their contact with children, and data is recorded in Capabiliti, the training management system. Child protection training is also provided to non-government agencies that receive funding from the Health Directorate. e-Learning is used as an alternative to the face-to-face session for Level 1 Child Protection Training (for all staff, once only) and includes an assessment. The Child Protection Team continues to provide face-to-face sessions for staff who do not have access to a computer.

A Level 2 Refresher e-learning package has been developed and piloted and is awaiting final review. Face-to-face sessions will still be offered. A training package has also been designed for volunteers and is being used for this group.

The Health Directorate, in partnership with the Community Services Directorate, has provided a series of workshops for government and non-government organisations with the aim of increasing individuals' confidence and ability when working with vulnerable families. The workshops have focused on:

- children and young people living with family violence
- children and young people living with a parent with a mental illness
- children and young people affected by parents' drug and alcohol misuse
- skills-focused workshops on ways of improving engagement with vulnerable families.

Number of Health Directorate staff, including Calvary staff, who attended child protection training in 2010–11

Level of training *	Total number trained
Level 1	334
Level 1 e-Learning	1244
Level 3	209
Level 2 Refresher	287
Level 3 Refresher	227
**Total ** **	**2301**

* Staff may attend more than one level of training.
** The participant total reflects full number of attendees at education sessions.

COMPASS Education

The Early Recognition of the Deteriorating Patient Program (COMPASS) is aimed at all health professionals who have patient contact or review clinical documentation to teach them a process that enables early recognition of the deteriorating patient to potentially improve outcomes. This program is delivered by the Early Recognition of the Deteriorating Patient team. The tiered package consists of an interactive CD-ROM, examples of observation charts of deteriorating patients with related questions, an education manual, and detailed information on physiological principles and underlying vital signs. Participants also learn about the use of the modified early warning scores and structured communication strategies and case scenarios, and complete an online assessment using multiple choices and a three-hour face-to-face interdisciplinary teaching session.

From July 2010 to June 2011, 44 three-hour COMPASS sessions were held, with a total of 415 participants across both the Canberra Hospital and Health Services and Calvary Health Care ACT, and 103 one-hour COMPASS Refreshers were held, including night duty, with 1052 staff attending. New medical staff also undertake the training in orientation each year in January.

The maternity COMPASS package accounts for the changing physiology of pregnant women. Training was undertaken prior to the introduction of their charts in September 2010, with nine sessions held for 50 participants. Two maternity refreshers were held, with 15 participants.

The refresher program for adults, paediatrics and maternity is now included in the Mandatory Update Day for nurses and midwives.

The COMPASS education program is used by facilities in Queensland, New South Wales, Victoria, South Australia, Western Australia, the Northern Territory, New Zealand and Oman in the Middle East. Ireland has also decided to make COMPASS its National Education Program for Deteriorating Patients.

Graduate Nurse Program

The Health Directorate offers a 12-month transitional program that focuses on every facet of the graduate experience to provide a high level of clinical and professional support, care, feedback and guidance during the transition from student to registered nurse. Clinical development nurses provide education and support in the workplace. Calvary Health Care ACT offers a separate program. Forty-eight per cent of graduates were from the ACT; the other graduates came from every state in Australia and overseas to participate in the program.

In 2010–11, 94 graduates were supported in the program.

August 2010 intake	20 participants
February 2011 intake	63 participants
June 2011 intake	7 participants
Graduates provided with extension	4 participants

Twenty-five per cent of program participants have converted from enrolled nurse to registered nurse.

Twenty graduates completed a Foundation Program during their graduate year within the Emergency Department, Intensive Care Unit or Perioperative Department.

On successful completion of the program, the retention rate for each intake was as follows:

- August 2009 to 2010, 100 per cent; February 2010 to 2011, 97 per cent; and May 2010 to 2011, 94 per cent.
- Five per cent of graduates commenced postgraduate studies immediately on completion of the program.

Graduate Midwife Program

In 2010, seven graduate midwives, two of whom are Bachelor of Midwifery graduates, were recruited and commenced the program. All successfully completed the program, and the entire cohort continues to be employed in the maternity unit at the Canberra Hospital. Formative and summative evaluations occurred and the program was updated according to the feedback received.

The 2011 Graduate Midwife Program commenced in March 2011 with 12 participants, who are due to finish in March 2012.

Enrolled Nurse Graduate Program

The Enrolled Nurse Graduate Program is a 12-month program designed to assist with the transition from student to enrolled nurse. In 2010–11, 24 enrolled nurses were recruited and supported in the program.

September 2010	13 participants
February 2011	6 participants
May 2011	3 participants
June 2011	1 participant
Graduates provided with extension	1 participant

On successful completion of the program, the retention rate from February 2010 to February 2011 was 73 per cent.

Introduction to Perioperative Nursing Program

The 12–month Introduction to Perioperative Nursing Program commenced in 2002 to attract and retain nurses within the Perioperative Department. The program delivers a broad team-orientated approach, providing education modules and clinical rotations encompassing all perioperative nursing specialties. In 2010–11, there were 18 participants, 100 per cent of whom successfully completed the program. As a new initiative, places were also offered to external applicants from regional hospital perioperative units and other ward nurses from within the Canberra Hospital. These nurses attended the learning modules of choice to update or refresh core knowledge in perioperative nursing. This initiative will continue to be offered with future courses.

Allied Health New Graduate Pilot Program

This initiative commenced in March 2011. Twenty-one graduates enrolled from 10 different allied health disciplines attended monthly professional development and education sessions. Formative evaluation indicates that the program is providing support for new graduates.

Baby Friendly Health Initiative

An important part of the accreditation for the Baby Friendly Health Initiative in the Health Directorate is staff education, with all staff who care for breastfeeding women and their babies requiring breastfeeding education. The Friendly Feeding workshop provides eight hours of breastfeeding education to staff based on the WHO/UNICEF 10 Steps to Successful Breastfeeding. In addition, a workshop was developed especially for staff caring for babies in the Centre for Newborn Care. This workshop focuses on breastfeeding the sick or pre-term baby.

Lactation course

The human lactation and breastfeeding course offers education points to participants to enable them to be eligible to sit the International Board of Lactation Consultant Examiners (IBLCE) exam. In 2010, 15 participants attended the course, with four successfully undertaking the IBLCE exam. The 2011 course commenced in February with 19 participants. Eight of the 19 participants are planning to sit the IBLCE exam. Due to the popularity of this course, and as funds are available from the ACT Breastfeeding Strategy (a joint initiative of the Health Promotion Branch and the Child, Youth and Women's Program), a second lactation course will be offered in 2011.

Mandatory Update Day for Nurses and Midwives

Mandatory Update Day was developed to enable nurses and midwives at Canberra Hospital to complete a large number of updates of their annual essential education in one day. It is conducted twice a month. In 2011 there were 975 positions provided for nurses and midwives to attend this course, with 851 nurses (87 per cent) attending. In 2011–12 the number of positions will be increased to 1035 to increase the opportunity for nurses to achieve competency.

Postgraduate courses for nurses and midwives

In 2010 the neonatal postgraduate programs continued to operate through the Australian Catholic University, delivering a Graduate Certificate and Master of Neonatal Intensive Care Nursing and Paediatric and Child Health. This education model combines theory and experiential learning for Health Directorate nurses and midwives. Students may study part time or full time. In 2010, three students completed the neonatal course. In 2011, five students commenced and there were four continuing students. Paediatric and Child Health is being conducted as an online course this year, and four students are enrolled.

Graduate Diploma in Midwifery

The Graduate Diploma in Midwifery is offered in partnership with the University of Canberra and the Health Directorate, Staff Development Unit. The aim of this course is to produce graduates eligible for registration with the Nursing and Midwifery Board of Australia. In January 2011, 13 of the 14 students graduated as midwives from the Graduate Diploma in Midwifery.

One student graduated in May 2011. Of the 14 graduates, 10 are working as midwives in the Health Directorate, three are working as midwives interstate and one is working as a registered nurse in the directorate.

In February 2011, 23 students were enrolled in the course, with 12 enrolled as clinical students, six enrolled as part-time students and five enrolled as deferred students. In February 2011, the Canberra Hospital employed five students, Calvary Public Hospital employed five students, Calvary Private Hospital employed one student and Queen Elizabeth II Family Centre employed one student.

All 12 clinical students are expected to register as midwives with the Nursing and Midwifery Board of Australia in January 2012.

Re-entry programs for registered nurses and midwives and overseas-qualified nurse program

The Health Directorate re-entry programs recruit and provide educational support to nurses (registered and enrolled) and midwives who have not worked in health care for up to 10 years. The overseas nurses program provides education and support for internationally qualified nurses to move into the ACT nursing workforce. All programs are accredited with the Nursing and Midwifery Accreditation Council of Australia.

2010–11	Completed	Recruited to Health Directorate	Percentage employed in Health Directorate
Registered Nurse Re-entry	6	6	100%
Midwifery Refresher	2	1	50%
Overseas Qualified	3	2	75%

Life support programs

Life support programs were revised in 2011 in line with recent changes in national resuscitation guidelines. The table below shows the training provided and the number of staff who attended.

Training	No. of participants
Basic Life Support—266 programs	2586
Advanced Life Support—17 programs	221
Advanced Life Support Refresher—16 programs	120
Neonatal Life Support—11 programs	
- Health Directorate	170
- Calvary	31
Update Neonatal Life Support—2 programs	43
Paediatric Life Support—6 programs facilitated by Advanced Paediatric Life Support (Victoria) held in Canberra	100
Paediatric Life Support Update Canberra Hospital—1 program	6

Scholarships for allied health, nursing and midwifery

In 2010–11, 26 allied health postgraduate scholarships were awarded to a diverse range of professionals, including cardiac technicians, sonographers and clinical neurophysiology scientists. Forty-six per cent of applicants for the allied health scheme represented areas of identified national and local workforce shortage. The total value of this investment is $139,388.

Ninety-eight nursing and midwifery postgraduate scholarships were awarded to nurses and midwives at the commencement of the 2011 academic year. The total amount granted was $191,314. Twenty scholarship recipients are continuing students, and 78 scholarship recipients are new students. In addition, 21 mental health scholarships were awarded, totalling $47,000.

Forty-seven percent of the scholarships awarded were given to nurses and midwives working in disciplines identified as having workforce shortages in the ACT and NSW region, including mental health, critical care and midwifery.

The Nursing and Midwifery Office offered two Aboriginal and Torres Strait Islander enrolled nursing scholarships this year. This was a new initiative by the Health Directorate in response to the Council of Australian Governments (COAG) National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. New and existing Aboriginal and Torres Strait Islander students were given the opportunity to undertake a Diploma of Nursing through the Canberra Institute of Technology on either a full-time or part-time basis.

This year, four enrolled nurses were awarded a scholarship to undertake a Bachelor of Nursing degree through a local university, and a pilot project will commence in October 2011 to train 25 enrolled nurses in the administration of intravenous medication, totalling $44,820. In addition, 27 enrolled nurses received a scholarship to complete the Canberra Institute of Technology's generic Medication Administration Course.

Five travel scholarships were awarded to nurses and midwives, totalling $9840. These scholarships provide financial assistance to nurses and midwives to enable them to present a paper or poster at a relevant interstate or international conference. Recipients use the scholarship funding to pay for costs incurred from travel, accommodation or conference registration. On return from the conference, the scholarship recipient is expected to present a summary report to their peers.

Nine practice development scholarships, totalling $45,000, were awarded in 2010–11. These scholarships assist nurses and midwives to undertake small practice development projects, which typically involve reviewing practice standards and developing and introducing evidence-based best practice initiatives.

Health Directorate learning and development activity

The Health Directorate schedules, books, approves and reports on learning and development activities using Capabiliti, a learning management system. Calvary Health Care ACT has a separate recording system, so the figures in the table below do not include internally run training at Calvary.

Health Directorate learning and development activity for face-to-face programs and e-Learning by health division as recorded in Capabiliti from July 2010 to June 2011

Division	No. of Attendances	Hours	Salary *	e-Learning completed
		3,234	$134,979	792
DDG Strategy and Corporate	2,064	4,770	$180,676	1,136
DDG Canberra Hospital & Health Services	44,419	87,288	$3,014,005	13,541
Calvary **	269	N/A	N/A	
Special Purpose Account	81	197	$6722	71
TOTAL	**47,813**	**95,292**	**$3,336,382**	**15,540**

* Salary costs are the costs of the salaries of staff attending and do not include the cost of the programs and salaries of the staff providing the program or e-Learning.

** Calvary hours and salary costs are not available.

Whole-of-government learning and development

Initiative	Details (No. of participants who attended each program)
ACTPS Graduate Program	1
Young Professionals Network	18
Future Leaders Program	2
Executive Development Program	2
PSM Program	1
Sponsored training for first-time and front-line managers	28
Study assistance	196
Use of ACTPS Calendar	85 (cost $26,641)

Future learning and development priorities

The following are the key learning priorities as determined by executives in the Health Directorate:

- performance management
- financial management
- customer service
- Essential Education.

Projects and programs are ongoing or are being designed around these key priorities.

C.9
Workplace health and safety

Our priority—a safe and healthy working environment for all employees

To enhance the efforts already made in keeping our staff healthy and safe and ensure this is a sustainable goal, the Health Directorate provides staff with health promotion opportunities in addition to a range of injury prevention and injury management services.

Health promotion opportunities are targeted and promoted to staff across the directorate by the Health Promotion Branch to assist them in improving their general health and wellbeing.

Injury prevention within the Health Directorate is a shared responsibility between staff and the Workplace Safety section. This section has overarching responsibility for keeping our staff healthy and safe and focuses on ensuring that the Health Directorate has an effective workplace safety management system to identify, manage and monitor safety risks. The Workplace Safety section also provides a holistic Early Intervention Physiotherapy Service to staff who have a muscular-skeletal accident or injury in the workplace and occupational medicine services across the directorate to prevent the likelihood of infectious disease transmission to healthcare workers. These services include pre-employment screening, a vaccination program (including annual influenza vaccinations), an immunisation drop-in clinic, occupational risk exposure (ORE) practices and follow-up management, counselling and advice, cytotoxic screening, a mobile clinic for seasonal flu vaccinations, and product monitoring on safety devices, surveillance and education.

Injury management services, coordinated by the Case Management section of the Human Resources Management Branch, focus on addressing the ongoing health, safety and welfare of employees injured in the course of their work to limit the impact on their lifestyle and on organisational performance.

Measures taken during 2010–11

Workplace safety measures undertaken during 2010–11 include:

- my health, the Health Directorate's new staff health and wellbeing program, was launched in May 2011 by the Health Promotion Branch, Population Health Division. The program aims to provide Health Directorate employees with increased access to information and programs that support healthy lifestyle change in areas such as physical activity, nutrition, smoking and emotional health and wellbeing, and to assist the Health Directorate as an employer to continue to build its capacity to provide a supportive environment for employees in healthy living matters.
- External audits of operational areas' compliance with the Safety Management System were conducted to provide recommendations for improvements in the Safety Management System.
- The focus on workplace safety representatives' and managers' training in work safety continued this year. To enable improved access and more flexible training opportunities, e-learning packages were developed for work safety legislation, manual tasks, work station set-ups, and dealing with violence and aggression.

In the 2010 Safe Work ACT Awards, Sasha Berryman, Assistant Director of Nursing, won the award for Best Individual Contribution to Health and Safety–non-OHS. Sasha was the ACT entrant in the 2010 National Safe Work Awards.

The three national targets

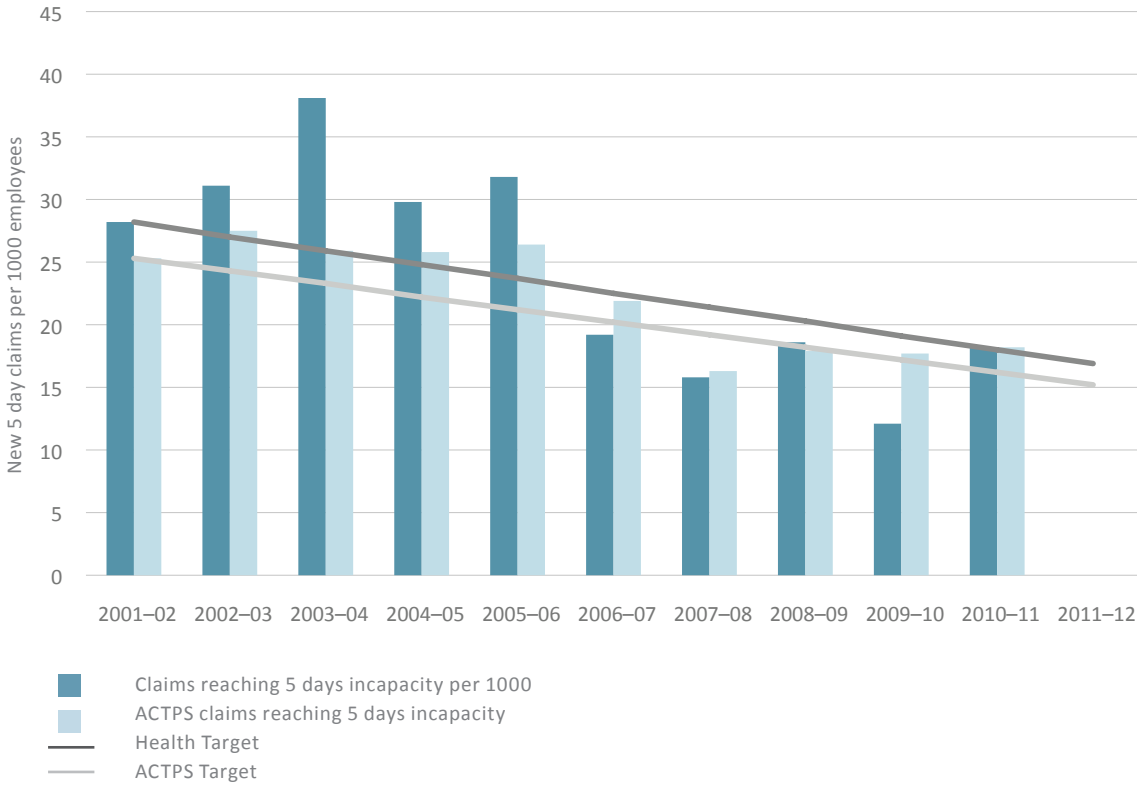
The ACT Government is party to the National Occupational Health and Safety Strategy 2002–2012. A range of measures are reported nationally and improvements targeted in three areas:

Target 1—Workplace injuries
Target 2—Work-related fatalities
Target 3—Lost time due to injuries.

Reporting on the injury prevention and management targets is by financial year.

Target 1—Incidence of workplace injuries

(Number of workers compensation claims with five or more days of time off work per 1000 employees) compared to the target of a 40 per cent reduction in this indicator over the period 2002 to 2012



Experience Quarter Ending	2001 –02	2002 –03	2003 –04	2004 –05	2005 –06	2006 –07	2007 –08	2008 –09	2009 –10	2010 –11	2011 –12
# new 5 day claims	94	126	139	111	126	78	69	84	58	90	-
Rate per 1000 employees	28.2	31.1	38.1	29.8	31.8	19.2	15.8	18.6	12.1	18.2	-
Health Target	28.2	27.0	25.9	24.8	23.7	22.5	21.4	20.3	19.1	18.0	16.9
ACTPS # new 5 day claims	412	473	448	440	459	379	291	330	333	355	-
Rate per 1000 employees	25.3	27.5	25.9	25.8	26.4	21.9	16.3	17.9	17.7	18.2	-
ACTPS Target	25.3	24.3	23.3	22.2	21.2	20.2	19.2	18.2	17.2	16.2	15.2

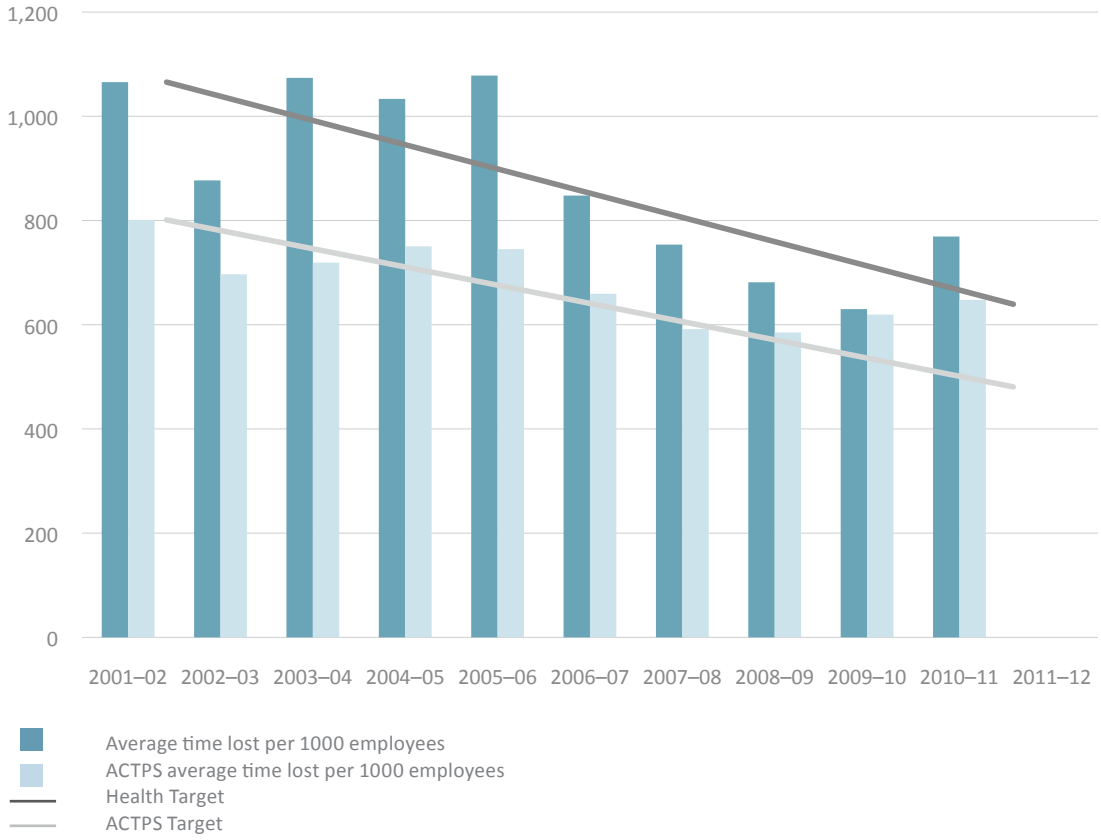
Target 2—Incidence of work-related fatalities

Compared to the target of zero fatalities by 2012

There were no recorded fatalities in this category during the year.

Target 3—Average lost-time rate

(Average number of weeks of time off work for workers compensation per 1000 employees) compared to the target of a 40 per cent reduction in this indicator over the period 2002 to 2012



Experience Quarter Ending	2001 –02	2002 –03	2003 –04	2004 –05	2005 –06	2006 –07	2007 –08	2008 –09	2009 –10	2010 –11	2011 –12
Weeks incap	3,557	3,549	3,914	3,850	4,273	3,453	3,297	3,083	3,025	3,802	-
Rate per 1000 employees	1,066	877	1,074	1,033	1,078	848	754	681	630	769	-
Health target	1,066	1,023	980	938	895	852	810	767	725	682	639
ACTPS target	801	769	737	705	673	641	609	577	545	513	481

The Health Directorate did not meet its target for this indicator this reporting year, as there was an overall increase in claims. There was an increased frequency of psychological illness claims, and these are generally associated with longer periods off work than those for physical illness.

Other key performance indicators

Staff accident/incident trends were as follows:

- 1219 accident and incident reports were lodged from 1 July 2010 to 30 June 2011. This was a drop from 1431 in the preceding year. Of these, 250 were 'body stressing' related incidents, making this the highest mechanism of injury for the Health Directorate. The second highest mechanism of injury was reported as mental health incidents or accidents.

Incidents, accidents, investigations and notices were as follows:

- Of the 1219 accident/incident reports lodged, 57 resulted in lost time of one day or more, compared to 127 in the preceding year.
- Ten accident/incidents were notified to WorkSafe ACT under section 38 of the *Workplace Safety Act 2008*, compared to 20 in the preceding year.
- One provisional improvement notice was issued under section 45 of the Workplace Safety Regulation 2009. The notice has since been revoked.
- One improvement notice was given to the Health Directorate under the *Work Safety Act 2008.* The notice has since been withdrawn.
- The number of elected Workplace Health and Safety representatives in the Health Directorate at 30 June 2011 was 240, compared to 224 in the preceding year.

Workers' compensation premium

Over the past seven years, the Health Directorate's workers' compensation premium rate has continued to decrease—from 4.65 per cent in 2004–05 to 3.34 per cent in 2010–11, as shown in the table below.

Year	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11
Premium rate	4.65%	4.4%	3.98%	3.67%	3.42%	3.41%	3.34%

C.10
Workplace relations

Australian Workplace Agreements (AWAs) negotiated under the terms of previous governments continued to operate during 2010–11. Consistent with government policy, no new AWAs were offered or approved.

Description	No. of individual SEAs	No. of group SEAs*	Total Employees covered by SEAs**	TOTAL
	A	B	C	A+C
Special Employment Arrangements (SEAs)				
Number of SEAs at 30 June 2011	79	22	321	400
Number of SEAs entered into during period	14	7	0	21
Number of SEAs terminated during period	7	0	0	7
Number of SEAs providing for privately plated vehicles at 30 June 2011	6	0	0	6
Number of SEAs for employees who have transferred from AWAs during period	0	0	0	0
Australian Workplace Agreements (AWAs)				
Number of AWAs at 30 June 2011	18	0	0	18
Number of AWAs terminated/lapsed (including formal termination and those that have lapsed due to staff departures)	0	0	0	0

*Or Equivalent level	Classification range	Remuneration at 30 June 2011
Individual and group SEAs	*ASO3–SOA	$55,088–$130,016
	Dentists 1–2 Dentists 4	$62,568–$174,321
	***Specialist–Senior Specialist	$146,783–$500,625
AWAs (includes AWAs that ceased during period)	0	0

* In the case of part-time officers, full time equivalent remuneration is shown.

** The Health Directorate has 22 group SEAs. Ten group SEAs' allowances are not included in the total number of employees covered in group SEAs or in the salary range. This is due to the variation of payments in a pay period. Officers are paid the SEA allowance only when a particular shift is worked and is payable on timesheets only.

*** The Chief Medical Physician and the Transitional Career Medical Officer have been included with Specialist and Senior Specialist to maintain the privacy of these employees.

C.11
Strategic Bushfire Management Plan

The Health Directorate did not have any facilities located in rural or ember zones between July 2010 and June 2011 and was therefore not required by the ACT Emergency Services Agency (ESA) to prepare a Bushfire Operational Plan under the Strategic Bushfire Management Plan.

In 2010 the ESA completed fire/ember risk assessments to identify at-risk ACT Government owned and operated facilities during high fire danger periods for the ACT Elevated Fire Danger Plan. Assessments were made of government owned or regulated properties where normal activities should be suspended when a catastrophic bushfire danger alert is in place.

One Health Directorate facility was identified by the ESA assessment—the proposed alcohol and drug treatment centre to be located at Mowera, in the foothills of the Brindabella ranges, in the far west of the ACT. Once the facility is developed and operational, the Health Directorate will be responsible for the development and maintenance of plans to guide staff and clients as to actions to be undertaken during periods of high fire danger as well as general bushfire awareness and management activities on the site.

C.12
Strategic asset management

Assets managed

The Health Directorate managed assets with a total written down value of $590.966 million as at 30 June 2011. Assets managed included:

Built property assets	$501.245 million
Land	$36.820 million
Plant and equipment	$47.059 million
Leased plant and equipment	$5.842 million

The estimated replacement value of these assets was $1251.48 million, of which property assets were $1071.84 million. The following table lists the directorate's property assets.

The Canberra Hospital Campus	Area m^2
Building 1—Tower Block	37,560
Building 2—Reception/Administration	5,950
Building 3—Oncology/Aged Care/Rehab	17,390
Building 3—Linear Accelerator	1,650
Building 4—ANU Medical School	4,115

Non-acute facilities	Area m^2
Belconnen Health Centre	3,800
Dickson Health Centre	490
Phillip Health Centre	3,676
Tuggeranong Health Centre	4,524
Independent Living Centre–Weston	1,143

The Canberra Hospital Campus	Area m^2
Building 5—Skills Centre/Accommodation	8,230
Building 6—Surgical Services/Offices	4,710
Building 7—Alcohol & Drug	1,260
Building 8—Pain Management	660
Building 9—Accommodation	740
Building 10—Pathology	10,250
Building 11—Maternity	5,900
Building 12—Diagnostic & Treatment	18,870
Building 13—Helipad Structured car park	7,980
Building 15—Psychiatry	2,020
Building 22—Information Management	243
Building 23—Redevelopment Unit	1,810
Building 24—Health Administration Offices	1,332
Building 26—Southern Multi-storey Car Park	53,000
Gaunt Pl Building 1—Dialysis Unit	871
Gaunt Pl Building 2—RILU	688
Gaunt Pl—3,4,5,6 (Mental Health & Aged Care)	668

Non-acute facilities	Area m^2
Karralika—Fadden	534
Karralika—Isabella Plains	1,400
Watson Hostel	2,431
Burrangiri Respite Care Centre	1,054
Lanyon Family Care Centre	194
Ngunnawal Family Care Centre	215
QE II Family Centre—Curtin	1,120
Arcadia House—Bruce	467
Hennessy House—Bruce	3,719
Northside Contractors—O'Connor	100
PRS—O'Connor	100
Health Protection Services—Holder	1,600
Clare Holland House	1,600
Mirowera—Paddy's River	206
Monash—Health Protection	N/A
Yamba Drive car park (Phillip Blk 7 Sec 1)	N/A

During 2010–11, the former Narrabundah Health Centre was removed from the asset register.

During 2010–11, the following assets were added to Health Directorate's asset register:

TCH Building 24—Health Administration Offices
TCH Building 26—Southern Multi-storey Car Park.

As at 30 June 2011, the directorate did not have any potentially surplus properties.

Assets maintenance and upgrade

Works were undertaken at properties throughout the Health Directorate's portfolio. These included:

- upgrades to the Pathology store and research aaboratories in Building 10, including installation of improved sterilisation and utility rooms, upgraded containment facilities, new laboratory areas to meet research standards, upgraded air filtering and additional storage areas for pathology blocks and slides
- fit-out works to enable Prosthetics and other rehabilitation services to occupy the Village Creek Centre
- replacement and upgrade of mechanical equipment and fire safety systems at various TCH sites
- installation of an airconditioning system in the TCH Building 5 patient lounge, replacement of the heating pipe work at TCH Building 6 and installation of a heating system at the Mitchell Supply Warehouse
- installation of energy-efficient hot water systems at the Watson Hostel and the replacement of cooling systems at Burrangiri Respite Centre
- pre-installation works to prepare the LINAC 4 Bunker for the new linear accelerator, and
- undertaking safety upgrades to the Building 12 Gas Room Enclosure, the Generator Fuel Delivery Area at Gaunt Place, by replacing floor coverings and improving roof safety works.

Details of the capital works program are included in section C.13 of the Annual Report.

Property, plant and equipment are maintained to a high standard to meet health requirements. Expenditure on repairs and maintenance (excluding salaries) was $9.104 million, which represents 0.73 per cent of the replacement value.

Building audits

Seventy-nine building condition assessments, hazardous materials audits and fire reports have been undertaken as part of a rolling three-year program to assess all buildings managed by the Health Directorate. Of these, 23 were obtained in 2010–11. These audits are used to inform the directorate's ongoing asset management program. The condition audits assessed these properties as being in normal/average condition. Disability access audits for all of the directorate's property assets were undertaken in 2006–07.

Office accommodation

The agency employs 5953 staff, of whom 905 people occupy office-style accommodation in the sites listed in the table below, at a utilisation rate of 16.0 m2 per employee.

Location	Property	Owned/ leased	Work points/ staff on 30/06/11	Office area (m2)	Utilisation rate m2 per employee
Civic	11 Moore Street	Leased	135	2,290	17.0
Civic	1 Moore Street	Leased	219	3,483	15.9
Garran	TCH Building 6	Owned	168	3,051	18.2
Garran	TCH Building 12	Owned	70	613	8.8
Garran	TCH Building 22	Leased	14	243	17.4
Garran	TCH Building 23	Owned	130	1,810	13.9
Garran	TCH Building 24	Owned	54	1,332	22.6
Holder	Health Protection Services	Owned	78	1,163	14.9
Phillip	1 Bowes Place	Leased	37	583	15.8

The other 5048 staff work in non-office environments within its acute and non-acute facilities. Due to the clinical nature of these environments the average area per employee is not applicable.

C.13
Capital works

The Health Directorate Capital Asset Development Plan (CADP) is a comprehensive and structured response to a complex mix of pressures, including an ageing population, changing technology, and provider and consumer expectations, all of which have contributed to a significant increase in projected demand for health services in the ACT. The CADP incorporates the total health system, including new models of care aimed at better management of chronic disease and keeping people out of hospital, better use of technology, different ways of providing care such as community-based post-hospitalisation support, or other step-up–step-down facilities, and workforce initiatives focused on sustainability via new workforce roles and expanded scope of practice for existing roles.

The CADP also incorporates the infrastructure to support these new approaches. This covers all public sector health services infrastructure, including hospitals and community health centres.

The ACT Government committed $300 million over four years in the 2008–09 budget for the implementation of the CADP. Prior to 2008–09, $29 million had been referred to CADP for the old carpark. New announcements in the 2009–10 budget, valued at $148 million, related to E-Health, the Belconnen Enhanced Community Health Centre, the Walk-in-Centre at the Canberra Hospital, the PET–CT, and forward design for other projects and infrastructure works. The government further extended its commitment in the 2010–11 budget through an additional $33.1 million for a significant expansion of the Tuggeranong Community Health Centre and a number of other projects. The 2011–12 budget continued the government's investment in new health infrastructure, with commitments of $129 million over four years related to design work to redevelop the Canberra Hospital campus, upgrading campus-wide infrastructure, development of an Integrated Cancer Centre, a new sterilising facility at the Canberra Hospital, identity and access management, and development of specifications and documentation for a proposed Northside Subacute Hospital. The total government commitment to health infrastructure projects to date is $639 million.

Projects completed in 2010–11 are described below.

- The new Neurosurgery Operating Suite was officially opened on 17 September 2010, with equipment that is state–of-the-art and the first of its type to be used in Australia.
- A new 16-bed Surgical Assessment and Planning Unit, located within close proximity to the Emergency Department, was completed in August 2010. This assists to streamline the admission process for non-critically ill surgical patients, allowing for increased throughput and rapid turnaround of short-stay surgical patients.
- Demountable buildings D and E were completed in December 2010. This administration block includes offices for the hospital executive and meeting rooms—the first step towards freeing up clinical space in TCH campus.
- In October 2010, Health Directorate extended its imaging capacity with the establishment of a single unit combining positron emission tomography (PET) and computed tomography (CT). The PET–CT is a hybrid scanner combining functional and anatomical imaging. This service, not previously available in Canberra, has greatly improved the accuracy of PET imaging and provides increased opportunities for continuity of care.
- The new Southern Multi-storey Carpark became operational on 24 December 2010, delivering 1720 car spaces. Level 8, the top floor, was completed in June 2011, allowing a roof to be placed on the building and a secure gate to be placed at the access to level 8 to prevent self-harm from the building's roof.
- In September 2010, Calvary Public Hospital capacity was enhanced by the completion of a new 16-bed critical care unit and an additional operating theatre.

- Design was completed for:
    i. the Adolescent and Young Adult Mental Health Inpatient Unit (Concept Design)
    ii. the new Gungahlin Community Health Centre, and a new Belconnen Community Health Centre, and
    iii. the Tuggeranong Community Health Centres will be enhanced and deliver services such as renal dialysis.

Works still in progress at year end are described below.

- Development of a project definition plan is standard practice in capital works projects. It is the step which precedes formal design of facilities in which planning assumptions are updated and further interrogated and concept designs developed to a greater level of detail.
- Construction commenced on the new Women's and Children's Hospital on TCH campus, which will draw together related healthcare services, including paediatrics, maternity, neonatal intensive care, gynaecology, foetal medicine and specialised outpatient services in one state-of-the-art facility. Health professionals and services will work together in multidisciplinary teams to provide comprehensive and coordinated care.
- Design commenced on:
    iv. campus infrastructure—This project involves updating existing services and plant to enable the redevelopment of the campus, including works on existing and new buildings.
    v. the Capital Region Cancer Centre—Total funding for this project is $43 million, with the Australian Government committing $27.9 million and the ACT Government contributing $15.1 million. Delivery of health care in an integrated Capital Region Cancer Centre on TCH campus aims to improve the quality of care for patients and meet the demands and realities of the future. The Capital Region Cancer Centre will become a place where comprehensive, integrated and patient-centred cancer care and treatment is delivered
    vi. forward design for the Skills Development Centre at TCH.
- Construction commenced on the Adult Acute Mental Health Inpatient Unit (AAMHIU) at TCH in 2010–11. The 40-bed state-of-the-art AAMHIU will be a centre of excellence for the provision of adult acute mental health inpatient services. It will be a therapeutic place for healing and will provide holistic, evidence-based quality care. The AAMHIU will replace the existing Psychiatric Services Unit and will provide specialised care and treatment for mental health consumers who require short-term intensive therapeutic intervention where less restrictive options have been deemed unsuitable or are unavailable. It will provide a pathway to healing for consumers that are admitted both voluntarily and involuntarily. The new building has been designed to recognise a consumer's journey, from serious illness to recovery, from withdrawal to social engagement, from despair to hope.

The ACT Government has delayed its decision on the construction of the Adult Secure Mental Health Inpatient Facility to allow a more detailed study of demand requirements to be conducted, taking into account the completion of the Adult Acute Mental Health Inpatient Unit, the impact of the Alexander Maconochie Centre since opening, and the availability of services in New South Wales.

Capital Upgrades Program

Works were undertaken at several Health Directorate properties, including the Watson Hostel, Mitchell Supply Warehouse, Burrangiri Respite Centre, Hennessy and Arcadia House, Phillip Health Centre, Kambah Village Creek Centre, TCH (Buildings 1, 5, 6, 10 and 12) and Gaunt Place.

The following tables contain Health Directorate capital works project information and the reconciliation schedule.

Capital works table

Project	Proposed or Actual completion date	Original project value $'000	Revised project value $'000	Prior years expend $'000	2010-11 expend $'000	Total expend to date $'000
New works - Departmental						
Clinical Services Redevelopment — Phase 2	Sep-12	15,000	9,800	N/A	295	295
Tuggeranong Health Centre — Stage 2	Sep-12	14,000	14,000	N/A	4	4
CADP Change Management and Communication Support	Jun-12	4,117	4,117	N/A	491	491
National Health Reform	Aug-12	15,098	15,098	N/A	1,971	1,971
Integrated Capital Region Cancer Centre — Phase 1	Sep-13	27,900	27,900	N/A	1,031	1,031
Capital Upgrades Program - Departmental						
Installation of Energy Savings Equipment and Sustainability Upgrades	Sep-11	235	235	N/A	154	154
Augmentation of Patient and Research Facilities	Dec-11	790	790	N/A	90	90
Workplace Improvements	Sep-11	640	640	N/A	307	307
Augmentation of Medical Offices	Oct-11	455	455	N/A	269	269
TCH Discharge Lounge Relocation	Sep-11	150	150	-	4	4
Capital Upgrades Program - Territorial						
Security Upgrades - Calvary	Sep-11	100	100	N/A	44	44
Fire Safety Upgrades - Calvary	Dec-11	300	300	N/A	84	84
Residential Accommodation Refurbishment - Calvary	Dec-12	310	310	N/A	-	-
Works in progress - Departmental						
Enhanced Community Health Centre - Belconnen	Dec-12	51,344	51,344	-	1,033	1,033
Mental Health Young Persons Unit	Jun-12	775	775	158	(37)	121
ACT Health Skills Development Centre	Dec-11	1,300	1,300	-	423	423
Adult Mental Health Inpatient Unit	Dec-11	23,630	23,630	-	9,186	9,186
Women and Children's Hospital	Sep-12	90,000	107,560	2,061	16,633	18,694
New Gungahlin Health Centre	Jun-12	18,000	18,000	5	529	534
Refurbishment of Health Centre - Tuggeranong	Sep-12	5,000	5,000	-	526	526

Project	Proposed or Actual completion date	Original project value $'000	Revised project value $'000	Prior years expend $'000	2010-11 expend $'000	Total expend to date $'000
Provision for Phase 1 CSR	Sep-12	57,000	26,630	9,279	9,591	18,870
Provision for Project Definition Planning	Sep-12	63,800	61,090	22,984	12,313	35,297
Adult Secure Mental Health Inpatient Unit - Forward Design	On-hold	1,200	1,200	344	141	485
Aboriginal Torres Strait Islander Residential Alcohol & Other Drug Rehabilitation Facility	Jun-13	5,883	5,883	621	3	624
Linear Accelerator Procurement and Replacement	Jun-12	18,700	17,700	14,245	1,069	15,314
An E-Healthy Future	Dec-13	90,185	90,185	7,558	8,482	16,040
Digital Mammography	Jun-12	5,715	5,715	2,985	983	3,968
Neonatal Intensive Care Unit - Video Streaming Service	Dec-11	200	200	100	-	100
Projects - Physically complete but financially incomplete - Departmental						
Walk-in Centre - TCH	Apr-10	2,157	2,157	1,788	304	2,092
Mental Health Assessment Unit	Apr-10	2,010	2,010	1,356	243	1,599
Neurosurgery Operating Theatre	Aug-10	5,500	10,500	8,473	1,993	10,466
Surgical Assessment and Planning Unit	Oct-10	4,100	4,100	2,534	1,142	3,676
Elective Surgery (Commonwealth Funding)	Sep-09	4,680	4,680	4,190	262	4,452
New Multistorey Car Park TCH	Jun-11	29,000	42,720	12,662	27,788	40,450
Procurement and Installation of a PET/CT Scanner	Nov-10	4,542	4,542	376	4,177	4,553
Completed Projects - Physically and financially complete - Departmental						
Additional Beds	Dec-09	2,400	2,400	2,341	64	2,405
Fire Systems Upgrade (Phase 1) TCH	Jun-11	2,600	2,600	2,206	394	2,600
Adult Acute Mental Health Inpatient Unit - Forward Design	Mar-11	2,290	2,290	1,667	623	2,290
Building Upgrades	Jun-11	556	556	N/A	556	556
Improvements to OH&S and Fire and Safety Systems	Jun-11	355	355	N/A	354	354
Upgrade of Mechanical Systems	Jun-11	540	540	N/A	540	540
Electrical, Plumbing, Floor Coverings and Air-Conditioning Upgrades (Stage1)	Mar-11	225	225	45	180	225
Energy Savings and Sustainability Works	Mar-11	305	305	191	114	305
Safety Upgrades	May-11	325	325	269	55	324
Refurbishment of Non-Clinical Accommodation at TCH	Oct-10	300	300	138	152	290
Address Building Condition and Asbestos Audit Requirements	Feb-11	380	380	242	137	379

Project	Proposed or Actual completion date	Original project value $'000	Revised project value $'000	Prior years expend $'000	2010-11 expend $'000	Total expend to date $'000
TCH Upgrades to Ambulatory Areas, Intensive Care Facilities, Pathology Laboratories and ED	May-11	525	525	223	310	533
Workplace Redesign to Meet Accommodation and OH&S Standards	May-11	290	290	96	194	290
Equipment Loans Scheme Relocation	Dec-10	620	620	25	595	620
Completed Projects - Physically and financially complete - Territorial						
Intensive Care Unit - Calvary	Oct-10	9,410	11,410	8,860	2,550	11,410
Improved Patient Amenity - Calvary	Aug-10	150	150	115	35	150
Infrastructure Improvements (Various) - Calvary	Sep-10	230	230	62	168	230
Occupational Health and Safety Upgrades (Various) - Calvary	Apr-11	312	312	69	243	312

Reconciliation schedule—capital works and capital injection

Approved Capital Works Program financing to capital injection as per cash flow statement						
	Original $m	Section16B $m	Variation $m	Deferred $m	Not drawn $m	Total $m
Capital works	165.291	5.172	0.000	-64.612	-24.361	81.489
An E-Healthy Future	25.000	4.256	0.000	-11.000	-2.245	16.011
Other capital injections	3.190	6.561	0.000	-2.458	-1.366	5.927
Total departmental *	193.481	15.989	0.000	-78.070	-27.973	103.427
Total territorial	**0.710**	**0.000**	**0.000**	**0.000**	**0.000**	**0.710**

* Capital injection on the cashflow statement also includes $2.8 million to fund staff sign-on bonus.

C.14
Government contracting

Basis of requirement

1. Government Procurement Act 2001
2. Government Procurement Regulation 2007
3. Government Procurement Amendment Regulation 2009 (No. 1).

Report descriptor

1 Procurement principles and processes

In 2010–11, the Health Directorate exercised all procurement activities in accordance with the government tender thresholds and complied with procurement policies and procedures as stated in the *Government Procurement Act 2001*, Government Procurement Regulation 2007 and Government Procurement Amendment Regulation 2009 (No. 1).

To ensure compliance with ACT Government procurement legislation, the Health Directorate:

i. sought advice on government procurement policies and procedures from Shared Services Procurement
ii. notified Shared Services Procurement of all procurements over $20,000 undertaken by the Health Directorate
iii. referred (where appropriate) procurements that required single, restrictive or open tender procurement processes to Shared Services Procurement
iv. referred (where necessary) all procurements that required Government Procurement Board consideration and/or approval to Shared Services Procurement.

To ensure that contractors meet their employee and industrial relations obligations, all tenders and contracts drafted by Shared Services Procurement on behalf of the Health Directorate include conditions provided by the ACT Government Solicitor's office to reflect the Government Procurement Act 2001 and Government Procurement Regulation 2007. These include the Ethical Suppliers Guideline and compliance with the government procurement circular on ethical suppliers.

In accordance with procurement legislation, the Health Directorate afforded the highest standard of probity and ethical behaviour towards prospective tenderers. Such behaviour is included but was not limited to:

i. equality
ii. impartiality
iii. transparency
iv. fair dealing.

2 External sources of labour and services

In 2010–11, the Health Directorate engaged a range of external consultants and contractors to undertake services in the following areas:

i. frontline clinical health services
ii. structural and procedural reviews of current business models
iii. dispute resolution services, including complaint investigation and mediation services
iv. capital works projects.

To ensure that the Health Directorate's contractors met their employee and industrial relations obligations, the directorate:

i. engaged the services of Shared Services Procurement to manage (where required) contracts on behalf of the Health Directorate
ii. used Shared Services Procurement documentation (including tender documentation and government contracts) that encapsulate all relevant industrial relations legislation as advised by the ACT Government Solicitor's office.

All the Health Directorate's construction contracts above $500,000 were established using Shared Services Procurement for project management and contractor pre-qualification.

All Head Contractors and Project Managers engaged on Health Directorate Capital Asset Development Plan capital works projects valued above $0.5 million are pre-qualified by the Territory. All Principal Consultants engaged in contracts valued above $50,000 were also prequalified by the Territory under the appropriate available pre-qualification category for consultants. The only exception was the engagement of the Health Directorate in-house adviser consultant (CroWpro), as the specific skills set required for this role did not fit into any pre-qualification category. CroWpro's engagement went through a public tender process to ensure selection of the consultant best placed to undertake this role for the Health Directorate.

The following tables list the Health Directorate's contractors, consultants and Visiting Medical Officers for the reporting period.

Contractors, consultants, and VMOs

Contractors

Name of Contractor	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Individual contracts which exceed $20,000; and smaller contracts awarded to the same contractor which, in total, exceed $20,000.						
Contractor **- A person who performs a Job, Task, Project on behalf of the organisation, i.e. a job that can be done by a staff member, but there are no resources to do in house.**						
Acute Services (Output 1.1)						
Accountants on Call	Provision of a Consultant to Provide Strategic Financial Services and Advice to the Canberra Hospital	$151,319.12	29-Nov-10	27-May-11	Yes	Specialist expertise
Accountants on Call	Temporary financial staff recruitment	$52,658.68		Month to Month	Yes	Specialist knowledge
ACT Nursing Service Pty Ltd	Provision of Agency Nurses	$3,628,041.42	16-Feb 10	16-Feb-14	No	
ASEPS	Provision of Agency Nurses	$85,287.78	16-Feb-10	16-Feb-14	No	
Australian Medical Placements	Medical Locum recruitment agency	$31,600.00	01-Jul-10	30-Jun-11	No	
Baptist Community Services NSW and ACT	Chaplaincy Services	$107,323.20	20-Sep-10	30-Jun-13	Yes	Specialist knowledge
Cogent Business Solutions Pty Ltd	Financial Governance and Management Review for the Canberra Hospital and Audit of the Perioperative Unit	$257,370.41	13-Oct-09	29-Nov-10	No	
ConsumerRad Unit Trust	Radiology Locum	$33,880.00		Month to Month	Yes	Specialist knowledge
Dept Immigration and Citizenship—TIS	Translation and Interpreting Service	$75,777.19		Ongoing	Yes	Specialist knowledge
Dr Alexander Hodge	Locum Gastroenterologist	26,326.49		Month to Month	Yes	Specialist knowledge
Dr Ben Wilson	Locum—Medical Imaging	$23,800.00		Month to Month	Yes	Specialist knowledge
Dr Carl Harmer	Locum medical practitioner	$21,960.00	01-Jul-10	30-Jun-11	Yes	Specialist knowledge
Dr Chrystal Chern Ying Fong	Locum medical practitioner	$49,993.55	01-Jul-10	30-Jun-11	Yes	Specialist knowledge
Dr Donald Marsden	Locum medical practitioner	$28,176.00	01-Nov-09	31-Aug-11	Yes	Specialist knowledge
Dr Joseph Hockley	Locum medical practitioner	$26,327.36	01-Jul-10	30-Jun-11	Yes	Specialist knowledge

Name of Contractor	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Dr Katrina Anderson	Locum medical practitioner	$23,385.32	30-Dec-10	30-Jun-11	Yes	Specialist knowledge
Dr Mahala Buckley	Locum medical practitioner	$93,990.98	01-Jul-10	30-Jun-11	Yes	Specialist knowledge
Dr Mohammed al-Moktar	Locum medical practitioner	$41,681.61	01-Jul-10	30-Jun-11	Yes	Specialist knowledge
Dr Shamsi Sherif	Locum—Medical Imaging	$47,000.00		Month to Month	Yes	Specialist knowledge
Dr Siroos Nasibi	Locum medical practitioner	$26,180.00	01-Jul-10	30-Jun-11	Yes	Specialist knowledge
Dr Timothy Buckenham	Locum—Medical Imaging	$38,000.00		Month to Month	Yes	Specialist knowledge
Dr Trylon M Tsang	Locum medical practitioner	$26,545.06	01-Jul-10	30-Jun-11	Yes	Specialist knowledge
Drs N. Hacker and G. Robertson	Locum medical practitioners	$47,928.00	01-Nov-08	30-Jun-11	Yes	Specialist knowledge
Global Medics	Medical Locum recruitment agency	$38,040.60		Month to Month	Yes	Specialist knowledge
Kelly Services Australia Limited	Contract staff services	$24,551.73		Month to Month	Yes	Contract staff at short notice
Kiwisstat/Ausstat Medical Recruitment	Locum Recruitment Agency	$64,985.00	01-Jul-10	30-Jun-11	Yes	Specialist knowledge
Medibank Health Solutions Telehealth Pty Ltd	Contract staff—schedule payments	$50,000.00	15-Jun-10	15-Jun-11	Yes	Specialist knowledge
Mediserve Pty Ltd	Provision of Agency Nurses	$812,659.07	16-Feb-10	16-Feb-14	No	
National Healthcare Services	Provision of Agency Nurses	$1,024,825.27	16-Feb-10	16-Feb-14	No	
Nursing Agency Australia	Provision of Agency Nurses	$42,491.79	16-Feb-10	16-Feb-14	No	
Professional Nursing Agency	Provision of Agency Nurses	$659,628.89	16-Feb-10	16-Feb-10	Yes	Specialist knowledge
Telemedcare Pty Ltd	Telemedicine Support Services	$20,249.85		Month to Month	Yes	Specialist knowledge

Name of Contractor	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Mental Health Services (Output 1.2)						
ACT Nursing Services	Provision of Agency Nurses	$132,606.28	16-Feb-10	16-Feb-14	Yes	Mental Health trained Contractors
Brindabella Civil Engineering Pty Ltd	Adult Acute Mental Health Inpatient Unit	$68,480.00	10-Aug-11	30-Nov-12	No	
Charman Earthmoving and Heavy Haulage Pty Ltd	Bush Healing contract services	$22,250.00		Month to Month	Yes	Specialist Services
Global Health	MHAGIC Support	$22,275.00	29-Aug-08	30-Jun-11	No	
Mediserve	Provision of Agency Nurses	$148,360.11	16-Feb-10	16-Feb-14	Yes	Mental Health trained Contractors
National Healthcare Service	Provision of Agency Nurses	$286,831.12	16-Feb-10	16-Feb-14	Yes	Mental Health trained Contractors
Staffing and Office Solutions Pty Ltd	Agency for Administrative Staff	$75,471.75	25-Mar-10	28-Feb-13	No	
Vedior Asia Pacific Pty Ltd t/a Ramstad Pty Ltd	Agency for Administrative Staff	$69,112.80	20-May-09	19-May-12	No	
Public Health Services (Output 1.4)						
Cancer Institute NSW	Health Survey Data Collection	$146,675.92	01-Jul-05	30-Jun-11	Yes	Specialised services
Building and Environmental Services Today	Food Premises Inspection	$49,760.00	07-Jan-11	30-Jun-11	Yes	Urgent need for services
Datacol Research Pty Ltd	2010 Midwives Data Processing	$27,515.35		Month to Month	Yes	Specialised services
Gammasonics Radiological Services Pty Ltd	Compliance Testing	$49,053.70	01-Jul-09	30-Jun-12	No	
NSW Department of Health	2010 ACT Health Survey	$83,772.73	01-Jul-09	30-Jun-12	No	
Simply Strategic	Facilitation, Planning and Organisational Development	$53,787.50	23-Dec-09	Ongoing	Yes	Specialised services

Name of Contractor	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Cancer Services (Output 1.5)						
Greater Southern Area Health Service	Provision of radiography services	$26,070.06	15-Dec-10	30-Jun-11	Yes	Expertise in field
Hays Specialist Recruitment	Provision of contract staff	$24,371.74		Month to Month	Yes	Expertise in field
South Eastern Area Laboratory Service	Contract laboratory services	$55,870.00	21-Sep-10	01-Jul-11	Yes	Expertise in field
Contractors distributed as Overheads of Outputs						
ACT Insurance Authority	Temporary support staff	$37,492.00		Month to Month	Yes	Expertise in field
Acumen Contracting and Recruitment Pty Ltd	Temporary staff recruitment	$157,162.50		Month to Month	Yes	Specialist knowledge
Australian National University	Salary & on-cost reimbursement to ANU for Prof Violeta Lopez	$137,230.46	01-Jul-10	30-Jun-11	Yes	Expertise in field
Australian National University	Contractual research affiliation with ANU	$287,644.97	30-Mar-10	Ongoing	Yes	Memorandum of Understanding
Calvary Health Care ACT Ltd	Resources for ACTPAS project at Calvary	$23,949.71		Month to Month	Yes	Expertise in field
Capital Day Surgical Centre	Delivery of elective surgery by private Practitioners	$507,367.00	01-Jul-10	30-Jun-11	Yes	Specialist Expertise
Chandler McLeod Ltd	Project manager and temporary staff recruited for E-rostering project	$30,454.53	01-Jul-10	30-Jun-11	Yes	Specialist Expertise
Cogent Business Solutions Pty Ltd	Audit of Perioperative Unit	$20,727.27	03-Sep-10	03-Sep-11	Yes	Specialist knowledge
Covance Pty Ltd	Statistical Services for the Academic Unit of General Practice & Community Health	$64,200.00	01-Jul-10	30-Jun-11	No	
Griffith Massage Centre	Remedial Massage	$47,378.00	01-Jul-10	30-Jun-11	Yes	Expertise and knowledge in relation to specific work related injuries
IBM Australia	E-health support	$48,000.00		Month to Month	Yes	Expertise in field
Intact	Outsourced IT provider of resources for E-Health project	$99,935.34	21-Jul-10	21-Jul-11	Yes	Preferred government provider

Name of Contractor	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Isoft Australia Pty ltd	Software developers for ACTPAS	$135,135.16	17-Mar-10	17-Mar-11	Yes	Specialist knowledge
National Health Call Centre Network Ltd	Participation in the National Call Network	$680,668.50	01-Jul-07	30-Jun-11	Yes	Preferred government provider
PCA People Pty Ltd	Preferred government provider for recruitment services	$95,784.54	09-May-09	08-May-12	No	
Resolutions International Pty Ltd	Temporary support staff for Medical Records	$52,213.40	19-Oct-10	19-Oct-11	No	
Rolls Filing	Clinical Coding Services for the Medical Records Department	$49,205.00	12-Aug-10	11-Aug-11	Yes	Preferred government provider
Yellow Edge Pty Ltd	Provision of Standard and Customised Training Courses	$57,970.71	11-Nov-08	10-Nov-11	No	

Consultants

Name of Consultant	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Individual contracts which exceed $20,000; and smaller contracts awarded to the same consultant which, in total, exceed $20,000.						
Consultant **- A person who has the knowledge and expertise to perform a task, project, or other which is not available within ACT Health and Produces a report, audit, investigation, or other to ACT Health or third parties.**						
Acute Services (Output 1.1)						
Paxus Australia Pty Ltd	Chronic Disease Management Register	$27,577.00	21-Sep-09	21-Sep-10	Yes	Specialist expertise
Walter Turnbull	Consultancy services	$29,070.00		Month to Month	Yes	Specialist expertise
Mental Health Services (Output 1.2)						
Burnet Institute for Medical Research and Public Health Ltd	Evaluation of Drug Policies and Services and their subsequent effects on Prisoners and Staff within the Alexander Maconochie Centre (AMC)	$69,890.62	18-May-10	15-Dec-10	No	

Name of Consultant	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Community Health Services (Output 1.3)						
Connetica Consulting Pty Ltd	Consultant to Facilitate the Community Mental Health Sector Review	$37,834.54	18-Mar-10	17-Sep-10	No	
Myndscape Consulting	RUSH Practitioner consultancy	$32,600.00	13-Sep-10	30-Sep-10	No	
Australian Healthcare Associates	Home and Community Care External Quality Appraisals	$23,727.27	01-Jan-09	31-Dec-12	No	
University of Canberra	Research on Breastfeeding Enablers, Barriers and Issues	$62,962.18	13-Jan-10	12-May-10	Yes	Expertise in field
Winangali Pty Ltd	Social Research for the Combined Social Marketing Campaign Regarding Tobacco and Healthy Lifestyle Behaviours of the Local Aboriginal and Torres Strait Islander Community	$27,293.00	25-Mar-11	15-Jul-11	Yes	Expertise in field
Public Health Services (Output 1.4)						
Canberra Property Management Pty Ltd	Professional Environmental Health Services	$84,585.42	01-Jul-10	30-Jun-11	No	
PriceWaterhouseCoopers	ACT WHP Needs Analysis	$46,700.91	14-Jun-10	14-Oct-10	No	
University of Canberra	Provision of Program Research and Evaluation Services	$44,472.72	01-Aug-10	30-Jun-11	Yes	Expertise in field
LeeJen Health Consultants Pty Ltd	Consultation—Youth Feasibility	$24,771.82	02-Nov-10	31-May-11	No	
Alcohol Tobacco and Other Drug Association Australian Capital Territory Incorporated	ACT Comorbidity Smokefree Pilot Project	$43,200.00	01-Jul-10	30-Jun-11	Yes	Expertise in field
Building and Environmental Services Today	State of Environment Report	$44,665.00	01-Jul-10	01-Jul-11	Yes	Expertise in field
Canberra Property Services Pty Ltd	Professional consultancy services on Property Management	$49,616.82		Month to Month	Yes	Expertise in field

Name of Consultant	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Cancer Services (Output 1.5)						
HBA Consulting	Review of organisational structures, systems and procedures	$27,250.00		Month to Month	Yes	Expertise in field
MA International	Consultancy in Cost Management and Diagnostic Review	$27,124.19	20-Oct-09	20-Oct-10	Yes	Expertise and project time constraint
Early Intervention and Prevention (Output 1.7)						
McKesson Asia-Pacific Pty Ltd	Clinical Decision-making Software	$202,901.00	26-Feb-10	26-Feb-11	Yes	Expertise in field and time constraints
Contractors distributed as Overheads of Outputs						
Acumen Control (Oakton Services)	Specialist IT consultant for the provision of Single Sign on Project	$116,212.50	21-Oct-08	20-Oct-11	No	
Australian National University	Dr Ian McRae—Health Economist, and Evaluation of Walk in Clinic.	23,070.45	01-Sep-10	30-Jun-11	Yes	Specialist Services
Black Circle	Classification Review	$52,420.00	22-Apr-11	31-Dec-11	Yes	Expertise in field
Cabrini Health	Review of R&M business arrangements within Business and Infrastructure Branch	$34,428.00	01-Sep-10	13-Oct-10	Yes	Specialist Experience
Calvary Health	Resources for Digital ICU Project	$173,332.23		Month to Month	Yes	Expertise in field
Centre for Public Management Pty Ltd	Executive coaching	$49,616.82		Month to Month	Yes	Expertise in field
Communio Pty Ltd	Provision of Chronic Disease Prevention Service	$37,818.17	22-Apr-09	21-Apr-12	No	
Delegate Healthcare Solutions Australia Pty. Ltd	Delegate Patients Services Software	$42,880.00	01-Apr-11	14-Feb-14	Yes	Specialist IT consultant
DH4 Pty Ltd	IM&IT Design project	$95,103.46		Month to Month	Yes	Specialist Services
Intact	ACT Chronic Disease Register Project Proposal	$112,321.00	10-Sep-10	10-Sep-11	No	
John Norman West QC	Provision of Legal Services	$26,313.00	21-Jun-10	21-Jun-11	Yes	Specialist services
Jon Graham Consulting	Organisational review	$170,972.66	04-Aug-10	10-Nov-10	Yes	Specialist services

Name of Consultant	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Kaizen Management	Provision of a Consultant to Undertake Safety Audits for ACT Health to Australian Standards 4801 and 4804	$61,394.00	01-Jul-10	31-May-11	Yes	Specialist Experience
Mercer (Australia) Pty Ltd	Job evaluation Services	$23,654.54	01-Jul-10	22-Dec-10	Yes	Specialist services
Mindpath Pty Ltd	Internal Investigations	$57,000.00	01-Jul-10	03-Nov-10	Yes	Specialist services
MKM Consulting	Provision of Diet Capture Screen & additional Validation Rules MESALS Software Licence and IT and Software Development for E-Health Projects and ACTPAS.	$173,950.00	04-Mar-10	04-Mar-11	Yes	Specialist expertise
National Health Reform Commission	Consultancy Services (B. Woodley)	$111,857.99	01-Jul-10	30-Jun-11	Yes	Expertise in field
Orion Health	Clinical Portal Improvement System	$1,089,628.93	31-Mar-10	31-Mar-11	Yes	Specialist IT and Software consultant
PolyOptimum Inc	ProAct Scheduling/ Rostering Software	$47,581.08		Month to Month	Yes	Specialist IT and Software Development for E-Health Projects
Public Health Association	Investigate a Trial Needle and Syringe Program in the Alexander Maconochie Centre	$31,425.00	06-May-11	31-Jul-11	Yes	Expertise in field
Stygron Systems	Consultancy Services for Supply Chain	$29,165.00	01-Jul-10	10-Sep-10	Yes	Expertise in field
Taleo	E-recruitment System	$138,385.45	17-Aug-09	Ongoing	No	
Third Horizon Consulting Partners Pty Ltd	Digital Health Enterprise Consultancy	$1,064,112.73	12-Dec-09	21-Dec-10	No	
Ultrafeedback Pty Ltd	ACT Health Consumer Satisfaction Survey	$137,206.00	25-Mar-09	24-Mar-12	No	
Unify Solutions Pty Ltd	Automation of Identity and Access Management (IAM) processes	$174,500.00		Month to Month	Yes	Specialist IT and Software Development for E-Health Projects
Wyagdon Enterprises Pty Ltd	Provision of Services—conducted Workshop for Risk Management	$25,781.86	19-Jul-10	19-Jul-10	Yes	Specialist services

Visiting medical officers

Title	Surname	First Name	Description of contract	Total Amount Paid (Excluding GST)	Date Contract Commences	Date Contract Expires
Acute Services (Output 1.1)						
Dr	Adham	Omar	VMO	$315,678.50	11-Jun-11	27-May-14
Dr	Albekaa	Safi	VMO	$85,963.77	01-Nov-07	01-Nov-14
Dr	Ashman	Bryan	VMO	$369,362.89	01-Sep-07	31-Aug-12
Dr	Aubin	Phil	VMO	$290,196.95	02-Aug-10	02-Aug-13
Dr	Auzins	Edwin	VMO	$39,981.45	01-Jul-08	01-Jul-11
Dr	Bassett	Mark (Mark Bassett Pty Ltd)	VMO	$140,348.73	25-Nov-09	25-Nov-16
Dr	Bihari	David (Melleray Pty Ltd)	VMO	$40,464.36	01-Jan-10	30-Jun-10
Dr	Bissaker	Peter	VMO	$414,498.16	01-Aug-08	01-Aug-15
Dr	Bradshaw	Stephen	VMO	$307,413.77	01-Aug-07	01-Aug-14
Dr	Brady	Marc	VMO	$42,246.77	30-Oct-10	29-Oct-11
Dr	Bromley	Jonathan	VMO	$135,772.73	01-Jan-11	31-Dec-14
Dr	Buchanan	Guy	VMO	$61,628.02	01-Dec-07	01-Dec-14
Dr	Burke	Bill	VMO	$131,958.10	02-Oct-10	02-Oct-13
Dr	Burns	Alexander	VMO	$283,655.41	01-Jun-08	01-Jun-15
Dr	Chapman	Peter	VMO	$115,032.22	01-Oct-07	01-Oct-14
Dr	Chong	Guan (Dr Guan Chong Pty Ltd)	VMO	$315,319.40	01-Jul-10	01-Jul-12
Dr	Choy	Ellis	VMO	$332,453.45	02-Apr-11	01-Apr-12
Dr	Clarke	Anthony	VMO	$222,316.32	07-Sep-10	31-Jul-14
Dr	Close	Susanne (Susie Close Pty Ltd)	VMO	$46,032.15	05-Oct-10	31-Jul-14
Dr	Crawford	Antony	VMO	$43,650.24	30-Nov-07	30-Nov-13
Dr	Crawshaw	Ian	VMO	$76,553.05	01-Oct-07	30-Sep-14
Dr	Crock	John (John Crock Pty Ltd)	VMO	$31,483.76	01-Apr-10	05-Jan-11
Dr	Damiani	Maurizio	VMO	$267,150.01	06-Jul-10	06-Jul-13
Dr	Davies	Stephen	VMO	$37,011.62	01-Mar-08	01-Mar-15
Dr	Davis	Ian	VMO	$198,098.31	01-Sep-07	01-Sep-14
Dr	Devine	Grant	VMO	$111,414.57	13-Sep-10	02-Aug-13
Dr	Dobson	Peter (Howard Dobson Pty Ltd)	VMO	$41,399.44	01-Apr-11	15-Apr-11

Title	Surname	First Name	Description of contract	Total Amount Paid (Excluding GST)	Date Contract Commences	Date Contract Expires
Dr	Dorai Raj	Anna	VMO	$157,208.05	01-Sep-07	01-Sep-14
Dr	Downes	Kenneth	VMO	$59,041.83	01-Aug-07	01-Aug-11
Dr	Drummond	Catherine	VMO	$40,580.37	01-Jul-10	01-Jul-11
Dr	Duke	David	VMO	$154,678.97	21-Jan-08	21-Jan-15
Dr	Ellingham	John	VMO	$206,844.15	29-Nov-09	29-Nov-16
Dr	Fahey	Caroline	VMO	$94,209.46	01-Sep-07	01-Sep-14
Dr	Freckmann	Mary-Louise	VMO	$71,835.73	01-Jul-08	30-Jun-15
Dr	French	James	VMO	$326,431.57	01-Sep-07	01-Sep-12
Dr	Fuller	John	VMO	$544,945.86	12-Nov-10	01-Aug-13
Dr	Gailani	Omar	VMO	$434,469.47	01-Jan-11	25-Feb-11
Dr	Gemmell-Smith	Nicholas	VMO	$55,282.77	01-Jun-08	01-Jun-15
Dr	Gillmore	Colin	VMO	$57,689.37	01-Feb-08	31-Jan-15
Dr	Halcrow	Stephen (Nenko Pty Ltd)	VMO	$400,777.73	12-Jul-10	13-Feb-11
Dr	Hardman	David	VMO	$341,267.97	01-Jul-08	01-Jul-15
Dr	Haxhimolla	Hodo	VMO	$168,806.22	01-Jul-10	01-Jul-13
Dr	Hehir	Andrew	VMO	$302,411.75	27-Jan-08	27-Jan-15
Dr	Hodge	Alexander	VMO	$23,933.17	20-Jun-11	19-Jun-12
Dr	Holz	Paul (Paul Holz Pty Ltd)	VMO	$125,675.30	02-Mar-11	01-Mar-14
Dr	Jeans	Phil	VMO	$186,697.02	07-Sep-10	01-Aug-12
Dr	Jonker	Benjamin	VMO	$73,013.55	07-Feb-11	06-Feb-12
Dr	Kaye	Graham	VMO	$251,745.52	07-Sep-10	30-Aug-14
Dr	Kim	James	VMO	$60,462.32	19-Jan-09	18-Jan-16
Dr	Kulisiewicz	Gawel	VMO	$304,252.89	07-Aug-09	07-Aug-15
Dr	Kwan	Bernard	VMO	$40,573.22	01-Sep-07	01-Sep-14
Dr	Lah	Frank	VMO	$435,214.95	01-Aug-07	31-Jul-11
Dr	Lang	Robert	VMO	$286,834.98	07-Sep-10	25-Jan-13
Dr	Lawson	Gerald (G.W. Lawson Pty Ltd)	VMO	$42,000.00	14-Mar-11	04-Jul-11
Dr	Lee	Elaine	VMO	$440,118.06	29-Oct-08	10-Oct-12
Dr	Lee	Tack-Tsiew	VMO	$75,701.46	01-Jun-08	01-Jun-15
Dr	Leerdam	Carolyn	VMO	$27,160.26	01-Jul-08	01-Feb-15
Dr	Lim	James	VMO	$117,252.77	30-Nov-10	29-Nov-13
Dr	Lu	Don Bunnag	VMO	$31,829.04	01-Dec-07	01-Dec-14
Dr	Major	Jennifer	VMO	$109,447.31	02-Nov-10	01-Nov-11
Dr	Malecky	George	VMO	$550,732.45	01-Nov-07	31-Oct-14

Title	Surname	First Name	Description of contract	Total Amount Paid (Excluding GST)	Date Contract Commences	Date Contract Expires
Dr	Marshall	Natalie	VMO	$350,268.13	01-Aug-07	31-Jul-14
Dr	May	Stewart	VMO	$60,919.01	01-Aug-07	01-Aug-14
Dr	McCarten	Greg (Gregory M. Carten Pty Ltd)	VMO	$398,416.18	23-Jun-11	22-Dec-11
Dr	McCredie	Simon	VMO	$129,443.62	01-Jul-10	01-Jul-13
Dr	McDonald	Tim	VMO	$138,565.12	01-Aug-07	01-Aug-14
Dr	McGuinn	Luke (L.J. McGuinn Pty Ltd)	VMO	$80,338.81	04-Apr-11	26-May-11
Dr	McInerney	Carmel	VMO	$70,331.33	01-Jun-08	01-Jun-12
Dr	Meares	Nicola	VMO	$42,431.92	24-Aug-10	30-May-13
Dr	Melhuish	Nicholas	VMO	$248,085.95	01-Oct-07	01-Oct-14
Dr	Merchant	John (Merdon Pty Ltd)	VMO	$172,854.99	20-Jan-11	19-Jun-11
Dr	Miller	Andrew	VMO	$45,841.66	30-Nov-10	29-Nov-13
Dr	Milovic	Vladimir	VMO	$18,395.84	28-Feb-11	27-Feb-14
Dr	Morrissey	Phillip (Dr P. Morrissey Pty Ltd)	VMO	$139,352.35	01-Nov-10	01-Nov-13
Dr	Mosse	Charles	VMO	$219,644.44	05-Apr-11	30-Nov-13
Dr	Mulcahy	Maurice	VMO	$246,176.05	01-Jan-09	31-Dec-15
Dr	Nadana Chandran	Kathiravelpillai	VMO	$358,486.02	09-Jun-07	08-Jun-10
Dr	Nicholls	Anthony John	VMO	$137,491.93	03-May-06	03-May-13
Dr	O'Connor	Simon	VMO	$246,810.98	01-Oct-07	30-Sep-14
Dr	Okera	Salim	VMO	$66,464.16	12-Apr-10	12-Apr-17
Dr	Patel	Chandra	VMO	$146,968.65	01-Nov-07	31-Oct-14
Dr	Peady	Clifford	VMO	$235,727.29	24-Aug-10	01-Aug-14
Dr	Peake	Ross	VMO	$229,378.11	22-Jul-10	22-Jul-13
Dr	Pham	Tuan	VMO	$232,639.18	01-Jun-08	01-Jun-13
Dr	Ponniah	Senthan	VMO	$50,890.93	24-Jan-11	23-Jan-14
Dr	Powell	Suzanna	VMO	$55,777.75	01-Jun-08	31-May-15
Dr	Rangiah	David	VMO	$163,124.02	01-Feb-08	01-Feb-15
Dr	Riddell	James (J. Riddell Pty Ltd)	VMO	$22,410.21	10-Dec-09	30-Nov-14
Dr	Roberts	Chris	VMO	$108,440.95	01-Nov-07	01-Nov-14
Dr	Robertson	Tanya	VMO	$98,337.45	01-Jun-08	01-Jun-15
Dr	Rosier	Michael	VMO	$93,648.71	01-Aug-07	01-Aug-14
Dr	Sharma	Divya	VMO	$50,000.00	29-Nov-03	28-Nov-10
Dr	Simpson	Erroll	VMO	$353,352.20	01-Nov-07	31-Oct-14

Title	Surname	First Name	Description of contract	Total Amount Paid (Excluding GST)	Date Contract Commences	Date Contract Expires
Dr	Smith	Paul	VMO	$365,569.18	02-Feb-11	01-Feb-14
Dr	Smith	Damian	VMO	$246,566.76	01-Jul-08	01-Jul-15
Dr	Smith	Denis	VMO	$354,992.28	26-Mar-11	21-Apr-11
Dr	Stone	Hilton	VMO	$125,652.06	01-Feb-11	31-Jan-14
Dr	Storey	Desmond	VMO	$30,176.05	30-Nov-10	29-Nov-13
Dr	Subramaniam	Peter	VMO	$210,653.44	02-Dec-10	02-Sep-13
Dr	Tharion	John	VMO	$301,467.67	01-Aug-07	01-Aug-12
Dr	Thomson	Andrew	VMO	$409,140.35	01-Oct-07	01-Oct-14
Dr	Thomson	Graeme	VMO	$129,965.91	01-Mar-10	13-Jan-17
Dr	Tin	Stephen	VMO	$39,083.75	01-Sep-07	01-Sep-14
Dr	Tsai	Nicholas (Yi-Chung Pty Ltd)	VMO	$523,605.86	25-Aug-10	08-Apr-17
Dr	Tymms	Kathleen	VMO	$112,399.70	01-Sep-07	01-Sep-14
Dr	Vrancic	Sindy	VMO	$189,984.54	01-Sep-09	01-Sep-16
Dr	Williams	Hugh	VMO	$88,928.72	01-Oct-07	01-Oct-12
Mental Health Services (Output 1.2)						
Dr	Adesanya	Adesina	VMO	$198,669.24	14-Oct-10	13-Oct-11
Dr	Behrens	Raymond	VMO	$50,050.97	02-Jul-11	01-Jul-12
Dr	Fernando	Noel	VMO	$155,290.41	05-Nov-10	04-Nov-11
Dr	Fitzgerald	Paul	VMO	$166,510.65	01-Aug-07	01-Aug-14
Dr	George	Graham	VMO	$241,803.19	01-Dec-07	01-Dec-12
Dr	Henderson	A Scott (A.S. Henderson Pty Ltd)	VMO	$216,662.23	01-Nov-07	31-Oct-14
Dr	Kasinathan	John	VMO	$282,227.53	01-Jul-08	01-Jul-15
Dr	Manoharan	Jayaseelan Augosten	VMO	$132,305.45	07-Mar-11	01-Jul-11
Dr	Narayanan	Manoj (Coastech Ventures Pty Ltd)	VMO	$163,475.75	02-May-11	01-May-12
Dr	Owen	Cathy	VMO	$73,447.69	01-Nov-07	01-Nov-14
Dr	Paull	Annita Dagmar	VMO	$213,967.48	06-Jan-11	05-Jan-12
Dr	Raymond	Judy	VMO	$169,492.70	01-Oct-07	01-Oct-14
Dr	Westcombe	David	VMO	$126,799.08	30-Nov-10	30-Nov-13
Dr	Wurth	Peter	VMO	$68,833.58	01-Feb-08	31-Jan-15

Title	Surname	First Name	Description of contract	Total Amount Paid (Excluding GST)	Date Contract Commences	Date Contract Expires
Community Health Services (Output 1.3)						
Dr	Bromley	Jennifer	VMO	$26,127.49	06-Feb-10	06-Feb-14
Dr	Eldridge	James Neil	VMO	$56,007.57	01-Feb-10	01-Feb-17
Dr	Morris	Philip	VMO	$98,210.35	27-Jan-11	26-Jan-12
Cancer Services (Output 1.5)						
Drs	Applied Imaging Pty Ltd	(Elizabeth Lim, Warwick Lee and Nigel Hunter)	VMOs	$109,637.35	01-Sep-08	01-Sep-15
Dr	Bell	Susanne	VMO	$164,043.15	10-Nov-09	10-Nov-11
Dr	Buckingham	John (John M. Buckingham Pty Ltd)	VMO	$25,230.32	01-Sep-08	01-Sep-15
Dr	Hazan	Georges	VMO	$413,757.09	01-Sep-08	01-Sep-15
Dr	McDonald	Anne	VMO	$50,240.15	12-Apr-11	30-Jun-11
Dr	Price	Jeremy	VMO	$327,784.84	01-Jan-08	01-Jan-11
Aged Care and Rehabilitation Services (Output 1.6)						
Dr	Mathew	Laji (L. Mathew Pty Ltd)	VMO	$78,742.68	01-Oct-09	01-Oct-12
Dr	Speldewinde	Geoffrey	VMO	$46,762.00	01-Nov-07	01-Nov-14

C.15
Community grants, assistance & sponsorship

In 2010–11, the Health Directorate provided grants, assistance and sponsorship to various organisations as set out in the following tables.

The outcomes of the grants, assistance and sponsorship provided in 2010–11 will be reported in the 2011–12 annual report due to reporting timeframes.

2010–11 Community Funding Round

The function of the Community Funding Round (CFR) is to fund activities related to the promotion of health across the population, founded on consistent healthy lifestyle messages, particularly in relation to physical activity and nutrition. Through the CFR, the Health Directorate Promotion Grants Program aims to increase the capacity of individuals and the community to control the factors that determine health. Projects funded through the CFR are expected to adopt the principles and practices of health promotion.

Organisation/recipient	Project description/process/period of time engaged	Amount
A Gender Agenda	Strength in Diversity—Building a Healthy Sex Gender Diverse Community	$69,000
A Gender Agenda	Strength in Diversity—Sex and Diversity Info Pack for individuals, health and community services	$35,000
Advocacy for Inclusion	Where's my 2 and 5? (Phase 2)	$87,802
AIDS Action Council of the ACT	Give yourself a pay rise! Quit Smoking	$7,000
Anglicare Canberra and Goulburn	Building Community Understanding of Mental Health and Wellbeing	$21,780
Arthritis ACT	Arthritis & Osteoporosis Amelioration Pilot Project Sustainability	$18,275
Burrunju Aboriginal Corporation	Carer Support: Social and Emotional Wellbeing	$53,080
Canberra Dance Theatre	Growing Old Disgracefully	$11,498
Canberra Environment & Sustainability Resource Centre	Calvary Hospital 'Eco Therapy' Mental Health Garden	$34,261
Canberra Firebirds Gridiron Club	Firebirds Team Spirit	$7,500
Canberra Institute of Technology (CIT)	Opportunities for Smoking Cessation for CIT Vocational College Students	$6,500
Canberra Mothercraft Society Inc.	Expanding into the Relaxing into Parenting Program	$44,251
Cancer Council ACT	ACT Vulnerable Youth: Reducing Chronic Disease Risk Factors	$124,973
Cranleigh School	'Generation Jumble'—students with a disability/mainstream, aged care residents interacting	$14,049
Diabetes Australia ACT	The Indigenous Community Nutrition Project	$23,388
Directions ACT	Healthy Food, Healthy Me	$46,400
Flyers Netball Club Incorporated	First Aid	$1,002
Headspace ACT	Connected—Mental Health and Wellbeing	$106,626
Heart Foundation ACT Division	Walk Canberra Web Portal	$27,340
Mental Health Carers Network	Peer Support Program for mental health carers	$7,300

Organisation/recipient	Project description/process/period of time engaged	Amount
Mental Illness Education ACT	Hang on to This—A Classroom Resource for the School Education Program	$23,000
Mental Illness Fellowship Victoria	Well Ways MI Recovery Program	$25,000
Ngunnawal Aboriginal Corporation	Aboriginal Health and Healing	$20,500
Noah's Ark Resource Centre Incorporated	Yoga for parents of young children with a disability	$28,622
OzHelp Foundation	Tradies Tune Up	$98,000
Picking Up the Peaces	PTSD Education Program Pilot	$31,350
Royal Life Saving Society ACT	Ngadyung—ATSI Aquatic Recreation Program	$98,522
Scouts ACT	Mental Health Training	$19,020
SHOUT Inc	Self-help support groups awareness week —helping each other to help ourselves	$9,470
Tandem Respite	Recreational Activities Program	$10,000
The Connection	Deadly Family BBQ and Art Attack	$30,000
Woden Community Service Inc.	Sharing Innovative Practice: Nutrition Program for Staff and Clients	$6,600
Women's Centre for Health Matters (WCHM) Inc.	Peer support for women living with mental health issues	$28,489
YMCA of Canberra	Positive Steps—Tuggeranong	$14,373
YMCA of Canberra	Rhyming Connections—A Parent—Child Mother Goose Program	$35,740
YWCA of Canberra	The ACT Walking School Bus Program	$90,156
36 projects		**$1,315,867**

2010–11 Stay On Your Feet® Funding Round

The role of the Health Directorate Promotion Grants Program in falls prevention is to deliver a funding round to assist community-based groups, not-for-profit organisations, residential aged care facilities and government agencies to reduce the incidence and severity of falls and falls injuries among older people in the ACT. Funding is provided for the development, implementation and evaluation of falls prevention programs.

Organisation/recipient	Project description/process/period of time engaged	Amount
Arthritis ACT	Helping people with musculoskeletal conditions to stay on their feet	$21,993
Diabetes Australia ACT	Diabetes Education and Falls Prevention Exercise in High Risk Populations	$9,970
Goodwin Aged Care Services Ltd	Goodwin Falls Prevention Program	$126,776
Multiple Sclerosis Ltd	Tai Chi for Health and Balance	$9,350
Southside Community Services	Falls Prevention for a CALD Population	$36,076
5 projects		**$204,165**

2011 Healthy Schools, Healthy Children Funding Round

Working in collaboration with the Education and Training Directorate, the Health Directorate Promotion Grants Program delivers the Healthy Schools, Healthy Children Funding Round, the aim of which is to provide children and young people with the knowledge, skills, responsibility and resources to live a healthy, active life through improved physical activity and healthy eating. The funding round also aims to build communication, collaboration and partnerships between schools and their communities. The Health Directorate Preventative Health—Healthy Futures Budget Initiative 2009–2012 supplemented funding of the Healthy Schools, Healthy Children Funding Round in 2011.

Organisation/recipient	Project description/process/period of time engaged	Amount
Ainslie School	Activity and Eating Well in the Great Outdoors	$8,900
Amaroo School	Amfit, AmHealth Program	$13,595
Belconnen High School	Belconnen Fitness Frenzy	$3,884
Calwell Early Childhood Centre	Vegetable Garden	$3,000
Calwell Primary School	The Earth as our Guide to Healthy Living	$7,738
Canberra Environment & Sustainability Resource Centre	Grow Together	$13,520
Caroline Chisholm School	Outdoor Education Program	$9,960
Charnwood—Dunlop School	Climbing for Better Health	$10,000
Companion House	Healthy Start in our New Home	$30,000
Gilmore Primary School	Healthy Kids, Healthy Families	$32,023
Giralang Primary School P&C Association	Keeping our Menu Green	$9,999
Good Shepherd Catholic Primary School	Vegetable Garden	$8,000
Good Shepherd Catholic Primary School	Safety Sporting Equipment for our School	$2,556
Gordon Early Childhood Centre	Building Physical Activity through 'Active Play'	$3,000
Gowrie Primary School	Promoting Positive Play	$2,022
Harrison School	Sports Ability 2 Kit	$2,080
Heritage Early Childhood Centre	Fit Beginnings—Big Steps for Small Bodies	$3,000
Jervis Bay School	Jervis Bay School Kitchen Garden Project	$16,400
Koala Playschool Inc.	Koala Healthy Kids	$3,000
Koori Preschool	Healthy Habits	$900
Kulture Break	Get Up and Party 2—Dance Sessions	$5,750
Malkara School	Active Playtime Activities	$4,079
Mawson Primary School	Increasing Physical Activity Opportunities for Students	$1,222
Merici College	Eat, Move, Live	$28,670
Migrant and Refugee Settlement Services (MARSS) of the ACT Inc.	Dig in Program (DIP)	$5,216
Nipperville Early Learning Centre	In Our Garden	$2,059

Organisation/recipient	Project description/process/period of time engaged	Amount
North Belconnen Community Association	Veggie Garden	$852
Northside Community Service	From the Garden to the Table	$2,383
Snow Gum Early Childhood Learning Centre	Get a Move On—Active Play	$1,750
Southside Community Service	Creating Healthy Children with Healthy Gardens	$38,616
St Monica's Primary School	Enhancing Physical Activity Opportunities and Programs	$2,224
Theodore Primary School	Life Skills Program	$4,200
Torrens Primary P-6 School	Eat Well, Live Well	$3,508
Turner School	Turner Bootcamp	$2,833
Village Creek Autism Early Intervention Unit	Yoga	$1,280
Wanniassa School	Wanniassa Cycling Group	$7,021
Wanniassa School	Boyzdance	$3,000
Woden Community Service—Lollipop Children's Centre	Yummy Food, Busy Play	$1,869
Yarralumla Primary School Parents and Citizens Association	Improved Outdoor Amenities Including Monkey Bars	$10,000
Yarralumla Primary School Parents and Citizens Association	Curriculum-Based Kitchen Garden	$25,000
YMCA of Canberra	YMCA Healthy Kids Week	$23,626
41 projects		**$358,735**

2010–11 Health Promotion Sponsorship Funding Round

One of the ways the Health Directorate Promotion Grants Program contributes to good health in the community is through the sponsorship of sports, recreation, and arts and cultural activities.

Health promotion sponsorships are a partnership between an organisation or an event in which the ACT Government, as the sponsor, publicly endorses the organisation or event and ties its reputation to that of the organisation or event being sponsored. A sponsorship is a commercial agreement that benefits both the organisation and the sponsor (in this case, the ACT Government) in their shared effort to promote health and wellbeing in the ACT community.

One of the main aims of a sponsorship is for the sponsored organisation to deliver a priority health message to their participants. The priority taglines for 2010–11 were:

- smoking reduction
- physical activity
- healthy eating
- water as the drink of choice.

In addition to the main goal of promoting a key health message, organisations are asked to create healthy environmental change by addressing such issues as equity and access, smoke-free areas, alcohol and other drugs, healthy catering, sun protection, injury prevention and 'No Waste' practices. In this way, the organisation is working towards becoming a health-promoting organisation.

Organisation/recipient	Amount
ACT Community Arts Office	$10,000
ACT Cricket Association	$10,000
AFL Masters	$10,000
AFL NSW/ACT	$20,000
Ausdance ACT	$20,000
Australian Institute of Aboriginal & Torres Strait Islander Studies (AIATSIS)	$20,000
Basketball Canberra	$10,000
Canberra Dragon Boat Association	$10,000
Canberra Raiders P/L	$20,000
Canberra Youth Theatre Co Inc.	$10,000
Capital Football	$10,000
Females In Training (FIT)	$30,000
Gugan Gulwan	$10,000
Jigsaw Theatre Company	$10,000
Migrant and Refugee Settlement Services (MARSS)	$10,000
Mpowerdome P/L	$20,000
Music For Everyone	$10,000
Onside Management P/L	$10,000
Orienteering ACT	$10,000
Pedal Power ACT Inc.	$20,000
QL2 Centre for Youth Dance Inc.	$20,000
Touch Football Australia	$10,000
Transplant Games	$50,000
Triathlon ACT Inc.	$20,000
Vision Impaired Sport ACT	$10,000
YMCA of Canberra	$20,000
26 sponsorships	**$410,000**

2010–11 Communication and learning and development

The Health Directorate Promotion Grants Program supports funded organisations through the Learning and Development Program by building ongoing capacity for health promotion delivery. In 2011, individuals and organisations interested in health promotion were given the opportunity to apply for sponsorships to attend the Australian Health Promotion Association 20th National Conference. The sponsorships covered the costs of registration, airfares and accommodation for the conference. Other learning opportunities included offering training to all successful grant applicants in Project Planning.

Organisation/recipient	Amount
Health Coaching Course	$19,298
Health Promotion Short Course	$20,632
Project Planning Training	$2,818
7 x sponsorship to attend Australian Health Promotion Association 20th National Conference 2011	$10,661
10 x sponsorship to attend ACT Council of Social Service Grant Writing Workshop	$618
5 projects	**$54,027**

2010–11 Research and evaluation

In 2010–11, funding was administered to the Centre for Research and Action in Public Health (formerly known as the Healthpact Research Centre for Health Promotion and Wellbeing) to evaluate health promotion projects and health research programs and establish new linkages with provider groups.

Organisation/recipient	Amount
CeRAPH	$186,324
1 project	**$186,324**

C.16 Territory records

Records Management Program

The Health Directorate's Records Management Program, approved by the Chief Executive of ACT Health in June 2009 and lodged with the Director of Territory Records, continues to be the instrument that the Health Directorate works under.

Records management procedures

The Records Management Program comprises the agency's policy statement supporting good records management practices and a comprehensive procedures manual, both of which are accessible to all staff on the intranet.

The Health Directorate's Records Management Policy was reviewed and updated in February 2011.

A review of the health records management procedures and guidelines manual is being undertaken in conjunction with the development of a Records Management e-Learning package.

Training

Throughout 2010–11, the policy and procedures were promoted to agency staff through formal and in-the-workplace training and education sessions. These are listed in the table below.

No.	Training / Education
4	Manager orientation programs conducted through Health Directorate Staff Development Unit (half-hour session presented)
2	Records management staff continued studies for the Certificate III in Recordkeeping
63	TRIM System User training sessions
606	Health Directorate staff attended workplace recordkeeping training sessions

Records Disposal Schedules

The Health Directorate's functional thesaurus includes 16 administrative functions common across the ACT Government and nine health-specific functions.

Further health-specific Records Disposal Schedules are under development for 2011–12 with the assistance of the Territory Records Office.

Preservation of Aboriginal and Torres Strait Islander information

Administrative records managed through the agency's Records Management Centre and involving Aboriginal and Torres Strait Islander people mainly belong to the general record series about Health Community Programs, Welfare and Health Issues and Policy rather than to a discrete series about Indigenous people.

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

Public access to Territory records

In 2010–11, the Health Records Management Centre continued to liaise closely with the Territory Records Office's Reference Archivist in response to public access requests under section 28 of the Territory Records Act 2002. There were seven requests for access to records.

C.17
Human Rights Act 2004

The Health Directorate is committed to building a human rights culture in the delivery of health services and to ensuring that Health Directorate managers are working within a human rights framework. Staff of the Health Directorate continue to be supported in their access to internal and external training opportunities relating to human rights issues. The Human Rights Commission provides regular training sessions on human rights issues for all Health Directorate employees, which are widely advertised within the directorate. Further dissemination of human rights training is undertaken by directorate staff using a 'train the trainer' approach. Staff are encouraged to attend training sessions, which are provided to them free of charge. In addition, representatives of the Human Rights Commission attend both Health Directorate managers and staff orientation induction modules and provide information on the human rights responsibilities of staff.

In addition to this training, 82 staff participated in the *Human Rights Act* for Managers course provided by internal trainers. A mixture of senior managers, policy officers, administrative and clinical staff attended the course. The breakdown for attendance in 2010–11 was one Senior Specialist, 13 Administrative Service Officers, 21 Senior Officers, 30 Health Professional Officers and 17 Registered Nurses.

The Health Directorate, in conjunction with the Human Rights Commission, has updated two brochures dealing with the *Health Records (Privacy and Access) Act 1997*. These brochures have been instrumental in providing consumers and record keepers with information about their rights and responsibilities under this legislation. The right to privacy of individuals regarding their health records and personal health information is an important human right protected by this legislation. In addition, the Health Directorate has been developing a Charter of Rights for People who Experience Mental Health Issues, which, when completed, will be made available to the general public and will help consumers better understand their rights, including human rights.

Liaison with the Human Rights Unit of the Justice and Community Safety (JACS) Directorate is initiated where staff experience uncertainty about human rights issues in the development of legislation and for the routine vetting of draft bills. Issues identified in any Health Directorate bills as a result of the Legislative Assembly's scrutiny process are also brought to the attention of relevant staff. In 2010–11, the Health Directorate prepared 25 Cabinet submissions and, of these, one related to a legislative proposal for which a human rights compatibility statement was issued. There were no unresolved issues regarding human rights requiring further consultation with the Human Rights Unit of the JACS Directorate.

All health legislation has been audited for consistency with the *Human Rights Act 2004*. The majority of legislation was found to be consistent with the principles and rights protected in the Act. Where it was found that the legislation was inconsistent, amendments were made. The remaining outstanding matters covered by the legislation audit are being implemented as part of legislative reviews undertaken periodically by the Health Directorate.

This year, for example, the Health Directorate continued its major review of the *Mental Health (Treatment and Care) Act 1994*, which engages a number of significant human rights issues. These issues are being addressed as part of this review. Likewise, the *Transplantation and Anatomy Act 1978*, which was also identified as requiring legislative review as a result of the human rights audit, has been subject to further consideration under the national reform package on organ and tissue donation for transplantation. The Health Directorate is working with the Australian Organ and Tissue Donation and Transplantation Authority to identify legislative barriers to improving organ and tissue donation rates in the ACT while at the same time balancing important human rights issues in the formulation of any recommendations for legislative changes.

In 2010–11 the Health Directorate was not a party to any litigation that involved major human rights issues.

C.18
Commissioner for the Environment

The recommendations made by the Commissioner for the Environment in the State of the Environment Report 2008 relating to health matters are:

- The community is kept informed and engaged in processing the implementation of key Government community strategies including (inter alia):
  (a) A New Way—Aboriginal and Torres Strait Islander Health and Family Wellbeing Plan 2006–11

- Community wellbeing and safety is strengthened by (inter alia):
  (b) Encouraging community health programs, particularly those aimed at exercise, healthy eating, mental wellbeing, and minimising excessive alcohol consumption.

The Government agreed to both recommendations by the Commissioner. The Health Directorate has already established mechanisms to keep the public informed of progress against A New Way — Aboriginal and Torres Strait Islander Health and Family Wellbeing Plan 2006 11.

The ACT Aboriginal and Torres Strait Islander Health Forum—which includes representation from Winnunga Nimmityjah Aboriginal Health Service, the Aboriginal and Torres Strait Islander Elected Body, the Health Directorate, the Commonwealth Government and the ACT Division of General Practice—has been tasked with delivering on the objectives of the plan and is kept informed about the Health Directorate's progress against relevant actions within A New Way.

The Health Directorate had already initiated a number of measures to improve community health in line with the Commissioner's second recommendation relating to health services. These include the:

- *Measure-Up* campaign, which raises awareness of the importance of maintaining a healthy weight in the prevention of chronic disease. Phase 2 of the campaign commenced in 2010, with the slogan 'Swap it. Don't stop it'. This campaign encourages people to make sustainable, incremental changes in their lifestyle choices
- *Go for 2 & 5* campaign, which promotes the importance of fruit and vegetable intake in a healthy diet
- *Find 30* campaign, to increase awareness of the need for regular exercise
- *Kids at Play* program, which provides organisations responsible for early childhood services with support to promote the five key messages for early childhood healthy habits. These messages are: breastfeeding, switch to play and reduce screen time, drinking tap water (and limiting sweet drinks), consuming fruit and vegetables and active play
- *Better General Health* program for people with mental illness, which provides clients who have chronic mental health issues with a range of general health interventions such as immunisations, health screening and prevention messages
- *Dry July* initiative, which benefits the ACT by raising funds for oncology services at the Canberra Hospital from people who give up alcohol for the month of July
  The program also provides details of the benefits of stopping, or at least minimising, alcohol consumption. The Health Directorate actively supports the campaign
- funding of a range of community organisations to provide mental health wellbeing programs, community education in relation to mental illness, crisis management and suicide prevention education, mental health education for schools, support for mental health advocacy services and mental heath psychosocial rehabilitation services
- participation in national initiatives such as *Protect your child from swine flu* campaigns
- *Tap into Water* initiative, which promotes water as the drink of choice

- funding of the *Active Living Project,* with Heart Foundation ACT, which encourages the incorporation of town planning and urban design principles to help tackle preventable health issues
- provision of a free information and telephone-based health coaching service.

All of these campaigns are supported through information on the Health Directorate website and through a range of media, including television, radio and print advertising.

The Health Directorate also produces a regular report on the health of our community through the Chief Health Officer's Report. This biennial report provides an indication of the effectiveness of community health campaigns by providing data against a range of indicators, such as life expectancy, exercise levels and immunisation rates.

Commissioner's State of the Environment Report 2011

During the year, Health Directorate staff responded to the Commissioner for Sustainability and the Environment's request for input into the 2011 State of the Environment Report. Health Directorate staff also participated in peer review meetings to comment on the consultant's draft report against four indicator clusters.

C.19
ACT Multicultural Strategy 2010–13

Focus Area	Progress
Languages	ACT Health continued to promote service accessibility to people with multicultural backgrounds through a range of language-targeted activities, including: • the provision of interpreter services at the Migrant Health Unit. This year the unit provided 1169 interpreter consultations in various languages, including Bosnian, Croatian, Serbian, Cantonese, Mandarin, Spanish and Vietnamese • the publication of translated material about key services • the provision of advice to the Office of Multicultural Affairs about Health Directorate translated information. Health Directorate staff who do not speak English well continue to be able to access appropriate support in the workplace on request. Managers and support staff assist staff from multicultural backgrounds to understand corporate programs, policies and expectations. The Health Directorate provides an allowance to staff who are able to communicate with clients in languages other than English. The directorate also encourages staff to use interpreters through the Migrant Health Service and through the national Translating and Interpreting Service. **Key Performance Indicator (KPI)—100 per cent of ACT Government publications include accessibility block information, that is information in alternative formats such as other languages** 100 per cent of Health Directorate publications (but not all posters, because of space limitations) include 'accessibility block' information. Translated documents, including alternative formats such as large print or audio, can be requested by the client. The Office of Multicultural Affairs is informed accordingly.

Focus Area	Progress
Children & Young People	The Health Directorate continued to promote and support health, wellbeing and social participation of children and young people with multicultural backgrounds through a range of activities. Examples include: • grants to support Companion House Assisting Survivors of Torture Inc. In providing primary health care services and improving mental health and wellbeing of refugees and migrants. A bridging program at Dickson College is available for refugee students who are at least 16 years old. Students can study Year 11 and 12 over three years. The program includes English as a second language and information communications technology support, mentoring, cultural orientation and life skills. The Health Directorate also has funded a one-off project called 'Healthy Start in Our New Home' to help the refugee students (including high school students) and their families understand the importance of nutrition, hydration and physical activity in their new cultural context • improving access to services that support the mental health of children, such as providing training to Youth Coalition about transcultural mental health issues; promoting an integrated message about the importance of good mental and physical health at schools and prominent youth events, such as Soccer for Life Multicultural Day; providing translated information for use by culturally and linguistically diverse (CALD) children of parents with mental illness (COPMI) families and service providers; and providing CALD-trained Child and Adolescent Mental Health Service clinicians at Headspace ACT. Headspace ACT provides support for people aged 12 to 25 years who are experiencing emotional or mental health issues and/or a substance use issue. • funding for health promoting activities for young people from culturally and linguistically diverse backgrounds. The Directorate's Health Promotion Funding Round funded the Migrant and Refugee Settlement Service to train young men in basketball skills and gain confidence in mainstream community. **KPI—Number of young people born in countries other than Australia accessing Mental Health ACT Child and Youth Mental Health Services.** In 2010–11, 28 children from 0 to 17 years from CALD backgrounds and 97 youths from 18 to 25 years from CALD backgrounds accessed these services. This represented 2.8 per cent and 7.5 per cent respectively of users of these services.
Older people and aged care	The Health Directorate continued to provide a range of mechanisms and strategies to support older people from multicultural backgrounds to participate in recreational activities and achieve a positive sense of mental health and wellbeing. Examples include: • multicultural representation and consultation about services for older people—for example, the Carers ACT Seniors CALD carers group • continued provision of translated information about services for older people • the provision of advocacy opportunities (e.g. the Canberra Multicultural Community Forum and Council on the Ageing Senior Citizens Expo) through seniors networks • embedding of the consultation and liaison role of the ACT Transcultural Mental Health Liaison Officer in the mental health sector, and providing advice on the Transforming Perceptions anti-stigma program • educating the aged CALD community on how to manage their foot health with confidence. The Footsure Podiatry Health Promotion Program provides educational resources, including a DVD with subtitles in Italian and Mandarin languages. The program is being reviewed to ensure it is meeting the needs of the CALD community. In 2010–11 the program was delivered to Indian, Spanish, Vietnamese, Chinese, Tamil, Italian, Tongan/Samoan and Polish communities • health promotion funding of non-government organisations to educate the aged in Spanish, Chinese and Croatian groups in falls prevention. The Health Directorate's Division of Rehabilitation, Aged and Community Care has two dedicated positions targeting CALD population and issues: the Community Partners Program (CPP) officer and the Partners in Culturally Appropriate Care officer. Staff coordinated information seminars, which interpreters helped to deliver. They also translated the information, which was distributed to communities afterwards.

Focus Area	Progress
	Initiatives included: • developing a resource that lists bilingual general medical practitioners • participating in interagency meetings such as the Asian Women's Friendship Association • training and placing CALD volunteers at residential aged care facilities • conducting a survey of CALD client use of residential aged care facilities and community aged care packages, and of the CALD staff involved in delivering these services. **KPI—Number of training sessions provided through the Aged Care Rehabilitation Services ACT Health.** A total of 249 face-to-face hours of training in cultural competency were delivered to staff at residential aged care facilities and 27 aged care information sessions for CALD community groups were delivered.
Women	The Health Directorate has continued to address the specific needs of women from multicultural backgrounds by: • ensuring that CALD women representing peak women's organisations are members of the Transcultural Mental Health Network, which is a voluntary group committed to improving mental health and wellbeing of people from CALD backgrounds by distributing information and influencing policy and attitudes across government and the community with the assistance of the Transcultural Mental Health Liaison Officer • promoting the Women's Health Service, which understands how disadvantage and vulnerability contribute to poor physical and emotional health. Priority is given to women who experience significant barriers to accessing health services, including language and culture. It provides Well Women Checks (aimed at helping women stay healthy) and nursing, medical and counselling services • offering a screening mammography service that is free to all women over 40 years old. BreastScreen ACT recommends regular screening of the target group—women aged 50–69 years– and has been effective in reducing deaths from breast cancer through early detection. Women are directed as necessary to the Cancer Australia website, which has information in Arabic, Chinese, Greek, Italian and Vietnamese. Staff at BreastScreen ACT were trained by the Canberra Multicultural Forum on the needs of the CALD community. **KPI—Number of women born in countries other than Australia attending programs developed or adapted to help meet the mental health needs of women from multicultural backgrounds** In 2010–11, 463 CALD women (16.7% per cent of all clients) accessed these services. **KPI—Proportion of clients attending Well Women's Checks at the Women's Health Service from multicultural backgrounds** In 2010–11, 462 CALD women (30 per cent of all clients) accessed this service. **KPI—Percentage of women with multicultural backgrounds in the BreastScreen ACT Program** In 2010–11, 1132 CALD women (6.4 per cent of all clients) accessed the ACT BreastScreen service.
Refugees, asylum seekers and humanitarian entrants	The Health Directorate continued meet the needs of refugees, asylum seekers and humanitarian entrants by providing access to health and wellbeing services so that this target group can maintain their dignity and physical and mental health. It did so by: • continuing to provide Medicare-ineligible asylum seekers with the same access as Health Care Card holders to public dental and community health services • collaborating with the Commonwealth Department of Immigration and Citizenship in accommodating the housing and health care needs of an additional 50 immigration detainees in the ACT community in 2011–12. This Expansion of Resident Determination Program will be fully funded by the Commonwealth • ensuring that there are advocacy opportunities for asylum seekers and refugees on the Transcultural Mental Health Network through the membership of Companion House Assisting Survivors of Torture Inc. Most people requiring transcultural services are asylum seekers or are from a refugee background.

Focus Area	Progress
	KPI—Develop data sets to record the number of consultations with refugees/ asylum seekers/immigration detainees/humanitarian entrants provided by ACT public hospital services by 2011 Developing and collating these datasets has proved to be too complex to include them this year. The Health Directorate is planning to hold discussions with the Health Directorate Data Management Committee to identify how the number of consultations provided by ACT public hospital services can be captured for each financial year.
Intercultural harmony and religious acceptance	The directorate promoted or conducted general programs for staff to enhance their understanding of the rights of their colleagues and clients. These initiatives included: • Human Rights Act training • workshops on managing and preventing discrimination, bullying and harassment • Australian Charter of Healthcare Rights training • e-Learning packages on managing work aggression and violence. The Health Directorate implements cultural awareness training for staff to promote a caring and competent health workforce. **KPI—Number of Health Directorate staff attending cross-cultural training to assist with the culturally appropriate delivery of services and programs** In 2010–11, the Health Directorate conducted two face-to-face Cultural and Linguistic Diversity training sessions (36 staff attended), six Cultural Awareness Training, CALD Module 2 of 3 sessions (61 staff attended) and six orientation sessions that incorporated a segment on Aboriginal and Torres Strait Islander Health (443 staff attended, including 67 graduate nurses).

C.20
Aboriginal & Torres Strait Islander reporting

Functional and resilient families and communities

The Health Directorate continues to implement strategies of the policy document A New Way: *The ACT Aboriginal and Torres Strait Islander Health and Family Wellbeing Plan 2006–2011.* The objectives of the plan are to:

- address the identified health and family wellbeing priority areas
- provide an effective and responsive health and family wellbeing system for Aboriginal and Torres Strait Islander people in the ACT
- influence the health and family wellbeing impacts of the health-related sector
- improve resourcing and accountability.

Progress in implementing the strategy is reported in section C.5, Internal accountability, on page 259.

The Health Directorate committed to develop a Reconciliation Action Plan in July 2010 and launched its plan in July 2011 for implementation by July 2012. The plan contains a range of actions to improve the health status of Aboriginal and Torres Strait Islander peoples and make a significant contribution to closing the life expectancy gap.

Substance use and misuse

The Health Directorate funds Winnunga Nimmityjah Aboriginal Health Service (Winnunga) to provide a range of programs to support clients with issues relating to substance use and misuse. Support provided includes: Information and Education/Support and Case Management/Counselling.

Funding is provided for a dedicated tobacco control worker to work from Winnunga to address priority areas of the ACT Aboriginal and Torres Strait Islander Tobacco Control Strategy.

From July to December 2010, Winnunga reported a total of 211 clients receiving support for dual diagnosis, youth detoxification and the opiate program.

Gugan Gulwan Youth Aboriginal Corporation (Gugan Gulwan) receives funding from the Health Directorate to provide an Alcohol and Other Drug Treatment and Support Service that targets young people who are at risk of or experiencing problematic alcohol, tobacco and/or other drug use. Support includes information and education, support and case management.

Gugan Gulwan is also funded to provide a Youth Outreach Network to support early diagnosis, treatment and advice for at-risk young people on a range of health problems that relate to at-risk behaviours. The tobacco control worker located at Winnunga provides an outreach service to support Gugan Gulwan clients.

The Health Directorate is developing the Ngunnawal Bush Healing Farm, a residential rehabilitation service for Aboriginal and Torres Strait Islander people living in the ACT which seeks to address the complex issues that relate to drug and alcohol abuse. In 2010–11 a model of care was developed and a health planning unit brief to inform the design phase was finalised.

An Aboriginal and Torres Strait Islander Drug and Alcohol Liaison Officer works directly with people on alcohol and other drug use and related offences. A weekly clinic is also run at the Alexander Maconochie Centre.

Early childhood development and growth

The Health Directorate funds Winnunga Nimmityjah Aboriginal Health Service to continue to deliver the Aboriginal Midwifery Access Program (AMAP), which provides antenatal and postnatal support to Aboriginal and Torres Strait Islander mothers and their babies. Support includes: outreach clinical and non-clinical assessment at home; referral to, and support in accessing, mainstream and specialist services; and information on mainstream services.

In 2010 the program reported that the proportion of low birth weight babies (<2500g) was 16 per cent.

In 2010 the program reported 38 per cent of women attending their first antenatal clinic in the first trimester, 48 per cent in the second trimester and 14 per cent in the third trimester. The proportion of women smoking in pregnancy was reported at 45 per cent, 29 per cent of women used alcohol in pregnancy and 12 per cent used other drugs in pregnancy.

The Health Directorate funds Gugan Gulwan to deliver a Youth Outreach Network to provide early diagnosis, treatment and advice to at-risk young people. Information on health issues such as sexual and reproductive health is provided through a culturally appropriate model.

Under the COAG National Partnership Agreement on Indigenous Early Childhood Development, the Health Directorate implements an initiative known as the Antenatal, Pre-pregnancy, Teenage Sexual and Reproductive Health project (APTSRH). A Steering Committee was established in 2010 and continues to meet to provide overall governance and direction to the project.

A significant consultation process was undertaken with community organisations and agencies that have direct and indirect responsibility for providing support to young Aboriginal and Torres Strait Islander people.

The outcomes of the consultations have also been used to develop a proposal for activities to be undertaken within the project in the next two years. The proposal has three main strategies: *sexual and reproductive health; early pregnancy, antenatal support and parenting; and resources/material support.*

Early school engagement and performance

The Health Directorate funds Winnunga Nimmityjah Aboriginal Health Service to provide a hearing health program for infants and children. The program includes a comprehensive school-based screening service, including education, treatment and referral for surgical interventions.

In 2010 the program reported a total of 340 screenings of children aged from zero to 14 years. Eighty children were seen by the general practitioner at Winnunga for otitis media, five children were referred for specialist treatment and there were 27 visits to schools (including preschools).

Effective environmental health systems

The health infrastructure, which includes sanitation, water, fresh food and housing, is of a consistently high standard in the ACT when compared to that of rural and remote environments. However, the ACT Government funds an Aboriginal and Torres Strait Islander housing program designed to ensure the availability of appropriate healthy living environments.

Economic participation and development

The Health Directorate is working with the Aboriginal and Torres Strait Islander Health Forum, which includes representation from Winnunga Nimmityjah Aboriginal Health Service and the ACT Aboriginal and Torres Strait Islander Elected Body, to develop a Health Workforce Strategy for the ACT.

C.21
Ecologically sustainable development

The Health Directorate actively supports whole-of-government sustainability initiatives and in 2010–11 provided input into the Carbon Neutral ACT Government Framework and the Review of the Environment Protection Act 1997 papers. The Health Directorate has also developed a Sustainability Strategy to assist with its planning processes.

The Sustainability Strategy provides a roadmap for a collaborative sustainable future, encapsulating a picture of where the Health Directorate wants to be in 30 years time and taking into account all elements contributing to a sustainable and dynamic future. The strategy contains actions for each of the seven focus groups (Models of Care, Buildings and Infrastructure, the Digital Health Environment, Transport, Regulatory Environment, Workforce, and Partnerships and External Service Delivery).

The Health Directorate continues to demonstrate its commitment to the principles of ecologically sustainable development by closely monitoring its use of resources, integrating economic, social and environmental considerations into decision making, and implementing measures to minimise the impact of agency activities on the environment.

The Agency Resource Use Data Table and category for office space apply to Bowes Place, and 1 and 11 Moore Street only. The Health Directorate occupies office space at other facilities; however, these are shared facilities and the lack of sub-metering does not allow office space data to be separated.

In this reporting period office spaces that cannot be separated, is reported in the total energy use category, which includes space used for the provision of patient services. Furthermore, calculations of office use data in the 2009–10 reporting period included energy and water used outside office spaces. Figures have been adjusted this reporting period to better report energy use in office spaces.

Energy use

Total energy use has increased by 477,097 megajoules, in comparison to 2009–10 energy consumption as a result of the growth and energy use associated with the Capital Asset Development Plan at the Canberra Hospital.

During the reporting period, the Health Directorate's use of renewable energy was 37.6 per cent.

In 2010–11, the following initiatives to improve energy management were implemented at the Canberra Hospital site:

- first stage replacement of calorifiers in Building 1
- installation of energy-efficient lighting and occupancy-sensor or time-controlled lighting for non-critical building lighting and air-conditioning systems
- further review, monitoring and tracking of large plant (e.g. chillers and boilers that are high-energy users) with programming adjustments made, where possible, by the Building Monitoring System (BMS) to maintain peak efficiency.

Water consumption

The Health Directorate's main use of water is for the provision of clinical treatment and associated services for patients and clients. The most significant consumption was attributable to:

- renal dialysis treatments
- sterilisation of surgical instruments

- provision of chilled and hot water services for air-conditioning systems for wards, operating rooms and treatment areas
- operation of kitchens and preparation of patient meals
- provision of patient bathroom and domestic requirements.

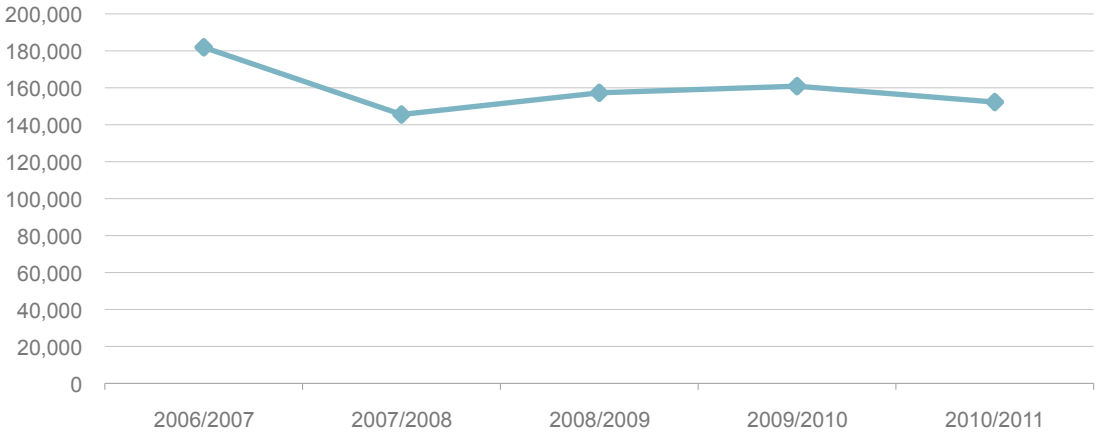
The Health Directorate's total water consumption decreased from 160,249 kilolitres in 2009–10 to 152,278 kilolitres in 2010–11, a decrease of 7971 kilolitres or 5 per cent. Water use is summarised in the table at the end of the section.

This decrease is attributable to:

- replacement of two water tanks in Building 1 at TCH
- replacement of old backflow prevention valves on the two major water feeds into TCH in early 2011.

The table below summarises total water consumption data for the Health Directorate, represented as total kilolitres.

Health Directorate Annual Water Consumption



The implementation of a range of water efficiency initiatives has continued through 2010–11, including:

- installation of flow restrictors on a range of plumbing fixtures (e.g. showers, hand basins and toilets for all new works and refurbishments)
- replacement of old sterilisers with modern water and energy efficient sterilisers
- installation of six-star energy rating fixtures as replacements, where practical
- delivery, by CADP projects, of a 620,000-litre water tank installed adjacent to the new southern car park
- continuation of the moratorium on outside watering at all facilities, including deactivation of all garden sprinklers, decommissioning of fountains and cessation of external washing of facility buildings, pavements and windows except when using tank water
- monitoring of water meters for cooling towers usage.

Transport

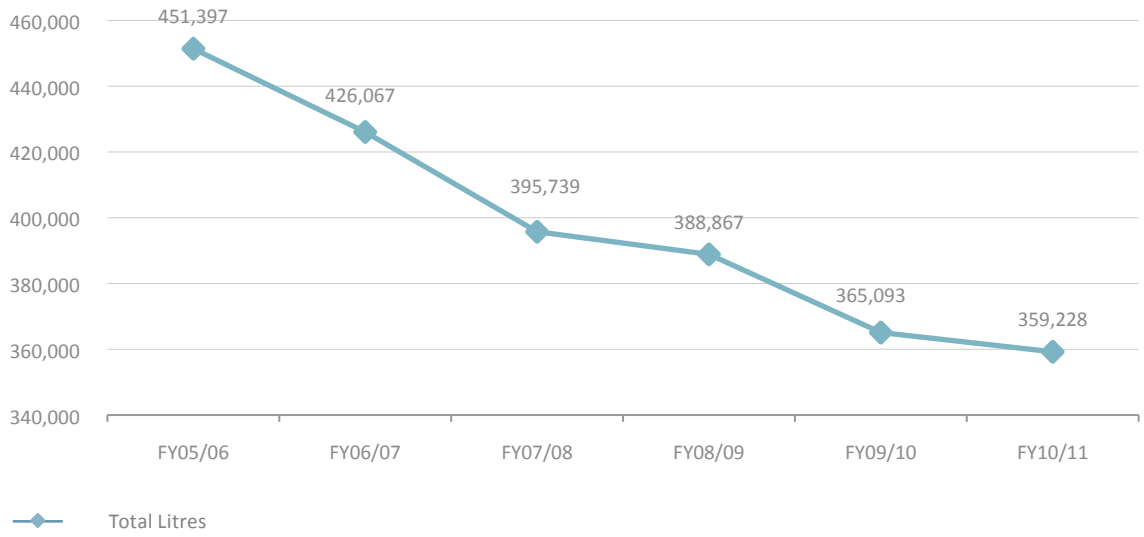
In 2010–11, the number of Health Directorate fleet vehicles increased by six (1.91 per cent), as more executives chose to lease a government-provided vehicle in lieu of taking the cash component.

Despite the small increase in fleet size over the year:

- fuel use decreased from 365,093 litres (petrol and diesel combined) to 359,228 litres (1.6 per cent)—refer to the table below

- vehicle utilisation improved from 12,000 km per vehicle to 12,744 km per vehicle (6.2 per cent)
- average fleet fuel consumption improved from 9.69 litres per 100 km to 8.81 litres per 100 km (9.1 per cent)
- total transport greenhouse gas emissions (all scopes) reduced from 972 tonnes CO2-e to 968 tonnes (0.4 per cent)
- transport greenhouse gas intensity improved from 0.2 tonnes CO2-e per FTE to 0.17 tonnes per FTE (15 per cent).

Fuel utilisation per financial year



Since 2005–06, the size of the Health Directorate's fleet has increased by only four vehicles (1.25 per cent), while average fleet fuel consumption has improved from 11.29 litres per 100 km to 8.81 litres per 100 km (22 per cent) and total transport greenhouse gas emissions (all scopes) has reduced from 1152 tonnes CO2-e to 968 tonnes (15.9 per cent).

To ensure that the Health Directorate can accommodate the future integration of electric vehicles, the recently built southern car park located at the Canberra Hospital has been designed to accommodate infrastructure to support electric vehicle integration, when required.

In June 2010, the Health Directorate entered into a contract with Carpool-It.com (Australia) Pty Ltd (also known as MyCarpools) for the development and hosting of a car pooling system for staff. At June 2011, 165 staff were registered on the system and there were 23 active car pools involving 50 of those registered staff.

Indicative data from the MyCarpools system shows that, for the month of June 2011, staff car poolers avoided using 743 litres of fuel, worth approximately $1050, and prevented the emission of 1.8 tonnes of CO2-e.

Waste and resource efficiency

ISS Health Services (ISS) provides a waste management solution for the Health Directorate under the terms of the Health Domestic and Environmental Services Contract. Services are provided at 17 sites, including the Canberra Hospital.

ISS, in conjunction with the Health Directorate, has developed a Health Waste Management Plan. The Health Waste Management Committee, which commenced in July 2011, will support the final endorsement and implementation of the waste plan. Final endorsement of the plan is anticipated for August 2011.

The management of all waste services by one provider and in accordance with the waste plan is to deliver a uniform approach to waste management activities. This approach will improve on the waste systems already put in place during the recent and successful Health Directorate accreditation process under the Australian Council on Healthcare Standards in February 2011.

Details of the Health Management Waste Plan are as follows:

- The plan will follow the principles of the ACT Sustainable Waste Strategy 2010–2025, currently in draft form.
- The plan provides for monitoring and measuring all services through external benchmarking activities and target setting.
- The plan includes initiatives to introduce and improve systems to recycle, reduce and reuse as many resources as possible from waste streams, including biodegradables.
- The Health Directorate is a signatory to the ACT Government Smart Business and Office program, which aligns with and supports the initiatives of the plan.

ISS has responsibility for implementing the Health Waste Management Plan and will support and achieve the improvement and strengthening of the existing waste management system, which includes:

- colour-coded bin systems to facilitate waste streaming
- waste streaming signage
- waste streaming education, including corporate orientation
- waste audits conducted on waste streams
- weekly environmental cleaning audits
- internal benchmarking activities
- the streaming and recycling of paper, cardboard, glass, plastic, cans, fluorescent tubes, metal, batteries and toner cartridges
- contractor compliance with relevant state and territory legislation, policies and codes through the procurement process
- periodic review of the Health Directorate's Waste Management Policy
- waste data reporting through the Online System for Comprehensive Activity Reporting (OSCAR) database
- waste data collection.

Greenhouse emissions

The Health Directorate supports and participates in the Australian Government Department of Climate Change benchmarking through the Online System for Comprehensive Activity Reporting (OSCAR) database. OSCAR standardises the calculation of greenhouse gas emissions to produce comparable data sets on environmental performance.

Improvements in data gathering implemented during 2010–11 will allow the Health Directorate to monitor trends in future years.

Agency resource data

	Indicator as at 30 June	Unit	2009-10		2010-11	
Line	**General**		**Office**	**Total**	**Office**	**Total**
L1	Occupancy — staff full-time equivalent	Numeric (FTE)	390	5594	391	5,953[1]
L2	Area office space — net lettable area	Square metres (m^2)	5,773	157,778	6,356[3]	214,270[4]
	Stationary Energy		**Office**	**Total**	**Office**	**Total**
L3	Electricity use	Kilowatt hours	846,782 [5]	33,354,457	2,238,958	32,119,755
L4	Renewable energy use (GreenPower + EDL land fill gases)	Kilowatt hours	[6]NA	9,757,084	858,349	12,070,491
L5	Percentage of renewable energy used (L4/L3 x 100)	Percentage	NA[7]	30	38.3	37.6
L6	Natural Gas use	Megajoules	1,175,213	87,614,846	2,414,358[8]	92,536,870
L7*	Total energy use	Megajoules	4,223,628[9]	[10]NA	10,474,606	208,167,988
	Intensities					
L8	Energy intensity per FTE (L7/L1)[11]	Megajoules/ FTE	10,829 [12]	[13]NA	26,789	34,968
L9	Energy intensity per square metre (L7/L2)	Megajoules / m^2	731[14]	NA[15]	1,647	971
	Transport		**Office**	**Total**	**Office**	**Total**
L10	Total number of vehicles	Numeric		314		320
L11	Total vehicle kilometres travelled	Kilometres (km)		N/A[16]		4,078,088
L12	Transport fuel (Petrol)	Kilolitres		253		218
L13	Transport fuel (Diesel)	Kilolitres		112		140
L14	Transport fuel (LPG)	Kilolitres				
L15	Transport fuel (CNG)	Kilolitres				
L16*	Total transport energy use	Gigajoules		12,729		12,903
	Water		**Office**	**Total**	**Office**	**Total**
L17	Water use	Kilolitres	N/A	160,249	N/A[17]	152,278
	Intensities					
L18	Water use per FTE (L17/L1)[18]	Kilolitres / FTE		[19]N/A	N/A[20]	25.58
L19	Water use per square metre (L17/L2)	Kilolitres / m^2		N/A		0.7
	Resource Efficiency and Waste		**Office**	**Total**	**Office**	**Total**
L20	Reams of paper purchased	Reams		51,194		46,160
L21	Recycled content of paper purchased	Percentage		5.6		2.88 [21]
L22	Estimate of general waste (based on bins collected)	Litres		14,482,285		16,490,562[22]

	Indicator as at 30 June	Unit		2009-10		2010-11
L23	Estimate of cominlged material recycled (based on bins collected)	Litres		2,880,050		851,125[23]
L24	Estimate of paper recycled (based on bins collected)	Litres		1,433,750		1,312,855[24]
L25	Estimate of organic material recycled (based on bins collected)	Litres		0%		0%
	Greenhouse Gas Emissions		**Office**	**Total**	**Office**	**Total**
L26*	Total stationary energy greenhouse gas emissions (All Scopes)	Tonnes CO2-e	1,472.2[25]	NA[26]	2,507	34,088
L27*	Total transport greenhouse gas emissions (All Scopes)	Tonnes CO2-e	NA[27]	972	NA	968
	Intensities					
L28	Greenhouse gas emissions per person (L26/L1)	Tonnes CO2-e / FTE		107[28]	4.20	5.7
L29	Greenhouse gas emissions per square metre (L26/L2)	Tonnes CO2-e / m^2	7.25[29]	NA[30]	0.25	0.15
L30	Transport greenhouse gas emissions per person (L27 / L1)	Tonnes CO2-e / FTE			NA	0.16

1. Headcount, not FTE.
2. Indicator criteria are for office net lettable area, yet column totals are assumed at total square metres for all occupied space.
3. Variation to 2009–10 is the addition of Bowes place of 583 (m^2). 1 and 11 Moore st, Bowes place.
4. Additional to 2009–10 is Building 24, Building 26 and Bowes place.
5. This amount was only partially reported in 2009–10; figure should be 2,311,305. Includes Bowes Pl 2010–11.
6. Not required to be reported in 2009–10.
7. Not required to be reported in 2009–10.
8. 1 Moore St only.
9. This amount was only partially reported in 2009–10. It relates to the figure in L3, and should be 9,495,911.
10. Not required to be reported in 2009–10. If reported, should be 207,690,891.
11. Head count used.
12. This amount was only partially reported in 2009–10. It relates to the figure in L7, and should be 24,348.
13. Not required to be reported in 2009–10.
14. This amount was only partially reported in 2009–10. It relates to the figure in L7, and should be 1,644.
15. Not required to be reported in 2009–10. If reported, should be 1,316.
16. Not required reported in 2009–10. If reported, should be 3,768,091.
17. Shared tenancy; not metered.
18. Head count used.
19. Not required to be reported in 2009–10.
20. Shared tenancy; not metered.
21. 2.88 — Reflects a reduction in the numbers of paper reams with recycled content purchased by specified ACT Health sites and TCH.
22. 16,490,562 — Reflects volumes of waste to landfill for TCH only (excludes other specified ACT Health sites).
23. 851,125 — Reflects volumes of plastics, cans and glass for TCH only (excludes other specified ACT Health sites). The figure of 851,125 is a significant reduction against the 2009–10 figure, which also included a cardboard (in litres) figure.
24. 1,312,855 — Reflects the volume of office paper (secure/non-secure) and cardboard recycled from specified ACT Health sites and TCH. Reflects a reduction in the volume of secure waste disposed of/recorded when compared with the previous year.
25. Refer to Line 2, Footnote 3. Increase in office area impacting on total.
26. Not required to be reported in 2009–10.
27. Not required to be reported in 2009–10.
28. This amount was reported partially in 2009–10; should be 3.7.
29. This amount was reported partially in 2009–10; should be 0.25.
30. Not required to be reported in 2009–10.

C.22
ACT Women's Plan

This section reports on the Health Directorate's contribution to the achievement of the key priorities of the ACT Women's Plan.

Economic priority

Strategic outcome

Women and girls equally and fully participate in and benefit from the ACT economy.

Priority areas

- responsive education, training and lifelong learning
- flexible workplaces
- economic independence and opportunities
- leadership and decision making

Indicators of progress

Evidence of education and training pathways for women and girls and of increased opportunities for the advancement of women in the workforce

In June 2011, 77 per cent of the Health Directorate workforce were women, including 60 per cent of the Executive. Ninety per cent of nurses, 80 per cent of allied health professionals, 43 per cent of medical officers, 42 per cent of support services staff, 73 per cent of technicians, 76 per cent of miscellaneous professionals and 80 per cent of administrators were women.

The Health Directorate's Staff Development Unit facilitates best practice in healthcare outcomes through leadership and promotion of a learning culture that enhances individual and organisational development for both clinicians and non-clinicians. There are a range of programs offered internally, such as Excel 2007, Hand Hygiene, Clinical Support and Supervision, Medication Calculation, Basic Life Support, Meetings and Minutes, and Managing and Preventing Discrimination, Bullying and Harassment. There are no programs specifically for women.

Study assistance is available to staff to access programs of study to meet their training and development needs. The program assists employees to undertake external study leading to a qualification related to their employment by providing discretionary access to paid study leave and/or financial assistance such as the Positive Professional Development Pathway (PPDP) Scheme.

Evidence of increased economic leadership and decision-making opportunities for women and girls

Sixty per cent of the Health Directorate Executive are women.

In 2010–11 the Directorate conducted three Leader and Manager Development Programs and two Supervisor and Team Leader Development Programs. A total of 60 female Health Directorate staff participated.

Forty-one per cent of the female workforce choose to work part-time. This demonstrates that the directorate is flexible in recruiting staff and that women, who are mainly responsible for looking after their children and extended family members, are not prevented from obtaining a healthy work–life balance.

The Leadership Network is a collaborative initiative to capitalise on the talent and experience of the directorate in the areas of great organisation, sustainability, patient experience and policy. A website is being developed called Leadership Central for all staff to access regarding the work and outcomes of the network.

Evidence of improved financial equity

The Health Directorate offers female staff and community members an opportunity to improve their financial circumstances in the way of grants, scholarships and excellence awards in progressing personal, professional and/or community development. For example, health promotion community grants specifically for women this financial year included projects in quitting smoking and increasing physical activity. The directorate manages service funding agreements with non-government organisations (including QE II Family Centre, Australian Breastfeeding Association, Pregnancy Support Service and Women's Centre for Health Matters) addressing the physical and/or mental health needs, interests and service needs for women and their children.

The directorate offers the following scholarships for staff:

- Aboriginal and Torres Strait Islander Nursing Scholarship with CIT Yurauna Centre
- Nursing and Midwifery Postgraduate Scholarship Scheme
- Mental Health ACT/University of Canberra Nursing Postgraduate Program
- Positive Professional Development Pathway Scheme
- Nursing and Midwifery Student Clinical Placements
- Personal Classification Level 2—Career Advancement.

Social priority

Strategic outcome

Women and girls equally and fully participate in sustaining their families and communities and enjoy community inclusion and wellbeing.

Priority areas

- safe and respectful relationships
- good health and wellbeing
- safe and accessible housing

Indicators of progress

Evidence of recognition of women and girls' contributions to the community

Each year the Health Directorate organises nursing and allied health excellence awards, which include management and leadership, and education and research categories.

The Health Directorate continues to ensure that women's perspectives are considered through strong consumer representation and community consultation in the planning of health services relevant to women.

Evidence of increased community leadership and decision-making opportunities for women and girls

Not applicable

Evidence of affordable and accessible gender and culturally sensitive services

Improving the health status of ACT women is key to achieving the ACT Government's vision of the ACT as a strong, inclusive community. The *Strategic Framework: Improving women's access to health care services and information 2010–2015* provides principles and actions for the Health Directorate. Implementation of the framework is the responsibility of the Women's Health Advisory Network (WHAN), which is a cross-agency expert committee of consumers, Health Directorate line areas and the ACT Office for Women.

Services are delivered at home, through community health centres or hospitals. They include postnatal, early childhood or parenting services, mental health support services, reproductive and sexual health services, weight management groups, breast and cervical screening services, and counselling and medical services for women affected by domestic violence.

Improving women's access to services and information benefits the whole community through the diverse roles that women have. The delivery of cultural awareness training of staff has been increased in recognition of the differing needs of women from culturally and linguistically diverse (CALD) and Aboriginal and Torres Strait Islander backgrounds. In 2010–11, the Health Directorate conducted two face-to-face culturally and linguistically diverse training sessions (36 staff attended), six cultural awareness training sessions (61 staff attended) and six staff orientation sessions that incorporated a segment on Aboriginal and Torres Strait Islander health (443 staff attended, including 67 graduate nurses).

The Migrant Health Unit interpreters assist CALD women to access services and understand information.

BreastScreen ACT assisted refugee women at Companion House Assisting Survivors of Torture Inc. with accessing screening services.

The Maternity Unit provides antenatal care to women in the local community setting. This allows women to have their antenatal visits in a community setting, with maternal and child health nurses providing a valuable link to the community following the birth of their babies. The Canberra Midwifery Program continues to provide a range of birthing options to suit the needs and preferences of women and families in the ACT.

The new maternity Model of Care (MoC) incorporates many of the principles of the MoC for the Women's and Children's Hospital program, such as continuity of care and carer (antenatal to post-birth) as well as meeting the needs of adolescent women, women from CALD backgrounds and those women who have additional risk due to social, drug and alcohol use, mental health or economic factors.

The ACT provides culturally appropriate care to Aboriginal and Torres Strait Islander women through the Aboriginal Midwifery Access Program, which is delivered by the Winnunga Nimmityjah Aboriginal Health Service.

The ACT Women's Health Service (WHS) provides a range of nursing, medical and counselling services for women by women in Civic, Gungahlin, Tuggeranong, Phillip and Belconnen. The WHS understands that disadvantage and vulnerability contribute to poor physical and emotional health for many women in our community. Priority is given to women who experience barriers to service due to the impact of physical, social or economic violence, disadvantage, disability, language, culture, sexuality or isolation.

ACT Health continues to fund Winnunga Nimmityjah Aboriginal Health Service to provide a range of primary healthcare services initiated and managed by the local Aboriginal community. The holistic model encompasses medical care, good health and healthy lifestyle programs. Services include midwifery access, hearing health, dental health, mental health, and drug and alcohol support. The Integrated Aboriginal and Torres Strait Islander Family Support Service provides targeted, intensive family support services to at-risk Aboriginal and Torres Strait Islander families through an integrated service delivery model jointly developed by the Health, Education and Community Services directorates. This service diverts at-risk children away from the statutory care and protection system, reducing care and protection reports and re-reports and improving access to services.

Evidence of pathways for women experiencing disadvantage, social exclusion and isolation

Women with mental health issues experience significant disadvantage, social exclusion and isolation. The Health Directorate continues to develop strategies aimed at the early identification and reduction of risk of self-inflicted harm and suicide for women and girls in the ACT through *Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009–2014 and Building a Strong Foundation and Managing the Risk of Suicide Two: A Suicide Prevention Strategy for the ACT 2009–2014.*

The directorate also funds the Post and Ante-Natal Depression Support and Information Service (PANDSI) to provide psychosocial support and information for women at risk of perinatal depression. The Perinatal Mental Health Service is a consultation and referral service for women with moderate to severe mental health presentations during the perinatal period. The service has two clinic days with a consultant psychiatrist and mental health clinicians. The service provides education to other services that provide care for women in the perinatal period.

The IMPACT Program (Integrated Multi-agencies for Parents and Children Together) is a partnership between the Health Directorate and the Office for Children, Youth and Family Support, general practice and community pharmacy to provide intensive and coordinated care for vulnerable families. The aim of the IMPACT Program is to improve outcomes for pregnant women, or those with children up to two years of age, who have been identified with a significant mental health issue or who are receiving opioid replacement therapy by providing a coordinated cross-agency system response to the needs of families.

The Adult Corrections Health Plan 2008–2012 and the Children's and Young People's Justice Health Services Plan 2008–2012 identify the management of the health of remandees and prisoners in detention and key health issues and services required to provide high-quality health care in correctional facilities. The Adult Corrections Health Plan acknowledges the unique health needs of women who enter the custodial environment.

A female doctor makes weekly visits to the Alexander Maconochie Centre (AMC), ensuring that the health care of pregnant remandees is paramount.

Evidence of addressing violence against women and their children and protection and support for victims

The Health Directorate is committed to ensuring the safety of women in the community and the workforce. The safety of the children of women experiencing violence is addressed through the mandatory reporting requirements of health professional staff where child abuse or the risk of child abuse is noted. The Women's Health Service is funded to provide medical and counselling services for women affected by domestic violence.

A Health Directorate Domestic Violence Policy and Standard Operating Procedure is being developed to raise staff awareness of the issues clients in hospital and community health settings face when they are experiencing, or are at risk of experiencing, domestic and family violence. The policy will provide staff with procedures to assist them in responding to clients' needs.

The Health and Community Services Directorates are collaborating in finalising the draft documents so that they are consistent with the National Plan to Reduce Violence Against Women and their Children (2011).

Environmental priority

Strategic outcome

Women and girls equally and fully participate in planning and sharing a safe, accessible and sustainable city.

Priority areas

- safe and responsive transport and urban planning
- sustainable environment

Indicators of progress

Evidence of available opportunities for women and girls in decisions about urban planning, transport and the environment

Not applicable

Evidence of consideration towards women and girls' safety, security and accessibility when designing, building or retrofitting public facilities

The Women's and Children's Hospital on the Canberra Hospital campus is being built surrounding the existing Maternity building at the northern end of the campus.

The new three-storey hospital will provide 146 beds; an increased number of ambulatory care (outpatient) consult rooms; clinical office space; education and training facilities; and family accommodation. It will also incorporate a playground, cafe and landscaped spaces.

Information and communication technologies will allow the automation of a broad range of clinical and clinical support functions, positioning the new hospital as an Australian leader in the provision of patient care and safety.

This tertiary referral centre will provide additional midwifery-led models of care, increased neonatal services, expansion of maternal–foetal medicine facilities and the establishment of a Maternity Assessment Unit. The Model of Care (MoC) key principles of service delivery are:

- family-centred care
- developmental care frameworks
- continuity of care and carer
- integrated and multidisciplinary care and treatment
- provision of research and information resources for clinicians, primary care providers, patients and their carers.

Executive Reference Groups have consumer and staff representatives who have considered in the planning phase of the new hospital the need for breastfeeding areas for staff and clients, soundproofing consultation rooms to allow for privacy, play areas in waiting rooms, lighting of carparks for staff on night shifts, disability access and E-Health technology to support excellence in the delivery of modern health care in the ACT and region.

C.23
Model Litigant Guidelines

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

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

Consumers are invited to provide feedback about the care they received at the point of service or by telephone, letter or fax. Feedback can also be submitted electronically at the Health Directorate website, by email or through the Health Directorate website email links.

The Health Directorate has an established Consumer Engagement Team (CET) and ensures consumer feedback is responded to and resolved where possible in a timely manner. The CET aims to acknowledge consumer complaints within five working days and coordinate investigations and inform the consumer of the outcome within 35 calendar days. If the consumer is not satisfied with the response to their complaint, the consumer is advised of the assistance available through the ACT Human Rights Commission (HRC). The HRC provides an independent means for dealing with complaints about health services through the Health Services Commissioner.

The Health Directorate is committed to responding to complaints about public sector health services in a timely and systematic manner. Complaints are a valuable part of the quality improvement system, which aims to optimise patient care and safety, to promote positive system changes and to ensure resolution of the complaint to the satisfaction of the HRC and the consumer where possible. In some instances, an alternative method of dispute resolution such as conciliation is considered. This involves the HRC acting as an impartial third party to help the consumer and health staff clarify issues and resolve matters raised in a complaint. Sometimes, in resolving the complaint, a financial settlement may be considered and agreed to in a formally binding agreement, reducing the risk of complaints developing into legal claims and reducing claim costs for both parties.

Delaying resolution of the complaint or claim historically, and logically, often increases the quantum of damages, as plaintiffs tend to be delayed in their recovery for psychological and financial reasons. The Health Directorate acknowledges that early resolution of a claim can not only have benefits for the plaintiff's health and wellbeing but also reduce the costs associated with litigation. The Health Directorate is committed to working with the ACT Government Solicitor (ACTGS) to ensure that our conduct in matters that progress to litigation is timely, efficient and effective and in accordance with the Model Litigant Guidelines.

It is important to note that, while the obligation to comply with the Model Litigant Guidelines is conferred on the agency, the ACTGS acts on behalf of the Health Directorate in all litigation and provides advice in accordance with the *Law Officer Act 1992* obligations. The ACTGS has advised that it is not aware of any breaches of the Model Litigant Guidelines in Health Directorate matters handled by it during 2010–11.

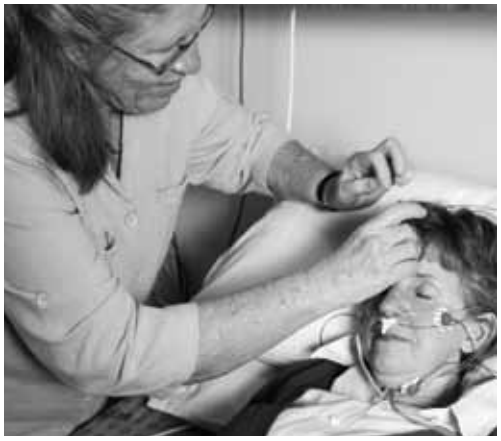
C.24
ACT Strategic Plan for Positive Ageing 2010–2014

Focus area	Progress
Information and communication	The Get Healthy Information and Coaching Service® is a free confidential telephone-based service which helps people make lifestyle changes regarding healthy eating, being physically active, and achieving and maintaining a healthy weight. This service has been offered to adults in the ACT since June 2010. The Health Promotion Branch has actively been promoting this service in the ACT community to encourage people to have a healthier lifestyle. Evaluation results show that 19.2 per cent of total calls made to the Get Healthy service were from the 50–59 age group and 13 percent of total calls were made from the 60–69 age group. The Health Promotion Branch continues to promote healthier lifestyles through the 'Swap it, don't stop it' campaign (formerly the 'How do you measure up?' campaign). This campaign is partially funded by the Australian Government and promotes the message of swapping unhealthy behaviours for healthy behaviours relating to food portion sizes, physical activity and active transport. This campaign has been promoted on TV, in print and through local events that the Health Promotion Branch has been involved in. There was significant participation by older people in a range of programs and initiatives provided by the Community Care Program, although the program does not specifically target older people. These included: • Living a Healthy Life with Chronic Conditions courses in conjunction with Arthritis Australia and SHOUT, in which the target group is more commonly made up of older people. The aim is to foster coping strategies and enhance independent living. One hundred and eight participants completed the courses in the calendar year 2010. • Community Care Program allied health and nursing staff participated in health promotion and awareness raising of Community Care health services at Seniors Week and the Chronic Conditions Expo. A Healthy Legs Club operated as an educational forum for older people who may be vulnerable to leg ulcers. Several new technologies and solutions were, or are being, implemented to support the Health Directorate's E Health strategy, including: • a new and innovative ICU critical care system (implemented) • a remote reading service for breast screening (implemented) • wireless connectivity to support point-of-care systems in the wards (being implemented) • upgrades to and improvement of the reliability of the network through the Medical Grade Network project (being implemented) • Community-Based Services clinical information system (procured for implementation) • mobile devices for community nursing (being tested) • Cancer Information Management System (being implemented) • renal clinical information system (procured for implementation) • Food Services/Nutrition system (being implemented) • establishment of a one-stop shop website for GPs to improve collaboration with Health Directorate services (being implemented) • electronic medication management (procuring).
Health and wellbeing	Projects funded in the 2010–11 Stay On Your Feet® Falls Prevention Round from July 2010 to June 2011, for which funding totalled $204,165, included: 1. Arthritis ACT–Helping people with musculoskeletal conditions to stay on their feet ($21,993). This project represents a further development of our 2009–10 project entitled More Ways to Help our Members Stay on their Feet. 2. Diabetes Australia ACT—Diabetes Education and Falls Prevention Exercise in High Risk Populations ($9970). A unique program has been proposed combining diabetes education with a falls prevention exercise component. This program is designed to build staff capacity in the area and manage people in aged care facilities.

Focus area	Progress
	3. Goodwin Aged Care Services—Goodwin Falls Prevention Program ($126,776). The project is offered to maximise the effectiveness of the ageing body, mind and spirit, plus expand social networks for residents of aged care facilities. 4. Multiple Sclerosis Ltd—Tai Chi for Health and Balance ($9350). The project provided two-day training for 25 health and support workers nominated by a range of community agencies working with older people in the ACT. 5. Southside Community Services (SCS)—Falls Prevention for a CALD Population ($36,076). The proposal has four elements: delivering a Falls Prevention Program to Spanish, Chinese and Croatian groups; falls prevention training for relevant staff within SCS delivered by the Council of the Ageing ACT; translating the written material in the 'Don't fall for it, falls can be prevented' booklet into Spanish and Croatian; and a presentation by a GP from the same ethnic background to each of the Spanish, Chinese and Croatian groups. The GP Aged Day Service (GPADS) provides an in-hours locum to support people who are homebound or in residential aged care facilities (RACFs) when their regular GP is unable to make a house call. The service aims to support ACT GPs and potentially reduce the load on hospitals by providing care to patients who need prompt attention and might otherwise end up in hospital. The ACT Division of General Practice holds a Service Funding Agreement with the Health Directorate to develop and manage the service until 2013. The service commenced on 21 March 2011 and had 66 referrals until 30 June 2011. The GPADS Practice Manager continues to work closely with ACT general practices and RACFs to promote the service and increase uptake.
Respect, valuing and safety	From 1 July to 30 June 2011, the Community Partners Program (CPP) and Partners in Culturally Appropriate Care (PICAC) presented 27 information sessions to CALD carers groups. In addition, 249 hours of cultural awareness training were provided to aged care staff. PICAC and CPP presented six information sessions to aged care service providers. In relation to CPP and PICAC, strategies and initiatives undertaken include: • networking opportunities to facilitate partnerships in the ACT CALD community • support and advice to aged care providers on culturally appropriate services/resources to support their CALD clients • development and distribution within the Health Directorate of a resource that lists general medical practitioners who are bilingual • participation in the Council on the Ageing (COTA) Senior Citizens Expo • presentations at interagency meetings, HACC, Disability Services and Support Asian Women's Friendship Association • placement of CALD volunteers at residential aged care facilities • survey of CALD client use of residential aged care facilities and community aged care packages, and the CALD staff involved in delivering these services • mentoring support for the CPP and Queanbeyan Multicultural Centre, and • cultural competency training for residential aged care facilities. Contributions were also made to the ACT Government Multicultural Summit, the ACT Government Multicultural Strategy, the Office of Ageing Positive Ageing forum and the ACT Disability Strategic Framework. The Health Directorate continued to promote the Respecting Patient Choices (RPC) Program to empower people regarding their future care. A total of 690 advance care plans were registered at 1 June 2011. In addition, during the reporting period, the RPC Program focused on the following activities: • Residential aged care facility (RACF) staff were trained with the aim of increasing the number of RPC facilitators in the aged care sector who can provide advice and assistance in end-of-life decision making. • Community presentations to help inform the local community about the RPC Program and how to access the service have increased exposure and raised the program's profile. • There was additional promotion of the program through newsletters, articles, community events and a joint venture to create a DVD with the Rural Health Education Foundation. • The RPC Program is participating in a quality improvement project led by the Health Directorate Chronic Care Program. A mobile unit is available every second Thursday to assist patients to complete documentation. • A research project is being undertaken by the oncology, haematology and radiation oncology units to assess the uptake and administration of advance care planning. The RPC Program Coordinator is providing training and resources for this project. • The RPC Program has received additional resources to better meet an increase in demand.

Focus area	Progress
Housing and accommodation	The Home Help Service ACT provided 13,430 hours of home maintenance to people aged over 65 from 1 July 2010 to 31 March 2011. In addition, the Home Help Service ACT provided home modifications to the approximate value of $560,000 to people aged over 65 from 1 July 2010 to 31 March 2011.
Support services	Rapid Assessment of the Deteriorating Aged at Risk (RADAR) received 239 referrals from general practitioners, of which 42 were received for residents in residential aged care facilities. The remaining referrals were for clients in other community settings. There were 285 occasions of service for the reporting period (1 July 2010 to 30 June 2011). Community Care Occupational Therapy received funding through HACC for two additional occupational therapist positions in late 2009. This has resulted in reduced waiting times for this service in 2010. A change in the model of care provided by the Community Rehabilitation Team has improved waiting times for access to the community rehabilitation service. A new trainee allied health assistant position was piloted to provide follow-on assistance following completion of the more formal rehabilitation, and aid community reintegration. This traineeship position commenced in March 2011 and is still under development and evaluation. While neither program specifically targets older people, the majority of clients are over 65 years. Only 46 of the 239 people referred to RADAR required admission. Therefore 195 people avoided admission. Of the people requiring admission, only six were admitted through the Canberra Hospital's Emergency Department and these were on the weekend or after hours. There was significant participation by older people in a range of programs and initiatives provided by the Community Care Program, although the program does not specifically target older people. These included: • Under a Healthy Communities Grant, Community Care allied health and nursing staff conducted Mini Health Checks for disadvantaged population groups in the ACT. Additionally, a Healthy Communities Grant for Nutrition enabled a dietician to conduct a nutrition education program for overweight and obese disadvantaged people. • Specialist clinic services in the areas of continence, wounds and stoma management provided additional clinical support for older people. • Clients enrolled in RADAR underwent mini-nutrition screening, while a project commenced in the Community Nursing and Nutrition team to identify older clients at risk of malnutrition who are accessing Community Nursing. This project is due for completion in July 2011. Carers ACT operates 12 groups for people from diverse cultural backgrounds on a monthly basis. They held 81 groups in 2010–11.
Transport and mobility	The Driver Assessment and Rehabilitation Services (DARS) completed 170 driver assessments with people over 75 from 1 July 2010 to 30 April 2011. The referral numbers for driver training have increased by 16 per cent in 2011. DARS have provided a range of education sessions in partnership with the RTA to the MS Society and to medical specialists, such as the Geriatric Medicine Team.
Work and retirement	Not applicable.

Annexed Reports



Dental Technicians and Dental Prosthetists Board Annual Report 2010–11

Requirement for the report

This report is provided in accordance with the *Annual Reports (Government Agencies) Act 2004* and the Annual Reports (Government Agencies) Notice 2011 (No. 1).

President's report

I am pleased to offer the Annual Report of the Dental Technicians and Dental Prosthetists Board for the period 1 July 2010 to 31 August 2011, when the Dental Technicians and Dental Prosthetists Board ceased.

With the implementation of the national registration of many health professions on 1 July 2010, dental prosthetists came under the jurisdiction of the Dental Board of Australia. Excluded from national registration, dental technicians ceased to be registered in the ACT.

To all those who have served on the ACT Dental Technicians and Dental Prosthetists Board over the years, I say thank you.

Constitution, goal and function

Under the Health Professionals Regulation 2004:

1. The board is made up of the president and six appointed members.
2. The appointed members must include:
    a. a community representative; and
    b. two dental prosthetists; and
    c. two dental technicians.
3. The remaining appointed member must be:
    a. a dental prosthetist; or
    b. if the president is a dental prosthetist—a dental technician.

The Board administers the Act and the regulation, which provide for the registration of appropriately qualified persons before they may practise in the Australian Capital Territory. They charge the Board with the responsibility for such registration and with ensuring the orderly conduct of the practice of the profession.

Registration is granted by the Board where criteria set out in the Act and regulation are met. The criteria are based on minimum levels of professional education and training so that only those who are competent to do so are allowed to practise. It is an offence under the Act for unregistered persons to practise in the Australian Capital Territory.

Membership (1 July 2010–31 August 2011)

President

Mr Rex Jefferson-Taite	Appointed Dental Prosthetist (May 2010)

Deputy President

Mr Rohan Scott	Appointed Dental Technician

Members

(Vacant)

Mr David McGuinness	Appointed Dental Prosthetist
Mr Chris McCarthy	Appointed Dental Technician
Mr Terry McHugh	Appointed Dental Prosthetist (May 2010)
Mrs Debbie Papadopoulos	Appointed Community Representative

Secretariat

Mr Alan Skelton	Manager/Executive Officer
Mr David Bale	Registrar

Committee reports

The Board did not meet formally during the reporting period. The President received two registration inquiries for dental prosthetists. Applicants were directed to the Australian Health Practitioner Regulation Authority.

Brought forward	$2,675
Revenue	Nil
Expenditure	Nil
Carried forward	$2,675

Registration statistics

At 30 June 2010, there were 59 dental technicians and 20 prosthetists on the register. On 1 July 2010, dental prosthetists came under the jurisdiction of the Dental Board of Australia. With the cessation of the Board on 31 August 2011, no new registrations for dental technicians occurred.

Complaints and disciplinary action

No complaint was received by the Board in the reporting period 1 July 2010 to 31 August 2011.

Mr Rex Jefferson-Taite
President

Medical Radiation Scientists Board Annual Report 2010–11

Requirement for report

This report is provided in accordance with the *Annual Reports (Government Agencies) Act 2004* and the Annual Reports (Government Agencies) Notice 2009 (No. 1).

President's report

The Medical Radiation Scientists Board (the Board) is in its third year of operation. During the year it set the fees and considered all applications for registration that had been received throughout the year. The Board approved the applications subject to the payment of fees, with effect from the date of receipt.

The Board has a set of standards statements, which were approved and published as a notifiable instrument on 3 September 2009. These statements provide information on how health professionals in the field of medical radiation science should practise, and all medical radiation scientists must comply with these standards.

The Australian Health Practitioner Regulation Agency has seen its first year of operation, with the 10 professions transitioned to the new national scheme on 1 July 2010. The National Registration and Accreditation Scheme (NRAS) is now working on the transition of the medical radiation scientists' profession, which is due to enter the scheme on 1 July 2012. Aboriginal health, Chinese medicine and occupational health workers will also join the scheme. The NRAS team are working on the IT data transfer, financial agreements, staffing strategies and registration categories, and seeking out those who are not currently registered in the states and territories. The appointment of the new Medical Radiation Practice Board of Australia will be announced by the Australian Health Workforce Ministerial Council on 18 July 2011.

The Board has engaged local registrants and employers by presenting the new national scheme and its implications for medical radiation practitioners at a number of workplace forums in Canberra. A program of engagement will continue until transition in July 2012.

The Medical Radiation Practitioners Boards of Australia and New Zealand Conference of Regulating Authorities—Medical Radiation Practice met regularly throughout the year to progress the profession to national registration. In addition, the Medical Radiation Practice National Steering Committee met to progress issues related to national registration and discussed the structure and new constitution of the Medical Radiation Practitioner Accreditation Authority, accreditation standards, and policy and guidelines for practice standards for recommendation to the new Medical Radiation Practice Board of Australia.

The Board

The ACT Medical Radiation Scientists Board was established by the *Health Professionals Act 2004 (the Act)*. The Board is a statutory body with perpetual succession and common seal, which has the powers and responsibilities prescribed by the Act.

Functions of the Board

The principal aim of the Board is to protect the public. The Board is responsible for ensuring that only persons who are eligible and hold appropriate qualifications are registered in the ACT as diagnostic radiographers, radiation therapists or nuclear medicine scientists. Once registered, those persons practise medical radiation science within the requirements of the *Health Professionals Act 2004 (the Act)* and the *Health Professionals Regulation 2004 (the Regulation)* and according to prescribed standards of practice.

The Board is jointly responsible, with the Health Services Commissioner, for the consideration of complaints against registered health professionals and for general monitoring of the conduct of the profession in the ACT. Part 2 of the Act empowers the Board to take disciplinary action against health professionals who may be in breach of certain provisions of the Act. The Board is committed to the improvement and development of customer service, and aims to continue to provide relevant, accurate and timely advice and assistance to the public and health professionals on matters relevant to the profession. The Board aims to raise its profile for the benefit of the profession and the public through the provision of regular newsletters and information nights and by the maintenance of a website.

Membership of the Board

Members are appointed to the Board for a term of up to four years in accordance with the provisions of the Act. The composition of the Board during 2010–11 was as follows:

President

Mr Christopher Hicks	Appointed

Deputy President

Ms Wendy Amos	Appointed

Members

Mr Christopher McLaren	Appointed member
Ms Janelle Hawkins	Appointed member
Mr James Percival	Appointed member
Ms Elizabeth Croft	Appointed member
Ms Jean Shannon	Appointed member (community representative)

Meetings of the Board

The Board met bi-monthly on six occasions during the year.

Registrations

The total number of registered medical radiation scientists in the ACT at 30 June 2011 was 222, of which the Board registered 157 diagnostic radiographers, 17 nuclear medicine scientists and 48 radiation therapists.

Standards statements

The Medical Radiation Scientists Board approved the statements and they are now a notifiable instrument and have been published as the current standards statements. These statements are part of the legislative framework for the profession and provide the detail regarding continuing professional development, recency and scope of practice and other requirements regarding registration and professional standards.

Medical radiation scientists standards statements cover the following topics:

1. Standards of Practice for ACT Allied Health Professionals
2. Competency Standards for Medical Radiation Scientists
3. Professional Practice Standards
4. Continuing Professional Development
5. Fair Handling of Information
6. Maintenance of Records
7. Professional Development Year
8. Professional Indemnity Insurance
9. Inappropriate Behaviour
10. English Proficiency
11. Impaired Practitioners.

Committees

The Board has a Complaints Officer and a Professional Standards Committee, comprising the Deputy President, the Complaints Officer and one other Board member. This committee is responsible for assessing complaints and considering appropriate action in conjunction with the Health Services Commissioner at a Joint Consideration Committee meeting. The Board is pleased that there were no complaints lodged for 2010–11.

Freedom of information

The Board received no request for release of information under the *Freedom of Information Act* during the year.

Newsletter

The Board produced an annual newsletter, which addressed issues such as the role of the Board, registration matters, the National Registration and Accreditation Scheme, information on the Board's standards statements and continuing professional development.

Registration fees

In 2010–11, the application fee for initial registration was $310 and the fee for renewal of registration was $280.

Finances

Brought forward	$4,190
Revenue	$60,135
Expenditure	$15,640
Carried forward	$48,685

Staff

The Medical Radiation Scientists Board is now run out of the Australian Health Practitioner Regulation Agency (AHPRA) office. The Registrar is Ms Susan Knight and the Principal Registration Officer is Ms Navjeet Sahota.

Access

The Medical Radiation Scientists Board may be contacted by telephone, mail, email or facsimile during business hours. The secretariat is located at:

RSM Bird Cameron Building Level 3, 103–105 Northbourne Avenue TURNER ACT 2612

Telephone	(02) 6195 2681
Facsimile	(02) 6195 2602
Email	mrsboard@act.gov.au
Website	www.health.act.gov.au/healthregboards

All correspondence should be addressed to:

The Registrar
ACT Medical Radiation Scientists Board
GPO Box 9958
CANBERRA ACT 2601

Christopher Hicks
President

Veterinary Surgeons Board Annual Report 2010–11

Requirement for the report

This report is provided in accordance with the *Annual Reports (Government Agencies) Act 2004* and the Annual Reports (Government Agencies) Notice 2010 (No. 1).

Functions, aim and goals of the Board

The ACT Veterinary Surgeons Board (the Board) administers the Veterinary Surgeons Schedule No. 12 to the *Health Professionals Regulation 2004.* The *Health Professionals Act 2004* charges the Board with responsibility for the registration of appropriately qualified persons as veterinary surgeons and veterinary specialists, enabling them to practise veterinary surgery in the Australian Capital Territory. The Board:

- ensures that the interests of the public and the welfare of animals in the ACT are protected
- ensures that only properly qualified persons are registered as veterinary surgeons in the ACT
- provides advice to government agencies and interest groups
- conducts inquiries, as required, to ensure professional standards of practice are met.

Membership of the Board

President

Dr Kevin Doyle

Deputy President

Dr John Aspley Davis

Members

Dr Kathy Gibson
Dr Simon Morris
Dr Roger Meischke
Dr William Ryan
Dr Sarah Webb

Community Representative

Ms Marienoëlle Cure

Secretariat

Health Protection Service

All members serve the Board in a personal and honorary capacity.

Meetings of the Board

From 1 July 2010 to 30 June 2011 the Board met on nine occasions. Meetings are generally held monthly at Howard Florey Centenary House, 25 Mulley Street, Holder.

President's report

I am pleased to present the Annual Report of the Veterinary Surgeons Board for the year ended 30 June 2011.

My appreciation is extended to all members of the Board for their considerable efforts during the year and over the term of their appointments. The Board farewelled Dr William Ryan, who served a full term on the Board, and welcomed Dr Roger Meischke in January 2011.

From 1 July 2010 the Board and the secretariat were relocated from the Health Professions Registration Boards to Howard Florey Centenary House in Holder as part of the Health Protection Service (HPS) of the ACT Health Directorate.

In addition to the secretariat functions being moved to Howard Florey Centenary House, a new database is being developed which will allow a better service for the registered veterinarians of the ACT and the Board itself. The database is in a testing phase and will be completed by the end of 2011.

The Board has continued a busy schedule and has been reviewing and updating its standard statements throughout the year. The Board sets high standards for professional competence in order to ensure public protection, which includes supporting and enforcing the now mandatory professional indemnity insurance (PII).

The Board has been active in the affairs of the Australasian Veterinary Boards Council (AVBC), on which it was represented by Dr Aspley Davis. The AVBC visited the state veterinary boards, including the ACT, to promote cooperation in strategic planning for the future of registered veterinarians and help improve veterinary services provided to the community. The AVBC also continues to provide uniform criteria for recognising qualifications for veterinary surgeon registrations and to provide advice on matters concerning the regulation of veterinary occupations.

The Board is currently going through the processes to implement the national recognition of veterinary registration (NRVR) by the end of the financial year 2011–12.

Registration

At 30 June 2011, a total of 256 veterinary surgeons were registered in the ACT.
The Board approved 14 initial applications for registration and 19 applications for registration under the provisions of the Mutual Recognition Act for registration in 2010–11.

Number of registrants

Year	2004	2005	2006	2007	2008	2009	2010	2011
Total	238	249	246	253	260	236	272	256

Activities

The Board addressed issues related to the following topics during the year:

- premises standards
- professional standards matters
- recency of practice
- continuing professional development
- national recognition of veterinary registration
- policy review
- database.

Complaints and disciplinary action

The Board has recognised that many complaints emerge from poor communication and/or intransigence of both parties.

Currently the Board nominates a Complaints Officer, Dr Lorna Citer, to examine complaints and work with the Human Rights Commission in the investigation and management of complaints against veterinary surgeons in the ACT.

The Board investigated a number of complaints or professional standards issues throughout the year. Continued monitoring by the Board is a factor in at least one case. A professional standards panel has been required in one case and the Board has nine complaints outstanding at 30 June 2011.

Matters of significance

National recognition of veterinary registration

The Board supports the process being put in place by the Primary Industries Standing Committee to move towards national recognition of veterinary registration. Each jurisdiction will retain its own board and legislation but will recognise registration in other jurisdictions as a right to practise in every jurisdiction without further registration. This will achieve mobility of veterinary surgeons between jurisdictions and assist in the aim of achieving consistency of standards. The Board hopes to introduce registration in the next financial year to recognise national recognition of veterinary registration in the ACT.

Continuing veterinary professional development

Continuing professional development (CPD) is compulsory in all the ACT health professions. The ACT is among only a small number of Australian jurisdictions to have compulsory CPD for veterinary surgeons. It is important that all registered veterinary surgeons demonstrate a commitment to continuing professional development if they wish to renew their registration.

Australasian Veterinary Boards Council (AVBC)

This year the annual general meeting was held in Adelaide in May 2011, with attendance by representatives and their registrars from the New Zealand Veterinary Council and all state and territory boards. Dr John Aspley Davis, the Board Deputy President, was in attendance along with the secretariat, Amanda Fintan, from the Health Protection Service. Reports were submitted and discussed on issues concerning registration, uniformity of legislation, the National Veterinary Examination (NVE), national registration and accreditation of courses.

Finances

The Board is self-funding but utilises the facilities of the ACT Health Directorate to manage its accounts.

Carryover	$77,817
Revenue	$49,695
Expenditure	$76,869
Carried forward	$50,643

Liaison with Australian Veterinary Association (AVA)

The Board maintains liaison with the AVA to ensure a free exchange of views and information and it takes this opportunity to acknowledge the cooperation of the AVA.

Contact details

ACT Veterinary Surgeons Board
C/o Health Protection Service

25 Mulley Street HOLDER ACT 2611

Telephone	(02) 6205 1700
Facsimile	(02) 6205 1705
Email	vetboard@act.gov.au
Website	www.health.act.gov.au/healthregboards

Dr Kevin Doyle
President

Chief Psychiatrist Annual Report 2010–11

The Mental Health (Treatment and Care) Act 1994 was implemented in the Australian Capital Territory on 6 February 1995.

Section 120

A report prepared by the Chief Psychiatrist under the *Annual Reports (Government Agencies) Act 2004* for a financial year must include:

a. statistics in relation to people who have a mental illness during the year

b. details of any arrangements with New South Wales during the year in relation to people who have a mental illness.

Emergency apprehension

The following table shows the number of emergency apprehensions in 2010–11 with a breakdown of who initiated them.

	Emergency action	Police officer	Mental health officer	Medical practitioner
Total	904	665	161	78

Emergency detention

The following table shows the number of emergency detention notifications issued in 2010–11 in comparison to previous years. Applications for extension of emergency detention (for a further period of up to seven days) and applications for mental health orders and variations of mental health orders are made to the ACT Civil and Administrative Tribunal.

Emergency detentions	July 07 –June 08	July 08 –June 09	July 09 –June 10	July 10 –June 11
Total	465	499	506	596

Outcome of those detained

	July 07 –June 08	July 08 –June 09	July 09 –June 10	July 10 –June 11
Revocation of 72 hr detention and/or 72 hr detention being allowed to lapse	183	282	302	322
Applications for extension of involuntary detention	292	217	204	274

Psychiatric treatment orders

Under the *Mental Health (Treatment and Care) Act 1994*, the Chief Psychiatrist is responsible for the treatment and care of a person to whom a psychiatric treatment order (PTO) applies. The maximum duration of a PTO is six months.

	July 07 –June 08	July 08 –June 09	July 09 –June 10	July 10 –June 11
PTOs granted by the tribunal	684	714	790	884
PTOs revoked	28	76	69	119
Breach of PTO	39	34	68	59
Restriction orders	7	2	3	3

Other matters

The Mental Health (Treatment and Care) Act 1994 provides for the authorisation of involuntary electro-convulsive therapy (ECT), including emergency ECT. It also has provisions for the interstate application of mental health laws, including for the transfer of persons to and from the ACT.

The Crimes Act 1900 provides for the court to order removal of an individual to the Canberra Hospital for the purposes of an emergency assessment to determine whether immediate treatment and care are required.

	July 07 –June 08	July 08 –June 09	July 09 –June 10	July 10 –June 11
Application for ECT authorised	23	22	19	17
Application for emergency ECT authorised	1	7	0	2
Transfers to/from NSW	12	6	12	4
Court ordered removal for assessment— *s309 of the Crimes Act 1900*	28	41	25	26

Key points arising

The following trends in key areas of activity related to the Office of the Chief Psychiatrist are noteworthy.

In 2010–11, 904 people were apprehended and brought to the Canberra Hospital for assessment. This is an increase of 25 per cent from the previous year. Of the 904 apprehended, 596 were detained for further assessment for up to three days. This increase may reflect increased accessibility with the opening of the Mental Health Assessment Unit.

Figures relating to emergency detention have increased by 17 per cent in comparison to the same reporting period last year. There was an increase of 34 per cent in applications for extension of further involuntary detention (of up to seven days). Levels of chronic enduring mental illness requiring careful assessment are reflected in these figures.

The ACT Civil and Administrative Tribunal (ACAT) granted 884 psychiatric treatment orders (PTO). This is an increase of 11 per cent from 2009–10 and a consistent increase over three years of 29 per cent. Upon application by a consultant psychiatrist, or of its own motion, ACAT revoked 119 orders, compared to 69 in the previous reporting period. Community psychiatry is proactive in management without orders where possible.

There were 17 electro-convulsive therapy applications authorised, a decrease of 10 per cent from the previous year. There were two applications for emergency ECT authorised under the legislative provisions in Part 7 of the Act, introduced in 2005.

Four cross-border agreements were made between the ACT and New South Wales. The ACT accepted one transfer from NSW and three transfers were made to NSW facilities. One cross-border agreement was made between the ACT and a Queensland facility.

Breach of PTOs decreased from 68 to 59, a 13 per cent decrease from 2009–10, with 21 people requiring immediate admission to hospital. Community teams make every effort to anticipate and manage crises early; often, if this is successful, a breach does not occur.

The ACT Magistrates Court made 26 referrals for assessment pursuant to section 309 of the *Crimes Act 1900*, a marginal decrease from the previous year. Twelve people required admission to the Psychiatric Services Unit for assessment purposes, with 14 being returned to court on the same day.

The review of the current *Mental Health (Treatment and Care) Act 1994* continues, with the hope of producing a draft of a new Act in 2012, which will then go out for consultation.

Dr Peter Norrie
Chief Psychiatrist

Human Research Ethics Committee Annual Report 2010–11

The ACT Health Directorate Human Research Ethics Committee (HREC) examines research projects, large and small, submitted for ethical review and approval by researchers involved with the Health Directorate, the Canberra Hospital, the medical school and other associated institutions, including Winnunga Nimmityjah Aboriginal Health Services.

HREC has three subcommittees that give a first opinion on clinical trials, examine survey instruments associated with projects and examine low-risk projects. The main committee and the first two subcommittees meet monthly while the Low-Risk Subcommittee meets fortnightly or more often if required to ensure rapid turnover of projects.

All communications, inward and outward, of the committee and subcommittees are handled electronically, with significant gains in efficiency from previous years. In 2010–11 the main committee reviewed 104 projects and approved 88; since its inaugural meeting in April 2010, the Low-Risk Subcommittee has examined 153 proposals, approved 140 and passed eight for consideration by the main committee.

HREC membership includes a lawyer, female and male laypersons, a minister of religion, a psychologist, a member providing Indigenous knowledge and expertise, and seven senior clinicians from the Canberra Hospital. The chairman is a former specialist in obstetrics and gynaecology, a former dean and postgraduate dean and currently an adjunct professor of medical education.

Membership of the committee

Chairman

Professor John Biggs

Members

A/Professor Peter Hickman
A/Professor Paul Pavli
A/Professor Abdel-Latif Mohamed
Dr Dipti Talaulikar
Dr Tony Huynh
Dr Jason Mazanov
Dr Louise Morauta
Rev Doug Hutchinson
Mr Ray Lovett
Mr Ray Comer
Ms Christine Murray

Terms of reference

1. To receive and consider ethical implications of all proposed research projects that involve clients/patients or staff of ACT Health and to determine whether they are acceptable on ethical grounds.
2. To delegate the review and approval of low-risk research projects to the Chairperson and/or Deputy Chairperson of the ACT Health HREC as permitted by the National Statement on Ethical Conduct in Human Research, section 5.1.22 (a) and (b).
3. To consider and advise ACT Health, specifically the ACT Health Research Office, on all ethical matters arising from research activity which require determination. The committee will have particular regard to the importance of obtaining informed consent of patients and volunteers and to the maintenance of the best interests of research participants.

4. To maintain a register of proposed and approved research proposals so that the following information is readily available:
    - name of the responsible institution
    - notification of indemnity
    - project identification number
    - principal investigator(s)
    - short title of the project
    - ethical approval or non-approval with date
    - dates designated for review.

    (Protocols of research projects shall be preserved in the form in which they were approved.)

5. To comply with the NHMRC National Statement on Ethical Conduct in Human Research (2007) and to provide an ACT Health HREC Annual Report to the NHMRC Australian Health Ethics Committee.
6. To abide by the principles laid down in the National Statement on Ethical Conduct in Human Research in regard to research involving people of Aboriginal and Torres Strait Islander background and to seek additional assessment of the research from:
    - people who have networks with Aboriginal and Torres Strait Islander peoples and/or knowledge of research with Aboriginal and Torres Strait Islander peoples
    - people familiar with the culture and practice of Aboriginal and Torres Strait Islander peoples with whom participation in the research will be discussed.
7. To provide surveillance and monitoring of the ethical conduct of research projects until their completion, including the submission of an Annual Report to the CEO of ACT Health via the ACT Health Research Office.
8. To ensure that the list of membership of the ACT Health HREC is made public on the research internet site and within annual reports.
9. To ensure that there is a process whereby researchers can request an interview with the ACT Health HREC for discussion on their proposed research project.

To ensure minimisation of the duplication of ethical review of research projects by a researcher affiliated with another institution, the Committee will forward the application to the director, ACT Health Directorate Research Office, for consideration.

Number of research projects

During 2010–11, HREC reviewed 104 proposals. Eighty-eight proposals were approved. Of the remaining 16 proposals, three were withdrawn by the applicant and 13 remain in consultation progressing towards approval.

Meetings of the Ethics Committee

The Committee met 11 times from 1 July 2010 to 30 June 2011. Meetings are held monthly.

Clinical Trials Subcommittee

The **Clinical Trials Subcommittee** (CTSC) reviewed 50 proposals, in each instance making recommendations to the main committee.

The **Low-Risk Subcommittee** (LRSC), from its inception in April 2010, reviewed 153 proposals and approved 140. Of the remaining 13, eight were referred for consideration by the main committee, two were withdrawn by the applicant and three are in consultation.

The **Survey Resource and Approval Subcommittee** (SRASC), formerly the Survey Resource Group (SRG), became a subcommittee of HREC in June 2010. Since then, SRASC has reviewed 41 proposals, providing endorsement of survey tools and/or recommendations to the main committee and Low-Risk Subcommittee.

Emergency apprehension

N/a

Psychiatric treatment orders

N/a

Other matters

N/a

Key points arising

The last 12 months have seen a number of achievements in research in the Health Directorate. The Human Research Ethics Committee has introduced significant reforms in its processes and is now achieving a turnaround time for major applications of 45 days or less. This is better than that of many of our interstate benchmark organisations. The Chair, Professor John Biggs, the committee members and the secretariat, August Marchesi and Sarah Flood, are providing a great service for both the research community and the people of the ACT.

Professor John Biggs MA MD
FRCOG, FRANZCOG, DHMSA

July 2010

Mental Health ACT Official Visitors Annual Report 2010–11

Introduction

Mental Health Official Visitors are appointed by the Minister for Health to visit and inspect psychiatric inpatient facilities and make inquiries as to the care and treatment of patients, as set out in the *Mental Health (Treatment and Care) Act 1994*. Matters covered include:

- the adequacy of services for the assessment and treatment of persons with mental dysfunction or a mental illness
- the appropriateness of recreation, occupation, education, training and rehabilitation services
- whether services are provided in the least restrictive environment possible and in the least intrusive manner possible
- any contraventions of the Mental Health (Treatment and Care) Act
- any complaint received from a person receiving treatment and care for mental illness or dysfunction.

Currently, Mental Health Official Visitors' roles cover the mental health services provided at the Brian Hennessy Rehabilitation Centre (BHRC), Ward 2N, the Older Persons Mental Health Inpatient Unit and Hyson Green at Calvary Public Hospital, as well as the Psychiatric Services Unit (PSU) at Canberra Hospital.

Throughout the year the Principal Official Visitor met regularly with Ms Katy Gallagher, the Minister for Health. Ms Gallagher continues to be very interested in the Official Visitor scheme and the Official Visitors' observations about the care of people with a mental illness in the ACT.

The Official Visitors enjoyed attending the NSW Official Visitors Conference in Sydney as guests of the NSW service in May. This served as an important liaison activity, and Official Visitors benefited from the educative function of the conference as well as from the informal discussions about the Official Visitor role.

The Official Visitors continue to regularly present at the orientation of new mental health staff.

Visits

Since December 2002, the Official Visitors have operated a monthly pre-determined schedule of formal visits to each of the facilities. Prior notice of the visit is given to the facility to reinforce a cooperative as opposed to an inspectorial approach with unit staff. In 2010–11, Official Visitors made 59 scheduled formal visits to the five mental health facilities.

Formal visits by the Official Visitors were supplemented by follow-up visits as required. Other visits were made upon request by patients of the facilities following contact either by means of telephone or through messages left in the Official Visitors' suggestion boxes, which are located in the facilities visited by Official Visitors. Official Visitor boxes are checked weekly. At the four facilities on the Calvary site, this has provided an opportunity for an Official Visitor to look around each facility at unscheduled times. Chance engagements between the Official Visitor and staff and clients on these occasions have proved fruitful.

Staff at the facilities have been extremely cooperative and open with the Official Visitors. In many instances, staff have gone out of their way to assist the Official Visitors in carrying out their duties. Detailed reports are provided to the team leaders and to senior mental health staff after each visit. The reports summarise all matters raised during the visits by patients and staff and discussed with the team leader. The strategy of meeting with the team leaders at the end of each visit to ensure issues are raised and addressed as soon as possible continued. Follow-up action is identified in the reports. Quarterly reports are provided to the Minister for Health.

Adequacy of assessment and treatment services

ACT Mental Health and its staff are committed to improving the quality of care at all facilities. The staff at the facilities endeavour to improve the experiences of their patients and to develop practices and procedures aimed at the long-term benefit of patients. It is particularly encouraging to note the successful focus on reducing the use of seclusion at the Psychiatric Services Unit (PSU) and the adoption of less punitive approaches to unacceptable behaviour. Both Calvary 2N and the PSU have usefully focused on providing more activities for their patients.

The Official Visitors continue to be impressed by Hyson Green and the Older Persons Mental Health Inpatient Unit (OPMHIU), which present as very well equipped and well staffed. Both are modern, light and spacious and designed for comfort and safety. The OPMHIU and the Brian Hennessey Rehabilitation Centre (BHRC) facilitate their staff accompanying patients into the community after discharge and assisting in their follow-up.

Appropriateness of recreation, occupation, education, training and rehabilitation services

Each facility operates a range of these types of programs and made changes in 2010–11 to improve the relevance and effectiveness of these activities. The general direction is to enhance the services provided.

PSU offers a regular film night to consumers as well as a range of other programs.

BHRC's rehabilitation and recreation focus is on patient participation in community programs outside the facility—for example, activities at the Belconnen Community Centre. Patients are encouraged to commence TAFE courses. Within the facility, programs tailored to individual patient needs are offered, such as healthy cooking lessons, media studies, relaxation techniques and gardening. Computer access is also available.

Ward 2N has activities on weekdays for all patients. Group programs run by Ward 2N and Hyson Green are very popular with inpatients and outpatients. Hyson Green has commenced a perinatal program for mothers and babies. The OPMHIU encourages patients to be as active and independent as possible.

Whether services are provided in the least restrictive environment possible

Inpatients in psychiatric facilities are admitted on a voluntary or involuntary basis. Enforcing involuntary detention involves a reduction of an individual's freedom while treating their mental illness. Patient safety is a paramount concern, as is the safety of the staff involved. While all facilities must primarily assist patients to improve their mental health, they focus on enhancing the skills patients need to reintegrate into the community, aim to discourage dependency on inpatient facilities and to reduce the duration of their admission time.

The PSU offers three levels of accommodation depending on the acuity of a patient's symptoms. Although the entire facility is locked, there is a low-dependency unit, a high-dependency unit and a seclusion area. It is encouraging that the unit is placing significant emphasis on reducing both the frequency and length of time any patient is confined in the seclusion or high dependency areas. During visits this year it was very evident that the rate of seclusion in the facility had been reduced.

Commendably, BHRC has made many efforts to ensure its consumers are integrated where possible into community-based programs to facilitate their transition from the facility into the community.

Any contraventions of the Mental Health (Treatment and Care) Act

No contraventions have come to the attention of the Official Visitors.

Complaints received from persons receiving treatment and care for mental illness or dysfunction

In general, patients and their carers provide positive feedback about their experiences in the facilities. Issues taken up with and acted on by the units include:

- treatment issues
- maintenance and cleanliness issues
- anxiety about tribunal hearing
- discharge plans
- lack of stimulation
- gym access
- access to staff.

Reports to the Minister for Health

The Principal Official Visitor provided the Minister for Health with two half-yearly written reports for the reporting year.

Mental Health Official Visitors

Persons working as Mental Health Official Visitors during the period were:

- Sue Connor, Principal Official Visitor
- Pamela Burton, Official Visitor
- Terry Melbourne, Official Visitor
- Bernette Redwood, Official Visitor
- Gerard Sandi, Official Visitor.

Average length of service by gender

Average length of service (years)	Female	Male	Total
0–2	-	1	1
2–4	2	1	3
4–6	-	-	-
6–8	-	-	-
8–10	1	-	1

Total average length of service by gender

Gender	Average length of service
Female	6yr 3 mths
Male	2yr 9 mths
Total	4yr 9 mths

Sue Connor
Principal Official Visitor

24 July 2011

Radiation Council Annual Report 2010–11

Chair's review

It is my pleasure to present the Annual Report of the Radiation Council for 2010–11.

The Radiation Council has had a productive year and has continued to address issues concerning licensing, registration and radiation safety requirements to provide adequate radiation protection to the community. The Council continues to address issues and amend procedures to maintain compliance with the *Radiation Protection Act 2006*.

During the year, four Council members' terms of appointment ended. All four Council members sought re-appointment and were re-appointed on 9 February 2011. Administrative delays in the appointment process meant that Cr Geoghegan remained the only member appointed to Council from 31 December 2010 to 9 February 2011. The Council provided a delegation to Cr Geoghegan on 15 December 2010 allowing licence and registration applications to be approved during the period after 1 January 2011 and before Council members were re-appointed. This delegation ended on 9 February 2011, when Council members were re-appointed. No approvals were granted under this delegation.

The Radiation Council grew in size to six members in 2011 with the appointment of Ms Elizabeth Croft. Ms Croft has many years experience working in the field of medical diagnostic imaging in both the public and private sectors. The Council welcomes Ms Croft and the valuable contribution she makes towards exercising Council functions.

The Radiation Protection (Tanning Unit) Amendment Regulation 2010 (No. 1) commenced on 17 November 2010. Owners and operators of solaria units were contacted before the regulation came into force informing them of the requirements for equipment registration and operator licensing. In May 2011 ARPANSA released an online training resource for operators of solaria. All solaria operators are required to complete this training to be granted a radiation licence.

The Council continues to monitor the development of codes of practice, standards and regulations from the Australian Radiation Protection and Nuclear Safety Agency (ARPANSA) regarding radiation safety. Information received from ARPANSA is considered in decisions made by the Council.

I wish to express my appreciation to the members of the Council for their expert contribution to the Council and to the staff of the Health Protection Service for their ongoing support.

Keith Fifield
Deputy Chair

June 2011

Council functions

The Radiation Protection Act 2006 (www.legislation.act.gov.au) controls the safe use, storage, transportation and disposal of radioactive material and irradiating apparatus. The Radiation Council is established under Part 5 of the *Radiation Protection Act 2006* and has the following functions:

- issuing licences
- registering regulated radiation sources
- advising the Minister on radiation protection issues
- exercising any other function given to it under the *Radiation Protection Act 2006* or another territory law.

Council members

The composition of the Radiation Council is specified in the *Radiation Protection Act 2006* as:

- one member who is a doctor registered under the *Health Practitioner Regulation National Law (ACT) Act 2010* in the specialist area of radiology
- one member with expert knowledge of the physical properties or biological effects of radiation
- a person who, in the Minister's opinion, has qualifications or experience relevant to assisting the Council to carry out its functions
- a member of the public.

A Council member must not be appointed for longer than three years.

Four Council members' terms of appointment ended on 31 December 2010. All four Council members sought re-appointment and were re-appointed to the Radiation Council on 9 February 2011. Members of the Radiation Council during 2010–11 were:

- Mr Anthony Agostino, Chair of the Council. Member since October 1996 and Chair since July 2003.
- Professor L Keith Fifield, Deputy Chair. Member since April 1999.
- Mrs Jean I Bennett. Member since May 1994.
- Dr Mervyn Despois. Member since September 2001.
- Dr Sean Geoghegan. Member since May 2009.
- Ms Elizabeth Croft. New member in February 2011.

Details of member appointments are given in Attachment 1.

Council meetings during 2010–11

The Radiation Council met nine times during the year. The dates of the meetings and member attendance are shown in Attachment 2.

Support for Council

The Health Protection Service of the ACT Health Directorate provided the secretariat service in support of the Radiation Council. The Health Protection Service has regulatory responsibility under the *Radiation Protection Act 2006.*

Regulatory standards

A number of standards, codes of practice, safety guides and recommendations are used by Council as a reference when considering matters relating to radiation protection policies, practices, conditions to be attached to licences, registrations and exemptions from the application of the *Radiation Protection Act 2006*. The list of reference materials is shown in Attachment 3.

Council activities and decisions

Approvals of regulatory instruments

Licences

The Council issued 296 new licences during the year. Together with licences reissued during the year, the total number of licence holders in the ACT is 859.

Registrations

The Council issued 54 new radiation registrations during the year. Together with registrations reissued during the year, the total number of registered radiation sources in the ACT is 515.

Radiation waste disposal

The Council received four reports on the disposal of radioactive material supervised by the ACT Health Directorate during 2010–11.

Decisions in 2010–11

The Council provided a delegation to Cr Geoghegan on 15 December 2010 allowing licence and registration applications to be approved during the period after 1 January 2011 and before Council members were re-appointed. This delegation ended on 9 February 2011.

National Directory for Radiation Protection

The National Directory for Radiation Protection provides the basis for achieving uniformity of radiation protection practices and legislation across all Australian jurisdictions for both ionising and non-ionising radiation. The directory is a constantly evolving document that reflects the best radiation protection practice of the time. The directory is updated following a prescribed process, designed to meet the *COAG Principles and Guidelines for National Standard Setting and Regulatory Action by Ministerial Councils and Standard-setting Bodies (November 1997)*, and after amendments are endorsed by the Australian Health Ministers' Conference.

The Council is regularly briefed on developments with regard to the work of the national Radiation Health Committee (RHC) of ARPANSA. The ACT has a jurisdictional representative on the RHC.

Exemptions, clinical trials, incidents

- The National Directory for Radiation Protection (Amendment 4) in April 2010 listed the following exemption in Schedule 5:
- (g) An electron capture detector or similar device used in gas chromatography containing a nickel-63 sealed source with activity not more than 750MBq, or tritium source with activity not more than 20GBq, is exempted from the requirements of registration, and of licensing the end user to possess or use.
- Consequently several registrations and licences pertaining to nickel-63 sealed sources were not required to be renewed during 2010–11.
- The Council did not receive any requests for clinical trials.
- No radiation incidents were reported to the Council during the year.

Enforcement

No legal proceedings were commenced in 2010–11.

Investigations conducted by the Council

There were no investigations conducted during 2010–11.

Keith Fifield
Deputy Chair

June 2011

Attachment 1

Members of Radiation Council during 2010–11 appointed under Radiation Protection Act 2006

Member	Designation	Appointed under	Appointment period
Mr A Agostino	Chair	Section 68 and 70	1 January 2008– 31 December 2010 Re-appointed 9 February 2011– 30 November 2013
Mrs J I Bennett	Serves as a member of the general public	Section 68	1 January 2008– 31 December 2010 Re-appointed 9 February 2011– 30 November 2013
Dr M Despois	Radiologist	Section 68	1 January 2008– 31 December 2010 Re-appointed 9 February 2011– 30 November 2013
Prof L K Fifield	Deputy Chair	Section 68 and 70	1 January 2008– 31 December 2010 Re-appointed 9 February 2011– 30 November 2013
Dr S Geoghegan	Member	Section 68	5 May 2009– 4 May 2012
Ms E Croft	Member	Section 68	9 February 2011– 30 November 2013

Attachment 2

Radiation Council meetings during 2010–11

Member	238 7 Jul	239 18 Aug	240 6 Oct	241 10 Nov	242 15 Dec	243 16 Feb	244 16 Mar	245 4 May	246 8 Jun
Mr A Agostino			A			A		A	
Prof L K Fifield	A						A		
Mrs J I Bennett									
Dr M Despois		A					A		
Dr S Geoghegan			A						
Ms E Croft	N/A	N/A	N/A	N/A	N/A				

attended
A apology

Attachment 3

Standards, codes of practice and recommendations employed to support Council decisions

Australian Radiation Protection and Nuclear Safety Agency (ARPANSA), Radiation Protection Series (RPS) and Radiation Health Series (RHS) publications (available from www.arpansa.gov.au)

All publications from ARPANSA, RPS and RHS.

Australian Standards

Automatic Fire Detection and Alarm Systems—Part 2: Point Type Smoke Detectors AS 1603.2—1990

Self-Contained Smoke Alarms—AS 3786—1990

Approval and test specification—Medical electrical equipment

Part 1.3: General requirements for safety—Collateral Standard: Requirements for radiation protection in diagnostic X-ray equipment—AS 3200.1.3:1996

Approval and test specification–Medical electrical equipment

Part 2.201: Particular requirements for safety—Dento-maxillofacial X-ray Equipment—AS 3200.2.201:1996

Safety in Laboratories—Part 4: Ionizing Radiations AS 2243.4—1998

Solaria for Cosmetic Purposes AS/NZS 2635:2002

International Atomic Energy Agency

IAEA Safety Series No. 115 (1996)
International Basic Safety Standards for protection against Ionizing Radiation and for the Safety of Radiation Sources

IAEA Safety Series No. 21 (202)
Optimization of Radiation Protection in the Control of Occupational Exposure

IAEA No. 37 (2004)
Methods for Assessing Occupational Radiation Doses due to Intakes of Radionuclides

IAEA Safety Series No. 39 (2006)
Applying Radiation Safety Standards in Diagnostic Radiology and Interventional Procedures Using X Rays

International Commission on Radiological Protection

ICRP 51 (1987)	Data for Use in Protection Against External Radiation
ICRP 57 (1989)	Radiological Protection of the Worker in Medicine and Dentistry
ICRP 60 (1990)	1990 Recommendations of the International Commission on Radiological Protection
ICRP 62 (1991)	Radiological Protection in Biomedical Research
ICRP 62 (1991)	Summary of the Current ICRP Principles for Protection of the Patient in Diagnostic Radiology
ICRP 64 (1993)	Protection from Potential Exposure: A Conceptual Framework
ICRP 68 (1994)	Dose Coefficients for Intakes of Radionuclides by Workers
ICRP 68 (1994)	Summary of the Current ICRP Principles for Protection of the Patient in Nuclear Medicine
ICRP 73 (1996)	Radiological Protection and Safety in Medicine
ICRP 75 (1997)	General Principles for the Radiation Protection of Workers
ICRP 80 (1998)	Radiation Dose to Patients from Radiopharmaceuticals
ICRP 84 (2000)	Pregnancy and Medical Radiation
ICRP 85 (2000)	Avoidance of Radiation Injuries from Medical Interventional Procedures
ICRP 86 (2000)	Prevention of Accidental Exposures to Patients Undergoing Radiation Therapy
ICRP 87 (2000)	Managing Patient Dose in Computed Tomography
ICRP 93 (2004)	Managing Patient Dose in Digital Radiology
ICRP 94 (2004)	Release of Patients after Therapy with Unsealed Radionuclides
ICRP 97 (2005)	Prevention of High-dose-rate Brachytherapy Accidents
ICRP 98 (2005)	Radiation Safety Aspects of Brachytherapy for Prostate Cancer using Permanently Implanted Sources
ICRP 99 (2005)	Low-dose Extrapolation of Radiation-related Cancer Risk
ICRP 101 (2006)	Assessing Dose of the Representative Person for the Purpose of Radiation Protection of the Public and the Optimisation of Radiological Protection: Broadening the Process
ICRP 102 (2007)	Managing Patient Dose in Multi-Detector Computed Tomography (MDCT)
ICRP 103 (2008)	Recommendations of the ICRP
ICRP 104 (2008)	Scope of Radiological Protection Control Measures
ICRP 105 (2008)	Radiological Protection in Medicine

Abbreviations

AHMC	Australian Health Ministers' Conference
ARPANSA	Australian Radiation Protection and Nuclear Safety Agency
COAG	Council of Australian Governments
HPS	Health Protection Service of ACT Government Health Directorate
RHC	Radiation Health Committee of ARPANSA

Alphabetical Index