GREATER SOUTHERN
AREA HEALTH SERVICE
NSW HEALTH

# Annual Report

## 2007-2008

GREATER SOUTHERN
AREA HEALTH SERVICE
NSW HEALTH

# GREATER SOUTHERN AREA HEALTH SERVICE

# ANNUAL REPORT

# 2007-2008

## Map of Greater Southern Area Health Service


**Acknowledgements**
Chief Executive, Executive team and staff of Greater Southern Area Health Services who contributed to this Annual Report.

January 2009

**Further copies of this report can be downloaded from:**
http://www.gsahs.nsw.gov.au/

GREATER SOUTHERN
AREA HEALTH SERVICE
NSW HEALTH

**Incorporating**

**Health Services**
Adelong
Albury
Ardlethan
Barellan
Barham
Barmedman
Batlow
Batemans Bay
Bega
Berrigan
Bombala
Boorowa
Braidwood
Coolamon-Ganmain
Coleambally
Cooma
Cootamundra
Corowa
Crookwell
Culcairn
Darlington Point
Delegate
Deniliquin
Eden
Finley
Goulburn
Griffith
Gundagai
Gunning
Hay
Henty
Hillston
Holbrook
Jerilderie
Jindabyne
Junee
Leeton
Lockhart
Mathoura
Moama
Moruya
Moulamein
Murrumburrah-Harden
Narooma
Narrandera
Pambula
Queanbeyan
Tarcutta
Temora
The Rock
Tocumwal
Tooleybuc
Tumbarumba
Tumut
Ungarie
Urana
Wagga Wagga
Weethalle
West Wyalong
Yass
Young

**Better Health for Rural People**

The Hon John Della Bosca, MLC
Minister for Health
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Minister

I have pleasure in submitting the Greater Southern Area Health Service 2007/08 Annual Report.

The Report complies with the requirements for annual reporting under the Accounts and Audit determination for public health organisations and the 2007/08 Directions for Health Service Annual Reporting.

Yours sincerely

**Heather Gray**
**Chief Executive**
**Greater Southern Area Health Service**

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## GREATER SOUTHERN AREA HEALTH SERVICE: THE YEAR IN REVIEW

It is with pleasure that I present the Greater Southern Area Health Service Annual Report for the 2007/08 period.

Greater Southern Area Health Service received positive feedback in the NSW Health 2007 Patient Survey where 90% of patients surveyed rated overall care as good, very good or excellent. GSAHS staff were rated amongst the highest in NSW for a number of key areas of the survey which demonstrates the highly regarded care and professionalism of staff in GSAHS facilities. I would like to formally acknowledge the excellence of our staff and congratulate them on the results of the survey.

A number of GSAHS managers and staff were thrilled to be recipients of Performance Awards announced at the 2007 NSW Health Awards. Staff from Albury Base Hospital and Goulburn Base Hospital both won category Best Performance Awards whilst the staff of Wagga Wagga Base Hospital the Most Improved Performance Award. These awards recognise the achievement of performance targets and are judged across peer hospital groups in NSW. I would like to congratulate the managers and staff at these sites on these outstanding results.

Another important achievement for the GSAHS corporate sector was the progression from certification status to achieve full accreditation with the Australian Council of Healthcare Standards (ACHS). This recognises the high standards of GSAHS practice against industry standards and quality improvement frameworks. ACHS certification was achieved by the mental health division and all 10 GSAHS Clusters during the 2007-08 period. The coming year will see continued preparation for full accreditation by clinical areas of the health service.

This positive recognition by patients, NSW Health and ACHS attests to the important work undertaken by GSAHS executive, managers and staff during the year. However, GSAHS is also looking forward in an effort to improve the health of our communities in years to come with a focus on programs and initiatives to prevent illness in the long term.

This reflects a significant international trend in health care in the move towards primary and preventative health care. This involves promoting well being in the community which prevents the inconvenience and expense of illness in the longer term. Preventative and primary health initiatives underway in GSAHS include dietary and nutrition programs for schools, smoking cessation activities and falls prevention programs for older members of the community. While the outcomes of these programs will not be realised for some years, I believe the work being undertaken now will be realised in a healthier future for rural people.

A number of major capital works were progressed and completed over the last 12 months including Berrigan, Bombala and Junee Multipurpose Services. I would like to thank all the staff, facility residents and community members involved in these projects. Also of note was the opening of the Wagga Wagga Base Hospital four bed stroke unit; a new Emergency Department at Griffith Base Hospital and a new Operating Theatre Suite and Dialysis Unit at Bega District Hospital.

Administratively, the 2007-08 financial year also saw changes to the internal alignment of GSAHS boundaries with the 10 cluster model replaced with three sectors. The sector model enables newly appointed General Managers to work more closely with facility staff and will strengthen relationships with local communities. The sectors also have increased operational support to improve planning and managing of health services in the area.

The consumer voice is important to GSAHS and the Greater Southern Area Health Advisory Council (GS AHAC) provided a great deal of valuable comment along with submissions on a range of topics at national, state and health service level. I would like to thank this group for their contribution to the health service and their assistance over the past year.

I would also like to thank our much valued volunteers and fundraising groups whose important work makes such a difference to the comfort and care of patients and clients of the health service.

Heather Gray
Chief Executive

## HIGHLIGHTS of 2007/2008

- Australian Council of Healthcare Standards (ACHS) accreditation achieved in the corporate sector. Certification achieved within mental health and all 10 GSAHS Clusters

- GSAHS Hospitals winners at the 2007 NSW Health Awards
  - Albury Base Hospital - Non Major Non Metropolitan Hospital Best Performance Award
  - Goulburn Base Hospital - Major Rural District Hospital Best Performance Award
  - Wagga Wagga Base Hospital - Non Major Non Metropolitan Hospital Most Improved Performance Award

- Completion of capital works and Official Opening of:
  - Berrigan Multipurpose Service
  - Bombala Multipurpose Service
  - Junee Multipurpose Service (opening scheduled for July 2008)
  - four bed stroke unit, Wagga Wagga Base Hospital
  - new Emergency Department, Griffith Base Hospital
  - new Operating Theatre Suite and Dialysis Unit, Bega District Hospital

- Appointment of Project Director, Procurement for the Wagga Wagga Health Service redevelopment

- GSAHS implemented an internal administrative realignment to aggregate the area into three sectors. General Managers were appointed to each Sector with a focus on localising decision making and increasing operational support at each Sector level

- The Mental Health Emergency Care Support Centre was launched. This initiative uses videoconferencing to provide 24 hour support for assessment and support of mental health clients in rural centres across the health service, improving outcomes for this client group. Roll out is continuing

- Oncology services were expanded in the Cooma area with the introduction of a Shared Care Model. This has enabled some oncology clients to receive treatment without travelling to a metropolitan area. Client care is delivered by specifically trained local General Practitioners and nursing staff under the guidance of Oncology Specialists in metropolitan areas

- Bridging the GAP (Goulburn Ambulatory Program) was introduced in Goulburn to reduce avoidable admissions to hospital for clients living with Chronic Respiratory Conditions.

- Commencement of a new model of care at Giles Court, Goulburn with a Transitional Behavioural Assessment and Intervention Service which provides intensive assessment and treatment of dementia clients by a multidisciplinary team of staff with specialised skills

- Introduction of antenatal shared care model at Young Health Service increasing the range of options for mothers by offering midwifery led support in partnership with Obstetricians. The model will be extended to other facilities in the area

- Achievement of surgical waitlist targets

- Realignment of mental health management structure to commune the management of Mental Health and Drug and Alcohol services
- Successful implementation of the drought relief initiative with activities across the area to support drought affected communities utilising a whole of government approach
- Planning for a 20 bed non-acute mental health inpatient unit in Griffith is well underway
- Continued increase numbers of staff in mental health workforce
- Successful application of service redesign methodology to address mental health access block, meeting benchmark every month for the year.

## TABLE OF CONTENTS

## Greater Southern Area Health Service Profile

Greater Southern Area Health Service (GSAHS) encompasses 39 local government areas, including:

| | | | |
|---|---|---|---|
| Albury | Cootamundra | Jerilderie | Temora |
| Bega Valley | Corowa | Junee | Tumbarumba |
| Berrigan | Deniliquin | Leeton | Tumut |
| Bland | Eurobodalla | Lockhart | Upper Lachlan |
| Bombala | Goulburn-Mulwaree | Murray | Urana |
| Boorowa | Greater Hume | Murrumbidgee | Yass Valley |
| Carrathool | Griffith | Narrandera | Young |
| Conargo | Gundagai | Palerang | Wagga Wagga |
| Coolamon | Harden | Queanbeyan | Wakool |
| Cooma - Monaro | Hay | Snowy River | |

Much of the industry of the Greater Southern area is related to agriculture. There is also a variety of business and industrial enterprises outside of agriculture including government departments, Defence Forces, tertiary institutions, forestry and tourism. GSAHS contributes significantly to communities as one of the region's major employers, employing just over 5000 Full Time Equivalent (FTE) staff in a range of clinical and non-clinical roles.

There are 33 hospitals and two affiliated public hospitals within GSAHS providing a range of services and varying levels of care.

There are also 12 fully established Multi Purpose Services and 62 Community Health Centres predominantly co-located with hospitals across the area. These major centres provide outreach services to another 40 smaller towns and villages. All hospitals are open 24 hours per day; seven days per week and community health facilities are open from 8.30am to 5.00pm Monday to Friday.

In 2006, GSAHS had an estimated resident population of approximately 474,000 people. The population is expected to grow to around 498,000 by 2016. In 2006 half of all GSAHS residents were aged 39 years or older. Over 15.5% of the population were aged 65 years and over. Projections to 2016 indicate an increase across all age groups over 50 in the coming years (see figure 1).

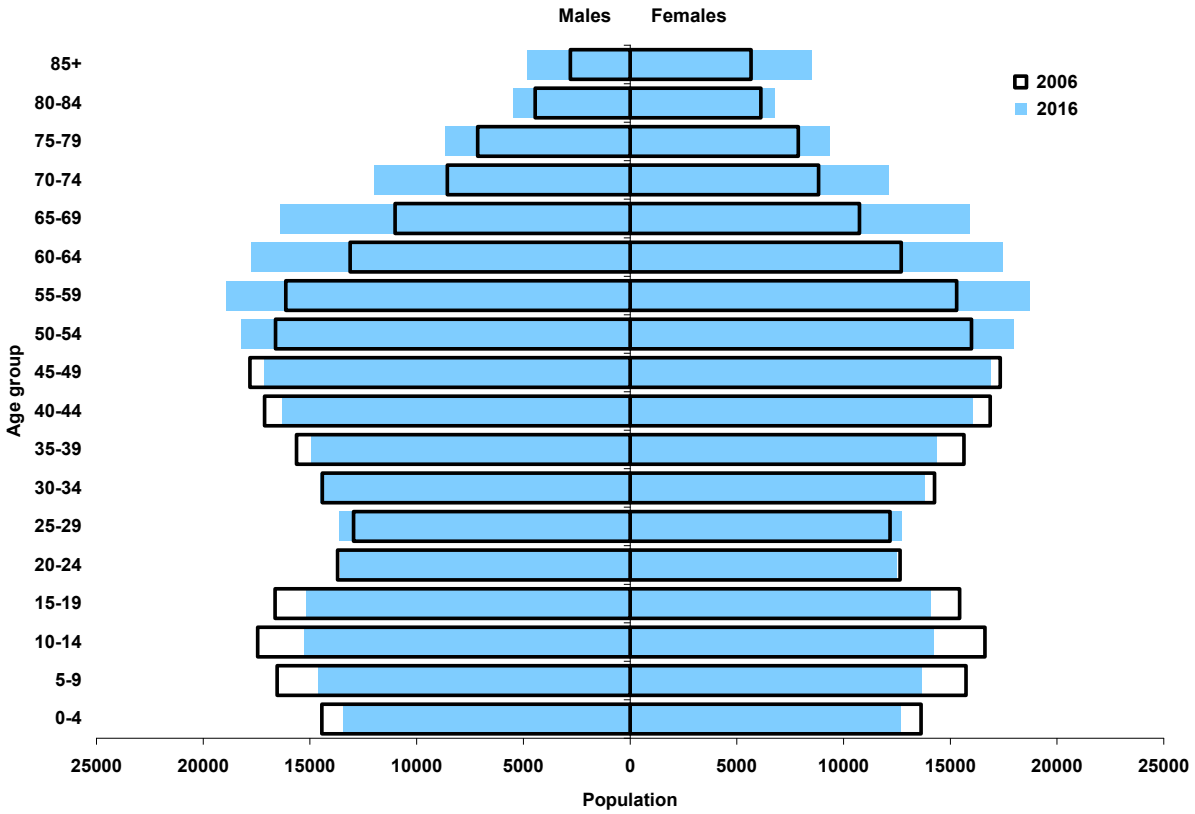
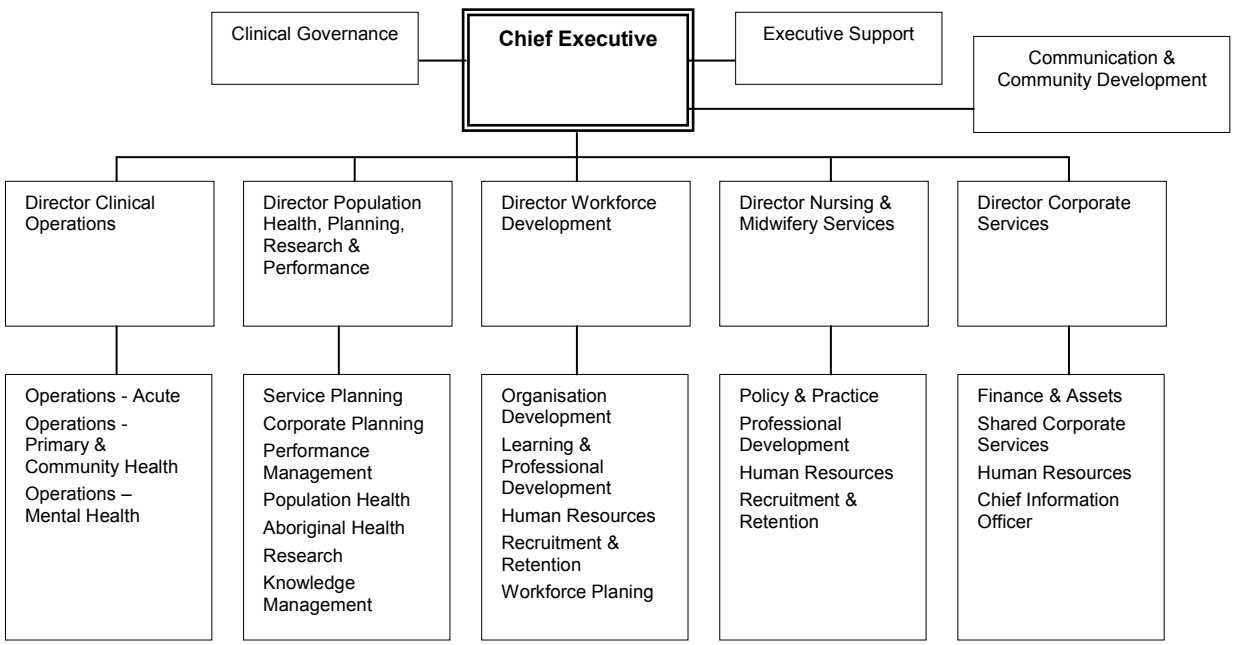



*Figure 1 - Population projections by age group and sex GSAHS 2006 to 2016*

Source: Transport and Population Data Centre (TPDC), NSW Department of Planning, NSW SLA Population Projections, 2001 to 2031, 2005 Release. GSAHS Population Health 2007.

## GSAHS Executive Management Structure



## GSAHS Vision and Goals

**Vision:**
Better health for rural people

**Mission:**
To promote and deliver accessible quality health services for all people living in the Greater Southern area through an integrated health system.

**GSAHS goals:**
- To keep people healthy
- To provide the health care that people need
- To deliver high quality services
- To manage health services well

**The Seven Strategic Directions:**
1. Make prevention everybody's business
2. Create better experiences for people using health services
3. Strengthen primary health and continuing care in the community
4. Build regional and other partnerships for health
5. Make smart choices about the costs and benefits of health services
6. Build a sustainable health workforce
7. Be ready for new risks and opportunities

The values identified by the organisation are:
- Patients first
- Best value
- Results matter
- Improvements through knowledge
- [Being] open to innovation and research

The concepts underpinning and activating these values are:
- Accountability
- Integrity
- Respect
- Competence
- Leadership
- Quality
- Equity
- Respect, caring and trust will characterise all our relationships

**GSAHS will:**
- Ensure the delivery of quality specialty and area-wide services
- Set directions and develop area-wide standards
- Allocate resources to support optimal health outcomes
- Measure, monitor and report on performance
- Foster the creation of knowledge and innovation through research and learning

# Strategic Direction 1
# Make prevention everybody's business

### Performance Indicator: Chronic disease risk factors
The NSW Health Survey includes a set of standardised questions to measure health behaviours.

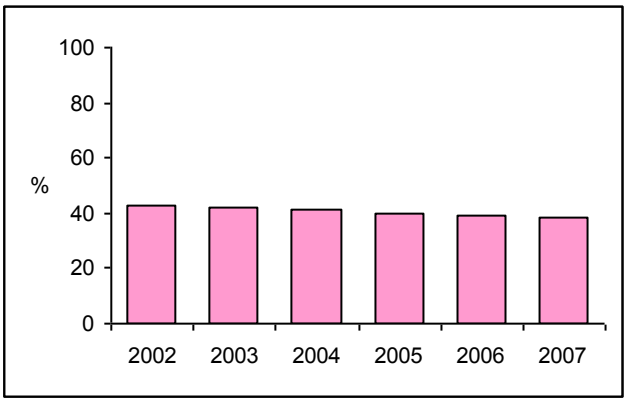
### Desired outcome
Reduced prevalence of chronic diseases in adults.

## Alcohol
Alcohol has both acute (rapid and short but severe) and chronic (long lasting and recurrent) effects on health. Too much alcohol consumption is harmful, affecting the health and wellbeing of others through alcohol-related violence and road trauma, increased crime and social problems.

**Chronic Disease Risk Factors:** Alcohol - risk drinking behaviour (%)
Source: NSW Health Survey. Centre for Epidemiology and Research – GSAHS

| | 1997 | 1998 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|---|
| **GSAHS %** | 47.6 | 46.8 | 43.1 | 41.9 | 41 | 40.2 | 38.9 | 38.2 |

GSAHS




### Comment
It is pleasing to note that risky drinking behaviour in GSAHS has reduced by almost 10% over the last 10 years, down to 38.2% in 2007. This is in line with major Commonwealth and State initiatives to reduce harm from alcohol consumption.

The GSAHS Drink-Drive Prevention Team has provided significant amounts of education and material resources to assist individuals to reduce risky drinking behaviour.

The Drug and Alcohol counselling team has provided therapy and support to many individuals to assist with managing alcohol problems. Over half the referrals to the Drug and Alcohol service relate to alcohol as the principle drug of concern.

During Drug Action Week in June 2008, a number of public awareness campaigns promoted the theme "Alcohol is a Drug Too!".

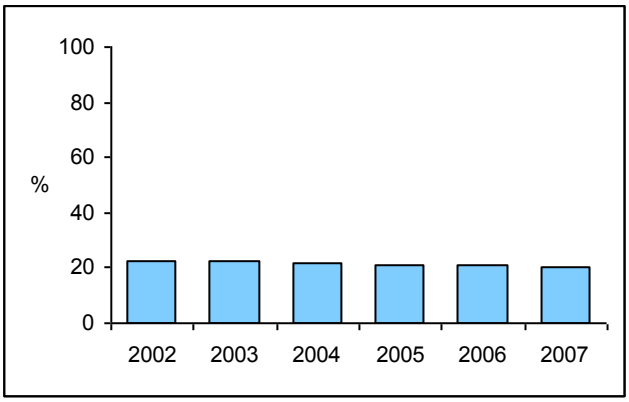
## Smoking

Smoking is responsible for many diseases including cancers, respiratory and cardio-vascular diseases, making it the leading cause of death and illness in NSW. The burden of illness resulting from smoking is greater for Aboriginal adults than the general population.

**Chronic Disease Risk Factors:** Smoking - daily or occasionally (%)
Source: NSW Health Survey. Centre for Epidemiology and Research – GSAHS

| | 1997 | 1998 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|---|
| **GSAHS %** | 25.4 | 24.9 | 22.7 | 22.2 | 21.9 | 21.2 | 20.8 | 20.1 |

GSAHS




**Comment**

Rates for these risk factors in GSAHS are still higher than the NSW average; of greater concern is the high prevalence in Aboriginal adults, including pregnant women. This group has remained at rates of 50% and over for the past decade, whilst the general population prevalence of daily/occasional smokers continues to decrease and is currently around 20%.

In July 2007, GSAHS sites implemented the final phase of the NSW Health Smoke Free Workplace Policy (excluding Mental Health Inpatient Facilities and Residential Aged Care Facilities), making all sites totally smoke free.

GSAHS has commenced development of a comprehensive two-strand project focusing on the reduction of smoking rates of pregnant women and their partners, and reducing environmental tobacco smoke exposure of pregnant women who smoke and their families. These projects will target disadvantaged population groups including people from an Aboriginal background and people of lower socio-economic status.

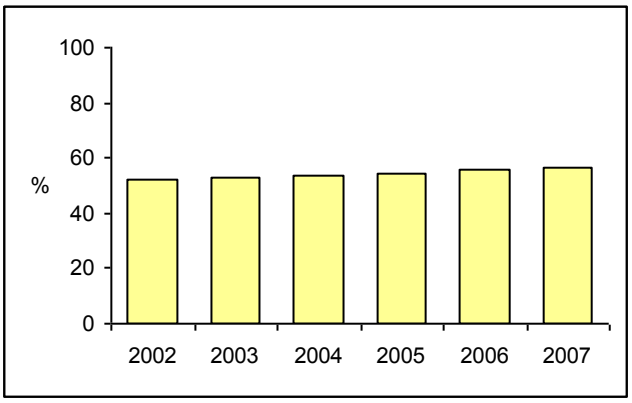
## Overweight and obese

Being overweight or obese increases the risk of a wide range of health problems, including cardio-vascular disease, high blood pressure, type 2 diabetes, breast cancer, gallstones, degenerative joint disease, obstructive sleep apnoea and impaired psychosocial functioning.

**Chronic Disease Risk Factors:** Overweight or obese (%)
Source: NSW Health Survey. Centre for Epidemiology and Research – GSAHS

| | 1997 | 1998 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|---|
| **GSAHS %** | 47.8 | 48.6 | 52.1 | 52.9 | 53.8 | 54.5 | 55.7 | 56.3 |

GSAHS




**Comment**

The increasing prevalence of overweight and obesity amongst GSAHS residents is consistent with trends across the developed world.

During 2007/08 GSAHS implemented a multi-strategic approach to preventing weight gain targeting mainly children 0-12 years of age in preschool and school settings. In 2007/08 GSAHS instigated the following strategies:

- Identification of a Health Development Officer to participate in the GSAHS Breastfeeding Network led by Women's Health
- Implementation of the *Eat Smart Play Smart* nutrition and physical activity program in 39 Out of School Hours Care services across GSAHS. Eighty one coordinators or staff delegates participated in professional development workshops conducted in partnership with the National Heart Foundation
- Implementation of the *Munch and Move* statewide initiative to improve fundamental movement skills, nutritional intake and reduce small screen viewing time of young children between two and five years of age. Fifty two of the 80 preschools invited by GSAHS to participate sent 80 staff members to training in Queanbeyan, Bega, Wagga Wagga, Albury and Griffith
- Implementation of the *Live Life Well@School* statewide initiative in 19 schools in GSAHS who took up the invitation by our partner agency Department Education and Training (DET) to participate. A GSAHS small grants program and Heath Development Officer enabled schools to implement their action plans to improve understanding of nutrition and physical activity
- Implementation and evaluation of the *Eat Well Move More* program, aimed at guiding people in making healthier choices when eating out in Albury, Lavington or Thurgoona. A small percentage of people indicated that they made healthier choices in line with the program
- Design of a resource to reinforce key messages associated with the Australian Better Health Initiative national social marketing campaign. The resource provides ideas for dried, canned and frozen alternatives to fresh fruit and vegetables and will be distributed to 12,000 households across GSAHS identified as the most disadvantaged through drought and associated circumstances, to coincide with phase one of the national campaign, October – November 2008
- Identification a Health Development Officer to represent the health development perspective on the GSAHS Area Implementation Team to be lead by Hotel Services
- Health Development Officers and Dietitians continued to provide support to existing Fresh Tastes@School canteen networks in Eurobodalla, Bega Valley and Wagga Wagga and a new network in Griffith/Leeton

- A project team investigated the extent of food security issues related to socio economic status in GSAHS using a set of indicators they developed for that purpose
- Completion of a needs assessment to determine the feasibility of conducting a Healthy Family Lifestyle Program in the Wagga Wagga Cluster and potentially other clusters within GSAHS

## Performance Indicator: Potentially avoidable deaths

Potentially avoidable deaths are those attributed to conditions that are considered preventable through health promotion, health screening and early intervention, as well as medical treatment. Potentially avoidable deaths data (before age 75 years) provides a measure that is more sensitive to the direct impacts of health system interventions than all premature deaths.

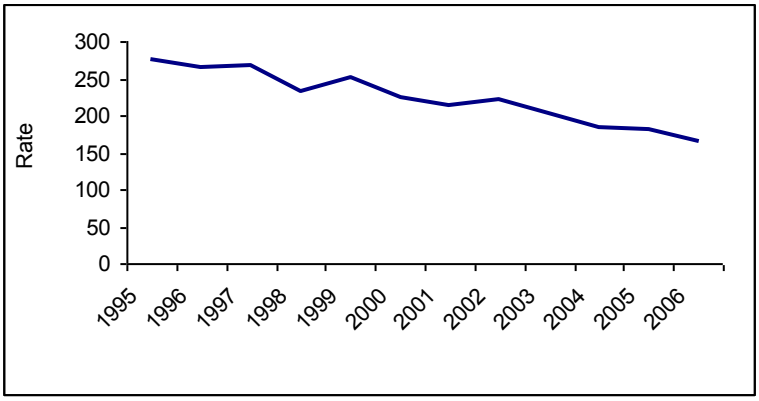
**Desired outcome**

Increased life expectancy.

**Potentially avoidable deaths -** persons aged 75 and under (age-adjusted rate per 100,000 population) – GSAHS

| | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **GSAHS** | 276 | 266 | 267 | 231 | 252 | 226 | 213 | 221 | 204 | 184 | 182 | 165 |

GSAHS




**Comment**

The majority of potentially avoidable deaths are preventable through primary interventions. GSAHS health development programs aimed at increasing physical activity, reducing falls and reducing tobacco use have contributed to the reduction in figures, along with immunisation and infectious disease prevention and control. In addition, cancer screening programs and improved management of chronic and complex diseases contribute to this decrease in potentially avoidable mortality.

## Performance Indicator: Adult immunisation

Vaccination against influenza and pneumococcal disease is recommended by the National Health and Medical Research Council (NHMRC) and provided free for people aged 65 years and over, Aboriginal people aged 50 and over, and those aged 15–49 years with chronic ill health.

**Desired outcome**

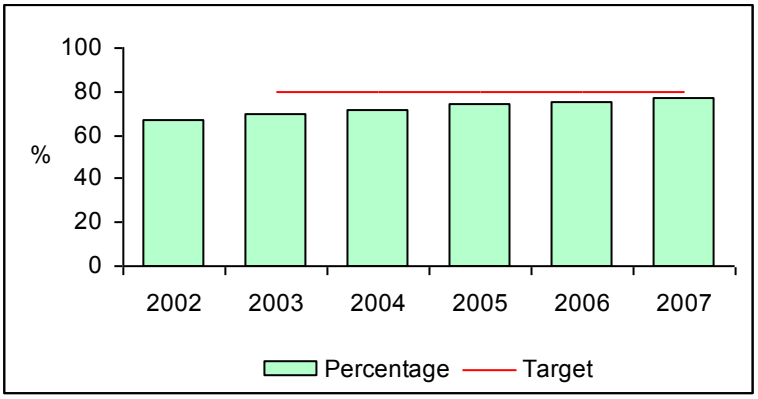
Reduced illness and death from vaccine-preventable diseases in adults.

**Adult Immunisation - GSAHS**
Source: NSW Health Survey, Centre for Epidemiology and Research

**People aged 65 years and over vaccinated against influenza -** in the last 12 months (%)

| | 1997 | 1998 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|---|
| **Percentage** | 59.5 | 60.7 | 67.1 | 69.6 | 71.9 | 73.9 | 75.5 | 76.9 |
| **Target** | - | - | - | 80 | 80 | 80 | 80 | 80 |

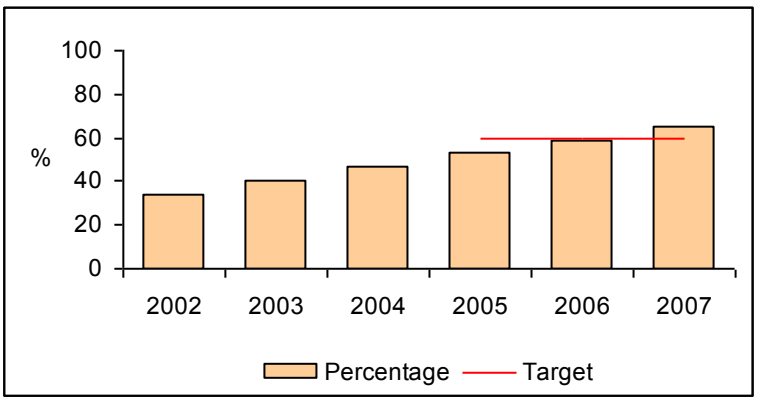
GSAHS




**People aged 65 years and over vaccinated against pneumococcal disease** - in the last 5 years (%)

| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|
| **Percentage** | 34.1 | 40.1 | 46.5 | 52.8 | 58.5 | 64.7 |
| **Target** | - | - | - | 60 | 60 | 60 |

GSAHS




**Comment**
GSAHS continues to promote influenza and pneumococcal vaccination and provides support to immunisation providers. These vaccinations are provided in the private market only. As such GSAHS relies heavily on State and Commonwealth promotional campaigns and General Practitioner (GP) diligence to achieve high vaccination rates in this age group.

GSAHS will continue to work with these groups in promoting vaccination.

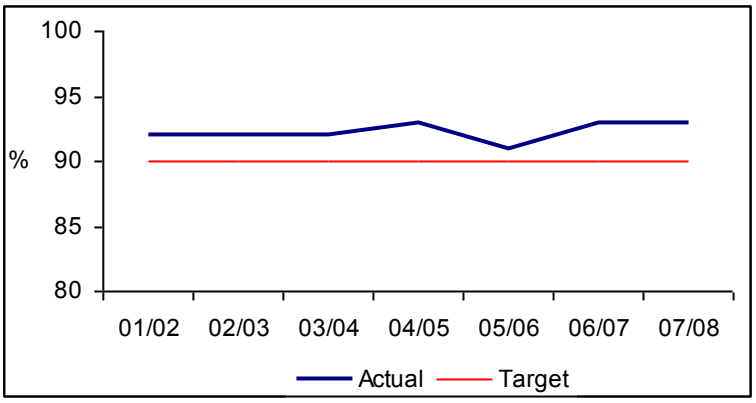
## Performance Indicator: Children fully immunised at one year

Although there has been substantial progress in reducing the incidence of vaccine preventable disease in NSW, it is an ongoing challenge to ensure optimal coverage of childhood immunisation.

**Children fully immunised at 1 year (%)** – GSAHS
Source: Australian Childhood Immunisation Register (ACIR)

| | 2001/02 | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|---|---|---|
| **Actual** | 92 | 92 | 92 | 93 | 91 | 93 | 93 |
| **Target** | 90 | 90 | 90 | 90 | 90 | 90 | 90 |

GSAHS




### Desired outcome

Reduced illness and death from vaccine preventable diseases in children.

### Comment

GSAHS continues to have amongst the highest vaccination rates in NSW and is consistently above NSW state targets.

The area health service provides public vaccination clinics, school based vaccinations and supports all immunisation providers through liaison and coordination with Divisions of General Practice, Aboriginal Medical Services and directly with GP's.

GSAHS will continue with current initiatives to maintain the above target rates.

## Performance Indicator: Fall injury hospitalisations – people aged 65 years and over

Falls is one of the most common causes of injury-related preventable hospitalisations for people aged 65 years and over in NSW. It is also one of the most expensive. Older people are more susceptible to falls, for reasons including reduced strength and balance, chronic illness and medication use. Nearly one in three people aged 65 years and older living in the community reports falling at least once in a year. Effective strategies to prevent fall-related injuries include increased physical activity to improve strength and balance, and providing comprehensive assessment and management of fall risk factors to people at high risk of falls.

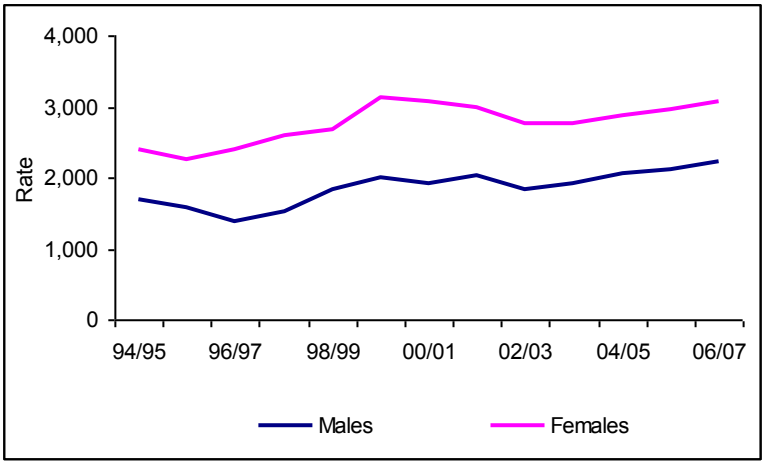
### Desired outcome

Reduced injuries and hospitalisations from fall-related injury in people aged 65 years and over.

**Fall injuries -** for people aged 65 yrs+ (age standardised hospital separation rate per 100,000 pop.) (excludes day-only stays) – GSAHS
Source: NSW Inpatient Statistics Collection and ABS population estimates (HOIST).

| | 94/95 | 95/96 | 96/97 | 97/98 | 98/99 | 99/00 | 00/01 | 01/02 | 02/03 | 03/04 | 04/05 | 05/06 | 06/07 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Males** | 1677 | 1587 | 1376 | 1529 | 1836 | 1992 | 1915 | 2028 | 1837 | 1917 | 2060 | 2112 | 2224 |
| **Females** | 2390 | 2250 | 2392 | 2597 | 2674 | 3137 | 3070 | 2989 | 2751 | 2774 | 2877 | 2958 | 3059 |

GSAHS




Note: This indicator is calculated differently than in previous years. The rate now includes same day hospital stays.

**Comment**
GSAHS has recognised the need for varied strategies to be effective in meeting the needs of the community in identifying, managing and preventing falls risk.

During 2007-08 GSAHS implemented a Physical Activity Leader Network (PALN) with an overall goal of ensuring low cost fall safe physical activity options for older people in rural communities. The outcome is to reduce falls injury. The PALN has trained 86 Tai Chi leaders and provides ongoing support to community volunteers to establish and enhance the delivery of a range of fall-safe exercise programs designed to improve balance and mobility on a not for profit basis. The program has been implemented in 47 communities across GSAHS with over 90 classes operating on a weekly basis. Some 1431 people are considered regular participants at Tai Chi classes.

This program will continue to expand in 2008-09 with formation of a research partnership with Charles Sturt University and the ongoing work of the Falls Project team to plan and implement a wide variety of strategies. These strategies will include:

- Implementation of a comprehensive communication plan
- Provision of network meetings for leaders
- Investment in further quality improvement measures for leaders eg. a Tai Chi Senior Trainer model as well as update and level 2 Tai Chi training for leaders as a quality improvement measure
- Ongoing promotion of classes and the network
- Support for Community Exercise Leaders to establish and maintain classes in a large number of communities across GSAHS

# Strategic Direction 2
# Create better experiences for people using health services

### Performance Indicator: Emergency department triage times - cases treated within benchmark times

Timely treatment is critical to emergency care. Triage aims to ensure that patients are treated in a timeframe appropriate to their clinical urgency, so that patients presenting to the emergency department are seen on the basis of their need for medical and nursing care and classified into one of five triage categories. Good management of emergency department resources and workloads, as well as utilisation review, delivers timely provision of emergency care.

### Desired outcome

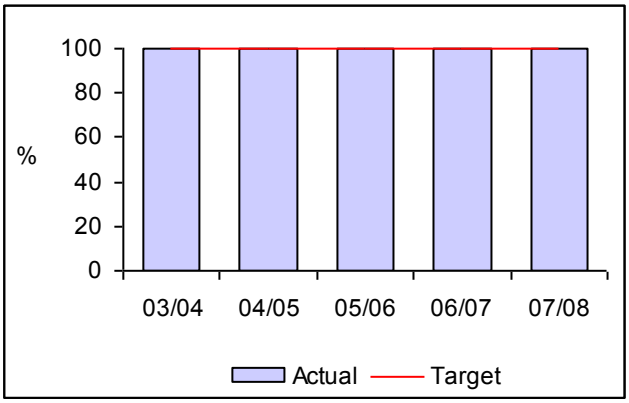
Treatment of emergency department patients within timeframes appropriate to their clinical urgency, resulting in improved survival, quality of life and patient satisfaction.

**Emergency department** - cases treated within Australian College of Emergency Medicine (ACEM) benchmark times (%) - GSAHS
Source: EDIS

**Triage 1 (within 2 minutes)**

| | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|---|
| **Actual** | 100 | 100 | 100 | 100 | 100 |
| **Target** | 100 | 100 | 100 | 100 | 100 |

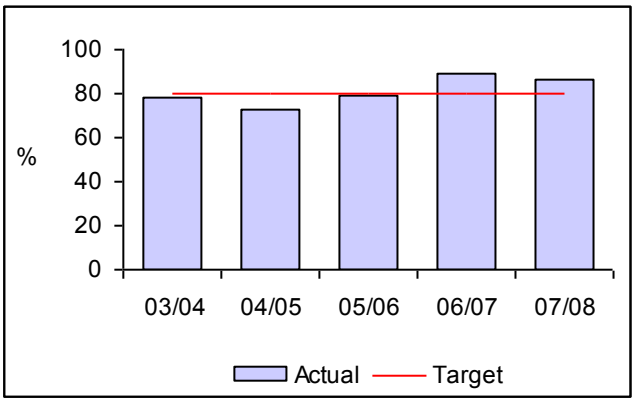
GSAHS




**Triage 2 (within 10 minutes)**

| | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|---|
| **Actual** | 78 | 73 | 79 | 89 | 86 |
| **Target** | 80 | 80 | 80 | 80 | 80 |

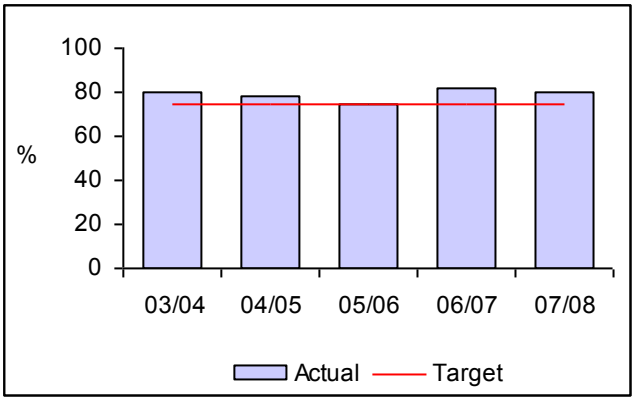
GSAHS




**Triage 3 (within 30 minutes)**

| | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|---|
| **Actual** | 80 | 78 | 75 | 82 | 80 |
| **Target** | 75 | 75 | 75 | 75 | 75 |

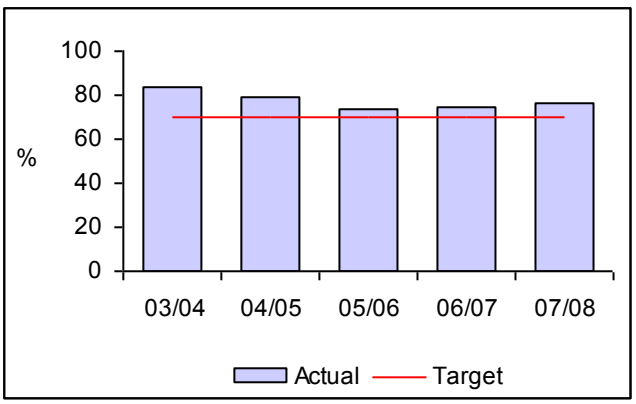
GSAHS




**Triage 4 (within 60 minutes)**

| | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|---|
| **Actual** | 84 | 79 | 74 | 75 | 76 |
| **Target** | 70 | 70 | 70 | 70 | 70 |

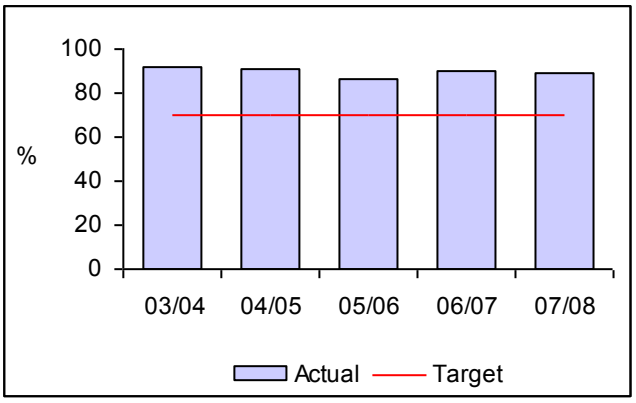
GSAHS



**Triage 5 (within 120 minutes)**

| | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|---|
| **Actual** | 92 | 91 | 86 | 90 | 89 |
| **Target** | 70 | 70 | 70 | 70 | 70 |

GSAHS




**Comment**
GSAHS facilities achieved all triage benchmarks in 2007/08 and maintained the high standard set in 2006/07 even though presentations were up by 2.6%.

## Performance Indicator: Off stretcher time < 30 minutes

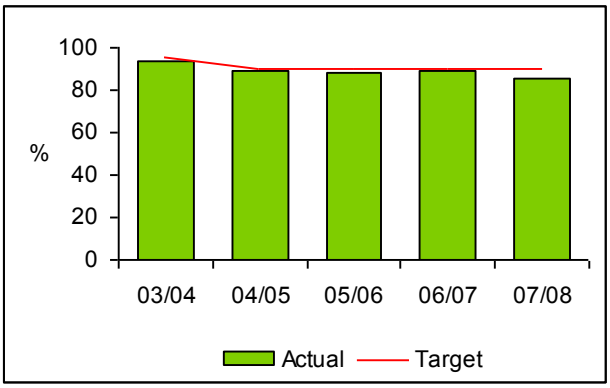
Timeliness of treatment is a critical dimension of emergency care. Better coordination between ambulance services and emergency departments allows patients to receive treatment more quickly. Also, delays in hospitals impact on Ambulance operational efficiency.

**Desired outcome**
Timely transfers of patients from ambulance to hospital emergency departments, resulting in improved survival, quality of life and patient satisfaction, as well as improved Ambulance operational efficiency.

**Off Stretcher time -** transfer of care to the emergency department < 30 minutes from ambulance arrival (%) - GSAHS
Source: Ambulance Service of NSW CAD System

| | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|---|
| **Actual** | 94 | 89 | 88 | 89 | 85 |
| **Target** | 95 | 90 | 90 | 90 | 90 |

GSAHS




**Comment**
GSAHS Off Stretcher Time decreased a little in 2007/08 compared to 2006/07. Additional cases in 2007/08 compared to 2006/07 impacted this benchmark.

## Performance Indicator: Emergency admission performance – patients transferred to an inpatient bed within 8 hours

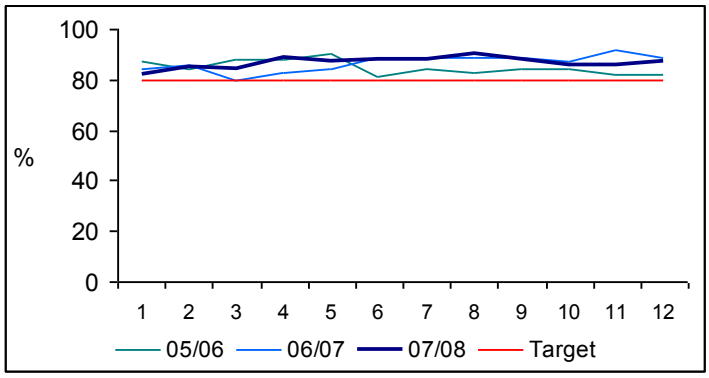
Patient satisfaction is improved with reduced waiting time for admission from the emergency department to a hospital ward, intensive care unit bed or operating theatre. Also, emergency department services are freed up for other patients.

**Desired outcome**
Timely admission from the emergency department for those patients who require inpatient treatment, resulting in improved patient satisfaction and better availability of services for other patients.

**Emergency Admission Performance** - Emergency department patients admitted to an inpatient bed within 8 hrs of commencement of active treatment (%) - GSAHS
Source: EDIS

| GSAHS | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 | Target |
|---|---|---|---|---|---|---|---|
| **Jul** | 86 | 17 | 84 | 87 | 84 | 82 | 80 |
| **Aug** | 87 | 85 | 84 | 84 | 86 | 85 | 80 |
| **Sep** | 87 | 87 | 84 | 88 | 80 | 84 | 80 |
| **Oct** | 89 | 87 | 88 | 88 | 83 | 89 | 80 |
| **Nov** | 86 | 86 | 85 | 90 | 84 | 87 | 80 |
| **Dec** | 89 | 15 | 89 | 81 | 89 | 88 | 80 |
| **Jan** | 89 | 16 | 87 | 84 | 89 | 88 | 80 |
| **Feb** | 88 | 86 | 88 | 83 | 89 | 90 | 80 |
| **Mar** | 88 | 86 | 88 | 84 | 89 | 88 | 80 |
| **Apr** | 88 | 85 | 88 | 84 | 87 | 86 | 80 |
| **May** | 85 | 85 | 84 | 82 | 92 | 86 | 80 |
| **Jun** | 84 | 85 | 83 | 82 | 89 | 87 | 80 |

GSAHS

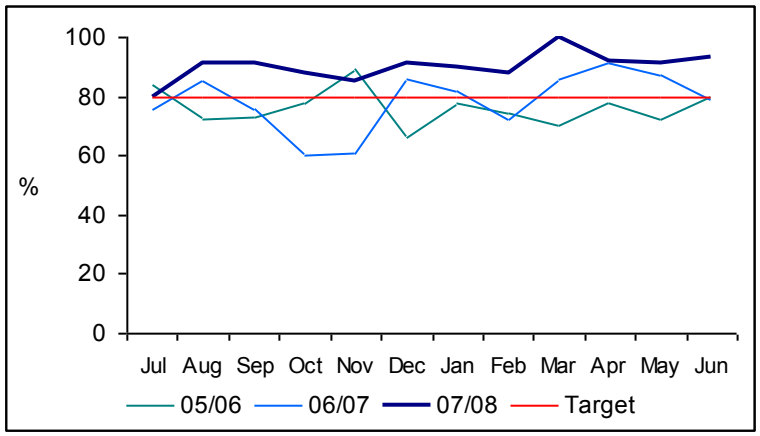



**Comment**
GSAHS has continued to perform above target for emergency admissions despite an increase in admissions by 4.6% over 2006/07.

**Emergency Admission Performance** - Mental health patients admitted to an inpatient bed within 8 hrs of commencement of active treatment (%) – GSAHS
Source: EDIS

| GSAHS | 2005/06 | 2006/07 | 2007/08 | Target |
|---|---|---|---|---|
| **Jul** | 84 | 76 | 80 | 80 |
| **Aug** | 72 | 85 | 91 | 80 |
| **Sep** | 73 | 76 | 91 | 80 |
| **Oct** | 78 | 60 | 88 | 80 |
| **Nov** | 89 | 61 | 85 | 80 |
| **Dec** | 66 | 86 | 91 | 80 |
| **Jan** | 78 | 82 | 90 | 80 |
| **Feb** | 74 | 72 | 88 | 80 |
| **Mar** | 70 | 86 | 100 | 80 |
| **Apr** | 78 | 91 | 92 | 80 |
| **May** | 72 | 87 | 91 | 80 |
| **Jun** | 80 | 79 | 93 | 80 |

GSAHS



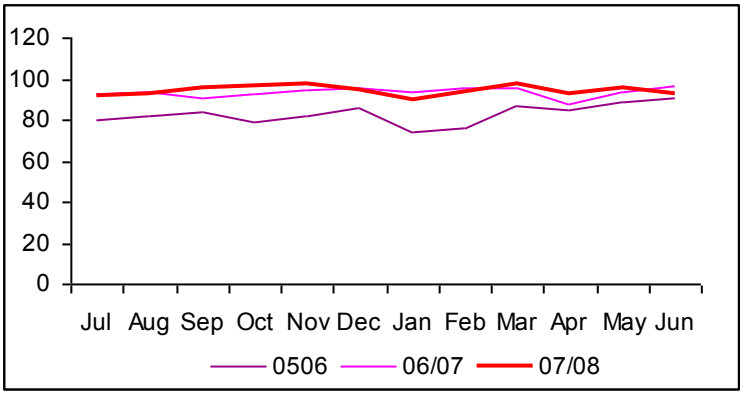

**Comment**
GSAHS has an average of 91% of mental health patients admitted to an inpatient bed within eight hours in 2007/08. This is favourable to benchmark and represents a 10% improvement on 2006/07 despite an additional 224 admissions.

**Elective Surgical Patients Admitted (%)**
Category 1 – within 30 days

**Category 1**

| Month | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|
| **Jul** | 80 | 92 | 92 |
| **Aug** | 82 | 94 | 92 |
| **Sep** | 84 | 91 | 95 |
| **Oct** | 79 | 92 | 97 |
| **Nov** | 82 | 95 | 97 |
| **Dec** | 85 | 96 | 95 |
| **Jan** | 74 | 94 | 90 |
| **Feb** | 76 | 96 | 94 |
| **Mar** | 86 | 96 | 97 |
| **Apr** | 85 | 88 | 92 |
| **May** | 89 | 93 | 95 |
| **Jun** | 91 | 97 | 93 |

GSAHS

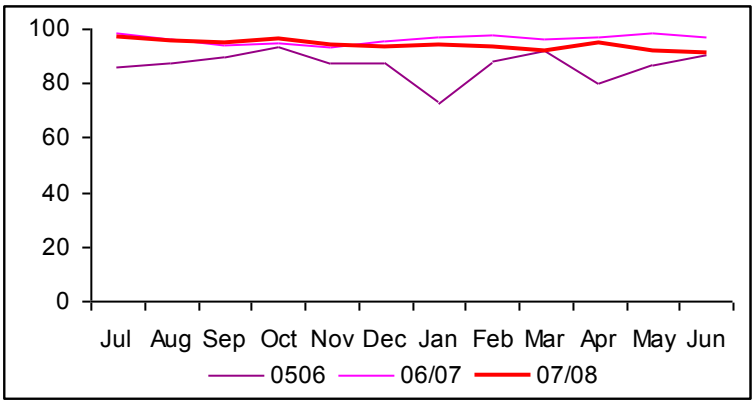



Category 3 – within 365 days

**Category 3**

| Month | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|
| **Jul** | 86 | 98 | 97 |
| **Aug** | 88 | 96 | 96 |
| **Sep** | 90 | 94 | 95 |
| **Oct** | 94 | 95 | 96 |
| **Nov** | 88 | 93 | 94 |
| **Dec** | 88 | 95 | 93 |
| **Jan** | 73 | 97 | 94 |
| **Feb** | 88 | 98 | 93 |
| **Mar** | 92 | 96 | 92 |
| **Apr** | 80 | 97 | 95 |
| **May** | 87 | 98 | 92 |
| **Jun** | 90 | 97 | 91 |

GSAHS




## Comment:

These results show that GSAHS has been consistent in admitting patients within the required time frame for the vast majority of patients, despite an increase in the number of additions to the waitlist - 26,092 in 2005/06 to 28,260 in 2007/08.

## Performance Indicator: Unplanned/unexpected readmissions within 28 days of separation – all admissions

Unplanned and unexpected re-admissions to a hospital may reflect less than optimal patient management. Patients might be re-admitted unexpectedly if the initial care or treatment was ineffective or unsatisfactory, or if post-discharge planning was inadequate. However, other factors occurring after discharge may contribute to readmission, for example poor post-discharge care. Whilst improvements can be made to reduce readmission rates, unplanned readmissions cannot be fully eliminated. Improved quality and safety of treatment reduces unplanned events.

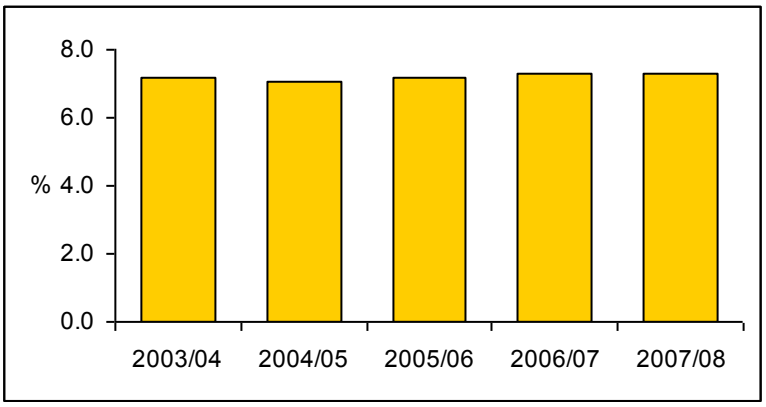
### Desired outcome

Minimal unplanned/unexpected readmissions, resulting in improved clinical outcomes, quality of life, convenience and patient satisfaction.

**Unplanned/unexpected readmissions within 28 days of separation** – all admissions (%) - GSAHS
Source: HIE

| Year | 2000/01 | 2001/02 | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|---|---|---|---|
| % | 6.5 | 6.8 | 6.8 | 7.2 | 7.1 | 7.2 | 7.3 | 7.3 |

GSAHS



**Comment**
On an area wide basis the unplanned readmission rate has remained stable. However, GSAHS is developing a program to assist specialties and facilities where the readmission rate is higher than expected.

## Performance Indicator: Healthcare Associated Bloodstream Infections

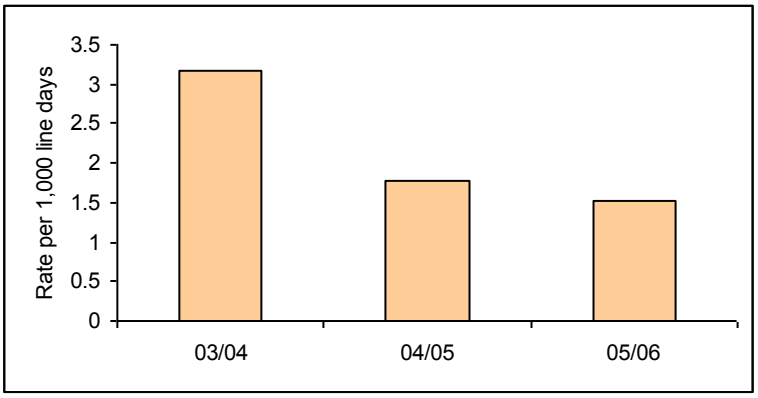
The implementation of the Clinical Excellence Commission Hand Hygiene Program "Clean Hands Save Lives", the recommendations made by the NSW Multi Resistant Organism Expert Group and the use of a best practice clinical guideline for inserting central lines, have positioned the NSW Health System to reduce the number of health care associated infections in ICU patients.

**Desired outcome**
Sustained, continual reduction in the incidence of central line bloodstream infections resulting in increased patient safety and improved clinical outcomes in ICU patients.

**Healthcare Associated Bloodstream Infections -** Rate of Intensive Care Unit Central line associated bloodstream infections per 1000 line days **–** GSAHS

| Year | 2003/04 | 2004/05 | 2005/06 |
|---|---|---|---|
| Rate | 3.18 | 1.77 | 1.51 |

GSAHS




**Comment**
GSAHS has implemented the Healthcare Associated Infections program which has resulted in reduced infections of all types including blood stream infections.

Initiatives include close monitoring of infection rates, improving hand hygiene compliance, infection control education and compliance with documented guidelines for the insertion of cental venous lines.

## Performance Indicator: Deaths as a result of a fall in hospital

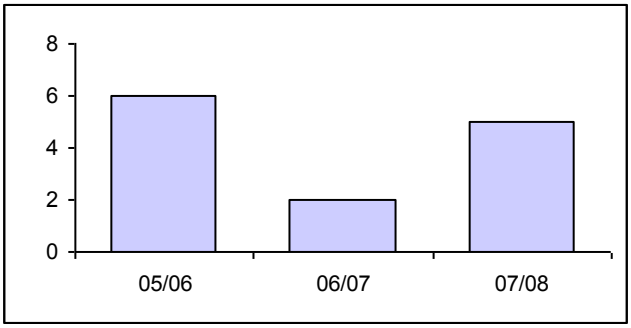
Falls are a leading cause of injury in hospital. The implementation of the NSW Fall Prevention Program will improve the identification and management of risk factors for fall injury in hospital thereby reducing fall rates. Factors associated with the risk of a fall in the hospital setting may differ from those in the community.

**Desired outcome**
Reduce deaths as a direct result of fall in hospital, thereby maintaining quality of life and improving patient satisfaction.

**Deaths as a result of falls in hospitals** (number) – GSAHS
Source: TRIM/Quality and Safety Branch ROB/RCA Database

| Year | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|
| Rate | 6 | 2 | 5 |

GSAHS




**Comment**
There has been significant training and increased awareness for staff in the areas of identification of falls and reporting of falls through the Incident Information Management System (IIMS).

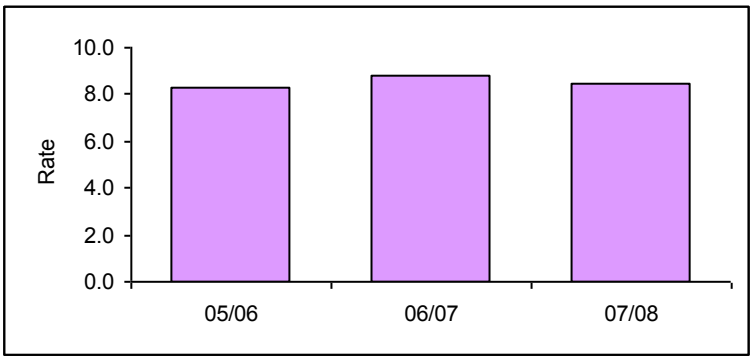
Actions being taken to reduce deaths as a result of falls in hospitals include:

- development of a GSAHS inpatient falls prevention program
- inclusive of residential aged care which is monitored monthly
- close monitoring, reporting and reviewing of every Severity Assessment Code (SAC) 1 and 2 inpatient falls through the Clinical Governance Unit
- all facilities within GSAHS will be assessed to ensure that falls prevention strategies are in place. Where there are deficiencies an action plan will be developed and monitored through the relevant Quality and Risk Committee. There will also be a review of current policy for inpatient falls prevention.

**Sentinel Events** (per 100,000 bed days) - GSAHS
Data source: SAC1 Clinical RIBS/HIE

| Year | 05/06 | 06/07 | 07/08 |
|---|---|---|---|
| Actual | 8.3 | 8.8 | 8.5 |

GSAHS




**Comment**

This data is the rate of SAC 1 incidents (eg community suicides, wrong site procedures such as an x-ray on the incorrect part of a body, unexpected deaths) notified on the Incident Information Management System (IIMS) and reported to NSW Health per 100 000 bed days.

The IIMS system has been in place across GSAHS since 2005 and the data indicates a similar rate of reporting across all three years. GSAHS continues to monitor all incidents reported on the IIMS. GSAHS has a robust investigation process for all SAC 1 incidents through the Root Cause Analysis (RCA) investigation process. All RCAs are endorsed by the GSAHS Chief Executive and recommendations for improvements actioned and monitored through the Clinical Governance Unit until complete.

# Strategic Direction 3
# **Strengthen primary health and continuing care in the community**

### Performance Indicator: Mental Health acute adult readmission

Mental Health problems are increasing in complexity and co-morbidity with a growing level of acuity in child and adolescent presentation. Despite improvement in access to mental health services, demand continues to rise for a wide range of care and support services for people with mental illness. A readmission to acute mental health admitted care within a month of a previous admission may indicate a problem with patient management or care processes. Prior discharge may have been premature or services in the community may not have adequately supported continuity of care for the client.

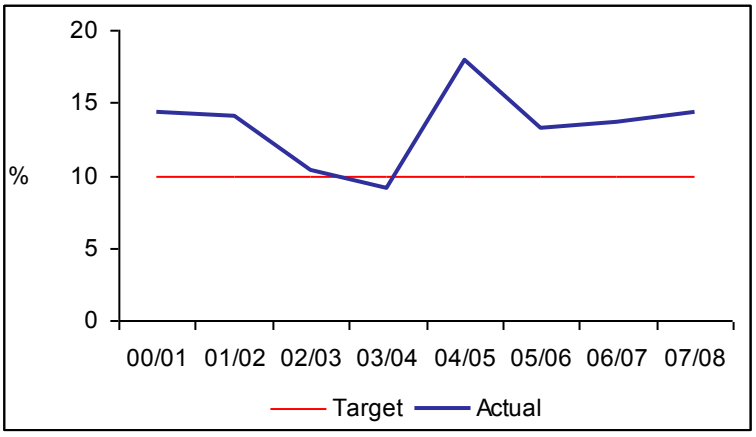
### Desired outcome

Rates of mental health readmission minimised, resulting in improved clinical outcomes, quality of life and patient satisfaction, as well as reduced unplanned demand on services.

**Mental Health acute adult readmission** - within 28 days to same mental health facility (%): GSAHS
Data source: InforMH on behalf of MHDAO

| | 2000/01 | 2001/02 | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|---|---|---|---|
| **Actual** | 14.4 | 14.1 | 10.3 | 9.1 | 18 | 13.2 | 13.7 | 14.3 |
| **Target** | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 |

GSAHS




### Comment

Due to the significant demand for acute services, readmissions within 28 days have remained fairly high. A number of strategies are being put in place to address these issues. This includes: an active review of all readmissions (patient by patient) being undertaken on a monthly basis; improved clinical follow up of discharged consumers by community mental health clinicians.

### Performance Indicator: Suspected suicides of patients in hospital, on leave, or within 7 days of contact with a mental health service

Suicide is an infrequent and complex event, which is influenced by a wide variety of factors. The existence of a mental illness can increase the risk of such an event. A range of appropriate mental health services across the spectrum of treatment settings, as outlined in

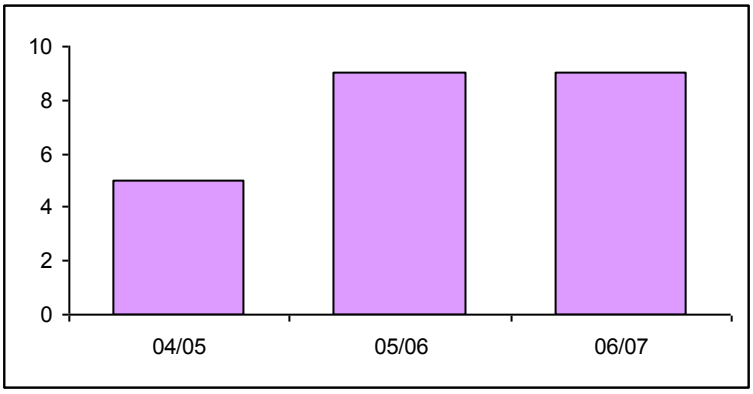
the Government's commitment, NSW: A New Direction for Mental Health, are being implemented between now and 2011 to increase the level of support to clients, their families and carers, to help reduce the risk of suicide for people who have been in contact with mental health services.

**Desired outcome**
Minimal number of suicides of patients following contact with a mental health service.

**Suspected suicides of patients in hospital, on leave, or within 7 days of contact with a mental health service (number):** GSAHS
Data source: InforMH on behalf of MHDAO

| Year | 2004/05 | 2005/06 | 2006/07 |
|---|---|---|---|
| Actual | 5 | 9 | 9 |

GSAHS




**Comment**
GSAHS has worked to reduce the potential for harm in all its Inpatient Units by addressing the recommendations of the Tracking Tragedy reports. Audits of each of the units have been undertaken regularly.

The health service has implemented policy and procedure to ensure that senior clinical advice is sought at key periods in the patient journey particularly on acute assessment, discharge and when a consumer is becoming unwell in the community.

Improved supervision and clinical support to clinicians is provided through the Clinical Review Support Program. All clinicians routinely receive active supervision and consultation around at-risk consumers and when risk is heightened.

## Performance Indicator: Mental Health:
## a) Ambulatory contacts
## b) Acute overnight inpatient separations

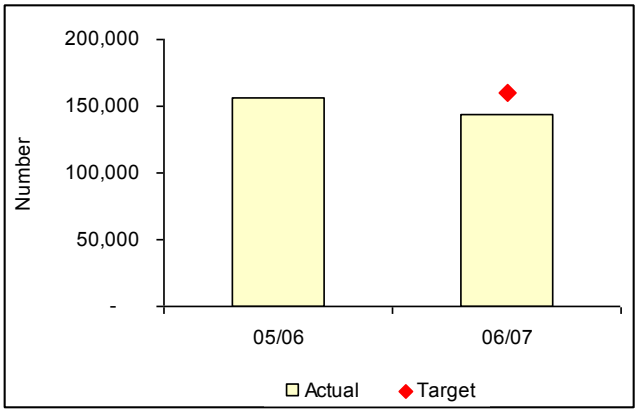
Mental Health problems are increasing in complexity and co-morbidity with a growing level of acuity in child and adolescent presentations. Despite improvements in access to mental health services, demand continues to rise for a wide range of care and support services for people with mental illness. Under 'New Directions', a range of community based services are being implemented between now and 2011; they span the spectrum of care types from acute care to supported accommodation. There is an ongoing commitment to increase inpatient bed numbers. Numbers of ambulatory contacts, inpatient separations and numbers of individuals would be expected to rise.

**Desired outcome**
Improved mental health and well-being. An increase in the number of new presentations to mental health services that is reflective of a greater proportion of the population in need of these services gaining access to them.

**Mental Health Ambulatory Contacts** - GSAHS
Data source: InforMH on behalf of MHDAO

| | 2005/06 | 2006/07 |
|---|---|---|
| **Actual** | 155,701 | 143,157 |
| **Target** | - | 159,878 |

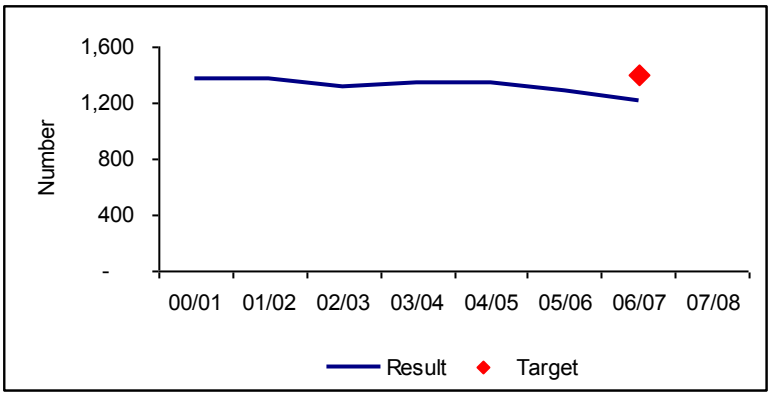
GSAHS




**Comment**
This data indicates that we are approaching target.

**Mental Health Acute Overnight Inpatient Separations: GSAHS**
Data source: InforMH on behalf of MHDAO

| Year | 00/01 | 01/02 | 02/03 | 03/04 | 04/05 | 05/06 | 06/07 |
|---|---|---|---|---|---|---|---|
| **Result** | 1,369 | 1,373 | 1,318 | 1,342 | 1,348 | 1,290 | 1,221 |
| **Target** | - | - | - | - | - | - | 1,400 |




**Comment**
There has been an increase in level of demand for acute services as demonstrated by an increase in overnight separations and supported by increased throughput and daily average of inpatients. There is a corresponding significant decrease in the average length of stay. GSAHS has considerable plans in place to increase the number of acute and non acute beds which is designed to address the bed availability over time.

## Performance Indicator: Antenatal visits – confinements where first visit was before 20 weeks gestation

The purpose of providing pregnancy care before twenty weeks of gestation is to monitor the health of both the mother and her baby, provide advice to promote the health of both the mother and her baby, to identify pregnancy complications and to provide appropriate interventions at the earliest time. The first visit involves the provision of pre-conception counselling, an assessment of risk factors (including maternal health), assessment of foetal wellbeing, assessment of complications. Information is provided on choices for infant feeding, the normal discomforts of pregnancy, emotional aspects (including postnatal depression), local birth and parenting preparation sessions, reducing risk of SIDS, child safety and other parenting issues. There is a discussion of birthing care options.

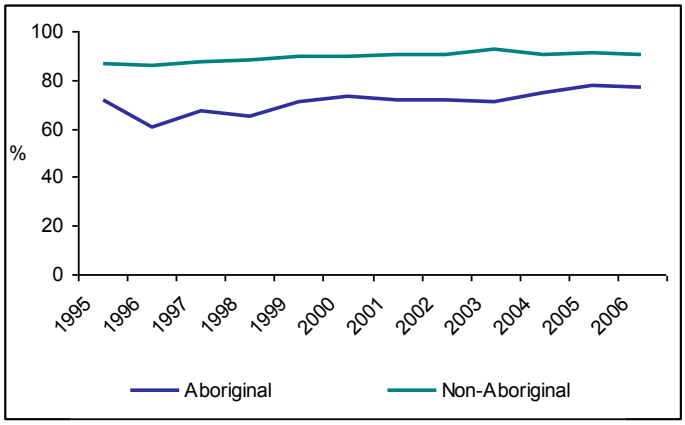
### Desired outcome

Improved health of mothers and babies.

**First antenatal visit** - before 20 weeks gestation (%): **GSAHS**
Source: NSW Midwives Data Collection (HOIST).

| | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Aboriginal** | 71.3 | 60.4 | 66.9 | 65.2 | 70.7 | 73.3 | 71.6 | 71.5 | 71.2 | 74.6 | 77.5 | 76.7 |
| **Non-Aboriginal** | 86.8 | 86 | 87.5 | 87.9 | 89.9 | 89.8 | 90.4 | 90.5 | 92.3 | 90.3 | 90.8 | 90.2 |

GSAHS




### Comment

The formalising of midwifery booking in services at all GSAHS maternity facilities and shared care programs will ensure women continue to access pregnancy care early. The NSW Health Pregnancy Care Program enables access to free midwifery care for women who give birth in public maternity facilities in southern NSW.

## Performance Indicator: Low birth weight babies – weighing less than 2,500g

Nationally 5% of all babies born in Australia have low birth weights. There are a range of factors that can affect a baby's birth weight. Low birth weight babies might also result from preterm birth, foetal growth restriction or a combination of the two. Some other factors that may contribute to low birth weight include socioeconomic disadvantage, the size and age of the mother, the number of babies previously born to the mother, the mother's nutritional status, smoking and other risk factors such as the use of alcohol, illness during pregnancy, multiple births and the duration of the pregnancy.

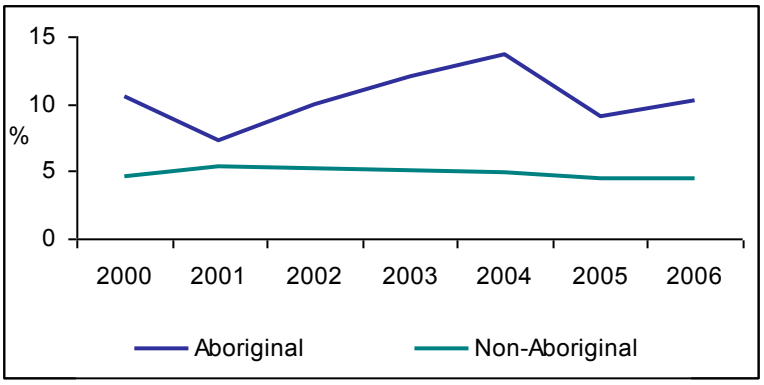
Low birth weight is associated with a variety of subsequent health problems. A baby's birth weight is also a measure of the health of the mother and the care that was received during pregnancy.

**Desired outcome**
Reduced rates of low weight births and subsequent health problems.

**Low birthweight babies -** births with birthweight less than 2,500g (%): GSAHS
Source: NSW Midwives Data Collection (HOIST).

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|---|---|
| **Aboriginal** | 10.6 | 7.3 | 10 | 12.1 | 13.7 | 9 | 10.2 |
| **Non-Aboriginal** | 4.6 | 5.3 | 5.2 | 5 | 4.9 | 4.4 | 4.4 |
| **Total** | 4.9 | 5.4 | 5.4 | 5.3 | 5.3 | 4.6 | 4.7 |

GSAHS




**Comment**
The data for Aboriginal people is reflective of the Aboriginal Mother and Babies programs operating across GSAHS. The aim of these programs is to improve pregnancy, labour, birth and postnatal care to decrease the risks of low birth weight babies.

Planning and maintenance of accessible and culturally appropriate pregnancy care programs are vital to promoting optimal perinatal health outcomes. Low birth weight has a direct correlation with poor perinatal outcomes and further reduction in these numbers will impact on the health of our communities.

## Performance Indicator: Postnatal home visits - families receiving a 'Families NSW' visit within 2 weeks of the birth

The Families NSW program aims to give children the best possible start in life. The purpose is to enhance access to postnatal child and family health services by providing all families with the opportunity to receive their first Child and Family Health nurse postnatal visits within their home environment.

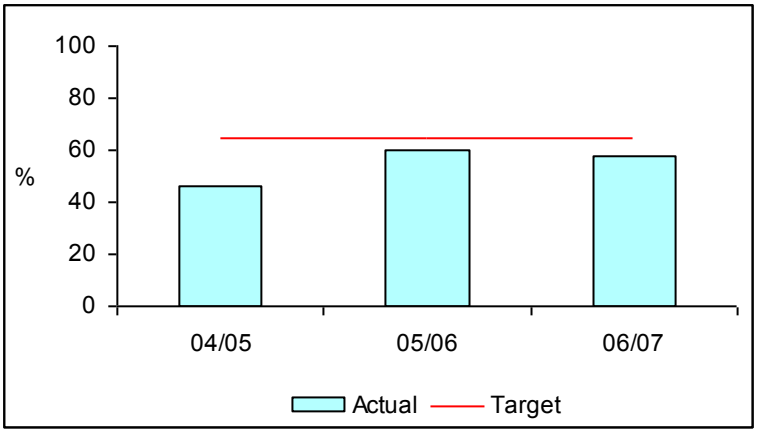
Child and Family Health nurses are provided with an opportunity to identify the individual needs of families in their own homes. This visit ensures early access to local support services, including the broader range of community health services.

**Desired outcome**
To solve problems in raising children early, before they become entrenched, resulting in the best possible start in life.

**Families NSW postnatal universal health home visit (UHHV) (%)** - GSAHS
Source: Families NSW Area Health Service Annual Reports 2003/04; 2004/05; 2005/06 HOIST for birth data.

| | 2004/05 | 2005/06 | 2006/07 |
|---|---|---|---|
| **Actual** | 46 | 60 | 58 |
| **Target** | 65 | 65 | 65 |

GSAHS




*Note: These percentages are based on Southern AHS figures only.*

**Comment**

These figures reflect a number of aspects of the program including the roll out of the Integrated Perinatal and Infant Care Program across GSAHS and delays in notifications of births. Strategies being undertaken to improve results include a review of child and family nursing practice; increased staffing for universal postnatal home visiting; a review of data collection processes and a review of cross border communication.

# Strategic Direction 4
# Build regional and other partnerships for health

### Performance Indicator: Otitis media screening - Aboriginal children (0 – 6 years) screened

The incidence and consequence of Otitis Media and associated hearing loss in Aboriginal communities has been identified and recognised. The World Health Organisation has noted that prevalence of Otitis Media greater than 4% in a population indicates a massive public health problem. Otitis Media affects up to ten times this proportion of children in many Indigenous communities in Australia.

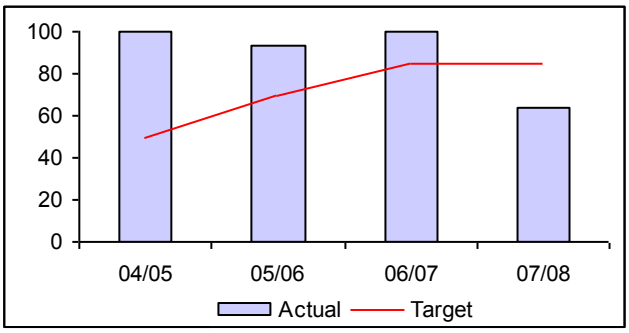
### Desired outcome

Minimal rates of conductive hearing loss, and other educational and social consequence associated with otitis media, in young Aboriginal children.

**Otitis media screening -** Aboriginal children aged 0 - 6 years screened (%): GSAHS
Data: Centre for Aboriginal Health

| Year | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|
| Actual | 100 | 93 | 100 | 64 |
| Target | 50 | 70 | 85 | 85 |

GSAHS




### Comment

Changes in staff, with new staff requiring training in screening with revised recording of activity meant a change in the actual numbers screened.

# Strategic Direction 5
# Make smart choices about the costs and benefits of health services

**Performance Indicator: Net cost of service – General Fund (General) variance against budget**

Net Cost of Services (NCOS) is the difference between total expenses and retained revenues and is a measure commonly used across government to denote financial performance. In NSW Health, the General Fund (General) measure is refined to exclude the:

- effect of Special Purpose and Trust Fund monies which are variable in nature dependent on the level of community support
- operating result of business units (e.g. linen and pathology services) which service a number of health services and which would otherwise distort the host health service's financial performance
- effect of Special Projects which are only available for the specific purpose (e.g. Oral Health, Drug and Alcohol)

**Desired outcome**

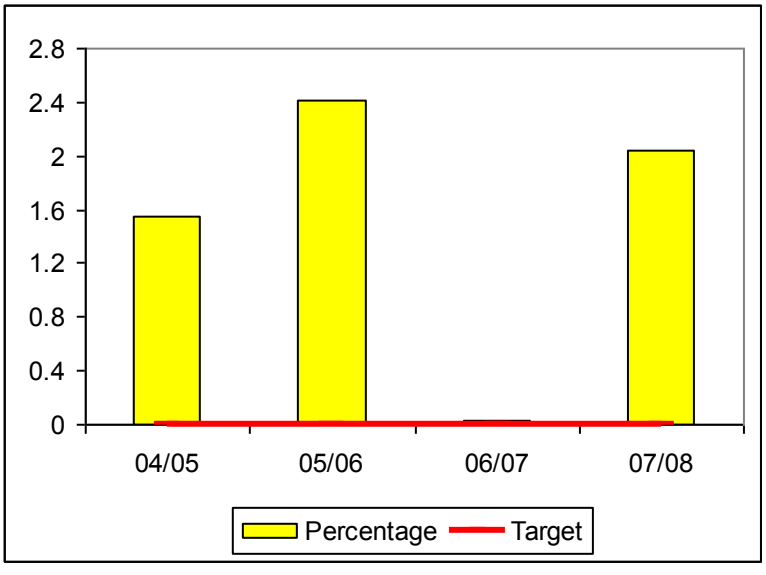
Optimal use of resources to deliver health care.

**Net cost of services General Fund (General) -** variance against budget (%): GSAHS

Data provided by: Financial Management & Planning Branch, Finance & Business Management Division

| | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|
| **Percentage** | 1.55 | 2.41 | 0.03 | 2.04 |
| **Target** | 0 | 0 | 0 | 0 |

GSAHS




**Comment**

A number of actions are being undertaken to reach financial targets including development of initiatives that are manageable, achievable and measurable.

The area health service has also implemented improved reporting and monitoring systems, as well as strengthened links between funding and planning considerations.

## Performance Indicator: Creditors > Benchmark as at the end of the year

Creditor management affects the standing of NSW Health in the general community, and is of continuing interest to central agencies. Creditor management is an indicator of a Health Service's performance in managing its liquidity.

While health services are expected to pay creditors within terms, individual payment benchmarks have been established for each health service.

### Desired outcome

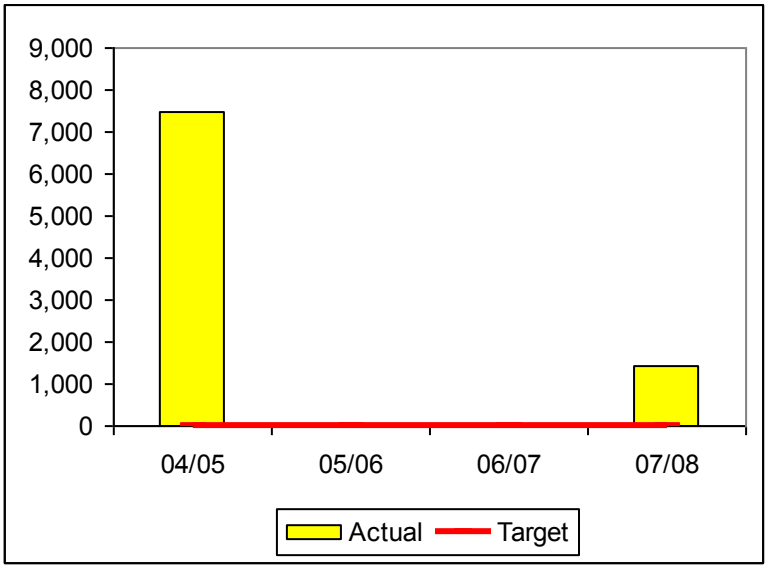
Payment of creditors within agreed terms.

**Number of Creditors exceeding target days as at the end of year -** Creditors exceeding 45 days $('000): GSAHS

Source: Financial Management & Planning Branch, Finance & Business Management Division

| | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|
| **Actual** | 7,488 | 0 | 0 | 1434 |
| **Target** | 0 | 0 | 0 | 0 |

GSAHS




### Comment

**As at 30 June 2008 the number of General Trade Creditors with invoices greater than 44 days was 1434.**

## Performance Indicator: Major and minor works - Variance against Budget Paper 4 (BP4) total capital allocation

Variance against total BP4 capital allocation and actual expenditure achieved in the financial year is used to measure performance in delivering capital assets.

### Desired outcome

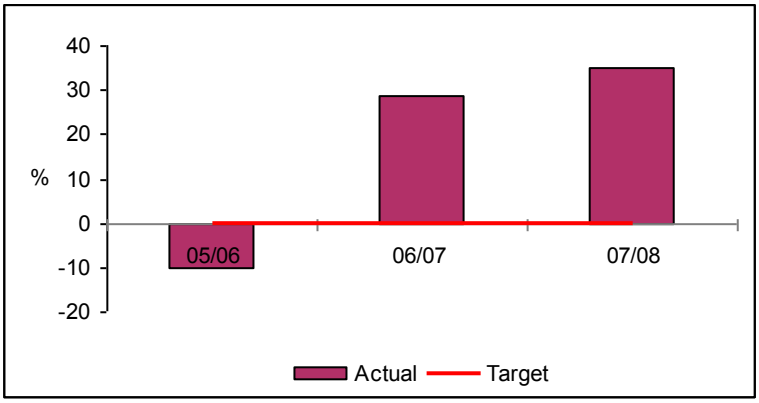
Optimal use of resources for asset management. The desired outcome is 0 per cent variance, that is, full expenditure of the NSW Health Capital Allocation for major and minor works.

**Major and Minor Works -** variance against BP4 capital allocation (%): GSAHS

Source: Asset Management Services

| | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|
| **Actual** | -10.0 | 28.9 | 35 |
| **Target** | 0 | 0 | 0 |

GSAHS




**Comment**

The major factors impacting performance include a number of major redevelopments currently underway: Queanbeyan Health Service, Batlow Adelong Health Service, Berrigan Health Service and Bombala Health Service.

# Strategic Direction 6
# Build a sustainable health workforce

The organisation and delivery of health care is complex and involves a wide range of health professionals, service providers and support staff. Clinical staff comprises medical, nursing, allied health and oral health professionals, ambulance clinicians and other health professionals such as counsellors and Aboriginal Health Workers.

These groups are primarily the front line staff employed in the health system. In response to increasing demand for services, it is essential that the numbers of front line staff are maintained in the line with that demand and that service providers continually examine how services are organised to direct more resources to frontline care. Note that the category of a small proportion of this group may be management or administration (such as ward clerks), where the primary function is supporting direct care provision and providing support for frontline staff.

# Number of Full Time Equivalent Staff (FTE) Employed as at June 2008

| | June -03 | June -04 | June -05 | June -06 | June -07 | June -08 |
|---|---|---|---|---|---|---|
| Medical | 122 | 127 | 119 | 133 | 138 | **171** |
| Nursing | 2,276 | 2,384 | 2,506 | 2,471 | 2,510 | **2,544** |
| Allied Health | 295 | 298 | 319 | 328 | 351 | **358** |
| Other Prof. & Para professionals | 245 | 247 | 197 | 204 | 217 | **210** |
| Oral Health Practitioners & Therapists | 55 | 56 | 63 | 58 | 57 | **57** |
| Ambulance Clinicians | 0 | 0 | 0 | 0 | 1 | **1** |
| Corporate Services | 288 | 304 | 277 | 257 | 234 | **238** |
| Scientific & technical clinical support staff | 198 | 200 | 259 | 264 | 286 | **293** |
| Hotel Services | 641 | 647 | 660 | 626 | 576 | **576** |
| Maintenance & Trades | 91 | 92 | 86 | 80 | 77 | **79** |
| Hospital Support Workers | 542 | 541 | 615 | 493 | 555 | **592** |
| Other | 5 | 5 | 4 | 3 | 3 | **3** |
| **Total** | 4,758 | 4,902 | 5,105 | 4,916 | 5,003 | **5,122** |

*Source: Health Information Exchange & Health Service local data*

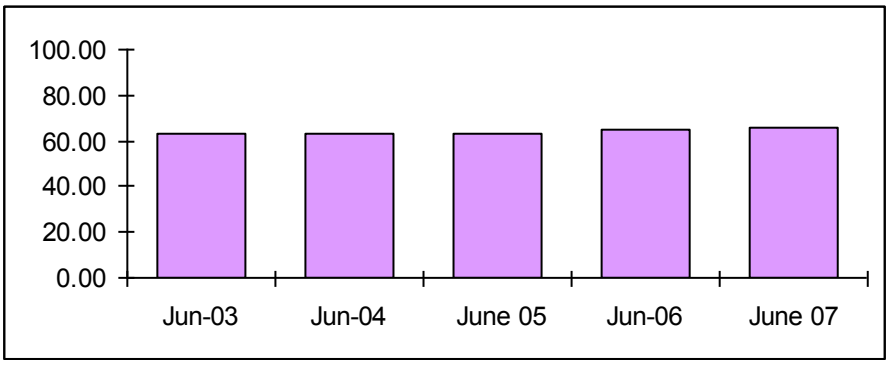
**Notes:**

1. FTE calculated as the average for the month of June, paid productive & paid unproductive hours.
2. As at March 2006, the employment entity of NSW Health Service staff transferred from the respective Health Service to the State of NSW (the Crown). Third Schedule Facilities have not transferred to the Crown and as such are not reported in the Department of Health's Annual Report as employees.
3. Includes salaried (FTEs) staff employed with 'Health Services, Ambulance Service of NSW and the NSW Department of Health'. All non-salaried staff such as contracted Visiting Medical Officers (VMO) are excluded.
4. 'Medical' is inclusive of Staff Specialists and Junior Medical Officers. 'Nursing' is inclusive of Registered Nurses, Enrolled Nurses and Midwives. 'Allied Health' includes the following; audiologist, pharmacist, social worker, radiographer and podiatrist. 'Oral Health Practitioners & Therapists' includes Dental Assistants/Officers/Therapists/Hygienists. 'Other Professionals & Para-professionals', which includes health education officers, interpreters etc. 'Ambulance Clinicians' include ambulance on road staff & ambulance support staff. 'Corporate Services' includes Hospital Executive, IT, Human Resource and Finance staff etc. 'Scientific & technical support workers' includes hospital scientists & cardiac technicians. 'Hotel Services' are inclusive of food services, cleaning and security etc. 'Maintenance & Trades' is inclusive of Trade Workers, Gardeners and Grounds Management etc. 'Hospital Support Workers' includes ward clerks, public health officers, patient enquiries and other clinical support staff etc. 'Other' is employees not grouped elsewhere.
5. FTEs associated with the following health organisations The Institute of Medical Education and Training, HealthQuest, Clinical Excellence Commission and the Health Professional Registration Boards are reported separately.
6. Previous to 2008, FTE associated with Health Support Services was reported separately. Information has been recast to reflect this change and will show variations from previous annual report. Health Support Services includes Health Support, Health Technology and Health Infrastructure.
7. Rounding errors are included in the table

**Clinical staff -** Medical, nursing, allied health professionals, other professionals, oral health practitioners & ambulance clinicians as a proportion of all staff - GSAHS
Source: HIE-DOHR-HR, Average FTEs (paid productive & paid unproductive hours). Excludes Third Schedule Facilities

| | Jun-03 | Jun-04 | Jun-05 | Jun-06 | Jun-07 |
|---|---|---|---|---|---|
| **Actual** | 62.9 | 63.5 | 62.8 | 65 | 65.4 |

GSAHS

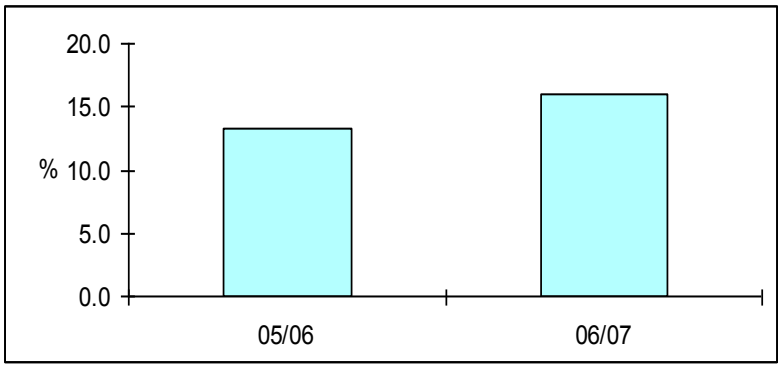



**Comment**
The increase in clinical positions as a percentage of the overall staffing is consistent with organisational priorities and highlights the ongoing efforts being made by GSAHS to the successful employment of clinical staff across the Area Health Service.

**Staff Turnover -** Permanent Staff Separation Rates (%) – GSAHS
Source: Premier's Workforce Profile (PWP)

| | 2005/06 | 2006/07 |
|---|---|---|
| **Actual** | 13.4 | 16.0 |

GSAHS

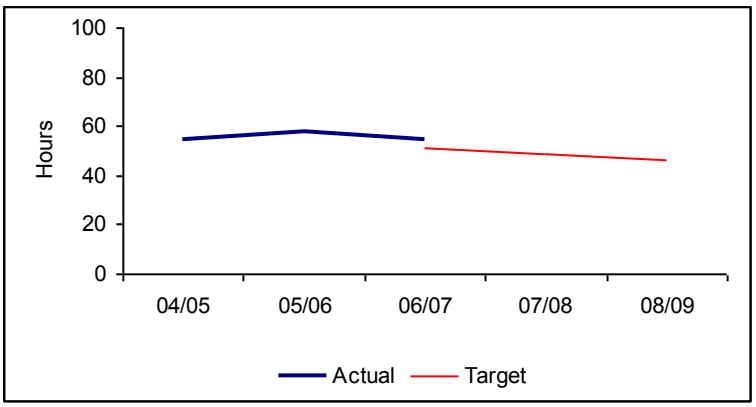



**Comment**
The GSAHS Staff Turnover performance has improved during 07/08 and is now at 15.2% against a State Result of 14.9%, with a voluntary separation rate of 7.6%.

**Paid Sick Leave per FTE** – GSAHS
Source: Business Objects

| | 2004/05 | 2005/06 | 2006/07 | 2007/08 | 2008/09 |
|---|---|---|---|---|---|
| **Actual** | 54.18 | 57.57 | 54.09 | - | - |
| **Target** | - | - | 51.47 | 48.76 | 46.05 |

GSAHS




**Comment**

The AHS has recognised it did not meet its target in 06/07 to reduce sick leave and as a result implemented a 'Managing Unplanned Absences' initiative in August 2008. This initiative included the monthly monitoring of sick leave performance, implementation of a 'Sick Leave Toolkit' for managers and development of site and facility activities aimed at improving attendance.

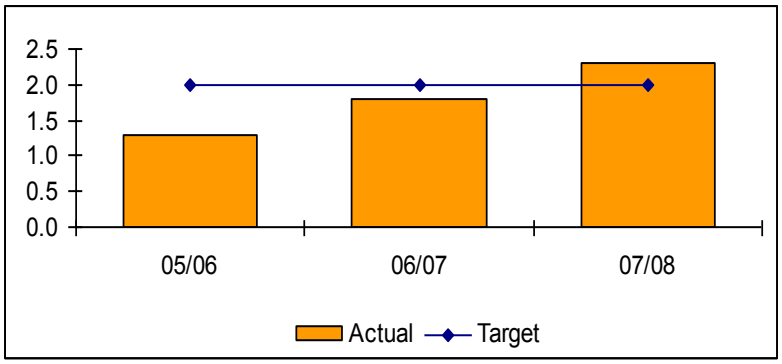
## Equal Employment Opportunity

**Aboriginal staff as a proportion of total (%)**

Source: Premier's Workforce Profile (PWP) – GSAHS

| | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|
| **Actual** | 1.3 | 1.8 | 2.3 |
| **Target** | 2 | 2 | 2 |

GSAHS




**Comment**

The percentage of Aboriginal staff in GSAHS showed continued improvement during 07/08. An Aboriginal Workforce Development Plan has been prepared and a Manager of Aboriginal Careers and Development has been established in the Workforce Development Unit. This position will responsible for a number of initiatives that advance the development of the existing Aboriginal employees, and contribute to increased participation of Aboriginal people in the GSAHS Workforce

## Learning and Development

- In 2007/08 GSAHS commenced the Clinical Excellence Commission's Statewide Clinical Leadership Program. This program is a 12 month leadership development program, provided over two (2) years, facilitated locally and provided to Senior Clinicians in Nursing, Allied Health and NSW Ambulance.
  The 2007 Cohort consisted of 16 Area Health Service (AHS) participants, with clinicians ranging from Nurse Managers, Nursing Unit Managers, Allied Health Manager, Scientist, Pharmacist, Senior Allied Health, Clinical Nurse Consultant and 2 NSW Ambulance participants who successfully completed the program.
  The 2008 Cohort consisted of 16 AHS participants, with clinicians ranging from Nurse Managers, Nursing Unit Managers, Allied Health Manager, Senior Allied Health and Clinical Nurse Consultants who have also successfully completed the program
  Each participant in the Statewide Clinical Leadership Program has embarked on personal leadership and team development strategies including a clinical process improvement project in their workplace.
- A number of new innovative and management training interventions were delivered internally during 2007/08. Over 198 managers participated in the two day programs for Implement Mediation Processes (Mediation/Conflict Management) and Coaching for Performance.
- A new Management in Practice Program was implemented. This two day program was specifically designed as a foundation program for managers and for managers in the early phase of their career. Eighteen managers completed the program.
- Three GSAHS managers were awarded Premiers Department scholarship places for the Graduate Diploma in Public Administration, Sydney University Graduate School of Government.
- Fifty (50) Return to Work Co-ordinators were trained and accredited in the NSW Workcover RTW Co-ordinator Training course in 2007/08. This has resulted in improved skill and knowledge in facilitating the injury management and return to work process across the AHS.
- A major initiative in improving the skills of GSAHS educators was undertaken in 2007 with 83 trainers and educators undertaking VETAB accredited units from the Certificate IV in Training and Assessment.
- The Area Orientation Program was revised during 2007/08 to include new content and new delivery methods through technology. The orientation can now be offered via videoconference linking up to 6 sites simultaneously across the AHS. One hundred and seventy-five (175) new staff members have participated in the videoconference orientation sessions. This format is supported by a new Area Staff Orientation Manual available on line.
- New traineeship programs provided an opportunity to offer traineeships to over two hundred staff in rural and remote locations, allowing them access to eleven different nationally recognised qualifications.
- GSAHS has been involved in the NSW Health Vocational Education and Training (VET) in Schools Implementation Committee in relation to both Nursing and Allied Health and in 2007 was designated as a pilot site for the Allied Health Assistants Project, with 36 trainees now enrolled in the program.
- In 2007/08 Nurse Strategy funding was utilised to replace staff attending internal learning and development training and external courses. In addition, it covered travel and accommodation costs.
- In-service and training programs are held at all GSAHS facilities. They are supported by Clinical Nurse Educators, Nurse Educators and Clinical Nurse and Midwife Consultants.
- GSAHS facilitates and supports
  - New graduate transitional RN program
  - Reconnect nurses and midwives

- Clinical placement for student nurses and midwives
- Instigated the GSAHS Nurses and Midwives Education Forum
- A training enrolled nurse program
- A cadetship program for indigenous nurses in training
- An Enrolled Nurse to Registered Nurses conversion program

## Research

There were 21 research proposals approved within GSAHS for the 2007/08 financial year. These included:

Border Medical Oncology: Dr Craig Underhill
*NCIC CO20 trial*: A multi-centre, prospective, double-blinded, randomised phase III clinical trial of brivanib in combination with cetuximab versus matched placebo in combination with cetuximab in patients previously treated with combination chemotherapy for metastatic colorectal carcinoma and for whom no standard anticancer therapy other than cetuximab is available.

GSAHS: Marissa Olsen
*Sharing decision-making in dietetic practice*: Qualitative study-semi structured interviews with dieticians and patients.

GSAHS: Dr Sarah McPherson and Dr Mike Bird
*Strains in dementia care scale*: A staff survey asking about use of the current form of the Strain in Dementia Care Scale. Use data to further develop the scale and reduce it to 25 items.

Charles Sturt University: Associate Professor Anne Bonner
*Health indicators in people with chronic kidney disease:* Longitudinal observational study examining quality of life in people with chronic kidney disease.

GSAHS: Rachel O'Loughlin
*Movement classes in residential aged care facilities*: A pre-post intervention evaluation of participant's functional mobility and other outcomes (before and after a 14 week period of specifically designed dance and movement exercises).

Charles Sturt University: Associate Professor Anne Bonner
*Testing two-way performance appraisal instruments:* Testing a two-way performance appraisal instrument with casual nurses and Nursing Unit Managers (NUMs).

Sydney South West Area Health Service/Greater Metropolitan Clinical Taskforce:
Helen Badge
*Brain injury rehabilitation community outcomes project:* A multi-centre study to pilot a selection of global outcome measures to support service evaluation of community based brain injury services.

North Coast Area Health Service/University of Newcastle: Danny Hills
*Introduction to rural mental health practice:* A mixed-method study to implement and evaluate an innovative training package to support health practitioners commencing employment in rural mental health services.

Charles Sturt University: Kristy Robson

*Falls program baseline survey V2*: A study to ascertain what community programs, skills, resources, instruments and referral pathways exist in GSAHS relevant to falls (use of two survey tools).

Australian National University: Felicity J Riddle
*The experience of grief in people living with a mental illness:* A study investigating experience of grief in people with schizophrenia (interviews with clients).

North Coast Area Health Service: Margaret Hewetson
*Pharmacy graduates study*: A pilot study involving qualitative and quantitative research to identify the professional and personal support needs and future careers of rural and metropolitan hospital pharmacy graduates in NSW.

Centre for Rural and Remote Mental Health/University of Newcastle: Anne-Marie Holley
*Farm-link*: Identification of target communities; development of farmers' mental health service networks and evaluation of their effectiveness.

GSAHS: Dr Bob Neumayer
*Cooma oncology unit evaluation report*: An evaluation of the service.

University of Wollongong/GSAHS: Susan A Liersch
*The meaning of resilience for people living with schizophrenia.*

University of NSW: Dr Bettina Meiser
*Evaluating telehealth cancer genetic counselling*: Interviews with clinicians and women who have experienced genetic counselling via telehealth; comparison of telehealth and face-to-face genetic counselling; interaction analysis of telehealth consultations.

GSAHS: Alison McTaggart Lamb
*Partnerships with Local Government:* An examination of a sample of current alliances between GSAHS and Local Government (phase 1 qualitative and quantitative survey data collection and analysis).

GSAHS: Annie Flint
*Hearty health for rural women*: An examination of issues identified by rural women with heart disease from small towns in GSAHS.

GSAHS: Virginia Bear
*Schizophrenia Treatment Adherence Investigation (STA*I): Multi-centre treatment review and feedback program to determine risk of poor medication adherence in outpatients diagnosed with Schizophrenia. Medical record review plus survey of clients at baseline and 6 and 12 months.

GSAHS: Lesley Scroope
*Physical activity programme for Indigenous women in the Yass area*

Greater Western Area Health Service/University of Sydney: Dr Stephanie Arnold
*Rural prevocational survey*: A tri-centre study in rural NSW to survey all current Junior Medical Officers to determine why they join a rural health service and what makes them stay.

GSAHS: Karla Calleja
*Food insecurity coping strategies used by mothers in Goulburn*: Semi-structured interviews with mothers to determine and analyse their strategies around food insecurity.

## Overseas Travel

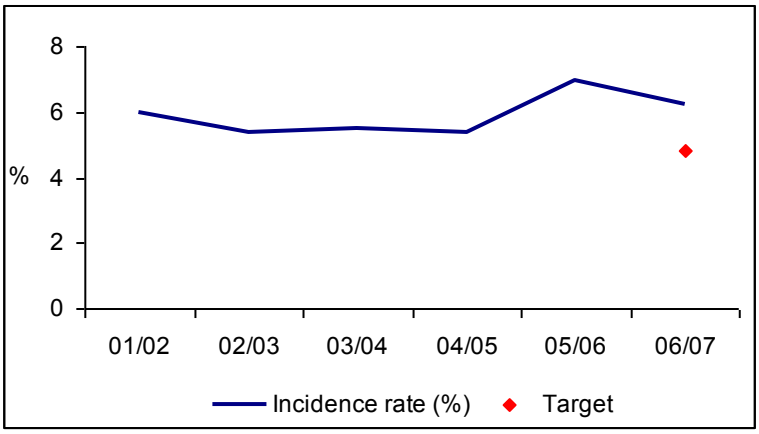
| Name | Unit | Purpose of visit | Places visited | Funding |
|---|---|---|---|---|
| Brian Callahan | Mental Health | Australian Professional Society of Alcohol and other Drugs Cutting Edge Conference | Auckland, New Zealand | General |

## Occupational Health, Safety and Wellbeing

**Workplace Injuries -** proportion of employees injured in the relevant year (%) – GSAHS
Source: Treasury Managed Fund via WorkCover NSW

| | 2001/02 | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 |
|---|---|---|---|---|---|---|
| **Number of injuries** | 293 | 269 | 274 | 291 | - | - |
| **Number of employees** | 4,895 | 4,952 | 5,000 | 5,381 | - | - |
| **Incidence rate (%)** | 6.0 | 5.4 | 5.5 | 5.4 | 6.9 | 6.2 |
| **Target** | - | - | - | - | - | 4.8 |

GSAHS




**Comment**

Whilst there has been an improvement in performance from 05/06 to 06/07, GSAHS has recognised that a greater focus is required on its OHS activity and as such has established a dedicated Occupational Health Safety and Wellbeing Unit.

## Corporate Governance Statement

The Chief Executive carries out the functions, responsibilities and obligations of that office in accordance with the Health Services Act, 1997.

GSAHS is committed to good corporate governance practices as outlined in the Corporate Governance and Accountability Compendium ('the Governance Compendium') issued by NSW Health. The Chief Executive has established internal management processes and controls that support and give effect to the following core principles set out in the Governance Compendium:

1. To promote and protect the health of the people of NSW and to ensure they have access to basic health services
2. To perform effectively and efficiently in clearly defined roles and functions
3. To promote and demonstrate our values through leadership and behaviour
4. To take informed transparent decisions and manage risks effectively
5. To develop the capacity and capability to provide effective and safe health services
6. To engage stakeholders and make accountability a reality

The Chief Executive has systems in place to ensure the primary governing responsibilities of GSAHS are fulfilled with respect to:

- Setting the Health Service's strategic direction
- Ensuring compliance with statutory requirements
- Monitoring the performance of the Health Service
- Monitoring the quality of health services provided
- Industrial relations / workforce development
- Monitoring clinical, consumer and community participation
- Ensuring ethical practice

The Chief Executive has established the following committees as required by the Standard By-Laws issued by the Director-General of NSW Health to assist in effectively discharging and overseeing the above functions:

- Audit and Risk Management Committee
- Finance and Performance Committee
- Health Care Quality Committee
- Medical and Dental Appointments Advisory Committee

These committees function in accordance with Chapter 12 of the Governance Compendium.

An Area Health Advisory Council facilitates involvement of providers and consumers of health services and members of the community in the governance of the Area Health Service. The Area Health Advisory Council functions in accordance with Chapter 10 of the Governance Compendium.

An Instrument of Delegations, approved by the Chief Executive, details the functions, authorities and expenditure approvals delegated to officers of the Health Service. The delegations of authority in the Instrument of Delegations are consistent with Chapter 3 of the Governance Compendium.

## Privacy

The privacy of personal information held by the Health Service is governed by the Privacy and Personal Information Protection Act 1998 and the Health Records and Information Privacy Act 2002. Patient records generally are covered by the Health Records and Information Privacy Act while all other personal information held by the Health Service is governed by the Privacy and Personal Information Protection Act. Both Acts establish privacy principles that must be observed by all public sector agencies, in the case of the Privacy and Personal Information Protection Act, and by all holders of personal health information, in the case of the Health Records and Information Privacy Act.

Both Acts provide for an internal review where an individual believes that an agency has breached the terms of the Act. During the year the Health Service received three applications for internal review and completed one internal review received in 2006/07.

In each of the four cases the client claimed that a staff member had disclosed his/her personal health information contrary to the provisions of the legislation and the Health Privacy Principles. However, in every case, the findings of the internal review were that, on the information discovered, no breach of the Act or the Health Privacy Principles was proved. The applicants were notified accordingly.

GSAHS has produced a pamphlet informing clients and the public generally of the privacy policy and their rights under that policy. A copy of the pamphlet is given to all clients on admission and is widely available in emergency departments and reception and waiting areas.

The Health Service has continued its comprehensive privacy training program. This training program has been designed to educate staff about the Health Service's and their own obligations under both Acts.

## Clinical Governance Statement

### Introduction

Clinical governance is "the system by which the governing body, managers and clinicians share responsibility and are held accountable for patient care, minimising risks to consumers and for continuously monitoring and improving the quality of clinical care".

In order to achieve this, NSW Health established the Patient Safety and Clinical Quality Program (PS&QCP) in 2004 with the aim of having "all significant adverse incidents are reported and reviewed so that education and remedial action can be applied across the whole health system". As part of this program Clinical Governance Units (CGU) were established in each Area Health Service in 2005. The Clinical Governance Unit has staff located across the Health Service to assist clusters in achieving the goals of PS&QCP.

The Clinical Governance Unit has maintained close working relationships with the Quality and Safety Branch in NSW Health, the Clinical Excellence Commission and the GSAHS Clinical Operations Directorate. These relationships have enabled the CGU to work together in driving some of the changes required to improve patient safety and quality.

### Investigation of Serious Adverse Events

All reported adverse events are entered into the Incident Information Management System (IIMS), which is monitored daily by CGU staff. Serious adverse events are reported to NSW Health and investigated according to the Root Cause Analysis (RCA) methodology. GSAHS has been successful in reporting these events to NSW Health within the 24 hour timeframe required and completing the RCA investigation with the 70 days allowed. 80% of recommendations from RCAs should be completed within the timeframe specified in the recommendation. In this regard GSAHS achieved 80% compliance. Overdue recommendations are tracked weekly with action taken to ensure implementation.

### Complaints Investigation

In 2006/07 GSAHS received 1136 complaints out of 109 033 admissions and 1687 087 outpatient contacts. NSW Health requires that 80% of complaints are investigated and resolved with the complainant within 35 days. GSAHS achieved this target during the year.

### ACHS Accreditation

GSAHS achieved Corporate Accreditation status following its survey in March 2008, with all criteria achieving the "Moderate Achievement" (MA) rating (the normal rating) and two criteria achieving "Extensive Achievement" (EA) rating. The criteria to achieve EA were: "*Healthcare incidents, complaints and feedback are manage to ensure improvements to the systems of care"* and *"Better health and wellbeing for consumers/patients, staff and the broader community are promoted by the organization".*

Certification status was achieved for the 10 previous GSAHS clusters and Mental Health in 2007. Following the GSAHS restructure the Eastern, Central, Western and Cross Border Sectors will proceed to an accreditation survey during 2009. Each sector survey will include Mental Health services.

### Correct Patient, Correct Procedure and Correct Site Model Policy

Following release of the NSW Health Policy Directive Patient Identification - Correct Patient, Correct Procedure and Correct Site Model Policy, the CGU implemented an education program targeted at operating theatre and radiology staff. The first of NSW Heath quarterly audits of the implementation of the policy was conducted in April 2008. A total of 10 facilities participated in the audit, with a total of 352 patient records audited against the respective audited indicators.

Since implementation of this policy directive there has not been a serious incident notified involving the wrong procedure performed on a patient in the operating theatre reported in the GSAHS. However a small number of incidents have occurred in Radiology. These incidents have been fully investigated through RCA and remedial action is being undertaken.

Further work has been conducted in ensuring there are tools available to assist staff in the emergency department and ward/unit areas in full compliance with the policy. Work continues with the radiology services within GSAHS. This includes linking with private providers within the area to ensure policy compliance and thus a safe environment for the patient.

**Complaints or concerns against a clinician**
The NSW Health policies *Complaint or Concern About a Clinician - Principles for Action* and *Complaint or Concern About a Clinician - Management Guidelines* were released by NSW Health on January 30, 2006.

The GSAHS Professional Practice Unit investigates complaints or concerns raised regarding the behaviour or competence of individual clinicians. An improved, positive reporting culture is responsible for the increasing numbers of professional practice referrals. There were 774 notifications of complaints or concerns about clinicians (doctors, nurses and allied health practitioners) which have been investigated. For some clinicians GSAHS receives multiple notifications. Approximately, 30% of notifications were serious in nature warranting in-depth investigations.

Following investigation a small number of these complaints or concerns result in notification to the appropriate Health Professional Board. Others are managed through the GSAHS performance management system. Identified systems issues are managed at a local level via specific action planning, or at an Area level when widespread system change is required. Recommendations are followed up at regular intervals by the Clinical Governance Unit.

**Credentialing**
GSAHS meets the mandatory requirements of the *National Standard for Credentialing and Defining the Scope of Clinical Practice* through the Medical and Dental Appointments Advisory Committee and Credentials Committee which reviews all applications from all medical and dental officers for permanent appointments and for locums working for greater than three months duration.

**Infection Control**
GSAHS actively works to reduce health care facility acquired infections by ensuring there are adequate policies, resources and training for staff. A comprehensive infection control intranet site has been developed to provide consistent and continual access to resources and information ensuring area wide consistency in approaches to and management of infection control issues.

The following area wide infection control education has been provided
- Multi Resistant Organisms : train the trainer workshops
- Infection Control for Graduate Nurses
- Introduction to Infection Control for site Infection Control Professionals
- Professional Development Education for Infection Control Professionals biannually
- Infection Control and Sterilising for Oral Health Care Professionals
- Incident Management of Occupational Exposures to Blood Borne Viruses

An Area Clinical Nurse Consultant Healthcare Associated Infection (HAI) has been employed to manage the HAI Reduction Program, implementation of the Multi Resistant Organisms

Policy and coordinate the collection and reporting of HAI data for 48 GSAHS facilities on monthly intervals. In addition, GSAHS specific infection control mandatory clinical indicators have been developed and are collected and reviewed monthly.

GSAHS Infection Control is represented at state level on both the HAI Expert Advisory Group and the HAI Working Party.

**Continuous Process Improvement**
A Continuous Process Improvement Toolkit has been developed for use by all staff. GSAHS has further increased monitoring of Continuous Process Improvement projects by the development of a Quality Improvement Register and Quality Improvement Data Base. Both the Register and Data Base are available to all staff via the intranet. Communication of quality projects also occurs through the GSAHS Excellence Awards and an internal newsletter.

**Quality Awards**
The GSAHS Awards were held in September 2007 with exciting results. GSAHS had 44 entries into the GSAHS Excellence Awards, with two entries per category entered into the NSW Health Baxter Awards.

The Excellence Awards aim to recognise and celebrate the achievements of staff in making a difference to client/customer groups. The Excellence Awards enable a broad selection of projects for entry in the NSW Health Awards and promote networking and cross fertilisation of ideas across GSAHS. The Awards promote morale and pride in GSAHS and its work and also recognises leadership throughout the presentation of Don Kendall Award for Leadership.

GSAHS was well represented at the NSW Health Awards in October 2007:

- Albury Base Hospital was awarded the Best Performance Major Non Metropolitan Hospital.
- Wagga Wagga Base Hospital was awarded the Most Improved Performance Major Non Metropolitan Hospital.
- Goulburn Base Hospital was awarded the Best Performance Major Rural District Hospital.
- The “Leeton District Hospital Midwifery Training Program” project was selected as a finalist for the NSW Health Director General’s Encouragement Award.
- The “Building our Rural Mental Health Workforce: A role for Enrolled Nurse Participation” was also selected as a finalist for the category Build a Sustainable Workforce.

**Policy Development**
The policy and procedure development system underwent further evaluation and improvement in 2007/2008 with more than 100 Policy Directives processed and adopted.

**Hand Hygiene**
GSAHS has retained a strong focus on improving hand hygiene compliance since the Clinical Excellence Commissions ‘Clean Hands Save Lives‘ project came to completion.

The inaugural ‘GSAHS Hand Hygiene Week’ was held 7-11 April with various promotional activities at sites. Monthly hand hygiene observational audits are undertaken within facility clinical areas, collated and an identifiable facility wide compliance rate is posted on the GSAHS intranet to celebrate good compliance rates and promote improvement and awareness where rates are lower.

Hand Hygiene as a topic is now included in all GSAHS infection control educational presentations.

At the March 2008 Infection Control Professional Development Forum a proposal to improve GSAHS Hand Hygiene Compliance rates was developed. The proposal includes a forearm dress code, display of Hand Hygiene audit results, comparison of audit results between facilities, counting the amount of alcohol hand rubs used, celebrating achievements and branding of the initiative, *"Hand Hygiene – So Simple, So Effective".*

**Incident Management**
A total of 12578 incidents (adverse events) and near misses/potential hazards were reported and managed within GSAHS via the NSW Health Incident Information Management System (IIMS) during 2007/08. This represents an increase of 18.2% on the number of incidents reported during 2006/07. The increase in incident reports is indicative in part of the success of the CGU in promoting the reporting of adverse events to ensure a robust and systems focussed reporting culture

The most common incident types reported related to falls, accidents/occupational health and safety, medications, behaviour/human performance and clinical management.

# GSAHS Clusters and Other Health Services

## Bega Valley Cluster

The Bega Valley Cluster includes Bega, Merimbula, Pambula, Eden and Bermagui, and smaller villages in the shire.

### Services delivered

A wide range of primary and community services including oncology, mental health, drug and alcohol, Aboriginal health, dental care, palliative care, post acute care, dementia and aged care, sexual health, health promotion, child and family care, diabetes care and community nursing. Medical and surgical services delivered include: orthopaedics, gynaecology, urology, obstetrics, emergency and day surgery, Transitional Restorative Aged Care Services (TRACS) and Community Acute / Post Acute Care (CAPAC).

### Major goals and outcomes

- Planning continues for the new health facility within the Bega Valley Shire
- Construction completed for the second operating theatre at Bega Hospital
- Increased the High Dependency Unit capacity from four beds to six
- Planning for two intensive care unit beds continues
- Opened renal dialysis unit at Bega Hospital
- Commenced planning for Interim Mental Health Unit
- Commenced implementation of Community Health clinical records to electronic form
- The Transitional and Restorative Aged Care Multidisciplinary team established incorporating a visiting Rehabilitation Specialist Medical officer

### Key issues and events

- Completion of the Clinical Services Plan for the proposed new Bega Valley Health Facility
- Continued to work with an extremely active and productive Local Health Service Advisory Committee
- Met all surgical long wait and category one, within 30 days, targets – including all orthopaedic joint replacement surgery

### Future directions

- Achieve ACHS Accreditation through continuous improvement programs in 2009
- Continue further integration of primary health and community care services
- Continue planning progress for new health facility
- Develop partnerships with other health service providers
- Increase consumer representation in health service planning
- Ensure patient safety through the continual improvement process
- Continued partnerships with the University of Wollongong and Australian National University
- Opening of a new Intensive Care Unit (ICU)
- Support a safe and sustainable maternity service for Bega Valley
- Complete implementation of C.H.I.M.E., an electronic system for patient records

## Eurobodalla Cluster

The Eurobodalla Cluster includes Batemans Bay, Moruya, Tuross Head, Eurobodalla and Dalmeny.

### Services delivered

A wide range of primary and community services including oncology, renal dialysis, mental health, drug and alcohol, Aboriginal health, dental care, palliative care, post acute care,

dementia and aged care, sexual health, health promotion, child and family care, diabetes care and community nursing. Medical and surgical services delivered include ophthalmology, orthopaedics, gynaecology, urology, obstetrics, emergency and day surgery.

**Major Goals:**

- Construction due to be completed mid-September for the 'Pathways Home' Ambulatory Unit at Moruya
- Worked in partnership with the South Eastern NSW Division of GPs on 'Healthy for Life' program (Koori Maternal Access Program)
- Patient Satisfaction Survey results for Eurobodalla Health Service – satisfactory result consistent with GSAHS
- Achieved zero patients on waiting list for category 1's and patients waiting longer than 12 months for surgery
- Recruitment finalised of second permanent staff surgeon
- Aged Services Emergency Team position successfully filled

**Key issues and events**

- Recruit Director of Critical Care
- Recruit Career Medical Officer for Batemans Bay emergency department
- Succession planning for medical and nursing
- Development of the Eurobodalla Operational Plan 2007/08
- Working collaboratively with Eurobodalla Health Service Advisory Committee

**Future directions**

- Prepare for ACHS accreditation 2009
- External Numerical Profile to assess OH&S compliance
- Further integration of primary health and community care services
- Develop partnerships with other health service providers
- Increase consumer representation in health service planning
- Ensure patient safety through the continual improvement process

## Golden Cluster

The Golden Cluster includes the towns of Coolamon, Junee, Narrandera, Leeton, Temora and West Wyalong, along with a number of other smaller communities.

**Services delivered**

There are four district hospitals, a community hospital and two Multi Purpose Services (MPS) delivering a wide range of services. These include general medical and surgical services, accident and emergency, obstetric services, palliative care, radiology and allied health services, residential aged care with dementia care. Community health services are provided in six local shires/towns. This incudes community nursing, drug and alcohol services, Aboriginal health education, immunisation, diabetes and asthma education, child and family services, health promotion, counselling, speech pathology, women's health, sexual assault services, aged day care, aged care assessment and social worker services.

**Major goals and outcomes**

- Network with other facilities to share services ensuring local communities are provided with equitable access to services
- Complete desired and necessary renovations to Leeton operating theatres
- Deliver high level of quality care to the community
- Education of staff to increase skills particularly in emergency care

- Commence a Student Midwife program at Narrandera in collaboration with Charles Sturt University, Wagga Wagga Base Hospital, Griffith Base Hospital and Leeton Health Service in February 2008
- Two Registered Nurses and two Endorsed Enrolled Nurses achieved competency in advanced emergency care

**Key issues and events**
- Ongoing challenges with recruitment of health professional staff
- Temora Radiology Department refurbishment
- Pilot a new model of care for Temora Maternity service
- Nelune Foundation funding for 2 years; $82 000 each year to provide a Cancer Care Nurse for Temora and surrounding towns
- Security and upgrade of the health care facility at Ardlethan
- Refurbishment of the Narrandera Staff accommodation to assist with recruitment and retention of staff; this was opened December 2007

**Future directions**
- Accommodate changes to administrative processes in line with the internal GSAHS move to a three sector structure
- Continue to train and support nurses undertaking advanced emergency care courses
- Continue to develop the shared care antenatal clinic service with midwives and medical practitioners
- Progess bed replacement program at Narrandera

## Greater Albury Cluster

The Greater Albury Health Service Cluster has staffing FTE of over 500 between all sites. Greater Albury covers the towns of Albury, Corowa, Urana, Lockhart, Henty, Holbrook and Culcairn.

**Services delivered**

A broad range of acute medical and surgical services, day surgery, emergency, rehabilitation, aged care radiology, pathology and other allied health services including physiotherapy, occupational therapy, dietician, speech pathology, social work and provision of aids for disabled people (PAPD). A comprehensive out patient service is available including tertiary community health services at Albury Community Health and local services in each town. Greater Albury also has a prosthetics and orthotic service located at the Diggers Road Campus. The South West Brian Injury Rehabilitation Service is located in Albury and forms part of the Greater Albury Cluster.

**Major goals and outcomes**
- While clinical staffing was stabilised at a number of sites within the Albury Cluster in 2007/08, recruitment remains a challenge
- Albury Base Hospital: Winner of 2007 NSW Health Hospital Performance Award – Major Non Metropolitan Hospital Group – Best Performance
- Maintenance of Albury Base Hospital benchmarks pertaining to emergency and surgical services as well as access and length of stay
- Co-ordination of all clinical services to accommodate an unprecedented increase in demand across key clinical departments at Albury Base Hospital
- Successful recruitment to a range of specialist medical positions at Albury Base Hospital including Director of Medical Services; Intensive Care Unit, Emergency Services, Ear Nose and Throat Physicians; and medical staff for orthopaedics and anaesthetics
- Partnership with Albury Wodonga Medical Recruitment Taskforce to further progress recruitment of a wide range of medical practitioners

- Progression of HealthOne model at Corowa
- Undertook work on the service plan for Lockhart Hospital
- Implementation of the Community Aged Care Package at Culcairn and Corowa; this very beneficial program has seen the reduction of inpatient stay in the acute ward
- Replacement of operating theatre equipment at Corowa Health Service
- Improved co-ordination of chronic and complex patients through a planned Sustainable Access Program including identified diagnosis
- Ongoing development of partnerships and care co-ordination with a range of external service providers including entering into a Memorandum of Understanding with the Albury Wodonga Aboriginal Service to improve access to service for Aboriginal people
- Ongoing development of partnerships with universities and other key educational services to support professional learning and development
- Build partnerships with the community members and consumers
- Completed Albury Community Health Service Plan for 2008-2010 and Implementation Plan

**Key issues and events**
- Participation in preparation for the World Youth Day pilgrimage of thousands of youths from Melbourne to Sydney planned for July 2008
- Implementation of Aged Care Funding Instrument Documentation programme at Culcairn Health Service
- Implementation of a Falls Clinic at Corowa Health service, including a 15 week outpatient program

**Future directions**
- Preparation to achieve full ACHS Accreditation in 2008/2009
- Progression of integration to Health Albury Wodonga
- Continue planning for a MultiPurpose Service at Lockhart
- Continue preparation for Corowa Aged Care Accreditation late in 2008
- Build on partnerships with external providers established in 2007/08
- Enhance the post-acute care program in Albury

**Lower Western Cluster**
The Lower Western Cluster includes Barham, Berrigan, Deniliquin, Finley, Jerilderie, Tocumwal, Mathoura, Moulamein, Tooleybuc and Moama.

**Services delivered**
A wide range of primary and community services including drug and alcohol, Aboriginal health, dental care, palliative care, community nursing, aged care, sexual health, health promotion, child and family care, occupational therapy and diabetes care. Lower Western has a range of health services including a District Hospital, Community Hospitals and an MPS providing a range of medical and surgical services including obstetrics, emergency care, day surgery, radiology, ultrasound, pathology, physiotherapy and aged care.

**Major goals and outcomes**
- To provide and maintaining a high level of health and preventative care to the communities
- Certification of all sites through the ACHS accreditation process
- Lower Western Cluster staff are proactive within their communities encouraging community input into the services provided and through community groups, interagency involvement, networking as well as working with individuals
- Completion and move to a new Multipurpose Service at Berrigan

- Implementation of a new model of service delivery developed by a Deniliquin Speech Pathologist which aims to reduce waiting time and reduce the number of clinical visits through education for each client
- Staff recruitment and retention – leave cover achieved by developing 'job share' arrangements. Outreach centres of Moama/Mathoura and Moulamein/Tooleybuc, work as two groups to support each other and meet monthly with Deniliquin colleagues
- Service planning completed at Cluster level
- Full transition to computerised radiology with faster turnaround of radiology results and diagnosis
- Finley Health Service improved their discharge planning processes
- Implementation of the Mental Health Emergency Care Support service, which links patients and health professional staff with experts in Wagga; there are improved outcomes for this group of consumers
- Completion of phase 1 of the patient and carer experience through a quality initiative at Finley Health Service
- Progress community health service relocation at Barham Koondrook Health Service
- Four staff within the cluster successfully completed the Certificate IV Business Frontline Management qualification
- A number of Enrolled Nurses completed the Endorsed Medication Course and/or the Enrolled Nurse Emergency Care Course
- Staff at Tocumwal Health Service have improved availability of resources for education with a dedicated computer and area for staff education
- Many of the facilities within the Lower Western Cluster enjoy health working relationships with local Hospital Auxiliaries and Local Health Service Advisory Committees

**Keys issues and events**
- Attracting health care professionals and medical staff to the cluster remains a problem
- There are some cross border issues that impact service delivery
- Maintaining the Visiting Medical Officer on call roster across the Finley, Berrigan and Tocumwal facilities has been a challenge

**Future directions**
- Work is being undertaken to redesign maternity services at Deniliquin Hospital
- Further work will be undertaken with patients and carers at Finley Health Service in the second phase of a quality project
- Progression to the new GSAHS Sector Structure
- Continue to support staff progressing from Enrolled Nurse to Registered Nurse qualifications at Barham Koondrook Health Service

## Monaro Cluster

The Monaro Health Service Cluster includes the city of Queanbeyan and the townships of Cooma, Braidwood, Bombala, Delegate, Bungendore, Jindabyne and Thredbo.

**Services delivered**

Services delivered include medical and surgical services, obstetrics, day surgery, emergency, radiology, pathology, aged care and a broad range of community health services.

**Major goals and outcomes**
- All sites within the Monaro Cluster have commenced working towards ACHS accreditation

- Construction of the new Queanbeyan health facility is close to completion, due for late 2008. Planning for service delivery in the new Queanbeyan Health Facility commenced
- The new Bombala Health Service commenced operation on the 31st of January 2008 and was officially opened by the Minister for Health on the 11th February 2008
- Cooma commenced operation of a new shared-care model for the delivery of oncology services in the region
- Cooma and Queanbeyan Hospitals achieved operating theatre waiting list benchmarks
- Cooma Health Service commenced working towards accreditation by ACHS
- The Queanbeyan Hospital emergency department medical staffing levels were enhanced and supported by recruitment of a permanent emergency department director
- Queanbeyan achieved re-accreditation as a 'Baby Friendly' hospital
- Transitional Restorative Aged Care Services (TRACS Home) program commenced in Queanbeyan
- Established a Drug and Alcohol Service outreach clinic in Braidwood

**Key issues and events**
- Planning underway for the Jindabyne HealthOne Model of Integrated Primary and Community Health
- Recruitment has continued in partnership with the local GP surgery to attract additional GPs to Bombala
- Braidwood MPS implemented a structured community consultation process, which identified future service needs for the service, and commenced a strategic service planning process
- Delegate MPS has been without a permanent GP in the community. A weekly, private GP clinic for the community commenced from the site
- The Braidwood MPS Committee in partnership with the Rural and Remote Medical Service successfully recruited a permanent GP to the region

**Future directions**
- Following a successful pilot, the Sub-Acute Fast-Track Elderly (SAFTE) Care project completed its first of a further four year extension under the new name of 'Healthy at Home'
- Preparation for ACHS accreditation
- Complete Queanbeyan redevelopment and move to new building

**Murrumbidgee Cluster**
The Murrumbidgee Health Service Cluster includes the city of Griffith and townships of Hay, Hillston, Darlington Point, Yenda, Hanwood, Yoogali, Beelbangera, Lake Wyangan, Tharbogang, Binya, Barellan and Coleambally.

**Services delivered:**
Acute medical/surgical, chronic and complex, rehabilitation, obstetric services, day surgery, emergency department, radiology, pathology, aged care, physiotherapy, Aboriginal liaison, oncology unit, renal dialysis unit, intensive/coronary and high dependency unit, large range of visiting services and a broad range of community health services.

**Major goals and outcomes**
- Griffith Base Hospital completed Emergency Department renovations
- The Mental Health Emergency Care Support Centre (MECHSC) program commenced this year and has substantially improved timely access to Mental Health Services for patients, and provides medical and nursing staff with sound direction and support in the management of acute mental health patients who present to the hospital

- Increased uptake of educational opportunities by Nursing Staff, particularly the Trauma Nurse Emergency Care Course (TNECC); Front Line Emergency Care Course (FLECC) and Medication Endorsement Certificate.
- A Hay Administration Officer successfully completed the Front Line Management Course
- Successful introduction of a falls program at Hillston Hospital as well as a successful pilot of the Ambulance integration program and the Carer Champion program
- Appointment of Nurse Practitioner and introduction of the fast track model in Griffith emergency department

**Key issues and events**
- Inability to recruit adequate numbers of medical and nursing staff, resulting in increased costs associated with recruiting locum medical officers and agency nurses.
- Griffith Base Hospital is working in collaboration with Griffith City Council on nurse recruitment

**Future Directions**
- Progress work on the mental health facility planned for Griffith Base Hospital
- Continue working towards the transition of Hillston Hospital to a Multipurpose Service
- Commence the GSAHS and NSW Ambulance Association Pilot Integration Project which aims to identify realistic opportunities where Ambulance Officers may contribute towards enhancing the delivery of health services in the community. The NSW Ambulance Service is co-located on the Hay Hospital site. This will commence in July 2008

## Southern Slopes Cluster

The Southern Slopes Cluster includes the acute and primary care and community health facilities at Batlow, Boorowa, Cootamundra, Gundagai, Murrumburrah-Harden, Tumbarumba, Tumut and Young. In addition Mercy Health and Aged Care, a third schedule hospital is located at Young.

**Services delivered**

A wide range of primary and community services including oncology, women's health, mental health, drug and alcohol, Aboriginal health, dental care, palliative care, post acute care, dementia and residential aged care, sexual health, health promotion, child and family care, diabetes care and community nursing. Medical and surgical services delivered include ophthalmology, orthopaedics, gynaecology, obstetrics, emergency and day surgery. Allied health services include physiotherapy, occupational therapy, dietetics and speech therapy.

**Major goals and outcomes**
- Successful transition from the old facility to the new Batlow Adelong MPS which demonstrated the hard work and commitment of a small team
- Implementation of Families NSW Safestart Program commenced in August 2007 at Cootamundra
- Introduction of Chronic and Complex care programs at a number of sites including Cootamundra Community Health who instigated regular Cardiac and Pulmonary rehabilitation groups, an educational group work for diabetes clients with the Dietitian and Diabetes educator and a smoking cessation group initiated this year, with good interest
- Establishment of a weekly discharge planning meeting at Tumbarumba to link service providers together to develop a seamless management of care to clients.
- Completion of Tumbarumba MPS service plan and development of the implementation plan
- Implementation of the telehealth mental health services project
- Float in the Festival of Falling Leaves – promoting Tumut health services
- Establish integrated perinatal care program at Tumut

- Provide multi disciplinary programs for healthy eating, physical activity and prevention of hearing loss in Aboriginal children in the Tumut area
- Pilot Carers program at Tumut; increased knowledge and resources to identify and support carers
- Adopted and implemented GSAHS falls prevention program; staff educated, patients screened for risk with a falls and balance clinic in partnership with the Riverina Division of General Practice
- Increased and improved ultra sound services at Tumut
- Screening services enhanced for otitis media in schools and generic four year old screening
- Established pre-admission clinic and improved antenatal booking services at Tumut
- Tumut has a visiting Pharmacist service – supported by area pharmacist

**Keys issues and events**
- Recruitment of staff at a number of sites to enable the correct skill mix required for service delivery
- Integration of services and models of care development for community health services within the Cootamundra HealthOne facility
- Develop and strengthen partnerships with a number of key partners including LHSACs and MPS Advisory Committees, Local Shire Councils and other health care providers
- Maintain maternity and operating theatre services at Tumut
- Attract additional suitably qualified GP VMO to Tumut – obstetric and anaesthetic
- Perioperative review at Tumut with action plan for completion
- Development of an early pregnancy shared care service for Tumut

**Future directions**
- Proceed to full implementation evaluation of the Families NSW Safestart Program in September 2008 at Cootamundra
- Continue to work on the planning of stage 2(CHC) of the Health One facility, with a view to completion of the facility by December 2009
- Continue work on progressing Gundagai to an MPS facility in cooperation with key stakeholders
- Planning of an MPS Recognition Ceremony for Boorowa in 2008/09
- Relocation of dental services from school site by December 2008

## Southern Tablelands Cluster

The Southern Tablelands Health Cluster (STHC) is made up of the major towns of Goulburn, Crookwell, Yass and Gunning.

**Services delivered**

General medical, surgical: orthopaedic, urology, ophthalmology, gynaecology, endoscopy, obstetrics, paediatrics, emergency, intensive care, renal dialysis, acute mental health and rehabilitation. Community health services such as community and child and family nursing, allied health services, Aboriginal liaison, a range of clinics, palliative care and health development.

**Major goals and outcomes**
- Implementation of Bridging the GAP (Goulburn Ambulatory Program) to reduce avoidable admissions to hospital for clients living with Chronic Respiratory Conditions. This program required integration between Goulburn Base Hospital and Goulburn Community Health Services

- Giles Court redevelopment to support a new model of service which focuses on behavioural aspects of care for dementia patients
- Through out 2007/2008 Southern Tablelands Health Cluster (STHC) commenced amalgamation of some significant services within Goulburn. These included therapy services, education and quality, security and wardspersons and integration of a number of community based services through increased communication and cooperation.
- A disability clinic has been established at Bourke Street Health Service provided by a local GP with an interest in this field
- A rehabilitation clinic commenced once a fortnight by a visiting Rehabilitation Physician with funding to support.
- Funding granted for additional staffing for nursing, allied health and medical positions
- Wait list timeframes for elective orthopaedics met. An additional 25 orthopaedic cases undertaken to meet Category 2
- Benchmarks for the time spent in preadmission clinic now met after review of the practices
- Correct site policy effectively implemented in the Operating Theatre and Radiology
- Achieved ACHS Certification
- LEAD (Leadership, Effectiveness, Analysis and Development) Project presentations by 10 middle managers in Aug 07 and March 08
- Implementation of Estimated Date of Discharge on the Medical Ward with excellent results and improvements in discharge planning
- Implementations of improved processes to reduce the length of stay of patients waiting for nursing home placement implemented at Bourke Street Health Service with excellent results
- Effective Local Health Advisory Committees working well in Goulburn, Crookwell and Yass. New members joined each committee in 2007/08
- Development of 2008-2010 Business Plan for STHC replacing the 2007-2008 versions
- Commencement of Innovative Practice days for STHC Services to recognise achievements
- Progress against recommendations in Health Service Plans for Goulburn, Crookwell and Yass reported through LHSACs

**Key issues and events**

- Recruitment and retention of nursing, allied health professionals is ongoing
- Achieved funding through Federal Governments Water Grants for tank installation on Goulburn Base Hospital Campus to support the gardens
- Australian National University Medical School extending its facilities at Goulburn Base Hospital.

**Future directions**

- Crookwell Health Services plan 2005 to 2010 implementation plan on target
- Continued work on amalgamating some significant services between Bourke Street Health Service and Goulburn based facilities. This includes Therapy Services, Education and Quality, Security and Wards persons and the Integration of a number of community based services through increased communication and cooperation
- Continue with presentation of projects from the LEAD program
- Commencement of a service which enhances the patients transition when returning to home with an emphasis on rehabilitation in the community

## Wagga Wagga Cluster

The Wagga Wagga Health Service Cluster incorporates Wagga Wagga Base Hospital, Wagga Wagga Community Health and Tarcutta Community Centre.

**Services delivered**
Wagga Wagga Base Hospital is the major acute care provider and referral hospital for Greater Southern and provides emergency, critical care, general medical and surgical services, obstetrics, paediatrics, mental health and clinical support services.

The main sub specialties offered are orthopaedics, cardiology, respiratory medicine, oncology, renal, gastroenterology, rheumatology, urology, ENT, ophthalmology, neurology and vascular surgery.

Teaching and research infrastructure includes linkages with the UNSW Southern Clinical School and Charles Sturt University.

**Major goals and outcomes**
- Ensuring skilled and experienced workforce
- Successful ACHS certification for Equip in 2007
- Achievement of State and Commonwealth waiting list targets at June 2008
- Installation of specialist neonatal ventilation equipment to improve the management of newborn infants with breathing problems
- Ensuring safe and effective elective and emergency care
- Ensuring increased integration of acute and community based services to improve patient outcomes

**Key issues and events**
- Successful consultancy tender for next stage of Wagga Wagga Integrated Regional Health Service redevelopment
- Further redevelopment of Emergency Department to provide enhanced patient care treatment areas and improved public amenities

**Future directions**
- Progress on redevelopment of the Wagga Wagga Integrated Regional Health Service

# Other Health and Health Support Services

## Aged and Extended Care

### Major goals and outcomes

- Improved health outcomes for older people in GSAHS
- Improved outcomes for older people following and acute episode of illness and discharge from hospital
- Older people are assisted to remain independent active and healthy
- Older people residing within GSAHS managed residential care facilities will be provided with high quality residential care

### Key issues and events

- Aged Care Services Emergency Teams (ASET) and Acute to Aged-Related Care Service (AARC) positions planned and implemented at Griffith; Wagga Wagga; Albury; Queanbeyan; Goulburn; Moruya; Bateman's Bay; Bega Valley; Cooma
- Two Dementia Acute Clinical Nurse Consultant (CNC) positions established within GSAHS; one in Albury to provide support to the western region of the area and one in Bega Valley to provide support in the eastern region
- The CNC in Albury obtained a Joanna Briggs Scholarship to participate in research project to improve detection and management of delirium of older people in the acute care environment. This work is focused on Albury Base Hospital
- GSAHS held a Dementia Forum at Batemans Bay in June which was attended by over 200 participants from across the health spectrum
- Transitional Aged Care Program established in several sites including; Griffith, Wagga Wagga; Junee; Albury; Queanbeyan; Goulburn; Moruya; and Bega Valley
- NSW Health ComPack program implemented across GSAHS. The Compack model of care is a brokered partnership model between Health and Community Options to provide post hospital support for a period of up to six weeks following acute care
- Training opportunities provided to GSAHS aged care providers to promote active ageing, fall injury and prevention programs
- GSAHS Aged Care Assessment Teams participated in a State-wide Consumer satisfaction survey; a report of the outcomes will be provided later in 2008
- Two ACAT workers appointed as education officers for ACAT teams across GSAHS
- GSAHS MPS sites have been expanded to include: Bombala; Junee; Berrigan; Batlow
- Residential Aged Care Standards reviews have been conducted at Hay; Jerilderie; Berrigan; Tocumwal; Batlow; Tumbarumba; Corowa; Holbrook; Leeton and Harden and have maintained their full Aged Care accreditation status

### Future directions

- Expand ASET and AARC services to support older people throughout the care continuum
- Planning for a GSAHS forum to provide orientation for ASET AARC Transitional Aged Care and ACAT teams in September 2008
- The Eastern Sector Dementia Forum will be held bi annually
- Another Dementia forum is planned for November 2008 in Wagga Wagga "Worried in Pain – Look for your Brain"
- Improved uptake of Compacks across GSAHS
- Promotion of active ageing programs in Day Care Centres
- Consumer satisfaction survey will be conducted every three years by NSW Health consultants. Outcomes of the survey will be included in future improvement plans
- Remaining MPS sites will be reviewed. Each site is expected to develop an improvement plan to address any recommendations from the review.

## Allied Health Services

### Major goals and outcomes

- Improved integration of Allied Health Services into the Health Service core priority business
- Improved sustainability of Allied Health Services in all communities by reviewing and developing new ways of delivering services and supporting professionals

### Key issues and events

- GSAHS Allied Health Locum Program funded by NSW Health continued to employ Physiotherapist, Occupational Therapist and Speech Pathologist to provide backfill to Allied Health Professionals throughout GSAHS
- A project officer was recruited with funding from NSW Institute of Rural Clinical Services and Teaching to develop new roles for trained Allied Health Assistants to enhance delivery of Allied Health Services in our rural environment. This has resulted in strong partnerships with many related industry external providers and other rural area health services as a state wide project being lead by GSAHS. Specifically, a new partnership has developed with the Riverina Institute of TAFE to be the registered Training Organisation for this qualification. The initial phase has been a collaborative between the two organisations to develop training, learning and assessment tools for the new qualification of Certificate IV Allied Health Assistant.
- Cootamundra and Young High Schools commenced a State pilot in Certificate 111 Allied Health Assistance as part of the Year 11 and 12 studies with 12 students commencing in January 2008.
- The Health Professionals Award was released in November 2007. This will allow Allied Health professionals to have both a clinical and a management stream

### Future Directions

- Utilising a grant of $15,000 from NSW DET, the Centre of Learning and Innovation will develop 8 training videos for the Certificate IV, Allied Health Assistant course
- 17 present GSAHS employees will commence training for the Certificate IV Allied Health Assistance course under an agreement with Riverina Institute of TAFE which with government incentives will be at no cost to GSAHS
- The Health Professional Award Translation will be implemented

## Cancer Services

Cancer Services includes three Cancer Networks which reflect GSAHS patient flows and networking of GSAHS Cancer services:

- Border Cancer Network
- Southern Cancer Network
- Riverina Cancer Network

Public Oncology Units, Radiation Oncology outreach clinics and Haematology outreach clinics are provided throughout GSAHS. The Cancer Institute NSW has funded GSAHS to appoint a range of directors, nurses, social workers and support staff.

**Major goals and outcomes**

- Successful grant application in partnership with Border Cancer Collaboration for two Multi Disciplinary Team projects (colorectal and prostate cancer)
- GSAHS and the Monaro Committee for Cancer Research were successful in attracting NSW Cancer Institute's Innovation Grant Program funding to establish a pilot "shared care" oncology service in Cooma, NSW. This enabled a new model of oncology service delivery through partnerships between metropolitan oncologists, local rural GPs and nursing staff. The model was designed differently from other rural oncology services in that there were to be no visiting oncologists to the site. The Pilot began in order to support an identified community need, allow access to services closer to patient's homes, meet chemotherapy treatment standards and ensure optimal patient outcomes. The Pilot Program also provided an opportunity to assess sustainability from financial, resource and skilled workforce perspectives.
- Successfully won two grants to foster development and sharing of innovative models of cancer service.
    - Aboriginal Health and Cancer Services - Working Together: this project will support Aboriginal people who seek medical treatment for cancer and subsequent psychosocial care.
    - Out on a Limb – Border Partnerships for Lymphoedema Support & Training: this project will improve access in the Border Region to lymphoedema assessment and management; and increase training opportunities in lymphoedema management.
- Achieved four year accreditation for BreastScreen Greater Southern (first in NSW to be accredited four years)
- Funding through the McGrath Foundation for part time Breast Care nurses in Bega and Moruya; recruitment completed
- Recent advice of further funding through the McGrath foundation as part of the Federal Government funded breast care nurse project for part time positions at Cooma, Young, Griffith, Goulburn and Wagga Wagga

**Key Issues and Events**

- Launch of the Emmett McGrath foundation Breast Care Nurse position based at Bega and Moruya
- Cancer Services Executive Committee strategic planning workshop held in June 2008 in Queanbeyan
- Cancer Services Workshop held in June in Albury for service providers to progress the development of the Clinical Services Plan

**Future Directions**

- Clinical Services plan being developed to provide Direction for GSAHS Cancer Services

## Clinical Redesign Unit

**Major Goals and Outcomes**

- Review, evaluation and report on implementation of a range of GSAHS projects
- Review, evaluation and report on Area Revenue strategies
- Walgan Tilly project representation; a statewide initiative aiming to improve health outcomes for the Aboriginal population in NSW
- Patient/Carer and patient/carer and staff (co-design) interviews and reports completed for Wagga Wagga Base Hospital emergency department, Finley, Griffith, Albury, Goulburn.
- Implementation of Goulburn Base Hospital Redesign Engineer Project for Avoidable Admissions
- Redesign staff skilled in Davis Balestracci "Data Sanity" and statistical modelling
- Development of Redesign team members through additional resources supplied by Clinical Services Redesign Program and Redesign Engineers School to strengthen approaches to project and change management
- Completion of recruitment to the Clinical Redesign Unit staff establishment

**Key Issues and Events**

- Davis Balestracci Data Sanity training sessions facilitated by Redesign Unit staff and conducted for GSAHS staff
- Accelerated Implementation Methodology (AIM) workshops focusing on change management and implementation held for GSAHS staff
- NSW Health conducted workshops for Patient and Carer/State wide survey
- Project management training to Southern Slopes cluster staff
- Commencement of emergency department project at Wagga Wagga Base Hospital reviewing patient flow through the department
- NSW Health: attendance at Redesign Presentations and Masterclasses
- Facilitated and supported training by NSW Health representative in Theory of Constraints

**Future Directions**

- Redesign Engineers appointed for WWBH Avoidable Admissions project (Respiratory) to improve access and use of resources for clients with respiratory illness
- Further rollout of AIM Training and provision of training on request from sector/site managers
- Training of additional site representatives to support each sector in incorporating Patient and Carer experience into current and future projects as both a diagnostic and evaluation tool
- The Clinical Redesign Unit will continue to provide GSAHS with ongoing project management training and support
- Development, implementation and coordination of training program to enhance the skill base of GSAHS staff working on LEAD and other projects
- Major project to be undertaken supporting episode base funding implementation – clinical coding, clinical costing, improvements in current patient journeys and strategic activity planning

## Critical Care Services

Critical Care Service provides a consultancy, planning, educational and advisory role for GSAHS Emergency Care services and Intensive Care. It liaises with hospitals, GSAHS directorates, and Victorian, ACT, Ambulance and Retrieval stakeholders to ensure seamless transfer of the critically ill to facilities where they may receive definitive care. Critical care staff have a advocacy role regarding resources, policy and protocol development to support

clinicians working in the 42 Emergency Departments, five Intensive Care Units (ICU) and multiple High Dependency Units throughout GSAHS.

**Major Goals and Outcomes**

- Institution and education surrounding major policies and procedures to ensure a safe standard of emergency and intensive care throughout GSAHS. These include Advanced Life Support, Trauma Management Guidelines, Clinical Practice Guidelines for ICU, Central Line Associated Bacteraemia Procedures; Cardiac Monitoring Guidelines
- Recruitment progressing for Directors of Intensive Care at Albury and Bega Hospitals
- Development of dedicated ventilated beds in Bega ICU in progress
- Full-time Nurse Educators appointed to Level 4 and 5 ICUs in GSAHS
- Clinical Education programmes skilling health professionals in First Line Emergency Care, Enrolled Nurse Emergency Care, Emergency Paediatrics. Advanced Life Support, intravenous cannulation, defibrillation, ventilated patient care and Critical Care Postgraduate Education; train-the-trainer course for Advanced Life Support Assessors

**Key Issues and Events**

- Participation in Emergotrain Exercise in ACT
- Colour-Coded Observation Chart Trial for recognition and management of the deteriorating patient progressing
- Liaison with neighbouring Victorian Health Regions to address issues involving transfer of acutely ill patients
- Rural Critical Care Conference 2008 held in Batemans Bay
- Engagement in critical care planning and prevention for World Youth Day pilgrims residing in Greater Southern
- Continued introduction of Mental Health Medical Assessment Guide across sites
- Nurse practitioner appointments to Emergency Departments in Griffith and Wagga
- Appointment of Clinical Nurse Consultant for Goulburn and Bega ICU
- Establishment of Albury Wodonga Health Emergency Management Committee
- Active involvement in ACT Critical Care Taskforce, Retrieval and Health Emergency Management Committees
- Continuation of rollout of Medical Emergency Team training to District Level and smaller hospitals
- Appointment of Emergency Physician to undertake medical education at Griffith Base Hospital
- Cooperation with NSW Ambulance in “Enhancing Health Care in Rural Communities” Project, running successfully in a number of small sites in GSAHS
- Disaster Exercises: Rural Fire Exercise in Albury, Pandemic Influenza Exercise in Yass
- Critical Care participation from GSAHS and ACT on Joint GSAHS/ACT Clinical Council
- NSW Education Collaborative for Specialty Services, Care of the Critically Ill Patient conference, held in Albury September 2008

**Future Directions**

- Conduct of the “Graduate Certificate in Critical Care – ICU Nursing Arm” in Goulburn, 2009 to attract, educate and retain ICU nursing staff in GSAHS
- Rural Critical Care Conference 2009 to be held in Wagga
- Working party in Aggression and Violence management to address Area-wide issues including security and including procedures for managing behaviourally disturbed individuals presenting to GSAHS hospitals
- Establishment of Colour Coded Observation Chart and procedures for management of the ‘deteriorating patient’ in all facilities
- Participate in planning to ensure that elderly patients who fall receive timely and appropriate intervention in all phases of their patient journey in GSAHS

## Nursing and Midwifery

The Nursing and Midwifery directorate continues to work towards setting the strategic direction for nurses and midwives across GSAHS. Professional development, leadership and support, education, clinical practice, policy and research, recruitment and retention, and training are all important in ensuring patients are receiving high levels of care.

**Major goals and outcomes**

- Recruitment and retention of nursing and midwifery staff to achieve a full nursing and midwifery workforce that is skilled, competent, effective and supported
- Leadership to demonstrate positive role-modelling, overcome obstacles, enable development of stronger competencies, display ethical integrity and undertake corrective action to progress strategically and achieve the targeted results
- Communication systems that are effective, easy to engage with and informative
- Clinical practice that is people-focused, contemporary and aligned with the best evidence
- Reform Policy and Practice documentation, meet accreditation standards and clinical governance requirements.
- Initiate practice development methodology, promote practice based on evidence and reform models of care
- Facilitate nurse strategy funding and nursing and midwifery professional development opportunities
- Provide professional management and clinical governance to GSAHS nurses and midwives
- Support IT based interventions and activities to assist monitoring and reporting
- Act as a communication conduit for, and representative of, GSAHS nurses and midwives
- Reform of nursing and midwifery structure
- Introduction of Practice Development methodology
- Development of disaster response for GSAHS including preparations for the World Youth Day period
- Provision of professional leadership: initiation of a change of salience to management practices, clinical leadership and evidence based models of care.
- Evaluation of Nursing and Midwifery policy and practice system. Four clinical networks were developed and 10 sites contributing to nursing and midwifery clinical policy and procedure development. Over 400 policies and procedures have been completely or partially completed.
- Completion and implementation of GSAHS Nursing and Midwifery structure, with development of professional and line management responsibility mapping.
- Practice Development partnership with Prince of Wales Hospital and International Practice Development School Collaborative Members; practice development initiative started at Wagga Wagga Base Hospital
- Leading the State in the implementation of the *Clinical guidelines for nursing and midwifery practice in NSW: identifying and responding to drug and alcohol issues.*
- Implementation of an Area Breastfeeding Policy with NSW Baby Friendly Health Initiative workshops held in Wagga Wagga in March 2008; establishment of Area Breastfeeding Network and reaccreditation of Queanbeyan Hospital as a Baby Friendly Health Initiative facility (one of five accredited facilities in NSW)
- Development and implementation of Integrated Perinatal Infant Care (IPC) Programs in the majority of the Area Health Service.
- Development of a Nursing and Midwifery Plan has been progressed. Consultations took place in February and March 2008 and a draft document was developed. Secondary consultation occurred in May and June. It is planned to complete by October 2008. The timeframe for the document January 2009 to June 2010.

**Key issues and events**

- Development of initiatives to address the potential increase in presentations at GSAHS Emergency Departments over the World Youth Day period in July 2008
- Activities held on International Nurses Day and International Midwives Day
- Significant consultation with nurses and midwives, for example in issues covering the realignment of the nursing and midwifery structure, policy development, planning, accreditation activities and changes to recruitment practices

**Future directions**

Alignment with the GSAHS Strategic Plan with a focus on the four priority areas:

- A full and skilled workforce
- Leadership
- Communication
- People centred clinical practice

## Oral Health Services

Oral health services are provided by registered dentists and dental therapists. This year 50,690 occasions of service were provided to adult clients and 40,589 occasions of service provided to children. The service successfully recruited to some vacancies and saw 13% more adults than last year.

**Major Goals and Outcomes**

- Two dentists were placed in GSAHS clinics again this year as part of the internationally qualified dentist program run by Sydney Dental Hospital and Westmead Centre for Oral Health
- As well as providing treatment, the oral health service aims to prevent oral health disease. There were many preventive programs run this year in which oral health staff worked with partners within and outside of the health service. Those programs included:
    - Life smiles
    - Start School Smiling
    - Life Smiles for Koori Kids
    - Life smiles for methadone families
    - Life smiles for diabetic children
    - Early childhood oral health program
    - Smoking cessation
    - Healthy at Home
    - Health Smart/Deadly Art
    - TAFE project
    - Nutrition: Fresh Start, Live Life Well, Munch and Move
    - Great Whites
    - Working with refugees
- GSAHS worked with partners, Teeth for Health Program and Palerang, Upper Lachlan and Eurobodalla Shire Councils to increase the level of fluoridated water supplies available to residents

**Key Issues and events**

- Staff from the oral health service participated in the National Child Oral Health Survey that has provided valuable data for planning and providing targeted oral health services for children
- Intake was centralised for all clinics; all clients have one contact point for the service on 1800 450 046

- As part of their education program, Bachelor of Oral Health students spent time at Queanbeyan dental clinic and final year Bachelor of Dentistry students were placed at Moruya and Goulburn

**Future directions**
- GSAHS is working with the Global Child Dental Taskforce on strategies to support communities with less than 1,000 residents without access to fluoridated water supplies
- Key senior staff have been involved in projects at state level including the development of an electronic oral health record
- Continue working on existing programs to improve oral health outcomes

## Shared Services

### Area Travel Unit

**Major Goals and Outcomes**
- Implementation of centralised booking services for accommodation and travel in accordance with NSW Health guidelines
- Transition of reimbursement payments to Accounts Payable

**Key Issues and Events**
- Continuing to achieve above benchmark figures in the provision of cost effective accommodation and air travel

**Future Directions**
- Continuing review of processes to achieve further cost efficiencies
- Explore an electronic application and approvals system

### Patient Transport Unit

**Major Goals and Outcomes**
- Replacement Patient Transport Vehicles at Wagga Wagga and Deniliquin
- Progression towards centralised patient transport booking system
- Reduction in processing time of IPTAAS claims
- IPTAAS Information Kits distributed to General Practitioners
- New Service Agreements with organisations providing Transport for Health services
- New transport assistance services established in some remote locations

**Key Issues and Events**
- New eligibility criteria for IPTAAS created a 32% spike in demand which has now plateaued

**Future Directions**
- Further progression of a centralised patient transport booking system
- New Patient Transport Vehicles to operate from Wagga Wagga and Temora
- New reporting system for community transport providers to meet NSW Health requirements

### Hotel Services

**Major Goals and Outcomes**
- Commenced the process of implementing the new Area-wide management and supervisory structure.
- Commenced preparations for the transition of Hotel Services to HealthSupport Services.

**Key Issues and Events**
- Received advice that the integrated Hotel Services model operating in GSAHS would be transitioned to Health Support Services

**Future Directions**
- Finalise implementation of supervisory structure
- Establish Hotel Services on a Business Unit model
- Prepare for transition to Health Support Services on 1 February 2009

**Fleet Management**

**Major Goals and Outcomes**
- Ongoing fleet optimisation program of replacing six cylinder cars with four cylinder cars

**Key Issues and Events**
- The Area adopted the NSW Health mandated Statefleet Management and Smartpool Booking systems

**Future Directions**
- Working with HealthSupport Services and Statefleet to improve the operation of these systems
- Continue fleet optimisation program

**Asset Management**

**Major goals and outcomes**
- Recruitment to the Asset Management Senior tiers
- Continuation of construction of Queanbeyan Health Service project
- Continuation of Wagga Wagga Base Hospital children's ward renovations
- Continuation of Wagga Wagga Base Hospital mortuary project
- Completion of the GSAHS Asset Strategic Plan
- Update and revision of asset related local procedures
- Implementation of the GSAHS Signage Style Guide
- Establishment of an area wide Dental Maintenance Service

**Key Issues and Events:**
- Continuation of fire and electrical safety audits and upgrades
- Completion of renovations for a four bed stroke unit at Wagga Wagga Base Hospital
- Completion of renovations to the Griffith Base Hospital emergency department
- Capital works completed for Junee, Batlow and Berrigan Multipurpose Services
- Completion of theatres at Bega
- Consolidation of Area Contracts

**Future Directions:**
- Planing for new MultiPurpose Services at Lockhart and Gundagai
- Continuation of planning for the redevelopment of Wagga Wagga Base Hospital
- Planning for Bega Valley Redevelopment
- Expansion on the asset management Intranet homepage and communication strategies
- Future expansion and utilisation of electronic tools and systems to support management of assets

## Information Services Unit

The information Services Unit (ISU) is responsible for all Information Technology (IT) related operational support to the GSAHS Corporate Data Network, computing infrastructure and voice telephony equipment. ISU also undertakes IT procurement and an asset management role ensuring a cost effective and sustainable information sharing environment.

**Major Goals and Outcomes**

- Upscale of Corporate Data Network bandwidth in preparation for radiology and converged telecommunication services
- Migration of all fixed and mobile voice services from previous provider to a new service
- Upgrade of the corporate email
- Completed the transition of the GSAHS IT helpdesk to Health Technology State Wide Service Desk
- Completed the migration of the legacy GSAHS computer operating environment to a consolidated Microsoft platform, incorporating the deployment of standard computing infrastructure on 3000 computers
- Completed implementation of the following systems:
  - OTIS
  - EDISSON
- Replaced a number of Hospital PABX phone systems including, Goulburn Base Hospital, Batemans Bay Hospital and Bourke Street Health Service
- Installed and commissioned an in house voice conferencing platform saving an average $15,000 per month against outsourced costs
- Decommissioning all legacy and low speed remote access services
- Implementation of mobile broadband remote access services
- Major replacement of Local Area Network infrastructure at 20 hospitals
- Managed the procurement and installations of 127 desktop computers, 73 Laptops, 47 printers/Multi function devices and 20 Data projectors
- ISU technical support staff completed 16,403 supports calls during the financial year

**Key Issues and Events**

- Commendation received from the Australian Telecommunications users group for the Mental Health Emergency Care Support video conference project
- ACHS accreditation achieved
- Information Services Unit structure finalised
- Completed the IT integration of the first HealthOne clinic at Cootamundra
- Implementation of converged telecommunications services (QoS) to the GSAHS Corporate network
- Completed stage 1 of clinical Outreach project at 12 hospitals enabling IP Video conferencing at each campus across the Corporate Data Network
- GSAHS Active Directory operating environment glued into state wide system to enhance application centralisation and delivery
- Introduction of “Survey” to the whole GSAHS computer environment, enabling GSAHS to maximise IT resource efficiency

**Future Directions**

- ISU will continue with progressing strategies detailed in their strategic plan, specifically initiatives that support collaboration and virtual services
- Continue expansion of corporate data network with Voice on IP trials between major GSAHS sites
- Recommence the implementation of the Electronic Medical Record
- Complete stage 2 & 3 of the Clinical Outreach Project
- Commence implementation of 21 Video Conference units into selected Community Health Campuses

- Migration of 31 ISDN based telehealth videoconference machines to high definition IP based conferencing
- Progress implementation of the following systems:
    - Obstetrix
    - CHIME Bega Valley
    - CBORD area wide
    - DR WHO
    - Microsoft Sharepoint

## Workforce Development

In 2007/08 a restructure of the Workforce Development Unit and functions led to improved responsiveness and support to the AHS.

EziSuite, a new automated system and process was implemented to support managers in the recruitment of appropriate staff. The new system enables applicants to apply on-line and provides identifiable audit trails which support compliance to policy and ensures that our employees are appropriately qualified, registered, screened and meet the required competency levels. The system ensures that recruitment to each position progresses in a timely way.

A cooperative recruitment advertising pilot was conducted with the Griffith City Council resulting in eight new permanent nurses appointed and 13 offers of employment progressing for overseas trained nurses in Griffith.

A new electronic dashboard was implemented to enable better analysis of workforce and staffing levels. The new CorVu system allows managers to review staffing measures and Full Time Equivalent (FTE) through easy to read graphs and tables on the GSAHS intranet. The data is updated monthly. An additional manual, which includes an FTE calculator, assists managers in identifying the FTE implication from any funds they may be allocated during the year. Additional workforce reports on CorVu have also been developed to allow managers to monitor trends and patterns in workers compensation and sick leave.

GSAHS payroll services transferred to NSW Health Support in 2007 as part of the NSW Health progress to centralise support functions. The functions formerly performed by GSAHS Payroll Unit were divided into three separate Units.

1. **Health Support Employee Services Unit**: Responsible for maintaining and updating employee personal and work related information in the human resources information system (HRIS) for all employees within GSAHS, ensuring employees are paid correctly based on the information provided.
2. **Health Support Payroll Unit:** Responsible for processing employees pays and ensuring payment is made to employee's bank accounts. In addition, Health Support Payroll maintain all employee's history, leave balances as well as the integrity of the payroll data.
3. **GSAHS Payroll & Staff Scheduling Unit:** Responsible for the system administration, database maintenance, training and user support of the PROACT Staff Scheduling System. User support includes helping managers complete their rosters in a correct and timely manner ensuring correct payment of employees.

PROACT, an electronic staff scheduling and roster system, was implemented for all staff except medical classifications with forward plans for including medical staff in 2008. This also streamlines the processing of payroll by having the payroll electronically interfaced with the Health Support payroll database. The implementation of PROACT has resulted in a

decrease in payroll processing costs, improved payroll processing quality and efficiency and improved access to timely management data.

A Manager Workforce Planning position was established and draft plans developed included:

- Workforce Plan for the Bega Valley Health Service Redevelopment project
- GSAHS Equal Employment Opportunity Management Plan
- Aboriginal Workforce Development Plan - to provide a focus for initiatives for existing and potential Aboriginal employees

A new Occupational Health Safety and Wellbeing (OHSW) Unit was established and is working in partnership with directors and managers to improve overall OHS and injury management performance and assist in the provision of efficient and effective health services across the AHS.

A Workers Compensation Management initiative was developed and overseen by the executive team to ensure that workers compensation claims were managed and monitored effectively across the AHS. Workers compensation claims improved by 14% when compared to the same time in 06/07. An additional Priority Placement Program for all workers compensation staff who could not return to their pre-injury duties was implemented to ensure that where possible, the staff member was retained within GSAHS.

An Injury Management Toolkit for managers was also developed to assist managers implement the principles of early intervention including timely notification of injury, ongoing support for the injured worker, and prompt referral to rehabilitation, timely identification and provision of suitable duties. This was further enhanced by targeted occupational assessments and continual return to work monitoring, supported by the Return to Work (RTW) Co-ordinators and the OHSW Unit.

Manual handling injuries are still a large proportion of all claims for GSAHS and the Manual Handling Working Party was established to identify best practice strategies for manual handling prevention across all work practices in GSAHS. A trial of a competency based Manual Handling Training Program commenced at Wagga Wagga Base Hospital.

A review of the Organisational Capability and Learning Unit was completed in February 2008 and identified the OCLU's strategic responsibility for the education and training system within a shared responsibility framework.

A new Performance Development Planning & Review procedure was developed for staff performance appraisal and implement across the AHS. The new templates were structured for each key discipline and provide managers with the tools to align workplace performance with strategic objectives and identify key development needs of staff.

## Internal Audit

The Internal Audit Unit undertakes a risk-based program of audits and reviews to provide independent assurance to the Chief Executive as to the extent of the organisation's achievement of objectives, effectiveness of controls, operational efficiency and resource utilisation, legal compliance and financial regularity.

Internal Audit is also responsible for fraud and corruption prevention and undertakes investigations of alleged misconduct or criminal activity. These investigations can arise from audits that are conducted, but are usually matters referred to Audit.

Internal Audit works to an approved Internal Audit Plan which is monitored quarterly by the Audit and Risk Management Committee.

Significant Achievements

In 2007-08, Internal Audit completed the following audits:
- IT Project Management
- IT Security
- Transition to Health Support
- Goods & Services Tax and Fringe Benefits Tax – Taxation Compliance Review
- Records Management
- Performance Review – Operation of the Occupational Health and Safety (OH&S) Framework
- Review of the appropriateness of payments made to VMOs.

As a result of the audits, improved processes were developed and implemented in the following areas:
- Developing a checking system of VMO invoices that highlights or flags instances of multiple patient consultations on the same day that are not supported by the clinical condition of the patient.
- Developing a system that identifies VMOs who are performing the same treatment on other VMOs patients. Any incidents are reported and reviewed.
- Developing an Area OH&S plan which provides the mechanisms for the implementation of policy and procedures, the monitoring of compliance with relevant policies and legislative requirements with defined safety improvement performance indicators.
- Developing a quarterly report which outlines the main OHS risks to GSAHS.
- Developing a comprehensive set of policies and procedures that are complete, accurate and up-to-date to cover all aspects of the record management function for all corporate records.

Thirty eight unplanned investigations were undertaken which had an impact on the number of audits that were completed. Investigations were conducted into matters such as theft from hospitals; breach of confidentiality; conflicts of interest; use of computer and telecommunication systems and compliance with legislation and NSW Health policy directives.

An effective internal audit capability is an important element of a robust corporate governance framework. To this end, in June 2007, two additional audit positions were created to strengthen the audit and investigative capability. The funding of the positions is cost neutral as money is being re-directed from funding for consultants who undertook the audits.

Performance audits will be undertaken in 2008/09 that are more aligned with Strategic Direction 5 (Making smart choices about the costs and benefits of health services). The focus will be on performance improvement to achieve best value for money and systems to better track and measure costs, benefits and results.

These additional audit resources will also enable the training of operational staff in the use of Control Self Assessments and the running of fraud control and corruption awareness sessions.

## Mental Health/Drug and Alcohol Services

Significant achievements for Mental Health/Drug and Alcohol Services include:

- Realignment of mental health management structure to commune the management of Mental Health and Drug and Alcohol services
- Successful implementation of the drought relief initiative with activities across the area to support drought affected communities utilising a whole of government approach
- Planning for a 20 bed non-acute mental health inpatient unit in Griffith is well underway
- Continued increase numbers of staff in mental health workforce
- Successful application of the service redesign methodology to address mental health access block, meeting benchmark every month for the year.

The GSAHS Mental Health Clinical Services Plan adopted in 2006 is reviewed at least annually and contains a range of priorities:

- Improve the equity of service for people who require mental health services
- Ensure a workplace culture of a corporate and clinical risk management approach at all levels
- Ensure an outcome focus
- Increase consumer and carer focus
- Establish clinical governance framework
- Enhance the Mental Health Workforce
- Increase integration across Mental Health, Health and other key services
- Information and financial management for planning, monitoring and evaluation
- Improving service availability across the population spectrum

A new initiative commenced in March 2008 is targeting improvements in the collection of community mental health care hours. Other strategies such as the appointment of permanent personnel to Team Manager and Senior Clinician positions across the Area will assist in improving activity collections.

The introduction of a clinical review and support system for Senior Clinicians across the area will assist in improving the collection of outcome measures across the Area. Through this process, clinicians are being supported to examine their consumer outcomes to improve the Quality of clinical services. This will be monitored through the governing body for the Mental Health Services, the Mental Health Executive.

Several initiatives are occurring within inpatient services to optimise self sufficiently strategies where this is possible and safer for patient care. A standardised set of policies and procedures have been developed for all services including inpatient services. Where inpatient services are unavailable within the Area, active steps are taken with the Area Health Service counterparts to maintain a professional relationship.

The Mental Health Service and Critical Care Services have worked collaboratively to reduce the emergency department access block for mental health patients. GSAHS has successfully sustained the benchmark of 80% access for the full year 2007/08. The collaborative strategies utilised include the introduction of a redesign initiative focussing on improving the patient journey through the weekly analysis of patient activity. Other strategies were commencement of dedicated Mental Health Emergency Care Support Centres co-located within the three acute Mental Health Inpatient Units. Ongoing strategies are continually being identified to maintain optimum quality and timely access for GSAHS patients.

Involvement with community is important to the mental health services with a number of strategies underway:

- Recent attendance at some Local Health Service Advisory Committees by senior Mental Health Service managers
- Mental health consumer focus groups are being formed in each major centre to determine perceived service effectiveness
- Participation in a Statewide consumer feedback project to attain feedback on service effectiveness, quality and efficiency
- The Mental Health Service provides funding to support wages and operational costs for the Mental Health Transcultural Rural and Remote Outreach Position in Griffith
- The GSAHS Area Procedure for Mental Health Consumer Participation, and GSAHS Area Procedure for Mental Health Carer Participation specifically outlines that special consideration and encouragement should be given to consumers from CALD backgrounds to increase their participation rates in service planning, development, implementation and evaluation processes to optimise service quality and consumer satisfaction
- Extensive links have been developed with specialist Mental Health non government organisations developed via specific funded programs such as the Housing Assistance Support Initiative and the Resources and Recovery Program. Service Level Agreements have been ratified an are being implemented in day to day service delivery
- Local contact with specific mental health NGOs and other related NGOs in related service delivery areas such as employment, training and respite care.

# Public Hospital Activity Data

**Selected Data for Year Ended June 2008 Part 2**

| Facility | Separations YTD | Planned Sep % | Same day Sep % | Total Bed Days (Days episode) | Acute Avg LOS | Daily Average | Occupancy Rate | Acute Bed Days | Acute Overnight Bed Days | Non Admitted Patient Services | ED Attendances |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Wyalong Health Service | 1,466. | 11.32 % | 40.65 % | 4,283. | 2.4 | 11.7 | | 3,415. | 2,822. | 13,342. | 2,901. |
| Albury Base Hospital | 11,067. | 34.62 % | 31.84 % | 45,720. | 3.8 | 124.9 | 78.8 % | 40,551. | 37,028. | 104,201. | 32,321. |
| Barham Health Service | 477. | 2.73 % | 33.54 % | 4,743. | 3.0 | 13.0 | | 1,309. | 1,151. | 7,388. | 1,769. |
| Berrigan Health Service | 527. | 11.95 % | 31.31 % | 3,330. | 2.6 | 9.1 | | 1,230. | 1,065. | 1,011. | 563. |
| Culcairn Multi-Purpose Service | 269. | 4.09 % | 23.79 % | 1,168. | 2.3 | 3.2 | | 481. | 417. | 7,958. | 867. |
| Corowa Health Service | 1,450. | 24.21 % | 44.41 % | 4,507. | 2.6 | 12.3 | | 3,560. | 2,922. | 19,595. | 4,948. |
| Deniliquin Health Service | 2,870. | 24.43 % | 33.45 % | 9,854. | 2.6 | 24.6 | 44.3 % | 6,461. | 5,503. | 49,191. | 7,459. |
| Finley Health Service | 768. | 4.56 % | 26.17 % | 2,498. | 2.8 | 6.8 | | 2,010. | 1,809. | 7,140. | 1,080. |
| Henty Health Service | 262. | 5.34 % | 27.10 % | 1,070. | 3.0 | 2.9 | | 738. | 668. | 1,482. | 626. |
| Holbrook Health Service | 601. | 0.83 % | 41.26 % | 2,405. | 3.7 | 6.6 | | 2,163. | 1,916. | 3,394. | 1,651. |
| Jerilderie Multi-Purpose Service | 212. | 17.92 % | 35.85 % | 611. | 2.3 | 1.7 | | 474. | 398. | 3,859. | 394. |
| Mercy Health Service - Albury | 557. | 39.86 % | 1.62 % | 9,464. | | 25.9 | | | | 25,547. | |
| Urana Multi-Purpose Service | 30. | 0.00 % | 90.00 % | 99. | 3.4 | 0.3 | | 98. | 71. | 2,774. | 87. |
| Tocumwal Health Service | 500. | 27.60 % | 41.60 % | 4,146. | 3.1 | 11.3 | | 1,404. | 1,200. | 4,721. | 922. |
| Tumbarumba Multi-Purpose Service | 588. | 0.17 % | 35.20 % | 1,708. | 2.5 | 4.7 | | 1,454. | 1,247. | 1,863. | 1,037. |
| Kenmore Psychiatric Hospital | 205. | 9.27 % | 0.00 % | 17,271. | 3.5 | 47.2 | | 7. | 7. | | |
| Bateman's Bay District Hospital | 4,137. | 33.45 % | 46.48 % | 11,814. | 2.4 | 32.3 | 84.1 % | 9,503. | 7,583. | 20,217. | 17,657. |
| Bega District Hospital | 5,681. | 39.02 % | 39.64 % | 19,078. | 3.0 | 52.1 | 71.5 % | 16,064. | 13,815. | 19,853. | 11,465. |
| Bombala Health Service | 246. | 10.16 % | 16.26 % | 3,012. | 4.0 | 8.2 | | 926. | 886. | 5,474. | 1,904. |
| Boorowa Health Service | 266. | 9.40 % | 15.79 % | 3,981. | 4.5 | 10.9 | | 1,115. | 1,073. | 7,368. | 936. |
| Braidwood Multi-Purpose Service | 106. | 3.77 % | 30.19 % | 728. | 3.9 | 2.0 | | 359. | 327. | 7,915. | 947. |
| Cooma Health Service | 2,984. | 27.38 % | 33.38 % | 10,183. | 3.1 | 27.8 | 63.9 % | 8,970. | 7,975. | 44,706. | 11,228. |
| Crookwell Health Service | 656. | 3.35 % | 17.23 % | 4,418. | 4.6 | 12.1 | | 2,677. | 2,565. | 18,327. | 3,181. |
| Delegate Multi-Purpose Service | 3. | 33.33 % | 0.00 % | 16. | 5.3 | 0.0 | | 16. | 16. | 2,398. | 530. |
| Goulburn Base Hospital | 8,376. | 44.76 % | 42.68 % | 28,985. | 3.3 | 79.2 | 71.2 % | 27,256. | 23,684. | 33,140. | 18,116. |
| Mercy Care Centre, Young | 412. | 33.98 % | 0.97 % | 7,213. | 15.1 | 19.7 | | 1,665. | 1,663. | 38,643. | |
| Moruya District Hospital | 6,703. | 43.26 % | 42.40 % | 17,478. | 2.4 | 47.8 | 68.0 % | 15,226. | 12,389. | 19,003. | 11,877. |
| Murrumburrah-Harden Health Service | 578. | 5.71 % | 32.35 % | 2,043. | 3.4 | 5.6 | | 1,929. | 1,743. | 10,737. | 2,331. |
| Pambula District Hospital | 2,725. | 19.30 % | 45.76 % | 8,281. | 2.5 | 22.6 | | 6,595. | 5,354. | 8,309. | 7,637. |
| Queanbeyan Health Service | 3,965. | 35.16 % | 49.10 % | 10,283. | 2.4 | 28.1 | 65.7 % | 9,256. | 7,309. | 79,878. | 16,974. |
| Bourke Street Health Service | 359. | 9.47 % | 0.28 % | 13,465. | 32.0 | 36.8 | | 96. | 96. | 11,329. | |
| Yass Health Service | 720. | 0.42 % | 32.22 % | 2,776. | 3.0 | 7.6 | | 1,942. | 1,710. | 21,378. | 5,049. |
| Young Health Service | 2,434. | 17.79 % | 39.11 % | 5,791. | 2.4 | 15.8 | | 5,658. | 4,712. | 33,944. | 9,833. |
| Batlow Health Service | 246. | 6.50 % | 28.05 % | 3,812. | 2.8 | 10.4 | | 558. | 489. | 1,630. | 409. |
| Griffith Base Hospital | 8,931. | 38.33 % | 50.07 % | 23,103. | 2.3 | 63.1 | 58.8 % | 20,266. | 15,861. | 51,316. | 20,741. |
| Gundagai Health Service | 890. | 2.13 % | 27.53 % | 7,486. | 2.7 | 20.5 | | 2,258. | 2,013. | 5,961. | 1,630. |
| Hay Health Service | 565. | 5.31 % | 43.54 % | 7,110. | 2.3 | 19.4 | | 1,152. | 912. | 8,496. | 2,240. |
| Hillston Health Service | 539. | 19.67 % | 51.02 % | 4,161. | 2.7 | 11.4 | | 1,368. | 1,093. | 2,992. | 1,026. |
| Junee Health Service | 647. | 4.33 % | 32.46 % | 9,980. | 2.1 | 27.3 | | 988. | 787. | 10,684. | 1,555. |
| Coolamon Multi-Purpose Service | 231. | 36.36 % | 67.97 % | 782. | 2.9 | 2.1 | | 632. | 477. | 3,332. | 988. |
| Leeton Health Service | 1,573. | 8.58 % | 31.91 % | 5,422. | 3.0 | 14.8 | | 4,519. | 4,018. | 18,891. | 5,744. |
| Lockhart Health Service | 297. | 5.39 % | 27.27 % | 4,260. | 2.3 | 11.6 | | 572. | 491. | 12,113. | 564. |
| Narrandera Health Service | 1,743. | 12.68 % | 24.61 % | 6,321. | 3.4 | 17.3 | | 5,592. | 5,165. | 14,356. | 3,400. |
| Temora Health Service | 1,635. | 7.34 % | 20.61 % | 5,518. | 2.6 | 15.1 | | 4,004. | 3,668. | 18,167. | 2,396. |
| Tumut Health Service | 2,301. | 10.65 % | 34.81 % | 6,978. | 2.5 | 19.1 | | 5,634. | 4,838. | 21,362. | 3,803. |
| Wagga Wagga Base Hospital | 23,832. | 37.77 % | 47.72 % | 73,701. | 2.6 | 201.4 | 70.4 % | 61,321. | 49,954. | 156,583. | 33,274. |
| Cootamundra Health Service | 1,867. | 21.48 % | 36.80 % | 5,641. | 2.5 | 15.4 | | 4,439. | 3,753. | 22,760. | 4,507. |
| Contracted to Private Hospitals | 1,536. | 100.00 % | 99.67 % | 1,543. | 1.0 | 4.0 | | 1,543. | 12. | | |
| Griffith Community Health | | | | | | | | | | 30,796. | |
| Wagga Wagga Community Health Service | | | | | | | | | | 84,798. | |
| Albury Community Health | | | | | | | | | | 60,768. | |
| BreastScreen NSW South West | | | | | | | | | | 16,119. | |
| Rural and Community Services | | | | | | | | | | 47,508. | |
| Amputee Services | | | | | | | | | | 3,005. | |
| South Western Brain Injury Service | | | | | | | | | | 6,070. | |
| Eurobodalla Community Health | | | | | | | | | | 51,575. | |
| Bega Valley Community Health | | | | | | | | | | 49,176. | |
| Goulburn Community Health Service | | | | | | | | | | 57,802. | |
| Southern Brain Injury Service | | | | | | | | | | 6,431. | |
| Mental Health Access Line | | | | | | | | | | 29,744. | |
| **GSAHS including Contracted to Private** | **109,033.** | **31.82 %** | **41.24%** | **428,240.** | **2.8** | **1,170** | **68.9 %** | **289,454.** | **244,655.** | **1,428,520.** | **258,567.** |
| **GSAHS excluding Contracted to Private** | **107,497.** | **30.85 %** | **40.40 %** | **426,697.** | **2.8** | **1,165.8** | **68.9 %** | **287,911.** | **244,643.** | **1,428,520.** | **258,567.** |

## HEALTH SERVICE COMMUNITY

### Community Participation within GSAHS

GSAHS demonstrates its commitment to community participation by:

- selecting the most appropriate method to consult with the community
- being open and frank in consultations
- providing avenues for the community to provide both positive and negative feedback on community participation
- identifying community members who will be able to provide relevant input
- recognising and acknowledging the value of the input from the community.

The GSAHS Community Engagement framework aims to:

- promote patient engagement in their own health maintenance and care, as active partners with professionals, including their carers
- enable patients and the public as a whole to become better informed about their treatment and care and to make informed decisions and choices
- ensure that patients, the public and staff have the knowledge, skills and support to enable them to influence planning, delivery and monitoring of health services
- actively involve patients and the public in planning, delivering and monitoring our services
- acknowledge and act on information we receive from patients and the public
- provide feedback to patients and the public about how their engagement has influenced the operation of health services.

### Area Health Advisory Council

Area Health Advisory Councils (AHACs) were established in each Area Health Service to enable clinicians (including doctors, nurses and allied health professionals), health consumers and local communities to have a stronger voice in health decision-making. In GSAHS, the AHAC has 12 members in addition to the Chair, and can co-opt people with specialist knowledge or skills if needed. The AHAC has a balance of clinicians and community members with at least one community member being an Aboriginal person.

The AHAC in GSAHS has the following broad functions:

- Obtain the views of clinicians, patients and community about the accessibility, quality, and safety of health services provided by GSAHS, ensuring that appropriate local consultation mechanisms are in place
- Incorporate the views of clinicians, patients and the community in planning delivering, monitoring and evaluating health services provided by GSAHS including the Area Health Services Plan
- Work with the Clinical Excellence Commission to promote delivery of safe and quality clinical services based on best available evidence and the most clinically and financially effective models
- Report to the community and clinicians about Council and GSAHS activities to improve health services accessibility, quality and patient safety.
- Provide advice to the Health Care Advisory Council about GSAHS activities that may have state-wide implications for the delivery of accessible, quality and safe health care services
- Monitor GSAHS's performance in promoting and establishing clinical networks

- Monitor GSAHS's performance in relation to major health initiatives and annual clinical and consumer performance targets based on key performance indicators (the 'dashboard' indicators)
- Develop a two year work plan for the approval of the Chief Executive

The Greater Southern Area Health Advisory Council does not have a role in the operations or management of the health service.

## Chair's Review

The 2007/08 year has seen continued progress in Greater Southern Area Health Service (GSAHS) in maintaining and increasing services in a time of generally tighter economic circumstances. The ongoing drought has caused increasing financial hardship to our farming communities which has had a significant flow on effect to rural communities.

The Area Health Advisory Council (AHAC) has contributed advice and feedback to a range of GSAHS initiatives that have occurred in response to the severe economic and psychological hardship evident in the communities that comprise GSAHS. The AHAC recognises the increased need for effective and targeted Mental Health programs to assist community members cope with these additional stressors as well as a range of acute and primary care services to maintain well-being.

The AHAC have also taken a role in disseminating information about these programs and initiatives through their links with the Cluster Health Advisory Committees (CHAC) and Local Health Service Advisory Committees (LHSAC). In addition, links with the CHAC's and LHSAC's have enabled local community issues to be brought to the attention of the Chief Executive and subsequent action to be reported back. This two-way flow of information has resulted in a transparent and effective communication policy that has benefited both local communities and the GSAHS.

During 2006/7 three Greater Southern Area AHAC members resigned. Recruitment for new members commenced and the remaining AHAC members look forward their contributions when the new members join us for meetings in the latter part of 2008.

The GS AHAC works within a portfolio system in order to gain the views of AHAC members on various topics, submissions and reports. This system has been active throughout the year. The AHAC has provided written advice to Heather Gray, Chief Executive, on subjects as diverse as the Australian Government Patient Assisted Transport Senate Inquiry; '10 tips for safer health care' brochures; Consenting to Treatment Discussion Paper and a range of GSAHS policy and planning documents. We trust that our comments have provided stimuli to thought and action in each of the matters addressed. The portfolio feedback also proved invaluable in the composition of reports and recommendations to the HCAC.

Finally, the AHAC have used the meeting schedule to organise additional meetings with local community members through the LHSAC's; local Council members and GSAHS staff and Medical Council members in each town visited. This has been a wonderful opportunity to increase communication channels between the communities and GSAHS and to give community members a sense that GSAHS values their input.

**Dr Ian Stewart**
Chair
Greater Southern Area Health Advisory Council

## Chief Executive's Review

Directions and activities of the Greater Southern Area Health Service (GSAHS) Area Health Advisory Council (AHAC) reflect the general movements and dynamics of our diverse rural communities and wide range of health services.

Of particular interest to the Greater Southern Area Health Advisory Council (GS AHAC) over the past year was the impact of the ongoing drought on farming and business communities across the health service. This has generated interest and focus on mental health services provided by GSAHS and how these target and support those requiring assistance while also promoting well being.

The broader movement of health towards primary and preventative care has resulted in GS AHAC members providing valuable advice and input into GSAHS strategies and activities related to chronic disease prevention. The GS AHAC also coordinated submissions to National and Government Inquiries, including the Australian Government Patient Assisted Transport Senate Inquiry which is of great significance to rural people.

It is of immense benefit for the community and GSAHS to have this group of community representatives providing advice and input into a range of key documents. The AHAC members enable timely, honest and practical input into development of our own plans for service delivery that in turn contribute to positive outcomes for our communities.

The GS AHAC has also moulded a new consumer participation framework for GSAHS in line with our own internal boundary re-alignments. As GSAHS moved from a 10 cluster structure to a three sector configuration, a review of how the GS AHAC interacted with the Cluster Advisory Councils and Local Health Service Advisory Committees (LHSACs) was undertaken. The outcome is strategies to enable a closer relationship and more direct communication pathway with LHSACs, which are centred on local health care facilities.

The 2007/08 year saw the GS AHAC Work Plan updated. This was an opportunity to pause and review the achievements of the GS AHAC since 2006 and it is clear that the Council provides a consolidated and progressive dimension to the health service. Development of a new plan for 2008-2010 will see the Council further develop community representation across preventative and primary health, patient satisfaction and organisational well being, amongst many other areas.

Three valued GS AHAC members, Mr Ray Gamble, Ms Jane Ayres and Reverend Tom Slockee resigned from the Council in 2007. I would like to sincerely acknowledge their valuable contributions to the GS AHAC and health service over the years and thank them for their efforts and support. I am pleased to advise that recruitment to the vacant positions is well underway and I am looking forward to welcoming our newest members to the Council in 2008/09.

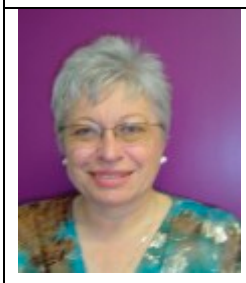
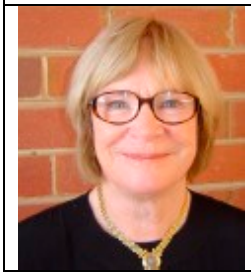
The Council represents a diversity of health professional and consumer voices critical to contributing to health service delivery. Thank you to all members of the GS AHAC for supporting GSAHS as we work towards our common goal of providing safe and high quality health care to the people of our communities.

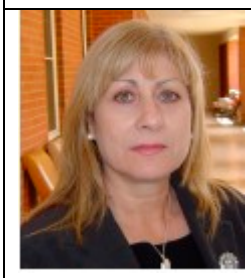
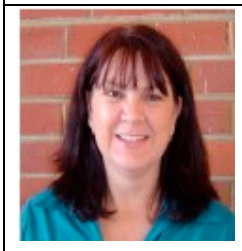
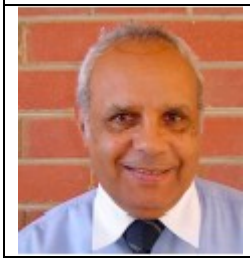
Ms Heather Gray
Chief Executive
Greater Southern Area Health Service

## Greater Southern Area Health Service Advisory Council Members

The GS AHAC has a broad based membership. Members of the GS AHAC are:

| | |
|---|---|
| • Dr Ian Stewart (Chair)<br>• Associate Professor Amanda Barnard<br>• Mr John (Jack) Barron<br>• Ms Fay Campbell<br>• Mr Robert McCully<br>• Ms Anne Napoli | • Ms Karen Pollard<br>• Dr Trish Saccasan-Whelan<br>• Dr Paul Sevier<br>• Rev Tom Slockee *(resigned November 2007)*<br>• Ms Jane Ayers *(resigned September 2007)*<br>• Mr Ray Gamble *(resigned October 2007)* |

| | |
|---|---|
|  | Dr Stewart, Chair of the GS AHAC, trained as a specialist in Obstetrics and Gynaecology and resides in Wagga Wagga. Practicing in Sydney and the United Kingdom before moving to Wagga Wagga, Dr Stewart has played an ongoing role in establishing a teaching program for obstetrics and gynaecology within the UNSW Rural Clinical School associated with Wagga Wagga Base Hospital. Dr Stewart is highly regarded in rural NSW for his work over three decades in medical practice and community involvement. |
|  | Ms Jane Ayers is a registered nurse with extensive experience in palliative care. She is the General Manager of Mercy Health Service Albury. She was awarded the Albury Electorate Woman of the Year in 2005. Ms Ayers resides in Albury. Ms Ayers resigned from the AHAC in September 2007. |
|  | Amanda Barnard is the Associate Professor of Rural Medicine and Director of the Rural Health Unit at the Australian National University. The medical school is committed to educating and training students who understand rural health issues, and are motivated to work in rural and regional areas. The rural clinical school places medical students across south east NSW and works closely with health providers and communities across the region. Dr Barnard is a GP who continues her clinical work part time in Braidwood. Her clinical interests include women's health and asthma. |
|  | Mr John (Jack) Barron is a fifth generation farmer from Ungarie; he has been involved in community health for 30 years and is a past Vice Chairman of the former Hospital Board, Chairman of the Ungarie Medical Centre Committee and more recently a member of the former Greater Murray Area Health Service Network Three Health Council. Jack graduated from Charles Sturt University with a Bachelor of Arts Degree in 2007. |
|  | Ms Fay Campbell is a former Mayor of Bombala. She operates a grazing property and was Chair of Bombala Hospital Board from 1983 to 1994. Ms Campbell has a long history of involvement in improving mental health services in rural NSW, serving on many boards and committees. Ms Campbell resides in Bombala. |

| | |
|---|---|
|  | Mr Ray Gamble is from Griffith and is the Managing Director of Associated Media Investments Pty Ltd which operates radio stations throughout Australia. He is Chairman of the Griffith Health Services Committee and Vice President of the Griffith Palliative Care Group. Mr Gamble resigned from the AHAC in October 2007. |
|  | Mr Robert McCully is from Hay and is the Managing Director of The Riverine Grazier newspaper and Travelscene Hay. He was Chair of the former Greater Murray Network One; the Hay Hospital Advisory Committee, and following completion of the new hospital, Chair of the Hay Local Health Advisory Committee. |
|  | Mrs Anne Napoli is an Italian born Australian citizen from Griffith who is a councillor on Griffith City Council. Mrs Napoli is a strong advocate for improved services for people living with a disability and is a member of the Multicultural Disability Advocacy Association of NSW. Mrs Napoli has a keen interest in Health and Education issues. |
|  | *MS KAREN POLLARD* has a background as a clinician and consumer. She is a qualified radiographer who currently coordinates the Medical Imaging and Medical Ultrasound courses at Charles Sturt University, Wagga Wagga. Ms Pollard resides in Wagga Wagga. |
| Dr Trish Saccasan Whelan is the Director of Critical Care for GSAHS. She also assists in the management of Goulburn Base Hospital Emergency Department, is a deputy Disaster Manager for GSAHS and is actively involved with the NSW Ambulance Service as a Rural Medical Adviser. She lives in Goulburn. | |
|  | Dr Paul Sevier is a General Practitioner and resides in Young. He is an active health provider in the region and is aware of the challenges involved in providing health services particularly in the rural areas. |
|  | Rev Tom Slockee is an Anglican Church priest. He is a former Chair of the Southern Area Health Service Board. He has a particular interest in Aboriginal Health and has extensive involvement in many Aboriginal corporations. Mr Slockee resides in Mogo. Rev Slockee resigned from the AHAC in November 2007. |

## Part A – Advice on engaging clinicians, consumers, and the local community

**Indicator 1**

How has the Council monitored and provided advice to increase engagement with clinicians, consumers and the community – especially among hard to engage groups (i.e. low income, non-English speaking and Aboriginal backgrounds, people with mental illness, people with disability, young people)?

Engagement with clinicians, consumers and the community occurs through a range of avenues including facility visits, meetings with local shire councils and community representatives, interest and backgrounds of GS AHAC members and the GSAHS consumer participation group structure.

The GS AHAC holds a number of its monthly meetings in different facilities across the health service. The GSAHS Chief Executive and members of the GS AHAC meet with LHSAC members, local Councils, local medical groups and hospital staff when they visit individual facilities across GSAHS throughout the year. This heightens the profile of the GS AHAC and strengthens direct and fruitful engagement at a local level. In 2007/08 meetings were held in the towns of Hay, Queanbeyan, Wagga, West Wyalong, Bega and Bombala.

The GS AHAC has a broad representation of members. Two members are direct carers of disabled and/or mentally ill persons, one is from a Non English Speaking Background, and another member who has since resigned from the GS AHAC is Aboriginal. A number of GS AHAC members represent areas which have amongst the lowest incomes in NSW.

Special consideration of minority and marginalised groups is considered during GS AHAC discussions including the newly arrived Sudanese and African refugees to Wagga Wagga, mental health issues and community members impacted by poor transport access.

Recruitment to vacancies created by the resignations of AHAC members during 2007/08 will consider potential member background and areas of interest to further broaden the diversity of groups represented on the GS AHAC.

Clinicians are actively engaged in the GS AHAC and provide feedback directly to Council members via communications with other clinicians who network with their respective disciplines. Personal communication by members of the GS AHAC with individual clinicians is used to gauge issues and convey GS AHAC recommendations.

All members of GS AHAC actively engage with patients, families, members of the community and staff from their areas of responsibility. The members receive feedback from these groups and in turn transmit that feedback to the other GS AHAC members and the GSAHS Chief Executive. The vast majority of that feedback is discussed at the meetings of the GS AHAC and actioned in some way by the Chief Executive.

Plans to further contact with communities include the hosting of three separate Community Forums in the three Sectors of the Area in the 2008/09 financial year. While GS AHAC understand that visiting and addressing community groups is perhaps more likely to gain information from and instill confidence in those groups and their members in ways that structured forums do not, we also recognise that our vast geographic spread makes the task of doing so a daunting one. This is an area of endeavor that we will give further thought to in 2008/09.

GSAHS has three tiers within the consumer participation framework. Each facility within GSAHS has a Local Health Service Advisory Committee (LHSAC) which works with local facility managers and communities on health related matters. In line with the GSAHS administrative cluster structure for 2007/08, a Cluster Advisory Council comprised of the chairs of each LHSAC met regularly to review common areas of concern and liaise with the GS AHAC.

While this structure provided a communication pathway for gathering information, distributing advice and engaging with a range of key groups, it was reviewed during the 2007/08 reporting period. Changes to the administrative structure of GSAHS saw dissolution of the 10 cluster structure and the introduction of three sectors. A new framework to accommodate these changes was developed and involved dissolution of the Cluster Advisory Councils and direct allocation of AHAC members to liaise with LHSACs within their geographic area. This will be introduced in the second half of 2008.

## Indicator 2

How has the Council monitored and provided advice to engage clinicians, consumers and the community in health promotion and preventative health initiatives which embed the principles of early intervention and prevention into services?

The GS AHAC has actively acknowledged and supported GSAHS initiatives relating to health promotion and early intervention particularly in relation to vulnerable young people, the elderly with chronic disease, mental health issues and substance abuse.

Early intervention by GS AHAC has, in the year 2007/08, concentrated on supporting the farming community in their ongoing drought-related crisis. This has been highlighted in the Chair's Review, in relation to the initiatives taken by the Mental Health teams across the Area.

Consultations have occurred with the Directorate of Population Health and the GS AHAC have requested talks from, discussion with, and frequent updating from persons engaged in health promotion and preventative health initiatives in GSAHS, including the Executive Director of Population Health, Planning, Research and Performance. There was some focus on the GSAHS Chronic care program aimed at population groups with chronic illnesses including cardiac illness, respiratory disease and diabetes.

The GSAHS Mental Health Directorate staff provided information on strategies to promote the importance of mental health and well being across the area. This included developing pathways to appropriate mental health care; strengthening concepts of community based support, particularly amongst farming groups; and developing interagency relationships to provide preventative and primary health approaches to mental health.

The Chief Executive requested advice on a number of occasions on relevant issues which has involved GS AHAC members consulting with clinicians and consumers to gain a picture of the current 'status quo' and ideas with respect to planning initiatives which may be of assistance in moving strategies forward.

Comments and consultation on a range of papers and documents occurred including The Disability Supported Accommodation Programme - National Consultation and 'How to Strengthen Service Delivery'.

GS AHAC members have tabled and discussed various programs that emanated from a range of sources. For example, changes to dental services for people with chronic and complex conditions were discussed and resulted in distribution of the relevant information through GSAHS consumer participation networks.

GS AHAC has recognised staff involved in programs addressing health promotion and prevention and publicised their work.

Part B – Advising the Chief Executive in relation to:

- supporting, encouraging and facilitating engagement
- performance agreements

**Indicator 3**

How has the Council advised the Chief Executive in relation to performance agreements?

The Chief Executive provides an overview of progress on key clinical and financial performance indicators relevant to the GSAHS performance agreement at each meeting. This includes presentation of statistical data against items such as waiting lists, separations and Emergency Department waiting times as well as information about initiatives linked with NSW Health and GSAHS strategic directions.

This generates wide ranging discussion amongst the GS AHAC with direct feedback to the Chief Executive during the meeting. There are often requests for further information across many topics in order to gain further information and facilitate more detailed advice, which is provided through briefing documents, presentations to the GS AHAC and meetings with key GSAHS Directors and staff. The GS AHAC provide advice on strategies in place to improve performance, as well as acknowledgement of the successes.

Advice related to key performance indicators is also provided through comments on internal GSAHS documents for clinical and staff related policy and strategies. Comment was sought by the Chief Executive, and advice provided, on topics such as ‘Strengthening Service Delivery’, a document related to chronic disease management; a GSAHS Toolkit for Managers on managing sick leave and the GSAHS Clinical Governance Framework.

The advice gathered from the GS AHAC is relayed to the relevant Director within GSAHS for consideration and inclusion in relevant plans and documents.

**Indicator 4**

How has the Council advised the Chief Executive to improve staff morale and patient satisfaction?

Anecdotal discussions from various sources including consumers and community participation groups have provided information regarding levels of patient satisfaction and dissatisfaction. This has been of sufficient concern to the GS AHAC to raise the issue at the Council meetings.

This, together with the state-wide survey of Health Service areas, which showed GSAHS performing well in most areas except customer satisfaction, led to Council advocating serious investigation into ways in which this could be changed.

Staff from the GSAHS Clinical Redesign Unit gave the members a presentation on a method for capturing and analysing patient and carer experiences which is a useful way to verify information derived through patient and carer interviews and/or to provide interim feedback to healthcare clinicians.

The GS AHAC recommended that the topic of patient satisfaction be 'workshopped' at the Annual Community Forums being planned for July, August and September in 2008. This will enable the LHSACs to become directly involved in providing ideas and input into aspects related to patient satisfaction. Planning for the fora is underway.

Concerns about staff morale were brought to the attention of the GS AHAC via a range of avenues including meetings with staff; items raised in the Chief Executive report; Cluster and LHSAC reports and through GS AHAC members. These concerns generated discussion and vigorous debate and provided the opportunity to act upon on some issues. Timely feedback from those discussions was provided to the LHSAC at the morning tea meetings.

Most notably, adverse staff response to new information technology requirements and staff security led to further investigation and action by GSAHS.

GS AHAC members contributed to activities that positively impacted staff morale such as judging excellence awards and attending presentations. This enabled members to celebrate the success with the staff and demonstrate that the GS AHAC valued staff achievements.

Part C – Liaison with other Councils in relation to both local and State-wide initiatives for the provision of health services.

**Indicator 5**

How has the Council collaborated with other Advisory Councils on local and state-wide initiatives?

Through the Chairs' and Chief Executives Forums (HCAC Forums) the GS AHAC has had the opportunity to contribute to the debate about the needs of the primarily rural Area Health Services (North Coast, Greater Western and Greater Southern) which do not have an urban component in their bailiwicks.

The fewer numbers of people over greater geographic areas in rural NSW requires that rural bodies work together to overcome health care challenges. Working together on shared interests enables rural organisations to increase their influence on governments to address issues unique to rural areas.

The essentially rural AHACs have joined together, only tentatively so far. The matters particularly emphasised by the rural AHACs have been transport, workforce availability, cross-border matters (eg. costs) and staff morale.

In the years to come the rural AHACs must form a stronger and more united front to highlight the contribution that the people of their Areas make to the general good of the citizens of the

State of NSW and of the State overall, so as to attract a more equitable distribution of health resources and the health dollar to the rural areas.

## Part D – publish reports about the council's work and activities

**Indicator 6**

How does the Council communicate work and activities undertaken to clinicians, consumers and the community?

The 2006/07 Annual Report of the GS AHAC was published and made available on the Greater Southern Area Health Service website at www.gsahs.nsw.gov.au.

The AHAC report was also incorporated as a section into the GSAHS Annual Report which was distributed widely across GSAHS and made available on the GSAHS website.

Other mechanisms used to provide information to stakeholders by the GS AHAC include:

- Media alerts and releases – as the GS AHAC meeting travels to various communities, local media are alerted and invited to interview the Chair and GS AHAC members
- GSAHS Weekly News Bulletin which is an internal publication distributed across GSAHS, to LHSACs and a small number of external stakeholders
- Attendance of GS AHAC members at the Cluster Advisory Councils – these councils are comprised of chairs of the LHSACs
- Distribution of the GS AHAC Minutes and Meeting Communiqués to LHSAC members across the GSAHS
- Visits by GS AHAC members to individual sites throughout the year where clinicians, local staff, local Councils and community members are engaged
- General discussions by GS AHAC members through their extensive community and professional networks
- The GS AHAC has a page on the GSAHS intranet which is available to GSAHS staff.

The GS AHAC plan to refresh their electronic presence with a review of the GSAHS internet site in 2008/09.

## PART E – OTHER FUNCTIONS AS ARE CONFERRED BY THE REGULATIONS

**Indicator 7**

Provide an update on implementation of the work plan, including budget allocations.

The GS AHAC Work Plan was reviewed in April 2008 and updated to include relevant targets listed in the NSW State Plan and NSW State Health Plan.

The achievements from the GS AHAC Work Plan from 2006-2008 were noted with activities being completed across consolidation of the AHAC communication frameworks, establishment and successful functioning of portfolio areas, provision of advice across a range of corporate and clinical topics and hosting a community forum.

Areas of action in the 2008-2010 Work Plan span the following topics:

- Support of health promotion programs: identification of barriers, ideas on increasing community participation and determining avenues to engage under represented groups
- Customer and patient satisfaction: advice on patient satisfaction survey results; ideas to improve results; increase AHAC contact with key groups that can provide feedback and increase web presence
- Service delivery and performance against health service plans: some focus on mental health services and increase community consultation.
- Contribution to workforce development and wellness strategies: comment on key documents and involvement in promotional activities.

An appropriate budget has been developed to support GS AHAC activities. In addition to the budget allocation, the Council receives resources in the form of secretariat and telecommunications support.

## Other Achievements:

- The GS AHAC commenced trials of using videoconferencing facilities for meetings to reduce costs associated with travel and accommodation
- Consideration of new pathways of communication with LHSACs including plans for each GS AHAC member to commence a sponsorship relationship with a designated LHSAC in 2008/9
- Supporting the relationship between LHSACs and local health service managers to promote effective communication
- Plans to host three community forums with LHSACs through more localised forums across GSAHS early in the new financial year.

## Table A. Attendance at AHAC meetings Year/Year & Record of Performance Reviews

***Attendance of AHAC Chair and Members in 2007/2008 & Record of Performance Reviews***

| AHAC | Performance Review – date completed | AHAC Meeting Dates | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | July 07 | Aug 07 | Sept 07 | Oct 07 | Nov 07 | Feb 08 | Mar 08 | Apr 08 | May 08 | June 08 |
| *AN STEWART, CH* | N/A | ✓ | n/a | ✓ | ✓ | ✓ | ✓ | n/a | ✓ | ✓ | ✓ |
| *Heather Gray,* ***Chief Executive*** | n/a | ✓ | n/a | ✓ | ✓ | ✓ | X | n/a | ✓ | ✓ | ✓ |
| *Assoc. Prof. Amanda Barnard* | June 07 | X | n/a | X | ✓ | ✓ | ✓ | n/a | ✓ | ✓ | X |
| *John Barron* | June 07 | ✓ | n/a | ✓ | ✓ | ✓ | ✓ | n/a | ✓ | X | ✓ |
| *Fay Campbell* | June 07 | ✓ | n/a | ✓ | ✓ | ✓ | ✓ | n/a | ✓ | ✓ | ✓ |
| *Robert McCully* | June 07 | ✓ | n/a | ✓ | ✓ | ✓ | ✓ | n/a | ✓ | ✓ | ✓ |
| *Anne Napoli* | June 07 | ✓ | n/a | X | ✓ | ✓ | ✓ | n/a | ✓ | ✓ | X |
| *Karen Pollard* | June 07 | ✓ | n/a | ✓ | ✓ | ✓ | ✓ | n/a | ✓ | ✓ | ✓ |
| *Dr Paul Sevier* | June 07 | X | n/a | ✓ | ✓ | ✓ | ✓ | n/a | ✓ | ✓ | ✓ |
| *Dr Trish Saccasan-Whelan* | June 07 | ✓ | n/a | ✓ | ✓ | X | X | n/a | ✓ | ✓ | ✓ |
| *Rev Tom Slockee* | June 07 | X | n/a | X | X | ✓ Resigned | | | | | |
| *Ray Gamble* | - | X | n/a | X | Resigned | | | | | | |
| *Jane Ayers* | - | X | n/a | Resigned | | | | | | | |
| *Meeting Location* | | Hay 4-5 July | No Meeting | Queanbeyan 4-5 Sept | Wagga 3-4 Oct | West Wyalong 6-7 Nov | Bega 4-5 Feb | Meeting cancelled | Bombala 1-2 April | Video conference | Video conference |

## Health Service Cluster Advisory Councils

Health Service Cluster Advisory Councils were formed in each GSAHS Cluster. These Councils meet between three and five times per year and meetings are attended by nominated members of the AHAC. This structure ensures the two-way flow of information from the community and GSAHS to the AHAC and back again.

Membership of Health Service Cluster Advisory Councils comprises:

- Chairs of each LHSAC within the Cluster
- A further representative from each LHSAC
- The Cluster General Manager (who also provides secretarial support)

The role of Health Service Cluster Advisory Councils is to:

- work in partnership with GSAHS to ensure that decisions about public health services in the Greater Southern Area reflect community needs
- progress community involvement in the planning, development and evaluation of health services, policies and programs
- form the link between the LHSAC, the AHAC and GSAHS Executive
- ensure a direct line of communication to the AHAC, as Cluster Chairs will meet with the Chief Executive and the Chair of the AHAC bi-annually and more frequently if required
- work to ensure the views of their communities are represented in planning health service delivery, priority setting and evaluation at the Area level.

Local Health Service Advisory Committees in the Bega Valley, the Eurobodalla and Wagga Wagga also act as the Cluster Advisory Council for their Cluster. With the realignment of internal boundaries within GSAHS, the Cluster Advisory Councils will be dissolved. This will be replaced with a direct allocation of each AHAC member to each LHSAC.

## Local Health Service Advisory Committees

Local Health Service Advisory Committees provide a community perspective for the provision of services and information. Community participation is critical to the future of health services. Proper community involvement results in more transparent, accountable and reliable services.

A total of 46 local Committees represent 55 different communities in GSAHS. Each Committee is made up of between five and seven community members, a staff representative and a clinical representative. They meet 10 times per year and support is provided by the local health service.

The commitment of the LHSAC members to the improvement of our health services and facilities is considerable, as is their commitment to the communities they represent.

During 2007/08, there has been increased attendance of Senior Mental Health Services managers at LHSAC meetings. This will continue to be formalised in the coming year to ensure consistent mental health representation at each meetings.

## Local Health Service Advisory Committees and MPS Committees – Members as at 30 June 2008

### Barham

| | |
|---|---|
| Ruth Morpeth | Chair |
| Joy Eagle | Communication Officer |
| Sally McConnell | Staff representative |
| Rebecca Lodge | |
| Chris Chapman | |
| Ciaran Keogh | |

### Batlow

| | |
|---|---|
| Janice Vanzella | Chair |
| Isobel Crain | Deputy Chair |
| Diana Droscher | Communication Officer |
| Christine Menon | |
| Scott Baron | |
| Jan Knott | |
| Heather Jamieson | |

### Bega Valley

| | |
|---|---|
| Jan Aveyard | Chair |
| Judith Reid | Communication Officer |
| Lynne Teale | |
| Ian Jessop | |
| Allen Collins | |
| Pat Luker | |
| Val Malcolm | |
| Wendy Grearly | |

### Berrigan

| | |
|---|---|
| Bernard Curtin | Chair |
| Rowan Perkins | |
| Elaine Hawkins | |
| Susanne Chisholm | |
| Marion Dickins | |
| John McGrath | |
| Bill Petzke | |
| Barbara Fox | |
| Inara Fox | |

### Bombala

| | |
|---|---|
| Ruth Allan | Chair |
| Leslie Smith | Communication Officer |
| Colin Pate | Medical representative |
| Jenni Platts | Staff representative |
| Fay Campbell | |
| Bronwen Longden | |
| Norman Vincent | |
| Anna Vincent | |
| Margaret Knight | |
| Steven Roccolett | |
| Jill Knight | |

### Boorowa

| | |
|---|---|
| Peter Sykes | Chair |
| Julie Styles | Staff representative |
| Hugh Darling | |
| Don Webster | |
| Jayne Apps | |
| Geoff Mackey | |
| Liz Webster | |

### Braidwood

| | |
|---|---|
| Jeremy Campbell-Davys | Chair |
| Mary Mathias | Deputy Chair |
| David Cargill | |
| Peter Camiller | |
| Jo Wilson | |
| Anthony Cairns | |
| Margaret Jones | |
| Geoffrey Bunn | |
| Kirsten Sturgiss | |

### Carrathool/Hillston

| | |
|---|---|
| Vincent Cashmere | Chair |
| Clifford Rose | Communication Officer |
| Arik Bronstein | Medical representative |
| Janette Anthony | Staff representative |
| Ellen McMaster | |
| Jenny Rose | |
| Wayne McLaughlin | |

### Coolamon

| | |
|---|---|
| William Levy | Chair |
| Cheryl O'Brien | Deputy Chair |
| Ruth Holden | |
| Jacqueline Gattenhoff | |
| Peter Mangan | |
| Betty Menzies | |
| Dianne Suidgeest | |

### Cooma

| | |
|---|---|
| Anthony Mackenzie | Chair |
| Judith Gibson | Staff representative |
| Patricia Scheele | |
| Christopher Reeks | |
| Anne Goggin | |
| John Neilson | |
| Lee Evans | |
| Davinia Blanchard | |
| Sue Litchfield | |
| Diana Davies | |

### Cootamundra

| | |
|---|---|
| Carmel Herald | Chair |
| Jeff Sowiak | Communication Officer |
| Jacques Scholtz | Medical representative |
| Fiona Grogan | Staff representative |
| Ruth O'Dwyer | |
| Margery Taprell | |
| John Dietsch | |
| Kyla Wallace | |
| Sue Fenning | |

### Corowa

| | |
|---|---|
| Keith Barber | Chair |
| Barbara Robinson | Communication Officer |
| Bruce Slonim | Medical representative |
| Gillian Kingston | Staff representative |
| Ida Mensforth | |
| Elizabeth Tidd | |
| Peter Wortmann | |

**Crookwell**

| | |
|---|---|
| David Rees | Chair |
| Johanna Kovats | Medical representative |
| Doreen Wheelwright | |
| John Bell | |
| Serina Kynch | |
| Barbara Carter | |
| Diana Layden | |

**Culcairn**

| | |
|---|---|
| David Gilmour | Chair |
| Nigel Preston | Deputy Chair |
| Janet Drummond | |
| Barry Gibbons | |
| Jenny Lodge | |
| Janice Scheuner | |
| Ian Bahr | |
| Mark Leov | |

**Darlington Point/Coleambally**

| | |
|---|---|
| James Tongue | Chair |
| Helen Mason | Staff representative |
| Gail Hibbert | |
| Monika Whelan | |
| Kylie Heath | |
| Marcus Zarins | |

**Delegate**

| | |
|---|---|
| Jan Ingram | Chair |
| Rhonda Linehan | Staff representative |
| Sue Guthrie | |
| Pat Ventry | |
| Natalie Armstrong | |
| Gloria Cotterill | |
| Jayne Sellers | |
| Charlie Burton | |

**Deniliquin**

| | |
|---|---|
| Elsa Bolton | Chair |
| Edgar Day | |
| Sylvia Baker | |
| Bobby Murphy | |
| Naomi Willis | |
| Sue Taylor | |
| Wendy Sizer | |

**Eurobodalla**

| | |
|---|---|
| Norman Parker | Chair |
| Angela Nye | Staff representative |
| David McCann | |
| Ursula Bennett | |
| Rosemary Testaz | |
| Edith Sorum | |
| Elizabeth Cook | |
| Raja Ratnam | |

**Finley**

| | |
|---|---|
| Sydney Dudley | Chair |
| Bradley Carlon | |
| Rosemary Brooks | |
| Esther Bryan | |

**Goulburn**

| | |
|---|---|
| Marie Heath | Chair |
| Gabriel Kolos | Medical representative |
| Lynne Lace | Staff representative |
| Julien Vanslambrouck | |
| Ian Cameron | |
| Simone Goppert | |
| Susan Harris | |
| Susan Hannan | |
| John Wiggan | |
| Rhonda Poulton | |
| Isobel Heaton | |
| Maureen Eddy | |

**Griffith**

| | |
|---|---|
| Andrew Crakanthorp | Chair |
| Jaime McEncroe | Medical representative |
| Julie Vardanega | Staff representative |
| Simon Croce | |
| Deanna Marriott | |
| Albert Ravanello | |
| Yvonne Turnell | |
| Ann-Maree Barbaro | |

**Gundagai**

| | |
|---|---|
| Keith Turner | Chair |
| Des Manton | |
| Rebecca Smart | |
| Jennifer McDonnell | |
| Colleen Sullivan | |
| David Gigmer | |
| Kerry Eager | |
| Rick Tribe | |
| Marilyn Ballard | |

**Gunning**

The Gunning District Community and Health Service Inc acts as a Health Service Advisory Committee for the Gunning community.

**Harden-Murrumburrah**

| | |
|---|---|
| Brian Dunn | Chair |
| Yusuf Khalfan | Medical representative |
| Zonia Argue | Staff representative |
| Paul Atherton | |
| Robert Bradly | |
| Carmel Brown | |
| Patricia Bulbeck | |

**Hay**

| | |
|---|---|
| Robert McCully | Chair |
| Deborah Payne | Staff representative |
| John Treloar | |
| Kellie Rutledge-Robinson | |
| Jennifer Grimm | |
| Wayne Mitchell | |
| Michael Beckwith | |
| Patricia Ray | |
| Annette Smith | |
| Jean Woods | |

**Henty**

| | |
|---|---|
| Michael Broughan | Chair |
| Roslyn Kilo | |
| Joan Uebergang | |
| Jean Bennett | |
| Mark White | |
| Emma Scholz | |
| Julie Meyer | |

**Holbrook**

| | |
|---|---|
| Graeme Joyce | Chair |
| John McInerney | |
| Desmond Lum | |
| Jane Bunyan | |
| Jody Whitely | |
| Kevin Farrelly | |
| Judy Wettenhall | |
| Heather Wilton | |

**Jerilderie**

| | |
|---|---|
| Ruth McRae | Chair |
| Ian Snedden | |
| Dawn Taylor | |
| Brian Nethery | |
| Denise Buckley | |

**Jindabyne**

| | |
|---|---|
| Bruce Hodges | Chair |
| Lee Taylor-Friend | Communication Officer |
| Shari Luckhurst | Staff representative |
| John McLoughlin | |
| Verity Jackson | |
| Cath Newman | |
| Jenne Gardner | |

**Junee**

| | |
|---|---|
| James Davis | Chair |
| Bronwyn Lemmich | Staff representative |
| Darren Corbett | |
| Leslie Eisenhauer | |
| Gary Dyson | |
| Robert Smith | |
| Elizabeth Lewis | |
| Phil Wood | |
| Peter Logan | |

**Leeton**

| | |
|---|---|
| Pat Bowles | Chair |
| Kate Alexander | Communication Officer |
| Daniel Pettersson | Medical representative |
| Julie Ramponi | |
| Robyn Whittaker | |
| Paul Maytom | |

**Lockhart**

| | |
|---|---|
| Larraine Hoffman | Chair |
| Donna Jones | |
| Ian McLeod | |
| Colleen Healy | |
| Myra Jenkyn | |
| Rosslyn Nimmo | |
| Alison Schirmer | |
| Frances Day | |

**Moama/Mathoura**

| | |
|---|---|
| Betty Murphy | |
| Teresa Kerr | |
| Richard Kerr | |

**Moulamein /Tooleybuc**

| | |
|---|---|
| Judith Gatacre | Staff representative |
| Georgina Douglas | Staff representative |
| Peg Watts | |
| Margaret Morton | |
| Barbara Culross | |
| Beverly McKindlay | |
| Roslyn Alcorn | |
| Kerry Lowing | |

**Narrandera**

| | |
|---|---|
| Gayle Murphy | Chair |
| Wade Mitchell | Medical representative |
| Pauline Hatherly | Staff representative |
| Joyce Spencer | |
| Shirley Walsh | |
| Sonya Hammer | |
| Leonie Flack | |
| Caroline Amirtharajah | |
| Bronwyn Lucas | |
| Patricia Haylar | |

**Queanbeyan**

| | |
|---|---|
| Kevin Grainger | Chair |
| Pamela Orr | Representing Bungendore |
| Nerida Dean | |
| Tom Mavec | |
| Wayne Brown | |
| Brigid Bol | |
| Brian Brown | |
| Doug Sawtell | |

**Temora**

| | |
|---|---|
| Rick Firman | Chair |
| Wendy Skidmore | Staff representative |
| Gail Lynch | |
| Elisabeth Kirkby | |
| Rex Bryant | |
| Gary Lavelle | |
| Alison Frater | |
| Peter Franker | |

**Tocumwal**

| | |
|---|---|
| Esther Bryan | |
| John Gradie | |
| Pauline Gilbee | |
| Val Cole | |

**Tumbarumba**

| | |
|---|---|
| Ronald Costello | Chair |
| Ken Campbell | Deputy Chair |
| Sue Powell | |
| Bruce Wright | |
| Graham Smith | |
| Russell Stevenson | |
| Beth Anderson | |

**Tumut**

| | |
|---|---|
| Alan Tonkin | Chair |
| Isobel Crain | |
| Daphne Clarke | |
| Geoffrey Pritchard | |
| Janette Wilson | |

**Ungarie**

| | |
|---|---|
| Robert Rattey | Chair |
| Patricia Daly | Secretary |
| John Barron | |
| Elaine Clemson | |
| Judy Rogan | |
| Emma McRae | |
| Mark Bryant | |

**Urana**

| | |
|---|---|
| Marea Urquhart | Chair |
| Denis Smith | |
| Janette Dodds | |
| Janina Korycki | |
| Harry Couzin | |
| John Hunt | |

**Wagga Wagga**

| | |
|---|---|
| Anna Nightingale | Chair |
| Alan Puckett | |
| Ruth Lennon | |
| Sonia Marshall | |
| Trish Carlson | |
| Georgina Shackleton | |
| Jens Loberg | |

**West Wyalong**

| | |
|---|---|
| Carolyn Stephenson | Chair |
| Deirdre Haub | Staff Representative |
| Frances Mitchell | |
| Mal Croucher | |
| Patricia Daly | Representing Ungarie |
| Robert Rattey | |
| Brian Monaghan | |
| Simone Maloney | Representing Weethalle |
| Louise Butler | |
| Maureen Lutherborrow | |
| Barbara Lueff | |
| Leanne Turner | |
| Dianne Stanley | |

**Yass**

| | |
|---|---|
| Eric Bell | Chair |
| Alison Bradley | Staff Representative |
| Owen Graham | Medical representative |
| David Harrison | Medical representative |
| Ross Shaw | |
| Terence Legge | |
| Kelvin Lees | |
| Cathy Campbell | |
| Jennifer Wilson | |
| Ginny Hewlett | |
| Penny Temple | |
| Dorothy Horsman | |
| Judith Williams | |

**Young**

| | |
|---|---|
| Helen Waugh | Chair |
| Stephen Ross | Medical representative |
| Russell Price | |
| Nola Noakes | |
| Eric Smith | |
| John Walker | |
| Cliff Sheridan | |

## Volunteers and Sponsorship

Volunteers contribute to all aspects of GSAHS work from assisting in our hospitals, community health services, acting as drivers, undertaking special training to provide a visiting service to home based clients and simply providing a listening ear to community members who are using our facilities. The work of volunteers in GSAHS is invaluable. Volunteers give many thousands of hours, sharing their time and skills to make a significant contribution to the services provided to the community.

In addition to Hospital Auxiliaries there are a great number of volunteers that support GSAHS activities. These include:

- Cancer Patients Assistance Society
- Pastoral carers
- Palliative Care and Oncology Support Groups
- Community transport providers
- Day care volunteers
- Diversional Therapy Volunteers
- Meals on Wheels volunteers
- Palliative care volunteers
- Pink Ladies
- Red Cross Cosmetic Care volunteers
- Legacy, Lions, Rotary and Soroptimist Clubs
- Friends of Hospitals
- Volunteer coordinators
- Individuals who undertake tasks such as attending to patients' flowers, assisting patients with writing of letters, providing cheerful company and conversation for patients, assisting with gardens and grounds, supplying fresh flowers to facilities, conducting music groups and those who visit patients to give them company and attention
- Local staff members who fundraise in their own time

Many thanks go to these volunteers for their assistance, hard work and dedication.

A special mention should be made of:

- Braidwood Auxiliary members who were awarded long service medals: Catherine Gilbert and Ken Thomas for 10yrs of service; Dawn Jonas, Margaret Lamb Shirley Shoemark and Berry McAuliffe for 30 yrs of service and Midge Stalker for 50 yrs of service. Mrs Clair Sutherland was presented with life membership of the UHA at Government House in Sydney, Clair is in her 48$^{th}$ year of service to the auxiliary 47 of those as secretary.
- The Albury Auxiliary re-formed in November 2007 from a small group of citizens within Albury who saw the need to raise money for equipment that the hospital needed to assist with patients recovery. Since November they have been successful in raising over $20,000 for equipment.
- The Narrandera United Hospital Auxiliary, the Narrandera Country Women's Association and community groups such as the Lions and Rotary clubs worked with local Narrandera Health Service staff to refurbish staff accommodation at the hospital.
- Barham Koondrook Health Service Auxiliary has one remaining active foundation member, Mrs Iris Mathers who joined in 1953 and has held executive positions.
- Kay Francis of the Corowa Hospital Auxiliary was awarded a certificate of appreciation for 18 years of service to the Auxiliary.
- Barb Touvi and Belinda Jenkins are two of Junee's dedicated volunteers who assist with providing assistance and companionship in the Aged Care Unit, as are Keith Hargraves and Phil Kearins who take the paper/lolly trolley to the patients, residents and staff.

## Ethnic Affairs Priority Statement (EAPS)

GSAHS strives to meet the needs of culturally and linguistically diverse (CALD) communities through the implementation of culturally appropriate programs and initiatives.

GSAHS' CALD population data indicates that the Non-English Speaking Background (NESB) population is 14,402, approximately 3.2% of the total population. Languages other than English are spoken at home by 4.5% of the population, however, only 0.5% of the total population speaks poor, or have no English.

Staff appointed to designated multicultural health positions help improve the health of people from a CALD background by establishing close collaboration with appropriate stakeholders and mobilising local resources to enhance health service provision to CALD communities. Activities include:

- instituting programs for language/cultural specific groups
- introduction sessions to orientate CALD communities to the range of health services available
- incorporating cultural awareness into staff training
- raising staff awareness of the availability of the Health Care Interpreter Service

The majority of interpreter service usage within GSAHS occurs in hospital outpatients at approximately 36% followed by community health centres (22%), hospital inpatients (19%) and other units within GSAHS (16%). The interpreter service occurs 60% over the telephone and 39% on a face-to-face basis. The majority of services were provided to Arabic, Dinka, Kirundi, Macedonian, Italian, Turkish and Cantonese language groups.

## Hospital Auxiliaries

**Albury Hospital Auxiliary**
President: Mr Gareth Jones
Secretary: Vacant
Treasurer: Ms Annette Monson

**Barellan Hospital Auxiliary**
President: Jean Inglis
Vice President: Margaret West
Treasurer: Val Hawker

**Barham-Koondrook Soldiers Memorial Hospital Auxiliary**
President – Betty Hodgkinson
Secretary - Joy Eagle
Treasurer - Ethelwyn Hahn

**Batemans Bay Hospital Auxiliary**
President: Noeline McNeish
Secretary: Cherie Clarke
Treasurer: Jacqui Mudge

**Batlow Hospital Auxiliary**
President – Clarice Ross
Secretary – Norma Jones
Treasurer – Linda Swales

**Bega Hospital Auxiliary**
President: Dorothy Mullaney
Secretary: Helen Robbie
Treasurer: Joan Finucane

**Berrigan Hospital Auxiliary**
President – Marion Dickins
Secretary – Marnie Dalgleish
Treasurer – Betty Burwood

**Bombala Hospital Auxiliary**
President: Betty Cowell
Secretary: Jenny Brownlie
Treasurer: Brenda Kelly

**Bookham Auxiliary**
President: Noeleen Hazell
Secretary: Mavis Armour
Treasurer: Wilma Bingley

**Boorowa Hospital Auxiliary**
President: Mary Marsh
Secretary: Judy McGuiness
Treasurer: Phoebe Stewart

**Braidwood Hospital Auxiliary**
President: Ken Thomas
Secretary: Clare Sutherland
Treasurer: Jill Judge

**Coolamon Auxiliary**
President – Betty Menzies
Secretary – Nolene Black
Treasurer – Cheryl O'Brien

**Ganmain Auxiliary**
President - Faye Jones
Secretary - Heather Kember
Treasurer - Nita Hare

**Cooma Hospital Auxiliary**
President: Janette Langwill
Secretary: Jan Carpenter
Treasurer: Mary McKee

**Cootamundra District Hospital Auxiliary**
President – Margaret Young
Secretary – Lila Collinridge
Treasurer – Maria Ryan

**Corowa District Hospital Auxiliary**
President: - Dorothy Long
Secretary - Margaret Lingham
Treasurer – Dawn Williams

**Crookwell Auxiliary**
President: Coralie Anthoney
Secretary: Val Smith
Treasurer: Janet Croker

**Delegate Auxiliary**
President: Heather Jones
Secretary/Treasurer: Gail Smallman

**Deniliquin Hospital Auxiliaries:**

**Mayrung Auxiliary**
President: - Jess Beer
Secretary – Barbara Ryan
Treasurer: Hilda Jones

**Naponda Auxiliary**
President – Maureen Strutt
Secretary – Pam Ellerman

**Mathoura Auxiliary**
President - Jean Osborne

Secretary - Denise Hanson
Treasurer: Leanne Vesty

**Moulamein Auxiliary**
President: - Cheryl Garrett
Secretary – Margaret Morton

**The Pink Ladies Auxiliary**
President - Joyce Atley
Secretary – Norma Drenkhahn

**Finley Hospital Auxiliary**
President: Marjorie Kable
Secretary: Madeleine Wark
Treasurer: Margaret Ryan

**Griffith Base Hospital Auxiliary**
President - Irene Pettiford
Secretary - Heather Eagleton
Treasurer - Lavelle Wallace

**Gundagai Hospital Auxiliary**
President - Helen Turner
Secretary - Josephine Bryan
Treasurer- Maureen Barrington

**Hay Hospital United Hospital Auxiliary**
President - Norma Milliken
Secretary – Nerida Reid
Treasurer – Wendy Heery

**Henty Hospital Auxiliary**
President: Pam Green
Secretary: Marilyn Broughan
Treasurer: Betty Willis

**Hillston Hospital Auxiliary**
President: Margaret Warren
Secretary: Pat Johnson
Treasurer: Eileen Whelan

**Holbrook Hospital Auxiliary**
President: Trish Bull
Secretary: Kym Hulme
Treasurer: Nanno MacKinlay

**Jerilderie Health Service Auxiliary**
President - Nancy Locke
Secretary Judy Ryan
Treasurer - Pam Collier

**Junee District Hospital Auxiliary**
President: Iris Gamble
Secretary: Peter Logan
Treasurer: Dennis Sullivan

**Leeton Hospital Auxiliary**
President - Des Driscoll
Secretary – Leanne Kidd
Treasurer – Kath Lamont

**Lockhart Hospital Auxiliary**
President: Larraine Hoffmann
Secretary: Jeanette Baker
Treasurer: Sylvia Creighton

**Mercy Care Young Auxiliary**
President: Joyce Cavanagh
Secretary: Marie Cass
Treasurer: Janice O'Reilly

**Moruya District Hospital Auxiliary**
President: Val Brown
Secretary: Kathleen Smith
Treasurer: Christine Smith

**Murrumburrah-Harden Hospital Auxiliary**
President: Carmel Brown
Secretary: Jackie Berrell
Treasurer: Rose Adler

**Narooma Community Health Auxiliary**
President: Raja Ratnam
Secretary: Lizabeth Fell
Treasurer: Anne Hunter

**Narrandera District Hospital Auxiliary**
President: Pauline Hatherly
Secretary: Helen Langley
Treasurer: Dianne McVicker

**Pambula Merimbula District Hospital Auxiliary**
President: Val Fryers
Secretary: Gail McCombie
Treasurer: J Bennett

**Tarcutta Auxiliary**
President: Joy Granger
Secretary: Fay Belling
Treasurer: Sue Hardwick

**Tathra Auxiliary**
President: Margaret McFadden
Secretary: Ben Boller
Treasurer: Ellen Harris

**Temora District Hospital Auxiliary**
President – Myre Bruest

Secretary – Valerie Haines
Treasurer - Mavis Bean

**Tocumwal Hospital Auxiliary**
President: Valda Cole
Secretary: Mrs Kaye Couch
Treasurer: Pauline Gilbee

**Tumut District Hospital Auxiliary**
President: Trish Clee
Secretary: Trish Rochester
Treasurer: Joan Brookes

**Urana Health Service Auxiliary**
President - Ann Bourke
Secretary - Kath Dore
Treasurer - Pauline Smith

**West Queanbeyan Hospital Auxiliary**
President: Tui Dawes
Secretary: Nancy Monk
Treasurer: Marion Coffey

**West Wyalong Hospital Auxiliary**
President - Betty Seberry
Secretary - Mavis Smith
Treasurer – Helen Murdoch

**Yass Hospital Auxiliary**
President: Wendy Findlay
Secretary: Lorraine Legge
Treasurer: Pat Longley

**Young Hospital Auxiliary**
President: Betty Booker
Secretary: Chris Page
Treasurer: Lyn Freudenstein

# Freedom of Information 1 July 2007 to 30 June 2008

Agencies and Ministers' offices are required to report annually on their administration of Freedom of Information. Agencies should report in their own annual reports and Ministers' offices should forward their reports to the Department of Premier and Cabinet for inclusion in the Department's Annual Report.

**Agencies which receive less than 10 Freedom of Information applications during the reporting year may provide the data in narrative form. Where no applications have been received for the period a "nil return" must be indicated instead of the statistical tables.**

*Note*: Except as otherwise stated, the sections below require agencies to identify the relevant number of Freedom of Information applications, rather than the number of documents sought by the application.

**Number of new FOI Requests from 1 July 2007 to 30 June 2008**

| How many FOI applications were received, discontinued or completed? | NUMBER OF FOI APPLICATIONS | | | | | |
|---|---|---|---|---|---|---|
| | PERSONAL | | OTHER | | TOTAL | |
| | (previous year) | (current year) | (previous year) | (current year) | (previous year) | (current year) |
| A1 New | 6 | 5 | 12 | 17 | 18 | 22 |
| A2 Brought forward | 0 | 0 | 0 | 0 | 0 | 0 |
| **A3 Total to be processed** | **6** | **5** | **12** | **17** | **18** | **22** |
| A4 Completed | 6 | 3 | 12 | 10 | 18 | 13 |
| A5 Discontinued | 0 | 2 | 0 | 6 | 0 | 8 |
| **A6 Total processed** | **6** | **5** | **12** | **16** | **18** | **21** |
| A7 Unfinished (carried forward) | 0 | 0 | 0 | 1 | 0 | 1 |

**Number of Discontinued FOI Applications**

| Why were FOI applications discontinued? | NUMBER OF <u>DISCONTINUED</u> FOI APPLICATIONS | | | | | |
|---|---|---|---|---|---|---|
| | Personal | | Other | | Total | |
| | (previous year) | (current year) | (previous year) | (current year) | (previous year) | (current year) |
| B1 Request transferred out to another agency (s.20) | 0 | 0 | 0 | 0 | 0 | 0 |
| B2 Applicant withdrew request | 3 | 1 | 0 | 0 | 3 | 1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| B3 Applicant failed to pay advance deposit (s.22) | n/a | 0 | n/a | 1 | n/a | 1 |
| B4 Applicant failed to amend a request that would have been an unreasonable diversion of resources to complete (s.25(1)(a1)) | n/a | 0 | n/a | 3 | n/a | 3 |
| **B5 Total discontinued** | **3** | **1** | **0** | **4** | **3** | **5** |

**Completed Applications**

| What happened to completed FOI applications? | NUMBER OF COMPLETED FOI APPLICATIONS | | | | | |
|---|---|---|---|---|---|---|
| | **Personal** | | **Other** | | **Total** | |
| | (previous year) | (current year) | (previous year) | (current year) | (previous year) | (current year) |
| C1 Granted or otherwise available in full | 2 | 2 | 6 | 6 | 8 | 8 |
| C2 Granted or otherwise available in part | 0 | 1 | 0 | 1 | 0 | 2 |
| C3 Refused | 2 | 0 | 5 | 2 | 7 | 2 |
| C4 No documents held | n/a | 0 | n/a | 1 | n/a | 1 |
| **C5 Total completed** | **4** | **3** | **11** | **10** | **15** | **13** |

Note: A request is granted or otherwise available in full if all documents requested are either provided to the applicant (or the applicant's medical practitioner) or are otherwise publicly available.

**Applications granted or otherwise available in full**

| How were the documents made available to the applicant? | NUMBER OF FOI APPLICATIONS (GRANTED OR OTHERWISE AVAILABLE IN FULL) | | | | | |
|---|---|---|---|---|---|---|
| | Personal | | Other | | Total | |
| | (previous year) | (current year) | (previous year) | (current year) | (previous year) | (current year) |
| **All documents requested were:** D1 Provided to the applicant | n/a | 2 | n/a | 6 | n/a | 8 |
| D2 Provided to the applicant's medical Practitioner | n/a | 0 | n/a | 0 | n/a | 0 |
| D3 Available for inspection | n/a | 0 | n/a | 0 | n/a | 0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| D4 Available for purchase | n/a | 0 | n/a | 0 | n/a | 0 |
| D5 Library material | n/a | 0 | n/a | 0 | n/a | 0 |
| D6 Subject to deferred access | n/a | 0 | n/a | 0 | n/a | 0 |
| D7 Available by a combination of any of the reasons listed in D1-D6 above | n/a | 0 | n/a | 0 | n/a | 0 |
| **D8 Total granted or otherwise available in full** | **n/a** | **2** | **n/a** | **6** | **n/a** | **8** |

**Applications granted or otherwise available in part**

| How were the documents made available to the applicant? | NUMBER OF FOI APPLICATIONS (GRANTED OR OTHERWISE AVAILABLE IN PART) | | | | | |
|---|---|---|---|---|---|---|
| | Personal | | Other | | Total | |
| | (previous year) | (current year) | (previous year) | (current year) | (previous year) | (current year) |
| **Documents made available were:** E1 Provided to the applicant | n/a | 1 | n/a | 1 | n/a | 2 |
| E2 Provided to the applicant's medical Practitioner | n/a | 0 | n/a | 0 | n/a | 0 |
| E3 Available for inspection | n/a | 0 | n/a | 0 | n/a | 0 |
| E4 Available for purchase | n/a | 0 | n/a | 0 | n/a | 0 |
| E5 Library material | n/a | 0 | n/a | 0 | n/a | 0 |
| E6 Subject to deferred access | n/a | 0 | n/a | 0 | n/a | 0 |
| E7 Available by a combination of any of the reasons listed in E1-E6 above | n/a | 0 | n/a | 0 | n/a | 0 |
| **E8 Total granted or otherwise available in part** | **n/a** | **1** | **n/a** | **1** | **n/a** | **2** |

**Refused FOI applications**

| Why was access to the documents refused? | NUMBER OF REFUSED FOI APPLICATIONS | | | | | |
|---|---|---|---|---|---|---|
| | **Personal** | | **Other** | | **Total** | |
| | (previous year) | (current year) | (previous year) | (current year) | (previous year) | (current year) |

| | | | | | | |
|---|---|---|---|---|---|---|
| F1 Exempt | n/a | 0 | n/a | 1 | n/a | 1 |
| F2 Deemed refused | n/a | 0 | n/a | 2 | n/a | 2 |
| **F3 Total refused** | **n/a** | **0** | **n/a** | **3** | **n/a** | **3** |

**Exempt documents**

| Why were the documents classified as exempt?<br><br>(identify <u>one</u> reason only) | NUMBER OF FOI APPLICATIONS<br>(REFUSED OR ACCESS GRANTED OR OTHERWISE AVAILABLE IN PART ONLY) | | | | | |
|---|---|---|---|---|---|---|
| | **Personal** | | **Other** | | **Total** | |
| | (previous year) | (current year) | (previous year) | (current year) | (previous year) | (current year) |
| **Restricted documents:**<br>G1 Cabinet documents (Clause 1) | n/a | 0 | n/a | 0 | n/a | 0 |
| G2 Executive Council documents (Clause 2) | n/a | 0 | n/a | 0 | n/a | 0 |
| G3 Documents affecting law enforcement and public safety (Clause 4) | n/a | 0 | n/a | 0 | n/a | 0 |
| G4 Documents affecting counter terrorism measures (Clause 4A) | n/a | 0 | n/a | 0 | n/a | 0 |
| **Documents requiring consultation:**<br>G5 Documents affecting intergovernmental relations (Clause 5) | n/a | 0 | n/a | 0 | n/a | 0 |
| G6 Documents affecting personal affairs (Clause 6) | n/a | 0 | n/a | 0 | n/a | 0 |
| G7 Documents affecting business affairs (Clause 7) | n/a | 0 | n/a | 2 | n/a | 2 |
| G8 Documents affecting the conduct of research (Clause 8) | n/a | 0 | n/a | 0 | n/a | 0 |
| **Documents otherwise exempt:**<br>G9 Schedule 2 exempt agency | n/a | 0 | n/a | 0 | n/a | 0 |
| G10 Documents containing information confidential to Olympic Committees (Clause 22) | n/a | 0 | n/a | 0 | n/a | 0 |
| G11 Documents relating to threatened species, Aboriginal objects or Aboriginal places (Clause 23) | n/a | 0 | n/a | 0 | n/a | 0 |
| G12 Documents relating to threatened species conservation | n/a | 0 | n/a | 0 | n/a | 0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| (Clause 24) | | | | | | |
| G13 Plans of management containing information of Aboriginal significance (Clause 25) | n/a | 0 | n/a | 0 | n/a | 0 |
| G14 Private documents in public library collections (Clause 19) | n/a | 0 | n/a | 0 | n/a | 0 |
| G15 Documents relating to judicial functions (Clause 11) | n/a | 0 | n/a | 0 | n/a | 0 |
| G16 Documents subject to contempt (Clause 17) | n/a | 0 | n/a | 0 | n/a | 0 |
| G17 Documents arising out of companies and securities legislation (Clause 18) | n/a | 0 | n/a | 0 | n/a | 0 |
| G18 Exempt documents under interstate FOI Legislation (Clause 21) | n/a | 0 | n/a | 0 | n/a | 0 |
| G19 Documents subject to legal professional privilege (Clause 10) | n/a | 0 | n/a | 0 | n/a | 0 |
| G20 Documents containing confidential material (Clause 13) | n/a | 0 | n/a | 0 | n/a | 0 |
| G21 Documents subject to secrecy provisions (Clause 12) | n/a | 0 | n/a | 0 | n/a | 0 |
| G22 Documents affecting the economy of the State (Clause 14) | n/a | 0 | n/a | 0 | n/a | 0 |
| G23 Documents affecting financial or property Interests of the State or an agency (Clause 15) | n/a | 0 | n/a | 0 | n/a | 0 |
| G24 Documents concerning operations of agencies (Clause 16) | n/a | 0 | n/a | 0 | n/a | 0 |
| G25 Internal working documents (Clause 9) | n/a | 0 | n/a | 0 | n/a | 0 |
| G26 Other exemptions (e.g., Clauses 20, 22A and 26) | n/a | 0 | n/a | 1 | n/a | 1 |
| G27 Total applications including exempt documents | n/a | 0 | n/a | 3 | n/a | 3 |

Note: Where more than one exemption applies to a request select the exemption category first occurring in the above table.

There were no Ministerial certificates issued.

**Formal consultations**

| How many formal consultations were conducted? | Number | |
|---|---|---|
| | (previous year) | (current year) |

| | | |
|---|---|---|
| I1 Number of applications requiring formal consultation | n/a | 1 |
| I2 Number of persons formally consulted | n/a | 5 |

Note: Include all formal consultations issued irrespective of whether a response was received.

There were no Amendment of personal records

There were no applications for Notation of personal records

**Fees and costs**

| What fees were assessed and received for FOI applications processed (excluding applications transferred out)? | Assessed Costs | | Fees Received | |
|---|---|---|---|---|
| | (previous year) | (current year) | (previous year) | (current year) |
| L1 All completed applications | $1961 | $3084 | $1961 | $1214 (one request of $1620 not paid) |

**Fee discounts**

| How many fee waivers or discounts were allowed and why? | NUMBER OF FOI APPLICATIONS (WHERE FEES WERE WAIVED OR DISCOUNTED) | | | | | |
|---|---|---|---|---|---|---|
| | Personal | | Other | | Total | |
| | (previous year) | (current year) | (previous year) | (current year) | (previous year) | (current year) |
| M1 Processing fees waived in full | n/a | 2 | n/a | 4 | n/a | 6 |
| M2 Public interest discount | n/a | 0 | n/a | 0 | n/a | 0 |
| M3 Financial hardship discount – pensioner or child | n/a | 0 | n/a | 0 | n/a | 0 |
| M4 Financial hardship discount – non profit organisation | n/a | 0 | n/a | 0 | n/a | 0 |
| **M5 Total** | **n/a** | **2** | **n/a** | **4** | **n/a** | **6** |

There were no Fee refunds granted as a result of significant correction of personal records

**Days taken to complete request**

| How long did it take to process completed applications? (Note: calendar days) | NUMBER OF COMPLETED FOI APPLICATIONS | | |
|---|---|---|---|
| | **Personal** | **Other** | **Total** |

| | (previous year) | (current year) | (previous year) | (current year) | (previous year) | (current year) |
|---|---|---|---|---|---|---|
| O1 0-21 days | 4 | 2 | 8 | 5 | 12 | 7 |
| O2 22-35 days | 0 | 0 | 3 | 5 | 3 | 5 |
| O3 Over 21 days | 0 | 0 | 0 | 1 | 0 | 1 |
| O4 Over 35 days | 0 | 0 | 0 | 0 | 0 | 0 |
| **O5 Total** | **4** | **2** | **11** | **11** | **15** | **13** |

**Processing time: hours**

| How long did it take to process completed applications? | NUMBER OF COMPLETED FOI APPLICATIONS | | | | | |
|---|---|---|---|---|---|---|
| | **Personal** | | **Other** | | **Total** | |
| | (previous year) | (current year) | (previous year) | (current year) | (previous year) | (current year) |
| P1 0-10 hours | 4 | 3 | 11 | 10 | 15 | 13 |
| P2 11-20 hours | 0 | 0 | 0 | 0 | 0 | 0 |
| P3 21-40 hours | 0 | 0 | 0 | 0 | 0 | 0 |
| P4 Over 40 hours | 0 | 0 | 0 | 1 | 0 | 1 |
| **P5 Total** | **4** | **3** | **12** | **11** | **15** | **14** |

**Number of reviews**

| How many reviews were finalised? | NUMBER OF COMPLETED REVIEWS | |
|---|---|---|
| | (previous year) | (current year) |
| Q1 Internal reviews | 1 | 0 |
| Q2 Ombudsman reviews | 0 | 1 |
| Q3 ADT reviews | 0 | 0 |

**Results of internal reviews**

**What were the results of internal reviews finalised?**

| GROUNDS ON WHICH THE INTERNAL REVIEW WAS REQUESTED | NUMBER OF INTERNAL REVIEWS | | | | | |
|---|---|---|---|---|---|---|
| | PERSONAL | | OTHER | | TOTAL | |
| | Original Agency Decision **Upheld** | Original Agency Decision **Varied** | Original Agency Decision **Upheld** | Original Agency Decision **Varied** | Original Agency Decision **Upheld** | Original Agency Decision **Varied** |
| R1 Access refused | 0 | 0 | 1 | 0 | 0 | 0 |
| R2 Access deferred | 0 | 0 | 0 | 0 | 0 | 0 |
| R3 Exempt matter deleted from documents | 0 | 0 | 0 | 0 | 0 | 0 |
| R4 Unreasonable charges | 0 | 0 | 0 | 0 | 0 | 0 |
| R5 Failure to consult with third parties | 0 | 0 | 0 | 0 | 0 | 0 |
| R6 Third parties views disregarded | 0 | 0 | 0 | 0 | 0 | 0 |
| R7 Amendment of personal records refused | 0 | 0 | 0 | 0 | 0 | 0 |
| **R8 Total** | 0 | 0 | 1 | 0 | 0 | 0 |

*Note: Figures in R8 should correspond to figures in A4.*

GREATER SOUTHERN
AREA HEALTH SERVICE
NSW HEALTH

## Certification of Parent/Consolidated Financial Statements for period Ended 30 June 2008

The attached financial statements of the Greater Southern Area Health Service for the year ended 30 June 2008:

I. Have been prepared in accordance with the requirements of applicable Australian Accounting Standards which include Australian Accounting Requirements, the requirements of the *Public Finance and Audit Act 1983* and its regulations, the Accounts and Audit Determination and the Accounting Manual for the Area Health Services and Public Hospitals;

II. Present fairly the financial position and transactions of the Greater Southern Area Health Service; and

III. Have no circumstances which would render any particulars in the financial statements to be misleading or inaccurate.

Ms Heather Gray
**Chief Executive**
**Greater Southern Area Health Service**
5th December 2008

Ms Angela Edwards
**Manager Finance**
**Greater Southern Area Health Service**
5th December 2008

GPO BOX 12
Sydney NSW 2001

# INDEPENDENT AUDITOR'S REPORT

## Greater Southern Area Health Service and its Controlled Entity

To Members of the New South Wales Parliament

I have audited the accompanying financial report of the Greater Southern Area Health Service (the Service), which comprises the balance sheet as at 30 June 2008, the operating statement, statement of recognised income and expense, cash flow statement, program statement - expenses and revenues, a summary of significant accounting policies and other explanatory notes for both the Service and the consolidated entity. The consolidated entity comprises the Service and the entities it controlled at the year's end or from time to time during the financial year.

### Auditor's Opinion

In my opinion, the financial report:

- presents fairly, in all material respects, the financial position of the Service and the consolidated entity as at 30 June 2008, and of their financial performance and their cash flows for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- is in accordance with section 45E of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2005.

My opinion should be read in conjunction with the rest of this report.

### Chief Executive's Responsibility for the Financial Report

The Chief Executive is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the PF&A Act. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

### Auditor's Responsibility

My responsibility is to express an opinion on the financial report based on my audit. I conducted my audit in accordance with Australian Auditing Standards. These Auditing Standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Chief Executive, as well as evaluating the overall presentation of the financial report.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

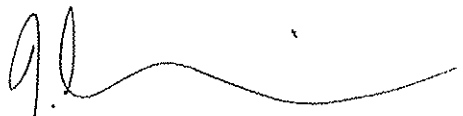
My opinion does *not* provide assurance:

- about the future viability of the Service or consolidated entity,
- that they have carried out their activities effectively, efficiently and economically,
- about the effectiveness of their internal controls, or
- on the assumptions used in formulating the budget figures disclosed in the financial report.

## Independence

In conducting this audit, the Audit Office of New South Wales has complied with the independence requirements of the Australian Auditing Standards and other relevant ethical requirements. The PF&A Act further promotes independence by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General, and
- mandating the Auditor-General as auditor of public sector agencies but precluding the provision of non-audit services, thus ensuring the Auditor-General and the Audit Office of New South Wales are not compromised in their role by the possibility of losing clients or income.



Jack Kheir BEc, FCPA
Director, Financial Audit Services

9 December 2008
SYDNEY

## Greater Southern Area Health Service
## Operating Statement for the year ended 30 June 2008

| PARENT | | | | | CONSOLIDATION | | |
|---|---|---|---|---|---|---|---|
| Actual 2008 $000 | Budget 2008 $000 | Actual 2007 $000 | | Notes | Actual 2008 $000 | Budget 2008 $000 | Actual 2007 $000 |
| | | | **Expenses excluding losses** | | | | |
| | | | Operating Expenses | | | | |
| 0 | 0 | 0 | Employee Related | 3 | 429,151 | 415,436 | 391,060 |
| 429,151 | 415,436 | 391,060 | Personnel Services | 4 | 0 | 0 | 0 |
| 54,816 | 55,564 | 54,445 | Visiting Medical Officers | | 54,816 | 55,564 | 54,445 |
| 327,771 | 318,662 | 300,218 | Other Operating Expenses | 5 | 327,771 | 318,662 | 300,218 |
| 22,763 | 22,868 | 15,727 | Depreciation and Amortisation | 2(i), 6 | 22,763 | 22,868 | 15,727 |
| 2,397 | 1,974 | 5,119 | Grants and Subsidies | 7 | 2,397 | 1,974 | 5,119 |
| 1,753 | 1,492 | 1,930 | Finance Costs | 8 | 1,753 | 1,492 | 1,930 |
| 12,953 | 11,417 | 14,040 | Payments to Affiliated Health Organisations | 9 | 12,953 | 11,417 | 14,040 |
| **851,604** | **827,413** | **782,539** | **Total Expenses excluding losses** | | **851,604** | **827,413** | **782,539** |
| | | | **Revenue** | | | | |
| 103,048 | 101,842 | 107,617 | Sale of Goods and Services | 10 | 103,048 | 101,842 | 107,617 |
| 1,557 | 1,470 | 1,671 | Investment Revenue | 11 | 1,557 | 1,470 | 1,671 |
| 19,915 | 5,663 | 19,359 | Grants and Contributions | 12 | 10,658 | 5,663 | 9,305 |
| 3,869 | 3,624 | 8,594 | Other Revenue | 13 | 3,869 | 3,624 | 8,594 |
| **128,389** | **112,599** | **137,241** | **Total Revenue** | | **119,132** | **112,599** | **127,187** |
| (2,649) | (2,704) | (63) | Gain/(Loss) on Disposal | 14 | (2,649) | (2,704) | (63) |
| (1,424) | (1,550) | (1,100) | Other Gains/(Losses) | 15 | (1,424) | (1,550) | (1,100) |
| **727,288** | **719,068** | **646,461** | **Net Cost of Services** | 30 | **736,545** | **719,068** | **656,515** |
| | | | **Government Contributions** | | | | |
| | | | NSW Department of Health | | | | |
| 669,913 | 669,913 | 623,576 | Recurrent Allocations | 2(d) | 669,913 | 669,913 | 623,576 |
| | | | NSW Department of Health | | | | |
| 68,066 | 69,606 | 38,132 | Capital Allocations | 2(d) | 68,066 | 69,606 | 38,132 |
| | | | (Asset Sale Proceeds transferred to the NSW Department of Health) | | | | |
| | | | Acceptance by the Crown Entity of | | | | |
| | | 0 | Employee Benefits | 2(a)(ii) | 9,257 | 9,905 | 10,054 |
| **737,979** | **739,519** | **661,708** | **Total Government Contributions** | | **747,236** | **749,424** | **671,762** |
| **10,691** | **20,451** | **15,247** | **RESULT FOR THE YEAR** | | **10,691** | **30,356** | **15,247** |

The accompanying notes form part of these Financial Statements

**Greater Southern Area Health Service**
**Statement of Recognised Income and Expense for the year ended 30 June 2008**

| PARENT | | | | | CONSOLIDATION | | |
|---|---|---|---|---|---|---|---|
| Actual 2008 $000 | Budget 2008 $000 | Actual 2007 $000 | | Notes | Actual 2008 $000 | Budget 2008 $000 | Actual 2007 $000 |
| 0 | 0 | 199,485 | Net Increase/(Decrease) in Property, Plant and Equipment Asset Revaluation Reserve | | 0 | 0 | 199,485 |
| **0** | **0** | **199,485** | **TOTAL INCOME AND EXPENSE RECOGNISED DIRECTLY IN EQUITY** | | **0** | **0** | **199,485** |
| 10,691 | 20,451 | 15,247 | Result for the Year | | 10,691 | 30,356 | 15,247 |
| **10,691** | **20,451** | **214,732** | **TOTAL INCOME AND EXPENSE RECOGNISED FOR THE YEAR** | | **10,691** | **30,356** | **214,732** |

The accompanying notes form part of these Financial Statements

**Greater Southen Area Health Service**
**Balance Sheet as at 30 June 2008**

| PARENT | | | | | CONSOLIDATION | | |
|---|---|---|---|---|---|---|---|
| Actual 2008 $000 | Budget 2008 $000 | Actual 2007 $000 | | Notes | Actual 2008 $000 | Budget 2008 $000 | Actual 2007 $000 |
| | | | **ASSETS** | | | | |
| | | | **Current Assets** | | | | |
| 8,826 | 18,351 | 12,682 | Cash and Cash Equivalents | 18 | 8,826 | 18,351 | 12,682 |
| 15,475 | 12,164 | 16,259 | Receivables | 19 | 15,475 | 12,164 | 16,259 |
| 3,589 | 2,806 | 3,506 | Inventories | 20 | 3,589 | 2,806 | 3,506 |
| **27,890** | **33,321** | **32,447** | **Total Current Assets** | | **27,890** | **33,321** | **32,447** |
| | | | **Non-Current Assets** | | | | |
| 764 | 818 | 818 | Receivables | 19 | 764 | 818 | 818 |
| | | | Property, Plant and Equipment | | | | |
| 532,067 | 535,899 | 489,101 | - Land and Buildings | 21 | 532,067 | 535,899 | 489,101 |
| 22,969 | 19,804 | 23,139 | - Plant and Equipment | 21 | 22,969 | 19,804 | 23,139 |
| 7,450 | 7,403 | 7,403 | - Infrastructure Systems | 21 | 7,450 | 7,403 | 7,403 |
| 562,486 | 563,106 | 519,643 | Total Property, Plant and Equipment | | 562,486 | 563,106 | 519,643 |
| **563,250** | **563,924** | **520,461** | **Total Non-Current Assets** | | **563,250** | **563,924** | **520,461** |
| **591,140** | **597,245** | **552,908** | **Total Assets** | | **591,140** | **597,245** | **552,908** |
| | | | **LIABILITIES** | | | | |
| | | | **Current Liabilities** | | | | |
| 65,270 | 48,898 | 46,245 | Payables | 23 | 65,270 | 48,898 | 46,245 |
| 8,040 | 2,508 | 7,279 | Borrowings | 24 | 8,040 | 2,508 | 7,279 |
| 116,864 | 120,370 | 104,882 | Provisions | 25 | 116,864 | 120,370 | 104,882 |
| **190,174** | **171,776** | **158,406** | **Total Current Liabilities** | | **190,174** | **171,776** | **158,406** |
| | | | **Non-Current Liabilities** | | | | |
| 10,526 | 16,482 | 16,446 | Borrowings | 24 | 10,526 | 16,482 | 16,446 |
| 3,703 | 1,713 | 1,466 | Provisions | 25 | 3,703 | 1,713 | 1,466 |
| **14,229** | **18,195** | **17,912** | **Total Non-Current Liabilities** | | **14,229** | **18,195** | **17,912** |
| **204,403** | **189,971** | **176,318** | **Total Liabilities** | | **204,403** | **189,971** | **176,318** |
| **386,737** | **407,274** | **376,590** | **Net Assets** | | **386,737** | **407,274** | **376,590** |
| | | | **EQUITY** | | | | |
| 210,628 | 0 | 211,172 | Reserves | 26 | 210,628 | 0 | 211,172 |
| 176,109 | 407,274 | 165,418 | Accumulated Funds | 26 | 176,109 | 407,274 | 165,418 |
| **386,737** | **407,274** | **376,590** | **Total Equity** | | **386,737** | **407,274** | **376,590** |

The accompanying notes form part of these Financial Statements

**Greater Southern Area Health Service**
**Cash Flow Statement for the year ended 30 June 2008**

| PARENT | | | | | CONSOLIDATION | | |
|---|---|---|---|---|---|---|---|
| Actual 2008 $000 | Budget 2008 $000 | Actual 2007 $000 | | Notes | Actual 2008 $000 | Budget 2008 $000 | Actual 2007 $000 |
| | | | **CASH FLOWS FROM OPERATING ACTIVITIES** | | | | |
| | | | **Payments** | | | | |
| | | | Employee Related | | (400,448) | (401,764) | (380,199) |
| (2,397) | (1,974) | (5,119) | Grants and Subsidies | | (2,397) | (1,974) | (5,119) |
| (1,753) | (1,492) | (1,930) | Finance Costs | | (1,753) | (1,492) | (1,930) |
| (783,390) | (782,782) | (745,814) | Other | | (382,942) | (381,018) | (365,615) |
| **(787,540)** | **(786,248)** | **(752,863)** | **Total Payments** | | **(787,540)** | **(786,248)** | **(752,863)** |
| | | | **Receipts** | | | | |
| 104,755 | 109,273 | 105,254 | Sale of Goods and Services | | 104,755 | 109,273 | 105,254 |
| 1,669 | 1,470 | 1,671 | Interest Received | | 1,669 | 1,470 | 1,671 |
| 14,527 | 9,287 | 17,899 | Other | | 14,527 | 9,287 | 17,899 |
| **120,951** | **120,030** | **124,824** | **Total Receipts** | | **120,951** | **120,030** | **124,824** |
| | | | **Cash Flows From Government** | | | | |
| 669,913 | 669,913 | 633,630 | NSW Department of Health Recurrent Allocations | | 669,913 | 669,913 | 633,630 |
| 66,769 | 69,606 | 38,132 | NSW Department of Health Capital Allocations | | 66,769 | 69,606 | 38,132 |
| | | | Asset Sale Proceeds transferred to the | | | | |
| 0 | 0 | 0 | NSW Department of Health | | 0 | 0 | 0 |
| 0 | 0 | 0 | Cash Reimbursements from the Crown Entity | | 0 | 0 | 0 |
| **736,682** | **739,519** | **671,762** | **Net Cash Flows from Government** | | **736,682** | **739,519** | **671,762** |
| | | | **NET CASH FLOWS FROM OPERATING** | | | | |
| **70,093** | **73,301** | **43,723** | **ACTIVITIES** | 30 | **70,093** | **73,301** | **43,723** |
| | | | **CASH FLOWS FROM INVESTING ACTIVITIES** | | | | |
| | | | Proceeds from Sale of Land and Buildings, Plant and Equipment | | | | |
| 504 | 0 | 182 | and Infrastructure Systems | | 504 | 0 | 182 |
| | | | Purchases of Land and Buildings, Plant and Equipment | | | | |
| (69,294) | (62,357) | (39,097) | and Infrastructure Systems | | (69,294) | (62,357) | (39,097) |
| **(68,790)** | **(62,357)** | **(38,915)** | **NET CASH FLOWS FROM INVESTING ACTIVITIES** | | **(68,790)** | **(62,357)** | **(38,915)** |
| | | | **CASH FLOWS FROM FINANCING ACTIVITIES** | | | | |
| | | 1,976 | Proceeds from Borrowings and Advances | | | | 1,976 |
| (5,159) | (7,729) | (6,906) | Repayment of Borrowings and Advances | | (5,159) | (7,729) | (6,906) |
| **(5,159)** | **(7,729)** | **(4,930)** | **NET CASH FLOWS FROM FINANCING ACTIVITIES** | | **(5,159)** | **(7,729)** | **(4,930)** |
| **(3,856)** | **3,215** | **(122)** | **NET INCREASE / (DECREASE) IN CASH** | | **(3,856)** | **3,215** | **(122)** |
| 12,682 | 12,682 | 12,804 | Opening Cash and Cash Equivalents | | 12,682 | 12,682 | 12,804 |
| **8,826** | **15,897** | **12,682** | **CLOSING CASH AND CASH EQUIVALENTS** | 18 | **8,826** | **15,897** | **12,682** |

The accompanying notes form part of these Financial Statements

**Greater Southern Area Health Service**
**Program Statement of Expenses and Revenues**
**for the Year Ended 30 June 2008**

| SERVICE'S EXPENSES AND REVENUES | Program 1.1 * | | Program 1.2 * | | Program 1.3 * | | Program 2.1 * | | Program 2.2 * | | Program 2.3 * | | Program 3.1 * | | Program 4.1 * | | Program 5.1 * | | Program 6.1 * | | Non Attributable | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2008 | 2007 | 2008 | 2007 | 2008 | 2007 | 2008 | 2007 | 2008 | 2007 | 2008 | 2007 | 2008 | 2007 | 2008 | 2007 | 2008 | 2007 | 2008 | 2007 | 2008 | 2007 | 2008 | 2007 |
| | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 |
| **Expenses excluding losses** | | | | | | | | | | | | | | | | | | | | | | | | |
| Operating Expenses | | | | | | | | | | | | | | | | | | | | | | | | |
| Employee Related | 45,598 | 38,582 | 2,439 | 1,921 | 11,176 | 17,953 | 27,277 | 41,371 | 217,914 | 181,905 | 44,634 | 24,073 | 38,996 | 33,221 | 31,805 | 44,718 | 7,828 | 5,410 | 1,484 | 1,906 | 0 | 0 | 429.151 | 391.060 |
| Visiting Medical Officers | 1,197 | 431 | 0 | 2 | 40 | 337 | 773 | 3,121 | 38,588 | 44,903 | 7,903 | 345 | 5,374 | 4,620 | 804 | 384 | 41 | 244 | 96 | 58 | 0 | 0 | 54.816 | 54.445 |
| Other Operating Expenses | 30,231 | 20,027 | 1,350 | 1,508 | 4,864 | 16,071 | 15,724 | 31,106 | 197,881 | 146,287 | 36,510 | 36,825 | 13,732 | 11,888 | 21,239 | 33,624 | 5,694 | 2,382 | 546 | 500 | 0 | 0 | 327.771 | 300.218 |
| Depreciation and Amortisation | 2,235 | 1,137 | 109 | 34 | 456 | 933 | 1,234 | 1,794 | 13,175 | 6,452 | 2,698 | 2,108 | 920 | 1,052 | 1,495 | 2,149 | 382 | 14 | 59 | 54 | 0 | 0 | 22.763 | 15.727 |
| Grants and Subsidies | 484 | 681 | 63 | 323 | 48 | 19 | 127 | 234 | 1,373 | 947 | 282 | 272 | 28 | 1,934 | (56) | 586 | 40 | 123 | 8 | 0 | 0 | 0 | 2.397 | 5.119 |
| Finance Costs | 189 | 48 | 9 | 0 | 40 | 0 | 105 | 241 | 1,033 | 1,061 | 211 | 290 | 0 | 0 | 130 | 290 | 33 | 0 | 3 | 0 | 0 | 0 | 1.753 | 1.930 |
| Payments to Affiliated Health Organisations | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 12,953 | 14,038 | 0 | 0 | 0 | 0 | 0 | 0 | 12.953 | 14.040 |
| Other Expenses | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Expenses excluding losses** | 79,934 | 60,906 | 3,970 | 3,788 | 16,624 | 35,313 | 45,240 | 77,867 | 469,964 | 381,557 | 92,238 | 63,913 | 59,050 | 52,715 | 68,370 | 95,789 | 14,018 | 8,173 | 2,196 | 2,518 | 0 | 0 | 851,604 | 782,539 |
| **Revenue** | | | | | | | | | | | | | | | | | | | | | | | | |
| Sale of Goods and Services | 866 | 8,027 | 30 | 0 | 126 | 1,233 | 2,364 | 2,315 | 77,008 | 57,008 | 16,019 | 12,211 | 507 | 405 | 6,054 | 26,403 | 64 | 15 | 10 | 0 | 0 | 0 | 103.048 | 107.617 |
| Investment Revenue | 30 | 0 | 0 | 0 | 2 | 0 | 46 | 0 | 1,136 | 1,165 | 232 | 177 | 0 | 0 | 109 | 329 | 2 | 0 | 0 | 0 | 0 | 0 | 1.557 | 1.671 |
| Grants and Contributions | 210 | 3,599 | 6 | 0 | 21 | 163 | 310 | 0 | 7,710 | 1,713 | 1,579 | 1,713 | 59 | 82 | 744 | 2,035 | 15 | 0 | 4 | 0 | 0 | 0 | 10.658 | 9.305 |
| Other Revenue | 383 | 6,650 | 18 | 0 | 54 | 458 | 203 | 16 | 2,477 | 489 | 507 | 484 | 24 | 60 | 148 | 263 | 49 | 174 | 6 | 0 | 0 | 0 | 3.869 | 8.594 |
| **Total Revenue** | 1,489 | 18,276 | 54 | 0 | 203 | 1,854 | 2,923 | 2,331 | 88,331 | 60,375 | 18,337 | 14,585 | 590 | 547 | 7,055 | 29,030 | 130 | 189 | 20 | 0 | 0 | 0 | 119,132 | 127,187 |
| Gain / (Loss) on Disposal | 0 | 0 | (883) | 0 | (883) | 0 | (883) | 0 | 0 | (27) | 0 | (27) | 0 | 0 | 0 | (9) | 0 | 0 | 0 | 0 | 0 | 0 | (2.649) | (63) |
| Other Gains / (Losses) | 0 | 0 | (475) | 0 | (475) | 0 | (474) | 0 | 0 | (472) | 0 | (472) | 0 | 0 | 0 | (156) | 0 | 0 | 0 | 0 | 0 | 0 | (1.424) | (1.100) |
| **Net Cost of Services** | 78,445 | 42,630 | 5,274 | 3,788 | 17,779 | 33,459 | 43,674 | 75,536 | 381,633 | 321,681 | 73,901 | 49,827 | 58,460 | 52,168 | 61,315 | 66,924 | 13,888 | 7,984 | 2,176 | 2,518 | 0 | 0 | 736,545 | 656,515 |
| Government Contributions | | | | | | | | | | | | | | | | | | | | | | | 747,236 | 671,762 |
| **RESULT FOR THE YEAR** | | | | | | | | | | | | | | | | | | | | | | | 10.691 | 15.247 |

* The name and purpose of each program is summarised in Note 17.

The program statement uses statistical data to 31 December 2007 to allocate the current period's financial information to each program.

No changes have occurred during the period between 1 January 2008 and 30 June 2008 which would materially impact this allocation.

## 1 The Health Service Reporting Entity

The Greater Southern Area Health Service was established under the provisions of the Health Services Act with effect from 1 January 2005.

The Health Service, as a reporting entity, comprises all the operating activities of the Hospital facilities and the Community Health Centres under its control. It also encompasses the Special Purposes and Trust Funds which, while containing assets which are restricted for specified uses by the grantor or the donor, are nevertheless controlled by the Health Service. The Health Service is a not for profit entity.

The consolidated entity has a deficiency of working capital of $162.3 million (2007 $126.0 million). Notwithstanding this deficiency the financial report has been prepared on a going concern basis because the entity has the support of the New South Wales Department of Health.

With effect from 17 March 2006 fundamental changes to the employment arrangements of Health Services were made through the amendment of the Public Sector Employment and Management Act 2002 and other Acts including the Health Services Act 1997.

The status of previous employees of Health Services changed from that date. They are now employees of the Government of New South Wales in the service of the Crown rather than employees of the Health Service. Employees of the Government are employed in Divisions of the Government Service.

In accordance with Accounting Standards these Divisions are regarded as special purpose entities that must be consolidated with the financial report of the related Health Service. This is because the Divisions were established to provide personnel services to enable a Health Service to exercise its functions.

As a consequence the values in the annual financial statements presented herein consist of the Health Service (as the parent entity), the financial report of the special purpose entity Division and the consolidated financial report of the economic entity. Notes capture both the parent and consolidated values with notes 3, 4, 12, 23, 25 and 30 being especially relevant.

In the process of preparing the consolidated financial statements for the economic entity consisting of the controlling and controlled entities, all inter-entity transactions and balances have been eliminated.

The reporting entity is consolidated as part of the NSW Total State Sector Accounts.

These financial statements have been authorised for issue by the Chief Executive on 05 December 2008.

## 2 Summary of Significant Accounting Policies

The Health Service's financial report is a general purpose financial report which has been prepared in accordance with applicable Australian Accounting Standards (which include Australian equivalents to International Financial Reporting Standards (AEIFRS)), the requirements of the Health Services Act 1997 and its regulations including observation of the Accounts and Audit Determination for Area Health Services and Public Hospitals.

Property, plant and equipment, investment property and assets held for trading and available for sale are measured at fair value. Other financial statement items are prepared in accordance with the historical cost convention.

All amounts are rounded to the nearest one thousand dollars and are expressed in Australian currency.

Judgements, key assumptions and estimations made by management are disclosed in the relevant notes to the financial report.

Comparative figures are, where appropriate, reclassified to give a meaningful comparison with the current year.

No new or revised accounting standards or interpretations are adopted earlier than their prescribed date of application. Set out below are changes to be effected, their date of application and the possible impact on the financial report of the Greater Southern Area Health Service.

| Standards/Interpretations | Operative Date | Comment |
|---|---|---|
| AASB3, AASB127 & AASB2008-3, Business Combinations | 1 July 2009 | The changes address business combinations and the Australian Accounting Standards Board has indicated that it is yet to consider its suitability for combinations among not-for-profit entities. |
| AASB101, AASB2007-3, Operating Segments | 1 July 2009 | The changes do not apply to not-for-profit entities and have no application within NSW Health. |
| AASB101 & AASB2007-8, Presentation of Financial Statements | 1 July 2009 | Health agencies are currently required to present a statement of recognised income and expense and no variation is expected. |
| AASB123 & AASB2007-6, Borrowing Costs | 1 July 2009 | Borrowing costs that are directly attributable to the acquisition, construction or production of a qualifying asset form part of the cost of that asset. As Health Service borrowings are restricted to the Sustainable Energy Development Authority negligible impact is expected. |
| AASB1004, Contributions | 1 July 2008 | The requirements on contributions from AASB27, 29 and 31 have been relocated, substantially unamended in AASB4. |
| AASB1049, Whole of Government and General Government Sector Financial Reporting | 1 July 2008 | The standard aims to provide the harmonisation of Government Finance Statistics and Generally Accepted Accounting Principles (GAAP) reporting. The impact of changes will be considered in conjunction with the reporting requirements of the Financial Reporting Code for Budget Dependent General Government Sector Agencies. |
| AASB1050 regarding administered items | 1 July 2008 | The requirements of AAS29 have been relocated, substantially unamended and are not expected to have material effect on Health entities. |
| AASB1051 regarding land under roads | 1 July 2008 | The standard will require the disclosure of "accounting policy for land under roads". It is expected that all such assets will need to be recognised "at fair value". The standard will have negligible impact on Health entities. |
| AASB1052 regarding disaggregated disclosures | 1 July 2008 | The standard requires disclosure of financial information about Service costs and achievements. Like other standards not yet effective the requirements have been relocated from AAS29 largely unamended. |
| AASB2007-9 regarding amendments arising from the review of AAS27, AAS29 and AAS31 | 1 July 2008 | The changes made are aimed at removing the uncertainties that previously existed over cross references to other Australian Accounting Standards and the override provisions in AAS29. |
| AAS2008-1, Share Based Payments | 1 July 2009 | The standard will not have application to health entities under the control of the NSW Department of Health. |

| | | |
|---|---|---|
| AASB2008-2 regarding puttable financial instruments | 1 July 2009 | The standard introduces an exception to the definition of financial liability to classify as equity instruments certain puttable financial instruments and certain instruments that impose on an entity an obligation to deliver to another party a pro-rata share of the net assets of the entity only on liquidation. Nil impact is anticipated. |

Other significant accounting policies used in the preparation of these financial statements are as follows:

**a) Employee Benefits and Other Provisions**

**i) Salaries & Wages, Annual Leave, Sick Leave and On Costs**

At the consolidated level of reporting liabilities for salaries and wages (including non monetary benefits), annual leave and paid sick leave that fall wholly within 12 months of the reporting date are recognised and measured in respect of employees' services up to the reporting date at undiscounted amounts based on the amounts expected to be paid when the liabilities are settled.

All Annual Leave employee benefits are reported as "Current" as there is an unconditional right to payment. Current liabilities are then further classified as "Short Term" or "Long Term" based on past trends and known resignations and retirements. Anticipated payments to be made in the next twelve months are reported as "Short Term". On costs of 17% are applied to the value of leave payable at 30 June 2008, such on costs being consistent with actuarial assessment (Comparable on costs for 30 June 2007 were 21.7% which in addition to the 17% increase also included the impact of awards immediately payable at 30 June 2007).

Unused non-vesting sick leave does not give rise to a liability as it is not considered probable that sick leave taken in the future will be greater than the benefits accrued in the future.

The outstanding amounts of workers' compensation insurance premiums and fringe benefits which are consequential to employment, are recognised as liabilities and expenses where the employee benefits to which they relate have been recognised.

**ii) Long Service Leave and Superannuation**

At the consolidated level of reporting Long Service Leave employee leave entitlements are dissected as "Current" if there is an unconditional right to payment and "Non Current" if the entitlements are conditional. Current entitlements are further dissected between "Short Term" and "Long Term" on the basis of anticipated payments for the next twelve months. This in turn is based on past trends and known resignations and retirements.

Long Service Leave provisions are measured on a short hand basis at an escalated rate of 8.1% (also 8.1% at 30 June 2007) for all employees with five or more years of service. Actuarial assessment has found that this measurement technique produces results not materially different from the estimate determined by using the present value basis of measurement.

The Health Service's liability for the closed superannuation pool schemes (State Authorities Superannuation Scheme and State Superannuation Scheme) is assumed by the Crown Entity. The Health Service accounts for the liability as having been extinguished resulting in the amount assumed being shown as part of the non-monetary revenue item described as "Acceptance by the Crown Entity of Employee Benefits". Any liability attached to Superannuation Guarantee Charge cover is reported in Note 23, "Payables".

The superannuation expense for the financial year is determined by using the formulae specified by the NSW Department of Health. The expense for certain superannuation schemes (ie Basic Benefit and First State Super) is calculated as a percentage of the employees' salary. For other superannuation schemes (ie State Superannuation Scheme and State Authorities Superannuation Scheme), the expense is calculated as a multiple of the employees' superannuation contributions.

**iii) Other Provisions**

Other provisions exist when: the agency has a present legal or constructive obligation as a result of a past event; it is probable that an outflow of resources will be required to settle the obligation; and a reliable estimate can be made of the amount of the obligation.

These provisions are recognised when it is probable that a future sacrifice of economic benefits will be required and the amount can be measured reliably.

**b) Insurance**

The Health Service's insurance activities are conducted through the NSW Treasury Managed Fund Scheme of self insurance for Government Agencies. The expense (premium) is determined by the Fund Manager based on past experience.

**c) Finance Costs**

Finance costs are recognised as expenses in the period in which they are incurred.

**d) Income Recognition**

Income is measured at the fair value of the consideration or contribution received or receivable. Additional comments regarding the accounting policies for the recognition of revenue are discussed below.

*Sale of Goods and Services*

Revenue from the sale of goods and services comprises revenue from the provision of products or services, ie user charges. User charges are recognised as revenue when the service is provided or by reference to the stage of completion.

*Patient Fees*

Patient Fees are derived from chargeable inpatients and non-inpatients on the basis of rates specified by the NSW Department of Health from time to time.

*Investment Revenue*

Interest revenue is recognised using the effective interest method as set out in AASB139, "Financial Instruments: Recognition and measurement". Rental revenue is recognised in accordance with AASB117 "Leases" on a straight line basis over the lease term. Dividend revenue is recognised in accordance with AASB118 "Revenue" when the Health Service's right to receive payment is established.

*Debt Forgiveness*

Debts are accounted for as extinguished when and only when settlement occurs through repayment or replacement by another liability.

*Use of Hospital Facilities*

Specialist doctors with rights of private practice are subject to an infrastructure charge for the use of hospital facilities at rates determined by the NSW Department of Health. Charges consist of two components:

* a monthly charge raised by the Health Service based on a percentage of receipts generated
* the residue of the Private Practice Trust Fund at the end of each financial year, such sum being credited for Health Service use in the advancement of the Health Service or individuals within it.

*Use of Outside Facilities*

The Health Service uses a number of facilities owned and maintained by the local authorities in the area to deliver community health services for which no charges are raised by the authorities. The cost method of accounting is used for the initial recording of all such services. Cost is determined as the fair value of the services given and is then recognised as revenue with a matching expense.

*Grants and Contributions*

Grants and Contributions are generally recognised as revenues when the Health Service obtains control over the assets comprising the contributions. Control over contributions is normally obtained upon the receipt of cash.

*NSW Department of Health Allocations*

Payments are made by the NSW Department of Health on the basis of the allocation for the Health Service as adjusted for approved supplementations mostly for salary agreements, patient flows between Health Services and approved enhancement projects. This allocation is included in the Operating Statement before arriving at the "Result for the Year" on the basis that the allocation is earned in return for the health services provided on behalf of the Department. Allocations are normally recognised upon the receipt of Cash.

General operating expenses/revenues of Affiliated Health Organisations have only been included in the Operating Statement prepared to the extent of the cash payments made to the Health Organisations concerned. The Health Service is not deemed to own or control the various assets/liabilities of the aforementioned Health Organisations and such amounts have been excluded from the Balance Sheet. Any exceptions are specifically listed in the notes that follow.

**e) Accounting for the Goods & Services Tax (GST)**

Revenues, expenses and assets are recognised net of the amount of GST, except where:

* the amount of GST incurred by the Health Service as a purchaser that is not recoverable from the Australian Taxation Office is recognised as part of the cost of acquisition of an asset or as part of an item of expense;
* receivables and payables are stated with the amount of GST included.

**f) Inter Area and Interstate Patient Flows**

Inter Area Patient Flows

Health Services recognise patient flows for patients they have treated that live outside the Service's regional area. The flows recognised are for acute inpatients (other than Mental Health Services), emergency and rehabilitation and extended care.

Patient flows have been calculated using benchmarks for the cost of services for each of the categories identified and deducting estimated revenue, based on the payment category of the patient. The flow information is based on activity for the last completed calender year. The NSW Department of Health accepts that category identification for various surgical and medical procedures is impacted by the complexities of the coding process and the interpretations of the coding staff when coding a patient's medical records. The Department reviews the flow information extracted from Health Service records, and once it has accepted it, requires each Health Service and the Children's Hospital at Westmead to bring to account the value of patient flows in accordance with the Department's assessment.

The adjustments have no effect on equity values as the movement in Net Cost of Services is matched by a corresponding adjustment to the value of the NSW Department of Health Recurrent Allocation.

Inter State Patient Flows

Health Services recognise the outflow of acute inpatients that are treated by other States and Territories within Australia who normally reside in the Service's residential area. The Health Services also recognise the value of inflows for acute inpatient treatment provided to residents from other States and territories. The expense and revenue values reported within the financial statements have been based on 2006/07 activity data using standard cost weighted separation values to reflect estimated costs in 2007/08 for acute weighted inpatient separations. Where treatment is obtained outside the home health service, the State/Territory providing the service is reimbursed by the benefiting Area.

The reporting adopted for both inter area and interstate patient flows aims to provide a greater accuracy of the cost of service provision to the Area's resident population and disclose the extent to which service is provided to non residents.

The composition of patient flow expense/revenue is disclosed in Notes 5 and 10.

**g) Acquisition of Assets**

The cost method of accounting is used for the initial recording of all acquisitions of assets controlled by the Health Service. Cost is the amount of cash or cash equivalents paid or the fair value of the other consideration given to acquire the asset at the time of its acquisition or construction or, where applicable, the amount attributed to that asset when initially recognised in accordance with the specific requirements of other Australian Accounting Standards.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and revenues at their fair value at the date of acquisition except for assets transferred as a result of an administrative restructure. (Note 2(x) refers)

Fair value means the amount for which an asset could be exchanged between knowledgeable, willing parties in an arm's length transaction.

Where settlement of any part of cash consideration is deferred beyond normal credit terms, its cost is the cash price equivalent, i.e. the deferred payment amount is effectively discounted at an asset-specific rate.

Land and Buildings which are owned by the Health Administration Corporation or the State and administered by the Health Service are deemed to be controlled by the Health Service and are reflected as such in the financial statements.

**h) Plant & Equipment and Infrastructure Systems**

Individual items of property, plant & equipment are capitalised where their cost is $10,000 or above.

“Infrastructure Systems” means assets that comprise public facilities and which provide essential services and enhance the productive capacity of the economy including roads, bridges, water infrastructure and distribution works, sewerage treatment plants, seawalls and water reticulation systems.

**i) Depreciation**

Depreciation for buildings and infrastructure assets is calculated using the diminishing value method so as to write off the depreciable amount of each asset as it is consumed over its useful life to the Health Service. Depreciation for all other depreciable assets is calculated using the straight line method. Land is not a depreciable asset.

Details of depreciation rates initially applied for major asset categories are as follows:

| | |
|---|---|
| Buildings | 2.5% |
| Electro Medical Equipment | |
| - Costing less than $200,000 | 10.0% |
| - Costing more than or equal to $200,000 | 12.5% |
| Computer Equipment | 20.0% |
| Infrastructure Systems | 2.5% |
| Motor Vehicle Sedans | 12.5% |
| Motor Vehicles, Trucks & Vans | 20.0% |
| Office Equipment | 10.0% |
| Plant and Machinery | 10.0% |
| Linen | 25.0% |
| Furniture, Fittings and Furnishings | 5.0% |

Depreciation rates are subsequently varied where changes occur in the assessment of the remaining useful life of the assets reported.

**j) Revaluation of Non Current Assets**

Physical non-current assets are valued in accordance with the NSW Department of Health's "Valuation of Physical Non-Current Assets at Fair Value" policy. This policy adopts fair value in accordance with AASB116, "Property, Plant & Equipment" and AASB140, "Investment Property".

Property, plant and equipment is measured on an existing use basis, where there are no feasible alternative uses in the existing natural, legal, financial and socio-political environment. However, in the limited circumstances where there are feasible alternative uses, assets are valued at their highest and best use.

Fair value of property, plant and equipment is determined based on the best available market evidence, including current market selling prices for the same or similar assets. Where there is no available market evidence the asset's fair value is measured at its market buying price, the best indicator of which is depreciated replacement cost.

The Health Service revalues Land and Buildings and Infrastructure at minimum every three years by independent valuation and with sufficient regularity to ensure that the carrying amount of each asset does not differ materially from its fair value at reporting date. The last revaluation for assets assumed by the Area as at 30 June 2007 was completed on 30 June 2007 and was based on an independent assessment.

Non-specialised assets with short useful lives are measured at depreciated historical cost, as a surrogate for fair value.

When revaluing non-current assets by reference to current prices for assets newer than those being revalued (adjusted to reflect the present condition of the assets), the gross amount and the related accumulated depreciation are separately restated.

For other assets, any balances of accumulated depreciation existing at the revaluation date in respect of those assets are credited to the asset accounts to which they relate. The net asset accounts are then increased or decreased by the revaluation increments or decrements.

Revaluation increments are credited directly to the asset revaluation reserve, except that, to the extent that an increment reverses a revaluation decrement in respect of that class of asset previously recognised as an expense in the Result for the Year, the increment is recognised immediately as revenue in the Result for the Year.

Revaluation decrements are recognised immediately as expenses in the Result for the Year, except that, to the extent that a credit balance exists in the asset revaluation reserve in respect of the same class of assets, they are debited directly to the asset revaluation reserve.

As a not-for-profit entity, revaluation increments and decrements are offset against one another within a class of non-current assets, but not otherwise.

Where an asset that has previously been revalued is disposed of, any balance remaining in the asset revaluation reserve in respect of that asset is transferred to accumulated funds.

**k) Impairment of Property, Plant and Equipment**

As a not-for-profit entity with no cash generating units, the Health Service is effectively exempt from AASB 136" Impairment of Assets" and impairment testing. This is because AASB136 modifies the recoverable amount test to the higher of fair value less costs to sell and depreciated replacement cost. This means that, for an asset already measured at fair value, impairment can only arise if selling costs are regarded as material. Selling costs are regarded as immaterial.

**l) Restoration Costs**

The estimated cost of dismantling and removing an asset and restoring the site is included in the cost of an asset, to the extent it is recognised as a liability.

**m) Non Current Assets (or disposal groups) Held for Sale**

The Health Service has certain non-current assets (or disposal groups) classified as held for sale, where their carrying amount will be recovered principally through a sale transaction, not through continuing use. Non-current assets (or disposal groups) held for sale are recognised at the lower of carrying amount and fair value less costs to sell. These assets are not depreciated while they are classified as held for sale.

**n) Intangible Assets**

The Health Service recognises Intangible assets only if it is probable that future economic benefits will flow to the Health Service and the cost of the asset can be measured reliably. Intangible assets are measured initially at cost. Where an asset is acquired at no or nominal cost, the cost is its fair value as at the date of acquisition. All research costs are expensed. Development costs are only capitalised when certain criteria are met.

[The useful lives of intangible assets are assessed to be finite] Intangible assets are subsequently measured at fair value only if there is an active market. As there is no active market for the Health Service's intangible assets, the assets are carried at cost less any accumulated amortisation. The Health Service's intangible assets are amortised using the straight line method based on the useful life of the asset for both internally developed assets and direct acquisitions. In general, intangible assets are tested for impairment where an indicator of impairment exists. However, as a not-for-profit entity the Health Service is effectively exempted from impairment testing (see Note 2[k]).

**o) Maintenance**

The costs of maintenance are charged as expenses as incurred, except where they relate to the replacement of a component of an asset in which case the costs are capitalised and depreciated.

**p) Leased Assets**

A distinction is made between finance leases which effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership of the leased assets, and operating leases under which the lessor effectively retains all such risks and benefits.

Where a non-current asset is acquired by means of a finance lease, the asset is recognised at its fair value at the commencement of the lease term. The corresponding liability is established at the same amount. Lease payments are allocated between the principal component and the interest expense.

Operating lease payments are charged to the Operating Statement in the periods in which they are incurred.

**q) Inventories**

Inventories are stated at cost. Costs are assigned to individual items of stock mainly on the basis of weighted average costs.

Obsolete items are disposed of in accordance with instructions issued by the NSW Department of Health.

**r) Loans and Receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the operating statement when impaired, derecognised or through the amortisation process.

Short-term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

**s) Investments**

Investments are initially recognised at fair value plus, in the case of investments not at fair value through profit or loss, transaction costs. The Greater Southern Area Health Service determines the classification of its financial assets after initial recognition and, when allowed and appropriate, re-evaluates this at each financial year end.

* *Fair value through profit or loss* - The Greater Southern Area Health Service subsequently measures investments classified as “held for trading” or designated upon initial recognition “at fair value through profit or loss” at fair value.

  The risk management strategy of the Health Service has been developed consistent with the investment powers granted under the provision of the Public Authorities (Financial Arrangements) Act.

**t) Impairment of financial assets**

All financial assets, except those measured at fair value through profit and loss, are subject to an annual review for impairment. An allowance for impairment is established when there is objective evidence that the entity will not be able to collect all amounts due.

For financial assets carried at amortised cost, the amount of the allowance is the difference between the asset’s carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate. The amount of the impairment loss is recognised in the operating statement.

When an available for sale financial asset is impaired, the amount of the cumulative loss is removed from equity and recognised in the operating statement, based on the difference between the acquisition cost (net of any principal repayment and amortisation) and current fair value, less any impairment loss previously recognised in the operating statement.

Any reversals of impairment losses are reversed through the operating statement, where there is objective evidence, except reversals of impairment losses on an investment in an equity instrument classified as “available for sale” must be made through the reserve. Reversals of impairment losses of financial assets carried at amortised cost cannot result in a carrying amount that exceeds what the carrying amount would have been had there not been an impairment loss.

**u) De-recognition of financial assets and financial liabilities**

A financial asset is derecognised when the contractual rights to the cash flows from the financial assets expire; or if the agency transfers the financial asset:

* where substantially all the risks and rewards have been transferred; or
* where the Health Service has not transferred substantially all the risks and rewards, if the entity has not retained control.

Where the Health Service has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the Health Service's continuing involvement in the asset.

A financial liability is derecognised when the obligation specified in the contract is discharged or cancelled or expires.

**v) Payables**

These amounts represent liabilities for goods and services provided to the Health Service and other amounts. Payables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method. Short-term payables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

Payables are recognised for amounts to be paid in the future for goods and services received, whether or not billed to the Health Service.

**w) Borrowings**

Loans are not held for trading or designated at fair value through profit or loss and are recognised at amortised cost using the effective interest rate method. Gains or losses are recognised in the operating statement on derecognition.

The finance lease liability is determined in accordance with AASB 117 Leases.

**x) Equity Transfers**

The transfer of net assets between agencies as a result of an administrative restructure, transfers of programs/functions and parts thereof between NSW public sector agencies is designated as a contribution by owners and is recognised as an adjustment to "Accumulated Funds".

Transfers arising from an administrative restructure between Health Services/Government Departments are recognised at the amount at which the asset was recognised by the transferor Health Service/Government Department immediately prior to the restructure. In most instances this will approximate fair value. All other equity transfers are recognised at fair value.

The Statement of Recognised Income and Expense does not reflect the Net Assets or change in equity in accordance with AASB 101 Clause 97.

**y) Trust Funds**

The Health Service receives monies in a trustee capacity for various trusts as set out in Note 28. As the Health Service performs only a custodial role in respect of these monies, and because the monies cannot be used for the achievement of the Health Service's own objectives, they are not brought to account in the financial statements.

**z) Budgeted Amounts**

The budgeted amounts are drawn from the budgets agreed with the NSW Health Department at the beginning of the financial reporting period and with any adjustments for the effects of additional supplementation provided.

**aa) Summary of Capital Management**

With effect from 1 July 2008 project management for all capital projects over $10M will be provided by Health Infrastructure, a division of the Health Administration Corporation created with the purpose of managing and coordinating approved capital works projects within time, budget and quality standards specified by the Department. Capital charging will also be introduced and will guide Health Services in the management of capital and subsequent budget impact when planning facility redevelopments and assessing the ongoing importance of under utilised land and buildings.

| PARENT | | | CONSOLIDATION | |
|---|---|---|---|---|
| **2008 $000** | **2007 $000** | | **2008 $000** | **2007 $000** |

### 3. Employee Related

Employee related expenses comprise the following:

| | | | | |
|---|---|---|---|---|
| 0 | 0 | Salaries and Wages | 299,481 | 280,505 |
| 0 | 0 | Awards | 13,516 | 14,352 |
| 0 | 0 | Superannuation - defined benefit plans | 9,257 | 10,053 |
| 0 | 0 | Superannuation - defined contributions | 26,555 | 22,937 |
| 0 | 0 | Long Service Leave | 15,007 | 11,390 |
| 0 | 0 | Annual Leave | 31,709 | 27,241 |
| 0 | 0 | Sick Leave and Other Leave | 10,291 | 6,808 |
| 0 | 0 | Redundancies | 0 | 934 |
| 0 | 0 | Nursing Agency Payments | 1,597 | 1,224 |
| 0 | 0 | Other Agency Payments | 12,230 | 5,051 |
| 0 | 0 | Workers Compensation Insurance | 9,250 | 10,414 |
| 0 | 0 | Fringe Benefits Tax | 258 | 151 |
| **0** | **0** | | **429,151** | **391,060** |

### 4. Personnel Services

Personnel Services comprise the purchase of the following:

| | | | | |
|---|---|---|---|---|
| 299,481 | 280,505 | Salaries and Wages | 0 | 0 |
| 13,516 | 14,352 | Awards | 0 | 0 |
| 9,257 | 10,053 | Superannuation - defined benefit plans | 0 | 0 |
| 26,555 | 22,937 | Superannuation - defined contributions | 0 | 0 |
| 15,007 | 11,390 | Long Service Leave | 0 | 0 |
| 31,709 | 27,241 | Annual Leave | 0 | 0 |
| 10,291 | 6,808 | Sick Leave and Other Leave | 0 | 0 |
| 0 | 934 | Redundancies | 0 | 0 |
| 1,597 | 1,224 | Nursing Agency Payments | 0 | 0 |
| 12,230 | 5,051 | Other Agency Payments | 0 | 0 |
| 9,250 | 10,414 | Workers Compensation Insurance | 0 | 0 |
| 258 | 151 | Fringe Benefits Tax | 0 | 0 |
| **429,151** | **391,060** | | **0** | **0** |

### 5. Other Operating Expenses

| | | | | |
|---|---|---|---|---|
| 43,739 | 42,785 | Allocation for Inter Area Patient Outflows, NSW (see (d) below) | 43,739 | 42,785 |
| 2,736 | 2,472 | Blood and Blood Products | 2,736 | 2,472 |
| 8,391 | 7,633 | Domestic Supplies and Services | 8,391 | 7,633 |
| 14,913 | 14,619 | Drug Supplies | 14,913 | 14,619 |
| 6,461 | 5,697 | Food Supplies | 6,461 | 5,697 |
| 6,034 | 5,977 | Fuel, Light and Power | 6,034 | 5,977 |
| 19,074 | 19,867 | General Expenses (See (b) below) | 19,074 | 19,867 |
| 14,625 | 11,410 | Hospital Ambulance Transport Costs | 14,625 | 11,410 |
| 4,904 | 5,446 | Information Management Expenses | 4,904 | 5,446 |
| 56 | 92 | Insurance | 56 | 92 |
| 117,160 | 106,208 | Interstate Patient Outflows (see (e) below) | 117,160 | 106,208 |
| | | Maintenance (See (c) below) | | |
| 3,100 | 3,262 | Maintenance Contracts | 3,100 | 3,262 |
| 5,052 | 7,256 | New/Replacement Equipment under $10,000 | 5,052 | 7,256 |
| 6,648 | 5,096 | Repairs | 6,648 | 5,096 |
| 3,152 | 3,546 | Other | 3,152 | 3,546 |
| 21,985 | 19,387 | Medical and Surgical Supplies | 21,985 | 19,387 |
| 3,849 | 2,700 | Postal and Telephone Costs | 3,849 | 2,700 |
| 1,928 | 1,584 | Printing and Stationery | 1,928 | 1,584 |
| 638 | 595 | Rates and Charges | 638 | 595 |
| 3,969 | 3,586 | Rental | 3,969 | 3,586 |
| 27,736 | 25,066 | Special Service Departments | 27,736 | 25,066 |
| 1,838 | 784 | Staff Related Costs | 1,838 | 784 |
| 5,680 | 2,073 | Sundry Operating Expenses (See (a) below) | 5,680 | 2,073 |
| 4,103 | 3,077 | Travel Related Costs | 4,103 | 3,077 |
| **327,771** | **300,218** | | **327,771** | **300,218** |

| PARENT | | | CONSOLIDATION | |
|---|---|---|---|---|
| **2008 $000** | **2007 $000** | | **2008 $000** | **2007 $000** |
| | | (a) Sundry Operating Expenses comprise: | | |
| 3,674 | 0 | Contract for Patient Services | 3,674 | 0 |
| 2,006 | 2,073 | Isolated Patient Travel and Accomodation Assistance Scheme | 2,006 | 2,073 |
| **5,680** | **2,073** | | **5,680** | **2,073** |
| | | (b) General Expenses include:- | | |
| 376 | 778 | Advertising | 376 | 778 |
| 360 | 204 | Books, Magazines and Journals | 360 | 204 |
| | | Consultancies | | |
| 1,150 | 1,801 | - Operating Activities | 1,150 | 1,801 |
| 2 | 0 | - Capital Works | 2 | 0 |
| 1,518 | 1,487 | Courier and Freight | 1,518 | 1,487 |
| 128 | 274 | Auditor's Remuneration - Audit of financial reports | 128 | 274 |
| 159 | 0 | Auditor's Remuneration - Other Services | 159 | 0 |
| 54 | (241) | Data Recording and Storage | 54 | (241) |
| 424 | 289 | Legal Services | 424 | 289 |
| 168 | 288 | Membership/Professional Fees | 168 | 288 |
| 4,387 | 4,387 | Motor Vehicle Operating Lease Expense - minimum lease payments | 4,387 | 4,387 |
| 2,295 | 2,591 | Other Operating Lease Expense - minimum lease payments | 2,295 | 2,591 |
| 6 | 0 | Payroll Services | 6 | 0 |
| 242 | 319 | Quality Assurance/Accreditation | 242 | 319 |
| 12 | 0 | Translator Services | 12 | 0 |
| | | (c) Reconciliation Total Maintenance | | |
| 17,952 | 19,160 | Maintenance expense - contracted labour and other (non employee related), included in Note 5 | 17,952 | 19,160 |
| 8,714 | 7,926 | Employee related/Personnel Services maintenance expense included in Notes 3 and 4 | 8,714 | 7,926 |
| **26,666** | **27,086** | Total maintenance expenses included in Notes 3, 4 and 5 | **26,666** | **27,086** |
| | | (d) Details of the Allocations applied to Inter Area Patient Outflows, NSW on an Area basis as accepted by the NSW Department of Health are as follows:- | | |
| 9,994 | 9,304 | Sydney South West AHS | 9,994 | 9,304 |
| 22,286 | 22,426 | Sydney East Illawarra AHS | 22,286 | 22,426 |
| 2,941 | 3,145 | Sydney West AHS | 2,941 | 3,145 |
| 2,504 | 1,555 | Northern Sydney/Central Coast AHS | 2,504 | 1,555 |
| 590 | 412 | Hunter New England AHS | 590 | 412 |
| 343 | 340 | North Coast AHS | 343 | 340 |
| 1,601 | 1,537 | Greater Western AHS | 1,601 | 1,537 |
| 3,480 | 4,066 | Children's Hospital | 3,480 | 4,066 |
| **43,739** | **42,785** | | **43,739** | **42,785** |
| | | (e) Expenses for Interstate Patient Flows are as follows:- | | |
| 73,455 | 62,248 | ACT | 73,455 | 62,248 |
| 756 | 1,145 | Queensland | 756 | 1,145 |
| 196 | 75 | South Australia | 196 | 75 |
| 42,234 | 41,829 | Victoria | 42,234 | 41,829 |
| 62 | 145 | Tasmania | 62 | 145 |
| 113 | 144 | Northern Territory | 113 | 144 |
| 344 | 622 | Western Australia | 344 | 622 |
| **117,160** | **106,208** | | **117,160** | **106,208** |

| PARENT 2008 $000 | PARENT 2007 $000 | | CONSOLIDATION 2008 $000 | CONSOLIDATION 2007 $000 |
|---|---|---|---|---|
| | | **6. Depreciation and Amortisation** | | |
| 17,156 | 11,261 | Depreciation - Buildings | 17,156 | 11,261 |
| 5,135 | 4,466 | Depreciation - Plant and Equipment | 5,135 | 4,466 |
| 472 | 0 | Depreciation - Infrastructure Systems | 472 | 0 |
| **22,763** | **15,727** | | **22,763** | **15,727** |
| | | **7. Grants and Subsidies** | | |
| 1,851 | 1,214 | Non Government Voluntary Organisations | 1,851 | 1,214 |
| 546 | 3,905 | Other | 546 | 3,905 |
| **2,397** | **5,119** | | **2,397** | **5,119** |
| | | **8. Finance Costs** | | |
| 1,747 | 1,920 | Interest on Bank Overdrafts and Loans | 1,747 | 1,920 |
| 6 | 10 | Other Interest Charges | 6 | 10 |
| **1,753** | **1,930** | Total Finance Costs | **1,753** | **1,930** |
| | | **9. Payments to Affiliated Health Organisations** | | |
| | | Recurrent Sourced | | |
| 5,777 | 6,110 | Mercy Care Centre - Young | 5,777 | 6,110 |
| 7,149 | 7,930 | Mercy Care Centre - Albury | 7,149 | 7,930 |
| 27 | 0 | Other | 27 | 0 |
| **12,953** | **14,040** | | **12,953** | **14,040** |

| PARENT 2008 $000 | PARENT 2007 $000 | | CONSOLIDATION 2008 $000 | CONSOLIDATION 2007 $000 |
|---|---|---|---|---|
| | | **10. Sale of Goods and Services** | | |
| | | (a) Sale of Goods comprise the following:- | | |
| 658 | 599 | Sale of Prosthesis | 658 | 599 |
| 131 | 140 | Pharmacy Sales | 131 | 140 |
| | | (b) Rendering of Services comprise the following:- | | |
| 60,572 | 55,153 | Patient Fees [see note 2(d)] | 60,572 | 55,153 |
| 0 | 84 | Staff-Meals and Accommodation | 0 | 84 |
| 3,525 | 3,316 | Infrastructure Fees - Monthly Facility Charge [see note 2(d)] - Annual Charge | 3,525 | 3,316 |
| 6,623 | 11,053 | Allocation from Inter Area Patient Inflows, NSW [see note (c)] | 6,623 | 11,053 |
| 259 | 240 | Cafeteria/Kiosk | 259 | 240 |
| 913 | 745 | Commercial Activities | 913 | 745 |
| 58 | 60 | Fees for Medical Records | 58 | 60 |
| 22 | 0 | Information Retrieval | 22 | 0 |
| 0 | 65 | Linen Service Revenues - Non Health Services | 0 | 65 |
| 780 | 840 | Meals on Wheels | 780 | 840 |
| 115 | 0 | PADP Patient Copayments | 115 | 0 |
| 15,592 | 22,928 | Patient Inflows from Interstate [see note (d)] | 15,592 | 22,928 |
| 316 | 0 | Salary Packaging Fee | 316 | 0 |
| 13,484 | 12,394 | Other | 13,484 | 12,394 |
| **103,048** | **107,617** | | **103,048** | **107,617** |

| | | | | |
|---|---|---|---|---|
| | | (c) Details of the Allocations received for Inter Area Patient Flows, NSW on an Area basis as accepted by the NSW Department of Health are as follows: | | |
| 816 | 809 | Sydney South West AHS | 816 | 809 |
| 1,382 | 1,569 | Sydney East Illawarra AHS | 1,382 | 1,569 |
| 352 | 477 | Sydney West AHS | 352 | 477 |
| 512 | 428 | Northern Sydney/Central Coast AHS | 512 | 428 |
| 464 | 355 | Hunter New England AHS | 464 | 355 |
| 298 | 280 | North Coast AHS | 298 | 280 |
| 2,799 | 7,135 | Greater Western AHS | 2,799 | 7,135 |
| **6,623** | **11,053** | | **6,623** | **11,053** |
| | | (d) Revenues from Patient Inflows from Interstate are as follows:- | | |
| 1,849 | 3,264 | ACT | 1,849 | 3,264 |
| 495 | 387 | Queensland | 495 | 387 |
| 141 | 290 | South Australia | 141 | 290 |
| 12,905 | 18,646 | Victoria | 12,905 | 18,646 |
| 56 | 142 | Tasmania | 56 | 142 |
| 39 | 44 | Northern Territory | 39 | 44 |
| 107 | 155 | Western Australia | 107 | 155 |
| **15,592** | **22,928** | | **15,592** | **22,928** |
| | | **11. Investment Revenue** | | |
| 886 | 1,055 | Interest | 886 | 1,055 |
| 671 | 616 | Other | 671 | 616 |
| **1,557** | **1,671** | | **1,557** | **1,671** |

| PARENT 2008 $000 | PARENT 2007 $000 | | CONSOLIDATION 2008 $000 | CONSOLIDATION 2007 $000 |
|---|---|---|---|---|
| | | **12. Grants and Contributions** | | |
| 4,200 | 3,343 | Commonwealth Government grants | 4,200 | 3,343 |
| 1,989 | 1,527 | Industry Contributions/Donations | 1,989 | 1,527 |
| 2,952 | 2,521 | Cancer Institute grants | 2,952 | 2,521 |
| 1,179 | 1,044 | NSW Government grants | 1,179 | 1,044 |
| 9,257 | 10,054 | Personnel Services - Superannuation Defined Benefits | 0 | 0 |
| 338 | 870 | Other grants | 338 | 870 |
| **19,915** | **19,359** | | **10,658** | **9,305** |
| | | **13. Other Revenue** | | |
| | | Other Revenue comprises the following:- | | |
| 14 | 0 | Bad Debts recovered | 14 | 0 |
| 68 | 63 | Commissions | 68 | 63 |
| 111 | 0 | Conference and Training Fees | 111 | 0 |
| 6 | 28 | Sale of Merchandise, Old Wares and Books | 6 | 28 |
| 2,995 | 4,683 | Treasury Managed Fund Hindsight Adjustment | 2,995 | 4,683 |
| 675 | 3,820 | Other | 675 | 3,820 |
| **3,869** | **8,594** | | **3,869** | **8,594** |
| | | **14. Gain/(Loss) on Disposal** | | |
| 16,185 | 286 | Property Plant and Equipment | 16,185 | 286 |
| 13,033 | 97 | Less Accumulated Depreciation | 13,033 | 97 |
| **3,152** | **189** | **Written Down Value** | **3,152** | **189** |
| 503 | 182 | Less Proceeds from Disposal | 503 | 182 |
| **(2,649)** | **(7)** | **Gain/(Loss) on Disposal of Property Plant and Equipment** | **(2,649)** | **(7)** |
| 0 | 56 | Assets Held for Sale | 0 | 56 |
| 0 | 0 | Less Proceeds from Disposal | 0 | 0 |
| **0** | **(56)** | **Gain/(Loss) on Disposal of Assets Held for Sale** | **0** | **(56)** |
| **(2,649)** | **(63)** | **Total Gain/(Loss) on Disposal** | **(2,649)** | **(63)** |
| | | **15. Other Gains/(Losses)** | | |
| (1,424) | (1,100) | Impairment of Receivables | (1,424) | (1,100) |
| **(1,424)** | **(1,100)** | | **(1,424)** | **(1,100)** |

**PARENT AND CONSOLIDATION**

**16. Conditions on Contributions**

| | Purchase of Assets | Health Promotion, Education and Research | Other | Total |
|---|---|---|---|---|
| | $000 | $000 | $000 | $000 |
| Contributions recognised as revenues during the current reporting period for which expenditure in the manner specified had not occurred as at balance date | 261 | 49 | 2,770 | 3,080 |
| Contributions recognised in amalgamated balance as at 30 June 2007 which were not expended in the current reporting period | 499 | 293 | 5,227 | 6,019 |
| Total amount of unexpended contributions as at balance date | 760 | 342 | 7,997 | 9,099 |

Comment on restricted assets appears in Note 22

## 17 Programs/Activities of the Health Service

**Program 1.1 - Primary and Community Based Services**

Objective: To improve, maintain or restore health through health promotion, early intervention, assessment, therapy and treatment services for clients in a home or community setting.

**Program 1.2 - Aboriginal Health Services**

Objective: To raise the health status of Aborigines and to promote a healthy life style.

**Program 1.3 - Outpatient Services**

Objective: To improve, maintain or restore health through diagnosis, therapy, education and treatment services for ambulant patients in a hospital setting.

**Program 2.1 - Emergency Services**

Objective: To reduce the risk of premature death and disability for people suffering injury or acute illness by providing timely emergency diagnostic, treatment and transport services.

**Program 2.2 - Overnight Acute Inpatient Services**

Objective: To restore or improve health and manage risks of illness, injury and childbirth through diagnosis and treatment for people intended to be admitted to hospital on an overnight basis.

**Program 2.3 - Same Day Acute Inpatient Services**

Objective: To restore or improve health and manage risks of illness, injury and childbirth through diagnosis and treatment for people intended to be admitted to hospital and discharged on the same day.

**Program 3.1 - Mental Health Services**

Objective: To improve the health, well being and social functioning of people with disabling mental disorders and to reduce the incidence of suicide, mental health problems and mental disorders in the community.

**Rehabilitation and Extended Care Services**

Objective: To improve or maintain the well being and independent functioning of people with disabilities or chronic conditions, the frail aged and the terminally ill.

**Program 5.1 - Population Health Services**

Objective: To promote health and reduce the incidence of preventable disease and disability by improving access to opportunities and prerequisites for good health.

**Program 6.1 - Teaching and Research**

Objective: To develop the skills and knowledge of the health workforce to support patient care and population health. To extend knowledge through scientific enquiry and applied research aimed at improving the health and well being of the people of New South Wales.

***No change from 2006/07***

| PARENT | | | CONSOLIDATION | |
|---|---|---|---|---|
| **2008 $000** | **2007 $000** | | **2008 $000** | **2007 $000** |
| | | **18. Cash and Cash Equivalents** | | |
| (415) | 5,458 | Cash at bank and on hand | (415) | 5,458 |
| 9,241 | 7,224 | Short Term Deposits | 9,241 | 7,224 |
| **8,826** | **12,682** | | **8,826** | **12,682** |
| | | Cash & cash equivalent assets recognised in the Balance Sheet are reconciled at the end of the financial year to the Cash Flow Statement as follows: | | |
| 8,826 | 12,682 | Cash and cash equivalents (per Balance Sheet) | 8,826 | 12,682 |
| | | Bank overdraft | | |
| **8,826** | **12,682** | Closing Cash and Cash Equivalents (per Cash Flow Statement) | **8,826** | **12,682** |

***Refer to Note 34 for details regarding credit risk, liquidity risk and market risk arising from financial instruments.***

| PARENT 2008 $000 | PARENT 2007 $000 | | CONSOLIDATION 2008 $000 | CONSOLIDATION 2007 $000 |
|---|---|---|---|---|
| | | **19. Receivables** | | |
| | | **Current** | | |
| 10,219 | 12,124 | (a) Sale of Goods and Services | 10,219 | 12,124 |
| 2,991 | 1,699 | NSW Health Department | 2,991 | 1,699 |
| 2,700 | 0 | Goods & Services Tax | 2,700 | 0 |
| 260 | 2,756 | Other Debtors | 260 | 2,756 |
| 16,170 | 16,579 | **Sub Total** | 16,170 | 16,579 |
| (1,160) | (1,039) | Less Allowance for impairment | (1,160) | (1,039) |
| 15,010 | 15,540 | **Sub Total** | 15,010 | 15,540 |
| 465 | 719 | Prepayments | 465 | 719 |
| **15,475** | **16,259** | | **15,475** | **16,259** |
| | | (b) Movement in the allowance for impairment | | |
| | | Sale of Goods & Services | | |
| (698) | (516) | Balance at 1 July | (698) | (516) |
| 1,106 | 716 | Amounts written off during the year | 1,106 | 716 |
| 17 | 0 | Amounts recovered during the year | 17 | 0 |
| 0 | 0 | Increase/(decrease) in allowance recognised in profit or loss | 0 | 0 |
| (1,170) | (898) | | (1,170) | (898) |
| (745) | (698) | Balance at 30 June | (745) | (698) |
| | | (c) Movement in the allowance for impairment | | |
| | | Other Debtors | | |
| (341) | (158) | Balance at 1 July | (341) | (158) |
| 197 | 19 | Amounts written off during the year | 197 | 19 |
| 0 | 0 | Amounts recovered during the year | 0 | 0 |
| 0 | 0 | Increase/(decrease) in allowance recognised in profit or loss | 0 | 0 |
| (271) | (202) | | (271) | (202) |
| (415) | (341) | Balance at 30 June | (415) | (341) |
| **(1,160)** | **(1,039)** | | **(1,160)** | **(1,039)** |
| | | **Non Current** | | |
| 764 | 818 | (a) Prepayments | 764 | 818 |
| **764** | **818** | | **764** | **818** |
| | | (b) Sale of Goods and Services Receivables (Current and Non Current) include: | | |
| 1,382 | 1,223 | Patient Fees - Compensable | 1,382 | 1,223 |
| 354 | 291 | Patient Fees - Ineligible | 354 | 291 |
| 4,188 | 4,095 | Patient Fees - Other | 4,188 | 4,095 |
| **5,924** | **5,609** | | **5,924** | **5,609** |

***Details regarding credit risk, liquidity risk and market risk, including financial assets that are either past due or impaired are disclosed in Note 34.***

| PARENT | | | CONSOLIDATION | |
|---|---|---|---|---|
| 2008 $000 | 2007 $000 | | 2008 $000 | 2007 $000 |
| | | **20. Inventories** | | |
| | | **Current - at cost** | | |
| 1,152 | 1,075 | Drugs | 1,152 | 1,075 |
| 2,043 | 2,014 | Medical and Surgical Supplies | 2,043 | 2,014 |
| 82 | 83 | Food and Hotel Supplies | 82 | 83 |
| 203 | 223 | Engineering Supplies | 203 | 223 |
| 109 | 111 | Other including Goods in Transit | 109 | 111 |
| **3,589** | **3,506** | | **3,589** | **3,506** |

Greater Southern Area Health Service
Notes to and forming part of the Financial Statements
for the Year Ended 30 June 2008

| PARENT | | | CONSOLIDATION | |
|---|---|---|---|---|
| 2008 $000 | 2007 $000 | | 2008 $000 | 2007 $000 |
| | | **21. Property, Plant and Equipment** | | |
| | | **Land and Buildings** | | |
| 1,012,024 | 963,956 | At Fair Value | 1,012,024 | 963,956 |
| 479,957 | 474,855 | Less Accumulated depreciation and impairment | 479,957 | 474,855 |
| **532,067** | **489,101** | Net Carrying Amount | **532,067** | **489,101** |
| | | **Plant and Equipment** | | |
| 75,558 | 73,526 | At Fair Value | 75,558 | 73,526 |
| 52,589 | 50,387 | Less Accumulated depreciation and impairment | 52,589 | 50,387 |
| **22,969** | **23,139** | Net Carrying Amount | **22,969** | **23,139** |
| | | **Infrastructure Systems** | | |
| 16,216 | 15,697 | At Fair Value | 16,216 | 15,697 |
| 8,766 | 8,294 | Less Accumulated depreciation and impairment | 8,766 | 8,294 |
| **7,450** | **7,403** | Net Carrying Amount | **7,450** | **7,403** |
| | | **Total Property, Plant and Equipment** | | |
| **562,486** | **519,643** | **At Net Carrying Amount** | **562,486** | **519,643** |

**PARENT AND CONSOLIDATION**

**21. Property, Plant and Equipment - Reconciliations**

| | Land | Buildings | Work in Progress | Leased Buildings | Plant and Equipment | Infrastructure Systems | Other Leased Assets | Total |
|---|---|---|---|---|---|---|---|---|
| | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 |
| **2008** | | | | | | | | |
| Carrying amount at start of year | **44,761** | **409,588** | **34,752** | **0** | **23,139** | **7,403** | **0** | **519,643** |
| Additions | 138 | 201 | 62,845 | | 5,606 | 519 | | **69,309** |
| Reclassifications to Intangibles | | | | | | | | |
| Recognition of Assets Held for Sale | | | | | | | | **0** |
| Disposals | (550) | (2,504) | 0 | 0 | (99) | 0 | 0 | **(3,153)** |
| Administrative restructures - transfers in/(out) | 0 | (542) | (8) | 0 | 0 | 0 | 0 | **(550)** |
| Net revaluation increment less revaluation decrements recognised in reserves | | | | | | | | |
| Impairment losses (recognised in "other gains/losses) | | | | | | | | |
| Depreciation expense | 0 | (17,156) | 0 | 0 | (5,135) | (472) | 0 | **(22,763)** |
| Reclassifications | 0 | 19,554 | (19,012) | 0 | (542) | 0 | 0 | **0** |
| Carrying amount at end of year | **44,349** | **409,141** | **78,577** | **0** | **22,969** | **7,450** | **0** | **562,486** |

| | Land | Buildings | Work in Progress | Leased Buildings | Plant and Equipment | Infrastructure Systems | Other Leased Assets | Total |
|---|---|---|---|---|---|---|---|---|
| | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 |
| **2007** | | | | | | | | |
| Carrying amount at start of year | **32,126** | **225,185** | **17,911** | **0** | **22,750** | **1,155** | **0** | **299,127** |
| Additions | 6 | 16,862 | 16,841 | 0 | 5,388 | 0 | 0 | **39,097** |
| Reclassifications to Intangibles | | | | | | | | |
| Recognition of Assets Held for Sale | | | | | | | | **0** |
| Disposals | (154) | 0 | 0 | 0 | (36) | 0 | 0 | **(190)** |
| Administrative restructures - transfers in/(out) | (150) | (347) | 0 | 0 | (1,652) | 0 | 0 | **(2,149)** |
| Net revaluation increment less revaluation decrements recognised in reserves | 12,933 | 179,149 | 0 | 0 | 0 | 7,403 | 0 | **199,485** |
| Impairment losses (recognised in "other gains/losses) | | | | | | | | **0** |
| Depreciation expense | 0 | (11,261) | 0 | 0 | (4,466) | 0 | 0 | **(15,727)** |
| Reclassifications | 0 | 0 | 0 | 0 | 1,155 | (1,155) | 0 | **0** |
| Carrying amount at end of year | **44,761** | **409,588** | **34,752** | **0** | **23,139** | **7,403** | **0** | **519,643** |

**Above categories and transaction type should be deleted if not applicable.**

(i) Land and Buildings include land owned by the Health Administration Corporation and administered by the Health Service [see note 2(g)].

(ii) Land and Buildings were valued by AON Valuation Services (Certified Practising Valuers) on 30 June 2007 [see note 2(j)]. AON Valuation Services are not an employee of the Health Service.

## 22. Restricted Assets

The Health Service's financial statements include the following assets which are restricted by externally imposed conditions, eg. donor requirements. The assets are only available for application in accordance with the terms of the donor restrictions.

| PARENT 2008 $000 | PARENT 2007 $000 | Category | Brief Details of Externally Imposed Conditions including Asset Category affected | CONSOLIDATION 2008 $000 | CONSOLIDATION 2007 $000 |
|---|---|---|---|---|---|
| 5,198 | 4,435 | Specific Purposes | Hospital/Ward Specific | 5,198 | 4,435 |
| 311 | 311 | Private Practice Funds | Private Practice Trust | 311 | 311 |
| 3,590 | 3,109 | Other (List Major Items) | Not restricted to specific hospitals | 3,590 | 3,109 |
| **9,099** | **7,855** | | | **9,099** | **7,855** |

| PARENT 2008 $000 | PARENT 2007 $000 | | CONSOLIDATION 2008 $000 | CONSOLIDATION 2007 $000 |
|---|---|---|---|---|
| | | **23. Payables** | | |
| | | **Current** | | |
| 0 | 0 | Accrued Salaries and Wages | 11,550 | 8,487 |
| 0 | 0 | Payroll Deductions | 5,209 | 3,044 |
| 16,759 | 11,531 | Accrued Liability - Purchase of Personnel Services | | |
| 42,281 | 28,483 | Creditors | 42,281 | 28,483 |
| 112 | 0 | Interest | 112 | 0 |
| | | Other Creditors | | |
| 3,879 | 4,562 | - Capital Works | 3,879 | 4,562 |
| 2,239 | 1,669 | - Intra Health Liability | 2,239 | 1,669 |
| **65,270** | **46,245** | | **65,270** | **46,245** |

***Details regarding credit risk, liquidity risk and market risk, including a maturity analysis of the above payables are disclosed in Note 34.***

| | | | | |
|---|---|---|---|---|
| | | **24. Borrowings** | | |
| | | **Current** | | |
| 8,040 | 7,279 | Other Loans and Deposits | 8,040 | 7,279 |
| **8,040** | **7,279** | | **8,040** | **7,279** |
| | | **Non Current** | | |
| 10,526 | 16,446 | Other Loans and Deposits | 10,526 | 16,446 |
| **10,526** | **16,446** | | **10,526** | **16,446** |

Other loans still to be extinguished represent monies to be repaid to the NSW Health Department/ Sustainable Energy Development Authority
Final Repayment is scheduled for 30 June 2013

| | | | | |
|---|---|---|---|---|
| | | **Repayment of Borrowings** | | |
| 8,040 | 7,279 | Not later than one year | 8,040 | 7,279 |
| 10,390 | 13,953 | Between one and five years | 10,390 | 13,953 |
| 136 | 2,493 | Later than five years | 136 | 2,493 |
| **18,566** | **23,725** | | **18,566** | **23,725** |

***Details regarding credit risk, liquidity risk and market risk, including a maturity analysis of the above borrowings are disclosed in Note 34.***

| PARENT 2008 $000 | PARENT 2007 $000 | | CONSOLIDATION 2008 $000 | CONSOLIDATION 2007 $000 |
|---|---|---|---|---|
| | | **25. Provisions** | | |
| | | **Current Employee benefits and related on-costs** | | |
| 0 | 0 | Annual Leave - Short Term Benefit | 26,462 | 28,507 |
| 0 | 0 | Annual Leave - Long Term Benefit | 22,831 | 15,205 |
| 0 | 0 | Long Service Leave - Short Term Benefit | 6,304 | 4,699 |
| 0 | 0 | Long Service Leave - Long Term Benefit | 61,267 | 56,471 |
| 116,864 | 104,882 | Provision for Personnel Services Liability | 0 | 0 |
| **116,864** | **104,882** | **Total Current Provisions** | **116,864** | **104,882** |
| | | **Non Current Employee benefits and related on-costs** | | |
| 0 | 0 | Long Service Leave - Conditional | 3,703 | 1,466 |
| 3,703 | 1,466 | Provision for Personnel Services Liability | 0 | 0 |
| **3,703** | **1,466** | **Total Non Current Provisions** | **3,703** | **1,466** |
| | | **Aggregate Employee Benefits and Related On-costs** | | |
| 116,864 | 104,882 | Provisions - current | 116,864 | 104,882 |
| 3,703 | 1,466 | Provisions - non-current | 3,703 | 1,466 |
| 0 | 0 | Accrued Salaries and Wages and on costs (Note 23) | 16,759 | 11,531 |
| 16,759 | 11,531 | Accrued Liability - Purchase of Personnel Services (Note 23) | 0 | 0 |
| **137,326** | **117,879** | | **137,326** | **117,879** |

## 26. PARENT AND CONSOLIDATION

| Equity | Accumulated Funds | | Asset Revaluation Reserve | | Available for Sale Reserves | | Total Equity | |
|---|---|---|---|---|---|---|---|---|
| | 2008 | 2007 | 2008 | 2007 | 2008 | 2007 | 2008 | 2007 |
| | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 |
| **Balance at the beginning of the financial year** | 165,418 | 152,320 | 211,172 | 11,687 | 0 | 0 | 376,590 | 164,007 |
| **Changes in equity - transactions with owners as owners** | | | | | | | | |
| Increase/(Decrease) in Net Assets from Administrative Restructure | 0 | (2,149) | 0 | 0 | 0 | 0 | 0 | (2,149) |
| Adjustment for building transferred to Health Support | 0 | 0 | (544) | 0 | 0 | 0 | (544) | 0 |
| **Total** | 165,418 | 150,171 | 210,628 | 11,687 | 0 | 0 | 376,046 | 161,858 |
| **Changes in equity - other than transactions with owners as owners** | | | | | | | | |
| Result for the year | 10,691 | 15,247 | 0 | 0 | 0 | 0 | 10,691 | 15,247 |
| Increment/(Decrement) on Revaluation of: | | | | | | | | |
| Land and Buildings | 0 | 0 | 0 | 192,082 | 0 | 0 | 0 | 192,082 |
| Plant and Equipment | 0 | 0 | 0 | 7,403 | 0 | 0 | 0 | 7,403 |
| **Total** | 10,691 | 15,247 | 0 | 199,485 | 0 | 0 | 10,691 | 214,732 |
| **Balance at the end of the financial year** | 176,109 | 165,418 | 210,628 | 211,172 | 0 | 0 | 386,737 | 376,590 |

The asset revaluation reserve is used to record increments and decrements on the revaluation of non current assets. This accords with the Health Service's policy on the "Revaluation of Physical Non Current Assets" and "Investments", as discussed in Note 2(j).

| PARENT 2008 $000 | PARENT 2007 $000 | 27. Commitments for Expenditure | CONSOLIDATION 2008 $000 | CONSOLIDATION 2007 $000 |
|---|---|---|---|---|
| | | **(a) Capital Commitments** | | |
| | | Aggregate capital expenditure for the acquisition of land and buildings, plant and equipment, infrastructure and intangible assets, contracted for at balance date and not provided for: | | |
| 1,432 | 2,516 | Not later than one year | 1,432 | 2,516 |
| | | Later than one year and not later than five years | | |
| | | Later than five years | | |
| **1,432** | **2,516** | **Total Capital Expenditure Commitments (including GST)** | **1,432** | **2,516** |
| | | **(b) Other Expenditure Commitments** | | |
| | | Aggregate other expenditure contracted for at balance date and not provided for: | | |
| 3,264 | 2,886 | Not later than one year | 3,264 | 2,886 |
| 5,170 | 4,089 | Later than one year and not later than five years | 5,170 | 4,089 |
| 331 | 231 | Later than five years | 331 | 231 |
| **8,765** | **7,206** | **Total Other Expenditure Commitments (including GST)** | **8,765** | **7,206** |
| | | **(c) Operating Lease Commitments** | | |
| | | Commitments in relation to non-cancellable operating leases are payable as follows: | | |
| 5,104 | 4,572 | Not later than one year | 5,104 | 4,572 |
| 3,310 | 4,205 | Later than one year and not later than five years | 3,310 | 4,205 |
| 245 | 160 | Later than five years | 245 | 160 |
| **8,659** | **8,937** | **Total Operating Lease Commitments (including GST)** | **8,659** | **8,937** |

**The operating lease commitments above are for motor vehicles, information technology, equipment including personal computers, medical equipment and other equipment**

## PARENT AND CONSOLIDATION

### 28 Trust Funds

The Health Service holds trust fund moneys of **$2.077** million which are used for the safe keeping of patients' monies, deposits on hired items of equipment and Private Practice Trusts. These monies are excluded from the financial statements as the Health Service cannot use them for the achievement of its objectives. The following is a summary of the transactions in the trust account:



| | Patient Trust | | Refundable Deposits | | Private Practice Trust Funds | |
|---|---|---|---|---|---|---|
| | 2008 $000 | 2007 $000 | 2008 $000 | 2007 $000 | 2008 $000 | 2007 $000 |
| Cash Balance at the beginning of the financial reporting period | 1,180 | 1,152 | 137 | 118 | 529 | 507 |
| Receipts | 599 | 490 | 34 | 80 | 4,667 | 4,362 |
| Expenditure | (608) | (462) | (30) | (61) | (4,431) | (4,340) |
| Cash Balance at the end of the financial reporting period | 1,171 | 1,180 | 141 | 137 | 765 | 529 |

## 29 Contingent Liabilities

### a) Claims on Managed Fund

Since 1 July 1989, the Health Service has been a member of the NSW Treasury Managed Fund. The Fund will pay to or on behalf of the Health Service all sums which it shall become legally liable to pay by way of compensation or legal liability if sued except for employment related, discrimination and harassment claims that do not have statewide implications. The costs relating to such exceptions are to be absorbed by the Health Service. As such, since 1 July 1989, apart from the exceptions noted above no contingent liabilities exist in respect of liability claims against the Health Service. A Solvency Fund (now called Pre-Managed Fund Reserve was established to deal with the insurance matters incurred before 1 July 1989 that were above the limit of insurance held or for matters that were incurred prior to 1 July 1989 that would have become verdicts against the State. That Solvency Fund will likewise respond to all claims against the Health Service.

### b) Workers Compensation Hindsight Adjustment

Treasury Managed Fund normally calculates hindsight premiums each year. However, in regard to workers compensation the final hindsight adjustment for the 2001/02 fund year and an interim adjustment for the 2003/04 fund year were not calculated until 2007/08. As a result, the 2002/03 final and 2004/05 interim hindsight calculations will be paid in 2008/09.

### c) Affiliated Health Organisations

Based on the definition of control in Australian Accounting Standard AASB127, Affiliated Health Organisations listed in Schedule 3 of the Health Services Act, 1997 are only recognised in the Department's consolidated Financial Statements to the extent of cash payments made.

However, it is accepted that a contingent liability exists which may be realised in the event of cessation of health service activities by any Affiliated Health Organisation. In this event the determination of assets and liabilities would be dependent on any contractual relationship which may exist or be formulated between the administering bodies of the organisation and the Department.

| PARENT 2008 $000 | PARENT 2007 $000 | | CONSOLIDATION 2008 $000 | CONSOLIDATION 2007 $000 |
|---|---|---|---|---|
| | | **30. Reconciliation Of Net Cash Flows from Operating Activities To Net Cost Of Services** | | |
| 70,093 | 43,723 | Net Cash Flows from Operating Activities | 70,093 | 43,723 |
| (22,763) | (15,727) | Depreciation | (22,763) | (15,727) |
| 0 | 0 | Acceptance by the Crown Entity of Employee Superannuation Benefits | (9,257) | (10,054) |
| (14,219) | (9,410) | (Increase)/ Decrease in Provisions | (14,219) | (9,410) |
| (756) | 3,096 | Increase / (Decrease) in Prepayments and Other Assets | (756) | 3,096 |
| (18,912) | (6,007) | (Increase)/ Decrease in Creditors | (18,912) | (6,007) |
| (2,631) | (63) | Net Gain/ (Loss) on Sale of Property, Plant and Equipment | (2,631) | (63) |
| (669,913) | (623,576) | (NSW Health Department Recurrent Allocations) | (669,913) | (623,576) |
| (68,066) | (38,132) | (NSW Health Department Capital Allocations) | (68,066) | (38,132) |
| 0 | 0 | (Asset Sale Proceeds transferred to the NSW Health Department) | 0 | 0 |
| 0 | 0 | (Cash Reimbursements from the Government) | 0 | 0 |
| (121) | (365) | Allowance for impairment of receivables | (121) | (365) |
| **(727,288)** | **(646,461)** | **Net Cost of Services** | **(736,545)** | **(656,515)** |

**31. 2007/08 Voluntary Services**

It is considered impracticable to quantify the monetary value of voluntary services provided to the health service. Services provided include:

- Chaplaincies and Pastoral Care
- Pink Ladies/Hospital Auxiliaries
- Patient Support Groups
- Community Organisations
- Patient & Family Support
- Patient Services, Fund Raising
- Practical Support to Patients and Relative
- Counselling, Health Education, Transport, Home Help & Patient Activities

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## 32 Unclaimed Moneys

Unclaimed salaries and wages are paid to the credit of the Department of Industrial Relations and Employment in accordance with the provisions of the Industrial Arbitration Act, 1940, as amended.

All money and personal effects of patients which are left in the custody of Health Services by any patient who is discharged or dies in the hospital and which are not claimed by the person lawfully entitled thereto within a period of twelve months are recognised as the property of health services.

All such money and the proceeds of the realisation of any personal effects are lodged to the credit of the Samaritan Fund which is used specifically for the benefit of necessitous patients or necessitous outgoing patients.

## 33 Budget Review - Parent and Consolidated

### Net Cost of Services

The actual Net Cost of Services was higher than budget by $8.2M (11.4%). This was primarily due to the continued high costs of providing a diverse range of public hospital services in a rural setting with increasing demands for services. Total expenditure was approx $24.1M (29.1%) unfavourable to budget. Major overruns evident in Interstate Patient Outflows $2.3M, Maintenance costs $4.6M, Employee Related expenses $13.7M and expenditure on Operational Goods & Services $2.6M. Total Revenue was favourable to target by $15.8M (13.9%).

### Result for the Year

The Result for the Year was unfavourable to budget by $9.7M. Government contributions totalled $669.9M and were on line with budget.

### Assets and Liabilities

Total Assets were below budget by $6.1M with the current year balance representing an increase of $38.2M on last year. The Area has also commenced a number of capital programs that have added $40.0M to the asset base. Total liabilities exceeded budget by $14.4M, much of this relates to an increase in payable amounts which have increased $19.0M from last year.

### Cash Flows

Closing Cash and Cash Equivalents has decreased by $3.9M and is $7.1M unfavourable to budget. Net Cash Flows from Operating Activities were $3.2M unfavourable to budget.

Movements in the level of the NSW Department of Health Recurrent Allocation that have occurred since the time of the initial allocation on **30 June 2007** are as follows:

| | '$000 |
|---|---|
| Initial Allocation, 30 June 2007 | 606,474 |
| Inter Area Patient Flows | 37,116 |
| Interstate Patient Flows | 9,472 |
| Medical Officer Supplementations | 3,284 |
| Nurse Strategies | 1,280 |
| Elective Surgery List Reduction | 1,188 |
| Commonwealth Elective Surgery Waiting List Reduction Plan | 1,188 |
| Rural Doctors Grants | 1,062 |
| Long Stay older Patients Initiatives | 880 |
| Mental Health Enhancements | 832 |
| Risk Shared Procurement | 739 |
| Drug & Alcohol Enhancements | 666 |
| Award Costs | 388 |
| Clinical Services Redesign | 311 |
| Highly Specialised Drugs | 186 |
| Oral Health Strategy | 113 |
| Other Miscellaneous Adjustments | 4,734 |
| Balance as per Operating Statement | 669,913 |

**Note 34 Financial Instruments**

The Health Service's principal financial instruments are outlined below. These financial instruments arise directly from the Health Service's operations or are required to finance its operations. The Health Service does not enter into or trade financial instruments, including derivative financial instruments, for speculative purposes.

The Health Service's main risks arising from financial instruments are outlined below, together with the Health Service's objectives, policies and processes for measuring and managing risk. Further quantitative and qualitative disclosures are included throughout this financial report.

The Chief Executive has overall responsibility for the establishment and oversight of risk management and reviews and agrees policies for managing each of these risks. Risk management policies are established to identify and analyse the risk faced by the Health Service, to set risk limits and controls and monitor risks. Compliance with policies is reviewed by the Audit Committee/Internal auditors on a continous basis.

a) **Financial Instrument Categories**

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| | | Total carrying amounts as per the Balance Sheet | |
|---|---|---|---|
| | | 2008 $000 | 2007 $000 |
| **Financial Assets** | | | |
| Class: | Category | | |
| Cash and Cash Equivalents (note 18) | | 8,826 | 12,682 |
| Receivables at Amortised Cost (note 19)1 | | 12,310 | 15,540 |
| Total Financial Assets | | 21,136 | 28,222 |
| **Financial Liabilities** | | | |
| Borrowings (Note 24) | | 18,566 | 23,725 |
| Payables (Note 23)2 | | 65,270 | 46,245 |
| Total Financial Liabilities | | 83,836 | 69,970 |

Notes

1 Excludes statutory receivables and prepayments (ie not within scope of AASB 7)

2 Excludes unearned revenue (ie not within scope of AASB 7)

b) **Credit Risk**

Credit risk arises when there is the possibility of the Entity's debtors defaulting on their contractual obligations, resulting in a financial loss to the Entity. The maximum exposure to credit risk is generally represented by the carrying amount of the financial assets (net of any allowance for impairment).

Credit risk arises from financial assets of the Entity i.e receivables. No collateral is held by the Entity nor has it granted any financial guarantees.

Credit risk associated with the Health Services's financial assets, other than receivables, is managed through the selection of counterparties and establishment of minimum credit rating standards. Authority deposits held with NSW Tcorp are guaranteed by the State.

Cash

Cash comprises cash on hand and bank balance deposited in accordance with Public Authorities (Financial Arrangements) Act approvals. Interest is earned on daily bank balances at rates of approximately 0.8% in 2007/08 compared to 0.7% in the previous year. The Tcorp Hour Glass cash facility is discussed in para (d) below.

Receivables - trade debtors

All trade debtors are recognised as amounts receivable at balance date. Collectibility of trade debtors is reviewed on an ongoing basis. Procedures as established in the NSW Department of Health Accounting Manual and Fee Procedures Manual are followed to recover outstanding amounts, including letters of demand. Debts which are known to be uncollectable are written off. An allowance for impairment is raised when there is objective evidence that the entity will not be able to collect the amounts due. The evidence includes past experience and current and expected changes in economic conditions and debtor credit ratings. No interest is earned on trade debtors.

The Health Service is not materially exposed to concentrations of credit risk to a single trade debtor or group of debtors. Based on past experience, debtors that are not past due (2008:$9,004; 2007: $4,504) and not more than [3] months past due (2008: $2,784; 2007:$6,927) are not considered impaired and together these represent 73% of the total trade debtors. In addition Patient Fees Compensables are frequently not settled with 6 months of the date of the service provision due to the length of time it takes to settle legal claims. Most of the Health Services' debtors are Health Insurance Companies or Compensation Insurers settling claims in respect of inpatient treatments. There are no debtors which are currently not past due or impaired whose terms have not been renegotiated.

The only financial assets that are past due or impaired are 'sales of goods and services' in the 'receivables' category of the balance sheet. Patient Fees Ineligibles represent the majority of fincial assets that are past due or impaired.

| | | $000 | |
|---|---|---|---|
| **2008** | **Total** | **Past due but not impaired** | **Considered impaired** |
| <3 months overdue | 9,089 | 9,086 | 3 |
| 3 months - 6 months overdue | 712 | 704 | 8 |
| > 6 months overdue | 3,669 | 2,520 | 1,149 |
| **2007** | | | |
| <3 months overdue | 11,431 | 11,188 | 243 |
| 3 months - 6 months overdue | 538 | 538 | 0 |
| > 6 months overdue | 4,610 | 3,814 | 796 |

The ageing analysis excludes statutory receivables, as these are not within the scope of AASB 7.

c) **Liquidity risk**

Liquidity risk is the risk that the Health Service will be unable to meet its payment obligations when they fall due. The Health Service continuously manages risk through monitoring future cash flows and maturities planning to ensure adequate holding of high quality liquid assets. The objective is to maintain a balance between continuity of funding and flexibility through effective management of cash, investments and liquid assets and liabilities.

The Health Service has negotiated no loan outside of arrangements with the NSW Department of Health or the Sustainable Energy Development Authority.

During the current and prior year, there were no defaults or breaches on any loans payable. No assets have been pledged as collateral. The Health Service's exposure to liquidity risk is considered significant. However, the risk is minimised as the NSW department of Health has indicated its ongoing support for the Greater Southern Area Health Service.

The liabilities are recognised for amounts due to be paid in the future for goods or services received, whether or not invoiced. Amounts owing to suppliers (which are unsecured) are generally settled in accordance with the policy set by the NSW Department of Health. If trade terms are not specified, payment is also generally made no later than the end of the month following the month in which an invoice or statement is received.

In those instances where settlement cannot be effected in accordance with the above, eg due to short term liquidity constraints, contact is made with creditors and terms of payment are negotiated.

The table below summarises the maturity profile of the Health Service's financial liabilities together with the interest rate exposure.

*Maturity Analysis and interest rate exposure of financial liabilities*

| | $'000 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Interest Rate Exposure | | | | | Maturity Dates | | | |
| **2008** | **Fixed Interest Rate** | **Variable Interest Rate** | **Nominal Amount** [1] | **Variable Interest Rate** | **Non - Interest Bearing** | **< 1 Yr** | **1-5 Yr** | **> 5Yr** | **Weighted Average Effective int rate** |
| | % | % | $ | $000 | $000 | $000 | $000 | $000 | % |
| Payables: | | | | | | | | | |
| Accrued salaries | | | 16,759 | | 16,759 | 16,759 | | | |
| Wages and payroll deductions | | | | | | | | | |
| Creditors | | | 48,511 | | 48,511 | 48,511 | | | |
| Borrowings: | | | | | | | | | |
| Bank Overdraft | | | | | | | | | |
| Other Loans and Deposits | 5.97 | | 23,485 | 975 | 17,591 | 8,040 | 10,390 | 136 | 5.97 |
| Finance leases | | | | | | | | | |
| [Specify other major categories] | | | | | | | | | |
| | | | 88,755 | 975 | 82,861 | 73,310 | 10,390 | 136 | |
| **2007** | | | | | | | | | |
| Payables: | | | | | | | | | |
| Accrued salaries | | | 11,531 | | 11,531 | 11,531 | | | |
| Wages and payroll deductions | | | | | | | | | |
| Creditors | | | 34,714 | | 34,714 | 34,714 | | | |
| Borrowings: | | | | | | | | | |
| Bank Overdraft | | | | | | | | | |
| Other Loans and Deposits | 6.25 | | 30,325 | 2,166 | 21,559 | 7,279 | 13,953 | 2,493 | 6.25 |
| Finance leases | | | | | | | | | |
| [Specify other major categories] | | | 76,570 | 2,166 | 67,804 | 53,524 | 13,953 | 2,493 | |

Notes:
[1]The amounts disclosed are the contractual undiscounted cash flows of each class of financial liabilities, therefore the amounts disclosed above will not reconcile to the balance sheet in respect of non interest bearing loans negotiated with the NSW Department of Health.

d) **Market risk**

Market risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in market prices. The Health Service's exposures to market risk are primarily through interest rate risk on the Health Service's borrowings and other price risks associated with the movement in the unit price of the Hour Glass Investment facilities. The Health Service has no exposure to foreign currency risk and does not enter into commodity contracts.

The effect on profit and equity due to a reasonably possible change in risk variable is outlined in the information below, for interest rate risk and other price risk. A reasonably possible change in risk variable has been determined after taking into account the economic environment in which the Health Service operates and the time frame for the assessment (i.e. until the end of the next annual reporting period). The sensitivity analysis is based on risk exposures in existence at the balance sheet date. The analysis is performed on the same basis for 2007. The analysis assumes that all other variables remain constant.

*Interest rate risk*

Exposure to interest rate risk arises primarily through the Health Service's interest bearing liabilities.

However, Health Services are not permitted to borrow external to the NSW Department of Health (Sustainable Energy Development Authority loans which are negotiated through Treasury excepted). Both SEDA and NSW Department of Health loans are set at fixed rates and therefore are generally not affected by fluctuations in market rates.

e) Fair Value

Financial instruments are generally recognised at cost, with the exception of the TCorp Hour Glass facilities, which are measured at fair value. As discussed, the value of the Hour Glass Investments is based on the Health Service's share of the value of the underlying assets of the facility, based on the market value. All of the Hour Glass facilities are valued using 'redemption' pricing.

Except where specified below, the amortised cost of financial instruments recognised in the balance sheet approximates the fair value because of the short term nature of many of the financial instruments. The following table details the financial instruments where the fair value differs from the carrying amount:

| | 2008 $'000 Carrying amount | 2008 $'000 Fair value | 2007 $'000 Carrying amount | 2007 $'000 Fair value |
|---|---|---|---|---|
| **Financial assets** | | | | |
| Cash and Cash Equiv. | 8,826 | 8,826 | 12,682 | 12,682 |
| Receivables | 12,310 | 12,310 | 15,540 | 15,540 |
| **Financial liabilities** | | | | |
| Payables | 65,270 | 65,270 | 46,245 | 46,245 |
| Borrowings | 18,566 | 18,566 | 23,725 | 23,725 |

**Note 35 Post Balance Date Events**

There are no post balance date events to be disclosed.

END OF AUDITED FINANCIAL STATEMENTS

GREATER SOUTHERN
AREA HEALTH SERVICE
NSW HEALTH

## Certification of Special Purpose Entity for Period Ended 30 June 2008

The attached financial statements of the Greater Southern Area Health Service Special Purpose Entity for the year ended 30 June 2008.

i. Have been prepared in accordance with the requirements of applicable Australian Accounting Requirements, the requirements of the *Public Finance and Audit Act 1983* and its regulations, the Health Services Act 1997 and its regulations, the Health Services Act 1997 and its regulations, the Accounts and Audit Determination and the Accounting Manual for Area Health Services and Public Hospitals;

ii. Present fairly the financial position of the Greater Southern Area Health Service Special Purpose Service Entity; and

iii. Have no circumstances which would render any particulars in the financial statements to be misleading or inaccurate.

Ms Heather Gray
**Chief Executive**
**Greater Southern Area Health Service**
5th December 2008

Ms Angela Edwards
**Manager Finance**
**Greater Southern Area Health Service**
5th December 2008

GPO BOX 12
Sydney NSW 2001

# INDEPENDENT AUDITOR'S REPORT

## GREATER SOUTHERN AREA HEALTH SERVICE
## SPECIAL PURPOSE SERVICE ENTITY

To Members of the New South Wales Parliament

I have audited the accompanying financial report of Greater Southern Area Health Service Special Purpose Service Entity (the Entity), which comprises the balance sheet as at 30 June 2008, the income statement, statement of recognised income and expense and cash flow statement for the year then ended, a summary of significant accounting policies and other explanatory notes.

### Auditor's Opinion

In my opinion, the financial report:

- presents fairly, in all material respects, the financial position of the Entity as at 30 June 2008, and its financial performance and cash flows for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- is in accordance with section 45E of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2005.

My opinion should be read in conjunction with the rest of this report.

### Chief Executive's Responsibility for the Financial Report

The Chief Executive is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the PF&A Act. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

### Auditor's Responsibility

My responsibility is to express an opinion on the financial report based on my audit. I conducted my audit in accordance with Australian Auditing Standards. These Auditing Standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the Entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Entity's internal controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Chief Executive, as well as evaluating the overall presentation of the financial report.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

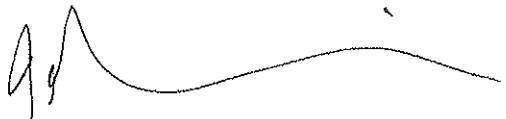
My opinion does *not* provide assurance:

- about the future viability of the Entity,
- that it has carried out its activities effectively, efficiently and economically, or
- about the effectiveness of its internal controls.

**Independence**

In conducting this audit, the Audit Office of New South Wales has complied with the independence requirements of the Australian Auditing Standards and other relevant ethical requirements. The PF&A Act further promotes independence by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General, and
- mandating the Auditor-General as auditor of public sector agencies but precluding the provision of non-audit services, thus ensuring the Auditor-General and the Audit Office of New South Wales are not compromised in their role by the possibility of losing clients or income.



Jack Kheir BEc, FCPA
Director, Financial Audit Services

9 December 2008
SYDNEY

## Income Statement of Greater Southern Area Health Service
## Special Purpose Service Entity for the Year Ended 30 June 2008

| | 2008 $000 | 2007 $000 |
|---|---|---|
| **Income** | | |
| Personnel Services | 429,028 | 396,532 |
| Acceptance by the Crown Entity of Employee Benefits | 9,257 | 10,054 |
| **Total Income** | **438,285** | **406,586** |
| **Expenses** | | |
| Salaries and Wages | 312,997 | 280,505 |
| Awards | | 14,352 |
| Defined Benefit Superannuation | 9,257 | 10,053 |
| Defined Contribution Superannuation | 26,555 | 22,937 |
| Long Service Leave | 15,007 | 11,390 |
| Annual Leave | 31,709 | 32,713 |
| Sick Leave and Other Leave | 10,291 | 6,808 |
| Redundancies | 0 | 934 |
| Nursing Agency Payments | 1,474 | 1,224 |
| Other Agency Payments | 12,230 | 5,051 |
| Workers Compensation Insurance | 9,250 | 10,414 |
| Fringe Benefits Tax | 258 | 151 |
| Grants & Subsidies | 9,257 | 10,054 |
| **Total Expenses** | **438,285** | **406,586** |
| **Result For The Year** | **0** | **0** |

*The accompanying notes form part of these Financial Statements.*

## Balance Sheet of Greater Southern Area Health Service
## Special Purpose Service Entity as at 30 June 2008

| | Notes | 2008 $000 | 2007 $000 |
|---|---|---|---|
| **ASSETS** | | | |
| **Current Assets** | | | |
| Receivables | 2 | 133,622 | 116,413 |
| **Total Current Assets** | | **133,622** | **116,413** |
| **Non-Current Assets** | | | |
| Receivables | 2 | 3,703 | 1,466 |
| **Total Non-Current Assets** | | **3,703** | **1,466** |
| **Total Assets** | | **137,325** | **117,879** |
| **LIABILITIES** | | | |
| **Current Liabilities** | | | |
| Payables | 3 | 16,758 | 11,531 |
| Provisions | 4 | 116,864 | 104,882 |
| **Total Current Liabilities** | | **133,622** | **116,413** |
| **Non-Current Liabilities** | | | |
| Provisions | 4 | 3,703 | 1,466 |
| **Total Non-Current Liabilities** | | **3,703** | **1,466** |
| **Total Liabilities** | | **137,325** | **117,879** |
| **Net Assets** | | **0** | **0** |
| **EQUITY** | | | |
| Accumulated funds | | **0** | **0** |
| **Total Equity** | | **0** | **0** |

*The accompanying notes form part of these Financial Statements*

## Statement of Recognised Income and Expense of Greater Southern Area Health Service Special Purpose Service Entity for the Year Ended 30 June 2008

| | 2008 $000 | 2007 $000 |
|---|---|---|
| Total Income and Expense Recognised Directly in Equity | | |
| Result for the Year | 0 | 0 |
| Total Income and Expense Recognised for the year | | |

*The accompanying notes form part of these Financial Statements*

## Cash Flow Statement of Greater Southern Area Health Service Special Purpose Service Entity for the Year Ended 30 June 2008

| | 2008 $000 | 2007 $000 |
|---|---|---|
| Net Cash Flows from Operating Activities | 0 | 0 |
| Net Cash Flows from Investing Activities | 0 | 0 |
| Net Cash Flows from Financing Activities | 0 | 0 |
| Net Increase/(Decrease) in Cash | 0 | 0 |
| Closing Cash and Cash Equivalents | 0 | 0 |

*The Greater Southern Area Health Service Special Purpose Service Entity does not hold any cash or cash equivalent assets and therefore there are nil cash flows.*

*The accompanying notes form part of these Financial Statements.*

# Greater Southern Area Health Service Special Purpose Service Entity
# Notes to and forming part of the Financial Statements
# for the Year Ended 30 June 2008

## 1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

### a) The Greater Southern Area Health Service Special Purpose Service Entity

The Greater Southern Area Health Service Special Purpose Service Entity *"the Entity"*, is a Division of the Government Service, established pursuant to Part 2 of Schedule 1 to the Public Sector Employment and Management Act 2002 and amendment of the Health Services Act 1997. It is a not-for-profit entity as profit is not its principal objective. It is consolidated as part of the NSW Total State Sector Accounts. It is domiciled in Australia and its principal office is at 34 Lowe Street Queanbeyan, New South Wales.

The Entity's objective is to provide personnel services to the Greater Southern Area Health

The Entity commenced operations on 17 March 2006 when it assumed responsibility for the employees and employee-related liabilities of the Greater Southern Area Health Service. The assumed liabilities were recognised on 17 March 2006 with an offsetting receivable representing the related funding due from the former employer.

The financial report was authorised for issue by the Chief Executive Officer on 05 December 2008.

### b) Basis of Preparation

This is a general purpose financial report prepared in accordance with the requirements of Australian Accounting Standards, the requirements of the Health Services Act 1997 and its regulations including observation of the Accounts and Audit Determination for Area Health Services and Public Hospitals.

Generally, the historical cost basis of accounting has been adopted and the financial report does not take into account changing money values or current valuations. However, certain provisions are measured at fair value. See note (j).

The accrual basis of accounting has been adopted in the preparation of the financial report, except for cash flow information.

Management's judgements, key assumptions and estimates are disclosed in the relevant notes to the financial report.

All amounts are rounded to the nearest one thousand dollars and are expressed in Australian currency.

### c) Comparative Information

The financial statements and notes comply with Australian Accounting Standards which include AEIFRS. Comparative figures are, where appropriate, reclassified to give meaningful comparison with the current year.

### d) New Australian Accounting Standards Issued But Not Effective

No new or revised accounting standards or interpretations are adopted earlier than their prescribed date of application. Set out below are changes to be effected, their date of application and the possible impact on the financial report of the Greater Southern Area Purpose Service Entity

**e) Income**

Income is measured at the fair value of the consideration received or receivable. Revenue from the rendering of personnel services is recognised when the service is provided and only to the extent that the associated recoverable expenses are recognised.

**f) Receivables**

A receivable is recognised when it is probable that the future cash inflows associated with it will be realised and it has a value that can be measured reliably. It is derecognised when the contractual or other rights to future cash flows from it expire or are transferred.

Receivables are non-derivative financial assets with fixed or deteminable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the operating statement when impaired, derecognised or through the amortisation process.

Short term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

If there is objective evidence at year end that a receivable may not be collectable, its carrying amount is reduced by means of an allowance for impairment and the resulting loss is recognised in the income statement. Receivables are monitored during the year and bad debts are written off against the allowance when they are determined to be irrecoverable. Any other loss or gain arising when a receivable is derecognised is also recognised in the income statement.

**g) Impairment of Financial Assets**

As both receivables and payables are measured at fair value through profit and loss there is no need for annual reviews for impairment.

**h) De-recognition of Financial Assets and Financial Liabilities**

A financial asset is derecognised when the contractual rights to the cash flows from the financial assets expire; or if the agency transfers the financial asset:

* where substantially all the risks and rewards have been transferred; or
* where the Entity has not transferred substantially all the risks and rewards, if the Entity has not retained control.

Where the Entity has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the Entity's continuing involvement in the asset

A financial liability is derecognised when the obligation specified in the contract is discharged or cancelled or expires.

**i) Payables**

Payables include accrued wages, salaries and related on costs (such as payroll deduction liability, payroll tax, fringe benefits tax and workers' compensation insurance) where there is certainty as to the amount and timing of settlement.

A payable is recognised when a present obligation arises under a contract or otherwise. It is derecognised when the obligation expires or is discharged, cancelled or submitted.

Payables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method. Short term payables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial. Payables are recognised for amounts to be paid in the future for goods and services received, whether or not billed to the Entity.

**j) Employee Benefit Provisions and Expenses**

i) *Salaries and Wages, Annual Leave, Sick Leave and On-Costs*

Liabilities for salaries and wages (including non-monetary benefits), annual leave and paid sick leave that fall wholly within 12 months of the reporting date are recognised and measured in respect of employees' services up to the reporting date at undiscounted amounts based on the amounts expected to be paid when the liabilities are settled.

All Annual Leave employee benefits are reported as "*Current*" as there is an unconditional right to payment. Current liabilities are then classified as "*Short Term*" and "Long Term" based on past trends and known resignations and retirements. Anticipated payments to be made in the next 12 months are reported as "*Short Term*". On costs of 17% are applied to the value of leave payable at 30 June 2008, such on costs being consistent with actuarial assessment. ( comparable costs for 30 June 2007 were 21.7% which, in addition to the 17% increase, also included the impact of awards immediately payable at 30 June 2007).

Unused non-vesting sick leave does not give rise to a liability, as it is not considered probable that sick leave taken in the future will be greater than the benefits accrued in the future.

The outstanding amounts of payroll tax, workers' compensation insurance premiums and fringe benefits tax, which are consequential to employment, are recognised as liabilities and expenses where the employee benefits to which they relate have been recognised.

*ii) Long Service Leave and Superannuation*

Long Service Leave employee leave entitlements are dissected as "Current" if there is an unconditional right to payment and "Non-Current" if the entitlements are conditional. Current entitlements are further dissected between "Short Term" and "Long Term" on the basis of anticipated payments for the next 12 months. This in turn is based on past trends and known resignations and retirements.

Long Service Leave provisions are measured on a short hand basis at an escalated rate of 8.1% above the salary rates immediately payable at 30 June 2008 (also 8.1% at 30 June 2007) for all employees with five or more years of service. Actuarial assessment has found that this measurement technique produces results not materially different from the estimate determined by using the present value basis of measurement.

The Entity's liability for the closed superannuation pool schemes (State Authorities Superannuation Scheme and State Superannuation Scheme) is assumed by the Crown Entity. The Entity accounts for the liability as having been extinguished resulting in the amount assumed being shown as part of the non-monetary revenue item described as "Acceptance by the Crown Entity of Employee benefits". Any liability attached to Superannuation Guarantee Charge cover is reported in Note 3, "Payables".

The superannuation expense for the financial year is determined by using the formulae specified in the NSW Health Department Directions. The expense for certain superannuation schemes (i.e. Basic Benefit and Superannuation Guarantee Charge) is calculated as a percentage of the employees' salary. For other superannuation schemes (i.e. State Superannuation Scheme and State Authorities Superannuation Scheme), the expense is calculated as a multiple of the employees' superannuation contributions.

## Greater Southern Area Health Service Special Purpose Service Entity

## Notes to and forming part of the Financial Statements for the Year Ended 30 June 2008

| | 2008 $000 | 2007 $000 |
|---|---|---|
| **2. RECEIVABLES** | | |
| **Current** | | |
| Accrued Income - Personnel Services Provided | 133,622 | 116,413 |
| **Non-Current** | | |
| Accrued Income - Personnel Services Provided | 3,703 | 1,466 |
| **Total Receivables** | **137,325** | **117,879** |

Details regarding credit risks, liquidity risk and market risks are disclosed in Note 5

| | | |
|---|---|---|
| **3. PAYABLES** | | |
| **Current** | | |
| Accrued Salaries and Wages and On Costs | 16,758 | 11,531 |
| **Total Payables** | **16,758** | **11,531** |

Details regarding credit risks, liquidity risk and market risk are disclosed in Note 5

| | | |
|---|---|---|
| **4. PROVISIONS** | | |
| **Current Benefits and Related On Costs** | | |
| Annual Leave - Short Term Benefit | 49,293 | 28,507 |
| Annual Leave - Long Term Benefit | | 15,205 |
| Long Service Leave - Short Term Benefit | 67,571 | 4,699 |
| Long Service Leave - Long Term Benefit | | 56,471 |
| **Total Current Provisions** | **116,864** | **104,882** |
| **Non-Current Employee Benefits and Related On Costs** | | |
| Long Service Leave - Conditional | 3,703 | 1,466 |
| **Total Non-Current Provisions** | **3,703** | **1,466** |
| **Aggregate Benefits and Related On Costs** | | |
| Provision - Current | 116,864 | 104,882 |
| Provision - Non-Current | 3,703 | 1,466 |
| Accrued Salaries and Wages and On Costs | 16,758 | 11,531 |
| **Total** | **137,325** | **117,879** |

## Note 5 Financial Instruments

The Entity's financial instruments are outlined below. These financial instruments arise directly from the Entity's operations or are required to finance its operations. The Entity does not enter into or trade financial instruments, including derivative financial instruments for speculative purposes.

The Chief Executive has overall responsibility for the establishment and oversight of risk management and reviews and agrees policies for managing each of these risks. The Entity carries minimal risks within its operation as it carries only the value of employee provisions and accrued salaries and wages offset in full by accounts receivable from the Parent Entity. Risk management policies are established by the Parent Entity to identify and analyse the risk faced by the Entity, to set risk limits and controls and monitor risks. Compliance with policies is reviewed by the Audit Committee/Internal auditors of the Parent Entity on a continous basis.

a) **Financial Instruments Categories**

| | | Total carrying amounts as per the Balance Sheet | |
|---|---|---|---|
| | | 2008 $000 | 2007 $000 |
| **Financial Assets** | | | |
| Receivables at Amortised Cost[1] (note 2) | | 137,325 | 117,879 |
| Total Financial Assets | | 137,325 | 117,879 |
| **Financial Liabilities** | | | |
| Class: | Category | | |
| Payables (Note 3[1]) | | 137,325 | 117,879 |
| Total Financial Liabilities | | 137,325 | 117,879 |

1Excludes statutory receivables and prepayments, i.e. not within the scope of AASB 7.

b) **Credit Risk**

Credit risk arises when there is the possibility of the Entity's debtors defaulting on their contractual obligations, resulting in a financial loss to the Entity. The maximum exposure to credit risk is generally represented by the carrying amount of the financial assets (net of any allowance for impairment).

Credit risk arises from financial assets of the Entity i.e receivables. No collateral is held by the Entity nor has it granted any financial guarantees.

Receivables - trade debtors

Receivables are restricted to accrued income for personnel services provided and employee leave provisions and are recognised as amounts receivable at balance date. The parent entity of the Greater Southern Area Health Service Special Purpose Service Entity is the sole debtor of the Entity and it is assessed that there is no risk of default. No accounts receivables are classified as "Past Due but not Impaired" or "Considered Impaired".

c) **Liquidity Risk**

Liquidity risk is the risk that the Entity will be unable to meet its payment obligations when they fall due. No such risk exists with the Entity not having any cash flows. All movements that occur in Payables are fully offset by an increase in Receivables from the Greater Southern Area Health Service parent entity.

d) **Market Risk**

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. The Entity's exposures to market risk are considered to be minimal and the Entity has no exposure to foreign currency risk and does not enter into commodity contracts.

*Interest rate risk*

Exposure to interest rate risk arises primarily through interest bearing liabilities.

However the Entity has no such liabilities and the interest rate is assessed as Nil. Similarly it is considered that the Entity is not exposed to other price risks.

e) **Fair Value**

Financial instruments are generally recognised at cost.

The amortised cost of financial instruments recognised in the balance sheet approximates fair value because of the short term nature of the financial instruments.

**Note 6 Related Parties**

The XXX Health Service is deemed to control the ….Health Service Special Purpose Service Entity in accordance with Australian Accounting Standards. The controlling entity is incorporated under the Health Services Act 1997.
Transactions and balances in this financial report relate only to the Entity's function as provider of personnel services to the controlling entity. The Entity's total income is sourced from the XXXX Health Service. Cash receipts and payments are effected by the XXXX Health Service on the Entity's behalf.

**Note 7 Post Balance Date Events**

No post balance date events have occurred which warrant inclusion in this report.

END OF AUDITED FINANCIAL STATEMENTS

# APPENDICES

## HEALTH SERVICES

**Albury Base Hospital**
Borella Rd
ALBURY
Telephone: 02 60584444
Fax: 02 60584504

**Albury Mercy Hospital**
Poole St
ALBURY
Telephone: 02 60421400
Fax: 02 60214378

**Barham Koondrook Soldiers Memorial**
Punt Rd
BARHAM
Telephone: 03 54532026
Fax: 03 54532656

**Batemans Bay District Hospital**
Pacific St
BATEMANS BAY
Telephone: 02 44751500
Fax: 02 44720678

**Batlow District Hospital**
Cnr Park St and Wakehurst Ave
BATLOW
Telephone: 02 69414333
Fax: 02 69491390

**Bega District Hospital**
McKee Dr
BEGA
Telephone: 02 64929111
Fax: 02 64923274

**Berrigan War Memorial Hospital**
Anzac Place
BERRIGAN
Telephone: 03 58885300
Fax: 03 58885359

**Bombala Hospital**
Wellington St
BOMBALA
Telephone: 02 64585777
Fax: 02 64583759

**Boorowa Hospital**
Dry St
BOOROWA
Telephone: 02 63853004
Fax: 02 63853206

**Bourke Street Health Service**
234 Bourke St
GOULBURN
Telephone: 02 48237800
Fax: 02 48219659

**Braidwood Hospital**
73 Monkittee St
BRAIDWOOD
Telephone: 02 48422566
Fax: 02 48422054

**Coolamon Ganmain Health Service**
Buchanan Dr
COOLAMON
Telephone: 02 69273303
Fax: 02 69273565

**Cooma Hospital**
2a Bent St
COOMA
Telephone: 02 64553222
Fax: 02 64522117

**Cootamundra Hospital**
MacKay St
COOTAMUNDRA
Telephone: 02 69420444
Fax: 02 69420433

**Corowa Hospital**
Guy St
COROWA
Telephone: 02 60331333
Fax: 02 60333646

**Crookwell Hospital**
Kialla Rd
CROOKWELL
Telephone: 02 48321300
Fax: 02 48322099

**Culcairn Health Service**
Balfour St
CULCAIRN
Telephone: 02 60298203
Fax: 02 60298762

**Delegate Multi Purpose Service**
Craigie St
DELEGATE
Telephone: 02 64588008
Fax: 02 64588156

**Deniliquin District Hospital**
411 Charlotte St
DENILIQUIN
Telephone: 03 58822800
Fax: 03 58822815

**Finley Hospital**
Dawe Ave
FINLEY
Telephone: 03 58831133
Fax: 03 58831457

**Goulburn Hospital**
130 Goldsmith St
GOULBURN
Telephone: 02 48273111
Fax: 02 48273248

**Kenmore Hospital**
Taralga Rd
GOULBURN
Telephone: 02 48273301
Fax: 02 48273315

**Griffith Base Hospital**
Noorebar Ave
GRIFFITH
Telephone: 02 69695555
Fax: 02 69695507

**Gundagai District Hospital**
O'Hagan St
GUNDAGAI
Telephone: 02 69441022
Fax: 02 69441630

**Hay Hospital and Health Service**
Murray St
HAY
Telephone: 02 69908700
Fax: 02 69908771

**Henty District Hospital**
7 Keighran St
HENTY
Telephone: 02 69294999
Fax: 02 69294940

**Hillston District Hospital**
Burns St
HILLSTON
Telephone: 02 69672502
Fax: 02 69672284

**Holbrook District Hospital**
Bowler St
HOLBROOK
Telephone: 02 60362522
Fax: 02 60362782

**Jerilderie Health Service**
Newel Highway
JERILDERIE
Telephone: 03 58861300
Fax: 03 58861277

**Junee District Hospital**
Button St
JUNEE
Telephone: 02 69248200
Fax: 02 69248224

**Leeton District Hospital**
Palm and Wade Ave
LEETON
Telephone: 02 69531111
Fax: 02 69531113

**Lockhart Hospital**
Hebden St
LOCKHART
Telephone: 02 69205206
Fax: 02 69205483

**Mercy Care Centre**
Campbell St
YOUNG
Telephone: 02 63821111
Fax: 02 63828400

**Moruya District Hospital**
River St
MORUYA
Telephone: 02 44742666
Fax: 02 44741586

**Murrumburrah-Harden Hospital**
Swift St
MURRUMBURRAH-HARDEN
Telephone: 02 63862200
Fax: 02 63862931

**Narrandera District Hospital**
Cnr Douglas and Adams St
NARRANDERRA
Telephone: 02 69591166
Fax: 02 69591063

**Pambula District Hospital**
Merimbula St
PAMBULA
Telephone: 02 64956002
Fax: 02 64956570

**Queanbeyan District Hospital**
Cnr Collette and Erin Sts
QUEANBEYAN
Telephone: 02 62989211
Fax: 02 62991536

**Temora and District Hospital**
Loftus St
TEMORA
Telephone: 02 69771066
Fax: 02 69771545

**Tocumwal Hospital**
Adams St
TOCUMWAL
Telephone: 03 58742166
Fax: 03 58742321

**Tumbarumba Health Service**
Albury St
TUMBARUMBA
Telephone: 02 69489600
Fax: 02 69482263

**Tumut District Hospital**
Simpson St
TUMUT
Telephone: 02 69471555
Fax: 02 69473074

**Urana Health Service**
Princess St
URANA
Telephone: 02 69208106
Fax: 02 69208263

**Wagga Wagga Base Hospital**
Edwards St
WAGGA WAGGA
Telephone: 02 69386666
Fax: 02 69215632

**West Wyalong Hospital**
Hospital Rd
WEST WYALONG
Telephone: 02 69790000
Fax: 02 69790006

**Yass District Hospital**
Meehan St
YASS
Telephone: 02 62202000
Fax: 02 62262944

**Young District Hospital**
Allanan St
YOUNG
Telephone: 02 63828888
Fax: 02 63828796

**COMMUNITY HEALTH**

**Adelong Community Health Centre**
Tumut St
ADELONG
Telephone: 02 69462055
Fax: 02 69462041

**Albury Community Health Centre**
596 Smollett St
ALBURY
Telephone: 02 60581800
Fax: 02 60581801

**Ardlethan Community Health Centre**
Redmond St
ARDLETHAN
Telephone: 02 69782066
Fax: 02 69771545

**Barellan Community Health Centre**
Bendee St
BARELLAN
Telephone: 02 69639266
Fax: 02 69639556

**Barham Community Health Centre**
Gonn St
BARHAM
Telephone: 03 54533299
Fax: 03 54532656

**Barmedman Community Health Centre**
Robertson St
BARMEDMAN
Telephone: 02 69762183
Fax: 02 69722802

**Batemans Bay Community Health Centre**
Pacific Street
BATEMANS BAY
Telephone: 02 44751620
Fax: 02 44720680

**Batlow Community Health Centre**
Wakehurst Ave
BATLOW
Telephone: 02 69491105
Fax: 03 69491390

**Bega Community Health Centre**
McKee Dr
BEGA
Telephone: 02 64929620
Fax: 02 64923257

**Berrigan Community Health Centre**
Memorial Place
BERRIGAN
Telephone: 03 58885300
Fax: 03 58885359

**Bombala Community Health Centre**
Wellington St
BOMBALA
Telephone: 02 64583166
Fax: 02 64583759

**Boorowa Community Health Centre**
Dry St
BOOROWA
Telephone: 02 63853450
Fax: 02 63853206

**Braidwood Community Health Centre**
74 Monkittee St
BRAIDWOOD
Telephone: 02 48422566
Fax: 02 48422054

**Coleambally Community Health Centre**
33 Brolga Pl
COLEAMBALLY

Telephone: 02 69544297
Fax: 02 69544420

**Coolamon Community Health Centre**
Cowabbie St
COOLAMON
Telephone: 02 69273303
Fax: 02 69273565

**Cooma Community Health Centre**
Cnr Victoria and Bombala Sts
COOMA
Telephone: 02 64553201
Fax: 02 64553360

**Cootamundra Community Health Centre**
37 Hurley St
COOTAMUNDRA
Telephone: 02 69401111
Fax: 02 69401199

**Corowa Community Health Centre**
Guy St
COROWA
Telephone: 02 60331340
Fax: 02 60334397

**Crookwell Community Health Centre**
Kialla Rd
CROOKWELL
Telephone: 02 48321300
Fax: 02 48322099

**Culcairn Community Health Centre**
Balfour St
CULCAIRN
Telephone: 02 60298917
Fax: 02 60297018

**Darlington Point Community Health Centre**
Boyd St
DARLINGTON POINT
Telephone: 02 69684131
Fax: 02 69684131

**Delegate Community Health Centre**
Craigie St
DELEGATE
Telephone: 02 64588008
Fax: 02 64588156

**Deniliquin Community Health Centre**
2 Macauley St
DENILIQUIN
Telephone: 03 58822900
Fax: 03 58822905

**Eden Community Health Centre**
144 Imlay St
EDEN
Telephone: 02 64961436
Fax: 02 64961452

**Finley Community Health Centre**
Dawe Ave
FINLEY
Telephone: 03 58833627
Fax: 03 58831527

**Goulburn Community Health Centre**
Cnr Goldsmith and Faithful Sts
GOULBURN
Telephone: 02 48273913
Fax: 02 48273943

**Griffith Community Health Centre**
Yambil St
GRIFFITH
Telephone: 02 69669900
Fax: 02 69641743

**Gundagai Community Health Centre**
O'Hagan St
GUNDAGAI
Telephone: 02 69441297
Fax: 02 69441878

**Hay Community Health Centre**
351 Murray St
HAY
Telephone: 02 69908732
Fax: 02 69908767

**Henty Community Health Centre**
Ivor St
HENTY
Telephone: 02 69294999
Fax: 02 69294940

**Hillston Community Health Centre**
48C Burns St
HILLSTON
Telephone: 02 69672201
Fax: 02 69672284

**Holbrook Community Health Centre**
Bowler St
HOLBROOK
Telephone: 02 60362787
Fax: 02 60362782

**Jerilderie Community Health Centre**
62 Southey St
JERILDERIE
Telephone: 03 58861300
Fax: 03 58861277

**Jindabyne Community Health Centre**
Bent St
JINDABYNE
Telephone: 02 64572074
Fax: 02 64572158

**Junee Community Health Centre**
77 Lorne St
JUNEE
Telephone: 02 69248207
Fax: 02 69248319

**Karabar Community Health Centre**
12 Southbar Rd
QUEANBEYAN
Telephone: 02 62997299
Fax: 02 62997601

**Leeton Community Health Centre**
Palm and Wade Ave
LEETON
Telephone: 02 69531205
Fax: 02 69531214

**Lockhart Community Health Centre**
Hebden St
LOCKHART
Telephone: 02 69205206
Fax: 02 69205483

**Mathoura Community Health Centre**
Livingstone St
MATHOURA
Telephone: 03 58843301
Fax: 03 58843604

**Moama Community Health Centre**
6 Meninya St
MOAMA
Telephone: 02 5482 4399
Fax: 02 54802707

**Moruya Community Health Centre**
River St
MORUYA
Telephone: 02 44741561
Fax: 02 44741591

**Moulamein Community Health Centre**
54 Barratta St
MOULAMEIN
Telephone: 03 58875012
Fax: 03 58875037

**Murrumburrah-Harden Community Health Centre**

Swift St
MURRUMBURRAH-HARDEN
Telephone: 02 63862200
Fax: 02 63862931

**Narooma Community Health Centre**
Marine Drive
NAROOMA
Telephone: 02 44762344
Fax: 02 44761731

**Narranderra Community Health Centre**
Cnr Douglas and Adams St
NARRANDERRA
Telephone: 02 69591166
Fax: 02 69591063

**Pambula Community Health Centre**
Merimbula St
PAMBULA
Telephone: 02 69457294
Fax: 02 64957448

**Queanbeyan Community Health Centre**
Antill St
QUEANBEYAN
Telephone: 02 62989233
Fax: 02 62996920

**Talbingo Community Health Centre**
Talbingo Medical Centre
TALBINGO
Telephone: 02 69495467
Fax: n/a

**Tarcutta Community Health Centre**
Oberne Rd
TARCUTTA
Telephone: 02 69287258
Fax: 02 69287385

**Temora Community Health Centre**
294-296 Hoskins St
TEMORA
Telephone: 02 69774951
Fax: 02 69774960

**The Rock Community Health Centre**
King St
THE ROCK
Telephone: 02 69202066
Fax: 02 69202502

**Tocumwal Community Health Centre**
Adams St
TOCUMWAL
Telephone: 02 5874 2166
Fax: 03 58742321

**Tooleybuc and Early Childhood**
Flat 2/34 Murray St
TOOLEYBUC
Telephone: 03 50305189
Fax: 03 50305251

**Tumbarumba Community Health Centre**
Albury Rd
TUMBARUMBA
Telephone: 02 69482566
Fax: 02 69482263

**Tumut Community Health Centre**
Simpson St
TUMUT
Telephone: 02 6947 1811
Fax: 02 69472220

**Ungarie Community Health Centre**
Condamine St
UNGARIE
Telephone: 02 6975 9102
Fax: 02 69720401

**Urana Community Health Centre**
Princess St
URANA
Telephone: 02 69208101
Fax: 02 69208263

**Wagga Wagga Community Health Centre**
Docker St
WAGGA WAGGA
Telephone: 02 69386411
Fax: 02 69386410

**Weethalle Community Health Centre**
Bulga St
WEETHALLE
Telephone: 02 69756120
Fax: 02 69720401

**West Wyalong Community Health Centre**
Hospital Rd
WEST WYALONG
Telephone: 02 69722122
Fax: 02 69720401

**Yass Community Health Centre**
Meehan St
YASS
Telephone: 02 62202111
Fax: 02 62202116

**Young Community Health Centre**
Allanan St
YOUNG
Telephone: 02 63828700
Fax: 02 63821047

## Other Services

Public Health

641 Olive Street
Albury NSW 2640
Telephone: 02 60214799 (24 hours)
Fax 02 60214899

**Other offices:**
34 Lowe Street
Queanbeyan NSW 2620
Telephone: 02 61289777
Fax 02 62996363

Mandala House
Bourke Street
Goulburn NSW 2850
Telephone: 02 48241830
Fax 02 48241831

375 Townsend Street
Albury NSW 2640
Telephone: 02 60581700
Fax 02 60581737

Level 2
75 Johnson Street
Wagga Wagga NSW 2650
Telephone: 02 69339100
Fax 02 693391104

**Southern Area Brain Injury Service**

'Carrawarra'
104 Bradley Street
GOULBURN NSW 2580
Telephone: 02 4823 7911
Facsimile: 02 4821 9165

**South West Brain Injury Rehabilitation Service**
PO Box 326
Albury NSW 2640
Australia
Telephone: 02 6041 9902
Facsimile: 02 6041 9928
Email:
swbirs@gsahs.health.nsw.gov.au

## 1800 Numbers

### Mental Health and Alcohol and Drug Services

GSAHS provides a telephone based risk assessment, triage, consultation, support and information service.

This service is provided through:

**Accessline**
**1800 800 944**

Accessline is available 24 hours a day, seven days a week, 365 days a year.

Accessline is the first contact point to access Mental Health and Drug and Alcohol Services within the western sector of GSAHS.

Accessline is staffed by trained mental health professionals. Accessline works with 'on-the-ground' services and has regular contact with case managers to support clients and contribute to care planning.

### Public Oral Health Clinics

**GSAHS: 1800 450 046**
**Griffith: 02 6969 5581**
**Deniliquin: 03 5882 2990**

All clients needing to access Oral Health Services in GSAHS should contact the relevant number.

### Domestic Violence Line
**1800 656 463**

The Domestic Violence Line provides telephone counselling, information and referrals for people who are experiencing or have experienced domestic violence.

### NSW Artificial Limb Service Accredited Clinic

Rehabilitation Department
P O Box 159
Wagga Wagga NSW 2650
Telephone: 02 6938 6344
Facsimile: 02 6040 1359

## GLOSSARY

### A

**ACAT** (Aged Care Assessment Team): A range of health professionals providing assessment, treatment, ongoing management and other services designed to meet the needs of elderly people. They are also responsible for assessing and approving placement into nursing home and hostels.

**Australian Council on Healthcare Standards (ACHS):** promotes a series of health care standards that enable hospitals and health care services to measure their performance.

**Acute Care:** The principal clinical intent is to do one or more or the following: manage labour (obstetric), cure illness or provide definitive treatment of injury; perform surgery; relieve symptoms or illness or injury (excluding palliative care); reduce severity of an illness or injury: protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; perform diagnostic or therapeutic procedures.

**Aged:** The aged population is defined as the group of people aged 65 and older. There are also younger groups of people with aged related needs e.g. dementia and disabilities, for whom it is appropriate to access age care services.

**Allied Health Staff:** Include qualified staff engaged in duties of a professional nature; audiologist, chiropractor and osteopath, dietician, occupational therapist, optometrist, orthopaedist, orthodontist, podiatrist, psychologies, prosthetist, physiotherapist, radiographer, social worker and counsellor and speech therapist.

**Ambulatory Care**: Describes health care services delivered to patients on a "day stay" basis, as an alternative to the patient being an inpatient.

**Antenatal:** The period between conception and birth. Same as ‘prenatal’.

**Audiology:** The study of hearing.

**Audiometry:** The measurement of hearing.

### B, C

**Community:** The people who live in a defined geographical locality.

**Community Based Services:** Services provided in the community.

**Community Consultation:** Consultation is regarded as a form of community participation where views and opinions are sought on specific issues. Consultation processes are usually one-off or short-term and are organised around a specific issue or topic.

**Community Development:** The process of involving people in initiatives to improve their health by supporting community actions to identify and overcome a community’s health problems e.g. Self help groups, support networks, improvements in transport, access to services.

**Community Health:** A service that provides coordinated community based health services to a defined community. Its size and service mix varies. Service components may include physiotherapy, mental health, screening of school children, child health, counselling, drug and alcohol services etc.

**Community Participation**: A range of activities and structures providing opportunities for individuals and organisations that are part of a community to identify issues/needs, comment on policies and programs (proposed and existing) and participate in the decision making process.

**Continuum of care:** The relationships between services so that there is an easy transition for patients either moving from one service to another or receiving care from a number of services.

**D**

**Day Care:** A service that provides personal care and supervision for a person for all or part of a day. This may occur on a regular or respite basis. A range of activities with a rehabilitation focus, to prevent deterioration and retain social skills, for the frail aged and/or disabled.

**Dementia:** An organic mental disorder characterised by a general loss of intellectual abilities involving impairment of memory, judgment and abstract thinking as well as changes in personality.

**Dietetics:** The study and regulation of the diet.

**Domiciliary Care:** A service dedicated to the provision of nursing or other professional paramedical care or treatment and also non-qualified domestic assistance to people in their own homes.

**E**

**ED:** Emergency departments are often recognised by the community as the main entry point into the hospital system. The emergency department operates as the interface between the hospital and the community. Despite location, size or specialty of the hospital all emergency departments provide a minimum standard of care.

**EN:** Enrolled Nurse

**Emergency Services:** Treatment provided on an un-planned basis or in a designated emergency department within a hospital. It is generally expected that the treatment is of a surgical or medical nature.

**F, G**

**Geriatrician:** A specialist in the branch of medicine concerned with the physiological and pathological aspects of the aged, including the clinical problems of being old and senility.

**GP:** General Practitioner

**H**

**HACC:** Home and Community Care

**Health:** A state of complete physical, mental, spiritual and social well-being, not merely the absence of disease or infirmity.

**Health promotion:** Health promotion is the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. It covers a number of approaches aimed at changing living conditions and lifestyles for the purpose of improving health, including health education.

**Home and Community Care (HACC) program**: For the frail aged, people with disabilities, and their carers. HACC services include community nursing, allied health services, personal care, meals on wheels and day-centre meals, home help, home modification and maintenance, transport and community based respite care.

**Home Nursing:** Defined as any nursing service provided to a client in their own home.

**Hostel Care:** Refers to residents in residential accommodation who do not require personal care support.

**Hostels:** Provide residential care for people requiring some form of assistance with daily living. Most do not provide nursing care. Staff are available on a 24-hour call basis and can assist with personal care tasks. Usually Commonwealth funded for low-level care.

**I**

**Integrated Care:** Seamless health care, where all aspects of care are linked and managed in a coordinated manner, to provide more effective and efficient health service provision.

**Intrapartum:** During labour and delivery or childbirth.

**J K, L**

**LAN:** Local Area Network

**LGA(s):** Local Government Area(s)

**M**

**Meals on Wheels:** Meals fresh or frozen are delivered to a person's residence.

**Multi Purpose Service (MPS):** Provide integrated acute, nursing home, hostel, community health and aged care services under one organisational structure, as agreed between the Commonwealth and State governments. MPSs provide a range of services that are negotiated with the community.

**N**

**Neurology:** The branch of science that treats disorders of the nervous system.

**NSW Health:** The NSW Health system is made up of Area Health Services both rural and metropolitan, the NSW Department of Health, Corrections Health Service, the Ambulance Service of NSW and the Children's Hospital.

**Nursing Care:** Type of service provided to a person who needs the assistance of qualified personnel with such things as the taking of medication and administration of an injection.

**Nursing Homes:** Provide accommodation for frail, older people who need ongoing nursing and help with personal care.

**O**

**Occupational Therapy:** A form of therapy that encourages and instructs manual activities for therapeutic or remedial purposes in mental and physical disorders.

**Oncology:** The study of diseases that cause cancer.

**Orthopaedic:** Pertaining to the correction of deformities of the musculoskeletal system; all the muscles, bones, and cartilages of the body collectively pertaining to orthopaedics.

**Outpatient Clinic:** Medical, surgical, diagnostic, nursing or paramedical services are provided to non-residents from a clinic on an appointment basis.

**P**

**Paediatrician:** A medical doctor who treats children and infants.

**Palliative Care:** Palliative care is provided when a person's condition has progressed beyond the state where curative treatment is effective and attainable, or where the person chooses not to pursue curative treatment. Palliation provides relief of suffering and enhancement of quality of life. An approach to care which supports the physical, psychological, emotional, cultural and spiritual needs of a dying person and their family and friends, and includes grief and bereavement support during the life of the patient and continuing after death.

**PANOC:** Physical (and emotional) Abuse and Neglect Of Children. PANOC workers provide a service aimed at assisting children to cope with their experiences and the effects of abuse and neglect. PANOC workers also assist families where abuse of children has occurred to provide a more nurturing environment for children to minimise the chances of re-abuse. PANOC services take referrals of substantiated child physical and emotional abuse and neglect from the department of Community Services and the police. The PANOC services see children and young people aged up to 18 years.

**Physiotherapy:** A physical therapist is a specialist trained to use exercise and physical activities to condition muscles and improve levels of activity. Physical therapy is helpful in those with physical debilitating illness (for example stroke).

**Podiatrist:** A podiatrist is trained to care for feet and recognise mechanical faults. (Podiatrists used to be called chiropodists.)

**Podiatry:** The medical study of the diagnosis and treatment of disorders of the foot.

**Postnatal:** Occurring after birth, with reference to the newborn.

**Primary Health Care:** The components of the health system which places an emphasis on health promotion and disease prevention as well as addressing illness/disability at an early stage. Also refers to an approach to health care that looks at the whole individuals in the whole community to ensure social justice is achieved.

**Psychology:** The science of the human soul; specifically, the systematic or scientific knowledge of the powers and functions of the human soul, so far as they are known by consciousness.

**Q, R**

**Radiology:** The study of X-rays in the diagnosis of a disease.

**Rehabilitation:** Establishments with a primary role in providing services to persons with an impairment, disability or handicap where the primary goal is improvement in functional status.

**Renal Services:** Services pertaining to care of patients with kidney disorders.

**Respite Care:** Provides relief for carers who have the responsibility for ongoing care, attention and support of another person. It provides an alternative form of care and enables the carer to have a break.

**Root Cause Analysis:** This is an investigative process used to review sentinel or major clinical events to determine the causes. This differs to previous investigative processes in that it seeks to determine system issues that may have led to the problem. Recommendations aim to rectify systemic issues, making the environment safer for patients, visitors and staff and reducing the likelihood of the event occurring again.

**S**

**SAFTE:** Sub-Acute Fast Track Elderly Care aims to minimise the need for older people to be admitted to hospital.

**Social Support Services:** Support systems that provide assistance and encouragement to individuals with physical or emotional disabilities in order that they may better cope. Informal social support is usually provided by friends, relatives, or peers, while formal assistance is provided by churches, groups, etc.

**Social Work:** The use of community resources, individual case work, or group work to promote the adaptive capacities of individuals in relation to their social and economic environments.

**Speech Pathology:** The science concerned with functional and organic speech defects and disorders.

**T, U**

**UPI:** Unique Patient Identifier

**V, W, X, Y, Z**

**VMO:** Visiting Medical Officer

**WinPAS:** Windows Patient Administration System