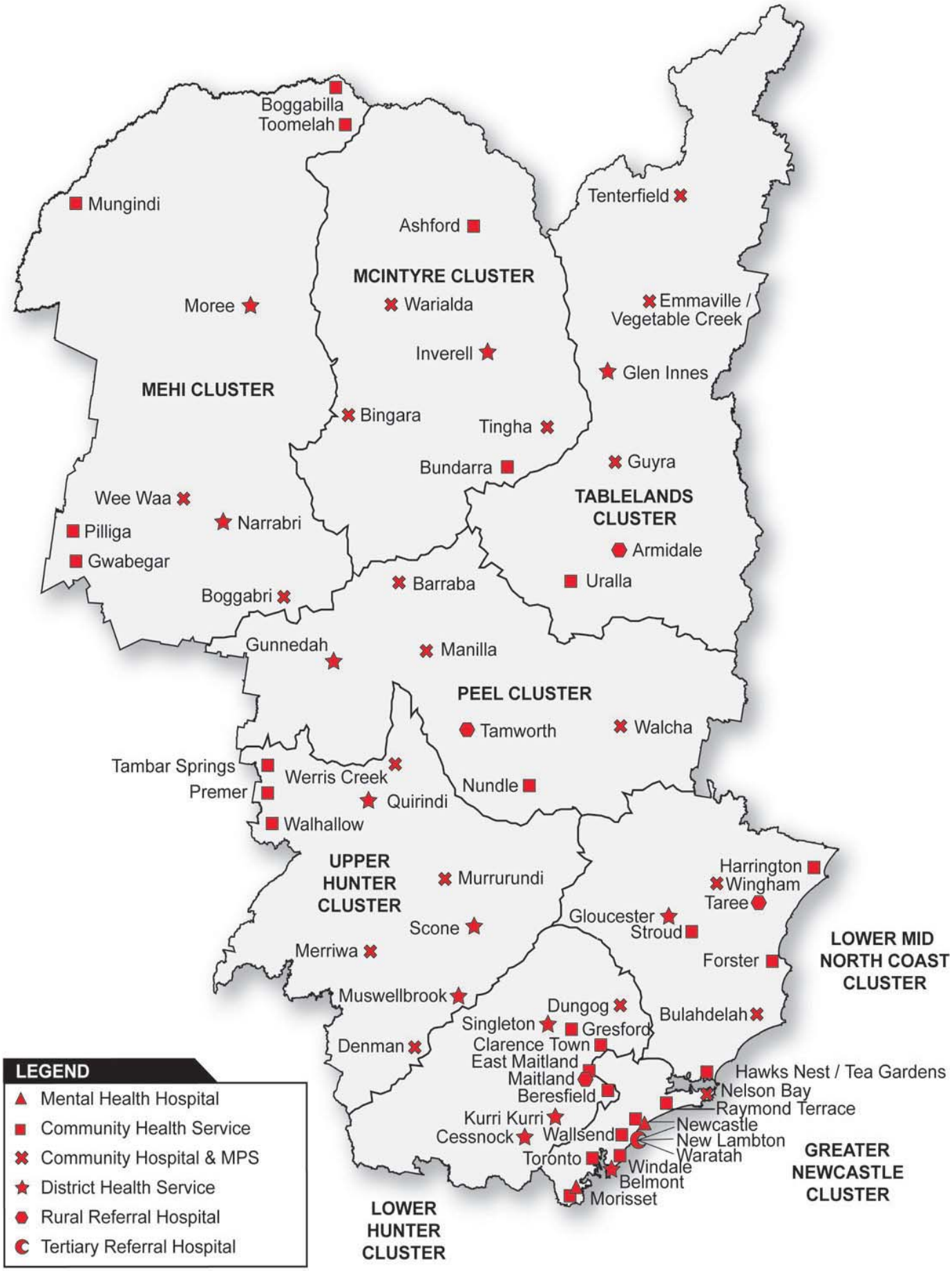
Hunter New England Area Health Service

Annual Report 2005/2006

HUNTER NEW ENGLAND | NSW HEALTH



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All Hunter New England hospitals are open 24 hours.

Letter to the Minister

November 2006

Hon John Hatzistergos MP
Minister for Health
Parliament of NSW
Macquarie Street, Sydney NSW 2000

Dear Mr Hatzistergos,

I have pleasure in submitting the Hunter New England Area Health Service 2005/06 Annual Report.

The Report complies with the requirements for annual reporting under the Accounts and Audit Determination for public health organisations and the 2005/06 Directions for Health Service Reporting.

Terry Clout
CHIEF EXECUTIVE

Contents

2005-2006 Highlights

- Opening of the $100-million Royal Newcastle Centre – the new home of specialist and outpatient services from Royal Newcastle Hospital and some medical, diagnostic and outpatient services previously provided at John Hunter Hospital.

- Highest coverage of immunisation for children 12-15 months of age in NSW with a rate of 92.9 per cent over the past 12 months.

- Winner of two NSW Health Aboriginal Health Awards: one for the Aboriginal Suicide Prevention Package implemented in Tamworth; and the other for Wiyiliin-ta – a partnership with the Awabakal and Aboriginal Medical Service in Newcastle.

- Implementation of new iPM computer software at Lower Mid North Coast hospitals, including Manning Hospital, to give staff improved access to patient information and streamline patient movement throughout the hospital.

- Opening of the $9.6-million Guyra Multi Purpose Service in August, bringing under one roof five acute hospital beds, 17 aged care beds, an emergency department and community health services, as well as co-locating Guyra's Home and Community Care (HACC) services.

- Establishment of a methamphetamine treatment clinic as part of a State pilot to offer a range of targeted information and treatment services to people who use the psycho-stimulant drug.

- $100,000 additional funding over two years for the Memory Assessment Program in Armidale to continue its work in the early detection and coordinated care of dementia sufferers.

- Opening of Stage 2 of Belmont Hospital's redevelopment – providing Lake Macquarie residents with access to a new operating theatre, an upgraded day surgery and new imaging facilities.

- Commencement of the Sub-Acute Fast Track Elderly Care program (SAFTE) - a year-long pilot program, focusing on people older than 75, who are at risk of acute deterioration.

- Enhancement of Tamworth Hospital's Cardiac Catheterisation Laboratory to boost the number of patients treated at the state-of-the-art facility, from 400-500 each year.

- Winner of eight awards at the Baxter 2005 NSW Health Awards, including Best Metropolitan Access Block Performance, and awards in consumer participation, education and training, effectiveness of healthcare and innovation.

2005-2006 Snapshot

Population we care for	837,670
Number of people cared for in our emergency departments	323,536
Episodes of care delivered in a hospital setting	181,786
Average length of stay for acute hospital patients (including same day admissions)	3.4 days
Number of people admitted for same day care (% of total admissions)	43.8%
Non-admitted patient services (includes community health)	2,750
Number of babies born	8440
Percentage of children in the Hunter New England Health region fully immunised at one year	93%

Message from the Chief Executive

Hunter New England Health is committed to building healthier communities and providing excellence in healthcare.

Over the past year we have worked hard to build an organisation that has skilled, enthusiastic and committed staff, a core set of values that are reflected in all that we do, robust systems, strong partnerships, sound financial management and an unwavering commitment to improving people's health.

We have once again met our budget and activity targets. This means we have been able to provide the care and services we promised within allocated resources.

During the past year we have refurbished or built new health facilities across our area, which enable our skilled staff to deliver even better care to local people. Among these was the $100-million Royal Newcastle Centre which opened in March and is now the home of specialist and outpatient services from Royal Newcastle Hospital and some medical, diagnostic and outpatient services previously provided at John Hunter Hospital.

Our service improvement program – the Maggie Program – continues to be rolled out across Hunter New England Health to redesign the way we provide services so we can better care for patients.

We continue to enhance services for all people – from the very young, through to the older people – in our communities. We continue to achieve the highest coverage of immunisation for children 12-15 months of age in NSW with a rate of 92.9 per cent over the past 12 months. And at the other end of the age spectrum, this year we began piloting a program designed to care for elderly people in their homes to avoid the need for hospitalisation - The Sub-Acute Fast Track Elderly Care program.

As an organisation we have invested considerable energy in planning for our health service to become completely Smoke-free by 31 October 2006 – a project which has demonstrated the organisation's leadership in its community and which is sending a strong message to local people about the harmful effects of tobacco smoke.

This year I have had the privilege of meeting an array of inspiring people and I have learnt about hundreds of innovative projects. This Annual Report provides a snapshot of some of this outstanding work and these achievements, as well as our challenges. There is still work to be done, and our commitment to ongoing improvement stands firm.

Each year we are able to deliver these impressive results thanks to the teamwork, skill, dedication, passion and caring of Hunter New England Health's 14,500 staff, 1500 visiting doctors, countless volunteers and our partners in the community. I acknowledge their efforts and commend their work – and am sure our community members are equally as proud.

Terry Clout
Chief Executive
Hunter New England Health

Hunter New England Health

Structure and Responsibilities

Hunter New England Health is one of eight Area Health Services in New South Wales. It is classified as one of four rural Area Health Services, but it is the only one with a metropolis (Newcastle/Lake Macquarie) within its borders.

Hunter New England Health has:

- approximately 14,500 staff (or approx. 10,500 Full Time Equivalents)
- about 1500 medical officers
- more than 1600 volunteers
- an Area Administration office in Newcastle and a Regional Office in Tamworth
- public hospitals/health facilities at: Armidale, Barraba, Belmont, Bingara, Boggabri, Bulahdelah, Cessnock, Denman, Dungog, Glen Innes, Gloucester, Gunnedah, Guyra, Inverell, James Fletcher (Newcastle), John Hunter (New Lambton), Kurri Kurri, Maitland, Manilla, Manning (Taree), Mater Misericordiae (Waratah), Merriwa, Moree, Morisset, Muswellbrook, Narrabri, Prince Albert Memorial (Tenterfield), Quirindi, Scott Memorial (Scone), Singleton, Tamworth, Tingha, Tomaree (Nelson Bay), Vegetable Creek (Emmaville), Walcha, Warialda, Wee Waa, Werris Creek and Wilson Memorial (Murrurundi)
- 56 Community Health Centres

Hunter New England is an area of more than 130,000 square kilometres – the size of England – and:

- spans 25 local council areas and 32 local government areas: Armidale Dumaresq, Barraba, Bingara, Cessnock, Dungog, Gunnedah, Glen Innes, Gloucester, Great Lakes, Greater Taree, Guyra, Inverell, Lake Macquarie, Maitland, Manilla, Moree Plains, Muswellbrook, Narrabri, Newcastle, Nundle, Parry, Port Stephens, Quirindi, Scone, Severn, Singleton, Tamworth, Tenterfield, Upper Hunter, Uralla, Walcha and Yallaroi
- has major employment in industries, manufacturing, retail, health, property and business, education, hospitality, recreation, tourism, government administration and defence, agriculture, viticulture, fishing, mining, construction and communications
- is traversed north to south by the New England Highway and passenger and freight rail lines
- has a growing commercial airport adjacent to the Royal Australian Air Force based at Williamtown
- has the second busiest harbour on the east coast situated at Newcastle

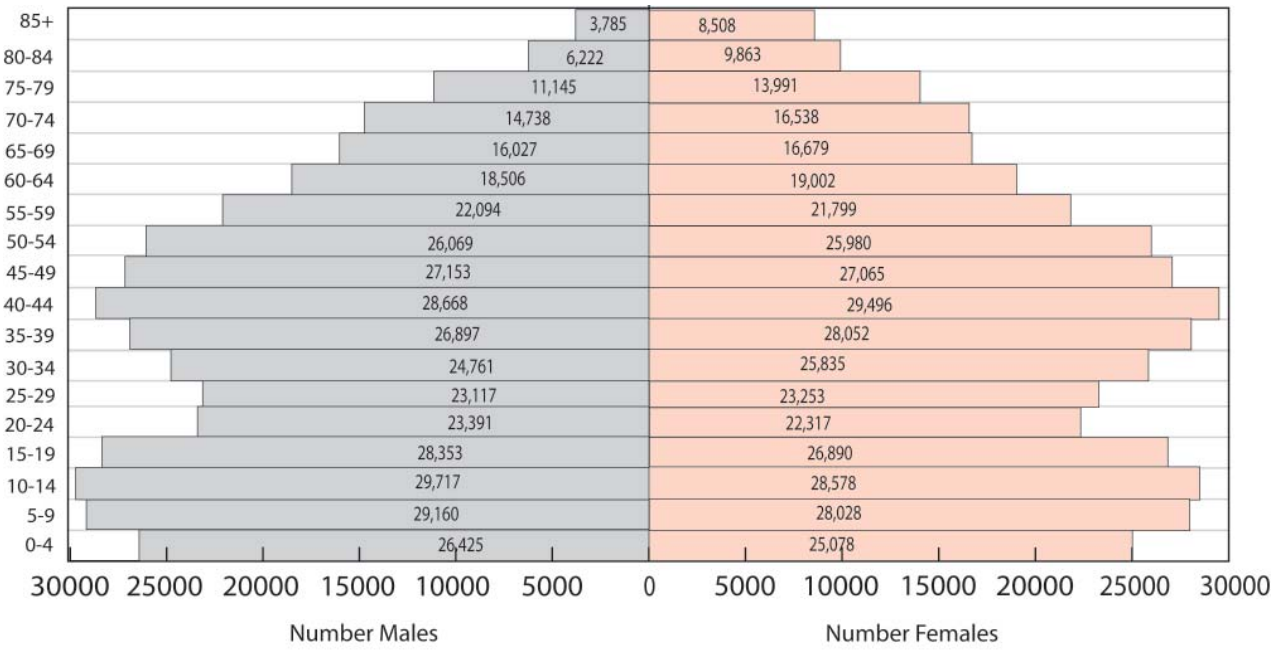
Hunter New England Health's population:

- The Hunter New England Health area currently has a population of 837,670 (DIPNR Dec 2004), approximately 12 per cent of the population of NSW
- The population is widely distributed across the Area: from a densely populated coastal zone to small rural townships with declining populations
- Modest population growth is projected: 2.8 per cent over the next five years (compared to 4.5 per cent in NSW)

reaching 856,870 in 2011 and 875,580 in 2016 (DIPNR Dec 2004)

- The main areas of population growth for 2006-2011 will be in the Great Lakes, Port Stephens and Maitland LGAs
- The Hunter New England Health area has the largest Aboriginal population of all Area Health Services: 21.6 per cent of the State's Aboriginal population or 3.3 per cent of the Hunter New England Health population compared with 2.1 per cent of the NSW population
- There is a high proportion of older people, mainly in the coastal and tablelands areas: 15.5 per cent aged 65 years and older compared to 13.4 per cent for NSW. The proportion of those aged over 80 years is increasing particularly across the McIntyre cluster and on the Lower Mid North Coast
- The highest concentrations of people from non-English-speaking backgrounds are in and around the city of Newcastle where they make up nearly 7 per cent of the population
- Newly arrived refugees are increasing in number across the Area
- Socio-economic disadvantage is spread across the area, particularly where there are pockets of high Aboriginal populations and high public housing/low employment areas. The most disadvantaged Local Government Areas in the Hunter New England Health area are: Moree Plains, Manilla, Tenterfield, Greater Taree, Cessnock and Muswellbrook
- The population aged less than 16 years is 23.9 per cent compared with 23.2 per cent for NSW
- The population of the Hunter New England is projected to increase by 2.8 per cent between 2006 and 2011 (compared with 4.5 per cent in NSW)

Hunter New England Population: ABS 2001 Census



Hunter New England Health

Structure and Responsibilities

Health Network

To effectively manage its vast and complex network of services, Hunter New England Health has divided the area into **eight geographical clusters**. Each cluster has its own unique characteristics, which helped to determine its boundaries. (See Area Health Service map on inside cover.)

Mehi Cluster - Covering the local councils of Moree Plains and Narrabri.

This cluster covers a large geographic area characterised by small widely-dispersed communities, a high Aboriginal population and extremes of wealth and poverty within the same local areas. The development of this cluster allows for equitable resource allocation between two communities which have historically had to compete for resources (Narrabri and Moree). Locating Boggabri, Narrabri, Moree and Wee Waa in the same cluster fosters a more integrated approach to supporting Aboriginal health in the far north-western part of Hunter New England Health.

McIntyre Cluster - Covering the local councils of Inverell and Gwydir, plus the communities of Tingha and Bundarra.

This cluster is characterised by small rural communities. Inverell is the major service town. Bingara and Warialda have several communities of interest but relate more to Inverell for health and welfare services than other towns, such as Moree or Tamworth. Tingha is a town with high levels of socioeconomic disadvantage and a high Aboriginal population. As the Multi Purpose Service is developed at Tingha it is important that strong existing links with Inverell for health service and aged care delivery are supported.

Tablelands Cluster - Covering the local councils of Tenterfield, Glen Innes, Severn, Guyra, Armidale Dumaresq and Uralla.

This cluster supports existing strong links between Glen Innes, Tenterfield and Emmaville, with many health and welfare services shared across these three communities. Armidale is the largest community of interest for all towns in this cluster, other than Tenterfield whose communities of interest tend to be Stanthorpe in Queensland and Lismore on the NSW North Coast. Linking these communities within the one cluster supports and strengthens the existing role of Armidale Community Health Centre as a provider of specialist primary and community health services to the smaller northern communities.

Peel Cluster - Covering the local councils of Tamworth, Walcha, and Gunnedah.

Communities in this cluster relate either to Tamworth as the largest regional centre or to Gunnedah. The Walcha community relates to both Tamworth and Armidale for different services, with social and welfare services generally being provided from Tamworth. Manilla

and Barraba have strong links to Tamworth, strengthened by the recent local council amalgamations.

Upper Hunter Cluster - Covering the local councils of Liverpool Plains, Upper Hunter and Muswellbrook.

This cluster includes health services from the former Hunter and the former New England area health services. It supports the development of a strongly integrated identity for Hunter New England Health by removing old demarcation lines. Murrurundi already supports Quirindi with a visiting GP service and early links with Muswellbrook for access to specialist community-based services have developed. There is already a strong relationship to Muswellbrook for Murrurundi, Scone, Denman and Merriwa.

Lower Hunter Cluster - Covering the local councils of Dungog, Singleton, Maitland and Cessnock.

As the population within clusters increases, geographic size decreases. Communities in the Lower Hunter Cluster are close together geographically and are connected into the Greater Newcastle area via the New England Highway and feeder roads. Despite the proximity to Newcastle there is still a rural component to the communities in this cluster and they differentiate themselves from the Greater Newcastle area. Within the cluster, Maitland, Kurri Kurri and Cessnock all relate to each other, with smaller communities coming into these larger towns. Strong links exist between these communities for health and welfare service delivery.

Lower Mid North Coast Cluster - Covering the local councils of Greater Taree, Great Lakes and Gloucester.

This cluster is characterised by a coastal population with some less populated smaller rural communities to the west. Taree is the major regional centre for the surrounding smaller communities.

Greater Newcastle Cluster - Covering the local councils of Newcastle, Lake Macquarie and Port Stephens.

This cluster comprises the metropolitan component of Hunter New England Health, with communities within the cluster strongly connected through existing health and welfare systems. By maintaining a metropolitan cluster, including feeder suburbs, the Area Health Service can plan service delivery models that suit metropolitan characteristics without imposing these on rural clusters.

In addition to the eight geographic clusters, there are **four acute hospital networks** to support the provision of clinical care as close as possible to where people live. The networks encourage stronger professional links between doctors, nurses and allied health professionals at tertiary referral hospitals and rural referral hospitals. This means stronger support for rural clinicians and better access for rural people to the wide range of hospital services available in the Hunter New England Health area.

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Greater Newcastle Acute Hospital Network – John Hunter Hospital, John Hunter Children's Hospital, Belmont Hospital, Newcastle Mater Misericordiae

Hospital and The Royal Newcastle Hospital.

John Hunter Hospital is a tertiary referral hospital and is the major referral centre for Hunter New England Health. It provides a range of services such as obstetrics and gynaecology, emergency medicine, trauma, cardiology and cardiac surgery, nephrology, kidney transplant, anaesthesia and intensive care, neonatal intensive care, neurology and neurosurgery and a full range of sub-specialty medical and surgical services.

John Hunter Children's Hospital is a tertiary referral facility. It is one of only three children's hospitals in New South Wales and the only such facility in Australia located outside of a capital city. The John Hunter Children's Hospital provides services such as medical, surgical, adolescent and day surgery, sleep unit and Kid's Kare telephone assistance line.

Belmont Hospital is a district hospital that provides services to the East Lake Macquarie area. It provides general medicine, general surgery, day surgery, coronary care, obstetrics and gynaecology and emergency services.

Newcastle Mater Misericordiae Hospital is an affiliated health care organisation owned by the Sisters of Mercy, Singleton. It has an agreement with Hunter New England Health to provide clinical haematology, clinical toxicology, coronary care, drug and alcohol, general medicine, general surgery, intensive care, palliative care, and oncology services.

The Royal Newcastle Hospital provides orthopaedic services, rehabilitation medicine, rheumatology, urology and a range of outpatient services.

Maitland Acute Hospital Network - The Maitland Hospital.

The Maitland Hospital is a rural referral hospital providing services such as specialist services in obstetrics and gynaecology, orthopaedics, paediatrics, general surgery and general medicine, rehabilitation, emergency, coronary care and mental health services.

Manning Acute Hospital Network - Manning Hospital, Taree.

Manning Hospital is a rural referral hospital that provides services such as surgery, medicine, critical care, obstetrics and gynaecology, paediatrics, emergency, oncology, palliative care, rehabilitation, high dependency, allied health and mental health services.

Tamworth / Armidale Acute Hospital Network - Tamworth Hospital and Armidale Hospital.

Tamworth Hospital is a rural referral hospital that provides services such as medicine, surgery, anaesthetics, dental, ear nose throat, obstetrics and gynaecology, cardiology, emergency, intensive care, paediatric, palliative care, rehabilitation, renal, oncology and mental health services.

Armidale Hospital is a rural referral hospital that provides services such as general medicine, surgery, obstetrics and gynaecology, paediatric, geriatric,

anaesthetics and intensive care, dental, mental health and emergency services.

In addition to the geographic clusters and acute hospital networks, Hunter New England Health is establishing a number of **Managed Clinical Networks**.

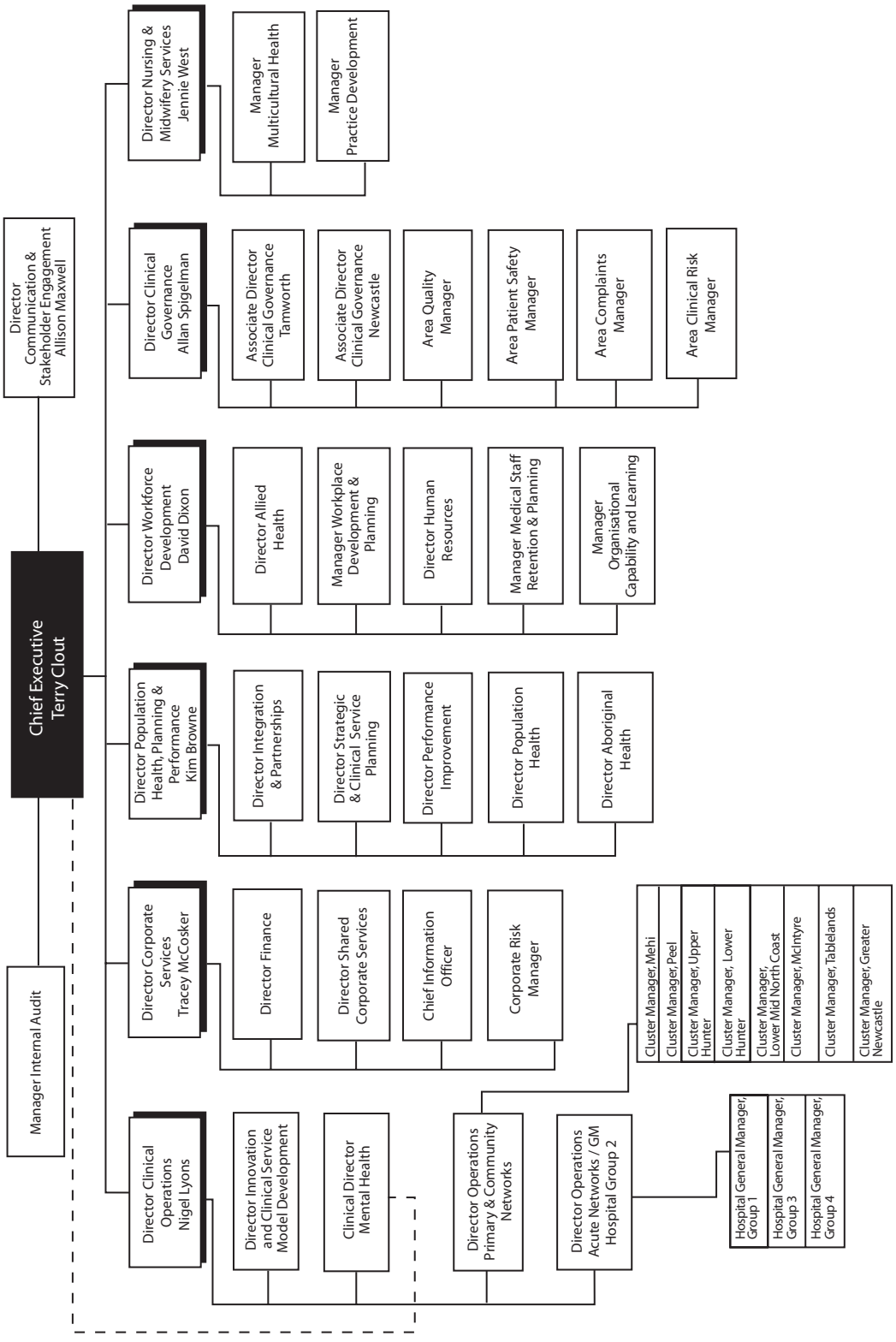
These networks enable linked groups of health professionals and organisations from primary, secondary and tertiary care to work together in a co-ordinated manner, unconstrained by existing professional and organisational boundaries to ensure equitable provision of high quality, clinically effective care. Managed clinical networks shift the emphasis from buildings and organisations towards services and consumers/ carers with a focus on the 'patient journey'.

Hunter New England Health's network of mental health services is an example of how Managed Clinical Networks will deliver services across the area.

Organisation Chart

The Organisation Chart (see next page) shows the management and reporting framework for Hunter New England Health.

Hunter New England Health Organisational Chart



Hunter New England Health

Our Vision, Purpose and Values

Our Vision
Healthier communities: Excellence in healthcare

Our Purpose
Working with our communities to deliver quality health services

Our Values

Teamwork
Working together with our colleagues, community partners and clients to improve the health of our communities.

Honesty
Demonstrating integrity and acting in good faith in all of our communication and actions.

Respect
Recognising the differences and individual worth of our staff and clients and treating each other with fairness, understanding, thoughtfulness, dignity and compassion.

Ethical
Maintaining the highest standards of fairness in all of our dealings and ensuring our decision making is open and transparent and informed by appropriate advice and accepted principles of probity and risk management.

Excellence
Striving to always do the best we can for the community and our staff in every circumstance with the resources available to us.

Caring
Genuinely having the interests of those we serve and those we work with as a primary consideration in everything we do.

Commitment
Making our best endeavour to achieve our vision and to persist in those endeavours regardless of the obstacles confronting us on a daily basis.

Courage
Preparedness to do the right thing in the face of opposition and personal cost.

Our Goals

The primary objective of Hunter New England Health is to:

- promote, protect and maintain the health of the community; and
- provide relief to sick and injured people through the provision of care and treatment.

To achieve this objective, the health service has identified a number of goals.

Healthier people
- Adopting healthy lifestyles.
- Preventing and detecting health problems.
- A healthy start to life.
- Improving mental health and wellbeing.

Fairer access
- Emergency care without delay.
- Treatment when you need it.

Quality health care
- Consumers satisfied with all aspects of services provided.
- Quality care and innovation.
- The right care.

Better value
- Sound resource and financial management.
- Skilled, motivated staff working in innovative environments.
- Strong corporate and clinical governance.

To keep people healthy

More people adopt healthy lifestyles

Vaccination against preventable diseases, the prevention of smoking and excessive alcohol consumption, inadequate physical activity and fruit and vegetable consumption as well as response to and planning for disease outbreaks and disasters are some of the key issues that Hunter New England Health focuses on to improve the general health of its communities.

These areas have been highlighted as national and state priorities and reflect the concerns of the community because of their direct influence on people's quality of life.

A number of initiatives have been developed or continued this year to help address these health problems:

- Vaccination of young children against a number of diseases
- Planning for a potential influenza pandemic
- Encouraging and supporting patients to quit smoking while being cared for in our health service
- Planning for the Health Service to become Smoke-free in late 2006
- Improving responsible service of alcohol in partnership with NSW Police and local Liquor Accords
- Facilitating improvements in healthy eating and physical activity in children and families through implementation of the Kids Healthy Eating and Physical Activity Project
- Planning for the implementation of the Area Falls Injury Prevention strategy
- Enhancing community awareness and understanding of the region's health status, health risks and determinants through the publication of the Health of the Hunter New England Health Report.

DASHBOARD INDICATOR: More people adopt healthy lifestyles

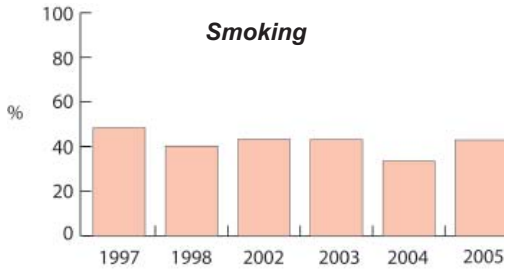
SMOKING

Context

Smoking is responsible for many diseases including cancers, respiratory and cardio-vascular diseases, causing more than 6,500 deaths and 55,000 hospitalisations in NSW each year.

Interpretation

Between 1997 and 2005, the prevalence of daily or occasional smoking among the Hunter New England adult population has decreased from 25.5% to 22.6%.



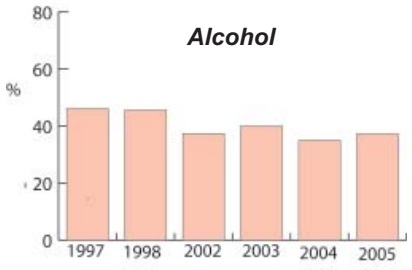
ALCOHOL

Context

Alcohol has both acute (rapid and short but severe) and chronic (long lasting and recurrent) effects on health.

Interpretation

There has been a decrease in the number of Hunter New England adults reporting 'at risk drinking behaviour', from 46.1% in 1997 to 37.3% in 2005



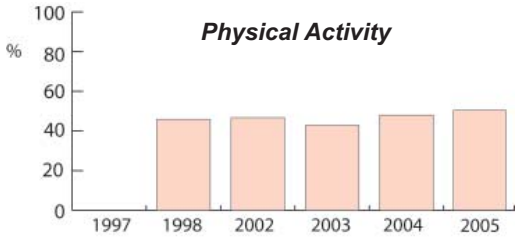
PHYSICAL ACTIVITY

Context

Physical activity is important for maintaining good health and is a factor in protecting people from a range of diseases including cardiovascular disease, cancer and diabetes.

Interpretation

There has been an increase in the number of Hunter New England adults who undertake adequate physical activity, from 45.9% in 1998 to 50.2% in 2005.



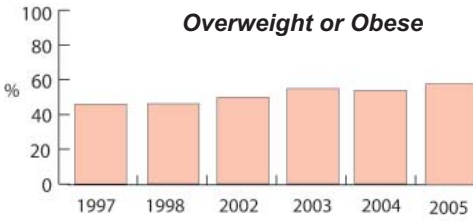
OVERWEIGHT OR OBESE

Context

Being overweight or obese increases the risk of a wide range of health problems.

Interpretation

The percentage of Hunter New England adults overweight or obese has increased from 45.9% in 1997 to 56.6% in 2005.



FRUIT AND VEGETABLE INTAKE

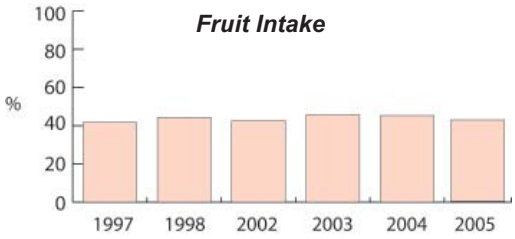
Context

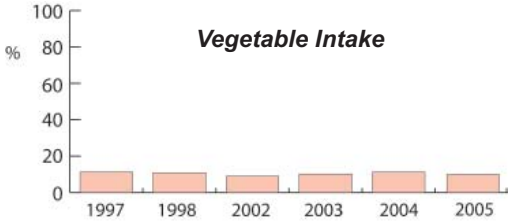
Nutrition is important at all stages in life and is strongly linked to health and disease. Good nutrition protects people from ill-health, whereas a poor diet contributes substantially to a large range of chronic conditions.

Interpretation

There has been a slight increase in the number of Hunter New England people consuming the recommended daily intake of fruit (41.7% in 1997 to 42.5% in 2005). However, the number of people consuming the recommended daily intake of vegetables has dropped to 9.3% over the same period.

Source for all graphs: NSW Health Survey





To keep people healthy

Prevention and early detection of health problems

Reducing fall injury

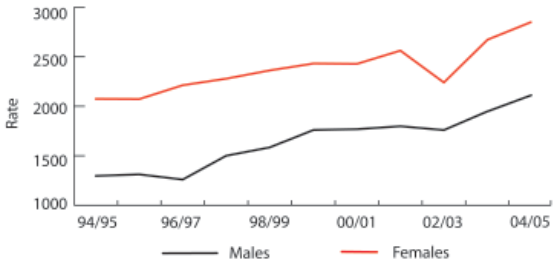
Injuries from falls are a major public health issue and will become even more important with the ageing of the population. The most important and costly consequence of falls for older people is a hip fracture. At least one in three people aged 65 years or older and living in the community will sustain a fall-related injury this year.

Fall-related injury costs the NSW health system more than any other single cause of injury. It is the most common injury related preventable hospitalisation.

Fall-related injuries can also have a significant, ongoing impact on older people, often resulting in a loss of independence, with only half of those admitted to hospital with a fall-related injury able to go home.

DASHBOARD INDICATOR:
Falls in older people

Context: Fall-related injuries are one of the most common injury-related preventable hospitalisations for people aged 65 years and over in NSW



Interpretation: The number of Hunter New England people aged 65 years or over who sustain fall-related injuries has increased from 3370 per 100,000 people in 1994-95 to 4932 per 100,000 in 2004-05. The rate is higher for women than men.
Source: NSW Inpatient Statistics Collection and ABS population estimates (HOIST)

Innovation reducing falls

Over the past year Hunter New England Health has continued to work with residential aged care facilities to reduce the risk and prevalence of fall-related injuries.

Research shows 25 per cent of hip fractures occur in aged care facilities. These patients use a very large number of hospital beds and have a high subsequent mortality rate, as high as 50 per cent or more in the first 12 months after the fracture. Many falls injuries also are preventable.

Hunter New England Health, together with The University of Newcastle, is conducting a three-year research project to reduce falls injuries, especially hip fractures, in aged care facilities. The project, which is funded by NSW Health, under the NSW Health Promotion Demonstration Research Grant Scheme aims to test whether the employment of a project officer to work with aged care facilities on a falls and falls injury prevention program can significantly reduce hip fractures.

A falls project officer has been liaising with aged care facilities to determine their current approaches to falls prevention and facilitate the adoption of best practice falls prevention strategies. The potential savings from the prevention of hip fractures are very large in terms of health care resources and costs.

Immunisation

Immunisation is one of the most effective and cost-efficient public health measures for the control of vaccine preventable diseases.

Hunter New England Health continues to achieve the highest coverage of children in 12-15 months of age in NSW with a rate over the past 12 months of 92.9 per cent compared with the state average of 90.3 per cent. These strong results are achieved through the partnership between Hunter New England Health and general practitioners.

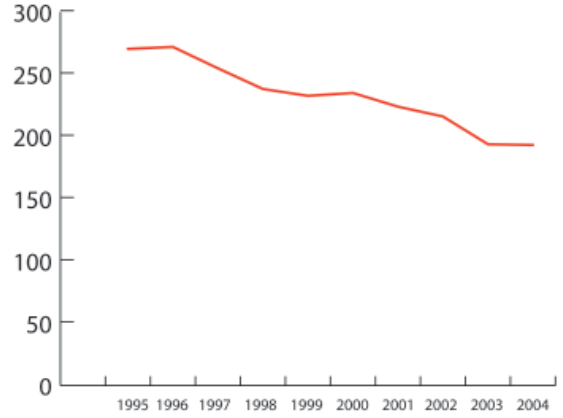
Despite Hunter New England Health achieving the highest immunisation coverage in the state, the Population Health Unit is working with Aboriginal Health in an effort to ensure Aboriginal and Torres Strait Islander children reach and sustain the national target for immunisation coverage of 94 per cent.

Hunter New England Health also oversees immunisation programs for all age groups provided in general practice, public clinics hospitals, aged care facilities and schools.

Hunter New England Health has been working to increase the rates of influenza and pneumococcal immunisation among adults.

DASHBOARD INDICATOR: Potentially Avoidable Premature Mortality

Context: Potentially avoidable deaths are those attributed to conditions that are considered preventable through health promotion, health screening and appropriate treatment. Examining the premature deaths (before age 75 years) provides a measure that is more sensitive to the direct impacts of health system interventions.



Interpretation: The rate for potentially avoidable premature deaths has improved consistently over the period 1995-2004.

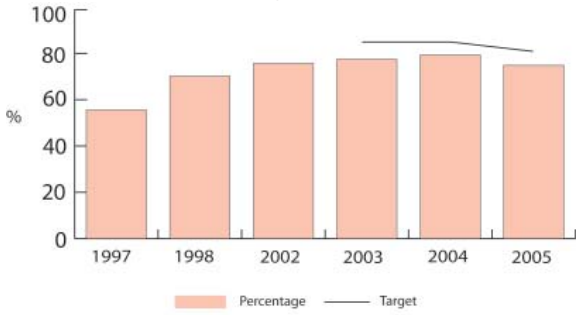
Source: ABS mortality data and population estimates (HOIST).

DASHBOARD INDICATOR: Adult immunisation

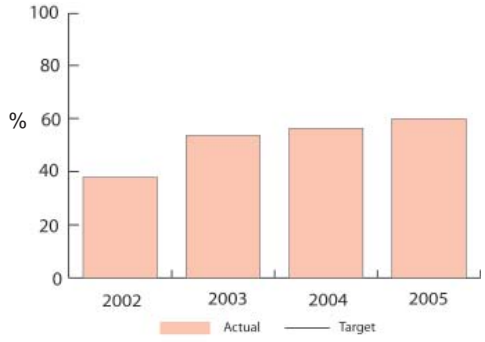
Context

Immunisation is one of the more effective medical interventions for the protection of both individual and the community from death and serious illness. The NSW Immunisation Strategy 2003-2006 sets a target to immunise 85% of people aged 65 years and over against influenza and to increase the number of eligible people who are immunised against pneumococcal disease.

Vaccination against influenza



Vaccination against Pneumococcal disease



Interpretation

There has been a steady increase in the number of Hunter New England people aged 65 years and over who have been immunised against influenza, from 57.5% in 1997 to 73.2% in 2005. The number of people immunised against pneumococcal disease has increased from 39.8% in 2002 to 59.3% in 2005. Hunter New England Health is continuing to work with General Practitioners and residential aged care facilities to improve immunisation rates.

Source: NSW Health Survey, Centre for Epidemiology and Research

To keep people healthy

A healthy start to life

Hunter New England Health employs thousands of midwives across its vast area to provide high level care to mothers and babies 365 days a year.

In 2005–2006 Hunter New England Health made significant progress in implementing a number of cultural changes within the organisation and the community promoting the role of midwives, breastfeeding and innovative delivery of care to Aboriginal mothers and babies.

Of particular note is the ongoing success of the midwifery-led Belmont Birthing Service (BBS). In 2005-06 staff and patients at the BBS celebrated the birth of the 100th baby at the new facility. Since the commencement of the BBS in 2005 midwives have supported 103 women through birth and have cared for 186 women, with 83 giving birth at nearby John Hunter Hospital.

As part of NSW Health's mandatory breastfeeding policy - Promotion, Protection and Support Hunter New England Health has completed an Area-wide breastfeeding policy implementation plan which we expect to roll out in 2007.

Under the plan Hunter New England Health facilities will enhance breastfeeding education and support into routine antenatal care, hospital and maternity care, child and family health services and paediatric services; develop breastfeeding friendly workplaces; and implement the Baby Friendly Initiative.

Other achievements across the Area in 2005-06 include:

- The establishment of a breastfeeding clinic at John Hunter Hospital for mothers who are discharged and subsequently develop breast feeding problems;
- Establishment of a breastfeeding clinic at Tamworth Hospital;
- Establishment of an antenatal clinic at Quirindi Hospital;
- Area-wide training for advanced life support for the neonate provided by the John Hunter Hospital neonatal intensive care staff;
- The establishment of two midwife-group practices at John Hunter birth centre;
- Significant expansion of the antenatal clinic at John Hunter Hospital – including the provision of additional antenatal waiting room and clinic space;
- Introduction of the Skin to Skin program for mothers undergoing elective caesarean section at John Hunter Hospital;
- The start of the Gunnedah Healthy for Life Program;
- Introduction Antenatal Expression of Colostrum at John Hunter Hospital for women whose babies are expected to require admission to the neonatal intensive care unit at birth;
- Successful in obtaining funding from Families First for Armidale Aboriginal Mothers and Babies Service – midwife component.

SWISH

The Statewide Infant Screening Hearing (SWISH) program which provides free hearing screening was introduced in December 2002.

All babies are offered the hearing screen either as an inpatient at their birthing hospital or at one of the many outpatient clinics conducted throughout Hunter New England Health. More than 95 per cent of newborn babies are screened for hearing loss, which is consistent with figures throughout the state.

As a result of the screening program, newborn babies are able to be diagnosed with significant permanent hearing impairment allowing them to access intervention programs early in their lives improving their speech and language outcomes.

Reducing Otitis Media

Hunter New England Health works with a broad group of partners to minimise the impact of ear disease on the long-term health, education and social development of young Aboriginal children.

Otitis media is very common in young children, with about 70 per cent of all children having had at least one episode of otitis media by the age of three years. In Aboriginal children the susceptibility is significantly higher; with infection commencing at a very young age and much more likely to result in chronic forms of otitis media.

The hearing loss resulting from otitis media can impact on the child's speech and language development, listening skills, learning and social development, leading to poor school performance and disruptive behaviour at home and school.
Hunter New England Health is working to assist local communities to identify otitis media, and provide strategies that can be used in the home, pre-school, school and other situations to reduce the impact of the condition.

Local otitis media working parties have been established in Moree, Tamworth, Armidale and Newcastle, enabling Aboriginal people to work within their local communities to provide education to young Aboriginal families and education organisations.

Mubali (pregnant) Mothers

Gamillaroi Community Midwifery Service at Moree, together with the Gamillaroi Community Midwifery Service led innovative health care practice for mothers-to-be in the Moree region.

The project (Mubali) encouraged young Aboriginal women to participate in a mothers group, enhancing their trust in health care providers and improving self-confidence. As part of the ongoing workshops, the women created plaster moulds of their pregnant bellies.

With death rates amongst Aboriginal mothers and babies more than twice that of non-Aboriginal Australians, the program was aimed at improving the statistics and making a real difference in people's lives.

The project involved a series of workshops to make and paint the belly moulds and we invited the community to observe this creative process.

The painted casts were displayed at a launch which also celebrated the involvement of the young women – all of whom have since had their babies and received postnatal follow-up from the Gamillaroi Community Midwifery Service.

The Mubali project was one of eight Hunter New England Health projects to be named a winner at the 2005 Baxter NSW Health Awards.

To keep people healthy

A healthy start to life

Newborn Services

Activity in the Neonatal Intensive Care Unit at the John Hunter Children's Hospital increased from 840 patients in 2005 to 961 patients in 2006. Additional funding of $2.9 million over three years allowed the Unit to expand to a 41-bed nursery supported by increased staffing levels.

Clinical areas previously given over to storage necessitated capital works construction of an additional storage area.

Neonatal Resuscitation Training

As the sole tertiary neonatal unit covering the Hunter, New England and North Coast of NSW, the John Hunter Children's Hospital Neonatal Intensive Care Unit (NICU) devised an outreach education program to ensure those involved in the care of newborn infants had access to resuscitation training. The resuscitation program was presented at 11 regional hospitals to an audience of 250 participants from 26 health service units. Of the participants present, 50 per cent had worked with newborns for less than 10 years. In May 2006, 40 facilitators were trained in updated neonatal resuscitation guidelines as well as evidence-based educational principles to ensure continuation of the program.

Newborn Retrievals

Because of increased staffing and bed number with the enhancements, NICU has been able to increase retrievals to the John Hunter Children's Hospital NICU as well as accepting in-utero transfers to obstetrics.

When babies get sick they get sick very quickly, so the ability to get out fast and bring them safely back to the NICU is vital. Our aero-medical retrieval service has grown dramatically expanding from 6 retrievals in 2003 to 60 in 2006. This year a significant donation from Xstrata Coal combined with other fundraising efforts totalling $180,000 meant a new purpose-built retrieval unit is able to be purchased. The retrieval unit is used to transport, by helicopter or ambulance, critically ill or premature babies born in regional areas to the nearest available intensive care bed.

Influencing Breastfeeding

The Kaleidoscope Greater Newcastle Child and Family Health Nursing Service (CFHN) has endeavoured to promote, protect and support breastfeeding through the implementation of Early Bird groups and Lactation Clinics. The Early Bird groups are offered as an open style, drop-in group for parents with infants aged 0-8 weeks. Parents can attend the group within the first week of leaving hospital. Participation at Early Bird groups help to reduce waiting times for new mothers for a CFHN appointment and offers peer support for breastfeeding from other breastfeeding mothers. The Lactation Service is a bi-weekly, morning specialist lactation service staffed by qualified lactation consultants for women having breastfeeding problems.

Research indicates that access to post-natal groups and to health professionals such as lactation consultants, by

mothers experiencing breastfeeding problems can influence the duration of breastfeeding (Hector, King and Webb, 2004).

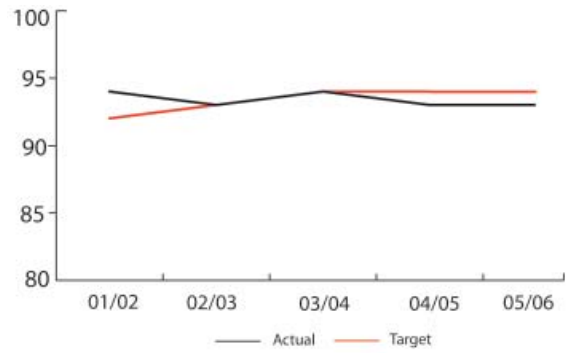
Immunisation

All of Kaleidoscope's Child and Family Health Nurses in Greater Newcastle are accredited Nurse Immunisers. Most Child Health Centres are equipped with vaccine fridges and dry goods for immunisation, allowing nurses to immunise at centres or opportunistically in the home.

Kaleidoscope provides free weekly immunisation clinics in Newcastle and Lake Macquarie. Families not able to attend free clinics or their GP are immunised in the home.The service immunises around 3000 children each year.

DASHBOARD INDICATOR:
Children fully immunised at 1 year %

Context



Interpretation

Source: Australian Childhood Immunisation Register (ACIR)

Molly's story

Neonatalogists at the John Hunter Children's Hospital first met Molly when she was born five weeks prematurely and required transfer from The Maitland Hospital. The surgeons met her soon after.

Molly was born with a very rare syndrome that affects about one in 40,000 babies – Vater Syndrome. The battle had begun.

Vater Syndrome consists of abnormalities affecting the vertebrae, heart, oesophagus, kidney, anus and limbs. At just one day old Molly had her first life-saving surgery; she'll endure up to six more before her second birthday.

Molly's story is one of challenge and hope. For the first two months of her life, the John Hunter Children's Hospital was home.

Thanks to the skill and efforts of our paediatric surgeons and the support of a dedicated multidisciplinary team, Molly has returned home to Maitland and although she'll be back, her healthcare team are confident that she will lead a healthy normal life.

To provide the care people need

Emergency care without delay

Hunter New England Health has 36 hospitals, which provide emergency services 24 hours a day to more than 296,000 people each year.

Hunter New England Health has made significant progress during 2005-06 in both triage and access block targets (see panel over for more on triage categories).

Despite an increase in the number of people attending emergency departments for treatment, almost all of Hunter New England Health's hospitals improved access block from July 2005 to June 2006.

Hunter New England Health reduced its access block (the percentage of patients who spend longer than eight hours in the emergency department once their treatment has commenced until they are admitted to the hospital) from 16 per cent in 2004-05 to 13 per cent in 2005-06, which is well below the NSW Health benchmark of 20 per cent.

Hunter New England Health's achievements and ongoing commitment to reducing access block were recognised both nationally and internationally. For example in October 2005 the health service was awarded the Baxter 2005 NSW Health Awards Best Metropolitan Access Block Performance.

Hunter New England Health also received international recognition, with John Hunter Hospital's Emergency Department awarded the prestigious Press Ganey Satisfaction Measurement 2005 Success Story Award.

While the performance results show the good work being done by our hospitals, there is still more work to do to continue improvements with emergency department access and care.

For example, Hunter New England Health has worked closely with the NSW Ambulance Service to develop an Ambulance Matrix system in emergency departments across the Hunter region. The Ambulance Matrix is a web-based system, which enables emergency departments to obtain information about ambulance arrivals and their status. This system allows hospitals to pro-actively manage inbound ambulance demand and proactive resource planning to assist in improving access block.

DASHBOARD INDICATOR: Emergency Department access block

Context
Reducing waiting times for admission to hospital from the emergency Department contributes to better patient comfort and the effective use of the Emergency Department services.

Access Block - Emergency Department patients not admitted to an inpatient bed within 8 hrs of commencement of active treatment (%)

Interpretation
Hunter New England Health has continued to reduce access block over the past three years, from 27 per cent in 2002-03 to 19 per cent in 2003-04 to 16 per cent in 2004-05 and 13 per cent in 2005-06. These figures are below the NSW Health benchmark.
Source: EDIS

Triage Categories

The triage system is universally recognised in the assessment of emergency department patients.

1. Resuscitation (critical)
   Life threatening, such as motor vehicle accident, cardiac arrest or burns
2. Emergency (serious)
   Could be life threatening and needs prompt attention, such as a heart attack or stroke.
3. Urgent (stable) Stretcher wounded or chest pain
4. Semi-urgent (satisfactory)
   Walking wounded, such as broken arm, cuts of appendicitis
5. Non-urgent
   Long standing problem present for more than one day, such as cough, cold or sore throat.

Enhancement of the retrieval service

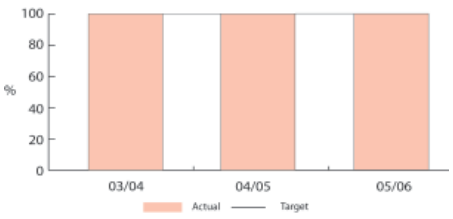
An enhancement of the Hunter New England Health (Southern) Retrieval Service is providing front-line care and treatment before the patient is transported to an appropriate hospital. With such a large geographical area to cover, the retrieval service is a key regional provider in the state-wide retrieval network. It provides the vital link between our hospitals.

Hunter New England Health is continuing to support rural emergency workers to provide the best possible care and treatment. Funding of $720,000 to enhance the service is allowing us to perform around 500 retrievals each year and deliver critical care to patients. The funding also supports Hunter New England Health's participation in the state-wide Critical Care and Trauma plans.

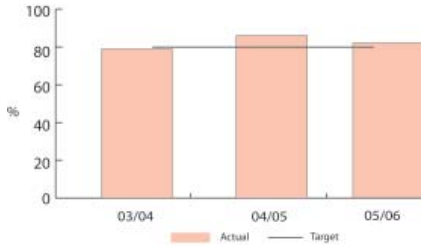
DASHBOARD INDICATOR: Cases treated in benchmark times

Context
Reduced waiting time for admission to hospital from the Emergency Department contributes to better patient comfort and the effective use of emergency Department services

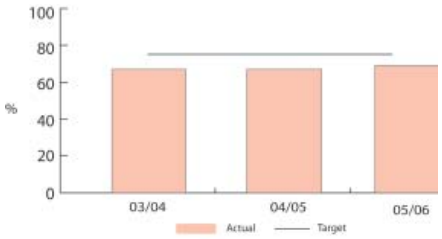
Triage 1 (within 2 minutes)



Triage 2 (within 10 minutes)

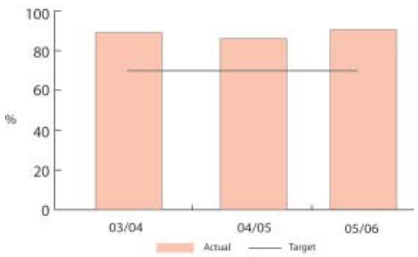


Triage 3 (within 30 minutes)

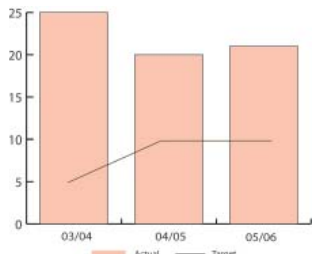


Triage 4 (within 60 minutes)

Triage 5 (within 120 minutes)



Off Stretcher time >=30 from ambulance arrival



Interpretation
Hunter New England Health has continued to reduce access block over the past three years, from 27 per cent in 2002-03 to 19 per cent in 2003-04 to 16 per cent in 2004-05 and 13 per cent in 2005-06. These figures are below the NSW Health benchmark.
Source: EDIS

To provide the care people need

Case Study

Improving waiting times in Emergency Department

Tamworth Hospital is a 270-bed facility with a 24-hour Emergency Department, treating 39,762 people at its Emergency Department each year.

The facility has been involved in the roll out of a highly successful “Maggie Program”, which assist doctors, nurses and allied health professionals to improve waiting times in the ED. It’s designed to improve the level of communication between patients their families and the hospital staff.

Using a consultative approach involving frontline staff, clinicians, managers, consumers and other stakeholders, a number of solutions for improvement were identified which included:

- The creation of a ‘bed booking checklist’ to ensure a more informed and timely bed allocation process for patients who are admitted to hospital from the Emergency Department
- The creation of an Emergency Department ‘Fast Track Team’ to streamline care for low acuity and non-urgent patients, freeing up other staff to treat those with more serious needs
- Clear definition of staff roles to improve coordination of patient care and reduce duplication
- Enhanced communication between staff and patients ad their family to reduce anxiety.

The service redesign project resulted in:

- A reduction in the number of patients waiting longer than 30 minutes from the time of arrival to time of triage from 59 per cent to 21 per cent
- A reduction in the number of patients waiting longer than 60 minutes from the time of arrival to time of triage from 60 per cent to 36 per cent
- The introduction of a mental health liaison nurse in the Emergency Department after hours has seen a reduction in the number of mental health clients who have extended waiting times.

Shorter waiting times for booked non-emergency care

Hunter New England Health has a large number of hospitals and serves a very large region. A key priority for Hunter New England Health is to improve access to health care for people in our communities. Throughout 2005-06, our focus has been particularly in the area of reducing long waits for elective surgery.

The 2005-06 budget provided an additional $5.3 million to reduce waiting lists for elective surgery.

This money allowed:

- Additional surgery at John Hunter, Maitland, Royal Newcastle and Manning hospitals
- Upgrade of theatre and ward equipment at Manning Hospital,
- Additional funding for adult and paediatric intensive care beds

As a result, Hunter New England Health has made significant progress in reducing the number of people waiting longer than 12 months for non-medical and surgical treatment.

For example in July 2005 there were 338 patients who had been waiting longer than 12 months for their surgery in Hunter New England Health. By June 2006 this number was reduced to nine. The number of patients waiting more than 30 days for their surgery was reduced from 236 in July 2005 to 126 patients in June 2006.

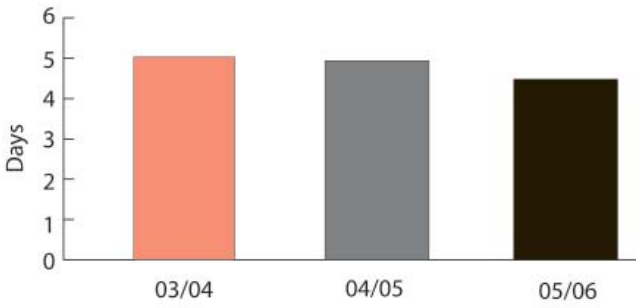
The reduction in waiting lists has been achieved through a number of strategies, included targeted recruitment of medical specialists, targeting a specific long wait lists, increased auditing and clinical review of waiting lists. This has all be achieved against a backdrop of an increasing emergency surgery workload. We will continue to work on our goal to ensure that no patient in Hunter New England Health waits longer than 12 months for their surgery.

Hunter New England Health has been actively recruiting and attracting medical specialists to work in the region in response to workforce shortages.

DASHBOARD INDICATOR: Length of Stay

Context

Reducing the average length of stay of hospital patients allows health services to treat more people, more effectively within the available resources.



Interpretation

Hunter New England Health is continuing to reduce the average length of stay patients require hospitalisation from 5.03 days in 2003-2004, to 4.94 days in 2004-05 to 4.5 days in 2005-06. Improvements identified through the health service's Maggie Program have contributed to the reduction in average length of stay and improved the patient's journey. *Source: ISC*

To provide the care people need

Transfer of Care Coordination Project improving access

In October 2005, the Transfer of Care Coordination Project was established to enable Hunter New England Health to more consistently manage the transfer of patients between facilities and healthcare teams.

Staff from across the area health service worked together with consumers to develop a range of improvements focused on standardising transfer and discharge processes to improve patient access to Hunter New England Health hospitals.

Examples improvements include the:

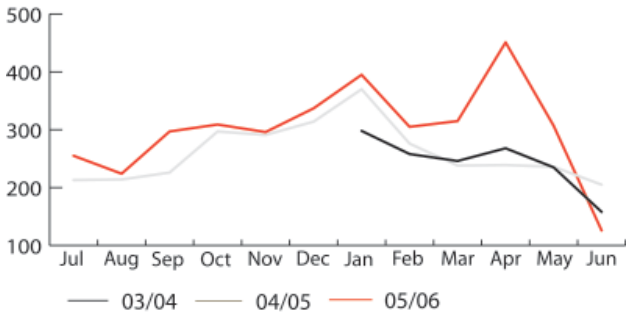
- Rollout of multidisciplinary patient planning sessions
- Standardisation of role responsibilities and accountabilities for staff that have primary responsibility for patient access
- Development of a set of core principles and rules for patient transfers
- Development of an electronic service directory to assist clinician decision making when transferring patients
- Implementation of strategies to involve patients in transfer decisions and improve communication with patients and their families

Each of these changes will play an important part in achieving the project goal of ensuring patients receive the right treatment, at the right location at the right time.

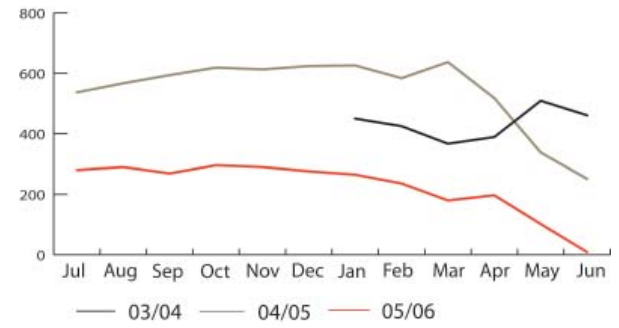
DASHBOARD INDICATOR: Long Wait lists

Context
Better management of waiting lists results in a lower proportion of patients experiencing excessive wait for treatment.

Bookied medical and surgical patients waiting more than 30 days



Booked medical and surgical patients waiting more than 12 months



Interpretation
The number of Hunter New England patients waiting longer than12 months for booked medical or surgical treatment declined significantly from 461 in 2003-04, to 251 in 2004-05 and then down to 9 in 2005-06. *Source: ISC*

Fair access to health services

In March 2006, The Premier of NSW the Hon Morris Iemma officially opened Hunter New England Health's new $100-million Royal Newcastle Centre. The facility is the new home for many of the specialist services from Royal Newcastle Hospital and some of the medical, diagnostic and outpatient services previously provided at John Hunter Hospital.

It enables Hunter New England Health to significantly expand its focus in the area of providing care for people who do not require overnight stays in hospital, which is becoming increasingly more important in health care provision.

The Royal Newcastle Centre staff provide treatment for patients in specialities such as orthopaedics, orthopaedic rehabilitation, rheumatology, urology, ophthalmology, dermatology, diabetes, immunology and podiatry.

Other clinical services include medical and surgical outpatients, cardiac catheterisation, endoscopy, diagnostic radiography, pathology testing, surgical services, interventional procedures and an integrated pain service.

It has 84 inpatient beds and 60 interventional suite beds.

Improving care for the elderly

In March 2006, a pilot program designed to care for elderly people in their homes and avoid the need for hospitalisation commenced in Newcastle and Lake Macquarie residents. The Sub-Acute Fast Track Elderly Care program (SAFTE) is designed to reach elderly members of the community aged 75+ (or 55 for Aboriginal/Torres Strait Islanders).

The SAFTE program seeks to minimise admissions to hospital and improve quality of life by better co-ordinating services in the community to provide care to frail older people.

The program responds to early identification of a person's deteriorating condition by providing appropriate health assessment and community service management, thus reducing the likelihood they will end up in the Emergency Department.

Services are provided by Community Health, Community Options and the Referral and Information Centre benefiting patients in the Newcastle and Lake Macquarie areas. The John Hunter Hospital is one of four sites across NSW selected by the State Government to pilot the $4-million, 12-month program.

Improved outpatient care

The establishment of the Referral Management Centre for the outpatient services at the Royal Newcastle Centre is providing direct and personalised feedback to the patient in relation to their outpatient booking.

The Referral Management Centre is a way of managing the referrals made to the outpatient services of the Royal Newcastle Centre to provide a unique patient focus.

To deliver the care people need

Previously, when patients were referred to see a specialist at the outpatient clinics of the John Hunter and Royal Newcastle hospitals, they would need to contact the individual hospital and make an appointment.

Now, the staff members at the centre receive the referral directly from a GP or other clinician and then contact and co-ordinate the appointments on behalf of the patient.

Mental Health Services

A pilot project in the former Mid North Coast in 2003/04 identified the need to improve access to mental health services in the rural and remote parts of NSW. As a result, funding has been allocated to all rural areas to improve access. For Hunter New England the focus of these initiatives has been in the Lower Mid North Coast and Northern sectors.

The project has involved improvement in services in a number of areas:

- The initial focus has been to recruit mental health staff to work in the Emergency Departments of Taree, Tamworth and Armidale. This will improve and increase the assessment capabilities in those three Emergency Departments to identify people with a mental illness and to recommend the most appropriate treatment and support options. Once employed the appointment of additional staff will also allow the Clinical Nurse Consultant based at Tamworth to provide education and training to the small Emergency Departments within the rural areas.
- The availability of a consultant psychiatrist after hours to assist with inquiries and support to staff after hours
- Establishment of a contact centre for all referrals. This allows all referrals to be managed in one location and then allocated to the most appropriate service. Currently this number operates on a five day a week basis with transfer to the Banksia Unit after hours.
- The final plan is for the introduction of a transport system. Discussions with Police, Ambulance and other health services in the northern sector have occurred. The model being proposed has been agreed and the fine detail is now being completed. Once implemented it is expected this will reduce the demand on police and ambulance, although their expertise will continue to be required from time to time.

The full roll-out of this initiative will improve access for rural and remote patients of Mental Health Service for Hunter New England.

Innovative initiatives at Gunnedah

Gunnedah Health Service received $200,000 in 2006 to run two innovative health programs to benefit the local community - NSW Health's Community Health Risk Factor Management project and the Commonwealth's Healthy for Life program.

Phase 1 of the Healthy for Life project focuses on developing interventions that will allow the health service in partnership with local Aboriginal people to expand and improve existing chronic disease and mothers and babies services for the Aboriginal community.

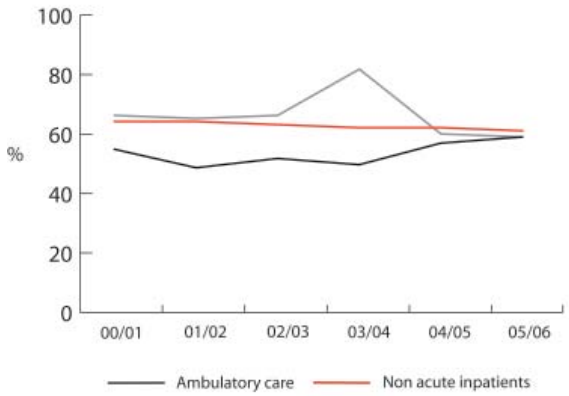
The Community Health Risk Factor Management Research Project aims to increase the capacity of community health services to address the chronic disease risk factors of smoking, nutrition, alcohol, and physical activity as part of their normal clinical work.

These projects are giving us the opportunity to really focus on these specific issues in the community and formulate ways we can address some core health problems and hopefully promote a healthier lifestyle. It also reflects a proactive culture within the health service to seek out new and innovative ways to provide services to the local community.

DASHBOARD INDICATOR: Mental health needs met

Context

The mental health of the population reflects broad social and economic factors, and indicates the effectiveness of mental health prevention, promotion and care programs. There have not been too many significant many changes to the indicators in the past 12 months.



Interpretation

Hunter New England Health continues to make improvements in meeting the needs of those with mental health problems. There has been a significant increase in meeting the needs of acute inpatients from 67 per cent 2001/01 to 84 per cent 2005/06.

Source: DOHARS (Acute inpatient, Non-acute inpatient), National Survey of Mental Health Services (Ambulatory Care)

To deliver high quality services

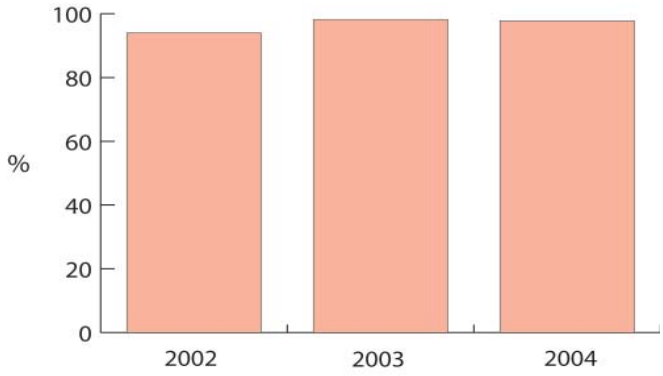
Satisfied Consumers

Ensuring patients and clients are satisfied with the health services we deliver is a key priority for Hunter New England Health. We strive to improve the consumer experience by continuing to look for improvements in patient journeys and in the delivery of high quality health services.

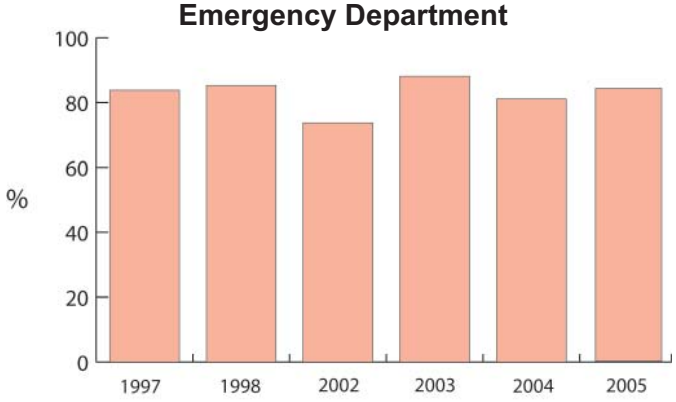
Consumer satisfaction surveys and results from our many quality improvement projects are used to measure consumer satisfaction with our health services.

DASHBOARD INDICATOR:
Patient and consumer experience

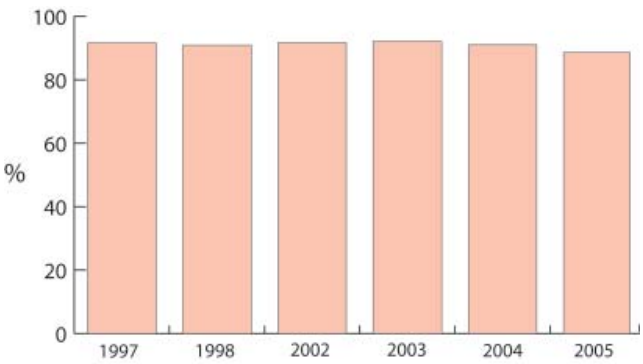
Community Health Centre



Emergency Department



Hospital Inpatient



Context
People attending an emergency department, hospital or community health centre in the past 12 months were asked to rate the care they received during the attendance. A rating of 'excellent', 'very good', or 'good' was considered to be a positive rating of care.

Interpretation
Overall, the percentage of people giving a positive rating of their care at hospitals, community health centres and emergency departments has remained high since 1997 (greater than 70 per cent). In 2005, 84.1 per cent of people attending an emergency department in Hunter New England, 88.6 per cent of people attending a hospital and 97.8 per cent (2004 figures) of people attending a community health centre gave a positive rating of their care. With the exception of emergency department visits which has improved by three per cent, these figures are slightly lower than in 2004, but remain at very high levels.

Source: NSW Health Survey, Centre for Epidemiology and Research

Maggie Program

Hunter New England Health's Maggie Program is fundamentally redesigning healthcare systems by focusing on improving patient journeys. We are doing this to maximise the safety and satisfaction of patients and staff.

Consumer satisfaction surveys are routinely conducted during the diagnostic phase of each Maggie Program project. Consumer satisfaction is then measured on an ongoing basis as part of overall performance measurement.

Patient Complaints

We strive to resolve complaints as soon as practicable. Recognising that a proportion of complaints may involve complex issues that take longer to address, the NSW Health system has a benchmark of 80 per cent of complaints resolved within 35 days. Figures compiled from the Statewide Complaints database show Hunter New England Health received 1310 complaints in 05/06. Of these complaints, 66 per cent percent were resolved within 35 days.

Quality Care And Innovation

Seven Hunter New England Health projects were named as finalists in the 2005 Baxter NSW Health Awards. These major annual awards recognise excellence and innovation in the public health system.

The projects are great examples of how individuals in the health system are working as a team with colleagues and other organisations to improve systems to the health benefit of people across Hunter New England Health and across the state.

2005 Baxter NSW Health finalists.

Mubali

Category: Consumer participation
Gamillaroi Community Midwifery Service, Moree, together with an Arts-Intervention organisation, has successfully targeted and engaged young pregnant Aboriginal women - encouraging participation in group activities, enhancing trust in their health providers and working to improve self-confidence and inspire creativity. This has been achieved while providing opportunities for health education and care. Workshops were delivered encouraging the young women to participate in a creative process in which plaster casts were made of their pregnant bellies and the hands of the midwifery team. Aboriginal aunt and grandmother elders provided cultural stories relating to family and birthing and with the young women were involved in painting the moulds, connecting health care back into the community. Ongoing involvement has brought improved participation in the Young Mothers Group, increased comfort with the Health Service and the community art activities have led to the launch of the 'Mubali' (pregnant) project as a local exhibition.

Children's Emergency Care Project

Category: Effectiveness
12 Paediatric Clinical Practice Guidelines (including those for gastroenteritis and asthma) were released by NSW Health and required implementation in emergency facilities

To deliver high quality services

across NSW. Representatives from Armidale District Hospital, Tamworth Hospital and Warialda MPS joined a statewide project with the Clinical Excellence Commission (CEC) to develop successful strategies for guideline implementation in the emergency setting. Site-specific approaches that recognised the role of emergency staff, clinical structures and processes as well as evidence for implementation were used by the Pilot team. The team developed many successful implementation strategies and conducted systematic audits to monitor changes in practice and to identify areas for continual improvement. Significant improvements were achieved at all three sites, as measured by targeted key clinical indicators. The Pilot Team has been identified as a State leader in the project and the model of implementation has been adopted by many other participating health services.

Enhancing Clinical Skills of a Rural Workforce: Intravenous Cannulation - a National Unit of Competence

Category: Education and training
Intravenous cannulation (IVC) is a very widely performed invasive procedure within the healthcare setting, with up to 80 per cent of patients being admitted to hospital receiving intravenous therapy. Healthcare facilities within the Northern region of Hunter New England Health had for many years provided non-accredited IVC training programs targeted, in the main, at registered nurses (RNs). Following a review of IVC practices and requests from clinicians, namely medical, nursing and allied health professionals, a partnership between NEAHS and Tafe NSW New England Institute was formed in 2003. The main task of the partnership was to develop a competency-based course curriculum and e-learning resources which enabled high quality delivery of education and training in intravenous cannulation aligned to the national unit of competence. The final product which is transferable across Australia promotes best practice in IVC including: infection control; occupational health and safety; wound and clinical product management.

Home Enteral Nutrition Reform in the Hunter Region

Category: Innovation and excellence certificate
Home Enteral Nutrition (HEN) is the provision of commercially formulated enteral (tube fed) or oral nutrition products to people living at home. In response to consumer and clinician dissatisfaction with existing HEN systems, the project designed and implemented a new service delivery model. Previously, clients were required to collect supplies from hospitals at considerable inconvenience, time and cost. Clients paid different amounts for identical products – from full price to nil – with no basis for price variations. The project introduced a home delivery service with standardised arrangements for delivery regardless of where the client lived – rural or metropolitan. A new fee structure was implemented, including a safety net to support disadvantaged people and clients with temporary extenuating circumstances. This ensured equitable contribution by clients. Following the implementation

of this project, evaluation has reported high levels of satisfaction by clients and has been met with enthusiasm from clinicians and managers.

Nocturnal Haemodialysis

Category: Innovation and excellence certificate

Over recent years there has been increasing interest in different haemodialysis regimes intended to address the issues of inadequate dialysis, poor quality of life and limited economic resources. In light of this and home haemodialysis patient concerns regarding social and lifestyle constraints, the John Hunter Hospital Nephrology Department introduced an alternate night haemodialysis program in June 2001, which has continued successfully for four years with more than 28 patients commencing. The alternate night haemodialysis prescription adopted requires the patient to dialyse for eight hours on alternate nights providing 56 hours of treatment time per fortnight compared with standard dialysis of 27 hours. Patient feedback is vital and has facilitated adjustment of the program to suit individual needs. Results have shown significantly improved clinical outcomes whilst enhancing social benefits within a cost effective framework. Patients have reported better well-being and appetite along with increased energy, improved cognition and decreased irritability.

Removing the Access Block

Category: Innovation and excellence certificate

Belmont Hospital, a 72 bed facility, treating approximately 18,000 ED presentations per year had a significant access block problem at times sustaining levels greater than 60%.

Using a consultative approach, a project was undertaken including consumer representation to develop a patient-centred service model and improve patient flows for Emergency and Medical Inpatients.
Outcomes include a reduction in Access Block by over 50 per cent, a reduction in the average length of stay in ED for admitted patients from 16 hours to 5.73 hours, a reduction in the number of patients waiting greater than 10 minutes from time of arrival to time of triage from 54 per cent to 15 per cent and a reduction in medical inpatient length of stay.

Care in the right setting

In addition to its acute hospital network, and the range of district and community hospitals, Hunter New England Health provides a vast array of generalist and specialist community health services throughout the area in fixed locations and as mobile services.

In fact, in the past year more than 2.5 million occasions of service were provided outside of the hospital setting in areas such as:

- Aboriginal health services
- home nursing (including nursing assessment, wound care, continence care and education, diabetic education, medication administration, co-ordination and referral to other services, client/carer education/ support, advocacy and community development)
- palliative care service provided as

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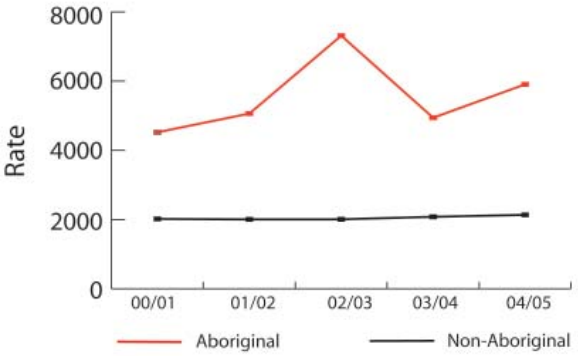
an on-call home nursing service for people with a terminal illness
- audiometry clinics offering audiometry screening for children less than 18 years of age
- population health services
- drug and alcohol services
- footcare clinics
- women's health
- screening for children entering school in Kindergarten for basic vision, hearing, and speech problems
- immunisation for children
- Child and Family Health providing early intervention, prevention and ongoing support for families with children 0-5 years old, including home visiting
- CAPAC services (Acute Care/ Post-Acute Care) including wound/medication management, management or treatment of the effects of severe illness
- recovery from recent treatment in hospital
- Home and Community Care (HACC) providing care and support for the frail aged or younger people with disabilities, and their carers
- chronic disease management, support and maintenance.

DASHBOARD INDICATOR: Potentially avoidable hospitalisations

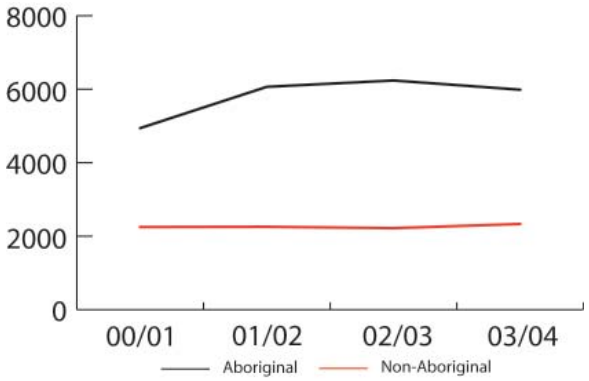
Context: There are some conditions for which hospitalisation is considered potentially avoidable through early disease management by general practitioners and in community health settings. The rates for Aboriginal people and non-Aboriginal people are compared because of the differences between these groups in health status and access to appropriate health services.



Interpretation: Aboriginal people experience a much higher rate of potentially avoidable hospitalisation. The year-to-year variations in the reported rates for Aboriginal people may also be due to inaccuracies in identifying these patients in hospital records. There has only been slight increases since 2001 in avoidable hospitalisations for non-Aboriginal people. *Source: NSW Inpatient Statistics Collection and ABS population estimates (HOIST)*

DASHBOARD INDICATOR:
Potentially avoidable hospitalisations for Aboriginal and non Aboriginal persons

Context: There are some conditions for which hospitalisation is considered potentially avoidable through early disease management by general practitioners and in community health settings. The rates for Aboriginal people and non-Aboriginal people are compared because of the differences between these groups in health status and access to appropriate health services.

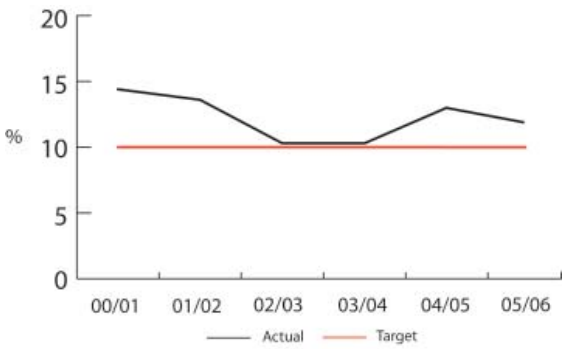


Interpretation: Aboriginal people experience a much higher rate of potentially avoidable hospitalisation. The year-to-year variations in the reported rates for Aboriginal people may also be due to inaccuracies in identifying these patients in hospital records.

Source: NSW Inpatient Statistics Collection and ABS population estimates (HOIST)

DASHBOARD INDICATOR:
Mental health acute adult readmission within 28 days to same mental health facility

Context



Interpretation

Source: Admitted Patient Collection on HOIST and HIE Datamart

To manage health services well

Sound resource and financial management

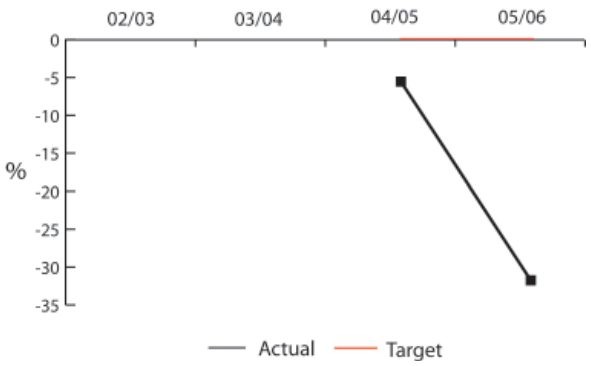
Since the creation of Hunter New England Health on 1 January 2005, the organisation has reaffirmed its commitment to sound financial management of the area's health services.

The amalgamation of the former Hunter Health, New England Area Health Service and the Lower Mid North Coast local government areas of Gloucester, Greater Taree and Great Lakes has provided a unique opportunity to streamline services, reduce duplication across the area and ensure our resources are being managed efficiently for the delivery of quality health services.

Administrative savings realised through the amalgamation of health services are already being used to improve clinical services.

DASHBOARD INDICATOR:
Major and minor works - Variance against Budget Paper 4 (BP4) total capital allocation

Context:



Interpretation:

Source: NSW Inpatient Statistics Collection and ABS population estimates (HOIST)

Workforce Development

It is imperative that a values based approach is embedded in the Health Service's policies, practices and behaviours and that Health Service staff understand these values, what they stand for and are committed to putting them into practice every day in every aspect of the Health Service's business. To support this process, Hunter New England Health has developed a values charter, to assist in further explaining the values and how they can inform our actions (see page 7).

During 2005/06, the Workforce Development directorate has coordinated the continuation of merging services resulting from the amalgamation of the three former Area Health Services, Hunter, New England and Lower Mid North Coast.

The unit has delivered the first iteration of our Area's Workforce Development Plan supported by Workforce Development Strategic Plan, and established the Workforce Development directorate, with completion of recruitment to the new structure well-advanced.

The new human resource structure and increased technology base for human resources within the Workforce Development directorate will result in a contemporary human resource structure and service delivery model with increased human resource matrix

capability across the Area Health Service.

The inclusion of both Allied Health and Medical Workforce Development within the Workforce structure sees Hunter New England Health well-placed to develop continuing innovative workforce strategies covering the full spectrum of health professions and occupations.

An effective sound consultative framework has been implemented within which positive and effective industrial relationships have been established with our staff associations and unions. The directorate has continued to contribute at a state level on various working parties, industry forums and reference groups.

Skilled, motivated staff working in innovative environments

Hunter New England Health recognises that building better managers, improving staff safety, encouraging innovation, developing a culture of teamwork and sharing knowledge are critical factors in creating and maintaining a workforce that can deliver on our vision of Healthier Communities: Excellence in Healthcare.

Hunter New England Health offers excellent, sought after, rural training opportunities, with a dedicated focus on Continuing Medical Education (CME) and quality assurance programs, comprising regular audit and clinical meetings, training sessions and access to the Hunter New England skills and simulation centre.

Junior Medical Staff

One hundred and sixty junior medical officers are employed throughout Hunter New England Health, with the majority employed through the two primary allocation centres of Tamworth Hospital and John Hunter Hospital. These doctors are rotated through Tamworth and through the Greater Newcastle area hospitals. Additionally, a number of doctors are rotated from Sydney hospitals into Manning and Armidale Hospitals.

Hunter New England Health has a strong reputation amongst junior doctors for exposure to rural training, to training in paediatrics, obstetrics, gynaecology and mental health and to subspecialties such as trauma and orthopaedics, toxicology and cancer care. Hunter New England Health is consistently rated as one of the more popular preferences for employment out of medical school and has strong connections with the University of Newcastle, including the Tamworth Rural Clinical School. We look forward to building a relationship with the University of New England, following the announcement of a new medical school partnership.

Challenges over the year have included the formation of the Hunter New England JMO Unit as part of the reorganisation of Medical Workforce, the addition of a mid-year intake of interns, preferential rural recruitment into Tamworth Hospital and managing the planning process for the recently announcement major re-organisation of pre-vocational training.

Continuing Medical Education

Hunter New England Health recognises that by offering innovative continuing professional education to our doctors we will provide an attractive incentive leading to better recruitment, job satisfaction, higher retention and improved quality of care for our patients.

To manage health services well

In response to this, the Centre for Medical Professional Development was established in September 2004, to provide educational opportunities to the Hunter New England medical workforce of 1500 doctors.

International Medical Graduates (IMG's)

Twenty per cent of our medical workforce joins us from overseas. For some of them, making the transition to an unfamiliar culture and clinical environment can be difficult.

Each year approximately 16 of our new interns have trained overseas and many have additional learning needs. Hunter New England Health has piloted an innovative program, which offers a three-day tailored orientation program, mentoring, one-to-one voice, accent and communication tuition, as well as group and individual meetings.

In the past IMGs have joined Hunter New England Health with little orientation to our culture or clinical environment. These service gaps placed them at greater risk of an adverse event.

In response to this we have developed a pre-departure website, three-day tailored orientation, quarterly educational evenings, as well as a protocol which is currently being developed on how to offer support to an IMG who is struggling with communication issues.

Career Medical Officers

With the current shortage of medical clinicians we are very dependent on our Career Medical Officers. These staff often work the difficult shifts in isolated conditions, and many are International Medical Graduates. They are a heterogeneous group with wide-ranging experiences, working across a range of disciplines including emergency, mental health and aged care. However, they all require the skills to act in an emergency situation.

After extensive consultation with Career Medical Officers (CMOs), the Centre, in collaboration with the Hunter New England Clinical Skills and Simulation Centre piloted a simulation program providing emergency care skills to a representative group of CMOs. The participants reported a major increase in their levels of competence and confidence.

This program is currently under evaluation with a view to extending it across our Area Health Service.

Strong Corporate Governance

The Chief Executive carries out all functions, responsibilities and obligations in accordance with the Health Services Act of 1997.
The Chief Executive is committed to better practices contained in the NSW Health corporate governance and accountability compendium guide issued by NSW Health.

The Chief Executive has in place practices that ensure that the primary governing responsibilities in relation to the public health organisation are fulfilled with respect to:

- setting strategic direction
- ensuring compliance with statutory requirements
- monitoring performance of the

organisation
- monitoring financial performance of the organisation
- monitoring the quality of health services
- industrial relations/workforce development
- monitoring clinical, consumer and community participation
- ensuring ethical practice.

Strategic direction

The Chief Executive has in place processes for the effective planning and delivery of health services to the communities and patients serviced by the public health organisation.

This process includes setting of a strategic direction for both the organisation and for the health services it provides.

Code of conduct

The Chief Executive and Hunter New England Health organisation has adopted the NSW Health Code of Conduct (the Code), 2005 to guide all employees and contractors in carrying out their duties and responsibilities. The Code covers such matters as: professionalism and competence, conflicts of interest and fairness in decision making.

Appropriate communication strategies have been in place during the year to ensure that all employees are aware of this code.

Risk management

The Chief Executive is responsible for supervising and monitoring risk management by Hunter New England Health, including the organisation's system of internal controls.

The Chief Executive has mechanisms for monitoring the operations and financial performance of the organisation.

The Chief Executive receives and considers all reports of the organisation's external and internal auditors and, through the Audit and Risk Management Committee, ensures that audit recommendations are implemented.

There is a risk management plan in place for Hunter New England Health. This plan enables the management of key risk areas including:

- leadership and management clinical care
- safe practice and environment
- information management
- workforce
- community expectations.

Committee structure

Hunter New England Health has a committee structure in place to enhance its corporate governance role and which complies with NSW Health policy regarding mandatory committees.

These committees meet regularly, have defined terms of reference and responsibilities and are evaluated against agreed performance indicators.

Health Care Quality Committee

The Chief Executive has in place systems and activities for measuring and routinely reporting on the safety and quality of care provided to the community. These systems and activities reflect the principles,

To manage health services well

performance and reporting guidelines as detailed in NSW Health's core documentation relating to Managing the Quality of Health Services in NSW.

Audit and Risk Management Committee

The Chief Executive has established an Audit and Risk Management Committee.

This committee is chaired by Vic Lewis and consists of Gary Pollock, Director, TAFE and Chief Executive Hunter New England Health Terry Clout.

Clinical Governance

The Clinical Governance Unit has responsibility for systems that encourage identification of potential risks and identification of areas for improvement. These systems include an active incident report and investigation system and an active complaints handling process. Supported by the network of patient safety officers, the Clinical Governance Unit works with clinical staff and management across the whole health service in providing information about incidents and clinical review. The collaboration between Clinical Risk Management and Corporate Risk Management is a feature of the Hunter New England Health approach, and has been a major factor in this year's successful development and implementation of the Integrated Risk Management Framework and System.

The implementation of the NSW Patient Safety and Clinical Quality Program for 2005-2006 focused on areas such as the implementation of new clinical service policies and guidelines relating to correct patient, correct side and correct site. Local implementation of the National Inpatient Medication Chart commenced, which will result in a consistent framework and system of documentation of medications for patients admitted to all hospitals in the health service.

One of the most important Clinical Governance initiatives of 2006 is the implementation of the new area framework for policy development. This framework sets out what needs to be considered when implementing new policy directives from NSW Health, or when developing local policy, including the communication and dissemination of policy to staff. Part of the work being done here is to ensure that staff can easily access policies as needed, which includes via use of the intranet.

In 2006, an initiative was implemented to improve service to patients and their families through better coordination of complaints management (including complaints through external agencies such as the Health Care Complaints Commission and Anti-Discrimination Board), privacy and freedom of information reviews, and communication with authorities such as the Coroner and NSW Health. The new Executive Support Service will be part of the Clinical Governance Unit, and will support the Chief Executive, Area Executive and their support staff to meet the expectations of patients and their families in these areas, as well as the timeframes and mandatory reporting requirements of relevant authorities.

Activity for year ended 30 June 2006

Selected activity levels

Facility	Separations YTD	Planned Separations	Planned Sep %	Same Day Separations	Same day Sep %	Daily Average	Total Bed Days (Days episode)
J201 - Armidale and New England Hospital	7,527.	4,023.	53.45%	3,061.	40.67%	66.7	24,335.
J202 - Barraba Multi-Purpose Service	411.	36.	8.76%	27.	6.57%	4.8	1,753.
J203 - Bingara District Hospital	316.	6.	1.90%	36.	11.39%	17.9	6,521.
J204 - Boggabri Multi-Purpose Service	109.	17.	15.60%	7.	6.42%	2.6	957.
J205 - Glen Innes District Hospital	1,788.	266.	14.88%	420.	23.49%	18.4	6,700.
J206 - Gunnedah District Hospital	2,361.	775.	32.83%	794.	33.63%	19.4	7,083.
J207 - Guyra and District War Memorial Hospital	371.	34.	9.16%	73.	19.68%	15.4	5,608.
J208 - Inverell District Hospital	4,248.	1,497.	35.24%	1,650.	38.84%	32.4	11,840.
J211 - Manilla District Hospital	630.	11.	1.75%	97.	15.40%	19.9	7,246.
J212 - Moree District Hospital	3,706.	1,462.	39.45%	1,568.	42.31%	25.7	9,397.
J213 - Narrabri District Hospital	2,197.	514.	23.40%	593.	26.99%	21.2	7,730.
J214 - Prince Albert Memorial, Tenterfield	833.			107.	12.85%	11.4	4,159.
J215 - Quirindi District Hospital	432.	15.	3.47%	38.	8.80%	9.7	3,547.
J216 - Tamworth Base Hospital	18,533.	8,551.	46.14%	7,286.	39.31%	189.8	69,266.
J217 - Tingha Hospital	37.	20.	54.05%	1.	2.70%	8.6	3,121.
J218 - Vegetable Creek Multi-Purpose Service	96.	6.	6.25%	11.	11.46%	1.5	564.
J219 - Walcha District Hospital	450.	2.	0.44%	35.	7.78%	6.0	2,205.
J220 - Warialda District Hospital	526.	1.	0.19%	60.	11.41%	15.0	5,457.
J221 - Wee Waa District Hospital	1,019.	141.	13.84%	234.	22.96%	9.5	3,459.
J222 - Werris Creek District Hospital	43.	2.	4.65%			12.0	4,373.
J223 - Bulahdelah District Hospital	385.			19.	4.94%	5.2	1,883.
J224 - Gloucester Soldier's Memorial Hospital - Hospital unit	1,176.	598.	50.85%	486.	41.33%	25.1	9,168.
J225 - Manning Base Hospital	13,121.	4,259.	32.46%	4,497.	34.27%	143.5	52,372.
J226 - Wingham Memorial Hospital	244.	22.	9.02%	2.	0.82%	13.9	5,059.
J278 - The Nita Reed Community Dialysis Centre - Taree	1,534.	1,534.	100.00%	1,534.	100.00%	4.2	1,534.
Q101 - Morisset Hospital	110.					119.2	43,497.
Q102 - James Fletcher Hospital	1,919.	4.	0.21%	100.	5.21%	83.0	30,279.
Q202 - Cessnock District Hospital	4,252.	1,547.	36.38%	1,516.	35.65%	50.7	18,504.
Q203 - Dungog District Hospital	248.	57.	22.98%	14.	5.65%	8.9	3,239.
Q205 - Kurri Kurri District Hospital	2,177.	1,383.	63.53%	1,091.	50.11%	29.5	10,779.
Q206 - Maitland Hospital	14,403.	3,058.	21.23%	3,123.	21.68%	173.0	63,159.
Q208 - Merriwa District Hospital	209.	39.	18.66%	37.	17.70%	9.1	3,332.
Q209 - Muswellbrook District Hospital	3,258.	1,280.	39.29%	1,448.	44.44%	25.0	9,127.
Q210 - Denman Multi-Purpose Service	38.	3.	7.89%	2.	5.26%	2.8	1,033.
Q211 - Newcastle Mater Misericordiae Hospital	11,844.	4,039.	34.10%	3,285.	27.74%	161.1	58,818.
Q213 - Royal Newcastle Hospital	4,856.	3,862.	79.53%	1,892.	38.96%	60.6	22,101.
Q214 - Belmont Hospital	6,615.	3,543.	53.56%	2,517.	38.05%	63.7	23,256.
Q216 - Scott Memorial Hospital, Scone	1,812.	505.	27.87%	579.	31.95%	14.4	5,252.
Q217 - Singleton District Hospital	4,084.	1,817.	44.49%	1,907.	46.69%	33.1	12,081.
Q219 - Wilson Memorial Hospital, Murrurundi	132.	40.	30.30%	5.	3.79%	8.7	3,172.
Q225 - Nelson Bay and District Polyclinic	823.	112.	13.61%	170.	20.66%	6.2	2,280.
Q230 - John Hunter Hospital	62,919.	33,506.	53.25%	31,230.	49.64%	666.9	243,436.
	181,792.	**78,587.**	**43.23%**	**71,552.**	**39.36%**	**2,215.6**	**808,682.**

Health Services

Tertiary Teaching Hospitals		Telephone	Fax
John Hunter	Lookout Road, New Lambton NSW 2305 Locked Bag 1, Hunter Region Mail Centre NSW 2310	(02) 4921 3000	(02) 4921 3999
John Hunter Children's Hospital	Lookout Road, New Lambton NSW 2305 Locked Bag 1, Hunter Region Mail Centre NSW 2310	(02) 4921 3000	(02) 4921 3599
Newcastle Mater Misericordiae	Edith Street, Waratah NSW 2298 Locked Bag 7, Hunter Region Mail Centre NSW 2310	(02) 4921 1211	(02) 4960 2673
Royal Newcastle	Pacific Street, Newcastle NSW 2300 PO Box 664J, Newcastle NSW 2300	(02) 4923 6000	(02) 4923 6204
Mental Health Hospitals		**Telephone**	**Fax**
James Fletcher (Newcastle)	72 Watt Street, Newcastle NSW 2300 PO Box 833, Newcastle NSW 2300	(02) 4924 6500	(02) 4924 6687
Morisset	Off Dora Street, Morisset NSW 2264 PO Box 833, Newcastle NSW 2300	(02) 4973 0222	(02) 4973 3442
Rural Referral Hospitals		**Telephone**	**Fax**
Armidale	Rusden Street, Armidale NSW 2350 Locked Bag 4, Armidale NSW 2350	(02) 6776 9500	(02) 6776 4774
Maitland	550 - 560 High Street, Maitland NSW 2320	(02) 4939 2000	(02) 4939 2270
Tamworth	Dean Street Tamworth NSW 2340 Locked Mail Bag 9783, Tamworth NEMSC NSW 2348	(02) 6767 7700	(02) 6766 1027
Taree - Manning	26 York Street, Taree NSW 2430 PO Box 35, Taree NSW 2430	(02) 6592 9111	(02) 6551 7135
District Health Services		**Telephone**	**Fax**
Belmont	Croudace Bay Road, Belmont NSW 2280 PO Box 2365, Gateshead DC NSW 2290	02) 4923 2000	(02) 4923 2106
Cessnock	View Street, Cessnock NSW 2325 PO Box 154, Cessnock NSW 2325	(02) 4991 0555	(02) 4991 0563
Glen Innes	94 Taylor Street, Glen Innes NSW 2370 PO Box 363, Glen Innes NSW 2370	(02) 6739 0200	(02) 6739 0143
Gloucester	Church Street, Gloucester NSW 2422 PO Box 33, Gloucester NSW 2422	(02) 6558 1307	(02) 6558 2218
Gunnedah	Marquis Street, Gunnedah NSW 2380 PO Box 243, Gunnedah NSW 2380	(02) 6741 8000	(02) 6740 2881
Inverell	Swanbrook Road, Inverell NSW 2360 PO Box 279, Inverell NSW 2360	(02) 6721 9500	(02) 6721 9567
Kurri Kurri	Lang Street, Kurri Kurri NSW 2327	(02) 4936 3200	(02) 4936 3239
Manilla	Court Street, Manilla NSW 2346 PO Box 74, Manilla NSW 2346	(02) 6785 4000	(02) 6785 1490
Moree	Alice Street, Moree NSW 2400 PO Box 138, Moree NSW 2400	(02) 6757 0000	(02) 6757 3625
Muswellbrook	Brentwood Street, Muswellbrook NSW 2333 PO Box 120, Muswellbrook NSW 2333	(02) 6542 2000	(02) 6542 2002
Narrabri	11 Cameron Street, Narrabri NSW 2390 PO Box 324, Narrabri NSW 2390	(02) 6799 2800	(02) 6799 5025
Quirindi	Nowland St, Quirindi NSW 2343 PO Box 120, Quirindi NSW 2343	(02) 6746 0200	(02) 6746 2002

Scone	Stafford Street, Scone NSW 2337	(02) 6540 2100	(02) 6540 2180
Singleton	Dangar Road, Singleton NSW 2330 PO Box 10, Singleton NSW 2330	(02) 6571 9222	(02) 6571 9282
Community Health Centres		**Telephone**	**Fax**
Armidale	Rusden Street, Armidale NSW 2350	(02) 6776 9600	(02) 6776 4900
Ashford	6 Kneipp Street, Ashford NSW 2361	(02) 6725 4239	(02) 6725 4308
Barraba	Edward Street, Barraba NSW 2347	(02) 6782 2507	(02) 6782 1808
Beresfield	Lawson Street, Beresfield NSW 2322	(02) 4966 1363	No Fax
Bingara	Keera Road, Bingara NSW 2404	(02) 6728 0100	(02) 6724 1708
Boggabilla	74 Merriwa Street, Boggabilla NSW 2409	(07) 4676 2418	(07) 4676 2129
Boggabri	Wee Waa Street, Boggabri NSW 2382	(02) 6749 7000	(02) 6743 4274
Bulahdelah	Cnr Richmond & Crawford Streets, Bulahdelah NSW 2423	(02) 4997 4240	(02) 4997 4571
Bundarra	2 Thunderbolts Way, Bundarra NSW 2359	(02) 6723 7206	(02) 6723 7191
Cessnock	View Street, Cessnock NSW 2325	(02) 4991 0438	(02) 4991 0584
Clarence Town	Prince Street, Clarence Town NSW 2321	(02) 4996 4450	No Fax
Day Care Centres: Allawah Wattlegrove Cottage	Nash Street, Wallsend NSW 2287 Neighbourhood Centre, Nash Street, Wallsend NSW 2287	(02) 4924 6141 (02) 4924 6361	No Fax (02) 49246 377
Denman	Ogilvie Street, Denman NSW 2328	(02) 4947 2202	(02) 6547 3903
East Lakes	Cnr South & Cherry Streets, Windale NSW 2306	(02) 4944 5300	(02) 4944 5310
East Maitland	Stronach Avenue, East Maitland NSW 2323	(02) 4931 2000	(02) 4931 2000
Forster	Breeze Parade, Forster NSW 2428 PO Box 448, Forster NSW 2428	(02) 6555 6822	(02) 6554 8874
Glen Innes	Taylor Street, Glen Innes NSW 2370	(02) 6739 0100	(02) 6739 0105
Gloucester (based at Gloucester Hospital)	Church Street, Gloucester NSW 2422	(02) 6558 1011	(02) 6558 2726
Gresford	Park Street, Gresford NSW 2311	(02) 4938 9207	(02) 4938 9442
Gunnedah	80 Marquis Street, Gunnedah NSW 2380	(02) 6741 8000	(02) 6740 2879
Guyra	17 Abercrombie Street, Guyra NSW 2365	(02) 6738 4000	(02) 6779 1579
Gwabegar	Bridge St, Gwabegar NSW 2356	(02) 6849 6100	(02) 6796 4473
Harrington	Pilot Street, Harrington NSW 2727	(02) 6556 1429	No Fax
Hawks Nest/Tea Gardens	Hawks Nest NSW 2324 PO Box 12, Hawks Nest NSW 2324	(02) 4997 0186	(02) 4997 1528
Inverell	Swanbrook Road, Inverell NSW,2360	(02) 6721 9600	(02) 6721 9580
Kurri Kurri	Lang Street, Kurri Kurrri NSW 2327	(02) 4936 3282	(02) 4936 3281
Manilla	Court Street, Manilla NSW 2346	(02) 6785 1490	(02) 6785 1490
Merriwa	McKenzie Street, Merriwa NSW 2329	(02) 6548 2006	(02) 6548 2527

Health Services

Moree	Alice Street, Moree NSW 2400	(02) 6757 3670	(02) 6757 3697
Morisset	Off Dora Street, Morisset NSW 2264	(02) 4973 0222	No Fax
Mungindi	82 St George Street, Mungindi NSW 2406	(02) 6753 2155	(02) 6753 2361
Murrurundi	Cnr O'Connell St and Paradise Rd, Murrurundi NSW 2328	(02) 6546 6106	(02) 6546 6518
Muswellbrook	Brentwood Street, Muswellbrook NSW 2333	(02) 6542 2050	(02) 6542 2005
Narrabri	11 Cameron Street, Narrabri NSW 2390	(02) 6799 2000	(02) 6799 5112
Nelson Bay	Kerrigan Street, Nelson Bay NSW 2315	(02) 49 840730	(02) 4984 0744
Newcastle	Hunter Street, Newcastle NSW 2300	(02) 4925 7800	(02) 4925 7803
Nundle	Jenkins Street, Nundle NSW 2340	(02) 6769 3187	(02) 6769 3192
Pilliga/Gwabegar	Dangar Street, Pilliga NSW 2388	(02) 6796 4473	(02) 6769 4473
Premer	Ellerslie Street, Premer NSW 2381	(02) 6744 2366	(02) 6744 2025
Quirindi (based at Quirindi Hospital)	50 Nowland Street, Quirindi NSW 2343	(02) 6746 0200	(02) 6746 0230
Raymond Terrace	Port Stephens Street, Raymond Terrace NSW 2324	(02) 4987 2078	(02) 4987 1660
Scone CHC	Stafford Street, Scone NSW 2337	(02) 6540 2136	(02) 6540 2170
Singleton CHC	Boonal Street, Singleton NSW 2330	(02) 6571 9248	(02) 6571 9286
Stroud CHC	Cowper Street, Stroud NSW 2425	(02) 4994 5188	No Fax
Tambar Springs CHC	Merrigula Street, Tambar Springs NSW 2381	(02) 6744 2366	(02) 6744 2025
Tamworth CHC	Dean Street, Tamworth NSW 2340	(02) 6767 8100	(02) 6766 3967
Taree – Aged Care Services	Suite 2, 57 - 61 Albert Street, Taree NSW 2430	(02) 6592 6900	(02) 6592 6901
Taree CHC	64 Pulteney Street, Taree NSW 2430 PO Box 35, Taree NSW 2430	(02) 6592 9315	(02) 6592 9607
Tenterfield CHC	Naas Street, Tenterfield NSW 2372	(02) 6739 5200	(02) 6736 2960
Toronto (Polyclinic)	James Street, Toronto NSW 2283	(02) 4935 8100	(02) 4935 8163
Uralla CHC	Cnr Bridge and Wood Street, Uralla NSW 2358	(02) 6778 4709	(02) 6778 3952
Walcha CHC	South Street, Walcha NSW 2354	(02) 6774 2400	(02) 6774 2435
Wallsend CHC	Nash Street, Wallsend NSW 2287	(02) 4924 6100	(02) 4924 6101
Warialda CHC	Long Street, Warialda NSW 2402	(02) 6728 9000	(02) 6729 1208
Wee Waa CHC	Alma Street, Wee Waa NSW 2388	(02) 6795 0400	(02) 6795 3028
Werris Creek CHC	North Street, Werris Creek NSW 2341	(02) 6768 7380	(02) 6768 7775

Area Health Care Service Planning

During 2005/06 planning efforts were focussed on developing Hunter New England Health's Strategic Directions 2006-2010. This is a suite of plans that provide the overall strategic framework for the provision and development of health services across the Hunter New England area.

Strategic Directions include the following key documents:

Area Strategic Plan
Our Strategic Plan presents Hunter New England Health's vision, purpose and values, and the strategic directions and initiatives to be implemented over the next five years.

Introducing the Area, the People and the Health Services
This companion document provides information and analysis about the geography, topography, demography, population projections, epidemiology, current service provision and use, current facility provision, demand for services, and significant issues and priorities affecting the health of the Area's residents. Detailed data and information are included as appendices.

Area Healthcare Services Plan
This plan is our highest level service planning document. It outlines the direction of clinical services development and delivery across the Hunter New England Area over the next five to 10 years.

It is expected that these plans will be launched in 2007.

A number of clinical services plans have also been developed including Aged Care and Rehabilitation, Cancer, Chronic Disease, Critical Care and Emergency Services, and mental Health Services.

Vision, Purpose, Focus Areas and Strategic Objectives

To achieve our vision, Hunter New England Health has identified key focus areas and strategic objectives to address each of the focus areas. Details of the strategic initiatives to achieve our strategic objectives are in the Area Strategic Plan.

Key Focus Areas	Strategic Directions
Communities and Patients	• Communities that feel empowered in relation to health • Improved health and well being for all • Reduced gap in health and well being between Aboriginal and non-Aboriginal people • Improved equity of access to services • A quality health service experience • Reduced health disadvantage
External Partners	• Engaging our partners in improving the health of our communities
Internal Networking and Processes	• Person-centred care and continuous service review • Effective clinical networks • Safe and evidence-based healthcare • Disease prevention and health promotion across all service areas • Organisational risk management
Resource Accountability	• Prioritisation and allocation of resources to best meet health needs • Effective management of resources and assets for maximum health benefit

Health Services

Our People, Culture and Capability	• Always demonstrating our shared organisational values and culture of service • Attracting and retaining high quality staff • Developing competence, capability, individual accountability and performance • Effective consultation and communication • Ensuring a safe working environment • Demonstrating innovative healthcare

Asset Management

Asset management is concerned with the provision and maintenance of assets and infrastructure to support Hunter New Engalnd Health's ability to deliver quality health services. To this end, an Asset Strategic Plan has been developed to ensure that health facilities in the Hunter New England area are well placed in the future, and are able to:

- Meet the health needs of local communities over the next 10-15 years
- Keep pace with developments in technology and clinical best practice
- Provide clinical environments that attract and retain high quality staff
- Continue to provide an environment for undergraduate and postgraduate training and research
- Achieve a greater integration and coordination of service providers
- Extract greater value from existing properties
- Keep to a minimum the costs of support services and building maintenances
- Transfer savings to frontline services

Drug and Alcohol

Summary of Activity

- A primary focus has been to facilitate the successful merger of Drug and Alcohol Services across the new Area Health Service in the Clinical Stream framework. This process is nearing completion.

- Drug and Alcohol Medical Specialist outpatient services are now provided at the Royal Newcastle Centre. A multidisciplinary team provides services to address addiction medicine issues for inpatients and outpatients within the John Hunter Hospital area. Medical Specialist consultation services are also provided at Lorna House Mater Hospital, Wallsend Campus, and Newcastle Pharmacotherapy Service.

- Pharmacotherapy Services across the area are operating at capacity. Taree service is working within a shared care framework with antenatal services at the Aboriginal Medical Service. Telehealth technology is currently being utilised in the Northern region to increase access to pharmacotherapy services and improve client care in rural areas.
- Detoxification services continue to be well utilised. Lakeview Detoxification Unit became a non-smoking unit. All patients were offered nicotine replacement therapy and provided with three days patches and referred to the Quitline upon discharge. Admission rates have not been affected.
- Counselling Services across the area are well accessed with referrals received from a range of services and individuals. An outreach model of service delivery is undertaken so that people can access appropriate services as close to where they live as possible.
- The Magistrate's Early Referral into Treatment (MERIT) Program provides services to local courts at Maitland, Raymond Terrace, Cessnock, Toronto, Muswellbrook, Singleton and Tamworth.

The MERIT program targets adult defendants with a demonstrable illicit drug problem. Eligibility is formally assessed by MERIT and aims to achieve the following outcomes: ceasing or significantly decreasing drug use, reducing the possibility of further criminal behavior and charges while engaging in the MERIT program, undertaking education/counselling activities that may assist the client to remain drug and crime free in the longer term.

Major Goals and Outcomes

- Take-Safe Evaluation Trial – An evaluation of the Take-Safe device was conducted in Tamworth and Newcastle in both public dosing facilities and community pharmacies. Take-Safe is a microprocessor controlled secure container, designed to time deliver methadone take-a-ways on a daily basis for up to six days. A total of 30 clients were recruited into the project. The project evaluation will be finalised in August. This trial was the only one undertaken across the state and results will influence service delivery state wide.•
- The Northern and Lower Mid North Coast regions have had an increase in the number of ATSI people accessing the service, with specific reference to the Moree area. Aboriginal Drug and Alcohol staff undertake a role as community liaison officers and have been accepted into communities, which is in line with the overall strategic direction for the Drug and Alcohol Service.

Key Issues and Events

- All units are continuing to develop service delivery models in collaboration with Mental Health that address the needs of dual diagnosis clients relating to psychostimulant use. An annual amount of $300,000 has been received over three years from NSW Health to develop effective psychostimulant treatment initiatives.
- Staff recruitment in rural drug and alcohol positions remains an ongoing issue.

Future Directions

- Further development of referral pathways/guidelines and protocols with Mental Health to improve care for dually diagnosed clients.
- Expand use of telehealth across the area to improve equity of access to the full range of Drug and Alcohol services offered.

Population Health and Health Promotion

Integration and Partnerships

Hunter New England Human Research Ethics Committee

In 2005 a working party oversaw the merger of the Research Ethics functions from the former Hunter and New England Area Health Services and, as of 1 January 2006 the Hunter New England Human Research Ethics Committee become operational. The new Committee is the sole Human Research Ethics Committee for Hunter New England Health and has been established to review research, and is supported by two advisory subcommittees namely, the Clinical Trials Subcommittee and Rural Research Methods Support Group.

Health Services

Hunter New England Health NGO Grant Administration Unit

Hunter New England Health is committed to building effective relationships with the Non Government Organisations sector to improve the health of the Hunter New England population. The NGO Grant Administration Unit, in conjunction with NSW Health and Hunter New England Health, is responsible for administration, service monitoring and support provision to NGOs funded under the NSW Health NGO Grant Program.

In 2005/2006, in conjunction with NSW Health, Hunter New England Health was responsible for the administration, service monitoring and support provision to 51 NGOs delivering 56 health funded projects with a total funding of $4,268,120.

General Practice Liaison and Integration

Five GP Access After Hours clinics are operated by the Hunter Urban Division of General Practice from Hunter New England Health premises at Maitland, Belmont and John Hunter Hospitals, and Toronto and Newcastle Community Health Centres. They provide a comprehensive after hours GP service (including clinic consultations, home visits, telephone advice and patient transport to the clinic) that aims to meet the population need for urgent GP care after hours. Another successful year was achieved in 2004-05, where over 65,000 people obtained telephone advice and 48,000 people attended GP clinics, with 90 per cent seen within 30 minutes. There are now over 260 GPs involved in the operation of the service.

In June 2006, a new three-year funding contract, between the Commonwealth, Hunter New England Health and the Hunter Urban Division of General Practice, was signed.

The Chief Executive established the General Practice Advisory Committee in mid-2005 and it met quarterly throughout 2005-06. Comprised of representatives of the five Divisions of General Practice, Hunter New England Heath, University of Newcastle and GP training providers it has provided strategic advice on issues relating to aspects of general practice primary care, and its relationship to the wider health service, and developed an agreed work program.

Aboriginal Health

Two key service delivery innovations for Aboriginal Health have been implemented in the past year:

- The Risk Assessment Program which won the Excellence in Program Delivery award at the NSW Aboriginal Health Awards. This program commenced in 1999 and was developed by a working group of medical and allied health specialists, Aboriginal Health and community members. The program provides a multi-faceted approach to the prevention, early diagnosis and management of diabetes and cardio vascular disease. The program has delivered an assessment rate 80 per cent of the high-risk target group of 30-34 year olds.
- The Shake-a-Leg program is a school based Aboriginal Health promotion package which was developed from a pilot project between Aboriginal

Health and Awabakal (AMS) but has now been extended to include three child health networks. The program utilises existing resources, some Aboriginal specific others mainstream all delivered in culturally sensitive way by Aboriginal health workers.
- Topics covered in the program include teeth and ears, drinking and smoking, healthy relationships, family violence, sexual abuse, getting active, nutrition, identity, safe sex, hygiene, otitis media and sexual abuse.

Dental Health

Summary of Activity

- Hunter New England Oral Health Service provides over 190,000 non-admitted patient occasions of care per annum with over 4700 new requests for care each month.
- Almost 60 per cent of the adult population within the Area is eligible for access to public dental care and all children under 18 years of age who are enrolled in school/studies

Major Goals and Outcomes

- Embedding a focus on quality oral health projects with an emphasis on population health for the communities of Hunter New England Health consistent with the vision in both Area and NOHN Strategic Plans.
- The merging of oral health services across Hunter New England Health and in particular creation of one clinical stream model for oral health services in the Northern region.
- Achievement of 93 per cent of activity against target met within allocated budget.
- Continue to ensure an innovative approach to managing an Area-wide specialty program that will demonstrate continued or improved efficiencies and effectiveness, thus enabling a focus on improved patient outcomes.
- Achievement of 115 per cent of child activity against target met within allocated budget.
- Further roll out of 'People, Posture and Positioning' Roadshow for dental teams focussing on safety in the dental setting.
- Successful monitoring of staff safety: two lost time injuries within period of 26 months across whole of the Oral Health Service.
- Further embedding of a learning culture across Oral Health teams with the rollout of an in-house education program.
- Improved identification of and strategies to address gaps in service delivery.
- Enhancement funding of $284,000 to upgrade dental chair units in the northern region and phase one of digital imaging implementation.
- Oral Health Promotion Team involvement at NSW state level in rollout of oral health promotion initiatives inclusive of developed strategies.

Key issues and events

- Substantial reduction of vacancies in Dental Officer positions across the Area and with particular emphasis on rural regions: Dental Officer vacancies have been reduced by 59 per cent by end June 2006.
- Further enhancement of career development and training opportunities for Oral Health staff with the employment of four traineeships for Dental Assistants with indigenous and rural focus.

Health Services

- Successful merge of Information System Oral Health (ISOH) database.
- Official opening of the Tenterfield Dental Clinic

Future Directions

- Provision of Adult Dental Outreach service whilst continuing to seek interest from private dental practitioners to work at the Tenterfield Dental Clinic.
- Provision of Adult Outreach Service in Barraba.
- Work collaboratively as members of NOHN in further implementing 'Teeth for Life' program for further fluoridation of communities.
- Progressive implementation of digital imaging.
- 2006-2007 Balanced Scorecard to be inclusive of Risk Management Framework.
- Complete final stage of merging process by end October 2006 including clinic co-ordination, redefining of roles and implementing professional team leader positions for northern region.
- Further preparation for move of Royal Newcastle Dental Clinic to Newcastle Community Health Centre.
- Explore opportunity for extended hours of operation and funding models to keep in line with Newcastle Community Health Dental Clinic.
- Customise and rollout all educational programs across the Oral Health service.

Diabetes Services

Summary of Activity and Services

Diabetes is a chronic condition identified for action in current National and NSW Chronic Disease Strategies because its incidence has increased significantly and is expected to continue to do so for some years. Against this background of increased demand, diabetes services within the area health service are merging. The central theme of merging is reviewing where resources are most needed and how they can be most equitably distributed.

Hunter Area Diabetes Services (HADS) provides diabetes services in the Greater Newcastle and Lower Hunter cluster.

Services include
- Specialist outpatient clinics, including podiatry services
- Group and individual education services including insulin pump work
- Aboriginal Vascular Health Project
- External professional training and education courses
- Staff participation in community seminars and camps for children with diabetes run by Diabetes Australia.

Major Goals and Outcomes

- Diabetes services for adults operate at some level in many of the major locations across the region. While most clusters have dedicated diabetes staff, all hospitals and community health centres have generalist multi disciplinary staff who address diabetes issues as part of their case load both for inpatient and outpatient groups.
- Tamworth Diabetes Centre in the Peel cluster has a prominent role providing group and individual education services. The centre has a strong medical presence via local specialists and general practitioners, and takes a leading role in clinical leadership for

surrounding staff.
- Across the Macintyre, Tablelands and Mehi clusters, generalist Community Health and acute sector nursing/ dietetics staff address diabetes issues and problems in their broader case loads. Strong links with GPs assist staff in areas where specialist review opportunities are limited, as are podiatry services.
- In the Upper Hunter cluster there is a limited primary health and health promotion role for diabetes funded by Regional Health, and a podiatry outreach service has been initiated through Community Health. The Lower Mid North Coast cluster provides group and individual programs, including specialist Aboriginal clinics.

Key Issues and Events

- Pit Stop Program for Aboriginal and Torres Strait Islander people held in Newcastle in NAIDOC Week,
- Staff training days held at locations such as Muswellbrook and Gloucester to enable staff from both Northern and Southern regions to attend.
- The Royal Newcastle Hospital (RNH) diabetes outpatient clinics moved from RNH to the new Royal Newcastle Centre on the Rankin Park campus.

Future Directions

- Training more generalist staff in acute settings and GP practices to be well resourced for addressing diabetes.
- Insulin pumps are being used increasingly so staff skills in initiating and maintaining pumps need to be addressed.
- Limited and metro-based endocrinology and podiatry services, both crucial to the long-term management of diabetes, are further key issues to be addressed in strategic planning.

Mental Health Services

Key Issues and Events

The Hunter New England Mental Health Service has been actively involved in the process of amalgamation and streaming of the extended Mental Health Service since November 2004.

The past year has seen a range of advancements that include:

- The appointment of an Area Director
- The completion of the merge process with active recruitment activity to a number of positions across the region including:
    - Service Managers to Cluster groups in Northern and Manning
    - Appointment of Staff Specialists psychiatrist to Northern area
    - Appointment of Senior Clinical Psychologist to the Northern area
    - Appointment of senior nursing positions to Northern area
    - Establishment of regional office in Northern and appointment of Regional Clinical Director

Recruitment action is continuing for medical staff across the region to further enhance services in the Northern and Manning sector.

Maggie

Mental Health Service has undertaken the Acute Adult Inpatient Maggie project

across the region.

This has aimed to ensure that standards are consistent across the service with introduction of the care coordinator model.

The service is currently undertaking a Maggie project for the Community Mental Health teams with initial focus on Southern services and commencing the extension of the project to southern early 2007.

Rural Mental Health Access

We have been active in extending the pilot project from the former Mid North Coast to the Northern sector to improve access to mental health services in the rural and remote settings. The project aims to reduce the inappropriate use of police and ambulance in mental health transporting, improve access through emergency departments by employing mental health skilled staff within the Emergency Departments at Taree, Tamworth and Armidale and also establish a centralised point of intake.

Hunter New England Mental Health Service is well on the way to implementing this initiative.

Public Private Partnership

A project officer has been appointed to assist with the design and development of the plans and procedures for the relocation of services from James Fletcher Hospital to the Mater Hospital in 2009. This role is responsible for the consultation and identification of requirements for the service when the facility is completed. The project officer will be working in conjunction with the Newcastle Strategy Team.

Non-Acute Inpatient Unit

Planning and development of a 20-bed non-acute inpatient unit for the James Fletcher site in Newcastle is currently underway.

Child and Adolescent Mental Health Service

This service is currently experiencing a number of challenges since the resignation of three of the four psychiatrists in the service. Recruitment action has been successful and a review is underway to identify a service model and improve access to services across the area.

Nursing and Midwifery

Summary of activities

Nursing Workforce planning, developing and marketing.

- Strategies are in place to ensure effective nursing workforce planning, recruitment and retention.
- Career development program functioning actively.
- Recruited and established Aboriginal and Torres Strait Islander cadetships.
- Clinical practice – nursing care is appropriate to the needs of the community, innovative and based on best practice models.
- Professional development – education programs for all nursing staff are

relevant, cost-effective and ensure a highly-skilled and professional workforce. A culture of continuous learning and research is highly promoted and supported.

Major goals and outcomes

- Increased new graduate nurse employment across the Area Health Service.
- Achieved 100 per cent employment of graduating Trainee Enrolled Nurses.
- Completed scoping of current nursing workforce.
- Facilitation of revision of models of care in response to multiple factors including skillmix and patient acuity.
- Facilitated nursing professional development through Nurse Strategy funding and Locum Nursing Exchange Program.
- Provided executive leadership in Clinical Redesign programs area-wide.
- Increased the number of Nurse Practitioners in Hunter New England Health.
- Have developed stronger links with the universities and UDRH (University Department of Rural Health) to promote and support clinical teaching.
- Lead development of Area Pandemic Plan.
- Executive sponsor for work towards achieving EQuIP Corporate.

Key issues and events

- Conducted Clinical Nurse Consultant Professional Day, Nursing Innovations Seminar and Models of Care Roadshows.
- Supported continuation of Area Nursing Council and Senior Nurse Managers' Consultative Committee.

Health Support Services

Corporate Services

Business Activity/Major goals and outcomes

During the 05/06 year the following items were undertaken

- Completion of the organisational design process for the proposed Facility Management structure for the merged Hunter New England Health..
- Completion of an Implementation Planning Study (IPS) and subsequent rollout of HealthAMMS version 5.2 across the whole of Hunter New England Health.
- Completion of negotiations with the Health Services Union and skilled trades unions around the implementation of the proposed Facility Management business model and organisational structure.
- Completion of a business process reviewing project in conjunction with the IPS for HealthAMMS.

Key Issues and Events

- Completion of a major upgrade to the Gloucester Hospital operating theatre utilising staff from both the Northern and Southern regions
- Completion of a major upgrade to the main sewer line for John Hunter Hospital
- Major upgrades to fire services at various sites across Hunter New England Health including Narrabri, Kurri Kurri, Singleton, Muswellbrook and Scone

Future Directions

- Finalise recruitment to the Facilities Management structure
- Finalise the following plans across the area:
  - Risk Management Plan
  - Compliance Plan
  - Optimum maintenance plan
  - Refurbishment plan
  - Quality Improvement plan

Shared Corporate Services

Patient Support Service was established with the aim of integrating hospital based non-clinical services into an area wide dedicated service units. The intention was to transform these hospital based services to a service provider model focussed on delivering patient satisfaction.

The formation of the Patient Support Services (now Shared Corporate Services) Group had as its principle aims:

- To allow hospital management to concentrate on the delivery of clinical services with effective service agreements for the delivery of non-clinical services.
- Align support services across the Area
- Improve the quality and delivery of service to the patient
- Redirect funds for clinical services
- Improve the sustainability of non-clinical services
- Ensuring that non-clinical services are competitive with external providers
- Retain jobs in rural and regional areas

These objectives were achieved by:

- Integrating and co-ordinating each non-clinical activity
- Targeting productivity gains
- Improving the quality and delivery of service

- Removing duplication
- Introducing a streamlined management structure
- Maximising work flexibilities

Future direction

The Patient Support Services model will continue to be implemented across the newly merged Hunter New England Health.

Patient Support services will focus strongly on the implementation of quality managements systems to support the integration of support services under a single management structure. The development of these systems will assist the service in ensuring it meets key outcomes in relation to service quality, safety, procurement and budget.

Financial Services

To ensure the sustainability of organisation, we must prioritise and optimise resource allocation; meet activity targets within budget; and find further opportunities to reduce costs and increase revenue that can be reinvested into public health services. This year financial services staff has worked to:

- Ensure improved, transparent budget process that is clearly communicated and understood by clinicians and managers.
- Commenced and completed the transfer of the financial transactions from the former New England Area Health Service's financial management information system, Sun Financials, to the Oracle Financial Management Information System. This ensured that appropriate and effective financial information management systems were in place to achieve clinical outcomes within budget.
- Restructured the Area Health Service's reporting of cost centre's in line with the new management structure and delegations.
- Ensure savings targets are achievable and there is a transparent process in regard to the reallocation of resources to clinical services.
- Commenced the implementation and rollout of the new patient billing system Playtpus 2. The new billing system, with the addition of HIC online, not only improves the billing process by automation, but also improves the debt recovery turn around times from six weeks to two days, having a positive impact on our cash position.
- Hunter New England Health has always maintained a strong cash position, which ensures the timely payment of its trade creditors according to their payment terms. The record of payment of creditors throughout the year met NSW Health's performance target benchmark of no creditors exceeding 35 days. In 2005-2006 the total general creditors profile monthly average was 30.3 days. There were no creditors greater than 45 days at the end of this financial year.

Asset Management Services

Royal Newcastle Centre

A major component of the Newcastle Strategy was the Royal Newcastle Centre building. This was commissioned and opened earlier this year catering for the services of urology, rheumatology, elective orthopaedics, rehabilitation and ophthalmology.

Facilities include inpatient units, ambulatory care, education, office accommodation and a range of day procedure and day surgery areas including operating rooms, interventional cardiology, endoscopy and procedure rooms. This project was finished on time and on budget and delivered state of the art facilities

Health Services

that will cater for the community of Hunter New England Health.

John Hunter Hospital
A range of projects have been completed in the John Hunter Hospital. These include:

- Sleep Lab project (a component of the Newcastle strategy) relocation of Sleep Laboratory from Royal Newcastle Hospital to John Hunter Hospital – currently in construction due for completion in September
- John Hunter Hospital Intensive Care Unit office and storage upgrade recently completed
- Neonatal Intensive Care Unit extension of storage and facilities to cater for increase in Level 3 cots completed early 2006
- Patient and staff amenity upgrade, including air conditioning is in the planning stages. Some early works packages have gone to tender with the main construction tender to be let later in year.

Rankin Park campus
There have also been a number of projects aimed at improving car parking and access around the Rankin Park campus.

- Car parking includes the completion of southern car park consisting of 90 spaces, completion of car park number 6, as a part of Royal Newcastle Centre containing 350 spaces, and a development application has been lodged for another car park containing 70 spaces
- A second access road to the campus is in construction.

Other projects occurring on the campus include:

- Upgrade of electrical supply to the site, a component of the Newcastle Strategy, will support the increase in services on site and is in the final stages of planning for implementation this financial year.
- Forensic Medicine project relocation of facilities onto south-western side of JHH. This project is well into construction and due for completion in March 2007
- The Hunter Medical Research Institute (HMRI) project is in the planning stage completion of a Service Procurement Plan is due by October 2006.

Mater Development
The Novacare consortium were successful in winning the tender for the Mater redevelopment project. This consortium will deliver services on the Mater site for the next 28 years. This group includes Abigroup as the builder, Suters PTW as design team, Honeywell & Medirest as hard and soft service providers and Westpac Banking Corporation is providing the financial backing.

The first stage of the Mater Hospital redevelopment will deliver the enhancement of radiotherapy services and is due for completion in January 2007. The “south” block construction is on target for completion in January 2008. South block includes new inpatient units, ambulatory care services, operating rooms and recovery areas, day surgery, education, chemotherapy area as well as support services including kitchen, cleaning, mortuary and loading dock.

Progress on the design of “north block” is continuing. This includes the acute mental health facilities currently

located on James Fletcher Campus as well as a new emergency department, intensive care unit, diagnostic centre, medical records department and office accommodation for the Mater.

Belmont
Belmont Hospital redevelopment stage three is due for completion in March 2007. This includes two new wards and refurbishment of level two to accommodate a 20 bed Transitional Care Unit. Other components of the redevelopment include upgraded pharmacy and a planned pathology service. The operating rooms, recovery area, imaging area and emergency department were completed in earlier stages. Car parking is also being improved on site.

Newcastle Community Health Centre
Newcastle Community Health Centre (formerly the Newcastle Polyclinic) is currently under construction and due for completion in June 2007. This will house the community based services currently provided from the Royal Newcastle Hospital site as well as a range of other health services including after hours GP service, X-ray and pathology.

Rural Hospital and Health Services Projects (previously known as the Multi-Purpose Service (MPS) program)
There are a range of projects in the MPS program at varying stages of completion. The MPS program includes the combination of a range of services on the one location and aims to cater for the smaller rural communities. Services included in the various MPS projects can include community health, residential aged care, acute care, emergency, ambulance facilities and support services such as kitchen, mortuary, cleaning, linen and storage facilities. For Merriwa, Warialda, Walcha, Guyra and Bingara staff accommodation is also included in the projects.

- Guyra MPS opened in August. This was a $9.6-million project
- Walcha MPS is under construction and due for completion in mid 2007 – this facility will house 18 residential aged care and nine acute inpatient beds.

Tingha, Bingara, Warialda and Merriwa
MPS projects are due to go to tender later this year with all facilities due to commence construction soon after. The Tingha, Bingara and Warialda projects are all totally new build on the current Health Service sites. Merriwa will involve extension and refurbishment to the current facilities.

Non-Acute Mental Health Unit
Planning is underway for the 20 bed non-acute Mental Health Inpatient Unit to be constructed on the James Fletcher Campus. Discussions are under way with Newcastle City Council regarding the demolition of the building known as Kirkwood House located on the portion of the campus nominated for development of the new unit.

Manning emergency department
The redevelopment of the Manning Hospital emergency department is also underway. This project includes the creation of a car park which will operate as a site for the builder during construction of the emergency department. The emergency department project will see a significant increase in treatment spaces from the current nine to 22. This project has a total cost of $15-million.

Narrabri
The community of Narrabri benefited from two separate projects at Narrabri Hospital. The $350,000 emergency department project was completed in June and involved the

Health Services

relocation of the emergency department from its old location across the corridor. The final design included improved storage, security, a dedicated triage area and improved waiting spaces. A further $340,000 was spent on fire rectification and upgrade of infrastructure on the site.

Staff Accommodation
Staff accommodation is a way of improving recruitment and retention of staff in more rural locations. The Gunnedah staff accommodation had $200,000 spent on its development and a further $344,000 funded the refurbishment of Inverell staff facilities. Many visiting staff have access to these facilities when attending meetings at more remote sites.

Other Projects
Another project completed this year was the $800,000 Armidale intensive care upgrade. This project required the temporary relocation of the unit into the Day Surgery Unit whilst the refurbishment occurred. The project also included a significant upgrade of the equipment for the unit and improved security for patients and staff.

Gloucester Hospital operating rooms were upgraded at a cost of $160,000.

Information Management

Hunter New England Health's Information and Technology Services is responsible for providing an extensive range of technology services including desktop support, telecommunications, telehealth, application services delivery, applications development, and clinical systems support.

Summary of activity and services

- Development and approval of Information Services Clinical Systems Strategic Plan 2005-2007.
- Successful completion of all strategies targeted for the 2005-2006 period.
- Commissioning of high speed network integration between all merging entities.
- Consolidation of major systems and services to central data centre.
- Progress with merging IT services.

Major Goals and Outcomes

- Successful implementation of Clinical Applications Portal in time for commissioning of the Royal Newcastle Centre.
- John Hunter Data Centre formally approved as one of the three strategic data centres with Health Technology.
- The Systems Services and Health Information Exchange Support and Testing teams successfully transitioned to Health Technology.
- Successful go-live within Hunter New England of the NSW Health Healthelink first pilot.
- Consolidation and extension of a wide range of clinical and corporate systems across the Area.

Key Issues and Events

- Developing a productive relationship with Health Technology.
- Merging critical systems including CHIME and HIE.
- Delivering all clinical strategies on time.

Future Directions

Key strategies are:
- Single patient identifier expected to be in place by April 2007.

- Continued rollout of the electronic medical record solution.
- Completion of single Windows Domain.
- To position Hunter New England Area Health to be a lead Area in the State Human Resource Information System Strategy.
- Assist NSW Health in the rollout of the electronic health record across the entire Area.

Communication Services

Hunter New England Health's Communication Unit is responsible for delivering a comprehensive range of communication services including internal staff communication, community engagement, media liaison, fundraising and sponsorship, corporate marketing, campaigns and events, and publishing, including management of the Hunter New England Health intranet and internet sites.

In delivering these services to the health service, its communities and the media, the aim of the Communication unit is to:

- support staff in the delivery of health care services to the community
- ensure consumers and community groups are informed and have opportunity for involvement in the planning and delivery of health care services
- facilitate media access to timely, accurate information about the health service and broader public health issues
- maintain the health service's duty of care to patients as set out in the Privacy and Personal Information Protection Act 1998 and the Health Records and Information Privacy Act 2002

In its media liaison capacity, the Communication unit works with more than 75 media outlets across Hunter New England.

The Communication unit provides communication services for the entire Hunter New England Health area and has staff based throughout the Hunter and New England.

Throughout 2005-06, the Communication unit continued to lead the strategic communication activities to support the health service amalgamation. The team also worked closely with health service managers to establish a new consumer and clinician engagement framework to ensure the health service has effective consultation mechanisms for staff, stakeholders and the broader community.

Internal Audit

Internal Audit is responsible for co-ordinating Hunter New England Health's risk based approach to the Internal Audit function. This involves the division of internal audit functions into two key objectives, corporate governance and performance improvement and is achieved through liaison with the Chief Executive and other senior managers to maintain an understanding of the main risks facing Hunter New England Health.

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The Area utilises a co-sourced model for the conduct of the internal audit program with external contractors working as a team with internal audit staff to perform audit assignments.

In addition to a wide range of compliance audits ranging from services such as payroll to cash handling the audit function is a partner in the area wide fraud and corruption awareness education program.

Future compliance and performance improvement programs managed by internal audit will involve the increased use of computer data monitoring and analysis techniques as well as controlled self assessment to ensure the maximum penetration of all risk areas.

Workforce profile

To assist Hunter New England Health to achieve its objectives, Workforce Development has adopted a multifaceted approach to workforce issues that will address the range of factors impacting on the ability of the workforce to function with maximum effectiveness. The emphasis of the Directorate will be on facilitation, capability and sustainability of the workforce thus ensuring the development and implementation of effective people-related initiatives and business solutions that deliver a strategic advantage to Hunter New England Health as well as building and sustaining organisational capability.

To provide a clear strategic direction for Hunter New England Health workforce the Strategic Workforce Development Plan has been developed. This plan is in its infancy as we move forward in developing a sound framework in managing workforce planning. The primary purpose of this first version is to develop an integrated workforce plan across the Workforce Directorate and to establish a baseline profile of our workforce to identify initial strategic direction for the ongoing management of the workforce. Strategy development and evaluation is an ongoing process and is dependent on achieving this primary purpose.

The primary purpose of developing a strategic framework is to ensure that we have:

- The right people with
- The right capabilities in
- The right places at
- The right time

The health workforce has become the single most critical issue impacting on health care delivery. Aiming to secure a sustainable health workforce is not unique to Hunter New England Health but is a national and international concern with an increasingly global and mobile workforce. It has become a competitive market in acquiring an adequate, skilled workforce supply.

Workforce Development Planning is based on the following premises:

- Workforce development is research and evidence based to provide an integrated strategic approach to support the vision and mission
- Effective planning processes are required to identify, manage and provide appropriate resources to optimise the capacity and capability of

the workforce to deliver safe health care
- Promotes effective engagement and integration of staff
- Supports an organisational culture that identifies and respects the workforce as the most important element in our health care delivery system and recognises effective leadership as an integral component in establishing Hunter New England Health as an employer of choice

The Health Strategic Workforce Development Plan will be able to provide managers with a strategic basis for making workforce management decisions by addressing present and anticipated workforce issues and aligning business plans with strategic direction.

Executive Reports

Name: Terry Clout
Title: Chief Executive

Key Responsibilities

Responsible to the Director General NSW Health for the efficient and effective operation of the health service including corporate, clinical and public sector governance systems and outcomes to improve the health of the people of Hunter New England Health region.

Significant achievements during the reporting year

- Implementation of the Health Service's Corporate Governance Framework
- Implementation of the area-wide Risk Management Plan
- Above average hospital performance and strong strategies in place for sustained performance
- Strong working relationship with the Area Health Service Advisory Council and Clinical Councils
- Strong community and clinician engagement

Name: Dr Nigel Lyons
Title: Director Clinical Operations

Key Responsibilities

Responsible for overall management of all clinical services across Hunter New England Health. Services range from community health in rural communities through to tertiary referral hospitals. Services provided from over 110 sites across 130,000 square kilometres.

Significant achievements during the reporting year

- Improved access to services
- Access block performance
- Waiting time for elective surgery
- Off stretcher for ambulance patients
- ED triage
- Implementation of new management structure across acute, primary and community and mental health services
- Commenced networking of clinical services across area
- Enhancements to renal, critical care, mental health across Area
- Successful introduction of Belmont Midwifery Model
- Commissioning of Royal Newcastle Centre
- Completion of clinical redesign projects in Tamworth, Taree Emergency Departments, Adult Acute Inpatient Mental Health, Area Transfer of Care

Name: Kim Browne
Title: Area Director Population Health, Planning and Performance

Key Responsibilities

- Aboriginal Health
- Integration and partnerships
- Performance improvement

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- Population Health
- Strategic and service planning

Significant achievements during the reporting year

- Commencement of major Child Obesity Prevention Project (Kids Healthy Eating and Physical Activity) under the NSW Health ASSIST program
- Active involvement in Toomelah/ Boggabilla Strategy in conjunction with New England/North West Regional Coordination Management Group
- Completion of draft Area Strategic Plan, Area Healthcare Services Plan and other priority Clinical Services Plans
- Incorporation of risk management approaches into planning and performance management processes under the Hunter New England Health Integrated Risk Management Framework
- Establishment of Hunter New England Aboriginal Health Partnership Forum in conjunction with Aboriginal Community Controlled Health Services
- Ongoing development of effective reporting tools to support performance improvement and risk management across the AHS
- Successful application of Social Impact Assessment to Lower Hunter Regional Strategy in collaboration with Hunter Regional Coordination Management Group
- Introduction of single Area-wide Human Research Ethics Committee
- Successful merging of related service structures within the portfolio

Name: Dr Kim Hill (appointed from 27 March 2006)
Title: Director Clinical Governance

Period in Position: Three months (until 30 June 2006)

Key Responsibilities
The Director Clinical Governance is responsible for establishing, directing, managing and leading the implementation of the quality and patient safety framework, to continuously improve the quality of health care services, to safeguard high standards of care and to create an environment of excellence in clinical care.

Significant Achievements

- Implementation of policies on incident management and correct patient/ procedure/site progressed.
- First report on level of engagement of medical staff participation in performance management completed.
- Clinical practice improvement training pilot undertaken and project outcomes presented.
- Policy Implementation and Evaluation Framework developed and approved.
- New model Executive Support Service established to better coordinate complaints management, Health Care Complaints Commission and Anti-Discrimination Board matters, privacy and freedom of information reviews, and communication with authorities such as the Coroner and NSW Health
- Clinical Risk Management framework integrated with Corporate Risk Management as part of an Integrated Risk Management Strategy.
- Extension of mortality audit across sites in progress.

Name: Conjoint Professor Jennie West
Title: Director, Nursing and Midwifery Services

Key Responsibilities

- To advise Chief Executive to enable the Area Health Service to maintain an appropriately qualified and competent nursing workforce.
- To address nursing workforce requirements of recruitment and retention, professional development and changes to models of service delivery.
- Focus on policy, clinical practice and professional development for nurses.
- Provide advice in relation to setting the strategic direction for nursing services and develop, monitor, implement and review local nursing initiatives to ensure alignment with strategic directions.
- Provide advice and assistance in the development of Area Clinical Service Plans.
- Promote expansion of nurse practitioners.
- Provide advice on the development of clinical information systems which impact on clinicians and reporting of clinical data.

Significant achievements during the reporting year

- Increased new graduate nurse employment.
- Achieved 100 per cent employment of graduating Trainee Enrolled Nurses.
- Completed scoping of current nursing workforce.
- Facilitated revision of models of care in response to multiple factors including skill mix and patient acuity.
- Facilitated nursing professional development through Nurse Strategy funding and Locum Nursing Exchange Program.
- Provided executive leadership in Clinical Redesign programs Area-wide.
- Increased the number of Nurse Practitioners in Hunter New England Health.
- Have developed stronger linkages with the universities and UDRH (University Department of Rural Health) to promote and support clinical teaching.
- Lead development of Area Pandemic Plan.
- Executive sponsor for work towards achieving EQuIP Corporate.
- Developed stronger linkages with the universities and UDRH (University Department of Rural Health) to promote and support clinical teaching.

Name: David Dixon
Title: Director Workforce Development
Period in position: Commenced January 2005
Key Responsibilities:

- Responsibility for workforce planning
- Workforce development strategy
- Human resources strategy
- Organisational change and workforce learning and development
- Directing the efficient and effective provision of occupational health and safety
- Human resource and employee/ industrial relations services

Significant achievements during the report year:

- Coordinated the merging of services resulting from the amalgamation of the three former Area Health Services, Hunter, New England and Lower Mid North Coast.
- Delivered the first iteration of our Area's Workforce Development Plan supported by Workforce Development Strategic

Health Services

Plan.
- Established the Workforce Development Directorate with completion of recruitment to the new structure well advanced. The new human resource structure and increased technology base for human resources within the Workforce Development Directorate. Will result in a contemporary human resource structure and service delivery model with increased human resource matrix capability across the Area Health Service. The inclusion of both allied health and medical workforce development within the workforce structure sees Hunter New England Health well-placed to develop continuing innovative workforce strategies covering the full spectrum of health professions and occupations.
- Effectively implemented a sound consultative framework within which positive and effective industrial relationships have been established with our staff associations and unions.

Name: Tracey McCosker
Title: Director, Corporate Services

Key Responsibilities:

Leadership and Management of the following portfolios:

- Finance
- Information Management and Technology
- Corporate Risk
- Capital Works
- Mater PPP Project
- Property Management
- Shared Corporate Services, including
  - Logistics
  - Hotel Services
  - Facilities Management
  - Food Services
  - Linen Services
  - Security Services
- Area Clinical Business Units, including
  - Imaging
  - Pathology
  - Pharmacy
  - Brain Injury Service
  - Hunter Rehabilitation Services

Significant achievements during reported year

- Achieved positive Net Cost of Services result
- Paid all creditors within benchmark
- Received unqualified Audit Report on Financial Statements
- Achieved amalgamation savings targets for 2005/06
- Integrated a number of critical information management systems across amalgamated AHS
- Amalgamation of a significant number of portfolios within Corporate Services
- Mater PPP progressing on time and on budget
- Majority of Capital Works completed on time and on budget

Name: Allison Maxwell
Title: Director, Communication and Stakeholder Engagement

Key Responsibilities:

- Strategic Communication - internal and external
- Stakeholder engagement
- Media Management

Significant achievements during the reporting year:

- Successful restructure of the AHS Communication Unit to provide comprehensive communication services to staff, media and the community across a large and diverse geographic area.

- Significant achievement toward establishment of Hunter New England Health's community engagement framework through 47 Local Health Advisory Committees and five Community Forums on Health.

Name: Michael Di Rienzo
Title: Director Operations – Acute Networks

Key Responsibilities:

- Directing and managing the effective and efficient planning and delivery of all acute clinical services in our district and referral hospitals including John Hunter, Belmont, Royal Newcastle, Mater, Maitland, Manning, Tamworth and Armidale hospitals.
- Ensuring these services are aligned with the strategic priorities of Hunter New England Health and NSW Health.
- Ensuring integration within and across networks to help deliver quality health care.
- Implement the Managed Clinical Networks.

Significant achievements during the reporting year

- Improvement in ambulance off stretcher time and introduction of NSW ambulance matrix system into southern acute hospitals.
- Significant improvement in emergency department triage times, achieving better than benchmark and better than state average in all triage categories.
- Continued improvement in access block finishing the year at 13 per cent significantly better than benchmark and state figures.
- Improved waiting list performance with long waits greater than 12 months reduced from 338 to nine and number of patients waiting over 30 days reduced from 236 to 126.
- Continued improvement in overall length of stay at the acute hospitals
- Completion of Transfer of Care Redesign Program and roll out of improvement solutions.
- Commissioning of Royal Newcastle Centre and leading the relocation of clinical services from the Royal Newcastle Hospital to the new facility.

Name: Scott McLachlan
Title: Director, Operations – Primary and Community Services

Key Responsibilities

- Managing and leading the improvement of primary care services, service redesign and ensuring integration across networks to achieve quality care delivery
- Managing and leading the eight operational Clusters across the Area that entail community health services and the small and medium sized facilities.
- Overseeing the Aged Care and Rehabilitation and Cancer Managed Clinical Networks and other Area wide services such as Drug and Alcohol and Oral Health.
- Working with key stakeholders, including General Practice, Department of Community Services to enable integrated primary care approaches and develop working partnerships in order to benefit

the community.
- Actively participating in the community consultation process to ensure communities have key role in the planning and delivery of health services.
- Contributing to and enhancing strategic planning and policy development across the network.
- Developing innovative service models to ensure resources are appropriately utilised and place Hunter New England Health as a leader in the delivery of Primary Care Services.

Significant achievements during the reporting year

- All clusters have achieved ACHS Accreditation and all aged care services have received Commonwealth Accreditation.
- Development of Area-wide service plans for Aged Care and Rehabilitation, Cancer and Chronic Disease which look at the challenges over the next five years and changing service needs over this time.
- Finalisation of plans for the development of six Multi Purpose Services (MPS) and approval for other facilities to develop plans for both minor and major capital works.
- Development of plans for two new Integrated Primary Health Care Services that will integrate services between a number of service providers.
- Expansion of the Referral Information Centre and implementation of a statewide pilot project Sub-Acute Fast Track Elderly Care program (SAFTE) to provide clinical support to persons over 75 that have been identified as likely to be admitted to hospital.
- Significant expansion of the Community Health clinical information system CHIME to enable clinicians to make evidence-based decisions on their models of care.
- Implementation of a new management structure across the network which has aligned some 90 management positions.
- Implementation of several new telehealth models of care supporting rural communities through the use of technology to access specialist services.

Our People

Full time equivalents (FTE) as at 30 June 2006

Hunter & New England	June -03	June -04	June -05	June -06
Medical	564	630	687.2	726
Nursing	3,794	3,901	4,525.7	4,638
Allied Health	662	737	829	842
Other Prof. and Para professionals	365	326	336	306
Oral Health Practitioners and Therapists	114	98	110	120
Corporate Services	680	655	589	521
Scientific and technical clinical support staff	502	506	647	686
Hotel Services	1,070	1,039	1,168	1,176
Maintenance & Trades	201	184	206	205
Hospital Support Workers	955	1,064	1,346	1,369
Other	41	44	42	37
Total	8,948	9,183	10,485	10,626
Medical, nursing, allied health, other health professionals & oral health practitioners as a proportion of all staff	61.5	62.1	61.9	62.4
Medical, Nursing, Allied & staff as a proportion of all staff (%)	63.6	64.3	63.2	62.4
Third Schedule (Mater)	792	790	866	

Note: 2004 corporate service FTE increased by 24 to reflect transfer of FTEs resulting for Health Service amalgamations
Source: DOH 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 Annual Report as employees.
3. Includes salaried (FTEs) staff employed with Health Services and the NSW Department of Health. All non-salaried staff such as contracted Visiting Medical Officers (VMO) are excluded.
4. In 2006, the collation of data has been improved by including an additional 4 staff categories to provide greater clarity between staff functions. Previous years data has been re-cast to reflect these changes, which has resulted in variations from figures reported in previous Annual Reports. The previous category 'Hospital Employees' has been replaced with 'Other Professionals & Para-professionals, which includes health education officers, interpreters etc and 'Scientific & technical support workers' e.g. hospital scientists & cardiac technicians. Award codes assigned to allied health have been reviewed and only the following professions have been included in the category; audiologist, pharmacist, social worker, dietitian, physiotherapist, occupational therapist, medical radiation scientist, clinical psychologist, psychologist, orthoptist, speech pathologist, orthotist/prosthetist, medical radiation therapist, nuclear medical technologist, radiographer and podiatrist to more accurately reflect this workforce. A category for Oral Health Practitioners & Therapists has been included as well as one for Hospital support workers, which includes ward clerks & IT support officers etc. Uniformed Ambulance officers have been revised to reflect ambulance on road staff & ambulance support staff.

Hunter New England Health values the diversity of the people who work for it and is committed to employment practices that are fair and equitable to everyone.

Hunter New England Health actively supports and works in collaboration with Migrant Work and Disability Employment Programs and collects Equal Employment Opportunity (EEO) information from its staff. This information helps to determine if EEO policies are making Hunter New England Health and equitable place to work, while also allowing better planning and implementation of EEO policies and programs.

Hunter New England Health will promote equal employment opportunity in the workplace by targeting groups such as Aboriginal people and Torres Strait Islanders, people whose first language is other than English.

The table below represents the income distribution of staff according to different levels of earnings, not including casuals.

Staff numbers by level

Level	Total staff	Respondents	Men	Women	Aboriginal people & Torres Straight Islanders	People from racial, ethnic, ethno-religious minority groups	People whose language spoken as a child was not english	People with a disability	People with a disability requir-ing work related adjust-ment
<32,606	228	210	35	193	14	9	6	11	2
$32,606-$42,824	4,612	4,129	1,077	3,535	110	116	112	137	40
$42,825 - $47,876	948	888	205	743	12	28	81	27	8
$47,877-$60,583	3,549	3,236	532	3,017	35	114	118	106	37
$60,584-$78,344	1,995	1,812	425	1,570	23	84	86	74	14
$78,345-$97,932	755	697	352	403	8	70	81	22	7
>$97,932 (non SES)	472	369	333	139	2	41	43	6	0
>$97,932 (SES)		0	0	0	0	0	0	0	0
Total	12,168	11,341	2,959	9,600	204	462	527	383	108

Staff numbers by employment status

The chart below represents the number of staff within Hunter New England Health according to various groups, including casuals and seasonal staff.

Level	Total staff	Respondents	Men	Women	Aboriginal people & Torres Straight Islanders	People from racial, ethnic, ethno-religious minority groups	People whose language spoken as a child was not english	People with a disability	People with a disability requir-ing work related adjust-ment
Permanent Full-time	6,542	5,950	2,088	4,454	111	257	248	224	58
Permanent Part-time	3,563	3,160	276	3,287	28	88	76	105	38
Temporary Full-time	1,458	1,317	412	1,046	42	77	167	23	4
Temporary Part-time	885	809	145	740	16	38	33	24	7
Contract - SES		0	0	0	0	0	0	0	0
Contract - Non SES	10	10	6	4	0	0	0	0	0
Training Positions	101	95	32	69	7	2	3	7	1
Retained Staff		0	0	0	0	0	0	0	0
Casual	2,148	1,815	372	1,776	34	157	191	35	10
Total	14,707	13,156	3,331	11,376	238	619	718	418	121

The following table is a representation of each group by employment basis.

EEO Group	**Benchmark or Target**	**2006**
Women	50%	76%
Aboriginal people and Torres Straight Islanders	2%	1.8%
People whose first language was not English	20%	5%
People with a disability	12%	3%
People with a disability requiring work related adjustment	7%	0.9%

Our People

Occupational Health and Safety

Hunter New England Health staff are its most precious resource. We are committed to maintaining a healthy and safe workplace. In 2005/06 the safety and risk management programs of Hunter and New England Health Services were integrated.

Performance Indicator	2004/05	2005/06
No. claims/ 100FTE	7.25	7.18
Cost of claims	$439.62	$198.20

Source: NSW Treasury Managed Fund database as at 30 June 2006.

The tables below express claims as a percentage of the total by accident type and occupational group.

Accident Type	2004/05	2005/06
Being Hit By Moving Objects	11%	12%
Biological Factors	1%	0%
Body Stressing	44%	44%
Chemicals And Other Substances	2%	2%
Falls Trips And Slips Of A Person	15%	14%
Heat Radiation And Electricity	1%	2%
Hitting Objects With A Part Of The Body	5%	5%
Mental Stress	7%	5%
Other And Unspecified Mechanisms Of Injury	7%	7%
Sound And Pressure	1%	1%
Vehicle	6%	8%

Occupation Group	2004/05	2005/06
GENERAL ADMN	12%	12%
HOTEL SERVCE	24%	24%
LINEN SERVCE	4%	2%
MAINTENANCE	5%	4%
MEDICAL	3%	3%
MEDICAL SUPP	8%	10%
NURSES	43%	45%
OTHER	1%	0%

Source: NSW Treasury Managed Fund database as at 30 June 2006.

Hunter New England Health was prosecuted during August 2005. A guilty verdict was handed down on 2 September 2005 on the grounds of breach of Section 15(1) of the OHS Act, 1983. The incident was the result of an employee being assaulted by a patient in the Kestrel Unit of Morisset Mental Health Hospital on 1 January 2001. Hunter New England Health was fined $105,000 and ordered to pay costs.

Teaching and Training Initiatives

Allied Health

- Active participation in the planning for the three year Podiatry program to commence at the University of Newcastle in 2007;
- Engagement with the recently developed pharmacy program at the University of Newcastle;
- The Area provided over 12,000 student clinical placement days in the clinical placements programs of 12 universities. This has included student feedback processes on clinical education and co-

ordination;
- An Area level Clinical Supervisor Register has been established for all professions
- Professional development plans and at least one major annual professional development forum per profession supports the ongoing training and development of our staff
- Student-run clinical programs are operational such as a malnutrition cooking skills program (Cooking for 1 or 2) and a university-run clinic at John Hunter Hospital for people who are overweight;
- Supporting staff participation in their own development including NSW Rural Allied Health Conference funding (some subsidy provided by NSW Health), National Rural Health Alliance Conference, and supporting staff to present at numerous conferences.
- A number of staff were successful in obtaining highly competitive Commonwealth or State level scholarships to advance their learning.

Physicians

- 47 Basic Physician Trainee Medical Registrars are providing service in Internal Medicine at seven hospitals, while participating in training. These seven hospitals include John Hunter Hospital (15 positions), Newcastle Mater Hospital (15), Belmont Hospital (4), Maitland Hospital (4), Manning Hospital (2) and Tamworth Hospital (2). We have five general leave relief positions.
- Comprehensive tutorial program to preparing candidates for the FRACP examination process.
- Lecture series delivered by specialist physicians from local hospitals.
- Access to a teleconference lecture series originating in Melbourne through telehealth facilities in John Hunter, Maitland, Manning and Tamworth hospitals.
- Professional development training programs for our trainees, as a pilot project in conjunction with the Victorian Postgraduate Medical Council.
- Ongoing tuition, assessment, and feedback sessions for examination candidates, developing trainee skills in short case and long case interpretation and presentation.
- In July 2005, nine basic trainees graduated into advanced training positions following their successful passage through the Royal Australasian College of Physicians examination process.
- 28 Advanced Trainee Medical Registrars are at various stages of training in the John Hunter Hospital and the Newcastle Mater Hospital, completing their Specialist Physician qualifications.

Undergraduate Medical students

- The number of students from rural areas is increasing. From 2007 (applications 2006) we will have a rural stream guaranteeing about 30 per cent of our students will be from rural areas.
- Planning is also underway with the University New England for a joint medical degree.

Junior Medical Officers (JMO)

- Rolling out Teaching on the Run across region with over 300 registrants.
- Simulation Crisis Management Workshops where participants

manage scenarios that reflect real life situations and practice teamwork, communication skills and delegation of responsibility including analyses of the causes of adverse events. Feedback received from 40 participants (Resident Medical Officers) in terms of educational value has been extremely positive.

Career Medical Officers

- Developing a distribution/circulation network
- providing simulation training in emergency care.
- Convened a highly successful medical education conference attracting 75 delegates including national leaders in medical education.

International Medical Graduates (IMGs):

- Established a tailored orientation program for Australian Medical Council (AMC) graduates joining the organisation through the JMO Unit.
- Successful in receiving a grant for $77,000 from NSW Health to pilot a case management program to support AMCs including English language tuition service and mentoring program.
- Consulting with Premier's Department and NSW Health regarding alternative assessment of AMCs in preparation for internship, developing a model for piloting.
- Three-day tailored orientation program for IMGs held throughout the year dependent upon need.

Area of Need Doctors

- Co-ordinated and facilitated two-day orientation program in Tamworth

Nursing and Midwifery

- Over 500 registered nurses have undertaken programs in clinical supervision.
- Increased number of students in Trainee Enrolled Nurse program.
- In excess of 500 nurses have undertaken education through Nurse Strategy fund initiative.
- Enrolled Nurse Perioperative program commenced.
- Continued to support Midwifery education program through Charles Sturt University and University of Newcastle.

Research

In 2005 a working party oversaw the merger of the Research Ethics functions from the former Hunter and New England Area Health Services and, as of 1 January 2006, the Hunter New England Human Research Ethics Committee (HNEHREC) become operational. The new Committee is the sole Human Research Ethics Committee for Hunter New England Health and has been established to review research:

- where patients, clients or employees of Hunter New England Health are participants;
- conducted by staff of Hunter New England Health;
- involving personal health data or tissue samples in the custody of Hunter New England Health; or
- using resources of Hunter New England Health.

The Committee will approve such research when it is in accordance with the National Statement in Ethical Conduct in Research Involving Humans 1999.

The Hunter New England Human Research Ethics Committee has two advisory two

subcommittees:

- The Clinical Trials Subcommittee advises HNEHREC on methodological and pharmacological aspects of applications to conduct clinical trials and innovative therapy.
- The Rural Research Methods Support Group advises HNEHREC on methodological and additional concerns about applications to conduct rural research in the Hunter New England Health area. The Rural Research Methods Support Group will also act as a resource for those embarking on research.

From the period January to June 2006 the Hunter New England Human Research Ethics Committee had reviewed 101 applications for ethical approval for research involving humans, 31 of which had been reviewed by the Clinical Trials Subcommittee and 20 of which were reviewed by the Rural Research Methods Support Group.

Hunter Medical Research Institute

Hunter Medical Research Institute undertakes health and medical research to change people's lives, to reduce suffering in those who are ill and to prevent or minimise the occurrence of illness in those who are well.

In partnership with the University of Newcastle, Hunter New England Health and the community, researchers are working at multiple levels to develop better methods of treatment, diagnosis and disease prevention, and to translate discoveries into commercial products and better health policies. HMRI receives funding through the NSW Health Research and Development Infrastructure Grants Program. This supports essential research infrastructure in the form of staff salaries, equipment and facilities and has resulted in the enhancement of our region's research capacity. Researchers work across six programs:

- Brain and mental health
- Cancer
- Cardiovascular health
- Public health
- Pregnancy and reproduction and
- Viruses, Infection/Immunity, Vaccines and Asthma (VIVA).

Our People

Official Overseas Travel

Hospital	Applicant Surname	Total Cost	Course Title	Course Location
JOHN HUNTER HOSPITAL	Evans	$1,438.33	Injury 2005	Auckland - New Zealand
JOHN HUNTER HOSPITAL	King	$1,888.33	Annual Injury Conference & Meeting of the Australasian Trauma Society	Auckland New Zealand
MAITLAND	Howard	$0.00	Annual meeting of European Soc for paediatric infectious diseases	Basel, Switzerland
MAITLAND	Howard	$2,510.00	Hunter Paediatric Society - Australian paediatric Endocrine Group	Fiji
JOHN HUNTER HOSPITAL	Fullerton	$0.00	Birthspirit's Technical skills for Midwives	Hamilton New Zealand
JOHN HUNTER HOSPITAL	Hastie	$0.00	Birthspirit's Technical skills for Midwives	Hamilton New Zealand
JOHN HUNTER HOSPITAL	Donnelly	$0.00	Birthspirit's Technical skills for Midwives	Hamilton New Zealand
JOHN HUNTER HOSPITAL	Kewley	$2,644.98	5th International Clinical Practice Development Conference	Hamilton New Zealand
JOHN HUNTER HOSPITAL	Ambler	$2,644.98	5th International Clinical Practice Development Conference	Hamilton New Zealand
PATIENT SUPPORT SERVICES	Pearce	$530.00	ISOPP Symposium on Oncology Pharmacy Practice	Kuala Lumpur Malaysia
HUNTER AREA PATHOLOGY SERVICE	Williams	$0.00	Excellence in Leadership - Meeting tomorrow Challenges today	Las Vegas Convention Centre Nevada
JOHN HUNTER HOSPITAL	Turner	$0.00	International Society of Affective Disorders	Lisbon, Portugal
JOHN HUNTER HOSPITAL	Williams	$0.00	ESPE/LWPES Seventht Joint meeting Paediatric Endocrinology (APEG)	Lyon, France
HUNTER AREA PATHOLOGY SERVICE	Kitcher	$4,735.00	Real-Time PCR for the Clinical Microbiology Laboratory	Rochester, Minnesota, USA
HUNTER AREA PATHOLOGY SERVICE	Watson	$4,735.00	Real-Time PCR for the Clinical Microbiology Laboratory	Rochester, Minnesota, USA
JOHN HUNTER HOSPITAL	Jones	$0.00	AASLD The Liver Meeting	San Francisco USA
JOHN HUNTER HOSPITAL	Ianna	$0.00	AASLD The Liver Meeting	San Francisco USA
CHILD & ADOL HH STATE NTWK	Cubis	$10,150.61	AACAP Conference	Toronto - Canada
MAITLAND	Porter	$2,532.00	ISQUA Innovating for Quality	Vancouver Canada
PRIMARY & COMMUNITY	Turner	$2,000.00	12th Internation conference on X-linked mental retardation & fragile X	Virginia, USA
JOHN HUNTER HOSPITAL	Thompson	$500.00	Australasian Conference on Child Abuse and Neglect	Wellington NZ
MAITLAND	Howard	$0.00	RCPCH Spring scientific meeting	York, UK

Our Community

Working with clinicians and the community

By engaging with clinicians and communities Hunter New England Health can improve the decisions it makes and ultimately improve the health of the people of Hunter New England.

Area Health Advisory Council

As part of the health service reforms, the NSW Minister for Health announced the establishment of an Area Health Advisory Council for each Area Health Service.

The Area Health Advisory Council provides an essential forum for the community to have its say in how health services are delivered across Hunter New England Health.

The Hunter New England Area Health Advisory Council advises the Chief Executive and facilitates involvement of clinicians, health consumers and other community members in the development of the Area Health Service's policies, plans and initiatives for the provision of health services.

The NSW Minister for Health John Hatzistergos announced the appointment of Associate Professor Lyn Fragar AO as the Chair of the Hunter New England Health Advisory Council in April 2005 and appointed the members of the Hunter New England Health Advisory Council on 29 September 2005.

The members are:

Associate Professor Lyn Fragar AO is director of the Australian Centre for Agricultural Health and Safety (University of Sydney). She was awarded Officer of the Order of Australia in recognition of work in farm health and safety at local, state and national levels. Prof Fragar is Director of the Australian Rural Health Research Collaboration. She is executive director Farmsafe Australia. Deputy chair of the Australian Pesticide and Veterinary Medicines Authority - a statutory authority of the Federal government. Prof Fragar is the instigator and inaugural secretary of the Moree and Community Rural Counselling Service, and is currently the Patron of that service. Prof Fragar resides in Moree.

Dr Jim Croker has been a consultant physician, general physician and rheumatologist at Tamworth Hospital since 1988. Dr Croker resides in Tamworth.

Professor John Marley is head of the Faculty of Health at The University of Newcastle. He has worked as a GP in Aboriginal communities. Professor Marley is a Fellow of the Australian College of Rural and Remote Medicine and Royal Australian College of General Practitioners. Professor Marley resides in Newcastle.

Dr Anthony Bookallil recently retired as a surgeon at John Hunter Hospital. He is a Past President of the NSW Neurosurgical Association. Dr Bookallil is a trained neurosurgeon and lives in Newcastle.

Ms Deborah Hogan is a registered

Our Community

nurse. She has a Master of Management in Community Management. Ms Hogan has worked in the disability sector for 15 years. She is operations manager for non-profit organisation Hunter Integrated Care inc. which provides services to frail aged people, people with a disability and carers. Ms Hogan resides in Singleton.

Mr Philip Webster is a retired senior manager from the Department of Education. He completed Consumer Health Advocacy Training in 2003. He was chair of the Community Health Forum of Great Lakes, Greater Taree and Gloucester in 2003 and 2004. Mr Webster is Chair of the Taree Prostrate Support Group and resides in Forster.

Ms Janice McKay is member of the Committee of Asthma NSW – Hunter Branch. She is a clinical psychologist at the Hunter Centre for Gynaecological Cancer, John Hunter Hospital. Ms McKay's qualifications include honours in psychology. She resides in Jewells and is an advocate for mental health services.

Dr Ian Kamerman is a GP and Visiting Medical Officer. He works at Tamworth and Barraba. Dr Kamerman is a director of the Australian College of Rural and Remote Medicine. He is a former New England Area Health Service Board member. Dr Kamerman resides in Calala.

Mr Peter Dennis is retired. He is President of the Gunnedah Multiple Sclerosis Group, life member of the NSW Pharmacy Guild, Foundation President of the Gunnedah Multiple Sclerosis Group as well as the Royal Blind Society. Mr Dennis resides in Gunnedah.

Dr Mary Cruickshank is a registered nurse and senior lecturer in the School of Health, University of New England. She resides in Armidale.

Mr Keith Gleeson is a medicine student in his final year at The University of Newcastle. He has been a ranger for National Parks and also chairman of the local Aboriginal Land Council. Mr Gleeson resides at Lake Munmorah.

Ms Wendy Hordern is manager, Community Health Services in Hunter New England Health Upper Hunter cluster. She has experience in both acute and community based health services as well as management at a senior level. Wendy is a registered nurse and midwife. She resides in Denman.

Ms Gaye Hart is a businesswoman with a background in education. She has held many senior positions including the role of Director of Hunter Institute – TAFE NSW. Ms Hart is a previous Board Member of the Newcastle Port Corporation and the Australian National Maritime Museum. She is currently president of the Australian Council for International Development and a Trustee of the Australian Multicultural Foundation. Ms Hart was awarded a Member in the Order of Australia in 1989. She resides in Newcastle.

Council members were selected for their understanding of the health challenges facing NSW communities. The Council is a crucial part of the health service's framework to ensure local communities and clinicians play an integral role in the planning and development of health services.

During 2005/2006, the Hunter New England Health Advisory Council has met at health sites across the region (including Manning Hospital, Guyra MultiPurpose Service and Maitland Hospital) and heard from local clinicians, as well as the Local Health Advisory Committees on how the Area Health Service can improve communication with clinical staff, as well as other matters of concern to clinicians.

Council members have also reviewed the role of the Council, the activities it will undertake and how best the Council members can play an effective, valued role within the Area Health Service.

Engagement Framework

Developing a framework for community and clinical engagement over Hunter New England Health's enormous geographic area with many sectional interest groups has been a challenging task over the past 12 months. With the diversity of population, it is not feasible to be truly representative of every group. Recognising this, Hunter New England Health's Community and Clinical Engagement Framework aims to make it possible for every group to have input at a variety of levels in different ways (see diagram).

The model has been developed taking into account:

- The geographic and population diversity of the new area
- The overall structure of Hunter New England Health
- The availability of appropriate resources
- Formal feedback structures
- Development of community trust
- Belief in transparency of decision making
- The relationship of the local community with the Area Health Advisory Council

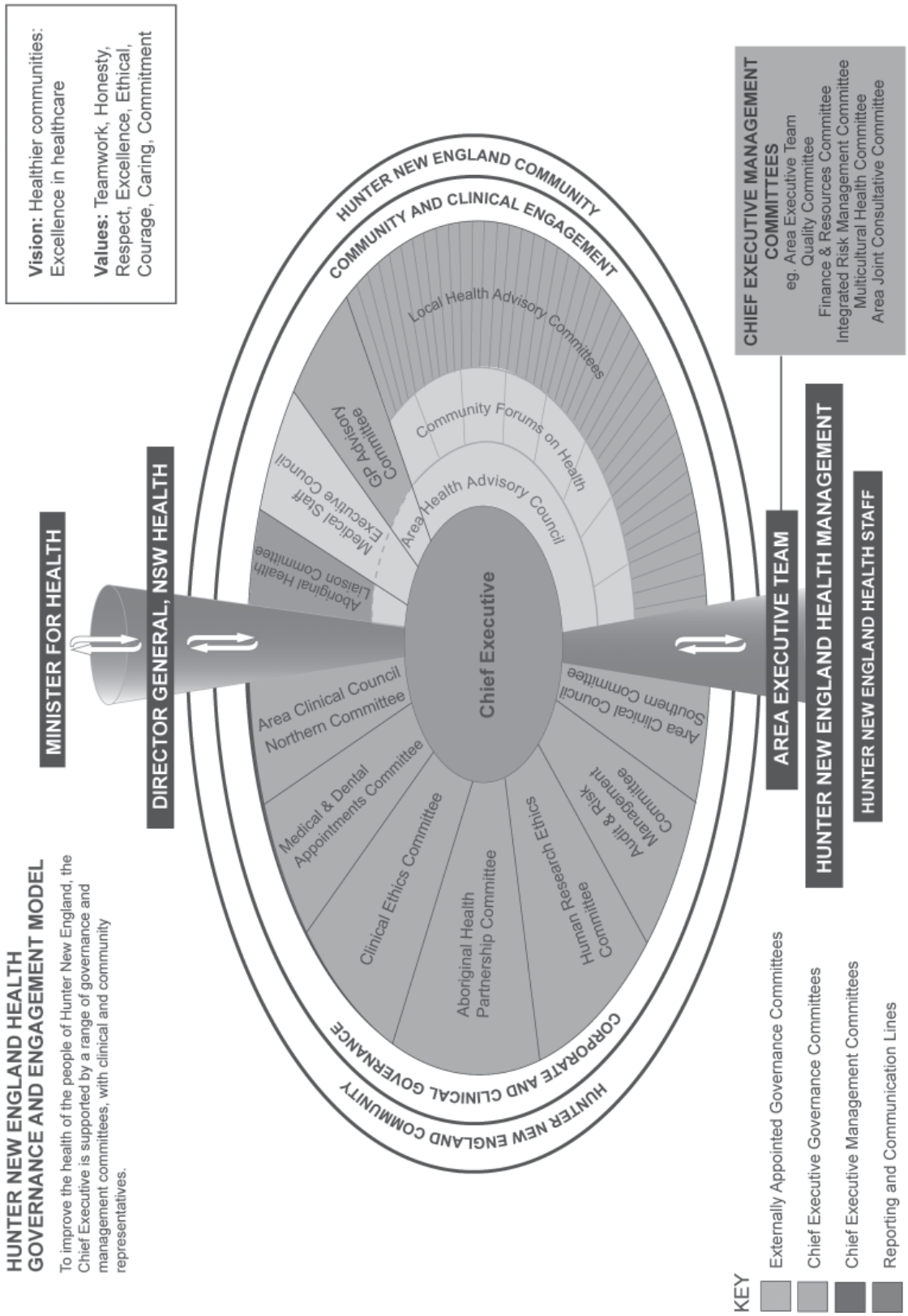
Hunter New England Health will engage with stakeholders by establishing and working with the following groups:

- Local Health Advisory Committees (locality-based)
- Community Forums on Health (geographic cluster-based)
- GO Advisory Committee
- Aboriginal health Liaison Committee
- Medical Staff Executive Council
- Area health Advisory Council (appointed by the NSW Minister for Health)

Our Community

Governance and Engagement Model

To view a full-colour version of the Governance and Engagement model visit:
www.hnehealth.nsw.gov.au/about/governance/index.htm



Our Community

Our Volunteers

Hunter New England Health is supported by approximately 1600 volunteers. Hospital auxiliaries, pink ladies, community groups and individuals donate their time, commitment and caring to enhance patient care and to support staff and visitors.

Many of our volunteers work directly to support our hospitals, managing gift shops and helping patients with daily grooming. Other volunteers support special programs such as play therapy and Arts for Health or are involved in fundraising groups to support specific areas such as Hunter Medical Research Institute or with patient support groups.

Hunter New England Health also gratefully receives support from clergy of all denominations, who provide spiritual support and pastoral care to hospital patients and aged care residents.

Multicultural Health

The overall aim of all the programs of the Multicultural Health Unit is to ensure that people of culturally and linguistically diverse (CALD) backgrounds have access to culturally and linguistically appropriate health care. The professional services of the unit are supportive to health professionals and clients alike and are integrated into the workings of the whole of Hunter New England Health Service.

Achievements for the past year include:

- A protocol has been developed which includes education on breast care, pap smears, sexually transmitted diseases and includes clinical test and consultations in sexual health clinics for refugee women.
- The program has begun for gradual replacement of Folstien Mini Mentals State Exam (MMSE) with Rudas by Aged Care teams across the area to test the cognitive function of elderly migrants. Rudas is a cognitive assessment tool developed to overcome the cultural, literacy and numeracy bias of the existing MMSE and does not disadvantage seniors who speak English as a second language.
- A meditation/prayer room for staff, family and patients has been developed in the newly opened Royal Newcastle Centre. The room has been especially designed to allow for people of Christian, non-Christian or no faith to be able to spend quiet time for spiritual renewal especially in times of great stress, suffering or loss. There is also a washing facility for Muslims wanting to follow their daily prayer rituals.
- Multicultural Access Committees in the northern region and Lower Mid North Coast have developed plans and protocols for regular meetings after consultation with members of the local migrant communities. The greater focus on the needs of CALD has already resulted in greater use of the services of the Multicultural Health Unit.
- A comprehensive education program has been developed across the sector to improve the understanding of staff about managing cultural and linguistic

differences in a mental health setting.

- By popular demand a series of education sessions have been provided to African men around the nature of sexually transmitted disease and how to manage a healthy sex life.
- A regular report on data related to the use of interpreters is prepared as a quality improvement activity to monitor the use of interpreters in emergency departments of major referral hospitals. A six monthly report on the use of interpreters for people who stated that they need an interpreter in emergency departments of the John Hunter Hospital, Belmont Hospital, Mater Hospital and Maitland Hospital will be followed up with education of 80 per cent of staff to ensure that they understand the requirements under the standard procedures and a repeat report covering a six month period will be conducted to measure improvement in performance.
- All failure to use an interpreter when one has been asked for or the medical record and circumstances indicate that one should have been used will be recorded in the IIMS data base and reported on as a miscommunication.
- A number of meetings have already been held with the divisions of GPs and the health department staff to discuss the best management of the health of newly arrived refugees in the Northern sector.
- To ensure that all newly-arrived refugees are able to access appropriate health care a Multidisciplinary Refugee Management Committee will be established to give direction and coordination to services across the Area.

Non Government Organisations Grant Administration Unit

Hunter New England Health is committed to building effective relationships with the NGO sector to improve the health of the Hunter New England population. The NGO Grant Administration Unit, in conjunction with NSW Health and Hunter New England Health, is responsible for administration, service monitoring and support provision to NGOs funded under the NSW Health NGO Grant Program.

Health-funded NGOs are community based, not-for-profit incorporated organisations with their own management structures that are responsible for the operation of their services and for compliance with legislation, government policy, accountability and quality assurance practices. Grants to NGOs are conditional on the organisation's performance as required in funding and performance agreements established with Hunter New England Health Health in line with the NSW Health NGO Grant Program Operational Guidelines.

In 2005/2006, in conjunction with NSW Health, Hunter New England Health was responsible for the administration, service monitoring and support provision to 51 NGOs delivering 56 health funded projects with a total funding of $4,268,120.

The following were major achievements:

- In line with the implementation of the NSW Carers Program in 2003, grants totalling $137,120 were allocated in 05/06 to the NGO sector for one-off local carer support initiatives.
- Community Dialysis Services provided by the Nita Reed project of the Mid North Coast Kidney Foundation were transferred to Hunter New England Health on 1 November 2005.
- Three Forums for health funded NGOs were conducted to provide information exchange and education including a training workshop on Key Performance Indicators based on the Mark Friedman model in December 2005 at Muswellbrook.
- Review of the number of Hunter New England Health Health NGO Forums to be convened and of the terms of reference was undertaken to align with the NSW Health NGO Advisory Committee and the NSW Health NGO Coordinators Committee.
- An NGO Policy Officers Workshop was conducted for Hunter New England Health Health Program area staff involved with monitoring and support to health funded NGOs.
- Hunter New England Health Health NGO Management Unit staff were nominated to represent Non Metropolitan NGO Coordinators on the NSW Health NGO Advisory Committee, and to the role of Chair of the NSW Health NGO Coordinators Committee for the calendar year of 2006.

Drug and Alcohol program

McAuley Outreach – Mercy Care
Project funded by Department of Health: Support services for parents with young children who have drug and alcohol problems
Amount of Funding : $179,700
Review date: June 2008

DREAMS – Mercy Care
A two year project funded by Department of Health: A residential rehabilitation service for Women and their children
Amount of Funding: $148,125
Review date: June 2006

Newcastle Youth Service
Project funded by Department of Health: Youth networking, streetwork / needle exchange, education and counseling for young people aged 12 – 24 years.
Amount of Funding: $105,400
Review date: June 2006

Salvation Army - Miracle Haven
Project supported by Department of Health: A residential rehabilitation service for those affected by alcohol and other drugs.
Amount of Funding: $338,070
Review date: June 2007

St Vincent de Paul – Freeman House
Project funded by Department of Health: A residential rehabilitation treatment place.
Amount of Funding: $94,225
Review date: June 2006

Upper Hunter Drug & Alcohol Services
Project funded by Department of Health: Community development, education, information and counseling in Drug and Alcohol for Upper Hunter.
Amount of Funding: Base Grant $137,200
Review date: June 2008
Project funded by Area Health: MERIT (Magistrate Early Referral Into Treatment) $30,000, METHADONE $45,000
Review date: June 2007

We Help Ourselves
Project funded by Department of Health: Seven MERIT (Magistrate Early Referrals Into Treatment) designated beds.
Amount of funding: $176,295
Review date: June 2007

AIDS Program

ACON NSW Inc
Project funded by Department of Health: Provide case management and referral services to people (HIV/AIDS affected) presenting with a range of needs including accommodation
Amount of Funding: $110,800
Review date: June 2007

Karumah Inc.
Project funded by Department of Health: A drop-in day centre for people who are HIV positive, their friends, families and carers.
Amount of Funding: $124,300
Review date: June 2008

Oral Health

BIRIPI AMS
Project funded by Hunter Oral Health: Provision of dental treatment to the Aboriginal community
Amount of funding$ 51,100
Review date: June 2006

Community Services, Women's Health and Health Transport

Asthma Foundation of NSW
Project funded by Department of Health: Asthma education programs throughout the Hunter Region for groups who have a role in the care of people with asthma.
Amount of Funding: $52,700
Review date: June 2006

CARELINK
Project funded by Department of Health: A support service for Cancer and Community Transport of Port Stephens Palliative Care patients, their carers and significant others,

Non Government Organisations Grant Administration Unit

who reside in the Upper Hunter Region.
Amount of Funding: $28,500
Review date: June 2006
Project funded by Department of Health: Provision of health related transport
Amount of Funding: $18,100
Review date: June 2008

Dungog Shire Palliative Care Volunteers
Project funded by Department of Health: Support services for people with a terminal illness and their carers.
Amount of Funding: $14,400
Review date: June 2007

FPA Health
Project funded by Department of Health and supported by Hunter New England Health: Provision of reproductive preventive and sexual health promotion interventions.

Homeless Housing Support Group Inc for specific population groups
Amount of Funding: $37,640
Review date: June 2007

Project funded by Department of Health: brokerage/outreach service for homeless men 18 years and over.
Amount of funding: $23,800
Review date: June 2008

Hunter Volunteer Centre Inc
Three Year Project funded by Hunter New England Health: To provide referral and resourcing of volunteers to Hunter New England Health and health related NGOs
Amount of Funding: $70,000
Review date: June 2006

Hunter Women's Centre
Projects funded by Department of Health:
• Counselling Service
• Health promotion and Group work

Inverell HACC Services Inc
• Medical and Nurse clinical services
Amount of Funding: $334,000
Review date: June 2007

Project funded by Department of Health: Provision of individual transport to severely transport disadvantaged people within the Inverell HACC sub-region.
Amount of Funding: $12,800
Review date: June 2008

Lifeline Newcastle & Hunter
Project funded by Department of Health: 24hrs/7day Telephone Crisis Counseling and Associated Welfare Services.
Amount of Funding: $69,300
Review date: June 2008

Lifeline Tamworth
Project funded by Department of Health: a 24-hour telephone counselling service accessible to New England and North West communities.
Amount of funding: $21,200
Review date: June 2008

Maitland Volunteer Palliative Care Service
Project funded by Department of Health: Support services for patients whose cancer or other life threatening illness no longer responding to curative treatment
Amount of Funding: $47,100
Review date: June 2006

Make Today Count
Project funded by Department of Health: Support services for people suffering life-threatening illness, their families and carers, and bereavement support.
Amount of Funding: $34,600
Review date: June 2006

Manning Valley & Area Community Transport
Project funded by Department of Health: Provision of health related transport
Amount of funding: $19,300
Review date: June 2008

Merriwa & District Community Care
Project funded by Department of Health: Provision of health related transport
Amount of funding: $6300
Review date: June 2008

Mid North Coast Kidney Association – Nita Reed
Project funded by Hunter New England Health: A community Dialysis Centre
Amount of Funding: $108,133
Review date: n/a. Service transferred to Hunter New England Health Health November 2005

Samaritan Foundation- Coalfields Healthy Heartbeat
Project funded by Department of Health: Heart health promotion within Cessnock LGA
Amount of Funding: $61,400
Review date: June 2007

Singleton HACC Services
Project funded by Department of Health: Provision of health related transport
Amount of funding: $15,000
Review date: June 2008

Tablelands Community Transport
Project funded by Department of Health: Provision of health related transport
Amount of funding: $22,500
Review date: June 2008

Upper Hunter Community Care Inc
Project funded by Department of Health: Provision of health related transport
Amount of funding: $6,300
Review date: June 2008

Wee Waa & District HACC Assoc Inc
Project funded by Department of Health: Provision of health related transport
Amount of funding: $22,500
Review date: June 2008

Mental Health Program

Association of Relatives and Friends of People Who Have a Mental Illness (ARAFMI)
Project funded by Department of Health: Mutual support services for families and carers of people with a mental illness.
Amount of Funding: $58,600 Base Grant
Review date: June 2007
Project funded by Hunter Mental Health: $51,150 Carers Support
Review date: June 2006

Billabong Clubhouse Inc:
Project funded by Department of Health: A Clubhouse psychosocial model of community support and rehabilitation for people with mental illness.
Amount of funding: $80,600
Review date: June 2008

Hunter Joblink

Kaiyu Enterprises – Lake Macquarie Clubhouse
Project funded by Hunter Mental Health: Vocational training and supported employment service for people with mental illness/psychiatric disability.
Amount of funding: $71,610
Review date: June 2006
Project funded by Department of Health:

A Clubhouse psychosocial model of community

Life Without Barriers
Support and rehabilitation for people with mental illness.
Amount of funding: $120,000
Review date: June 2006

Project funded by Hunter Mental Health: Sport and recreational opportunities for people with a mental illness.
Amount of funding: $52,173
Review date: June 2006

Psychiatric Rehabilitation Association
Project funded by Hunter Mental Health: Community Rehabilitation Program for people with serious and persistent mental illness through a range fo social and rehabilitation practices.
Amount of funding: $334,521
Review date: June 2006

Richmond Fellowship
Project funded by Hunter Mental Health: Supported accommodation service for people with mental illness/ psychiatric disability.
Amount of funding: $564,185
Review date: June 2006

Schizophrenia Fellowship
Project funded by Department of Health: Community development project to ensure sustainable support groups
Amount of Funding: $37,173
Review date: June 2006

Aged and Disabled/Carers Program

The Australian Arthrogryposis Group
Project funded by Department of Health: Provision of support and information to families affected by arthrogryposis and interested professionals
Amount of Funding: $5100
Review date: June 2006

Mercy Community Care
Project funded by Department of Health: Provision of home nursing, day centre activities, counselling and support for aged and frail people and their carers.
Amount of Funding: $190,100
Review date: June 2008

Gwydir Shire Council
One off Carers project funded by Department of Health:
Amount of Funding: $38,000
Review date: n/a

Forster Neighbourhood Centre
One off Carers project funded by Department of Health
Amount of Funding: $12,000
Review date: n/a

Inverell HACC Inc
One off Carers project funded by Department of Health
Amount of Funding: $5,120
Review date: n/a

Joblink Plus Inc
One off Carers project funded by Department of Health
Amount of Funding: $42,000
Review date: n/a

Respite Volunteers Palliative Care Maitland
One off Carers project funded by Department of Health
Amount of Funding: $40,000
Review date: n/a

Freedom of Information

Statistical Return 1 July 2005 to 30 June 2006

APPLICATION INFORMATION	PERSONAL	NON-PERSONAL
NUMBER OF APPLICATIONS:		
Applications Carried Forward	2	1
New Applications	4	7
Applications Completed	6	8
Applications Not Completed at 30/6/05		
Number of Amendments or Notations		
OUTCOME OF APPLICATIONS COMPLETED:		
Granted in Full	3	5
Granted in Part	1	1
Refused	2	1
No documents available		
Application withdrawn		
APPLICATIONS GRANTED IN PART OR REFUSED:		
Exempt		1
Oherwise Available	3	
Refused - Section 22 (3)*		1
NUMBER OF DISCOUNTS ALLOWED		
Financial Hardship	2	
Public Interest		
TIME TAKEN TO PROCESS:		
0-21 Days	4	1
21-31 Days		2
> 31 Days	2	5
REVIEWS AND APPEALS:		
Internal Reviews and Appeals		
Number of Ombudsman's Reviews		
Administrative Decision Tribunal		
FEES:		
Received	$120	$645

There has been a significant fall in the number of applications received for access to information under FOI. This is primarily due to the other avenues that are available for people to access personal medical information. As a general principle, applications for the release of medical records are processed in accordance with Department of Health guidelines for the "release of information".

**Section 22 (3) of the FOI Act 1989, states that an agency may refuse to continue dealing with an application of it has requested payment of an advance deposit in relation to the application, and payment of the deposit has not been made within the period of time specified in the request.*

Note: This return is a combination of FOI Applications received from the former Lower Mid North Coast, New England and Hunter Area Health Services during 2004/05. These three Health Services merged as at 1 January 2005 to form the Hunter New England Area Health Service.

Certification of Parent / Consolidated Financial Statements for Period Ended 30 June 2006

The attached financial statements of the Hunter New England Area Health Service for the year ended 30 June 2006

i) Have been prepared in accordance with the requirements of applicable Australian Accounting Standards, other authoritative pronouncements of the Australian Accounting Standards Board, Urgent Issues Group Interpretations, the requirements of the *Public Finance and Audit Act Regulation 2005* 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 and transactions of the Hunter New England Area Health Service;

iii) Have no circumstances which would render any particulars in the financial statements to be misleading or inaccurate;

iv) The provision of the Charitable Fundraising Act 1991, regulations under the Act and the conditions attached to the fundraising authority have been complied with by the Hunter New England Health Service; and

v) The internal controls exercised by the Hunter New England Area Health Service are appropriate and effective in accounting for all income received and applied by the Hunter New England Area Health Service from any of its fundraising appeals

.....

Terry Clout - Chief Executive

Hunter New England Area Health Service

22 September 2006

.....

Tracey McCosker – Director Corporate Services

Hunter New England Area Health Service

22 September 2006

AUDITOR-GENERAL
NEW SOUTH WALES

GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDIT REPORT

HUNTER NEW ENGLAND AREA HEALTH SERVICE

To Members of the New South Wales Parliament

Audit Opinion Pursuant to the *Public Finance and Audit Act 1983*

In my opinion, the financial report of the Hunter New England Area Health Service (the Service):

- presents fairly the Service's and the consolidated entity's (defined below) financial position as at 30 June 2006 and their performance for the year ended on that date, in accordance with Accounting Standards and other mandatory financial reporting requirements in Australia, and
- complies with section 45E of the *Public Finance and Audit Act 1983* (the PF&A Act) and the *Public Finance and Audit Regulation 2005*.

Audit Opinion Pursuant to the *Charitable Fundraising Act 1991*

In my opinion:

- the financial report of the Service shows a true and fair view of the financial result of fundraising appeals for the year ended 30 June 2006
- the ledgers and associated records of the Service have been properly kept during the year in accordance with the *Charitable Fundraising Act 1991* (the CF Act) and the *Charitable Fundraising Regulation 2003* (the CF Regulation)
- money received as a result of fundraising appeals conducted during the year has been properly accounted for and applied in accordance with the CF Act and the CF Regulation, and
- there are reasonable grounds to believe that the Service will be able to pay its debts as and when they fall due.

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

Scope

The Financial Report and Chief Executive Officer's Responsibility

The financial report comprises the operating statements, statements of changes in equity, balance sheets, cash flow statements, the program statement - expenses and revenues and accompanying notes to the financial statements for the Service and consolidated entity, for the year ended 30 June 2006. The consolidated entity comprises the Service and the entities it controlled during the financial year.

The Chief Executive Officer of the Service is responsible for the preparation and true and fair presentation of the financial report in accordance with the PF&A Act. This includes responsibility for the maintenance of adequate accounting records and internal controls that are designed to prevent and detect fraud and error, and for the accounting policies and accounting estimates inherent in the financial report.

Audit Approach

I conducted an independent audit in order to express opinions on the financial report. My audit provides *reasonable assurance* to Members of the New South Wales Parliament that the financial report is free of *material* misstatement.

My audit accorded with Australian Auditing Standards and statutory requirements, and I:

- assessed the appropriateness of the accounting policies and disclosures used and the reasonableness of significant accounting estimates made by the Chief Executive Officer in preparing the financial report,
- examined a sample of the evidence that supports:
  - the amounts and other disclosures in the financial report,
  - compliance with accounting and associated record keeping requirements pursuant to the CF Act, and
- obtained an understanding of the internal control structure of fundraising appeal activities.

An audit does *not* guarantee that every amount and disclosure in the financial report is error free. The terms 'reasonable assurance' and 'material' recognise that an audit does not examine all evidence and transactions. However, the audit procedures used should identify errors or omissions significant enough to adversely affect decisions made by users of the financial report or indicate that the Chief Executive Officer had not fulfilled his reporting obligations.

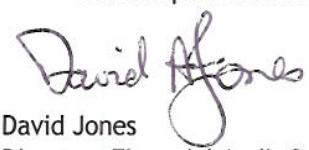
My opinions do *not* provide assurance:

- about the future viability of the Service or its controlled entities,
- 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.

Audit Independence

The Audit Office complies with all applicable independence requirements of Australian professional ethical pronouncements. 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 are not compromised in their role by the possibility of losing clients or income.



David Jones
Director, Financial Audit Services

SYDNEY
20 October 2006

Hunter New England Area Health Service
Operating Statement for the year ended 30 June 2006

PARENT					CONSOLIDATION		
Actual 2006 $000	Budget 2006 $000	Actual 2005 $000		Notes	Actual 2006 $000	Budget 2006 $000	Actual 2005 $000
			Expenses excluding losses				
			Operating Expenses				
548,748	550,938	373,047	Employee Related	3	806,299	806,794	373,047
257,551	255,856	-	Personnel Services	4	-	-	-
57,197	58,008	26,687	Visiting Medical Officers		57,197	58,008	26,687
337,200	333,260	164,471	Other Operating Expenses	5	337,200	333,260	164,471
50,745	50,402	23,375	Depreciation and Amortisation	2(i), 6	50,745	50,402	23,375
8,117	8,689	3,233	Grants and Subsidies	7	8,117	8,689	3,233
458	458	47	Finance Costs	8	458	458	47
79,653	79,234	35,007	Payments to Affiliated Health Organisations	9	79,653	79,234	35,007
1,339,669	**1,336,845**	**625,867**	**Total Expenses excluding losses**		**1,339,669**	**1,336,845**	**625,867**
			Retained Revenue				
173,703	165,071	80,461	Sale of Goods and Services	10	173,703	165,071	80,461
4,943	3,555	2,869	Investment Income	11	4,943	3,555	2,869
29,118	27,223	10,999	Grants and Contributions	12	23,030	21,672	10,999
8,564	11,673	1,264	Other Revenue	13	8,564	11,673	1,264
216,328	**207,522**	**95,593**	**Total Retained Revenue**		**210,240**	**201,971**	**95,593**
125	238	67	Gain/(Loss) on Disposal	14	125	238	67
(662)	(1,206)	(835)	Other gains/(losses)	15	(662)	(1,206)	(835)
1,123,878	**1,130,291**	**531,042**	**Net Cost of Services**	34	**1,129,966**	**1,135,842**	**531,042**
			Government Contributions				
			NSW Health Department				
1,053,878	1,053,878	472,834	Recurrent Allocations	2(d)	1,053,878	1,053,878	472,834
			NSW Health Department				
72,336	72,336	34,292	Capital Allocations	2(d)	72,336	72,336	34,292
			Acceptance by the Crown Entity of				
13,666	13,665	30,393	employee superannuation benefits	2(a)	19,754	19,216	30,393
1,139,880	**1,139,879**	**537,519**	**Total Government Contributions**		**1,145,968**	**1,145,430**	**537,519**
16,002	**9,588**	**6,477**	**RESULT FOR THE YEAR**		**16,002**	**9,588**	**6,477**

The accompanying notes form part of these Financial Statements

2005 comparatives cover only the six months ended 30 June 2005 as the Area was only established with effect from 1 January 2005.

Hunter New England Area Health Service
Statement of Changes in Equity for the year ended 30 June 2006

PARENT					CONSOLIDATION		
Actual 2006 $000	Budget 2006 $000	Actual 2005 $000		Notes	Actual 2006 $000	Budget 2006 $000	Actual 2005 $000
-	-	114,748	Net increase/(decrease) in Asset Revaluation Reserve	29	-	-	114,748
-	-	114,748	**TOTAL INCOME AND EXPENSE RECOGNISED DIRECTLY IN EQUITY**		-	-	114,748
16,002	9,588	6,477	Result for the Year		16,002	9,588	6,477
16,002	9,588	121,225	**TOTAL INCOME AND EXPENSE RECOGNISED FOR THE YEAR**		16,002	9,588	121,225
			EFFECT OF CHANGES IN ACCOUNTING POLICY AND CORRECTION OF ERRORS				
2,025	2,025	-	Accumulated Funds	2(aa)	2,025	2,025	-

The accompanying notes form part of these Financial Statements

2005 comparatives cover only the six months ended 30 June 2005 as the Area was only established with effect from 1 January 2005.

Hunter New England Area Health Service
Balance Sheet as at 30 June 2006

PARENT					CONSOLIDATION		
Actual 2006 $000	Budget 2006 $000	Actual 2005 $000		Notes	Actual 2006 $000	Budget 2006 $000	Actual 2005 $000
			ASSETS				
			Current Assets				
73,797	55,708	64,298	Cash and Cash Equivalents	19	73,797	55,708	64,298
28,540	32,521	41,213	Receivables	20	28,540	32,521	41,213
4,798	5,387	5,387	Inventories	21	4,798	5,387	5,387
107,135	93,616	110,898			107,135	93,616	110,898
3,007	-	3,429	Non Current Assets Held for Sale	23	3,007	-	3,429
110,142	**93,616**	**114,327**	**Total Current Assets**		**110,142**	**93,616**	**114,327**
			Non-Current Assets				
1,899	2,811	2,811	Receivables	20	1,899	2,811	2,811
			Property, Plant and Equipment				
830,332	853,150	806,349	- Land and Buildings	22	830,332	853,150	806,349
89,236	74,989	76,111	- Plant and Equipment	22	89,236	74,989	76,111
51,178	50,684	52,712	- Infrastructure Systems	22	51,178	50,684	52,712
970,746	**978,823**	**935,172**	Total Property, Plant and Equipment		**970,746**	**978,823**	**935,172**
972,645	**981,634**	**937,983**	**Total Non-Current Assets**		**972,645**	**981,634**	**937,983**
1,082,787	**1,075,250**	**1,052,310**	**Total Assets**		**1,082,787**	**1,075,250**	**1,052,310**
			LIABILITIES				
			Current Liabilities				
54,544	57,492	63,667	Payables	25	54,544	57,492	63,667
1,069	1,069	-	Borrowings	26	1,069	1,069	-
225,568	219,509	203,815	Provisions	27	225,568	219,509	203,815
1,411	252	267	Other	28	1,411	252	267
282,592	278,322	267,749			282,592	278,322	267,749
282,592	**278,322**	**267,749**	**Total Current Liabilities**		**282,592**	**278,322**	**267,749**
			Non-Current Liabilities				
5,050	4,874	7,686	Borrowings	26	5,050	4,874	7,686
4,808	4,809	4,550	Provisions	27	4,808	4,809	4,550
450	3,773	465	Other	28	450	3,773	465
10,308	**13,456**	**12,701**	**Total Non-Current Liabilities**		**10,308**	**13,456**	**12,701**
292,900	**291,778**	**280,450**	**Total Liabilities**		**292,900**	**291,778**	**280,450**
789,887	**783,472**	**771,860**	**Net Assets**		**789,887**	**783,472**	**771,860**
			EQUITY				
113,745	113,681	112,990	Reserves	29	113,745	113,681	112,990
675,812	669,791	658,179	Accumulated Funds	29	675,812	669,791	658,179
789,557	783,472	771,169			789,557	783,472	771,169
			Amounts recognised in equity relating to assets				
330	-	691	held for sale	23	330	-	691
789,887	**783,472**	**771,860**	**Total Equity**		**789,887**	**783,472**	**771,860**

The accompanying notes form part of these Financial Statements

Hunter New England Area Health Service
Cash Flow Statement for the year ended 30 June 2006

PARENT					CONSOLIDATION		
Actual 2006 $000	Budget 2006 $000	Actual 2005 $000		Notes	Actual 2006 $000	Budget 2006 $000	Actual 2005 $000
			CASH FLOWS FROM OPERATING ACTIVITIES				
			Payments				
(512,884)	(520,717)	(312,401)	Employee Related		(770,435)	(776,573)	(312,401)
(95,707)	(96,221)	(41,056)	Grants and Subsidies		(95,707)	(96,221)	(41,056)
-	-	(47)	Finance Costs		-	-	(47)
(692,462)	(695,702)	(198,454)	Other		(434,911)	(439,846)	(198,454)
(1,301,053)	**(1,312,640)**	**(551,958)**	**Total Payments**		**(1,301,053)**	**(1,312,640)**	**(551,958)**
			Receipts				
185,570	170,776	83,317	Sale of Goods and Services		185,570	170,776	83,317
3,784	2,840	1,964	Interest Received		3,784	2,840	1,964
75,379	89,462	26,575	Other		75,379	89,462	26,575
264,733	**263,078**	**111,856**	**Total Receipts**		**264,733**	**263,078**	**111,856**
			Cash Flows From Government				
1,060,707	1,060,707	464,625	NSW Health Department Recurrent Allocations		1,060,707	1,060,707	464,625
72,336	72,336	34,292	NSW Health Department Capital Allocations		72,336	72,336	34,292
1,133,043	**1,133,043**	**498,917**	**Net Cash Flows from Government**		**1,133,043**	**1,133,043**	**498,917**
96,723	**83,481**	**58,815**	**NET CASH FLOWS FROM OPERATING ACTIVITIES**	34	**96,723**	**83,481**	**58,815**
			CASH FLOWS FROM INVESTING ACTIVITIES				
2,181	7,155	3,268	Proceeds from Sale of Land and Buildings, Plant and Equipment and Infrastructure Systems		2,181	7,155	3,268
-	-	38	Proceeds from Sale of Investments		-	-	38
(89,405)	(99,051)	(47,304)	Purchases of Land and Buildings, Plant and Equipment and Infrastructure Systems	22	(89,405)	(99,051)	(47,304)
(87,224)	**(91,896)**	**(43,998)**	**NET CASH FLOWS FROM INVESTING ACTIVITIES**		**(87,224)**	**(91,896)**	**(43,998)**
			CASH FLOWS FROM FINANCING ACTIVITIES				
-	(176)	(4,495)	Repayment of Borrowings and Advances		-	(176)	(4,495)
-	**(176)**	**(4,495)**	**NET CASH FLOWS FROM FINANCING ACTIVITIES**		**-**	**(176)**	**(4,495)**
9,499	**(8,591)**	**10,322**	**NET INCREASE / (DECREASE) IN CASH**		**9,499**	**(8,591)**	**10,322**
64,298	**64,298**	**53,976**	Opening Cash and Cash Equivalents		**64,298**	**64,298**	**53,976**
73,797	**55,707**	**64,298**	**CLOSING CASH AND CASH EQUIVALENTS**	19	**73,797**	**55,707**	**64,298**

The accompanying notes form part of these Financial Statements

2005 comparatives cover only the six months ended 30 June 2005 as the Area was only established with effect from 1 January 2005.

Hunter New England Area Health Service
Program Statement - Expenses and Revenues
for the Year Ended 30 June 2006

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 *		Total	
	2006	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006	2005
	$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	70,973	35,788	3,606	1,722	78,579	35,630	62,895	27,852	299,730	128,120	51,925	26,987	95,582	49,536	102,628	49,419	10,077	4,520	30,304	13,473	806,299	373,047
Visiting Medical Officers	641	365	6	-	3,306	1,768	8,579	3,191	29,233	12,630	10,078	5,157	2,219	1,266	2,757	1,340	126	50	252	920	57,197	26,687
Other Operating Expenses	17,368	8,853	852	410	30,255	13,717	23,503	10,799	171,350	84,531	36,365	18,442	19,191	8,735	31,761	14,496	3,034	1,574	3,521	2,914	337,200	164,471
Depreciation and Amortisation	3,430	1,527	101	49	5,739	2,384	4,105	1,609	20,567	9,898	4,943	2,234	5,059	2,342	6,019	2,694	233	159	549	479	50,745	23,375
Grants and Subsidies	5,193	1,728	54	1	14	9	-	16	-	111	-	62	2,786	1,242	64	20	2	2	4	42	8,117	3,233
Finance Costs	72	6	7	1	23	3	41	4	167	17	35	5	32	4	75	6	5	1	1	-	458	47
Payments to Affiliated Health Organisations	1,453	654	-	-	15,576	6,930	7,651	3,442	38,035	16,960	3,438	1,016	-	-	6,334	3,066	3,599	1,557	3,567	1,382	79,653	35,007
Total Expenses excluding losses	99,130	48,921	4,626	2,183	133,492	60,441	106,774	46,913	559,082	252,267	106,784	53,903	124,869	63,125	149,638	71,041	17,076	7,863	38,198	19,210	1,339,669	625,867
Revenue																						
Sale of Goods and Services	4,101	2,454	140	104	13,477	4,790	9,516	3,512	92,692	46,145	13,850	6,674	5,936	3,014	30,236	11,465	226	225	3,529	2,078	173,703	80,461
Investment Income	927	255	20	12	481	273	254	132	1,683	1,049	381	190	316	182	682	474	58	79	141	223	4,943	2,869
Grants and Contributions	3,028	789	310	70	635	409	637	257	2,407	1,279	557	193	578	232	8,835	3,111	4,317	3,405	1,726	1,254	23,030	10,999
Other Revenue	584	349	13	3	912	90	643	85	3,351	413	567	59	708	82	920	77	67	3	799	103	8,564	1,264
Total Revenue	8,640	3,847	483	189	15,505	5,562	11,050	3,986	100,133	48,886	15,355	7,116	7,538	3,510	40,673	15,127	4,668	3,712	6,195	3,658	210,240	95,593
Gain / (Loss) on Disposal	8	10	-	-	14	19	10	5	52	27	12	5	12	13	15	(15)	1	1	1	2	125	67
Other Gains / (Losses)	(42)	(69)	(1)	(4)	(76)	(71)	(53)	(68)	(286)	(365)	(76)	(107)	(47)	(43)	(69)	(87)	(5)	(10)	(7)	(11)	(662)	(835)
Net Cost of Services	90,524	45,133	4,144	1,998	118,049	54,931	95,767	42,990	459,183	203,719	91,493	46,889	117,366	59,645	109,019	56,016	12,412	4,160	32,009	15,561	1,129,966	531,042

* The name and purpose of each program is summarised in Note 18.

The program statement uses statistical data to 31 December 2005 to allocate the current period's financial information to each program. No changes have occurred during the period between 1 January 2006 and 30 June 2006 which would materially impact this allocation

2005 comparatives cover only the six months ended 30 June 2005 as the Area was only established with effect from 1 January 2005.

1 The Health Service Reporting Entity

The Hunter Area Health Service was established under the provisions of the Health Services Act with effect from 1 January 2005. As a reporting entity the Health Service comprises the services previously provided by the former Hunter, New England and the Southern part of Mid North Coast Area Health Services.

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.

With effect from 17 March 2006 fundamental changes to the employment arrangements of Health Services were made through amendment to the Public Sector Employment and Management Act 2002 and other Acts including the Health Services Act 1997. The status of the 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 for the economic entity. Notes have been extended to capture both the Parent and Consolidated values with 3, 4, 12, 25, 27 and 34 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 22 September 2006.

2 Summary of Significant Accounting Policies

The Health Service's financial statements are 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, assets held for trading and available for sale are measured at fair value. Other financial statements 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 statements.

The financial statements and notes comply with Australian Accounting Standards which include AEIFRS. As Area Health Services were established with effect from 1 January 2005 the comparatives available for the previous accounting period are based on the six months of operation and have been presented in accordance with AEIFRS requirements.

Note 2aa includes separate disclosure of the 1 July 2005 equity adjustments arising from the adoption of AASB132 and AASB139.

The following Accounting Standards are being early adopted from 1 July 2005:
- AASB 2005-4 regarding the revised AAS139 fair value option;
- UIG 9 regarding the reassessment of embedded derivatives; and
- AASB 2005-06, which excludes from the scope of AASB3, business combinations involving entities or businesses under common control.

Any initial impacts on first time adoption are discussed as part of the AEIFRS first time adoption note disclosure (refer Note 2aa) along with the other AEIFRS impacts.

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

a) Employee Benefits and Other Provisions

i) Salaries & Wages, Current Annual Leave, Sick Leave and On Costs (including non-monetary benefits)

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".

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.

Consequential to the legislative changes of 17 March 2006 no salary costs or provisions are recognised by the Parent Health Service beyond that date.

ii) Long Service Leave and Superannuation Benefits

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 17.4% for short term entitlements and 7.6% for long term entitlements above the salary rates immediately payable at 30 June 2006 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 25, "Payables".

The superannuation expense for the financial year is determined by using the formulae specified by the NSW Health Department. The expense for certain superannuation schemes (i.e. Basic Benefit and First State Super) 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.

Consequential to the legislative changes of 17 March 2006 no salary costs or provisions are recognised by the Parent Health Service beyond that date.

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) Borrowing Costs

Borrowing 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, i.e. 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 Health Department from time to time.

Investment Income

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 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 Health Department. 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 with cost being determined as the fair value of the services given which is then duly recognised as both revenue and matching expense. The amount of these services provided are not material in value and no amount of revenue or expense has been included in the financial statements.

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.

The Health Service, as a not-for-profit entity has applied the requirements in AASB 1004 Contributions regarding contributions of assets (including grants) and forgiveness of liabilities. There are no differences in the recognition requirements between the new AASB 1004 and the previous AASB 1004. However, the new AASB 1004 may be amended by proposals in Exposure Draft ED 125 Financial Reporting by Local Governments and ED 147 Revenue from Non-Exchange Transactions (Including Taxes and Transfers). If the ED 125 and ED 147 approach is applied, revenue and/or expense recognition will not occur until either the Health Service supplies the related goods and services (where grants are in-substance agreements for the provision of goods and services) or until conditions are satisfied. ED 125 and ED 147 may therefore delay revenue recognition compared with AASB 1004, where grants are recognised when controlled. However, at this stage, the timing and dollar impact of these amendments is uncertain.

NSW Health Department Allocations

Payments are made by the NSW Health Department 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 other States 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 the Mater Misercordiae Hospital have only been included in the Operating Statement prepared to the extent of the cash payments made to the Health Organisation concerned. The Health Service is not deemed to own or control the various assets/liabilities of the aforementioned Health Organisation and such amounts have been excluded from the Balance Sheet. Any exceptions are specifically listed in the notes that follow.

e) Goods & Services Tax (GST)

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

* 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 from 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 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 Health Recurrent Allocation.

Inter State Patient Flows

Health Services recognise the outflow of acute inpatients from the area in which they are resident to other States and Territories within Australia. 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 2004/05 activity data using standard cost weighted separation values to reflect estimated costs in 2005/06 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 revenue/expense 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.

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 costing $5,000 and above are capitalised.

"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 is provided for on a straight line basis for all depreciable assets so as to write off the depreciable amount of each asset as it is consumed over its useful life to the Health Service. 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	2.5%
Computer Equipment	20.0%
Infrastructure Systems	2.5%
Office Equipment	10.0%
Plant and Machinery	10.0%
Linen	20.0%
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 Health Department's "Valuation of Physical Non-Current Assets at Fair Value". 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 five 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 1 January 2005 was completed on 1 April 2005 and was based on an independent assessment.

Non-specialised generalised 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 exempted 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) Assets Not Able to be Reliably Measured

The Health Service holds certain assets that have not been recognised in the Balance Sheet because the Health Service is unable to measure reliably the value for the assets. An example of an asset that may not be capable of reliable measurement is land under roads.

m) 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.

n) 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.

o) Investment Property

Investment property is held to earn rentals or for capital appreciation, or both. However, for not-for-profit entities, property held to meet service delivery objectives rather than to earn rental or for capital appreciation does not meet the definition of investment property and is accounted for under AASB 116 *Property, Plant and Equipment*.

The Health Service owns properties held to earn rentals and / or for capital appreciation. These investment properties are stated at fair value supported by market evidence at the balance sheet date. Gains or losses arising from changes in fair value are included in the Operating Statement in the period in which they arise. No depreciation is charged on investment

p) 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 over a period of 5 years. 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]).

q) Maintenance and Repairs

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.

r) 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.

s) 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 Health Department.

t) Other Financial Assets

Financial assets are initially recognised at fair value plus, in the case of financial assets not at fair value through profit or loss, transaction costs.

The Health Service subsequently measures financial assets classified as held for trading at fair value through profit or loss. Gains or losses on these assets are recognised in the Operating Statement. Assets intended to be held to maturity are subsequently measured at amortised cost using the effective interest method. Gains or losses on impairment or disposal of these assets are recognised in the Operating Statement. Any residual investments that do not fall into any other category are accounted for as available for sale financial assets and measured at fair value directly in equity until disposed or impaired. All financial assets (except those measured at fair value through profit or loss) are subject to annual review for impairment.

Purchases or sales of financial assets under contract that require delivery of the asset within the timeframe established by convention or regulation are recognised on the trade date i.e. the date the Health Service commits itself to purchase or sell the assets.

u) 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 establishment of Hunter New England Area Health Service as at 1 January 2005 was made by the transfer of Net Assets of $ 512.6 million from the former Hunter Area Health Service, $ 93.2 million from the former New England Area Health Service and $ 44.8 million from the former southern part of Mid North Coast Area Health Service.

The Statement of Changes in Equity does NOT reflect the Net Assets or change in equity in accordance with AASB 101 Clause 97.

v) Financial Instruments

Financial instruments give rise to positions that are a financial asset of either Hunter New England Area Health Service or its counter party and a financial liability (or equity instrument) of the other party. For Hunter New England Area Health Service these include cash at bank, receivables, other financial assets, payables and interest bearing liabilities.

In accordance with Australian Accounting Standard AASB39, "Financial Instruments: Recognition and Measurement" disclosure of the carrying amounts for each of the AASB139 categories of financial instruments is disclosed in Note 38. The specific accounting policy in respect of each class of such financial instrument is stated hereunder.

Classes of instruments recorded and their terms and conditions measured in accordance with AASB139 are as follows:

Cash

Accounting Policies - Cash is carried at nominal values reconcilable to monies on hand and independent bank statements.

Terms and Conditions - Monies on deposit attract an effective interest rate of approximately 5.8% as compared to 5.6% in the previous year.

Loans and Receivables

Loans and receivables 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. Short-term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial. An allowance for impairment of receivables is established when there is objective evidence that the entity will not be able to collect all amounts due. 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. Bad debts are written off

Terms and Conditions - Accounts are generally issued on 30-day terms.

Low or zero interest loans are recorded at fair value on inception and amortised cost thereafter. In 2005/06 this has involved the restatement of loan values as at 1 July 2005 for all loans negotiated prior to that date.

Trade and Other Payables

Accounting Policies -– These amounts represent liabilities for goods and services provided to the Health Service and other amounts, including interest. 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.

Terms and Conditions - Trade liabilities are settled within any terms specified. If no terms are specified, payment is made by the end of the month following the month in which the invoice is received.

All financial instruments including revenue, expenses and other cash flows arising from instruments are recognised on an accruals basis.

w) Payables

These amounts represent liabilities for goods and services provided to the Health Service and other amounts, including interest.

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.

x) Borrowings

Non interest bearing loans within NSW Health are initially measured at fair value and amortised thereafter. All other loans are valued at amortised cost.

y) Trust Funds

The Health Service receives monies in a trustee capacity for various trusts as set out in Note 31. 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) The Financial Impact Of Adopting Australian Equivalents To International Financial Reporting Standards (AEIFRS)

The Health Service has applied the AEIFRS for the first time in the 2005/06 financial report. The key areas where changes in accounting policies have impacted the financial report are disclosed below. Some of these impacts arise because AEIFRS requirements are different from previous AASB requirements (AGAAP). Other impacts arise from options in AEIFRS that were not available or not applied under previous AGAAP. The Health Service has adopted the options mandated by NSW Treasury for all NSW public sector agencies. The impacts below reflect Treasury's mandates and policy decisions.

The impacts of adopting AEIFRS on total equity and the Result for the Year as reported under previous AGAAP are shown below. There are no material impacts on the Health Service's cash flows.

(a) Financial Instruments - 1 July 2005 first time adoption impacts

As discussed in the opening of Note 2, the comparative information for 2004/05 for financial instruments has not been restated and is presented in accordance with previous AGAAP. AASB 132 and AASB 139 have been applied from 1 July 2005. Accordingly, the 1 July 2005 AEIFRS opening equity adjustments for the adoption of AASB 132 / AASB 139 follow:

	Note	Accumulated Funds $'000	Other reserves $'000	Total $'000
Total opening 1 July 2005 AEIFRS equity	1	658,179	113,681	771,860
Interest-free loan measured at fair value on initial recognition	2	2,025	-	2,025
Restated opening 1 July 2005 AEIFRS equity (after applying AASB 139)		660,204	113,681	773,885

Notes to table above

1. Impairment testing. Under AASB 139, all financial assets except those measured at fair value through profit or loss are subject to review for impairment. The Standard requires a specific impairment test which needs to be supported by objective evidence that the group of assets is impaired or uncollectible. This means that agencies can no longer raise a general provision for doubtful debts. As a result, the allowance for impairment recognised under previous AGAAP has been reduced.

2. Interest-free and low interest loans. Under AASB 139, these types of loans must initially be recognised at fair value, and thereafter at amortised cost. The fair value of a long-term loan receivable that carries no interest or below market interest is estimated as the present value of all future cash receipts, discounted using the prevailing market rates of interest for a similar instrument with a similar credit rating (based on the NSW TCorp government bond rate). Any additional amount lent is an expense or grant unless it qualifies for recognition as some other type of asset. Amortisation of the loan is recognised as investment revenue. Previously, such loans were measured at nominal amount or face value, with no grant or expense recognised. This change has reduced the amount of the loan receivable.

For the comparative information to have complied with AASB 139, similar types of adjustments, as discussed above, would have been required. However, for the above changes, it is not practicable for the Health Service to detail the amounts of the adjustments to the result for the year and opening accumulated funds for the comparative period, had the new accounting policies been applied from the beginning of the comparative period. In addition, it is not practicable for the Health Service to detail for the current period the amounts of the adjustments resulting to each line item in the financial report.

ab) Joint Venture Operation

The propotionate interests in the assets, liabilities and expenses of a joint venture operation have been incorporated in the financial statements under the appropriate headings. Details of the joint venture are set out in note 16.

PARENT 2006 $000	PARENT 2005 $000		CONSOLIDATION 2006 $000	CONSOLIDATION 2005 $000
		3. Employee Related		
		Employee related expenses comprise the following:		
411,999	273,942	Salaries and Wages	598,388	273,942
24,242	12,615	Awards	30,876	12,615
13,665	9,352	Superannuation [see note 2(a)] - defined benefit plans	19,754	9,352
32,391	21,041	Superannuation [see note 2(a)] - defined contributions	46,893	21,041
12,746	16,660	Long Service Leave [see note 2(a)]	27,809	16,660
37,752	29,329	Annual Leave [see note 2(a)]	58,945	29,329
1,088	-	Redundancies	2,818	-
506	346	Nursing Agency Payments	660	346
1,099	721	Other Agency Payments	1,501	721
13,377	8,712	Workers Compensation Insurance	18,596	8,712
(117)	329	Fringe Benefits Tax	59	329
548,748	**373,047**	**Total**	**806,299**	**373,047**
		The following additional information is provided:		
39	1,946	Employee Related Expenses capitalised - Land and Buildings	42	1,946
-	402	Employee Related Expenses capitalised - Plant and Equipment	-	402
		Note 1 addresses the changes in employment status effective from 17 March 2006		
		4. Personnel Services		
		Personnel Services comprise the purchase of the following:		
186,389	-	Salaries and Wages	-	-
6,635	-	Awards	-	-
6,088	-	Superannuation [see note 2(a)] - defined benefit plans	-	-
14,503	-	Superannuation [see note 2(a)] - defined contributions	-	-
15,063	-	Long Service Leave [see note 2(a)]	-	-
21,192	-	Annual Leave [see note 2(a)]	-	-
1,730	-	Redundancies	-	-
154	-	Nursing Agency Payments	-	-
402	-	Other Agency Payments	-	-
5,218	-	Workers Compensation Insurance	-	-
177	-	Fringe Benefits Tax	-	-
257,551	**-**	**Total**	**-**	**-**
		The following additional information is provided:		
3	-	Personnel Services Expenses capitalised - Land and Buildings	-	-
		Note 1 addresses the changes in employment status effective from 17 March 2006		
		5. Other Operating Expenses		
6,346	2,909	Blood and Blood Products	6,346	2,909
6,358	3,280	Domestic Supplies and Services	6,358	3,280
39,259	17,790	Drug Supplies	39,259	17,790
9,524	4,428	Food Supplies	9,524	4,428
8,863	3,737	Fuel, Light and Power	8,863	3,737
28,225	14,499	General Expenses	28,225	14,499
11,577	4,551	Hospital Ambulance Transport Costs	11,577	4,551
4,359	4,380	Information Management Expenses	4,359	4,380
246	307	Insurance	246	307
67,338	35,182	Inter Area Patient Outflows, NSW	67,338	35,182
8,719	3,519	Interstate Patient Outflows	8,719	3,519
		Maintenance (See (c) below)		
11,040	3,876	Maintenance Contracts	11,040	3,876
8,863	4,957	New/Replacement Equipment under $5,000	8,863	4,957
9,664	4,610	Repairs	9,664	4,610
514	625	Maintenance/Non Contract	514	625
1,287	905	Other	1,287	905
62,507	27,648	Medical and Surgical Supplies	62,507	27,648
5,375	3,040	Postal and Telephone Costs	5,375	3,040
3,838	1,764	Printing and Stationery	3,838	1,764
1,453	621	Rates and Charges	1,453	621
5,022	2,278	Rental	5,022	2,278
18,605	9,592	Special Service Departments	18,605	9,592
6,756	3,946	Staff Related Costs	6,756	3,946
2,453	1,030	Sundry Operating Expenses	2,453	1,030
9,009	4,997	Travel Related Costs	9,009	4,997
337,200	**164,471**	**Total**	**337,200**	**164,471**

PARENT 2006 $000	PARENT 2005 $000		CONSOLIDATION 2006 $000	CONSOLIDATION 2005 $000
		5. Other Operating Expenses (Continued)		
		(a) Sundry Operating Expenses comprise:		
350	150	Contract for Patient Services	350	150
2,103	880	Isolated Patient Travel and Accommodation Assistance Scheme	2,103	880
2,453	**1,030**	**Total**	**2,453**	**1,030**
		(b) General Expenses include:-		
1,167	662	Advertising	1,167	662
702	356	Books, Magazines and Journals	702	356
		Consultancies		
1,058	739	- Operating Activities	1,058	739
57	24	- Capital Works	57	24
1,597	830	Courier and Freight	1,597	830
156	170	Auditor's Remuneration - Audit of financial reports	156	170
49	-	Auditor's Remuneration - Other Services	49	-
983	540	Legal Services	983	540
4,806	2,204	Membership/Professional Fees	4,806	2,204
6,238	2,830	Motor Vehicle Operating Lease Expense - minimum lease payments	6,238	2,830
1,965	1,090	Other Operating Lease Expense - minimum lease payments	1,965	1,090
17	17	Payroll Services	17	17
381	91	Quality Assurance/Accreditation	381	91
		(c) Reconciliation Total Maintenance		
31,368	14,973	Maintenance expense - contracted labour and other (non employee related), included in Note 5	31,368	14,973
6,613	4,371	Employee related/Personnel Services maintenance expense included in Notes 3 and 4	9,284	4,371
37,981	**19,344**	**Total maintenance expenses included in Notes 3, 4 and 5**	**40,652**	**19,344**
		(d) Expenses for Inter Area Patient Flows, NSW on an Area basis are as follows:-		
5,600	3,222	Children's Hospital Westmead	5,600	3,222
416	224	Greater Southern	416	224
1,500	573	Greater Western	1,500	573
7,115	2,803	North Coast	7,115	2,803
19,779	10,716	Northern Sydney Central Coast	19,779	10,716
16,835	10,241	South East Illawarra	16,835	10,241
8,859	4,431	Sydney South West	8,859	4,431
7,234	2,972	Sydney West	7,234	2,972
67,338	**35,182**	**Total**	**67,338**	**35,182**
		(e) Expenses for Interstate Patient Flows are as follows:-		
52	142	Australian Capital Territory	52	142
75	54	Northern Territory	75	54
7,359	2,818	Queensland	7,359	2,818
50	87	South Australia	50	87
61	50	Tasmania	61	50
750	261	Victoria	750	261
372	107	Western Australia	372	107
8,719	**3,519**	**Total**	**8,719**	**3,519**
		6. Depreciation and Amortisation		
29,263	13,711	Depreciation - Buildings	29,263	13,711
19,194	8,770	Depreciation - Plant and Equipment	19,194	8,770
2,288	894	Depreciation - Infrastructure Systems	2,288	894
50,745	**23,375**	**Total**	**50,745**	**23,375**
		7. Grants and Subsidies		
6,164	2,574	Non Government Voluntary Organisations	6,164	2,574
1,250	-	Hunter Medical Research Institute	1,250	-
703	659	Other	703	659
8,117	**3,233**	**Total**	**8,117**	**3,233**

PARENT 2006 $000	PARENT 2005 $000		CONSOLIDATION 2006 $000	CONSOLIDATION 2005 $000
		8. Finance Costs		
458	47	Interest on Bank Overdrafts and Loans	458	47
458	**47**	**Total**	**458**	**47**
		9. Payments to Affiliated Health Organisations		
		(a) Recurrent Sourced		
75,935	34,810	Mater Misercordiae Hospital	75,935	34,810
75,935	**34,810**		**75,935**	**34,810**
		(b) Capital Sourced		
3,718	197	Mater Misericordiae Hospital	3,718	197
3,718	**197**		**3,718**	**197**
79,653	**35,007**	**Total**	**79,653**	**35,007**
		10. Sale of Goods / Rendering of Services		
		(a) Sale of Goods comprise the following:-		
2,771	1,432	Sale of Prosthesis	2,771	1,432
		(b) Rendering of Services comprise the following:-		
79,805	37,050	Patient Fees [see note 2(d)]	79,805	37,050
1,610	932	Staff-Meals and Accommodation	1,610	932
24,513	11,430	Infrastructure Fees - Monthly Facility Charge [see note 2(d)]	24,513	11,430
5,323	3,703	- Annual Charge	5,323	3,703
2,963	1,387	Car Parking	2,963	1,387
601	280	Child Care Fees	601	280
316	217	Clinical Services (excluding Clinical Drug Trials)	316	217
3,614	1,183	Commercial Activities	3,614	1,183
240	121	Fees for Medical Records	240	121
2,735	763	Linen Service Revenues - Other Health Services	2,735	763
4,030	1,861	Linen Service Revenues - Non Health Services	4,030	1,861
753	408	Meals on Wheels	753	408
10,882	4,600	Services Provided to Non NSW Health Organisations	10,882	4,600
175	56	PADP Patient Copayments	175	56
668	147	Pharmacy Sales	668	147
2,316	722	Patient Inflows from Interstate	2,316	722
24,411	12,011	Inter Area Patient Inflows, NSW	24,411	12,011
-	3	Salary Packaging Fee	-	3
4,133	1,409	Recoveries Salary & Wages	4,133	1,409
1,844	746	Other	1,844	746
173,703	**80,461**	**Total**	**173,703**	**80,461**
		(c) Revenues from Inter Area Patient Flows, NSW on an Area basis are as follows:		
485	243	Greater Southern	485	243
3,406	1,622	Greater Western	3,406	1,622
8,359	4,003	North Coast	8,359	4,003
8,534	4,336	Northern Sydney Central Coast	8,534	4,336
977	418	South East Illawarra	977	418
1,369	602	Sydney South West	1,369	602
1,281	787	Sydney West	1,281	787
24,411	**12,011**	**Total**	**24,411**	**12,011**
		(d) Revenues from Patient Inflows from Interstate are as follows:-		
309	29	Australian Capital Territory	309	29
(8)	35	Northern Territory	(8)	35
1,457	449	Queensland	1,457	449
78	14	South Australia	78	14
64	17	Tasmania	64	17
384	152	Victoria	384	152
32	26	Western Australia	32	26
2,316	**722**	**Total**	**2,316**	**722**

PARENT 2006 $000	PARENT 2005 $000		CONSOLIDATION 2006 $000	CONSOLIDATION 2005 $000
		11. Investment Income		
3,784	1,964	Interest	3,784	1,964
1,159	894	Lease and Rental Income	1,159	894
-	11	Dividends	-	11
4,943	**2,869**		**4,943**	**2,869**
		12. Grants and Contributions		
419	283	Clinical Drug Trials	419	283
5,623	2,107	Commonwealth Government grants	5,623	2,107
112	99	Commonwealth Teaching Hospital grants	112	99
6,710	3,095	Industry Contributions/Donations	6,710	3,095
4,722	1,928	Mammography grants	4,722	1,928
798	168	NSW Government grants	798	168
6,088	-	Personnel Services, Superannuation Defined Benefits	-	-
1,720	1,760	Research grants	1,720	1,760
2,926	1,559	Other grants	2,926	1,559
29,118	**10,999**	**Total**	**23,030**	**10,999**
		13. Other Revenue		
		Other Revenue comprises the following:-		
7	-	Bad Debts recovered	7	-
298	80	Commissions	298	80
77	19	Sale of Merchandise, Old Wares and Books	77	19
6,831	-	Treasury Managed Fund Hindsight Adjustment	6,831	-
1,351	1,165	Other	1,351	1,165
8,564	**1,264**	**Total**	**8,564**	**1,264**
		14. Gain/(Loss) on Disposal of Non Current Assets		
14,271	4,647	Property Plant and Equipment	14,271	4,647
11,612	1,546	Less Accumulated Depreciation	11,612	1,546
2,659	**3,101**	**Written Down Value**	**2,659**	**3,101**
1,112	3,168	Less Proceeds from Disposal	1,112	3,168
(1,547)	**67**	**Gain/(Loss) on Disposal of Property Plant and Equipment**	**(1,547)**	**67**
849	-	Assets Held for Sale	849	-
2,521	-	Less Proceeds from Disposal	2,521	-
1,672	**-**	**Gain/(Loss) on Disposal of Assets Held for Sale**	**1,672**	**-**
125	**67**	**Total Gain/(Loss) on Disposal**	**125**	**67**
		15. Other Gains/(Losses)		
(662)	(835)	Impairment of Receivables	(662)	(835)
(662)	**(835)**	**Total**	**(662)**	**(835)**

PARENT 2006 $000	PARENT 2005 $000		CONSOLIDATION 2006 $000	CONSOLIDATION 2005 $000
		16. Interest in Joint Ventures		
		Hunter New England Area Health Service has a 50% interest in the assets, liabilities and output of a Joint Venture operation called Pacific Linen Services, for the washing and cleaning of hospital linen.		
		The interest in the joint venture is included in the accounts as follows:		
6,861	3125	Expenses	6,861	3125
7,096	3249	Revenue	7,096	3249
(235)	**(124)**	**Movement in Accumulated Fund**	**(235)**	**(124)**
		Current Assets		
1,226	1,019	Cash & Cash Equivalents	1,226	1,019
1,026	997	Receivables	1,026	997
2,252	**2,016**	**Total Current Assets**	**2,252**	**2,016**
		Non Current Assets		
94	97	Land & Buildings	94	97
2,439	2,630	Plant & Equipment	2,439	2,630
2,533	**2,727**	**Total Non Current Assets**	**2,533**	**2,727**
4,785	**4,743**	**Total Assets**	**4,785**	**4,743**
		Current Liabilities		
171	69	Accounts Payable	171	69
598	592	Provision for Employee Entitlement	598	592
769	**661**	**Total Current Liabilities**	**769**	**661**
		Non Current Liabilities		
25	25	Provision for Employee Entitlement	25	25
25	**25**	**Total Non Current Liabilities**	**25**	**25**
794	**686**	**Total Liabilities**	**794**	**686**
579	**908**	**Operating lease Commitments**	**579**	**908**

PARENT

17. 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	842	9,708	2,393	12,943
Contributions recognised in amalgamated balance as at 30 June 2005 which were not expended in the current reporting period	3,936	20,159	4,581	28,676
Total amount of unexpended contributions as at balance date	4,778	29,867	6,974	41,619

Comment on restricted assets appears in Note 24

CONSOLIDATION

17. 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	842	9,708	2,393	12,943
Contributions recognised in amalgamated balance as at 30 June 2005 which were not expended in the current reporting period	3,936	20,159	4,581	28,676
Total amount of unexpended contributions as at balance date	4,778	29,867	6,974	41,619

Comment on restricted assets appears in Note 24

18. 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.

Program 4.1 - 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.

PARENT 2006 $000	PARENT 2005 $000		CONSOLIDATION 2006 $000	CONSOLIDATION 2005 $000
		19. Current Assets - Cash and Cash Equivalents		
20,797	11,298	Cash at bank and on hand	20,797	11,298
53,000	53,000	Short Term Deposits	53,000	53,000
73,797	**64,298**		**73,797**	**64,298**
		Cash assets recognised in the Balance Sheet are reconciled to cash at the end of the financial year as shown in the Cash Flow Statement as follows:		
73,797	64,298	Cash and cash equivalents (per Balance Sheet)	73,797	64,298
73,797	**64,298**	**Closing Cash and Cash Equivalents (per Cash Flow Statement)**	**73,797**	**64,298**
		20. Current/Non Current Receivables		
		Current		
7,290	6,894	(a) Sale of Goods and Services	7,290	6,894
1,702	5,161	Leave Mobility	1,702	5,161
3,498	11,781	NSW Health Department	3,498	11,781
7,161	4,960	Debtors GST	7,161	4,960
1,936	1,836	Other User Charges	1,936	1,836
1,236	1,921	Intra Health User Charges	1,236	1,921
886	964	Expense / Payments	886	964
4,041	7,000	Other Debtors	4,041	7,000
27,750	40,517	**Sub Total**	27,750	40,517
(756)	(983)	Less Allowance for impairment	(756)	(983)
26,994	39,534	**Sub Total**	26,994	39,534
1,546	1,679	Prepayments	1,546	1,679
28,540	**41,213**	**Total**	**28,540**	**41,213**
		(b) Impairment of Receivables during the year - Current Receivables		
466	517	- Sale of Goods and Services	466	517
277	87	- Other	277	87
743	**604**	**Total**	**743**	**604**
		Non Current		
225	284	(a) Sale of Goods and Services	225	284
1,885	2,730	Leave Mobility	1,885	2,730
2,110	3,014	**Sub Total**	2,110	3,014
(211)	(203)	Less Allowance for impairment	(211)	(203)
1,899	2,811	**Sub Total**	1,899	2,811
1,899	**2,811**	**Total**	**1,899**	**2,811**
		(b) Impairment of Receivables during the year - Non Current Receivables		
138	33	- Sale of Goods and Services	138	33
138	**33**	**Total**	**138**	**33**
		(c) Sale of Goods and Services Receivables include:		
813	1,382	Patient Fees - Compensable	813	1,382
139	113	Patient Fees - Ineligible	139	113
6,338	5,684	Patient Fees - Other	6,338	5,684

PARENT 2006 $000	PARENT 2005 $000		CONSOLIDATION 2006 $000	CONSOLIDATION 2005 $000
		21. Inventories		
		Current - at cost		
2,512	2,365	Drugs	2,512	2,365
1,974	2,426	Medical and Surgical Supplies	1,974	2,426
247	279	Food and Hotel Supplies	247	279
63	206	Engineering Supplies	63	206
2	111	Other including Goods in Transit	2	111
4,798	**5,387**	**Total**	**4,798**	**5,387**
		22. Property, Plant and Equipment		
		Land and Buildings		
1,398,085	1,344,829	At Fair Value	1,398,085	1,344,829
567,753	538,480	Less Accumulated depreciation and impairment	567,753	538,480
830,332	**806,349**		**830,332**	**806,349**
		Plant and Equipment		
204,092	182,161	At Fair Value	204,092	182,161
114,856	106,050	Less Accumulated depreciation and impairment	114,856	106,050
89,236	**76,111**		**89,236**	**76,111**
		Infrastructure Systems		
95,952	95,198	At Fair Value	95,952	95,198
44,774	42,486	Less Accumulated depreciation and impairment	44,774	42,486
51,178	**52,712**		**51,178**	**52,712**
		Total Property, Plant and Equipment		
970,746	**935,172**	**At Net Carrying Value**	**970,746**	**935,172**

PARENT

22. Property, Plant and Equipment - Reconciliations

	Land $000	Buildings $000	Work in Progress $000	Infrastructure Systems $000	Plant and Equipment $000	Total $000
2006						
Carrying amount at start of year	**78,264**	**655,183**	**72,902**	**52,712**	**76,111**	**935,172**
Additions	351	580	72,769	42	15,663	**89,405**
Recognition of Assets Held for Sale	(427)	-	-	-	-	**(427)**
Disposals	(55)	-	(1)	-	(2,603)	**(2,659)**
Depreciation expense	-	(29,260)	-	(2,288)	(19,197)	**(50,745)**
Reclassifications	69	88,819	(108,862)	712	19,262	-
Carrying amount at end of year	**78,202**	**715,322**	**36,808**	**51,178**	**89,236**	**970,746**

	Land $000	Buildings $000	Work in Progress $000	Infrastructure Systems $000	Plant and Equipment $000	Total $000
2005						
Carrying amount at start of year	-	-	-	-	-	-
Additions	-	994	38,023	31	8,256	**47,304**
Recognition of Assets Held for Sale	(3,315)	(114)	-	-	-	**(3,429)**
Disposals	(1,950)	(166)	-	-	(985)	**(3,101)**
Administrative restructures - transfers in/(out)	52,434	605,038	44,511	26,397	74,645	**803,025**
Net revaluation increment less revaluation decrements recognised in reserves	31,095	57,489	-	26,164	-	**114,748**
Depreciation expense	-	(13,711)	-	(894)	(8,770)	**(23,375)**
Reclassifications	-	5,653	(9,632)	1,014	2,965	-
Carrying amount at end of year	**78,264**	**655,183**	**72,902**	**52,712**	**76,111**	**935,172**

(i) Land and Buildings include land owned by the NSW Health Department and administered by the Health Service [see note 2(g)]

(ii) Land and Buildings were valued by Global Valuation Services Pty Ltd (FRICS, FVLE Val & Econ Registered Number 27) on 1 April 2005 (see note 2(j)]. Global Valuation Services Pty Ltd is not an employee of the Health Service.

CONSOLIDATION

22. Property, Plant and Equipment - Reconciliations

	Land $000	Buildings $000	Work in Progress $000	Infrastructure Systems $000	Plant and Equipment $000	Total $000
2006						
Carrying amount at start of year	**78,264**	**655,183**	**72,902**	**52,712**	**76,111**	**935,172**
Additions	351	580	72,769	42	15,663	**89,405**
Recognition of Assets Held for Sale	(427)	-	-	-	-	**(427)**
Disposals	(55)	-	(1)	-	(2,603)	**(2,659)**
Depreciation expense	-	(29,260)	-	(2,288)	(19,197)	**(50,745)**
Reclassifications	69	88,819	(108,862)	712	19,262	-
Carrying amount at end of year	**78,202**	**715,322**	**36,808**	**51,178**	**89,236**	**970,746**

	Land $000	Buildings $000	Work in Progress $000	Infrastructure Systems $000	Plant and Equipment $000	Total $000
2005						
Carrying amount at start of year	-	-	-	-	-	-
Additions	-	994	38,023	31	8,256	**47,304**
Recognition of Assets Held for Sale	(3,315)	(114)	-	-	-	**(3,429)**
Disposals	(1,950)	(166)	-	-	(985)	**(3,101)**
Administrative restructures - transfers in/(out)	52,434	605,038	44,511	26,397	74,645	**803,025**
Net revaluation increment less revaluation decrements recognised in reserves	31,095	57,489	-	26,164	-	**114,748**
Depreciation expense	-	(13,711)	-	(894)	(8,770)	**(23,375)**
Reclassifications	-	5,653	(9,632)	1,014	2,965	-
Carrying amount at end of year	**78,264**	**655,183**	**72,902**	**52,712**	**76,111**	**935,172**

(i) Land and Buildings include land owned by the NSW Health Department and administered by the Health Service [see note 2(g)]

(ii) Land and Buildings were valued by Global Valuation Services Pty Ltd (FRICS, FVLE Val & Econ Registered Number 27) on 1 April 2005 (see note 2(j)]. Global Valuation Services Pty Ltd is not an employee of the Health Service.

PARENT 2006 $000	PARENT 2005 $000		CONSOLIDATION 2006 $000	CONSOLIDATION 2005 $000
		23. Non Current Assets held for sale		
		Assets held for sale		
3,007	3,429	Land and Buildings	3,007	3,429
3,007	**3,429**	**Total**	**3,007**	**3,429**
		Amounts recognised in equity relating to assets held for sale		
330	691	Property, plant and equipment asset revaluation increments/decrements	330	691
330	**691**	**Total**	**330**	**691**

Land and Buildings held for sale are;

Land, Ocean Street Dudley - formerly Dudley Nursing Home
Land, Lot 1 Kanagra Drive Taree
Land, Lot 1 to 12 Singleton
Land, Lot 37 Legge Street Walcha

The Land is surplus to health service requirements and it is expected that the sale will occur within the next 12 months. Their sale has management and Department of Health approval and assets are available for immediate sale.

24. 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 2006 $000	PARENT 2005 $000	Category	Brief Details of Externally Imposed Conditions including Asset Category affected	CONSOLIDATION 2006 $000	CONSOLIDATION 2005 $000
4,778	3,529	Specific Purposes	Condition Imposed by Donor	4,778	3,529
18	96	Perpetually Invested Funds	Original principal not to be spent	18	96
13,616	11,139	Research Grants	Condition imposed by granting body	13,616	11,139
16,233	13,615	Private Practice Funds	Trust Deed	16,233	13,615
6,974	6,266	Other	Condition Imposed by Donor	6,974	6,266
41,619	**34,645**	**Total**		**41,619**	**34,645**

PARENT 2006 $000	PARENT 2005 $000		CONSOLIDATION 2006 $000	CONSOLIDATION 2005 $000
		25. Payables		
		Current		
-	19,603	Accrued Salaries and Wages	16,555	19,603
-	5,554	Payroll Deductions	2,065	5,554
18,620	-	Accrued Liability, Purchase of Personnel Services	-	-
29,331	24,643	Creditors (enter Trade Creditors only)	29,331	24,643
1,211	1,192	Taxation Payables-Goods and Services Tax	1,211	1,192
		Other Creditors		
351	86	- Capital Works	351	86
1,387	3,168	- Intra Health Liability	1,387	3,168
3,644	9,421	-Other	3,644	9,421
54,544	**63,667**	**Total**	**54,544**	**63,667**
		26. Current/Non Current Borrowings		
		Current		
1,069	-	Other Loans and Deposits	1,069	-
1,069	**-**	**Total**	**1,069**	**-**
		Non Current		
5,050	7,686	Other Loans and Deposits	5,050	7,686
5,050	**7,686**	**Total**	**5,050**	**7,686**

Other loans still to be extinguished represent monies to be repaid to the NSW Health Department. Final Repayment is scheduled for 2010 / 2011

Repayment of Borrowings
(excluding Finance Leases)

1,069	-	Not later than one year	1,069	-
5,050	6,000	Between one and five years	5,050	6,000
-	1,686	Later than five years	-	1,686
6,119	**7,686**	**Total Borrowings at face value (excluding finance leases)**	**6,119**	**7,686**

PARENT 2006 $000	PARENT 2005 $000		CONSOLIDATION 2006 $000	CONSOLIDATION 2005 $000
		27. Provisions		
		Current Employee benefits and related on-costs		
-	51,496	Employee Annual Leave - Short Term Benefit	54,300	51,496
-	22,837	Employee Annual Leave - Long Term Benefit	27,030	22,837
-	13,139	Employee Long Service Leave - Short Term Benefit	13,328	13,139
-	116,343	Employee Long Service Leave - Long Term Benefit	130,910	116,343
225,568	-	Provision for Personnel Services Liability	-	-
225,568	**203,815**	**Total Current Provisions**	**225,568**	**203,815**
		Non Current Employee benefits and related on-costs		
-	4,550	Employee Long Service Leave - Conditional	4,808	4,550
4,808	-	Provision for Personnel Services Liability	-	-
4,808	**4,550**	**Total Non Current Provisions**	**4,808**	**4,550**
		Aggregate Employee Benefits and Related On-costs		
225,568	203,815	Provisions - current	225,568	203,815
4,808	4,550	Provisions - non-current	4,808	4,550
-	25,157	Accrued Salaries and Wages and on costs (Note 25)	18,620	25,157
18,620	-	Accrued Liability, Purchase of Personnel Services (Note 25)	-	-
248,996	**233,522**	**Total**	**248,996**	**233,522**
		28. Other Liabilities		
		Current		
1,411	267	Income in Advance	1,411	267
1,411	**267**	**Total**	**1,411**	**267**
		Non Current		
450	465	Income in Advance	450	465
450	**465**	**Total**	**450**	**465**

Income in advance relates to monies originally received from Armidale Private Hospital and the balance at 30th June was $0.45 million. Other major components of income in advance relates to grants for HACC Dementia Advisory Service $0.306 million, RHS Program $0.205 million, Multicultural Day Care Centres $0.124 million, Lake Macquarie & Newcastle Community Options $0.269 million, Commonwealth Careline $0.163 million and Clinical Excellence $0.1 million.

PARENT

29. Equity

	Accumulated Funds		Asset Revaluation Reserve		Available for Sale Reserves		Total Equity	
	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000
Balance at the beginning of the financial reporting period	**658,179**	-	**112,990**	-	**691**	-	**771,860**	-
Effect of Changes in Accounting Policy and Correction of Errors	2,025						2,025	-
Restated Opening Balance	660,204	-	112,990	-	691	-	773,885	-
Changes in equity - transactions with owners as owners								
Decrease in Net Assets from Administrative Restructure	-	650,635	-	-	-	-	-	650,635
Total	660,204	650,635	112,990	-	691	-	773,885	650,635
Changes in equity - other than transactions with owners as owners								
Result for the year from Ordinary Activities	16,002	6,477	-	-	-	-	16,002	6,477
Increment/(Decrement) on Revaluation of:								
Land and Buildings	-	-	(260)	87,892	260	691	-	88,583
Infrastructure Systems	-	-	-	26,165	-	-	-	26,165
Total	16,002	6,477	(260)	114,057	260	691	16,002	121,225
Transfers within equity								
Asset revaluation reserve balances transferred to accumulated funds on disposal of asset	(394)	1,067	1,015	(1,067)	(621)	-	-	-
Total	(394)	1,067	1,015	(1,067)	(621)	-	-	-
Balance at the end of the financial reporting period	675,812	658,179	113,745	112,990	330	691	789,887	771,860

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).

Hunter New England Area Health Service
Notes to and forming part of the Financial Statements
for the Year Ended 30 June 2006

CONSOLIDATED

29. Equity

	Accumulated Funds		Asset Revaluation Reserve		Available for Sale Reserves		Total Equity	
	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000
Balance at the beginning of the financial reporting period	**658,179**	-	**112,990**	-	**691**	-	**771,860**	-
Effect of Changes in Accounting Policy and Correction of Errors	2,025						2,025	-
Restated Opening Balance	660,204	-	112,990	-	691	-	773,885	-
Changes in equity - transactions with owners as owners								
Decrease in Net Assets from Administrative Restructure	-	650,635	-	-	-	-	-	650,635
Total	660,204	650,635	112,990	-	691	-	773,885	650,635
Changes in equity - other than transactions with owners as owners								
Result for the year from Ordinary Activities	16,002	6,477	-	-	-	-	16,002	6,477
Increment/(Decrement) on Revaluation of:								
Land and Buildings	-	-	(260)	87,892	260	691	-	88,583
Infrastructure Systems	-	-	-	26,165	-	-	-	26,165
Total	16,002	6,477	(260)	114,057	260	691	16,002	121,225
Transfers within equity								
Asset revaluation reserve balances transferred to accumulated funds on disposal of asset	(394)	1,067	1,015	(1,067)	(621)	-	-	-
Total	(394)	1,067	1,015	(1,067)	(621)	-	-	-
Balance at the end of the financial reporting period	675,812	658,179	113,745	112,990	330	691	789,887	771,860

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 2006 $000	PARENT 2005 $000		CONSOLIDATION 2006 $000	CONSOLIDATION 2005 $000

30. Commitments for Expenditure

(a) Capital Commitments

Aggregate capital expenditure contracted for at balance date but not provided for in the accounts:

27,720	32,374	Not later than one year	27,720	32,374
349	1,375	Later than one year and not later than five years	349	1,375
-	132	Later than five years	-	132
28,069	**33,881**	**Total Capital Expenditure Commitments (including GST)**	**28,069**	**33,881**

Of the commitments reported at 30 June 2006 it is expected that $ 5,883 will be met from locally generated monies.

(b) Operating Lease Commitments

Commitments in relation to non-cancellable operating leases are payable as follows:

7,134	6,012	Not later than one year	7,134	6,012
11,767	5,643	Later than one year and not later than five years	11,767	5,643
40,507	25	Later than five years	40,507	25
59,408	**11,680**	**Total Operating Lease Commitments (including GST)**	**59,408**	**11,680**

Operating Leases represent Rental of Premises, Vehicles and Plant and Equipment
Future rental payments are determined by a Lease Contract
No option to purchase clauses are present, renewal is between 3 and 5 years with options and escalation is determined by CPI
Restrictions include access and use of property

(c) Contingent Asset related to Commitments for Expenditure

The total of "Commitments for Expenditure" above includes input tax credits of $ 5.401 million that are expected to be recoverable from the Australian Taxation Office.

(d) Mater Misercordiae Hospital Public, Private Partnership (PPP)

In 2005-06, the Health Administration Corporation entered into a contract with a private sector provider, Novacare Project Partnership for financing, design, construction and commissioning of a new Mater Hospital facility, a mental health facility and refurbishment of existing buildings, and facilities management and delivery of ancillary non-clinical services on the site until November 2033. The redevelopment will be completed in three stages and full service commencement is anticipated in mid

When construction is completed, the Hunter New England Area Health Service (HNEAHS) will transfer the new Mater Hospital facility to Mercy Health Care (Newcastle) Limited and will recognise the transfer as a grant expense of $107m. The recognition is based on the fact that services will be delivered by Mercy Health being a Third Schedule Hospital health care provider which is outside the accounting control of either HNEAHS or the Department.

HNEAHS will recognise the new mental health facility as an asset of $39m. The refurbished Convent and McAuley buildings at the new Mater hospital facility, to be occupied by HNEAHS, will also be recognised as an asset and offsetting liability of $11m. The basis for the accounting treatment is that services will be delivered by HNEAHS on the site of Mater Hospital for the duration of the Head Lease of the these facilities until November 2033.

In addition, the Hunter New England Area Health Service will recognise the liability to Novacare, payable over the period to 2033, for the construction of both hospitals.

An estimate of the commitments is as follows:

2006 $000	2005 $000	(a) Capital Commitments – New Mental Health Building and Refurbished Buildings	2006 $000	2005 $000
20,202	-	Later than one year and not later than five years	20,202	-
104,585	-	Later than five years	104,585	-
124,787	**-**	**Total Capital Expenditure Commitments (including GST)**	**124,787**	**-**

(b) Other Expenditure Commitments – Redevelopment of new Mater Hospital facility (which will be recognised as a grant after completion of construction) and provision of facilities management and other non-clinical services to both hospitals.

90,344	-	Later than one year and not later than five years	90,344	-
779,576	-	Later than five years	779,576	-
869,920	**-**	**Total Other Expenditure Commitments (including GST)**	**869,920**	**-**

The expenditure commitments include Goods and Services Tax. Related input tax credits of $90M (2005: nil) are expected to be recoverable from the Australian Taxation Office.

PARENT

31. Trust Funds

The Health Service holds trust fund moneys of $ 2.284 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	
	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000
Cash Balance at the beginning of the financial reporting period	**1,279**	**-**	**237**	**-**	**1,483**	**-**
Amount transferred on 1 January 2005 from Administrative Restructure of Health Services	**-**	**715**	**-**	**240**	**-**	**2,876**
Receipts	1,284	1,356	478	249	36,973	14,426
Expenditure	1,444	792	441	252	37,565	15,819
Cash Balance at the end of the financial reporting period	**1,119**	**1,279**	**274**	**237**	**891**	**1,483**

CONSOLIDATED

31. Trust Funds

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PARENT | CONSOLIDATION

32. 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. Open Public Liability claims against the Health Service at 30 June 2006 number 87 with an estimated value of $28.4 million (91 claims with an estimated value of $ 29.5 million at 30 June 2005). 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 1999/2000 fund year and an interim adjustment for the 2001/2002 fund year were not calculated until 2005/06. As a result, the 2000/2001 final and 2002/03 interim hindsight calculations will be paid in 2006/07.

c) Affiliated Health Organisations

Based on the definition of control in Australian Accounting Standard AAS24, 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.

d) Mater Misercordiae Hospital Public, Private Partnership (PPP)

The liability to pay Novacare for the redevelopment of the new Mater Hospital facility is based on a financing arrangement involving CPI-linked finance and fixed finance. An interest rate adjustment will be made as appropriate for the CPI-linked interest component over the project term. The estimated value of the contingent liability is unable to be fully determined because of uncertain future events.

PARENT

33. Charitable Fundraising Activities

Fundraising Activities

The Hunter New England Area Health Service conducts direct fundraising in all hospitals under its control.

All revenue and expenses have been recognised in the financial statements of the Hunter New England Area Health Service. Fundraising activities are dissected as follows:

	INCOME RAISED $000	DIRECT EXPENDITURE* $000	INDIRECT EXPENDITURE+ $000	NET PROCEEDS $000
Appeals (In House)	13	-	-	13
Fetes	2	-	-	2
Raffles	12	-	-	12
Functions	133	-	-	133
Total	160	-	-	160
Percentage of Income	100%	%	%	%

* Direct Expenditure includes printing, postage, raffle prizes, consulting fees, etc
\+ Indirect Expenditure includes overheads such as office staff administrative costs, cost apportionment of light, power and other overheads.

The net proceeds were used for the following purposes:	$000
Purchase of Equipment	3
Held in Special Purpose & Trust Fund Pending Purchase	157
	160

The provision of the Charitable Fundraising Act 1991 and the regulations under that Act have been complied with and internal controls exercised by the Hunter New England Area Health Service are considered appropriate and effective in accounting for all the income received in all material respects.

CONSOLIDATED

33. Charitable Fundraising Activities

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PARENT			CONSOLIDATION	
2006 $000	2005 $000		2006 $000	2005 $000

34. Reconciliation Of Net Cost Of Services To Net Cash Flows from Operating Activities

96,723	58,815	Net Cash Flows from Operating Activities	96,723	58,815
(50,745)	(23,375)	Depreciation	(50,745)	(23,375)
220	(198)	Provision for Doubtful Debts	220	(198)
(13,666)	(30,393)	Acceptance by the Crown Entity of Employee Superannuation Benefits	(19,754)	(30,393)
(22,012)	(15,978)	(Increase)/ Decrease in Provisions	(22,012)	(15,978)
(9,016)	(4,080)	Increase / (Decrease) in Prepayments and Other Assets	(9,016)	(4,080)
7,537	(16,984)	(Increase)/ Decrease in Creditors	7,537	(16,984)
125	67	Net Gain/ (Loss) on Sale of Property, Plant and Equipment	125	67
(1,060,708)	(464,624)	(NSW Health Department Recurrent Allocations)	(1,060,708)	(464,624)
(72,336)	(34,292)	(NSW Health Department Capital Allocations)	(72,336)	(34,292)
(1,123,878)	**(531,042)**	**Net Cost of Services**	**(1,129,966)**	**(531,042)**

35. 2005/06 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 -	Patient & Family Support
. Pink Ladies/Hospital Auxiliaries -	Patient Services, Fund Raising
. Patient Support Groups -	Practical Support to Patients and Relative
. Community Organisations -	Counselling, Health Education, Transport, Home Help & Patient Activities

36. 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.

37. Budget Review

Net Cost of Services

The actual Net Cost of Services was lower than budget by $ 5.876 million, this was primarily due to higher than anticipated infrastructure fees and other Sale of Goods and Services income.

Result for the Year from Ordinary Activities

The actual Result for the year from Ordinary Activities was higher than budget by $ 6.414 million, this was primarily due to higher than anticipated infrastructure fees and other Sale of Goods and Services income.

Assets and Liabilities

Current Assets were higher than budget by $16.526 million due to higher than anticipated cash at bank. This was due to the Nett Cost of Services result and spending less on Land & Budings than anticipated.

Non Current Assets were lower than budget by $8.989 million due to lower than anticipated spending on Land and Buildings.

Current Liabilities were higher than budget by $ 4.270 million due to higher than ancipitated Provisions for Leave Liabilities.

Non Current Liabilities were lower than budget by $ 3.148 million due to lower than ancipitated Income in advance.

Cash Flows

The actual Net Cash Flows from Operating Activities was higher than budget by $ 13.242 million, this was primarily due to higher than anticipated infrastructure fees and other Sale of Goods and Services income.

The actual Net Cash Flows from Investing Activities was lower than budget by $ 4.672 million, this was primarily due to lower than anticipated Purchase of Land & Buildings.

PARENT CONSOLIDATION

37. Budget Review (Continued)

Movements in the level of the NSW Health Department Recurrent Allocation that have occurred since the time of the initial allocation on 22nd July 2005 are as follows:

		$000
Initial Allocation, 22nd July 2005		858,650
Award Increases		43,071
Special Projects;		
High Cost Drugs	2,856	
National Mental Health	1,919	
Cancer Services	1,632	
P.A.D.P.	1,563	
IMMS - Mental Health	1,179	
Mental Health Enhancement	813	
Mental Health - PECS	750	
Managed Fund Insurance	728	
Dental	512	
Aboriginal Health	395	
Intermittent Care Pilot Places	385	
Pathways Home	353	
Clinical Excellence Professional Practice	349	
Other	764	
		14,198
Other;		
Superannuation - SGC	50,266	
Inter Area & Interstate Flows	44,505	
Growth	11,000	
1st Stage 387 Beds	10,714	
1st Stage 345 Beds	7,614	
Adult ICU's	3,500	
Commonwealth Share of Transitional Care Places	3,308	
Amalgamations Staff Separation Costs	2,456	
Nursing Strategies Allocation	1,814	
Neonatal care	1,800	
Clinical Service Redesign Program	1,670	
Elective Surgery - Long Wait Reduction	1,416	
Health Reform Strategy	1,300	
High Cost Drugs	1,110	
Workforce Development & Leadership	1,082	
Elective Surgery	951	
Rural Doctors	843	
Special Project Rollovers - Subsidy witheld	(7,871)	
Revenue Escallation	(3,874)	
Amalgamation Savings	(3,000)	
Other	7,355	
		137,959
Balance as per Operating Statement		1,053,878

PARENT

38. Financial Instruments

a) Interest Rate Risk

Interest rate risk, is the risk that the value of the financial instrument will fluctuate due to changes in market interest rates. The Hunter New England Area Health Service's exposure to interest rate risks and the effective interest rates of financial assets and liabilities, both recognised and unrecognised, at the (consolidated) Balance Sheet date are as follows:

Financial Instruments	Floating interest rate		Fixed interest rate maturing in: I year or less		Over 1 to 5 years		More than 5 years		Non-interest bearing		Total carrying amount as per the Balance Sheet		Weighted average effective interest rate *	
	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 %	2005 %
Financial Assets														
Cash	20,688	11,222	53,000	53,000	-	-	-	-	109	76	73,797	64,298	5.8%	5.6%
Receivables	-	-	-	-	-	-	-	-	30,439	44,024	30,439	44,024	-	-
Total Financial Assets	20,688	11,222	53,000	53,000	-	-	-	-	30,548	44,100	104,236	108,322		
Financial Liabilities														
Borrowings-Other	-	-	1,069	-	5,050	6,000	-	1,686	-	-	6,119	7,686	6.0%	6.0%
Payables	-	-	-	-	-	-	-	-	54,534	63,667	54,534	63,667	-	-
Total Financial Liabilities	-	-	1,069	-	5,050	6,000	-	1,686	54,534	63,667	60,653	71,353		

* Weighted average effective interest rate was computed on a semi-annual basis. It is not applicable for non-interest bearing financial instruments.

b) Credit Risk

Credit risk is the risk of financial loss arising from another party to a contract/ or financial position failing to discharge a financial obligation thereunder. The Hunter New England Area Health Service's maximium exposure to credit risk is represented by the carrying amounts of the financial assets included in the consolidated Balance Sheet.

Credit Risk by classification of counterparty.

	Governments		Banks		Patients		Other		Total	
	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000
Financial Assets										
Cash	109	76	73,688	64,222	-	-	-	-	73,797	64,298
Receivables	3,497	21,597	-	-	6,761	6,386	20,181	16,041	30,439	44,024
Total Financial Assets	3,606	21,673	73,688	64,222	6,761	6,386	20,181	16,041	104,236	108,322

The only significant concentration of credit risk arises in respect of patients ineligible for free treatment under the Medicare provisions. Receivables from these entities totalled $ 0.139 million at balance date.

c) Derivative Financial Instruments

The Hunter New England Health Service holds no Derivative Financial Instruments.

CONSOLIDATION

38. Financial Instruments

a) Interest Rate Risk

Interest rate risk, is the risk that the value of the financial instrument will fluctuate due to changes in market interest rates. The Hunter New England Area Health Service's exposure to interest rate risks and the effective interest rates of financial assets and liabilities, both recognised and unrecognised, at the (consolidated) Balance Sheet date are as follows:

Financial Instruments	Floating interest rate		Fixed interest rate maturing in: I year or less		Over 1 to 5 years		More than 5 years		Non-interest bearing		Total carrying amount as per the Balance Sheet		Weighted average effective interest rate *	
	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 %	2005 %
Financial Assets														
Cash	20,688	11,222	53,000	53,000	-	-	-	-	109	76	73,797	64,298	5.8%	5.6%
Receivables	-	-	-	-	-	-	-	-	30,439	44,024	30,439	44,024	-	-
Total Financial Assets	20,688	11,222	53,000	53,000	-	-	-	-	30,548	44,100	104,236	108,322		
Financial Liabilities														
Borrowings-Other	-	-	1,069	-	5,050	6,000	-	1,686	-	-	6,119	7,686	6.0%	6.0%
Payables	-	-	-	-	-	-	-	-	54,534	63,667	54,534	63,667	-	-
Total Financial Liabilities	-	-	1,069	-	5,050	6,000	-	1,686	54,534	63,667	60,653	71,353		

* Weighted average effective interest rate was computed on a semi-annual basis. It is not applicable for non-interest bearing financial instruments.

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Credit Risk by classification of counterparty.

	Governments		Banks		Patients		Other		Total	
	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000
Financial Assets										
Cash	109	76	73,688	64,222	-	-	-	-	73,797	64,298
Receivables	3,497	21,597	-	-	6,761	6,386	20,181	16,041	30,439	44,024
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The only significant concentration of credit risk arises in respect of patients ineligible for free treatment under the Medicare provisions. Receivables from these entities totalled $ 0.139 million at balance date.

c) Derivative Financial Instruments

The Hunter New England Health Service holds no Derivative Financial Instruments.

PARENT	CONSOLIDATION

39. After Balance Date Events

a) Transfer of Mercy Health Care (Newcastle) Limited

Mercy Health Care (Newcastle) Limited operate the Mater Misercordiae Hospital at Waratah. Under a performance agreement between the Hunter New England Health Service and the Mercy Health Care (Newcastle) Limited cash payments are made in return for meeting performance and activity indicators. These payments are recorded in the Income Statement as Payments to Affiliated Heath Organisations.

On 4th September 2006, the Trustees of the Sisters of Mercy (Singleton) announced that they had reached in principle agreement to the transfer of control of Mercy Health Care (Newcastle) Limited from the Sisters of Mercy (Singleton) to Little Company of Mary Health Care Limited, subject to satisfactory completion of due diligence processes. The due diligence process was commenced on 11th September, 2006 and remains underway at the time of compiling and publishing this report. Subject to a satisfactory outcome from the due diligence, it is anticipated that the transfer will be affected before the end of 2006.

END OF AUDITED FINANCIAL STATEMENTS

Certification of Special Purpose Entity for Period Ended 30 June 2006

The attached financial statements of the Hunter New England Area Health Service for the year ended 30 June 2006:

i) Have been prepared in accordance with the requirements of applicable Australian Accounting Standards which include Australian equivalents to International Financial Reporting Standards (AEIFRS), the requirements of the *Public Finance and Audit Act Regulation 2005* 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 and transactions of the Hunter New England Area Health Service; and

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

.....

Terry Clout - Chief Executive

Hunter New England Area Health Service

22 September 2006

.....

Tracey McCosker – Director Corporate Services

Hunter New England Area Health Service

22 September 2006

GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDIT REPORT

HUNTER NEW ENGLAND AREA HEALTH SERVICE SPECIAL PURPOSE SERVICE ENTITY

To Members of the New South Wales Parliament

Audit Opinion

In my opinion, the financial report of the Hunter New England Area Health Service Special Purpose Service Entity (the *Entity*):

- presents fairly the Entity's financial position as at 30 June 2006 and its performance for the period 17 March 2006 to 30 June 2006, in accordance with Accounting Standards and other mandatory financial reporting requirements in Australia, and
- complies with section 41B of the *Public Finance and Audit Act 1983* (the Act) and the *Public Finance and Audit Regulation 2005*.

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

Scope

The Financial Report and Chief Executive's Responsibility

The financial report comprises the balance sheet, income statement, statement of changes in equity, cash flow statement and accompanying notes to the financial statements for the Entity, for the period ended 30 June 2006.

The Chief Executive of the Entity is responsible for the preparation and true and fair presentation of the financial report in accordance with the Act. This includes responsibility for the maintenance of adequate accounting records and internal controls that are designed to prevent and detect fraud and error, and for the accounting policies and accounting estimates inherent in the financial report.

Audit Approach

I conducted an independent audit in order to express an opinion on the financial report. My audit provides *reasonable assurance* to Members of the New South Wales Parliament that the financial report is free of *material* misstatement.

My audit accorded with Australian Auditing Standards and statutory requirements, and I:

- assessed the appropriateness of the accounting policies and disclosures used and the reasonableness of significant accounting estimates made by the Chief Executive in preparing the financial report, and
- examined a sample of evidence that supports the amounts and disclosures in the financial report.

An audit does *not* guarantee that every amount and disclosure in the financial report is error free. The terms 'reasonable assurance' and 'material' recognise that an audit does not examine all evidence and transactions. However, the audit procedures used should identify errors or omissions significant enough to adversely affect decisions made by users of the financial report or indicate that the Chief Executive had not fulfilled his reporting obligations.

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.

Audit Independence

The Audit Office complies with all applicable independence requirements of Australian professional ethical pronouncements. The 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 are not compromised in their role by the possibility of losing clients or income.

David Jones
Director, Financial Audit Services

SYDNEY
20 October 2006

Hunter New England Area Health Service Special Purpose Service Entity
Income Statement for the period ended 30 June 2006

	2006 $000
INCOME	
Personnel Services	257,551
Acceptance by the Crown Entity of Employee Superannuation Benefits	6,088
Total income	263,639
EXPENSES	
Salaries & Wages	194,754
Superannuation - Defined Benefit Plans	6,088
Superannuation - Defined Contributions	14,503
Long Service Leave	15,063
Annual Leave	21,192
Nursing Agency Payments	154
Other Agency Payments	402
Workers Compensation Insurance	5,218
Fringe Benefits Tax	177
Grants & Subsidies	6,088
Total Expenses	263,639
RESULT FOR THE YEAR	-

The accompanying notes form part of these Financial Statements

Hunter New England Area Health Service Special Purpose Service Entity
Statement of Changes in Equity for the period ended 30 June 2006

Result for the Year	-
TOTAL INCOME AND EXPENSE RECOGNISED FOR THE YEAR	-

The accompanying notes form part of these Financial Statements

Hunter New England Area Health Service Special Purpose Service Entity
Balance Sheet as at 30 June 2006

	Notes	2006 $000
ASSETS		
Current Assets		
Receivables	2	244,188
Total Current Assets		244,188
Non-Current Assets		
Receivables	2	4,808
Total Non-Current Assets		4,808
Total Assets		248,996
LIABILITIES		
Current Liabilities		
Payables	3	18,620
Provisions	4	225,568
Total Current Liabilities		244,188
Non-Current Liabilities		
Provisions	4	4,808
Total Non-Current Liabilities		4,808
Total Liabilities		248,996
Net Assets		-
EQUITY		
Accumulated funds		-
Total Equity		-

The accompanying notes form part of these Financial Statements

Hunter New England Area Health Service Special Purpose Service Entity
Cash Flow Statement for the period ended 30 June 2006

CASH FLOWS FROM OPERATING ACTIVITIES	
Payments	
Employee Related	-
Total Payments	-
Receipts	
Sale of Goods and Services	-
Total Receipts	-
NET CASH FLOWS FROM OPERATING ACTIVITIES	-
NET INCREASE / (DECREASE) IN CASH	-
Opening Cash and Cash Equivalents	-
CLOSING CASH AND CASH EQUIVALENTS	-

The accompanying notes form part of these Financial Statements

Hunter New England Area Health Service Special Purpose Entity
Notes to and forming part of the Annual Financial Statements
for the Year Ended 30 June 2006

1. Summary of Significant Accounting Policies

(a) Reporting Entity

The Hunter New England Area Health 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 New Lambton

The Entity's objective is to provide personnel services to Hunter New England Area Health Service.

The Entity commenced operations on 17 March 2006 when it assumed responsibility for the employees and employee-related liabilities of the Hunter New England Area Health Service. The assumed liabilities were recognised on 17 March 2006 together with an offsetting receivable representing the related funding due from the former employer.

The financial report was authorised for issue by the Chief Executive on 22 September 2006. The report will not be amended and reissued as it has been audited.

(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

This is the first financial report prepared on the basis of Australian equivalents to International Financial Reporting Standards.

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.

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

As this is the Entity's first financial report, comparative information for the previous year is not provided.

(d) 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.

(e) Goods & Services Tax (GST)

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

* 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) 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.

A receivable is measured initially at fair value and subsequently at amortised cost using the effective interest rate method, less any allowance for doubtful debts. A short-term receivable with no stated interest rate is measured at the original invoice amount where the effect of discounting is immaterial. An invoiced receivable is due for settlement within thirty days of invoicing.

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 doubtful debts 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) Payables

Payables include accrued wages, salaries, and related on costs (such as 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 substituted.

A short-term payable with no stated interest rate is measured at historical cost if the effect of discounting is immaterial.

(h) Employee benefit provisions and expenses

Provisions are made for liabilities of uncertain amount or uncertain timing of settlement.

Employee benefit provisions represent expected amounts payable in the future in respect of unused entitlements accumulated as at the reporting date. Liabilities associated with, but that are not, employee benefits (such as fringe benefits tax) are recognised separately.

Superannuation and leave liabilities are recognised as expenses and provisions when the obligations arise, which is usually through the rendering of service by employees.

Long-term Long Service Leave (i.e. that is not expected to be taken within twelve months) is measured on a short hand basis at an escalated rate of 17.4% for short term entitlements and 7.6% for long term entitlements above the salary rates immediately payable at 30 June 2006 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 superannuation expense for the financial year is determined by using the formulae specified by the NSW Health Department. The expense for certain superannuation schemes (i.e. Basic Benefit and First State Super) is calculated as a percentage of the 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.

Consequential to the legislative changes of 17 March 2006 no salary costs or provisions are recognised by the Parent Health Service beyond that date.

(i) Accounting standards issued but not yet effective

The following Accounting Standards are being early adopted from 1 July 2005:

- AASB 2005-4 regarding the revised AAS139 fair value option;
- UIG 9 regarding the reassessment of embedded derivatives; and
- AASB 2005-06, which excludes from the scope of AASB3, business combinations involving entities or businesses under common control.

	2006 $000
2. Current/Non Current Receivables	
Current	
Intra Health User Charges	244,188
Total Current Receivable	244,188
Non Current	
Intra Health User Charges	4,808
Total Non Current Receivable	4,808
3. Payables	
Current	
Accrued Liability, Purchase of Personnel Services;	
Accrued Salaries and Wages	16,555
Payroll Deductions	2,065
Total	**18,620**
4. Provisions	
Current Employee benefits and related on-costs	
Provision for Personnel Services Liability;	
Employee Annual Leave - Short Term Benefit	54,300
Employee Annual Leave - Long Term Benefit	27,030
Employee Long Service Leave - Short Term Benefit	13,328
Employee Long Service Leave - Long Term Benefit	130,910
Total Current Provisions	**225,568**
Non Current Employee benefits and related on-costs	
Provision for Personnel Services Liability;	
Employee Long Service Leave - Conditional	4,808
Total Non Current Provisions	**4,808**
Aggregate Employee Benefits and Related On-costs	
Provisions - current	225,568
Provisions - non-current	4,808
Accrued Liability, Purchase of Personnel Services (Note 3)	18,620
Total	**248,996**

5. Financial Instruments

a) Interest Rate Risk

Interest rate risk, is the risk that the value of the financial instrument will fluctuate due to changes in market interest rates. The Hunter New England Area Health Service Special Purpose Entity's exposure to interest rate risks and the effective interest rates of financial assets and liabilities, both recognised and unrecognised, at the (consolidated) Balance Sheet date are as follows:

Financial Instruments	Floating interest rate	Fixed interest rate maturing in:			Non-interest bearing	Total carrying amount as per the Balance Sheet	Weighted average effective interest rate *
		1 year or less	Over 1 to 5 years	More than 5 years			
	2006 $000	2006 $000	2006 $000	2006 $000	2006 $000	2006 $000	2006 %
Financial Assets							
Receivables	-	-	-	-	248,996	248,996	-
Total Financial Assets	-	-	-	-	248,996	248,996	
Financial Liabilities							
Payables	-	-	-	-	18,620	18,620	-
Total Financial Liabilities	-	-	-	-	18,620	18,620	

* Weighted average effective interest rate was computed on a semi-annual basis. It is not applicable for non-interest bearing financial instruments.

b) Credit Risk

Credit risk is the risk of financial loss arising from another party to a contract/ or financial position failing to discharge a financial obligation thereunder. The Hunter New England Area Health Service Special Purpose Entity's maximium exposure to credit risk is represented by the carrying amounts of the financial assets included in the consolidated Balance Sheet.

Credit Risk by classification of counterparty.

	Governments	Banks	Patients	Other	Total
	2006 $000	2006 $000	2006 $000	2006 $000	2006 $000
Financial Assets					
Receivables	248,996	-	-	-	248,996
Total Financial Assets	248,996	-	-	-	248,996

c) Derivative Financial Instruments

The Hunter New England Health Service Special Purpose Entity holds no Derivative Financial Instruments.

END OF AUDITED FINANCIAL STATEMENTS

A detailed list of all Hunter New England Health facilities including contact details, addresses and parking information is available at www.hnehealth.nsw.gov.au.