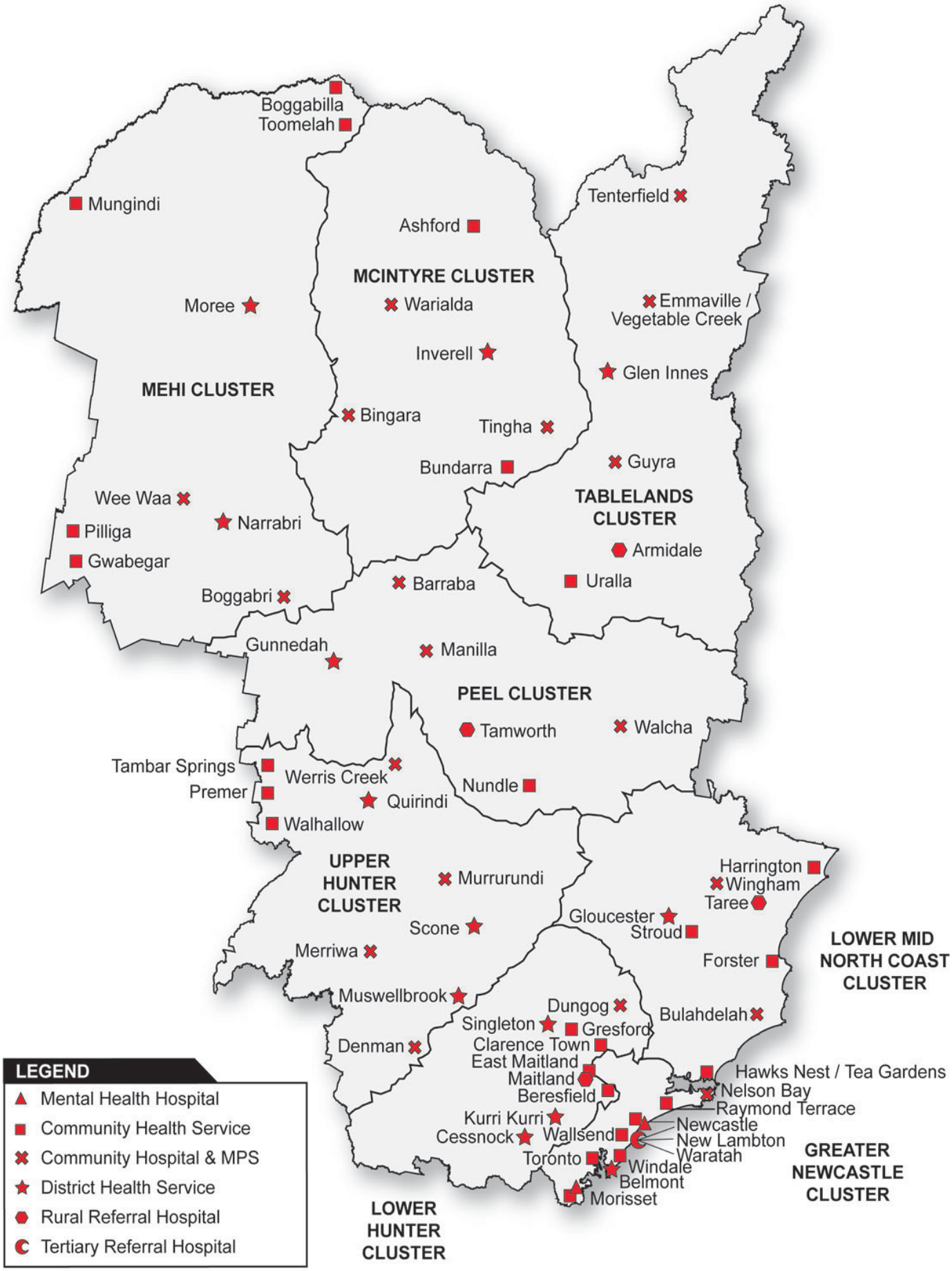
Hunter New England Area Health Service

Annual Report 2004/2005

HUNTER NEW ENGLAND | NSW HEALTH



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All Hunter New England hospitals are open 24 hours.

Letter to the Minister

November 2005

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 2004/05 Annual Report.

The Report complies with the requirements for annual reporting under the Accounts and Audit Determination for public health organisations and the 2004/05 Directions for Health Service Reporting.

Terry Clout
CHIEF EXECUTIVE

Contents

2004-2005 Highlights

- On budget with almost all activity targets exceeded.
- 174,546 episodes of care in public hospitals.
- Access block reduced across Hunter New England Health from 27 per cent in 2002-03 to 16 per cent in 2004-05.
- Significant reductions in the number of patients waiting more than 12 months for non-urgent surgical or medical treatment.
- 98.7% of people attending a community health centre, 91% of people attending a hospital and 81.1% of people attending an emergency department rated their care as excellent, very good or good.
- Opened Barraba Health Service, a multi-purpose service incorporating residential aged care, acute hospital care, community health and emergency services all under the one roof.
- Expansion of the Aged Care Transitional Implementation Program (ACTIP) in Forster – a service which provides transitional assistance, particularly focused on rehabilitation, to older people with a change in health status that would otherwise need hospitalisation.
- Celebrated the 50,000th baby born at John Hunter Hospital.
- The networked Emergency Departments of John Hunter and Belmont hospitals received international recognition as one of the best performing emergency departments in Australia and one of the most innovative in the world. The departments received the 2005 Press Ganey Associates Australian Success Story Award as well as the emergency department category of the International Press Ganey Awards.
- Consistently high childhood immunisation rates – Hunter New England Health has one of the state's highest immunisation rates for children aged 12-15 months at 93.5%, higher than the NSW average of 91%.
- Celebrated 100 years of care at Kurri Kurri District Hospital – the celebration was awarded Community Event of the Year as part of the local Australia Day awards in 2005.
- Continued progress on the Newcastle Strategy – the largest investment ever in improved health facilities in Newcastle and Lake Macquarie.

2004-2005 Snapshot

Population we care for	840,000+
Number of people cared for in our emergency departments	296,412
Episodes of care delivered in a hospital setting	174,546
Average length of stay for acute hospital patients (including same day admissions)	3.5 days
Number of people admitted for same day care (% of total admissions)	38.4%
Non-admitted patient services (includes community health)	2,535,569
Number of babies born	8440
Percentage of Hunter children aged 12-15 months that are fully immunised	93.5%

Message from the Chief Executive

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

To achieve this, we need an organisation that has skilled, enthusiastic and committed staff, robust systems, strong partnerships, sound financial management and an unwavering commitment to improving people's health.

Over the past twelve months we have worked hard to build a new organisation with all of these qualities.

We have made significant progress in merging the three former organisations of Hunter Health, New England Area Health Service and the southern parts of the Mid North Coast Area Health Service including the Great Lakes, Greater Taree and Gloucester local government areas. As part of this process, our organisation has developed a set of values, known as the 'Three Cs' which embody the qualities of our health service:

Teamwork
Honesty
Respect
Ethics
Excellence
Caring
Commitment
Courage

These are the values that set the foundation for our organisation – they are the building blocks that will help us to develop a strong health service able to make a real difference in people's lives, and able to lead the way in health care.
Over the past 12 months there have been many significant achievements.
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.

We have also made improvements through the recruitment of additional medical specialists, particularly in New England, establishment of a Registrar training program on the Lower Mid North Coast and through the integration of services such as Mental Health across the area, to name a few.

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. Further evidence of the value of this program came in June when, as a result of implementing improvements identified through the Maggie Program, the networked emergency departments of John Hunter and Belmont hospitals won the 2005 Press Ganey Associates Australian Success Story Award as well as the emergency department category of the International Press Ganey awards.

This year I have been witness to an array of quality projects and inspiring people. This Annual Report provides a snapshot of some of our outstanding work and an outline of our achievements and challenges. There is still work to be done, and our commitment to ongoing improvement stands firm.

I would like to acknowledge that the achievements of 2004-05 have been because of the skills, innovation, commitment and caring of Hunter New

England Health's 14,500 staff, 1500 visiting doctors, countless volunteers and our business partners. The communities across this vast Area Health Service should be as proud of them as I am and continue to acknowledge their efforts and support their work.

Terry Clout
Chief Executive
Hunter New England Area Health Service

Hunter New England Health

Structure and Responsibilities

Organisation

Hunter New England Health was created on 1 January 2005, following the merger of Hunter Area Health Service, New England Area Health Service and the Lower Mid North Coast local government areas of Gloucester, Greater Taree and Great Lakes.

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:

- was estimated at 825,536 people in 2003 (ABS Estimated Resident Population)
- comprises 12% of the State's population
- is concentrated in coastal areas and large country towns, with high population densities and growth in the coastal areas, and decreasing densities

in the north and west

- comprises 21.6% of the State's Aboriginal population (which equals 3.3% of the Hunter New England population, compared with 2.1% of NSW's population).

The major difference between the Aboriginal and non-Aboriginal population is the proportion of people aged 65 years and over: 3% compared to 15% respectively. This reflects the poor health status of Aboriginal people who have a life expectancy 20 years lower than non-Aboriginal people.

Generally, Hunter New England has a population distribution as shown below.

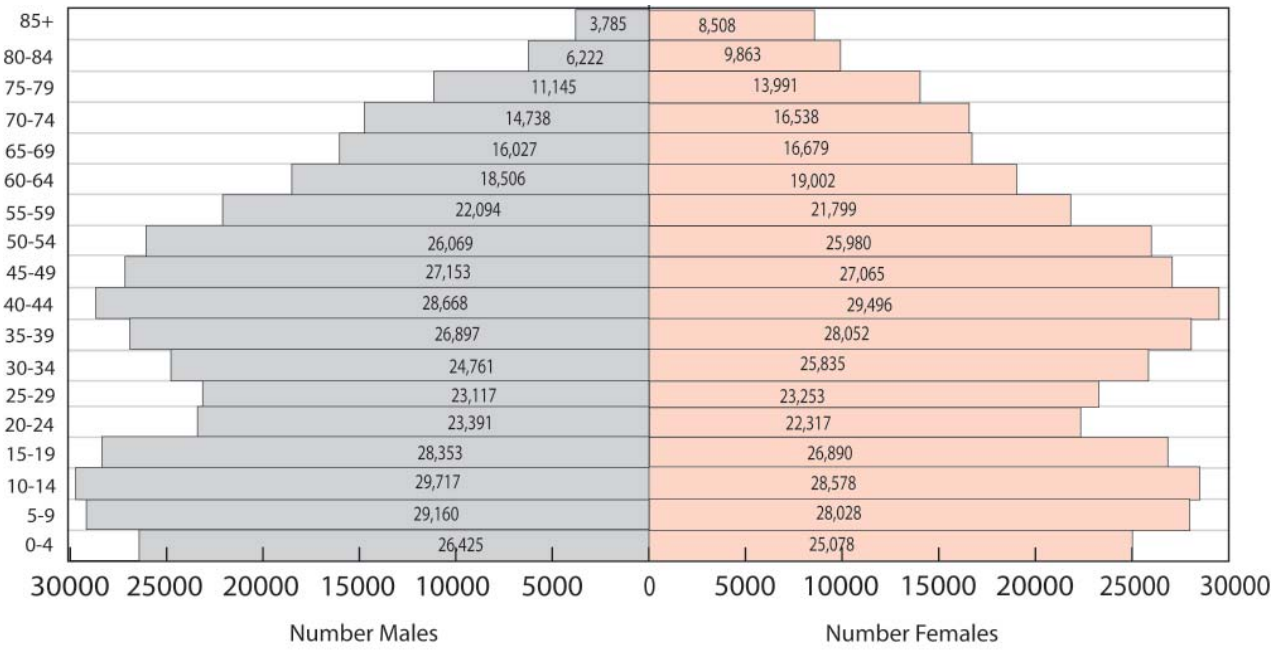
Population growth within Hunter New England is predicted to be 2.8% over the next five years (compared with 4.5% in NSW), with estimates of 856,870 people in 2011 growing to 875,580 in 2016.
The main areas of population growth are expected to be Newcastle, Maitland, Port Stephens and Great Lakes. The greatest concentration of population occurs in these areas. Growth is also occurring in Lake Macquarie.

The area around the regional city of Tamworth is also likely to experience an increase in population as the city has a diverse infrastructure to support employment and education. Merriwa and Dungog are also likely to have an increase with people relocating to rural properties.

Areas likely to experience population decline are Murrurundi, Gunnedah and Glen Innes.

The Hunter New England

HNE 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.

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

Hunter New England Health

Structure and Responsibilities

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

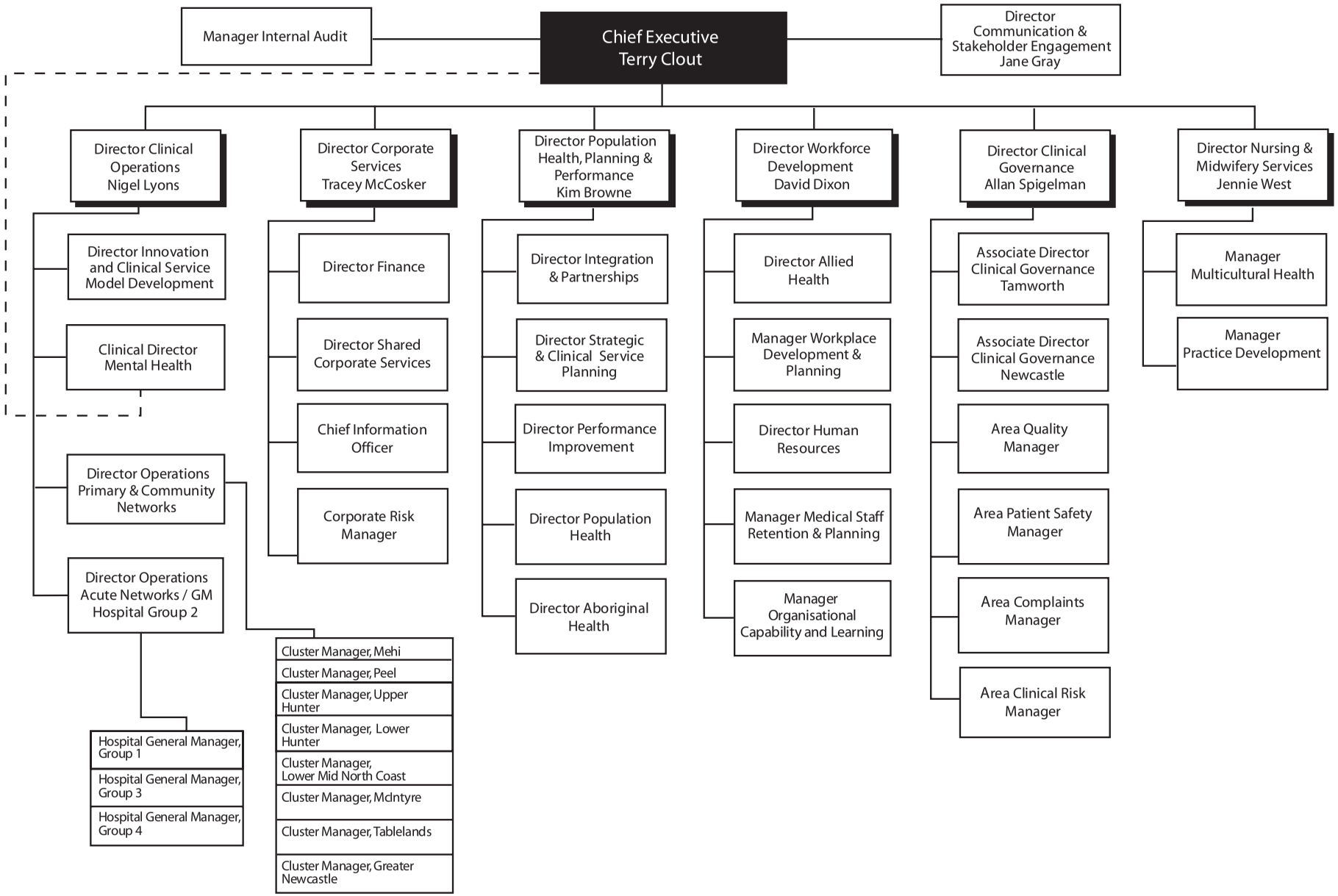
and acute hospital networks, Hunter New England Health is establishing a number of **Managed Clinical Networks**.

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.


Manager Internal Audit
Chief Executive
Terry Clout
Director
Communication &
Stakeholder Engagement
Jane Gray
Director Clinical
Operations
Nigel Lyons
Director Corporate
Services
Tracey McCosker
Director Population
Health, Planning &
Performance
Kim Browne
Director Workforce
Development
David Dixon
Director Clinical
Governance
Allan Spigelman
Director Nursing &
Midwifery Services
Jennie West
Director Innovation
and Clinical Service
Model Development
Clinical Director
Mental Health
Director Operations
Primary & Community
Networks
Director Operations
Acute Networks / GM
Hospital Group 2
Hospital General Manager,
Group 1
Hospital General Manager,
Group 3
Hospital General Manager,
Group 4
Director Finance
Director Shared
Corporate Services
Chief Information
Officer
Corporate Risk
Manager
Cluster Manager, Mehi
Cluster Manager, Peel
Cluster Manager, Upper
Hunter
Cluster Manager, Lower
Hunter
Cluster Manager,
Lower Mid North Coast
Cluster Manager, McIntyre
Cluster Manager, Tablelands
Cluster Manager, Greater
Newcastle
Director Integration
& Partnerships
Director Strategic
& Clinical Service
Planning
Director Performance
Improvement
Director Population
Health
Director Aboriginal
Health
Director Allied
Health
Manager Workplace
Development &
Planning
Director Human
Resources
Manager Medical Staff
Retention & Planning
Manager
Organisational
Capability and Learning
Associate Director
Clinical Governance
Tamworth
Associate Director
Clinical Governance
Newcastle
Area Quality
Manager
Area Patient Safety
Manager
Area Complaints
Manager
Area Clinical Risk
Manager
Manager
Multicultural Health
Manager
Practice Development

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.

Ethics
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.

Healthier People

Adopting Healthy Lifestyles

Performance

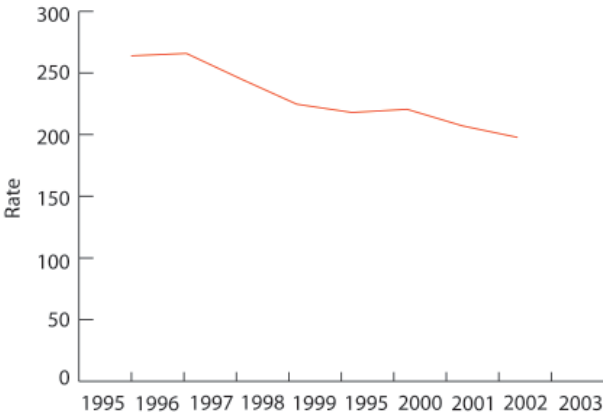
Smoking, alcohol consumption, physical activity and the consumption of fruit and vegetables are some of the key indicators that Hunter New England Health uses to measure the general health of its communities. These areas have been highlighted as concerns because of their direct influence on people's quality of life.

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

- Encouraging and supporting patients to quit smoking while being cared for at hospital.
- Improving responsible service of alcohol through expansion of the Alcohol Linking Program (in partnership with NSW Police) and through support of the Liquor Accords (in partnership with licensed clubs and hotels).
- Targeted physical activity programs, such as Akktiv Kurri Kurri, a community-wide initiative aimed at increasing physical activity and the consumption of fruit and vegetables.

DASHBOARD INDICATOR: Avoidable 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 1995-2003.

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

DASHBOARD INDICATOR: Adopting healthy lifestyles

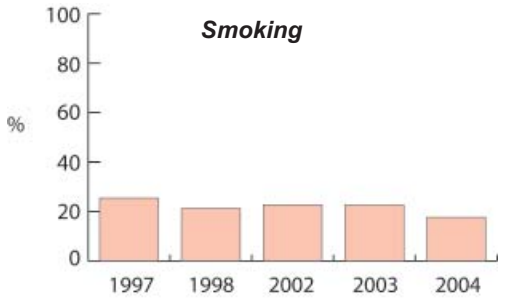
SMOKING

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 2004, the prevalence of daily or occasional smoking among the Hunter New England Health adult population has decreased from 25.5% to 17.7%. This decrease is in line with a decline in daily or occasional smoking rates across NSW from 24% or the adult population in 1997 to 20% in 2004.



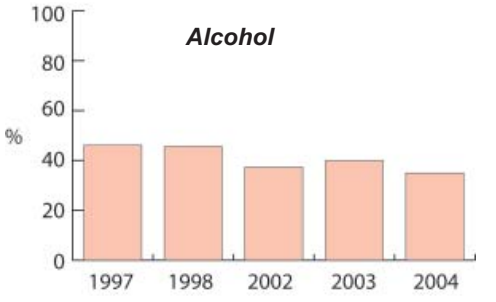
ALCOHOL

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 35% in 2004. Over the same period, the percentage of adults who reported 'at risk drinking behaviour' across NSW fell from 42.3% to 35.3%. Hunter New England males had significantly higher 'at risk drinking behaviour' than females.



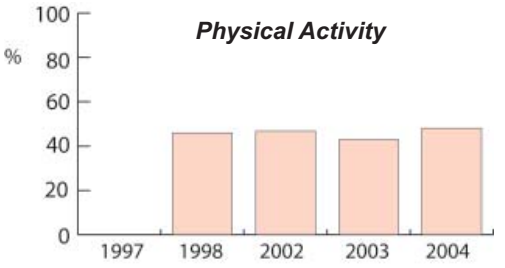
PHYSICAL ACTIVITY

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 48% in 2004. This rise is in line with increased levels of adequate physical activity across NSW (47.9% in 1998 to 52.4% in 2004).



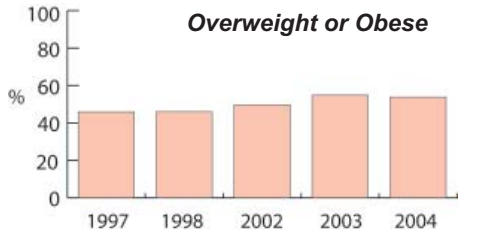
OVERWEIGHT OR OBESE

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 over the past five years, from 45.9% in 1997 to 53.8% in 2004.



FRUIT AND VEGETABLE INTAKE

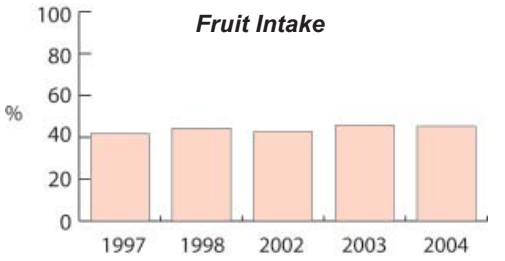
Context

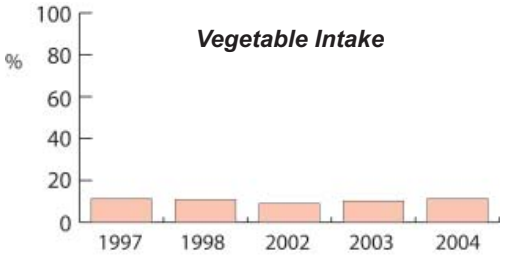
Nutrition is important at all stages in life and is strongly linked to health and disease. Good nutrition protects people from ill-health, whereas a poor diet contributes substantially to a large range of chronic conditions.

Interpretation

Over the past five years there has been an increase in the number of Hunter New England people consuming the recommended daily intake of fruit (41.7% in 1997 to 45.3% in 2004). However, the number of people consuming the recommended daily intake of vegetables has remained stable at 11.2% over the same period.

Source for all graphs: NSW Health Survey





Healthier People

Preventing and Detecting Health Problems

Performance

Reducing Falls

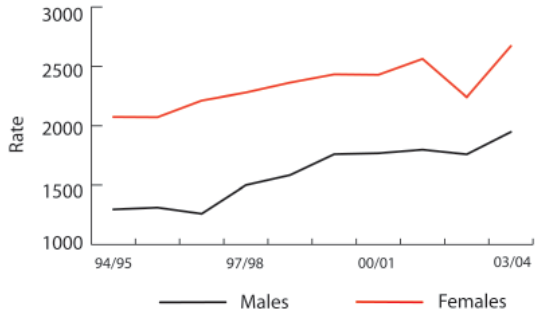
At least one in three people aged 65 years or older and living in the community will sustain a fall-related injury this year.

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.

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

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 3778.8 per 100,000 people in 1997-98 to 4618.2 per 100,000 in 2003-04. The rate is higher for women (2670.4 per 100,000) than men (1947.8 per 100,000). The Hunter New England rate of fall-related injuries is lower than the state incidence of 4823 per 100,000 people.

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

Innovation reducing falls

This year, Denman Multi Purpose Service became the first NSW public hospital to install Invisa-Beam, a new invention aimed at reducing the number of falls and improving patient safety.

Invisa-Beam acts as a bed monitor by defining the edge of the bed with invisible laser beams.

All patients undergo a falls risk assessment upon admission, enabling staff to determine whether a patient requires the bed monitor. The Invisa-Beam warning system plugs into the normal nurse call system and alerts staff immediately when a patient attempts to leave their bed. It allows staff to decrease the use of restraints on at-risk patients, improving patient comfort without compromising their safety.

In the first three months of installation the number of falls was reduced by up to 75 per cent.

Invisa-Beam was developed by ACT-based inventor Basil Bautovich and costs around $1,400 per beam.

Immunisation

Hunter New England Health continued its high performance in childhood immunisation rates this year, with 93.5% coverage for children aged 12-15 months compared with the NSW average of 91%. These strong results are achieved through the partnership between Hunter New England Health and General Practitioners.

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

DASHBOARD INDICATOR: Adult immunisation

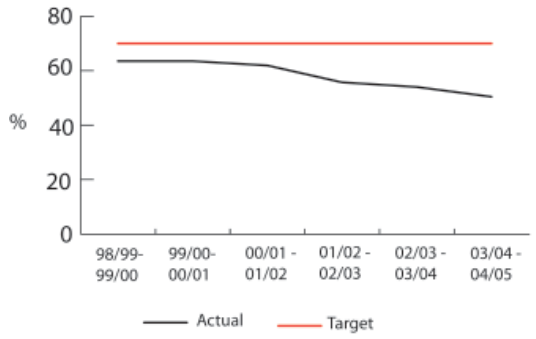
Context
Immunisation is one of the more effective medical interventions for the protection of both individuals and the community from death and serious illness. The NSW Immunisation Strategy 2003-2006 sets a target to immunise 85% of people aged 65 years and over against influenza and to increase the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

	Year				
People aged 65 years and over vaccinated against:	1997	1998	2002	2003	2004
Influenza - in the last 12 months (%)	57.5	69.1	75.9	76.8	77.5
Pneumococcal disease - in the last 5 years (%)	na	na	39.8	54.6	55.1

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 77.5% in 2004. The number of people immunised against pneumococcal disease has increased from 39.8% in 2002 to 55.1% in 2004. 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

DASHBOARD INDICATOR: Breast Cancer Screening

Context
Mammographic screening assists in the early detection of breast cancer and is seen as the best method for reducing mortality and morbidity that results from breast cancer.



Interpretation
Between 1998 and 2004 there has been a decrease in participation rates every year. The latest rate of 50.4% is below the NSW average of 51.8%. Work on increasing the rate continues. Staff continue to prioritise appointments for women in the target population.

Source: BreastScreen NSW

Healthier People

A Healthy Start To Life

Paediatric Guidelines: A Standard Approach

Hunter New England Health has adopted the Guidelines for Networking of Paediatric Services in NSW. These guidelines ensure that no matter where a child is treated, there is a common approach to treatment.

This assists healthcare providers, particularly those who move between services, such as registrars, nurses, and allied health staff.

These common approaches give parents and carers certainty that treatment plans will be unlikely to alter significantly, even if the child required transfer to a different centre.

Neonatal Retrievals

Significant improvements have been made to John Hunter Children's Hospital's Neonatal Retrieval Service over the past year. The service is now staffed by five Neonatologists, two Fellows, one Registrar, two Nurse Practitioners and 24 nursing staff and educators.

The development of in-house and outreach education programs means staff at more than 30 health facilities throughout Hunter New England Health are now trained in the basics of neonatal resuscitation and stabilisation.

With these improvements in place the service has completed its busiest year ever – undertaking 60 retrievals, from 16 hospitals in the area (80% performed with the assistance of the Westpac Rescue Helicopter Service).

Specialist Outreach Programs

In partnership with the Northern Child Health Network, Hunter New England Health has secured Commonwealth funding to provide specialist outreach clinics and education opportunities for rural clinicians across Hunter New England and North Coast area health services. The clinics and associated education sessions focus on paediatric surgery, endocrinology and neurology.

The multidisciplinary team approach to clinics and education sessions ensures rural children are not disadvantaged by not visiting larger centres.

Ten formal sessions and three workshops have been attended by more than 150 people and resource material has also been provided at the request of local practitioners.

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.

SWISH

More than 21,000 newborn babies in the Hunter New England Health area have received a free hearing screen since the introduction of the Statewide Infant Screening Hearing (SWISH) program in December 2002.

As a result of the screening program, 12 newborn babies have been diagnosed with significant permanent bilateral hearing impairment since July 2004. This means that 12 babies identified with hearing loss have been able to access intervention programs early in their lives improving their speech and language outcomes. Three infants have been identified with auditory neuropathy.

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 NSW figures.

Mubali Mothers

Gamillaroi Community Midwifery Service at 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 encourage the young women to participate in a creative process in which plaster casts are 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 the young women are 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.

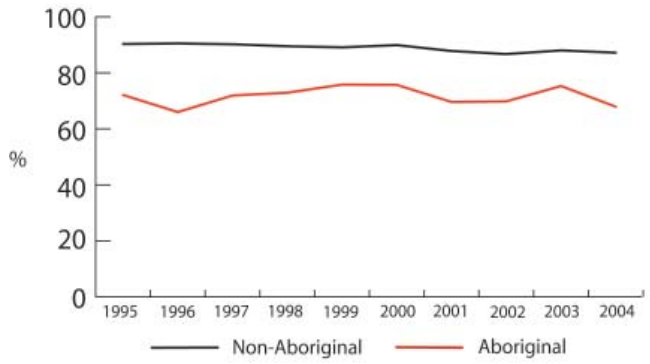
Healthier People

A Healthy Start To Life

Performance

DASHBOARD INDICATOR:
Antenatal visits before 20 weeks gestation

Context
Antenatal visits are used to monitor the health of both mother and baby throughout pregnancy, provide advice and identify any problems so they can be treated properly.



Interpretation
In 2004, about 87% of non-Aboriginal mothers and 68% of Aboriginal mothers in Hunter New England Health started antenatal care before 20 weeks gestation (halfway through pregnancy). This is in line with the NSW rates of 88% of non-Aboriginal mothers and 70% of Aboriginal mothers.

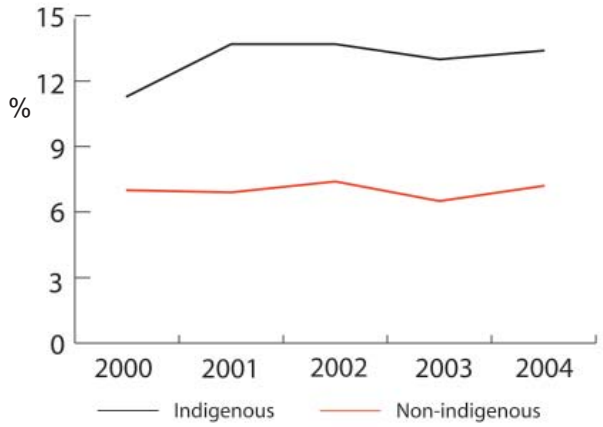
Source: NSW Midwives Data Collection (HOIST)

Other highlights:

- Enhanced orthopaedic services including the appointment of a Clinical Nurse Consultant, Occupational Therapist, Physiotherapist, and Occupational Therapist time for Botox.
- Neonatal Intensive Care Unit (NICU) services enhanced through provision of infrastructure for one additional bed, social work, nurse and ventilator equipment.
- Enhanced chronic pain management services.
- Commenced Child and Youth Maggie Project.
- Introduced a diabetes manual for patients using insulin pumps.
- Electronic Discharge System (EDRS) successfully introduced.
- Established Community Brain Injury team.
- Appointed NBN Telethon Children's Cancer research fellow to enhance the health outcomes for young cancer patients in the region.
- Introduced out of home care clinics.
- Commenced refugee clinics.
- Transition care coordinator appointed to develop a plan for preparation and planning for transition of children with chronic and complex care to adult services.
- Commenced the Fairy Sparkle Forest Garden.

DASHBOARD INDICATOR: Low birthweight babies

Context
Low birth weight is associated with a variety of health problems.

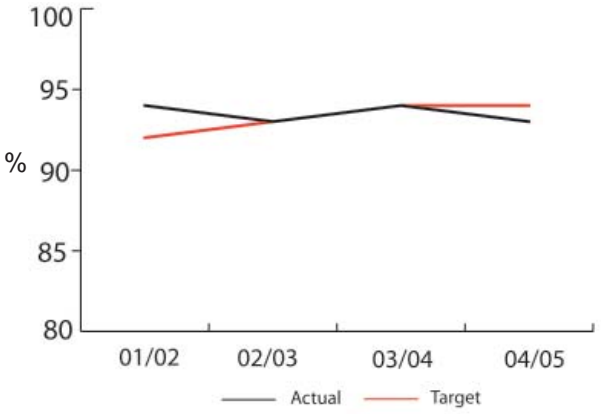


Interpretation
The rates for low birth weight are relatively stable. The rate for babies of Aboriginal mothers remains substantially higher (almost double) than that for babies of non-Aboriginal mothers.

Source: NSW Midwives Data Collection (HOIST)

DASHBOARD INDICATOR: Infants fully immunised at 12 to < 15 months %

Context
Immunisation reduces illness and death of children from vaccine- preventable diseases.



Interpretation
This year a childhood immunisation rate of 93 percent was achieved which is one percent below last year and the target. Hunter New England Health has had 93-94 percent childhood immunisation rates for the past four years. While these rates are higher than the NSW average of 91 it is an ongoing challenge to maintain and further increase them.

Source: Australian Childhood Immunisation Register (ACIR)

Healthier People

Performance

Improving Mental Health and Wellbeing

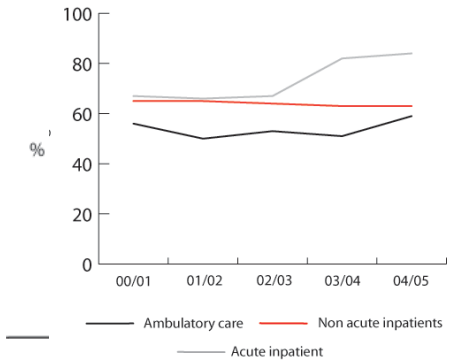
The creation of Hunter New England Health provided an opportunity for the integration of mental health services across the Hunter, Lower Mid North Coast and New England regions. This service was one of the first to merge in the new organisation.

In the past 12 months the health service and the communities it serves have seen real benefits from this integrated service, including the ability for mental health staff to share expertise and experience across the area and the successful recruitment of additional specialist mental health staff, particularly in Tamworth.

The integration of mental health services into a network across the Area Health Service provides staff with greater access to education and training and provides patients with improved access to mental health services.

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.

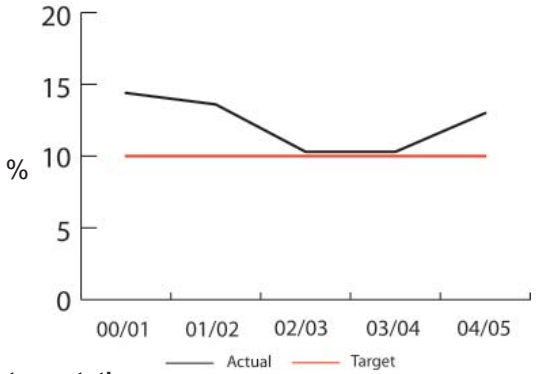


Interpretation
Hunter New England Health is continuing to make improvements in meeting the needs of those with mental health problems. There has been a significant increase in meeting the needs of acute inpatients from 67% in 2000-01 to 84% in 2004-05.

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

DASHBOARD INDICATOR: Mental health acute adult readmission

Context
A readmission for acute mental health care may suggest a problem in patient management or care processes, such as the patient was inappropriately discharged or the hospital and community services may not have been well coordinated. A benchmark of 10 per cent has been adopted in NSW for unplanned overnight adult mental health readmissions.



Interpretation
The readmission rate has increased from the target rate to slightly above it at 13 percent for 2004/05. This includes all readmissions to the same hospital, some of which may have been planned. The NSW Admitted Patient Collection does not distinguish planned and unplanned admissions.
Source: Admitted Patient Collection on HOIST and HIE Datamart

Mental Health First Aid

Hunter New England Health and the Hunter Institute for Mental Health this year launched the Mental Health First Aid Training Program, encouraging people to learn the skills necessary to provide immediate assistance to people with mental health problems.

The program recognises that, just as learning first aid skills can help someone who has suffered a physical injury, learning mental health first aid skills can have a significant and positive impact in helping someone with a mental health problem obtain appropriate care.

The Mental Health First Aid course provides information about common mental health problems as well as teaching practical strategies for providing initial help, both in crisis and non-crisis situations. It is designed to provide people with the information and skills they need to be able to recognise the signs and symptoms of mental health problems so they can provide help for family, friends and work colleagues who may be experiencing mental health problems.

Hunter New England Health has commenced an improvement program (as part of its Maggie Program) examining the journey for adult acute mental health patients.

It is the first improvement program to be conducted on an area-wide basis – underscoring the health service's commitment to mental health services.

Through the Maggie Program, staff, consumers, carers and other stakeholders such as police, ambulance officers and general practitioners will share their experiences and work together to design the changes needed to improve the adult acute inpatient mental health journey.

It is an exciting opportunity to further integrate mental health services and improve the way care is provided across the inpatient mental health facilities at Tamworth, Maitland, Taree and Newcastle.

Fairer Access

Emergency Care

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

Importantly, Hunter New England Health made significant progress during 2004-05 in triage, access block and off stretcher time targets. Timely access to emergency care is critical.

Almost all of Hunter New England Health's hospitals improved access block from June 2004 to June 2005, despite an increase in the number of people attending emergency departments for treatment.

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 27 per cent in 2002-03 to 16 per cent in 2004-05. This is below the NSW Health benchmark of 20 per cent.

Hunter New England Health's achievements and ongoing commitment to reducing access block were recognised in October 2004 when the health service was awarded the Minister's Access Award for Most Improved Metropolitan Hospital Emergency Access.

Off stretcher time measures whether the transfer of care to the emergency department is greater than or equal to 30 minutes. Off stretcher time performance has improved to 20 per cent, down from 25 per cent on the previous year. The data is subject to a number of reporting anomolies which are currently being addressed.

There is still more work to do to continue improvements with emergency department access and care. This year, Hunter New England Health has expanded its successful Maggie Program – which has reduced access block and improved patient satisfaction at John Hunter and Belmont hospitals – to Tamworth and Manning hospitals.

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 heart attack or stroke.
3. Urgent (Stable)
Stretcher wounded or chest pain.
4. Semi-urgent (Satisfactory)
Walking wounded, such as broken arm, cuts or appendicitis.
5. Non-Urgent
Long-standing problem present for more than one day, such as cough, cold or sore throat.

DASHBOARD INDICATOR: emergency department access block

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.

Interpretation
Hunter New England Health has continued to reduce access block over the past three years, from 27% in 2002-03 to 19% in 2003-04 and 16% in 2004-05. These figures are below the NSW Health benchmark of 20% and well below the NSW average of 31%.
Source: EDIS

Reducing access block

Belmont Hospital is a 72-bed facility which treats about 18,000 people at its emergency department each year. The facility has had a significant problem with 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). At times, the hospital sustained levels of access block greater than 60 per cent.

Using a consultative approach involving staff from the emergency department and other areas of the hospital and consumers, a project was undertaken to develop a patient-centred service model and improve patient flows for emergency and medical inpatients.

The service redesign project resulted in a reduction in:

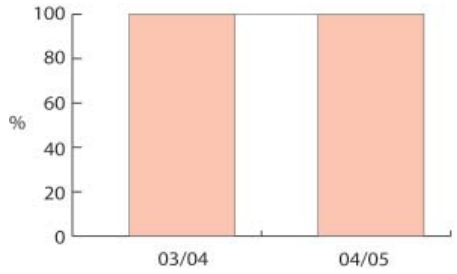
- access block by more than 50 per cent
- a reduction in the average length of stay in the emergency department for patients being admitted to the hospital from 16 hours to less than six hours
- a reduction in the number of patients waiting longer than 10 minutes from time of arrival to time of triage from 54 per cent to 15 per cent
- a reduction in medical inpatient length of stay.

DASHBOARD INDICATOR: Cases treated in benchmark times

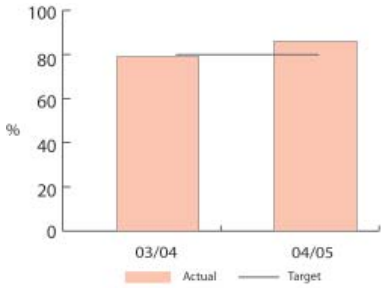
Context

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

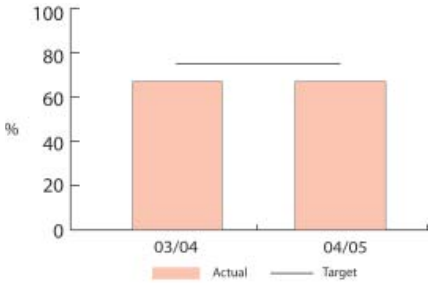
Triage 1 (within 2 minutes)



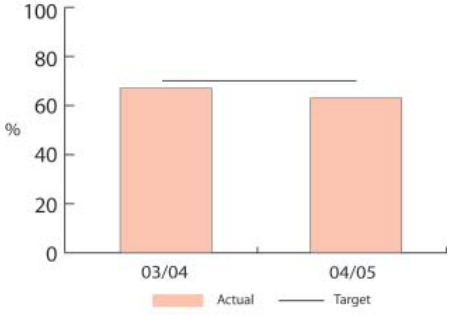
Triage 2 (within 10 minutes)



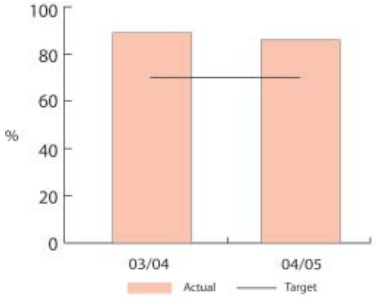
Triage 3 (within 30 minutes)



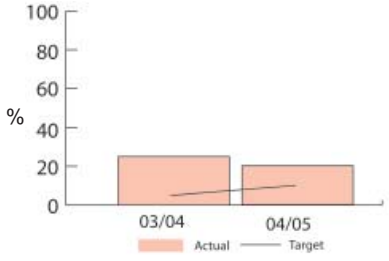
Triage 4 (within 60 minutes)



Triage 5 (within 120 minutes)



Off Stretcher time >=30 from ambulance arrival



Interpretation

Treatment time targets were met for three triage categories (category 1,2 and 5). While off stretcher times are below target, improvements have been made. *Source: EDIS*

Fairer Access

Treatment When You Need It

Improving access to health care is a key priority for Hunter New England Health. Throughout 2004-05 our focus has been particularly in the area of reducing long-waits for elective surgery.

The 2004-05 budget provided an additional $6.9 million to reduce waiting lists for elective surgery. This money enabled:

- additional surgery at John Hunter, Maitland, Belmont and Royal Newcastle hospitals
- the establishment of orthopaedic services at Belmont Hospital
- additional renal transplants to be undertaken
- support for intensive care and anaesthesiology recruitment.

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

For example, in June 2004 there were 461 patients who had been waiting longer than 12 months for their surgery in Hunter New England. By June 2005 this number was reduced to 251.

The reduction in waiting lists has been achieved through a number of strategies, including targeted recruitment of medical specialists, targeting specific long-wait lists, and increased auditing and clinical review of waiting lists. This has all been done with an increasing emergency surgery workload.

Workforce shortages continue to be a major issue impacting on waiting access to planned surgery. Hunter New England Health has been actively recruiting and attracting medical specialists to work in the Hunter New England Health region.

Other Highlights

- An Aboriginal Renal Education Officer was employed as part of the health service's commitment to provide Aboriginal people with better access to information about kidney disease and simple screening to identify early warning signs. Based in Moree, the officer provides screening and education services through home visits and working with local land councils and Aboriginal health education officers throughout the area.
- In March 2005 Hunter New England Health established a Patient Flow Unit. The unit provides a single point of contact for key stakeholders involved in the transfer of patients in between hospitals to ensure the process is smooth and well co-ordinated for all patients to ensure better access and care at the right facility in a timely manner.
- Women's Health Nurse Clinics were recommenced in 2005 at Uralla, Guyra, Tenterfield, Bundarra, Tingha, Inverell and Emmaville. The clinics provide the community with better access to services offered by the women's health nurse including pap tests, breast checks and information and advice on issues like contraception, pregnancy and menopause.

- Access to health services for Aboriginal people in the Forster area improved with the opening in June 2005 of the Tobwabba Aboriginal Medical Service's new building. Services are provided through a tripartite agreement between Tobwabba Aboriginal Medical Service, Forster Local Aboriginal Land Council and Biripi Aboriginal Medical Service, working in partnership with Hunter New England Health.

Improving patient flow

In April 2005 John Hunter Hospital opened a new Patient Transit Ward as part of its strategy to improve access and patient flow through the hospital. The ward accommodates patients who are ready for discharge and are awaiting transport, either with family or via Ambulance.

The ward has capacity for six to eight patients who are under the care of a nurse. It assists with the efficient movement of patients through the hospital by providing an area specifically dedicated for patients ready for discharge or transfer, beds are freed up for patients waiting to be admitted, particularly from the emergency department.

Access to new services

The residents of Barraba and the surrounding region now have access to a brand new Multi-Purpose Service, after it was opened on 6 November 2004. The facility was purpose-built to meet the health needs of the local community and draws together many services under one roof including:

- acute hospital beds for people needing short term hospital treatment
- long-term residential care for nursing home patients
- community health services
- an emergency department
- NSW Ambulance Service.

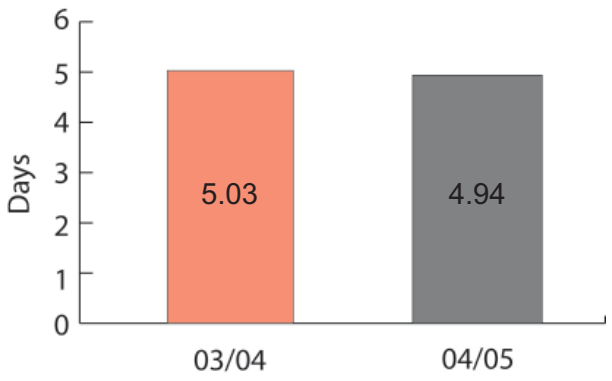
The redevelopment of the Barraba Health Service is an example of the community and Hunter New England Health working together to provide better access to comprehensive health services.

Fairer Access

Performance

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 time patients require hospitalisation, from 5.03 days in 2003-04 to 4.94 days in 2004-05. Improvements identified through the health service's Maggie Program have contributed to the reduction in average length of stay and improved the patient journey. *Source: ISC*

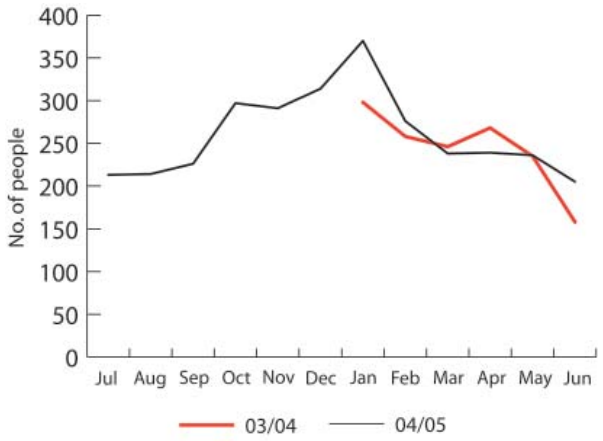
DASHBOARD INDICATOR: Waiting times for booked non-emergency care

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

Waiting more than 12 months

Interpretation
The number of Hunter New England patients waiting longer than 12 months for booked medical or surgical treatment declined significantly from 461 in 2003-04 to 251 in 2004-05. *Source: ISC*

Waiting more than 30 days

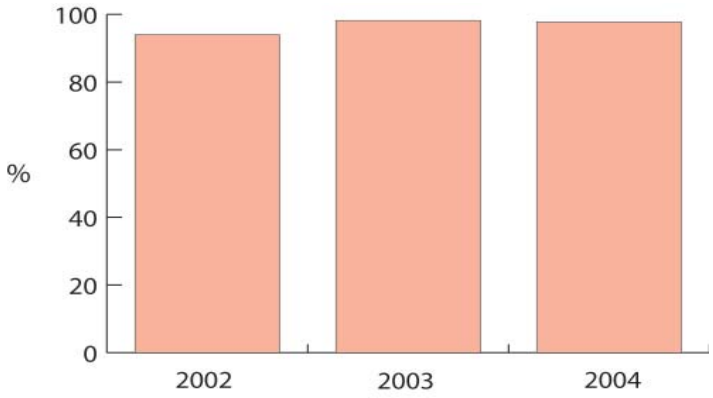


Interpretation
The number of Hunter New England patients waiting longer than 30 days for booked medical or surgical treatment was 213 in July 2004 and 205 in June 2005. *Source: ISC*

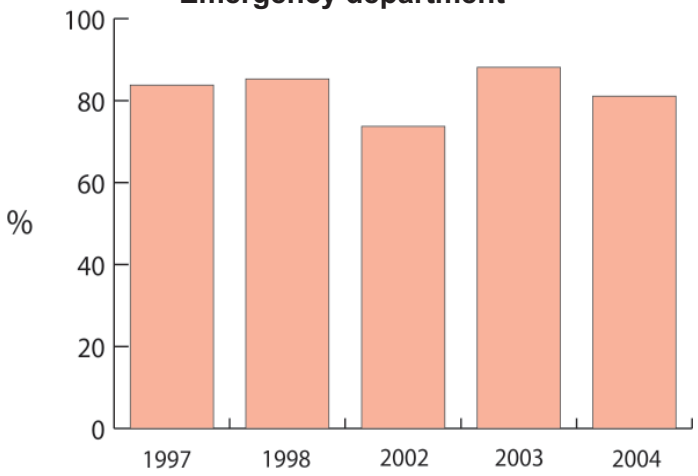
Quality Health Services

DASHBOARD INDICATOR:
Patient and consumer experience

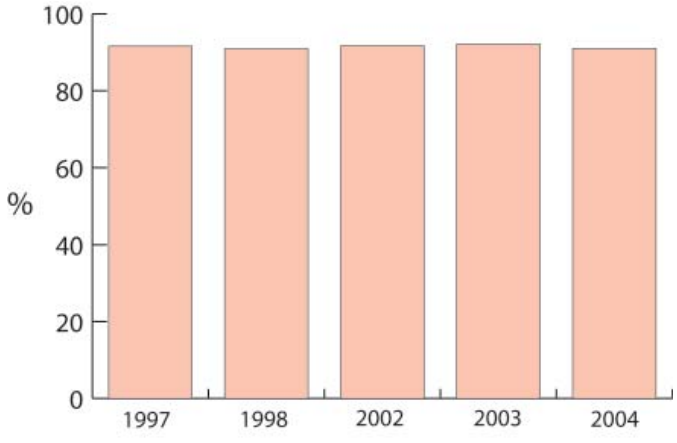
Community Health Centre



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%). In 2004, 98.7% of people attending a community health centre in Hunter New England, 91% of people attending a hospital and 81.1% of people attending an emergency department gave a positive rating of their care. These figures are slightly lower than in 2003, but remain at very high levels.

Source: NSW Health Survey, Centre for Epidemiology and Research

Quality Health 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.

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 projects. 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 practible. Recognising that a proportion of complaints may involve complex issues that take longer to address, NSW Health has a benchmark of 80 percent of complaints resolved within 35 days. Figures compiled from the Statewide Complaints database show Hunter New England Health received 221 complaints between July and December 2004. Data from the former Hunter Area Health Service had to be excluded because of data quality issues. Of these 221 complaints, 187 or 85 percent were resolved within 35 days.

Quality Care And Innovation

Twelve Hunter New England Health projects were named as finalists in the 2004 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.

2004 Baxter NSW Health Finalists:

Tiddalick Takes on Teeth
Category: Consumer Participation in Health Care
A project of the Hunter Oral Health Service and Awabakal Newcastle Aboriginal Coop, Tiddalick Takes on Teeth aims to reduce the incidence of excessive dental decay in children aged 0-5 years. The Tiddalick's Toothy Tale package encourages pre-school aged Indigenous and non-Indigenous children to drink water rather than other drinks between meals and snacks and to 'Swig, Swish and Swallow' water after eating.

International recognition

The networked emergency departments of John Hunter and Belmont hospitals received international recognition this year, when they were awarded the 2005 Press Ganey Associates Australian Success Story Award as well as winning the emergency department category of the International Press Ganey awards.

The awards confirm the networked emergency departments as being among the best performing emergency departments in Australia and the most innovative in the world.

Press Ganey is the world's largest patient survey company and the awards recognised the Maggie Program (Perfecting Healthcare Delivery) which fundamentally redesigned the way the hospitals work in order to increase patient and staff satisfaction in the emergency departments.

As a result of the improvement program, patient satisfaction moved to the top 25 per cent of Australian peer hospitals and average x-ray completion times dropped from 60 minutes to just 14 minutes, with pathology completion times improving by 30 per cent.

These improvements were all achieved despite a 10 per cent increase in patient admissions.

Innovation in PD catheter insertion (WINNER)
Category: Appropriateness
This project, by the Renal Outreach Service at Tamworth, changed the PD catheter insertion practice which had, in the past, involved a full anaesthetic and a lengthy hospital stay. Patients nearing End Stage Renal Disease (ESRD) now have their catheters implanted under local anaesthetic as a short 'day only' admission. Tamworth Hospital became the first site in Australasia to undertake this procedure, and has since become the training provider to other sites in Australia.

Educating today's nurses to meet tomorrow's challenges
Category: Competence
This project of the Child and Adolescent Mental Health Statewide Network (CAMHSNET) involved a program to recruit, educate and sustain a workforce of nurses to help address the national nursing workforce shortage and ensure nurses are appropriately trained and prepared to deliver children's mental health care.

Improving care with dementia mapping (WINNER)
Category: Competence
This project of the CARE Network and Greater Newcastle Sector in conjunction with the Centre for Learning, Development and Research, Calvary,

Quality Health Services

Cessnock, aimed to improve the care of patients with dementia, delirium or confusion through 'Dementia Care Mapping'. Nurses changed routines and procedures in hospital wards, resulting in significant improvement in the physical and emotional health and safety of patients.

Development of a clinical audit tool
Category: Competence
Through this project, staff at Kurri Kurri Hospital's Emergency Department used a set of nurse-initiated guidelines to educate and up-skill nursing staff, resulting in improved treatment times for patients in the emergency department.

Reworking the emergency department
Category: Efficiency of Service Provision
When moving into a refurbished emergency department, staff from John Hunter Hospital's Division of Emergency Medicine took the opportunity to redesign their systems with the patient at the centre. The project resulted in significant improvements in triage targets and ambulance turn-around times and a decrease in access block. Patient and staff satisfaction also improved.

Orientation for new staff using Voicemap
Category: Education and Training
This project of John Hunter Hospital's Emergency Department saw the introduction of a hand-held self-guided audio program and testing application called Voicemap for new staff being inducted into the hospital's emergency department. Voicemap has saved resources, improved patient flow, reduced patient falls and medication errors and reduced needle stick injuries and manual handling incidents.

Rural General Practice Training in Public Health
Category: Education and Training
New England Rural Training Unit and the North West Slopes Division of General Practice established the first Australian rural academic GP post in public health teaching skills in applied research and education as part of this project. This model of training is being developed nationally, based on the pilot outcomes.

Access to best practice foot care
Category: Access
This project increased access to regular podiatry and basic foot care and saw podiatry service provision increase by 300 per cent across 17 health sites in the New England region. This project was led by a working group, which built on the existing policy and voucher system to provide services for high-risk clients.

Improving care in the general medicine unit
Category: Continuity of Care
This project by John Hunter Hospital's Division of General Medicine used a structured re-engineering process to redesign the General Medicine ward layout, rosters and systems of care in just 12 weeks. As a result, the unit is now caring for 20 per cent more patients and staff satisfaction has increased.

Connecting people and information using technology
Category: Information Management
The Learning Services Team established 'Discus', an inaugural online discussion facility to provide rural and remote staff with access to information, learning and support. The innovation also helped fast-track the development of an intranet and internet site.

Get smart, Get LOST
Category: Information Management
This project saw the development of a tool by the Performance Improvement Unit to enable staff to better understand length of stay trends to better manage beds and ultimately provide better care for patients. The easy-to-use web-based Length of Stay Tool (LOST) application helped staff to understand and manage their unit's length of stay.

Care In The Right Setting

In addition to its acute hospitals 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.

This 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 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.

Managing Chronic Conditions

Hunter New England Health introduced a new program under which volunteers were trained to work with and teach people with chronic conditions what they could do themselves to enjoy better health.

When people self-manage their chronic

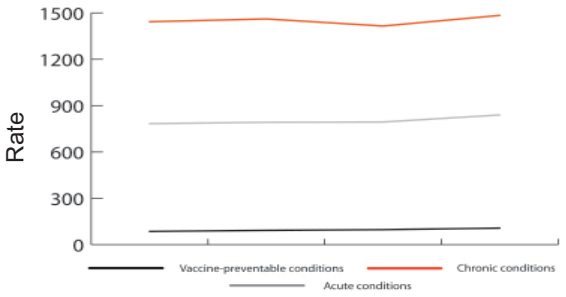
Quality Health Services

illness it helps them to develop a more positive attitude and to live with their illness at a higher level of well-being. The self-management of chronic conditions gives patients some power and control, helping to create a partnership with their health professionals in managing their illness.

The training was based on a successful self-management approach developed by US chronic diseases expert Dr Kate Lorig. Volunteers who completed the training are now working with groups of people with illnesses such as diabetes, arthritis, heart disease and respiratory disease as part of Hunter New England Health's Chronic Disease Program.

DASHBOARD INDICATOR: Potentially avoidable hospitalisations

Context: There are some conditions for which hospitalisation is considered potentially avoidable through early disease management by general practitioners (GPs) and in the community setting.

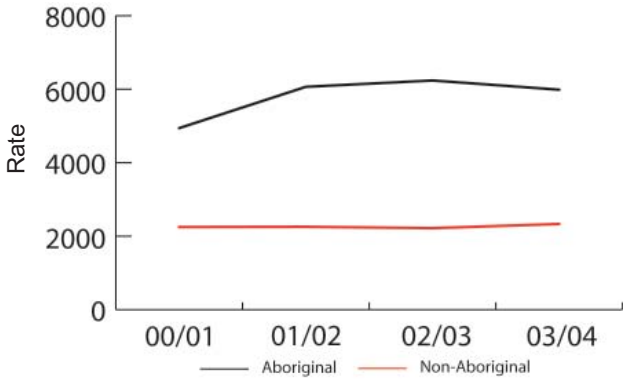


Interpretation: Since 2000/01, rates of potentially avoidable hospitalisations have increased from 85.6 per 100,000 population for vaccine-preventable conditions to 107.1 per 100,000 population in 2003/2004 and from 1442.9 per 100,000 for chronic conditions in 2000/01 to 1483.9 per 100,000 in 2003/2004. For acute conditions, the rate has increased from 783.4 per 100,000 to 839.4 per 100,000 during this period.

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.

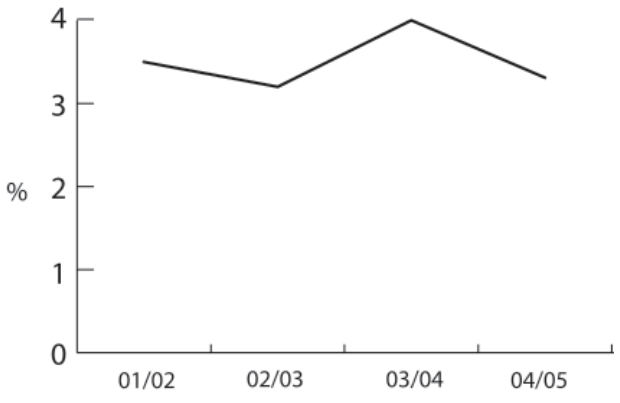


Interpretation: Aboriginal people experience a much higher rate of potentially avoidable hospitalisation. The year-to-year variations in the reported rates for Aboriginal people may also be due to inaccuracies in identifying these patients in hospital records.

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

DASHBOARD INDICATOR: Unplanned hospital readmission

Context: An unplanned treatment may suggest a problem in patient management or care processes or a new health problem or unrelated complication.



Interpretation: The number of unplanned hosptial readmissions remains stable.

Source: Australian Council of Healthcare Standards

Better Value

Managing our Resources

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.

Resource Allocation

Total enhancement funding of $40.9 million was received in 2004-05, representing a 6 per cent increase on the previous year. Enhancement funding was directed to priority areas including:

- reducing Access Block
- reducing waiting lists for patients waiting > 12 months for surgery
- establishing transitional care places for older people awaiting nursing home placement
- engaging additional medical and nursing staff to improve patient services in the emergency departments and busy hospital wards
- improving Mental Health services
- improving clinical information services across the Area Health Service.

Skilled, Motivated Staff

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.

The shortage of medical staff and hospital specialists is a significant issue for Hunter New England and all other parts of rural and regional Australia. Improving the recruitment and retention of staff is an ongoing priority for Hunter New England Health.

Retaining the medical officers already working in Hunter New England is also

a high priority, as is encouraging these doctors to help recruit new medical professionals to the area.

Medical Interns

Sixty-eight new medical interns commenced work in hospitals throughout Hunter New England Health network in 2005 – the largest allocation of medical interns in any area in NSW.

Hunter New England Health has a strong reputation for offering high quality training and development programs for graduates and junior medical officers. It was the second most popular preference among this year's final medical students within NSW, an encouraging sign of the growing number of interns who are choosing to work and learn within the area's public hospital system.

Better Value

More than 60 per cent of the interns trained locally at the University of Newcastle. Fifteen were trained at Sydney universities, one in South Australia and eight joined Hunter New England Health from overseas, having completed Australian Medical Council exams and become permanent residents in Australia.

International Medical Graduates

International medical graduates play a vital role in our health system, with at least 20 per cent of our medical recruits joining us from overseas.

Hunter New England Health has developed a unique orientation program for international medical graduates, providing these highly-trained professionals with an opportunity to explore aspects of the clinical environment and Australian culture which may be unfamiliar to them and to develop confidence in their clinical skills in the Australian health context.

This program is an important part of welcoming doctors to our health system and supporting them in the transition to not only their new role, but also their new country and community.

Hunter New England Health has recently secured $77,000 in Commonwealth funding to expand this orientation program in partnership with Northern Sydney Central Coast Area Health Service.

Strong Clinical Governance

Clinical Governance is the framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Hunter New England Health's Clinical Governance Unit was established in 1999 (by the then Hunter Health) and was the first of its kind in Australia.

The unit aims to improve patient safety, outcomes and overall quality of care. It assists with the management, monitoring, co-ordination, facilitation and evaluation of initiatives that protect the safety of patients through clinical quality activities and clinical risk management processes.

The NSW Patient Safety and Clinical Quality Program was implemented in 2004 to improve clinical governance by providing health staff across NSW with the support they need to deliver safer, better quality care.

Patient Safety Officers

This year, Hunter New England Health's Clinical Governance Unit recruited an additional 12 patient safety officers, bringing the total number deployed across Hunter New England to 19.

Patient safety officers support clinicians and managers in reporting and investigating clinical incidents and improving patient safety.

Managing Complaints

Hunter New England Health has appointed a Senior Complaints Officer and has developed a robust system for reporting of complaints. A continued focus of the Senior Complaints Officer will be ensuring that information provided through complaints is used appropriately to improve patient care.

Good 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 the NSW Department of 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 Hunter New England Health.

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 the public 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 communications 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 in place a risk management plan 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 Department of 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, performance and reporting guidelines as detailed in NSW Department of Health core documentation relating to Managing the Quality of Health Services in NSW.

Audit Committee

The Chief Executive has established an Audit Committee.

This committee is chaired by Michael Slator and consists of the following members: Terry Clout and Gary Polluck.

The Audit Committee meets four times per year. The objectives of the Audit Committee are to:

- maintain an effective internal control framework

- review and ensure the reliability and integrity of management and financial information systems
- review and ensure the effectiveness of the internal and external audit functions
- monitor the management of risks to the Health Service.

Finance and Performance Committee

The Chief Executive has established a Finance and Resource Committee. This committee is chaired by Terry Clout and consists of the following members: Tracey McCosker, Mark Jeffrey, Michael Di Rienzo, Stewart Leeman and David Dixon. The Finance and Performance Committee meets monthly.

The objectives of the Finance and Performance Committee are to:

- examine budget allocations
- monitor overall financial performance in accordance with budget targets

- developand maintain an efficient, cost effective finance function and information systems
- ensure appropriate financial controls are in place
- manage funds efficiently.

The Chief Executive complies with the provisions of the Accounts and Audit Determination for Health Services issued by the NSW Department of Health.

Performance appraisal

The Chief Executive has ensured that there are three processes in place to:

- monitor progress of the matters and achievement of targets contained within the Performance Agreement between the Chief Executive and the Director-General of the NSW Department of Health
- regularly review the performance of the Area Health Service through the Annual Governance Review process.

Activity for year ended 30 June 2004

Public Hospitals

KEY:

A: Separations, B: Planned as % of Total Separation, C: % of Same Day Separation, D:Total Bed Days, E: Average Length of Stay (Acute)[3], F: Daily Average of Inpatients[4], G: Acute Beddays, H: Overnight Acute Beddays, I: Non Admitted Patient Services, J: ED Attendances[6]

Facility	A	B %	C %	D	E	F	G	H	I	J
Hunter & New England	175,858	42.9	38.9	820,955	3.5	2,248.5	580,739	513,045	2,535,569	296,412
Total NSW	**1,415,422**	**41.0**	**42.0**	**6,212,216**	**3.5**	**17,020**	**4,658,364**	**4,087,072**	**24,526,422**	**2,004,107**
Armidale and New England Hospital	7,575	48.8	37.2	26,062	3.3	71.4	23,933	21,123	54,033	12,555
Barraba Multi-Purpose Service	410	7.6	13.4	1,665		4.6	0	0	13,671	2,634
Bingara District Hospital	326	0.0	12.9	6,039		16.5	0	0	4,821	608
Boggabri Multi-Purpose Service	105	6.7	5.7	835		2.3	0	0	3,652	517
Glen Innes District Hospital	1,808	18.5	22.9	7,134	3.9	19.5	6,872	6,458	10,537	2,552
Gunnedah District Hospital	2,265	32.5	32.9	6,826	2.7	18.7	5,823	5,079	16,635	6,563
Guyra and District War Memorial Hospital	452	10.0	18.4	6,192		17.0	0	0	6,719	2,123
Inverell District Hospital	4,166	36.2	38.6	11,747	2.5	32.2	9,922	8,358	24,399	6,384
Manilla District Hospital	577	5.0	20.5	7,952		21.8	0	0	6,096	2,261
Moree District Hospital	3,798	41.5	43.2	10,664	2.6	29.2	9,852	8,211	14,739	8,846
Narrabri District Hospital	2,147	28.4	28.9	8,184	3.5	22.4	7,220	6,601	9,262	3,647
Prince Albert Memorial, Tenterfield	819	0.0	12.0	4,476	5.4	12.3	4,427	4,329	8,610	1,357
Quirindi District Hospital	635	10.7	13.5	3,983	5.4	10.9	3,216	3,131	11,093	2,501
Tamworth Base Hospital	18,868	48.7	41.3	77,289	3.5	211.8	64,272	56,481	128,303	38,306
Tingha Hospital	41	56.1	0.0	3,615		9.9	0	0	712	0
Vegetable Creek Multi-Purpose Service	86	7.0	10.5	595		1.6	0	0	4,408	388
Walcha District Hospital	435	1.8	6.7	2,195		6.0	0	0	7,626	658
Warialda District Hospital	599	0.0	6.8	5,827		16.0	0	0	4,438	757
Wee Waa District Hospital	895	6.7	15.9	3,149	3.3	8.6	2,882	2,740	7,881	2,440
Werris Creek District Hospital	70	12.9	4.3	3,852		10.6	0	0	2,212	264
Bulahdelah District Hospital	415	0.0	5.5	2,107	4.9	5.8	2,014	1,992	2,297	2,212
Gloucester Soldier's Memorial Hospital	1,174	62.3	54.4	10,518	3.0	28.8	3,493	2,960	5,070	2,945
Manning Hospital - Great Lakes Health Service	12,847	32.1	33.9	51,161	3.8	140.2	47,455	43,109	51,630	20,873
Wingham Hospital	231	0.4	0.4	9,975		27.3	0	0	29,190	0

Continued on page 43

Activity for year ended 30 June 2004

Public Hospitals

Belmont Hospital	6,877	43.9	32.2	25,532	3.7	70.0	25,248	23,035	70,690	18,263
Cessnock District Hospital	4,157	42.0	38.2	17,812	3.4	48.8	13,366	11,792	59,475	11,741
Dungog and District Hospital	176	27.8	4.0	4,091		11.2	0	0	3,630	2,519
James Fletcher Hospital - Morrisset	130	0.0		50,539		138.5	0	0	340	0
James Fletcher Hospital - Newcastle	1,862	0.0	5.5	28,121		77.0	0	0	5,159	0
John Hunter Hospital	56,080	53.2	49.9	210,200	3.5	575.3	191,139	163,155	512,088	52,036
Kurri Kurri District Hospital	2,246	57.4	45.9	11,045	3.5	30.3	7,493	6,463	23,990	6,535
Maitland Hospital	14,384	21.8	21.6	57,972	3.8	158.8	53,362	50,265	117,295	31,725
Merriwa District Hospital	233	17.6	12.4	3,869		10.6	0	0	1,657	1,278
Muswellbrook District Hospital	3,547	43.9	46.0	9,617	2.7	26.3	9,595	7,963	10,206	6,624
Denman Hospital	92	18.5	7.6	1,287		3.5	0	0	944	849
Mater Misericordiae Hospital	11,338	32.0	27.9	54,082	4.5	148.2	48,053	44,910	195,921	23,851
Nelson Bay Polyclinic	783	6.9	15.3	2,417	3.1	6.6	2,309	2,198	8,996	7,644
Royal Newcastle Hospital	6,154	75.7	39.2	26,621	3.5	72.9	20,322	17,909	85,750	0
Scott Memorial Hospital	1,722	28.6	31.5	6,294	3.6	17.2	6,142	5,600	5,224	3,575
Singleton District Hospital	3,806	46.3	48.2	12,552	2.9	34.4	11,017	9,183	20,044	7,532
Wilson Memorial Hospital	144	10.4	4.2	3,267		9.0	0	0	869	849
Taree Community Dialysis Centre	1,312	100.0	100.0	1,312		3.6				
Taree Community Health									72,065	
Buladelah Community Health									2,773	
Forster Tuncurry Community Health									27,999	
Gloucester Community Health									9,245	
Tamworth Community Health									64,375	
Armidale Community Health									26,986	
Inverell Community Health									16,544	
Narrabri Community Health									12,507	
Moree Community Health									23,616	
Gunnedah Community Health									13,181	
Glen Innes Community Health									8,337	
Community Mental Health - Hunter Area									71,470	
Greater Newcastle Community Health									149,276	
Lower Hunter Community Health									56,482	
Upper Hunter Community Health									49,131	
Lowrey Lodge Detox. Unit									122,170	
Hunter Area Clinical Services									24,451	
Hunter Public Health Unit									1,068	

Activity for year ended 30 June 2004

Hunter Pathology Service									73,913	
Hunter Rehabilitation Service									18,536	
Hunter Medical Genetics									4,519	
Hunter Area Dental Service									136,605	
Boggabri Residential Aged Care	30	100.0		5,739		15.7			9	
Vegetable Creek Residential Aged Care	9	88.9	22.2	4,773		13.1				
Walcha Residential Aged Care	25	60.0	4.0	3,855		10.6				
Denman Residential Aged Care	7	85.7		3,901		10.7				
Wallsend District Nursing Home				4,015		11.0				

Figures for Muswellbrook Nursing Home, Gloucester Nursing Home, Barraba Residential Aged Care, and Kimbara Lodge Gloucester not included.

Expenses- All Program
Hunter New England Health: $1,180,430,000
NSW Health: $10,146,453,000

Note:
1. Inpatients activity data are not directly comparable to previous years' published data in the following ways:
   - HIE data were used except three areas where DOHRS data were used for beddays
   - Number of separation includes care type changes.
2. Include service contracted to the private sector
3. Acute average length of stay=(Acute Beddays)/(Acute Separation)
4. Daily average of inpatient=Total Bed Days/365
5. Acute separation is defined by service category of acute or newborn
6. ED attendances are based on DOHRS and EDIS and not comparable to previous years' data as pathology and radiology services performed in EDs are excluded from 04-05 data.

Available Beds

Number of average available beds – June 2005

	General Hospital units	Nursing Home Units	Community Residential	Other Units	Bed equivalents	Total	Occupancy Rate[1] %
Hunter and New England	2,603	202	48	220	-	3,073	86.4
Total NSW	**19,134**	**1,086**	**427**	**1,155**	**305**	**22,106**	**90.8**

1. The bed occupancy rate includes only June data and covers only major facilities (peer groups A1a to C2). This is not comparable with earlier reports as bed occupancy previously contained information for a full year and included community and non-acute facilities. The following bed types are excluded from all occupancy rate calculations: Emergency Departments, Delivery Suites, Operating Theatres and Recovery Wards. From 2004/05 Residential Aged Care, Confused and Disturbed Elderly, Community Residential and Respite activity was also excluded. Unqualified baby bed days were included in occupied bed days from 1 July 2002.

OTHER NOTES

The numbers of available beds presented reflect the average for June 2005 and are not comparable with information for a full year, which was published in earlier reports.

Since March 2005, the bed information previously obtained from DOHRS was replaced by a new beds collection, which provided more detailed information on bed type and availability. Owing to the limited period that new bed collection has been in place it is not possible to provide an average number of beds for the year.

Beds in Emergency Departments, Delivery Suites, Operating Theatres and Recovery Wards are excluded.

The number of bed equivalents is not comparable with those in earlier reports as they were derived based on admissions reclassified to non-inpatients; data on such activity is no longer collected.

Health Services

Hunter New England Health Facilities

The health service classifications used by Hunter New England Health are derived from the Report of the Rural Health Implementation Coordination Group's *The NSW Rural Health Report* (September 2002) and the NSW Government's Response to the Report *The NSW Rural Health Plan* (September 2002).

Tertiary Referral Hospitals
Tertiary referral hospitals provide complex tertiary health services. As a minimum, tertiary referral hospitals should be able to provide for all but the most complex health needs of residents in their Area.

Where: John Hunter Hospital.

Rural Referral Hospitals
Rural referral hospitals provide a comprehensive range of core health services to residents, including Emergency Medicine, General Medicine, General Surgery, Orthopaedics, Intensive Care, Obstetrics, Psychiatry, Paediatrics, Community Health and Child Protection services. In addition, Rural Referral Hospitals may offer more complex tertiary services either locally or through formal networking arrangements with other Areas.

Where: Armidale, Tamworth, Taree, Maitland.

District Health Services
District health services provide hospital and community health services (including Community Health Centres, Primary Health Care, Public Health and Health Promotion services) to their local population in both rural and metropolitan settings. Patients requiring higher level services not provided at the District Health Service are managed at the Rural Referral Hospital within the same Area.

Where: Moree, Narrabri, Inverell, Glen Innes, Gunnedah, Quirindi, Scone, Muswellbrook, Singleton, Cessnock, Kurri Kurri, Belmont, Gloucester.

Community Hospitals
Community hospitals provide predominantly residential care for aged people in combination with some primary care services. At times they provide a welfare role and low-level acute care services, which may include emergency care.

Where: Wee Waa, Warialda, Bingara, Tingha, Tenterfield, Guyra, Manilla, Walcha, Werris Creek, Murrurundi, Merriwa, Dungog, Buladelah, Wingham, Nelson Bay.

Multi Purpose Services (MPSs)
MPSs have services jointly funded by the Commonwealth and states to facilitate a more flexible range of services than was possible under traditional funding structures. MPSs provide integrated acute health, nursing home, hostel, community health and aged care services under one organisational structure.

Where: Boggabri, Emmaville/ Vegetable Creek, Barraba, Denman.

Mental Health Hospitals
Establishments devoted solely to the treatment and care of inpatients with psychiatric disorders. Other hospitals may also provide inpatient mental health services.

Where: James Fletcher Hospital (Newcastle), Morisset Hospital and inpatient mental health facilities at Maitland, Tamworth and John Hunter hospitals.

Community Health Services
Includes community health centres, primary health care, public health and health promotion services.

Where: Mungindi, Ashford, Boggabilla, Uralla, Toomelah, Pilliga, Gwabegar, Nundle, Bundarra, Tambar Springs, Premer, Walhallow, Stroud, Harrington, Forster, Gresford, Clarence Town, Beresfield, East Maitland, Morisset, Toronto, Windale, Wallsend, Raymond Terrace, Hawks Nest/Tea Gardens, Armidale, Barraba, Bingara, Boggabri, Bulahdelah, Cessnock, Denman, Glen Innes, Gloucester, Gunnedah, Guyra, Inverell, Kurri Kurri, Manilla, Merriwa, Moree, Murrurundi, Muswellbrook, Narrabri, Nelson Bay, Newcastle, Quirindi, Scone, Singleton, Tamworth, Taree, Tenterfield, Walcha, Warialda, Wee Waa and Werris Creek.

Health Service Planning

Between April and June 2005, Hunter New England Health conducted a total of 88 consultation workshops with staff and community members across the area. Information used in the process was also available on the health service's intranet and internet sites.

The consultations were designed to facilitate participant input into the development of Hunter New England Health's vision, purpose and values. It also allowed staff and communities to identify the most significant health issues for their communities and what health services were needed to address those health issues. The most significant health issues identified by the community included:

- chronic illness and disease
- lifestyle behaviours leading to poor health, especially obesity, smoking, poor nutrition, physical inactivity
- mental illness
- issues around the ageing population
- alcohol and other drug misuse
- injury, including farm and work-related, general injury and motor vehicle trauma
- health issues for young people, especially teenage pregnancies, risk behaviours, mental health problems of depression and suicide
- general socioeconomic factors impacting on health, including isolation, unemployment, lack of family support
- child and family health
- oral health and dental hygiene
- Aboriginal health.

Health Services

Hunter New England Health Facilities

Participants were also invited to identify organisational issues that must be addressed to enable Hunter New England Health to ensure the quality and sustainability of service provision across the area. Organisational issues identified included:

- workforce – recruitment and retention, training and support
- buildings and infrastructure – specific facilities, maintenance
- information technology – access to equipment, training and support
- equity of funding and resources – particularly in rural areas.

The information gathered through the staff and community consultations was considered, along with reviews of existing strategic plans and other data analysis, to formulate *Hunter New England Health's Strategic Directions* for the next five years. This document is expected to be finalised by January 2006.

Health Support Services

All aspects of Health Support Services exist to assist Hunter New England Health's clinicians, patients and staff.

Information And Technology

Hunter New England Health is ensuring that it has information technology systems that support staff in delivering high quality patient care. This year the focus has been on assessing and prioritising information management requirements across the new organisation. An area wide Information Technology Plan has been developed. It will be implemented based on agreed priorities.

Financial Services

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

- ensure improved, transparent budget process that are clearly communicated and understood by clinicians and managers
- ensure appropriate and effective financial information management systems in place to achieve clinical outcomes within budget
- ensure savings targets are achievable and there is a transparent process in regard to the reallocation of resources to clinical services
- improve the cash position of Hunter New England Health.

In 2004-2005 the total general creditors profile monthly average was 44.9 days. There were no creditors greater than 45 days at the end of this financial year.

Communication Services

Hunter New England Health's Communication Unit is responsible for delivering a comprehensive range of communication services across the entire Hunter New England area 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 website.

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 access for more than 75 media outlets 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.*

Throughout 2004-05, the Communication Unit led the strategic communication

activities to support the health service amalgamation. This role is ongoing as Hunter New England Health services continue integrating.

The Communication Unit is continuing to work 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.

Asset Management

The 2004-05 budget provided the continuation of a number of significant capital works programs throughout Hunter New England, including:

- $42 million for continuation of construction of a new health facility on the John Hunter Hospital campus - a $97.4 million overall project to provide a bone and joint centre of excellence, outpatient medical centre, and diagnostic, physical therapies and education facilities
- $10.8 million for the Newcastle Mater Hospital Redevelopment – a significant project to provide new emergency and intensive care units, operating suite and new day only beds
- $2.6 million for continuation of the Belmont Hospital upgrade – a $28 million project which includes a new emergency department, clinical care centre, improved medical imaging and day surgery facilities
- $7 million for the John Hunter Forensic Upgrade to provide a new forensic medicine facility on the John Hunter Hospital campus
- $2.5 million for the $8.13 million construction of a new Multi Purpose Service health facility (MPS) in Guyra to provide a mix of acute care, aged care, emergency, medical imaging, community health and primary care services with support facilities
- $300,000 for the $2.5 million development of a new health facility in Tingha to provide eight aged care beds and community services
- $800,000 for the $9.16 million construction of a new health facility in Walcha to include acute beds, residential aged care beds, emergency, imaging, pathology, pharmacy, community health, home and community care, dental care and support services.

Many other projects completed or commenced this year will deliver improved facilities and services for Hunter New England Health staff, patients and the community.

Intensive Care Unit Upgrades

$1.2 million was spent on the refurbishment of John Hunter Hospital's Intensive Care Unit (ICU) to provide improved family waiting areas, additional storage facilities and new floor and wall finishes. The project was undertaken in a series of six stages between October 2004 and January 2005 to ensure minimal disruption to patients, visitors and staff as well as no impact on the number of beds available in the ICU. The refurbishment of the ICU is part of the Newcastle Strategy - the largest single investment in health facilities in the Hunter.

The ICU at Armidale Hospital is also being upgraded to provide state-of-the-art intensive care equipment and an improved environment for patients, their families and visitors.

Health Support Services

The $800,000 upgrade involves expansion and reconfiguration of the existing ICU area, a complete upgrade of security and access controls, medical gases and lighting, new internal surfaces such as floor coverings, internal partitions and storage units and new furnishings. The upgrade also includes new intensive care beds and new monitors.

The refurbishment project is being undertaken in a series of carefully planned stages to ensure minimal disruption to patients, visitors and staff. It is scheduled for completion in December 2005.

Newcastle Community Health Centre

Austcorp/Abigroup was selected to build the five-storey, 11,500 square metre Newcastle Community Health Centre (formerly known as the Newcastle Polyclinic project).

Hunter New England Health will be a long-term tenant, occupying almost half of the building, to provide a new, modern home for community-based services relocating from the Royal Newcastle Hospital and Newcastle Health Centre. The building will also provide an after-hours GP service and new services such as x-ray and pathology.

Newcastle Community Health Centre will provide a more comprehensive range of community-based health services to people living and working in Newcastle and is an essential part of plans to have more services being provided in community-based facilities rather than at acute hospital sites.

Renal Unit Upgrade

A $300,000 redevelopment will see an expansion of Armidale Health Service's renal unit to provide additional services for local renal patients.

A major benefit of the expanded dialysis service will be an increase from four to six renal dialysis chairs which will provide in-centre dialysis for six people, three days a week. The larger unit will also house an expanded support service for people undertaking at-home dialysis.

Our People

Full time equivalents (FTE) as at 30 June 2005

Hunter & New England	June -01	June -02	June -03	June -04	June -05	% change 04-05
Medical	522	506	564	630	687.2	9.1
Nursing	3,717	3,853	3,794	3,901	4,525.7	16
Administration and Clerical	1,278	561	554	514	589	14.6
Allied Health Professional	1,266	1,237	1,330	1,358	1,418	4.5
Hospital employees (eg Wardsmen, Technical Assistants)	464	1,245	1,330	1,425	1,924	35
Hotel Services	1,185	1,191	1,128	1,093	1,066.7	-2.4
Maintenance & Trades	207	210	203	188	152.5	-18.9
Other	52	43	45	50	120.6	141.2
Total	8,691	8,846	8,948	9,159	10,484.5	14.5
Medical, Nursing, Allied & staff as a proportion of all staff (%)	63.3	63.3	63.6	64.3	63.2	
Third Schedule (Mater)		766	792	790	866	

1. The categorisation of staff is based on the Treasury Codes extracted from the HIE
2. Corporate Administration FTE provided by the AHS
3. Hospital Employees includes the surplus of staff identified under the Treasury Code for Administration & Clerical less Corporate Administration FTE identified by the AHS.

Workforce Development

Hunter New England Health has established a Workforce Development Unit to coordinate the development and implementation of innovative approaches to workforce planning and management.

The Workforce Development Unit will:

- drive cultural and organisational change, with particular emphasis on workforce planning and development
- develop workforce planning, strategic recruitment and retention strategies and policies
- develop and implement strategies within a broader workforce capability framework to support succession planning, multi-skilling, career development and career progression within the health service
- build the health service's capability to develop and implement creative methods of attracting and retaining staff
- build partnerships with training institutions to influence student intake levels, course profile and content.

Improving Organisational Capability

In September 2004, the health service piloted a new training program for front line managers: Managing Fundamentals.

Rolled out in the southern part of the health service in November 2004, the program is made up of nine modules designed to provide practical training focused on the real issued faced by front line managers. Training is delivered close to where staff work by local content matter experts in the fields of human resource management, staff performance, finance, patient safety, managing change, communication, staff

Our People

safety, unit performance and managing the quality health experience.

More than 250 managers have already commenced the training program. Early results indicated a significant increase in management confidence across the area.

In early 2006, a new version of the Management Fundamentals Program incorporating a blend of face-to-face and online training will be rolled out in the northern part of the health service.

Executive Responsibilities

Chief Executive
Mr Terry Clout
Appointed Administrator on 2 July 2004
Commenced in role on 1 January 2005

Responsible for merging the former New England Area Health Service, Hunter Area Health Service and parts of the Mid North Coast Area Health Service to establish Hunter New England Area Health Service. 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.

Director of Clinical Operations
Dr Nigel Lyons
Commenced in role on 1 January 2005

Responsible for the effective and efficient management of the health service's clinical services including the development of policies and practices which to enhance access to clinical services as well as provide clinician engagement in the management of clinical services and the development of inter-disciplinary clinical teams.

Director Population Health, Planning & Performance
Ms Kim Browne
Commenced in role on 17 January 2005

Responsible for leading and directing the development, implementation, monitoring and evaluation of a strategic approach to health service development, performance improvement and population health approaches to build the health service's capacity to effectively meet the needs of its staff, patients and communities.

Director of Clinical Governance
Professor Allan Spigelman
Commenced in role on 1 January 2005

Responsible for establishing, directing and managing Hunter New England Health's Clinical Governance Unit to promote and support clinical excellence within the health service and to analyse, maintain and improve patient safety and clinical quality systems.

Director of Nursing & Midwifery
Conjoint Professor Jennie West
Commenced in role on 1 January 2005

Responsible for maintaining an appropriately resourced, qualified and competent nursing workforce as well as the professional development of the nursing and midwifery services.

Director of Workforce Development
Mr David Dixon
Commenced in role on 17 January 2005

Responsible for workforce planning, workforce development strategy, human

resources strategy, organizational change and workforce learning and development and for directing the efficient and effective provision of occupational health and safety, human resource and employee/ industrial relations services.

Director of Corporate Services

Ms Tracey McCosker
Commenced in role on 1 January 2005

Responsible for leading and managing the delivery of financial management, information management and technology, administrative and corporate support services across the health service.

Director of Communication and Stakeholder Engagement

Ms Jane Gray
Commenced in role on 1 January 2005

Responsible for establishing and maintaining a high level corporate and public image for Hunter New England Health through the delivery of high quality corporate communication services including media liaison, advertising and marketing, public relations, issues management, stakeholder engagement, publications, and the internet/intranet.

NOTE: Mr Michael Di Rienzo was appointed Director Operations-Acute Networks and Mr Scott McLachlan appointed Director Operations – Primary and Community Networks at the end of this reporting year.

Equal Employment Opportunity

Hunter New England Health values the diversity of the people who work for it and is committed to employment practises 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 an 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 with disabilities and people whose first language is other than English.

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

Our People

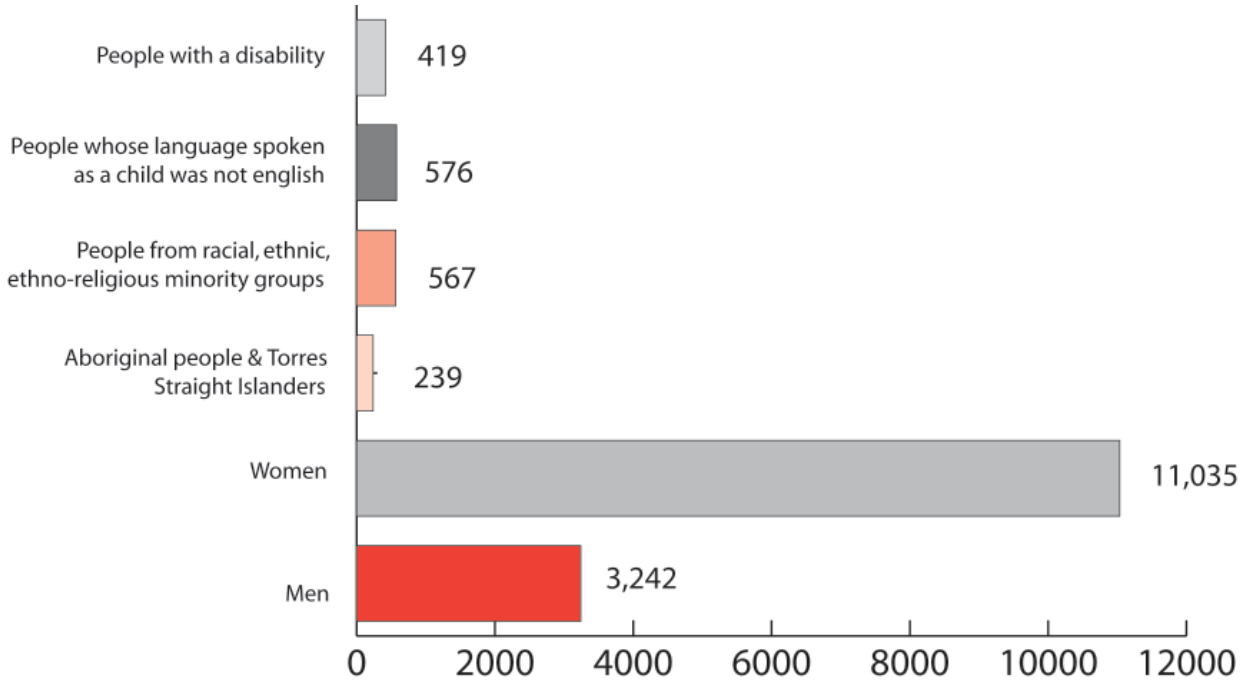
Staff numbers by level

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
<31,352	335	298	57	278	13	9	10	9	1
$31,352-$41,177	4,346	3,873	1,044	3,302	109	108	88	141	43
$41,178 - $46,035	901	835	150	751	13	27	60	22	6
$46,036-$58,253	3,530	3,179	554	2,976	30	113	94	108	39
$58,254-$75,331	1,797	1,631	408	1,389	19	91	76	69	13
$75,332-$94,165	797	730	337	460	10	65	61	27	9
>$94,165 (non SES)	462	346	320	142	1	36	39	5	0
>$94,165 (SES)		0	0	0	0	0	0	0	0
Total	12,168	10,892	2,870	9,298	195	449	428	381	111

Staff numbers by employment status

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	6,429	5,836	2,061	4,368	100	255	217	236	61
Permanent Part-time	3,497	3,059	300	3,197	32	84	75	100	37
Temporary Full-time	1,244	1,099	332	912	41	64	101	24	5
Temporary Part-time	894	814	136	758	17	43	32	20	8
Contract - SES		0	0	0	0	0	0	0	0
Contract - Non SES	9	0	6	3	0	0	0	0	0
Training Positions	95	84	35	60	5	3	3	1	0
Retained Staff		0	0	0	0	0	0	0	0
Casual	2,109	1,740	372	1,737	44	118	148	38	10
Total	14,277	12,632	3,242	11,035	239	567	576	419	121

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



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 the two previous area health services will be integrated.

There were no incidents during the past year which have led to a prosecution by WorkCover under the Occupational Health and Safety Act, 2000.

Performance Indicator	Hunter	New England
No. claims/ 100FTE	7	6
Cost of claims	$548	$499

Source: NSW Treasury Managed Fund database as at 30 June 2005.

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

Accident Type	Percent
Body stress	44%
Falls, trips and slips	15%
Hit by objects	11%
Mental stress	7%
Vehicle	6%
Hitting objects with part of the body	5%
Other	7%
Heat radiation and electricity	1%
Chemicals and other substances	2%
Sound and pressure	1%
Biological factors	1%

Occupation Group	Percent
Nursing	43%
Hotel services	28%
General admin	12%
Medical/support	11%
Maintenance	5%
Other	1%

Source: NSW Treasury Managed Fund database as at 30 June 2005.

Nursing and midwifery

As Hunter New England Health is formed one challenge continues to be the development of the capacity of the nursing and midwifery workforce to deal with changes in demand.

This year work has started on recruiting the new Area nursing team. An Area Nursing Profile has been developed to contribute to the development of the Area Workforce Plan. Development of Joint Business Plan with University of Newcastle and University of New England for clinical practice development is also underway.

Over the coming year our focus will include:

- developing new models of care
- develop the skills of the existing workforce to work with new models and approaches to care
- develop the leadership required to inspire and facilitate the changes required in the nursing and midwifery workforce.

Teaching And Training Activities

The teaching and training initiatives of the former area health services will continue to be integrated over the coming year.

Hunter New England Health provides a range of teaching and training opportunities. Key areas include:

- medical officer education
- nursing education
- management development.

In undertaking teaching and training the health service has continued to work in partnership with a range of organisations including the University of Newcastle, New England University, TAFE and the New England Area Training Scheme.

Research

The Hunter Medical Research Institute (HMRI) is a unique partnership between Hunter New England Health, The University of Newcastle and the community. HMRI is a research hub, providing a focal point for the coordination of research strategy, resources and funding.

HMRI has established research programs in six key areas of Brain & Mental Health, Cancer, Cardiovascular Health, Health Behaviour & Public Health,
Mothers & Babies and VIVA (Vaccines, Immunology, Viruses & Asthma).

Each research program spans multiple sites and involves long term collaborations between hospital and university based researchers.

Brain and Mental Health
HMRI's Brain and Mental Health Program investigates how the nervous system functions at molecular, cellular and systems levels in health and disease using humans and laboratory models. The aim is to develop better treatments for people with, and those at risk of

Our People

developing, common neurological and mental health disorders.

Focus areas

Stroke - focusing on stroke epidemiology, genetics and population surveillance, health systems research, acute stroke therapy trials, brain imaging and stroke prevention and recovery research.

Psychosis and Schizophrenia Researching - the biological basis of, improved methods for diagnosing and risk factors (such as cannabis use) for the onset schizophrenia.

Biological mechanisms involved in behavioural disorders - research using animal models to investigate the biological basis of psychological stress.

Development of behavioural interventions for mental disorders and substance abuse - developing new ways of delivering cognitive behavioural therapy in rural and community settings to people with behaviour and substance abuse problems.

Spinal cord mechanisms underlying pain - the use of electrophysiological techniques and genetically modified mice to investigate the cellular mechanisms underlying pain processing in the spinal cord.

Molecular and Cellular Neurobiology - researching the way in which different cells in the nervous system use molecules to communicate with each other and how this communication changes during development in health and disease (particularly ageing, Parkinson's disease, tinnitus, myopia, stroke, epilepsy, psychosis and depression).

Researchers
Dr Christopher Levi, Dr Mark Parsons, Dr Michael Pollack, Professor Vaughan Carr, A/Professor Ulrich Schall, Dr Amanda Baker, and Dr Pat Johnston. Professor Pat Michie, Dr Frini Karyanidis and Dr Bill Budd, Trevor Day, Dr Amanda Baker, Dr Frances Kay-Lambkin, Prof Brian Kelly, Prof Mike Hazelton, Prof Mike Startup, A/Prof Bob Callister, Dr Alan Brichta, Dr Phillip Jobling, Dr Philip Bolton, Prof Nick Bogduk, Prof Darren Rivett, Prof David Pow, A/Prof Alistair Sim, Prof Peter Dunkley, Dr Phil Dickson, Prof John Rostas, Prof Mike Calford.

Cancer
HMRI's Cancer Research Program is researching ongoing improvements in preventing, diagnosing and treating cancer. Research is being conducted into cancer biology, the development of more effective and novel cancer therapies, evaluation of therapies through clinical trials and improving community screening and education programs.

Focus areas

- Cellular and Molecular Oncology
- Pharmaco-Genetics of cancer
- Development of anti-cancer therapies
- Cancer metastasis
- Melanona Research.

Clinical trials

- Australian and New Zealand Breast Cancer Trials Group (ANZBCTG)
- Trans Tasman Radiation Oncology Group (TROG).

Researchers

Prof Rodney Scott, Prof Allan Spigelman, Prof Steve Ackland, Dr Jennette Sakoff, A/Prof Adam McClusky, Prof Leonie Ashman, Dr Lisa Lincz, Dr Arno Eno, Renate Griffith, Peter Hersey, A/Prof Michael Agrez, Dr Gordon Burns, Prof John Forbes, Prof Jim Denham, Prof Peter O'Brien, Dr Martin Ebert, Peter Greer, Prof Peter Hersey.

Cardiovascular Health

The Cardiovascular Health program explores the human heart disease across several levels including the prevention, revascularisation, and quality of life for cardiovascular and cardiopulmonary disease patients.

Focus areas

Human heart disease - investigating the revascularisation of the ischaemic heart, acute treatments for heart attack and clinical trials for cardiovascular disease therapies.

Control of heart-lung interactions - defying the basic mechanisms that control the blood flow to the heart and lungs.

Cell Biology and Biophysics - researching the role of calcium ion stores in establishing heart beats as well as the role of key proteins in regulating calcium in the cell and how dietary components and genetic mutations influence this role.

Researchers

Dr Suku Thambar, Prof Peter Flecther, Dr Greg Bellamy, Dr Bruce Bastian, Dr James Leitch, A/Prof Manahar Garg, Prof Saxon White, A/Prof Tony Quail, Dr David Cottee, Dr Dirk van Helden, Dr Derek Laver.

Health Behaviour and Public Health

HMRI's Health Behaviour and Public Health Program undertakes collaborative research in ageing, health services delivery and quality, health risk modification and social determinants of health and behavioural science.

Focus areas

Health Behaviour and Psychosocial Research - strategies for disease prevention and health promotion and research to affect organisational change.

Centre for Research and Education in Ageing (CREA) - focusing on research and education for ageing in response to changing needs of our ageing population. This includes research into healthy ageing and research into an effective public response to an ageing population.

Pharmacoepidemiology - research into the pattens of drug use, drug prescribing practices and drug policy.

Genetic epidemiology - focusing on whether genetic information can improve both risk prediction and medication use.

Health Services Research Group (HSRG) - researching health service utilisation and the effectiveness of health service delivery.

Our People

Researchers
Prof Afaf Girgis, Prof Robert Sanson-Fisher, Dr John Wiggers, Dr Chris Paul, Dr Sue Outram, Prof Julie Byles, Prof Kichu Nair, Prof David Henry, Prof John Marley, Dr John Attia, Prof Wayne Smith, A/Prof Kate D'Este, Prof Robert Gibberd.

Mothers and Babies
HMRI's Mothers and Babies Research Program undertakes research into the areas of premature birth, the effects of asthma during pregnancy, maternal and paternal contribution to pregnancy and the health of the newborn child, male infertility and testicular cancer.

Focus areas

Mothers and Babies Research Centre - investigating basic mechanisms of placental hormone action, and hormonal mechanisms of fetal development, in order to better understand the mechanisms involved in the mechanisms involved in the onset of human labour. The group particularly focuses on premature birth and the effects of asthma during pregnancy on both the mother and the developing baby.

Reproductive Sciences Group - researching improved healthcare for women and their newborn babies, new methods of contraception and fertility control, an understanding of the causes of testicular cancer and the development of new transgenic technology. The Reproductive Sciences Group is a member of the Australian Research Council Centre of Excellence in Biotechnology and Development (CBD).

Researchers
Prof Roger Smith, Dr Vicki Clifton, Dr Rick Nicholson, Dr Tamas Zakar, Dr Ian Wright, Prof Warrick Giles, Prof Trish Crock, Dr Andrew Bisits, Prof John Aitken, Dr Eileen McLaughlin, Dr Minji Lin, Prof Russell Jones, Dr Shaun Roman

Vaccines, Immunity, Viruses and Asthma (VIVA)
HMRI's Vaccines, Immunity, Viruses and Asthma (VIVA) Program is investigating characteristics and mechanisms of infectious diseases and asthma, viral vectors in disease mechanisms and treatment, and vaccines for the prevention and treatment of disease.

Focus areas

Vaccines - the development of protective vaccines to prevent genital and respiratory tract infections. This work also has application to animal based vaccines in native marsupial species.

Immunology - the role of viral and bacterial infection, particularly of mucosal surfaces, in disease and develops therapeutic strategies to fight such infections.

Viruses - using viruses as therapeutic agents to fight cancer and other diseases.

Asthma - basic research and translational research. In the area of asthma and other airway diseases, as they apply to

pregnancy, childhood, adult life and the elderly. Asthma research will increase the understanding of asthma and pregnancy, dietary influences on asthma, the role of viruses in asthma, innate immunity in airway disease, the link between bacterial infections and asthma and the role of pneumococcal infection in treating asthma.

Researchers
Prof Ken Beagley, Prof John Roger, Prof Phil Hansbro, Prof Caroline Blackwell, Prof Robert Clancy, Prof Marie Gleeson, Dr Michael Boyle, A/Prof Stephen Graves, Dr John Ferguson, A/Prof Darren Shaffren, A/Prof Richard Barry, Prof Paul Foster, Prof Peter Gibson, Dr Peter Wark, Prof Michael Hensley, Dr Lisa Wood, Dr Vanessa Murphy, Dr Bruce Whitehead.

Highlights

- The development of an alcohol harm reduction program which is now being implemented across NSW by the NSW Police Service and is also being adopted in New Zealand.
- Shown pregnant women who have asthma they can continue their asthma medication without endangering their baby's health. Based on these findings, United States has recently changed its clinical guidelines on how pregnant women with asthma should be treated.
- An international team led by HMRI has developed a new technique for brain imaging. They were able to show that impaired thought patterns observed in schizophrenia are likely to be due to structural alterations in the brain.
- HMRI researchers Peter Gibson and Paul Foster are leading the largest node of a $26.44 million Cooperative Research Centre for Asthma and Airways. They have been funded by the Federal Government and pharmaceutical companies for seven years to develop better diagnostic tests and more effective and safer treatments for asthma and chronic lung disease.
- Internationally renowned senior cancer researcher, Professor Rodney Scott has been appointed as the HMRI NBN Telethon Children's Cancer Research Fellow. This appointment will enhance the health outcomes for young cancer patients in the region.
- The University of Newcastle Research Associates (TUNRA) Ltd has signed a licensing agreement worth approximately $10 million with the biotechnology company Psiron Ltd, to develop anti-cancer treatments.
- Hormone therapy given to men with inoperable prostate cancer a few months before radiotherapy can help stop the cancer returning after treatment.
- Developed Media Doctor, which reviews current news items about medical treatments and rates the quality from one to five with a star system.
- Identified that there is a potential link between human genes and the inflammatory responses detected in infants who die of Sudden Infant Death Syndrome (SIDS).

Overseas Travel For Health Service Staff

Name of officer	Purpose of visit	Place visited	Costs met from general funds or sponsorship?
Dr Paul Varghese	Attend European Society of Cardiology Congress 2004	Munich, Germany	$5,720.90 Special Purpose and Trust Fund
Elizabeth Nunn	Attend international Society for Paediatric & Adolescent Diabetes Annual Scientific Meeting	Singapore	$2528 Special Purpose and Trust Fund
Jane Collins	Attend Australasian Paediatric Endocrine Group Annual Scientific Meeting	Auckland, New Zealand	$1707 Special Purpose and Trust Fund $100 Personal
Paul Cardew	Participant at Annual Congress of European Association of Nuclear Medicine and Study Tour Visits to University College in London Newcastle General Hospital and Carlisle General Hospital	Helsinki, Finland London, England	$7023.24 Nuclear Medicine Trust Fund
Susan Dooley	Participant Bleeding & Thrombosing Diseases: Basics and Beyond Conference	Rochester, Minnesota USA	$5,222.98 Private Practice Trust Fund
Irene Goodhew	Participant Bleeding & Thrombosing Diseases: Basics and Beyond Conference	Rochester, Minnesota, USA	$5,222.98 Private Practice Trust Fund
A/Prof. Maree Gleeson	Invited Presenter Babes in Arms AGM 8th SIDS International Conference	Leicester, UK Edinburgh, UK Loughborough, UK Edmonton, Canada	$3,717 Private Practice Trust Fund $10,000 Sponsorship
Ms Lida Lowe	Participant HUGO Mutation Detection Training Course	Newcastle, UK	$5461.06 General Fund
Brenda Simm	Clinical teaching in masters of nursing.	Hong Kong	$3377.70 Special Purpose and Trust Fund
Peter Schofield	Alzheimers Disease & related Disorders	Philadelphia, USA	$4408.53 General Fund
Marina Vamos	Psychodynamis Interpersonal Therapy & TNCT Annual Conference	UK	$3926.33 General Fund
Sudarsan Balakrishnan	Continuing education in Neuropsychology	India	$6586.60 General Fund
Stephanie Oak	Narrative research in health & illness / healing humanities	UK	$5172.89 General Fund
Samit Roy	7th International conference on philosophy, psychiatry and psychology.	Germany	$3344.17 General Fund
Leanne Crittenden	Attend Women's & Children's Hospitals Australasia Annual Conference	Christchurch, New Zealand	$3257.40 Special Purpose and Trust Fund
Margaret Piper	Attend Women's & Children's Hospitals Australasia Annual Conference.	Christchurch, New Zealand	$3257.40 Special Purpose and Trust Fund
Patricia Marks	Attend Women's & Children's Hospitals Australasia Annual Conference.	Christchurch, New Zealand	$3257.40 Special Purpose and Trust Fund
Aven James	Attend Euro PCR 05 Conference	Paris, France	$2264.00 Special Purpose and Trust Fund
Brenda Wegener	Attend Euro PCR 05 Conference	Paris, France	$2264.00 Special Purpose and Trust Fund

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 Health Minister announced the establishment of an Area Health Advisory Council for each Area Health Service. The Area Health Advisory Council will provide 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 will advise the Chief Executive and will facilitate 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

Associate Professor Lyn Fragar AO was appointed Chair of the Hunter New England Health Advisory Council in April 2005.

Professor Fragar resides in Moree and 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. Professor Fragar is Director of the Australian Rural Health Research Collaboration. She is Executive Director Farmsafe Australia. Deputy Chair of the Australian Pestcide and Veterinary Medicines Authority - a statutory authority of the Australian government. Professor Fragar is Instigator and inaugural secretary of the Moree and Rural Community Rural Counselling Service, and is currently the Patron of that service. Professor Fragar resides in Moree.

Appointment of the Council members was expected in September.

Engagement Framework

Developing a framework for community and clinical engagement over Hunter New England Health's enormous geographic area with many sectional interest groups is a challenging task. 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)
- GP Advisory Committee
- Aboriginal Health Liaison Committee
- Medical Staff Executive Council
- Area Health Advisory Council (appointed by the NSW Minister for Health).

The framework and other information about these groups is available on the health service's website http://www.hnehealth.nsw.gov.au/about/governance/index.htm

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.

Ethnic Affairs Policy Statement

The overall aim of all the programs of the Migrant 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 Area Health Service.

Please see next page for more information.

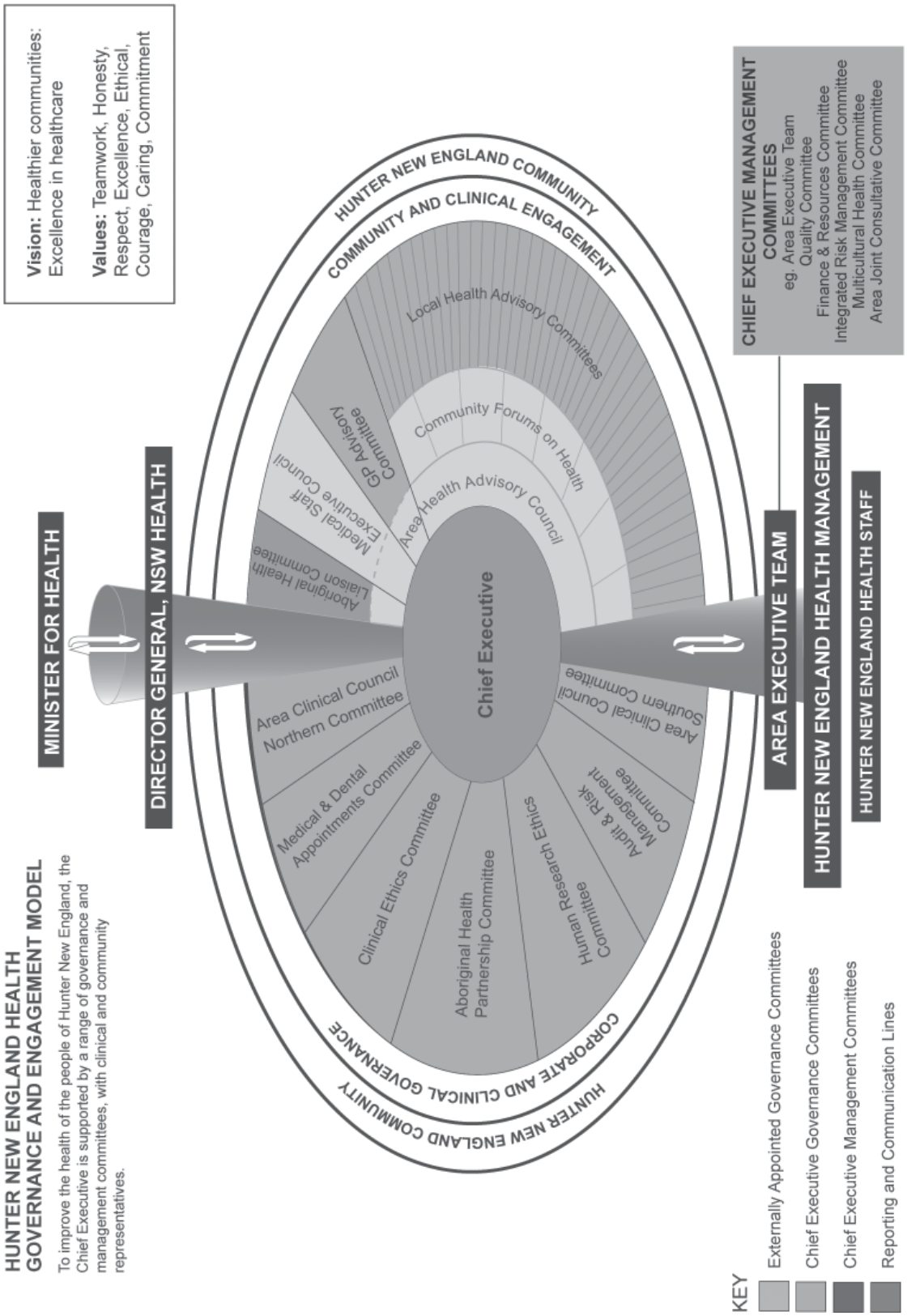
Our Community

Ethnic Affairs Priority Statement

Equity and Improved Access	All refugees on arrival in the Hunter are given access to health care through special clinics. Two paediatricians, an infectious disease specialist, a general practitioner, immunisation nurses, STARRTS worker and interpreters provide expert care. Immunisation is given for all childhood illnesses. All are examined for diseases endemic in Africa. Treatment and referrals are given as necessary.
	One morning a week is set aside for refugee women in the ante natal clinics at the John Hunter Hospital. This enables women to have support from others in their community and enables the clinic to concentrate on the special needs of these women.
	A new multicultural liaison position was established at Belmont Hospital to ensure that patients and staff in that hospital were aware of the mandatory requirements relating to the use of interpreters and the standards for the care of people of CALD backgrounds.
Culturally and Linguistically Appropriate Care	Members of the regional interpreter panels were trained to give on site talks at each orientation programme held in Tamworth Armidale and Taree and to provide further staff education on working in a multicultural workplace.
	Multicultural Health Liaison Officers from the Hunter visited the Manning and New England regions to provide support to staff and make multicultural resources available.
Improved Population Health	Health Education was provided to 972 people from 13 different ethnic communities in Newcastle and the Rural Hunter areas. Topics covered included managing stress, health eating, the value of exercise, and the dangers of smoking.
Informed and Involved communities	Staff attended the Multicultural Interagency meetings in rural and metropolitan areas exchanged information and gave support to other agencies working especially with refugee groups.
	Meetings were held in Moree to establish an interpreter panel in that town and for the Mehi Cluster.

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



Freedom of Information

Statistical Return 1 July 2004 to 30 June 2005

APPLICATION INFORMATION	PERSONAL	NON-PERSONAL
NUMBER OF APPLICATIONS:		
Applications Carried Forward		
New Applications	7	10
Applications Completed	6	10
Applications Not Completed at 30/6/05	1	
Number of Amendments or Notations	1	
OUTCOME OF APPLICATIONS COMPLETED:		
Granted in Full	2	7
Granted in Part	3	
Refused	1	1
No documents available		1
Application withdrawn		1
APPLICATIONS GRANTED IN PART OR REFUSED:		
Exempt	1	1
Oherwise Available		1
Refused - Section 22 (3)*	1	
NUMBER OF DISCOUNTS ALLOWED		
Financial Hardship	1	1
Public Interest		
TIME TAKEN TO PROCESS:		
0-21 Days	4	7
21-31 Days		
> 31 Days	2	3
REVIEWS AND APPEALS:		
Internal Reviews and Appeals		
Number of Ombudsman's Reviews		
Administrative Decision Tribunal		
FEES:		
Received	$1,785	$377

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.

Financial Report

Audit Report

GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDIT REPORT

HUNTER AND 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 and New England Area Health Service:

(a) presents fairly the Hunter and New England Area Health Service's financial position as at 30 June 2005 and its financial performance and cash flows for the six months ended on that date, in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia, and

(b) complies with section 45F of the *Public Finance and Audit Act 1983* (the PF&A Act), (the Act) and presents fairly according to applicable Australian Accounting Standards, and other mandatory professional reporting requirements in Australia:

the financial position of the [organisation] as at [date], and
its financial performance and cash flows for the year ended [date].

Audit Opinion Pursuant to the *Charitable Fundraising Act 1991*

In my opinion:

(a) the accounts of the Hunter and New England Area Health Service show a true and fair view of the financial result of fundraising appeals for the period ended 30 June 2005

(b) the accounts and associated records of the Hunter and New England Area Health Service have been properly kept during the period in accordance with the *Charitable Fundraising Act 1991* (the CF Act) and the *Charitable Fundraising Regulation 1998* (the CF Regulation)

(c) money received as a result of fundraising appeals conducted during the period has been properly accounted for and applied in accordance with the CF Act and the CF Regulation, and

(d) there are reasonable grounds to believe that the Hunter and New England Area Health 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.

The Chief Executive Officer's Role

The financial report is the responsibility of the Chief Executive Officer of the Hunter and New England Area Health Service. It consists of the statement of financial position, the statement of financial performance, the statement of cash flows, the program statement - expenses and revenues and the accompanying notes.
thereto [as set out on pages ... to ...], and the information contained therein.

The Auditor's Role and the Audit Scope

As required by the PF&A Act and the CF Act, I carried out an independent audit to enable me 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. Based on my audit as required by the *Public Finance and Audit Act 1983* (the PF&A Act) and the *Charitable Fundraising Act 1991* (the CF Act).

Financial Report

Audit Report

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

- evaluated the accounting policies and significant accounting estimates used by the Chief Executive Officer in preparing the financial report,
- examined a sample of the evidence that supports:
  - (i) the amounts and other disclosures in the financial report,
  - (ii) compliance with accounting and associated record keeping requirements pursuant to the GF Act, and
- obtained an understanding of the internal control structure for 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 failed in his reporting obligations.

My opinions do not provide assurance:

- about the future viability of the Hunter and New England Area Health Service,
- that it has carried out its activities effectively, efficiently and economically,
- about the effectiveness of its 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 PFAA 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, FCA
Director, Financial Audit Services

SYDNEY
28 October 2005

Financial Report

Statement Certification

Certification of Financial Statements for Period Ended 30 June 2005

The attached financial statements of the Hunter New England Area Health Service for the six month period ended 30 June 2005:

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 Consensus Views, the requirements of the *Public Finance and Audit Act 1983* 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

2 October 2005

.....

Tracey McCosker – Director Corporate Services

Hunter New England Area Health Service

2 October 2005

Financial Report

Financial Overview

The audited financial statements presented for Hunter New England Health recognise the amalgamation of Hunter Area Health Service, New England Area Health Service and the Lower Mid North Coast local government areas of Gloucester, Greater Taree and Great Lakes, which had effect from 1 January 2005.

In achieving the 20004/05 results Hunter New England Health is satisfied that it has operated within the level of government cash payments and restricted operating costs to the budget available. It has also ensured that no general creditors exist at the end of the month in excess of levels agreed with the NSW Department of Health. Also all loan repayments have been effected within the time frames agreed.

Consistent with the establishment date of the Area Health Service the audited financial statements are presented for a six-month period only. Information is available for the 12 months ended 30 June 2005, compared with 2003/04 (combined information for the previous Area Health Services, or parts thereof, that now comprise Hunter New England Health).

	2004/05 Actuals $000	**2004/05 Budget $000**	**2003/04 Actuals $000**
Employee Related Expenses	700,057	706,709	628,749
Visiting Medical Officers	49,481	48,374	45,313
Goods & Services	285,412	282,478	250,051
Maintenance	26,185	25,319	24,941
Depreciation & Amortisation	44,785	44,824	41,647
Grants & Subsidies	5,570	5,586	5,601
Borrowing Costs	149	195	62
Payments to Affiliated Health Organisations	68,791	68,791	71,685
Other Expenses			
Total Expenses	1,180,430	1,182,276	1,068,049
Sale of Goods & Services	156,371	147,342	159,548
Investment Income	4,857	3,117	3,323
Grants & Contributions	21,582	17,597	24,959
Other Revenue	9,654	4,396	4,360
Total Revenues	192,464	172,452	192,190
Gain/Loss on Disposal of Non Current Assets	(201)	240	(1,006)
Net Cost of Services	988,167	1,009,584	876,865

This information is detailed below:

The variations in the two years reported stem from budget adjustments and other movements as follows.

Budget Increases 2004/05

Category of Increase	$ Million
Inter Area Patient Inflows	46.3
Transfer of lower portion of North Coast to Hunter New England	33.2
Award Increases	19.3
Blood & Blood Products	5.8
Winter Beds	3.8
Sustainable Access Plan	2.9
Cancer Services	2.3
Drug & Alcohol	2.3
Nurse Strategy	1.5
Mental Health	1.2
Other	6.5
TOTAL BUDGET INCREASES	**125.1**

Program Reporting

The Area Health Service reporting of programs is consistent with the 10 programs of health care delivery utilised across NSW Health and satisfies the methodology for apportionment advised by the NSW Department of Health.

No comparisons are available in the audited statements, although Table A (on next page) has been prepared comparing the combined results of Hunter New England Health and its former Area components for the full two-year period 1 July 2003 to 30 June 2005.

Total expenditure increased by $112 million or 10.5% over last year. The transfer of the lower portion of North Coast Area Health Service has contributed to approximately $42 million of this increase.

Program increases of more than 15% together with all program reductions are explained as in the chart on the next page.

Financial Report

Table A: Program Reporting

PROGRAM	2003/04			2004/05		
	Exp	Rev	NCOS	Exp	Rev	NCOS
	$000	$000	$000	$000	$000	$000
Primary & Community	84,513	7061	77,452	89,229	7,311	81,918
Aboriginal Health	4,686	403	4,283	4,122	342	3,780
Outpatient Services	98,266	11,344	86,922	116,073	11,874	104,199
Emergency Care Services	79,134	6,516	72,618	87,866	8,141	79,725
Overnight Acute	446,041	101,357	344,684	480,541	99,175	381,366
Same Day Acute	88,993	13,617	75,376	99,433	14,251	85,182
Mental Health Services	92,808	6,692	86,116	118,454	7,531	110,923
Rehab & Extended Care	130,910	31,874	99,036	133,480	30,836	102,644
Population Health	13,315	6,879	6,436	14,767	6,655	8,112
Teaching & Research	29,383	5,441	23,942	36,465	6,147	30,318
Total	1,068,049	191,184	876,865	1,180,430	192,263	988,167

Program Expenditure

Program No	Program Description	$ 000Inc/(Dec)	%Inc/(Dec)	Explanation of Increase or Decrease between Years
1.3	Outpatient Services	17,807	18.1	Increase in Non Chargeable NAPOOS by 33,000. At an average cost of $158 per NAPOOS this amounts to $5.2 million. Correct allocation of Diabetes, Genetics and Sexual Assault allocations to Outpatients from Primary & Community in the previous year.
3.1	Mental Health Services	25,646	27.6	Enhancement funding received in 2004/05 and the timing of the expenditure of enhancement funding received in 2003/04 to this financial year.
6.1	Teaching & Research	7,083	24.4	Additional recruitment of Salaried Staff Specialists replacing Visiting Medical Officers.
1.2	Aboriginal Health	(61)	(15.1)	No recurrent funding ceased in 2004/05.
2.1	Emergency Care Services	1,625	24.9	Increased capture rates of chargeable patients presenting through Emergency.

Directions in Funding

As a result of the establishment of the new Area Health Services on 1 January 2005, it has become necessary for each Area Health Service to prepare its financial statements utilising the Australian Equivalents to International Financial Reporting Standards (AEIFRS). Each Area Health Service is therefore twelve months in advance of the majority of Government agencies.

In addition to the need to adopt AEIFRS, Hunter New England Health has needed to respond to several other significant challenges:

- the amalgamation of accounting and financial systems; and
- the restructuring of corporate and business support services designed to generate funds to allocate towards front line clinical services.

The 2005/06 Budget – About the Forthcoming Year

Hunter New England Health received its 2005/06 allocation on 22 July 2005. The allocation is earmarked by the provision of additional funding to address:

- the provision of increased bed capacity to improve access block performance and provide sustainable management of elective surgery – it is expected that the funding provided of $18.3 million will facilitate the establishment and opening of an additional 91 beds
- $4 million for the provision of more elective surgery to tackle existing waiting lists
- $5.3 million for an increase of 4.5 intensive care beds and 6 neonatal cots, expected to open and operate in 2005/06
- $2.7 million for Mental Health Service improvements, including Rural Health Access, Child & Adolescents, Mental Health for Older People, Housing Assistance Support Initiatives and enhanced medical services in Northern Area
- the continued enhancement of the delivery of cancer research and direct patient services.

Hunter New England Health will work with the NSW Department of Health in a major reform program that will focus on ensuring that each patient has the best possible journey through the health system. This will ensure that patient care is better coordinated, leading to improved patient outcomes and more efficient use of resources.

The Area Health Service amalgamation, as announced by the Minister for Health on 27 July 2004, serves to better align population growth centres with existing centres of excellence and specialist medical expertise, and also link areas of traditional clinical resource strength to areas of traditional shortage. In addition, the new Areas will integrate a range of administrative and clinical systems, removing duplication and overlap, with the savings being progressively invested in clinical services.

A major internal reform program has also been initiated to consolidate and share corporate and business support services across the NSW public health system. These reforms are aimed at redirecting resources to frontline health care, while also improving the cost effectiveness, consistency and accessibility of support services across NSW. The initial focus

Financial Report

of these reforms is linen, food and IT systems and overall procurement practices, this approach being consistent with the NSW Government 's Shared Corporate Services Reform Strategy.

The Minister for Health has announced the following new capital works:

- $6.5 million for the new Guyra Multi Purpose Service;
- $800,000 for the upgrade of the Armidale Hospital Intensive Care Unit;
- $840,000 to construct a new four vehicle ambulance station at Gunnedah;
- $1 million for the commencement of construction on the new Tingha Health Service;
- $4 million for the commencement of major works on the Walcha Rural Hospital and Health Service including acute beds, residential aged care, emergency, imaging and pathology;
- $4 million for the commencement of the Forensic Medicine Facility construction on the John Hunter Hospital site.

In addition, the 2005/06 capital program also provides for the continuation of 2004/05 projects including:

- 67.1 million for the ongoing Newcastle Strategy which includes:
- $7.2 million for the ongoing Belmont Hospital upgrade including a new ward block to commence construction in November 2005
- $37.6 million for the construction of the new Royal Newcastle Centre and intensive care infrastructure at John Hunter Hospital
- $6 million for the Newcastle Community Health Centre
- $13.5 million for the redevelopment of the Mater Hospital.

Hunter New England Area Health Service
Operating Statement for the six months ended 30 June 2005

	Notes	Actual 2005 $000
Expenses		
Operating Expenses		
Employee Related	3	373,047
Visiting Medical Officers		26,687
Goods and Services	4	150,333
Maintenance	5	14,973
Depreciation and Amortisation	2(j), 6	23,375
Grants and Subsidies	7	3,233
Finance Costs	8	47
Payments to Affiliated Health Organisations	9	35,007
Total Expenses		**626,702**
Retained Revenue		
Sale of Goods / Rendering of Services	10	80,461
Investment Income	11	2,869
Grants and Contributions	12	10,999
Other Revenue	13	1,264
Total Retained Revenue		**95,593**
Gain/(Loss) on Disposal of Non Current Assets	14	67
Net Cost of Services	32	**531,042**
Government Contributions		
NSW Health Department Recurrent Allocations	2(d)	472,834
NSW Health Department Capital Allocations	2(d)	34,292
Acceptance by the Crown Entity of employee superannuation benefits	2(a)	30,393
Total Government Contributions		**537,519**
RESULT FOR THE PERIOD FROM ORDINARY ACTIVITIES		**6,477**

The accompanying notes form part of these Financial Statements

Hunter New England Area Health Service
Statement of Changes in Equity for the six months ended 30 June 2005

	Notes	Actual 2005 $000
Net increase/(decrease) in Asset Revaluation Reserve	27	114,748
TOTAL INCOME AND EXPENSE RECOGNISED DIRECTLY IN EQUITY		**114,748**
Result for the Year from Ordinary Activities		**6,477**
TOTAL INCOME AND EXPENSE RECOGNISED FOR THE PERIOD		**121,225**

The accompanying notes form part of these Financial Statements

Hunter New England Area Health Service
Balance Sheet as at 30 June 2005

	Notes	Actual 30 June 2005 $000
ASSETS		
Current Assets		
Cash and Cash Equivalents	18	64,298
Receivables	19	41,213
Inventories	20	5,387
		110,898
Non Current Assets Held for Sale	22	3,429
Total Current Assets		**114,327**
Non-Current Assets		
Receivables	19	2,811
Property, Plant and Equipment		
- Land and Buildings	21	806,349
- Plant and Equipment	21	76,111
- Infrastructure Systems	21	52,712
Total Property, Plant and Equipment		**935,172**
Total Non-Current Assets		**937,983**
Total Assets		**1,052,310**
LIABILITIES		
Current Liabilities		
Payables	24	63,667
Provisions	25	65,713
Other	26	267
		129,647
Total Current Liabilities		**129,647**
Non-Current Liabilities		
Provisions	25	142,652
Other	26	8,151
Total Non-Current Liabilities		**150,803**
Total Liabilities		**280,450**
Net Assets		**771,860**
EQUITY		
Reserves	27	112,990
Accumulated Funds	27	658,179
		771,169
Amounts recognised on equity relating to assets held for sale	22	691
Total Equity		**771,860**

The accompanying notes form part of these Financial Statements

Hunter New England Area Health Service
Cash Flow Statement for the six months ended 30 June 2005

	Notes	Actual 2005 $000
CASH FLOWS FROM OPERATING ACTIVITIES		
Payments		
Employee Related		(312,401)
Grants and Subsidies		(41,056)
Finance Costs		(47)
Other		(198,454)
Total Payments		**(551,958)**
Receipts		
Sale of Goods and Services		83,317
Interest Received		1,964
Other		26,575
Total Receipts		**111,856**
Cash Flows From Government		
NSW Health Department Recurrent Allocations		464,625
NSW Health Department Capital Allocations		34,292
Net Cash Flows from Government		**498,917**
NET CASH FLOWS FROM OPERATING ACTIVITIES	32	**58,815**
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from Sale of Land and Buildings, Plant and Equipment and Infrastructure Systems		3,268
Proceeds from Sale of Investments		38
Purchases of Land and Buildings, Plant and Equipment and Infrastructure Systems		(47,304)
NET CASH FLOWS FROM INVESTING ACTIVITIES		**(43,998)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Repayment of Borrowings and Advances		(4,495)
NET CASH FLOWS FROM FINANCING ACTIVITIES		**(4,495)**
NET INCREASE / (DECREASE) IN CASH		**10,322**
Cash transferred in/(out) as a result of administrative restructure		**53,976**
CLOSING CASH AND CASH EQUIVALENTS	18	**64,298**

The accompanying notes form part of these Financial Statements

Hunter New England Area Health Service
Program Statement - Expenses and Revenues
for the six months ended 30 June 2005

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
	2005	2005	2005	2005	2005	2005	2005	2005	2005	2005	2005
	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
Expenses											
Operating Expenses											
Employee Related	35,788	1,722	35,630	27,852	128,120	26,987	49,536	49,419	4,520	13,473	373,047
Visiting Medical Officers	365	-	1,768	3,191	12,630	5,157	1,266	1,340	50	920	26,687
Goods and Services	7,157	312	12,407	9,989	80,159	17,341	7,020	12,442	1,188	2,318	150,333
Maintenance	1,765	102	1,381	878	4,737	1,208	1,758	2,141	396	607	14,973
Depreciation and Amortisation	1,527	49	2,384	1,609	9,898	2,234	2,342	2,694	159	479	23,375
Grants and Subsidies	1,728	1	9	16	111	62	1,242	20	2	42	3,233
Finance Costs	6	1	3	4	17	5	4	6	1	-	47
Payments to Affiliated Health Organisations	654	-	6,930	3,442	16,960	1,016	-	3,066	1,557	1,382	35,007
Total Expenses	48,990	2,187	60,512	46,981	252,632	54,010	63,168	71,128	7,873	19,221	626,702
Revenue											
Sale of Goods and Services	2,454	104	4,790	3,512	46,145	6,674	3,014	11,465	225	2,078	80,461
Investment Income	255	12	273	132	1,049	190	182	474	79	223	2,869
Grants and Contributions	789	70	409	257	1,279	193	232	3,111	3,405	1,254	10,999
Other Revenue	349	3	90	85	413	59	82	77	3	103	1,264
Total Revenue	3,847	189	5,562	3,986	48,886	7,116	3,510	15,127	3,712	3,658	95,593
Gain / (Loss) on Disposal of Non Current Assets	10	-	19	5	27	5	13	(15)	1	2	67
Net Cost of Services	45,133	1,998	54,931	42,990	203,719	46,889	59,645	56,016	4,160	15,561	531,042

* The name and purpose of each program is summarised in Note 17. The program statement uses statistical data to 31 December 2004 to allocate the current period's financial information to each program.

No changes have occurred during the period between 1 January 2005 and 30 June 2005 which would materially impact this allocation.

Hunter New England Area Health Service
Notes to and forming part of the Financial Statements
for the six months ended 30 June 2005

1 The Health Service Reporting Entity

The Hunter New England Area Health Service was established under the provisions of the Health Services Act with effect from 1 January 2005 and as such has presented its financial statements only for the six month period ended 30 June 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 reporting entity is consolidated as part of the NSW Total State Sector Accounts.

2 Summary of Significant Accounting Policies

The Health Service's financial statements are a general purpose financial report which has been prepared on an accruals basis and in accordance with applicable International Financial Reporting Standards (which include Australian equivalents to International Financial Reporting Standards (AEIFRS)), other authoritative pronouncements of the Australian Accounting Standards Board (AASB) where it is necessary to detail the scope and applicability of the International Standards in the Australian environment, Urgent Issues Group (UIG) Consensus Views and 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.

The Area Health Service's financial statements are prepared for the six months ended 30 June 2005 and are therefore covered by AASB101, "Presentation of Financial Statements", which requires the adoption of International Financial Reporting Standards for reporting periods beginning on or after 1 January 2005.

Where there are inconsistencies between the above requirements, the legislative provisions have prevailed.

In the absence of a specific Accounting Standard, other authoritative pronouncements of the AASB or UIG consensus View is considered.

Except for property, plant and equipment, investment property and financial assets held for trading and available for sale which are measured at fair value, the financial statements 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.

The financial report complies with Australian Accounting Standards, which include AEIFRS.

This is the first financial report prepared based on AEIFRS and no comparatives for the year ended 30 June 2004 are available due to the this Area Health Service entity being established on 1 January 2005. Reconciliations of AEIFRS equity and profit or loss for 30 June 2005 to the previous accounting standards in accordance with *AASB1 First-time Adoption of Australian Equivalents to International Financial Reporting Standards* is not required.

The creation of the new Hunter New England Area Health Service occurred on 1 January 2005 that resulted in an Administrative Restructure of prior Hunter, New England and southern part of Mid North Coast Area Health Service boundaries to form the new entity which is recognised during the reporting period. To assist users of these financial statements the note 2ac details the Assets and Liabilities taken up by the new entity on 1 January 2005.

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)

Liabilities for salaries and wages, current annual leave and vesting sick leave and related on-costs are recognised and measured in respect of employees' services up to the reporting date at nominal amounts based upon the amounts expected to be paid when the liabilities are settled.

Employee benefits are dissected between the "Current" and "Non Current" components on the basis of anticipated payments for the next twelve months. This in turn is based on past trends and known resignations and retirements.

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 employee benefits to which they relate have been recognised.

ii) Non Current Annual Leave, Long Service Leave and Superannuation

Long Service Leave is measured on a short hand basis at an escalated rate of 6.95% above the salary rates immediately payable at 30 June 2005 for all employees with five or more years of service. This escalated rate takes into account measurement at present value in accordance with AASB 119 *Employee Benefits* adjusted for known wage rate increases and on costs. Non Current annual leave has been escalated by 3.4%.

Employee leave entitlements are dissected between the "Current" and "Non Current" components on the basis of anticipated payments for the next twelve months. This in turn is based on past trends and known resignations and retirements.

The Health Service's liability for superannuation 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".

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.

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.

If the effect of the time value of money is material, provisions are discounted using a pre-tax rate that reflects the current market assessments of the time value of money and the risks specific to the liability.

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

Revenue is recognised when the Health Service has control of the good or right to receive, it is virtually certain that the economic benefits will flow to the Health Service and the amounts of revenue can be measured reliably. 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 Health Service obtains control of the assets that result from them.

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 as it accrues. Rent revenue is recognised in accordance with AASB117 "Leases". Dividend revenue is recognised 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
* 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 theses 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.

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 Period from Ordinary Activities" 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 Organisations concerned. The Health Service is not deemed to own or control the various assets/liabilities of the aforementioned Health Organisations and such amounts have been excluded from the Balance Sheet. Any exceptions are specifically listed in the notes that follow.

e) 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 2003/04 activity data using standard cost weighted separation values to reflect estimated costs in 2004/05 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 4 and 10.

g) Receivables

Receivables are recognised and carried at cost, based on the original invoice amount less a provision for any uncollectible debts. An estimate for doubtful debts is made when collection of the full amount is no longer probable. Bad debts are written off as incurred.

h) 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 payment for an item 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.

i) Plant and Equipment

Individual items of plant & equipment costing $5,000 and above are capitalised.

j) 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.

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

Buildings	2.5%
Electro Medical Equipment	
- Costing less than $200,000	10.0%
- Costing more than or equal to $200,000	12.5%
Computer Equipment	20.0%
Computer Software	20.0%
Infrastructure Systems	2.5%
Office Equipment	10.0%
Plant and Machinery	10.0%
Linen	20.0%
Furniture, Fittings and Furnishings	5.0%

k) Revaluation of Property, Plant & Equipment

Physical non-current assets are valued in accordance with the NSW Health Department's "Guidelines for the Valuation of Physical Non-Current Assets at Fair Value". This policy adopts fair value in accordance with AASB116, "Property, Plant & Equipment". There is no substantive difference between the fair value valuation methodology and the previous valuation methodology adopted by the Health Services now amalgamated as the Hunter New England Area Health Service.

Where available, fair value is determined having regard to the highest and best use of the asset on the basis of current market selling prices for the same or similar assets. Where market selling price is not available, the asset's fair value is measured as its market buying price i.e. the replacement cost of the asset's remaining service potential. The Health Service is a not for profit entity with no cash generating operations.

Each class of property, plant & equipment is revalued every five years and with sufficient regularity to ensure that the carrying amount of each asset in the class 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 is separately restated.

Otherwise, 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 Period from Ordinary Activities, the increment is recognised immediately as revenue in the Result for the Period from Ordinary Activities.

Revaluation decrements are recognised immediately as expenses in the Result for the Period from Ordinary Activities, 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 the Area Health Service was only established as at 1 January 2005 no asset revaluations reserves were brought forward at that date.

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.

l) 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. For an asset already measured at fair value, impairment can only arise if selling costs are material. In most cases, selling costs are immaterial.

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 classified as 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 properties.

p) Intangible Assets

Computer software which is not integral to the related hardware is treated as an intangible asset and amortised over their useful lives.

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.

q) Maintenance and Repairs

The costs of day to day servicing costs or 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

"Other financial assets" are generally recognised at cost, with the exception of TCorp Hour Glass Facilities and Managed Fund Investments, which are measured at market value.

For non-current "other financial assets", revaluation increments and decrements are recognised in the same manner as physical non-current assets.

For current "other financial assets", revaluation increments and decrements are recognised in the Operating Statement.

u) Non Current Assets (or disposal groups) held for sale

A non-current asset (or disposal group) must be classified as held for sale where it satisfies strict criteria. Assets held for sale are measured at the lower of carrying amount and fair value less costs to sell; not depreciated; reclassified from non-current to current; and separately presented in the balance sheet. An impairment loss is recognised in profit or loss for any initial and subsequent write down from the carrying amount measured immediately before reclassification or re-measurement to fair value less costs to sell.

v) 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. 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 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 Paragraph 97.

The effect of the administrative restructure on the net assets and equity of the Hunter New England Area Health Service are detailed in Note 2ac.

w) 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 borrowings.

Information is disclosed in Note 35 in respect of the credit risk and interest rate risk of financial instruments. All such amounts are carried in the accounts at net fair value. The specific accounting policy in respect of each class of such financial instrument is stated hereunder.

Classes of instruments recorded at cost and their terms and conditions at balance date 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 5.6%.

Receivables

Accounting Policies - Receivables are recognised and carried at cost, based on the original invoice amount less a provision for any uncollectible debts. An estimate for doubtful debts is made when collection of the full amount is no longer probable. Bad debts are written off as incurred. No interest is earned on trade debtors. Accounts are issued on 30 day terms.

Trade and Other Payables

Accounting Policies - 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.

Borrowings

Accounting Policies - Loans are carried at the principal amount. Interest is charged as an expense as it accrues.

Terms and Conditions - Non interest bearing loans of $ 7.686 million are repayable in annual instalments of $ 1.5 million commencing 2006/07 with the final instalment due on 2010/11.

There are no classes of instruments which are recorded at other than cost.

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

x) 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.

y) Borrowings

All loans are valued at current capital value.

z) Trust Funds

The Health Service receives monies in a trustee capacity for various trusts as set out in Note 29. 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.

aa) Budgeted Amounts

As this is the first financial report prepared for the Hunter New England Area Health Service and the results are for part of the 2004/05 financial year beginning 1 January 2005 and ended 30 June 2005, budget comparisons have not been provided. This is due to the significant retrospective payments for awards and other supplementations for the period 1 July 2004 to 31 December 2004 that occurred after 1 January 2005. Budget comparisons for all Health Services will be included as part of the consolidated result for NSW Health Department.

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 15.

Hunter New England Area Health Service
Notes to and forming part of the Financial Statements
for the six months ended 30 June 2005

2ac - Opening Balance sheets for comparative purposes

The Area Health Service's financial statements are prepared as a new entity for the six months ended 30 June 2005 and are therefore covered by AASB101, "Presentation of Financial Statements", Financial Reporting Standards.

Under these standards a new entity would not have items in its Balance Sheet at the start of the reporting period. To assist users of these financial statements the following note details the Assets and Liabilities taken up by the new entitv on 1 Januarv 2005.

	Notes	1 January 2005 Balances (following Restructure) - for Comparative Purposes
		$000
ASSETS		
Current Assets		
Cash and Cash Equivalents	18	53,976
Receivables	19	37,275
Inventories	20	5,340
Financial Assets at Fair Value		23
Total Current Assets		**96,614**
Non-Current Assets		
Receivables	19	2,979
Property, Plant and Equipment		
- Land and Buildings	21	701,983
- Plant and Equipment	21	74,645
- Infrastructure Systems	21	26,397
Total Property, Plant and Equipment		**803,025**
Total Non-Current Assets		**806,004**
Total Assets		**902,618**
LIABILITIES		
Current Liabilities		
Payables	24	46,459
Borrowings		656
Provisions	25	62,622
Other	26	461
		110,198
Total Current Liabilities		**110,198**
Non-Current Liabilities		
Borrowings		3,838
Provisions	25	129,765
Other	26	8,182
Total Non-Current Liabilities		**141,785**
Total Liabilities		**251,983**
Net Assets		**650,635**
EQUITY		
Accumulated Funds	27	650,635
		650,635
Total Equity		**650,635**

The accompanying notes form part of these Financial Statements

	2005 $000

3. Employee Related

Employee related expenses comprise the following:

Salaries and Wages	273,942
Awards	12,615
Long Service Leave [see note 2(a)]	16,660
Annual Leave [see note 2(a)]	29,329
Nursing Agency Payments	346
Other Agency Payments	721
Workers Compensation Insurance	8,712
Superannuation [see note 2(a)]	30,393
Fringe Benefits Tax	329
Total	**373,047**

The following additional information is provided:

Maintenance staff costs included in Employee Related Expenses	4,371
Employee Related Expenses capitalised - Land and Buildings	1,946
Employee Related Expenses capitalised - Plant and Equipment	402

Note 5 further refers.

4. Goods and Services

Blood and Blood Products	2,909
Computer Related Expenses	4,380
Domestic Charges	3,280
Drug Supplies	17,790
Food Supplies	4,428
Fuel, Light and Power	3,737
General Expenses	15,414
Hospital Ambulance Transport Costs	2,963
Insurance	307
Inter Area Patient Outflows, NSW	35,182
Interstate Patient Outflows	3,519
Medical and Surgical Supplies	27,648
Postal and Telephone Costs	3,040
Printing and Stationery	1,764
Rates and Charges	621
Rental	2,278
Special Service Departments	9,592
Staff Related Costs	3,866
Sundry Operating Expenses	2,618
Travel Related Costs	4,997
Total	**150,333**

(a) Sundry Operating Expenses comprise:

Aircraft Expenses (Ambulance)	1,588
Contract for Patient Services	150
Isolated Patient Travel and Accommodation Assistance Scheme	880
Total	**2,618**

	2005 $000
(b) General Expenses include:-	
Advertising	662
Books and Magazines	356
Consultancies	
- Operating Activities	739
- Capital Works	24
Courier and Freight	830
Auditor's Remuneration - Audit of financial reports	170
Legal Expenses	540
Membership/Professional Fees	427
Management Fees	1,039
Motor Vehicle Operating Lease Expense - minimum lease payments	2,830
Other Operating Lease Expense - minimum lease payments	1,090
Payroll Services	17
Provision for Doubtful Debts	835

(c) Expenses for Inter Area Patient Flows, NSW on an Area basis are as follows:-

Children's Hospital Westmead	3,222
Greater Southern	224
Greater Western	573
North Coast	2,803
Northern Sydney Central Coast	10,716
South East Illawarra	10,241
Sydney South West	4,431
Sydney West	2,972
Total	**35,182**

(d) Expenses for Interstate Patient Flows are as follows:-

Australian Capital Territory	142
Northern Territory	54
Queensland	2,818
South Australia	87
Tasmania	50
Victoria	261
Western Australia	107
Total	**3,519**

5. Maintenance

Repairs and Routine Maintenance	9,391
Other	
Renovations and Additional Works	625
Replacements and Additional Equipment less than $5,000	4,957
Total	**14,973**

The value of Employee Related Expense (Note 3) applicable to Maintenance staff was $ 6.719 million for the six months ended 30 June 2005.

6. Depreciation and Amortisation

Depreciation - Buildings	13,711
Depreciation - Plant and Equipment	8,770
Depreciation - Infrastructure Systems	894
Total	**23,375**

		2005 $000
7. Grants and Subsidies		
Non Government Organisations		2,574
Other		659
Total		**3,233**
8. Finance Costs		
Interest on Bank Overdrafts and Loans		47
Total		**47**
9. Payments to Affiliated Health Organisations		
(a) Recurrent Sourced		
Mater Misercordiae Hospital		34,810
		34,810
(b) Capital Sourced		
Mater Misercordiae Hospital		197
		197
Total		**35,007**
10. Sale of Goods / Rendering of Services		
(a) Sale of Goods comprise the following:-		
Sale of Prosthesis		1,432
(b) Rendering of Services comprise the following:-		
Patient Fees [see note 2(d)]		37,050
Staff-Meals and Accommodation		817
Infrastructure Charge	- Monthly Facility Fees [see note 2(d)]	11,430
	- Annual Charge	3,703
Car Parking		1,387
Child Care Fees		280
Commercial Activities		2,117
Fees for Medical Records		121
Non Staff Meals		592
Linen Service Revenues - Other Health Services		763
Linen Service Revenues - Non Health Services		1,861
Recoveries Salaries & Wages		1,032
Patient Inflows from Interstate		722
Inter Area Patient Inflows, NSW		12,011
Other		5,143
Total		**80,461**

	2005 $000
10. Sale of Goods / Rendering of Services (Continued)	
(c) Revenues from Inter Area Patient Flows, NSW on an Area basis are as follows:	
Greater Southern	243
Greater Western	1,622
North Coast	4,003
Northern Sydney Central Coast	4,336
South East Illawarra	418
Sydney South West	602
Sydney West	787
Total	**12,011**
(d) Revenues from Patient Inflows from Interstate are as follows:-	
Australian Capital Territory	29
Northern Territory	35
Queensland	449
South Australia	14
Tasmania	17
Victoria	152
Western Australia	26
Total	**722**
11. Investment Income	
Interest	1,964
Lease and Rental Income	894
Dividends	11
Total	**2,869**
12. Grants and Contributions	
Clinical Drug Trials	283
Commonwealth Government grants	2,206
Industry Contributions/Donations	3,095
Mammography grants	1,928
Research grants	1,760
Other grants	1,727
Total	**10,999**
13. Other Revenue	
Other Revenue comprises the following:-	
Commissions	80
Sale of Merchandise, Old Wares and Books	19
Other	1,165
Total	**1,264**

	2005 $000
14. Gain/(Loss) on Disposal of Non Current Assets	
Property Plant and Equipment	4,647
Less Accumulated Depreciation	1,546
Written Down Value	**3,101**
Less Proceeds from Disposal	3,168
Gain/(Loss) on Disposal of Non Current Assets	**67**
15. 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:

Total Expenses	3,125
Result for the Period	**(124)**
Current Assets	
Cash & Cash Equivalents	1,019
Receivables	997
Total Current Assets	**2,016**
Non Current Assets	
Land & Buildings	97
Plant & Equipment	2,630
Total Non Current Assets	**2,727**
Total Assets	**4,743**
Current Liabilities	
Payables	69
Provisions	223
Total Current Liabilities	**292**
Non Current Liabilities	
Provisions	394
Total Non Current Liabilities	**394**
Total Liabilities	**686**
Operating lease Commitments	**908**

16. Conditions on Contributions

	Purchase of Assets	Health Promotion, Education and Research	Other	Total
	$000	**$000**	**$000**	**$000**
Contributions recognised as revenues during the current reporting period for which expenditure in the manner specified had not occurred as at balance date	676	6,645	1,376	**8,697**
Contributions recognised in amalgamated balance as at 1 January 2005 which were not expended in the current reporting period	3,223	18,205	4,520	**25,948**
Total amount of unexpended contributions as at balance date	**3,899**	**24,850**	**5,896**	**34,645**

Comment on restricted assets appears in Note 23

17 Programs/Activities of the Health Service

Program 1.1 - Primary and Community Based Services

Objective: To improve, maintain or restore health through health promotion, early intervention, assessment, therapy and treatment services for clients in a home or community setting.

Program 1.2 - Aboriginal Health Services

Objective: To raise the health status of Aborigines and to promote a healthy life style.

Program 1.3 - Outpatient Services

Objective: To improve, maintain or restore health through diagnosis, therapy, education and treatment services for ambulant patients in a hospital setting.

Program 2.1 - Emergency Services

Objective: To reduce the risk of premature death and disability for people suffering injury or acute illness by providing timely emergency diagnostic, treatment and transport services.

Program 2.2 - Overnight Acute Inpatient Services

Objective: To restore or improve health and manage risks of illness, injury and childbirth through diagnosis and treatment for people intended to be admitted to hospital on an overnight basis.

Program 2.3 - Same Day Acute Inpatient Services

Objective: To restore or improve health and manage risks of illness, injury and childbirth through diagnosis and treatment for people intended to be admitted to hospital and discharged on the same day.

Program 3.1 - Mental Health Services

Objective: To improve the health, well being and social functioning of people with disabling mental disorders and to reduce the incidence of suicide, mental health problems and mental disorders in the community.

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.

		30 June 2005 $000
18. Current Assets - Cash and Cash Equivalents		
Cash at bank and on hand		11,298
Short Term Deposits		53,000
		64,298
Cash and Cash Equivalents assets recognised in the Balance Sheet are reconciled to cash at the end of the financial period as shown in the Cash Flow Statement as follows:		
Cash and cash equivalents (per Balance Sheet)		64,298
Closing Cash and Cash Equivalents (per Cash Flow Statement)		**64,298**
19. Current/Non Current Receivables		
Current		
(a) Sale of Goods and Services		6,894
Leave Mobility		5,161
NSW Health Department		11,781
Debtors GST		4,960
Other User Charges		1,836
Intra Health User Charges		1,925
Expense / Payments		964
Other Debtors		6,996
Sub Total		40,517
Less Allowance for impairment		(983)
Sub Total		39,534
Prepayments		1,679
		41,213
(b) Bad debts written off during the reporting period - Current Receivables	- Sale of Goods and Services	517
	- Other	87
		604
Non Current		
(a) Sale of Goods and Services		284
Leave Mobility		2,730
Sub Total		3,014
Less Allowance for impairment		(203)
Total		2,811
(b) Bad debts written off during the reporting period - Non Current Receivables	- Sale of Goods and Services	33
		33
(c) Sale of Goods and Services includes	Patient Fees - Compensable	1,382
	Patient Fees - Ineligible	113
	Patient Fees - Other	5,684

	30 June 2005 $000
20. Inventories	
Current - at cost	
Drugs	2,365
Medical and Surgical Supplies	2,426
Food and Hotel Supplies	279
Engineering Supplies	206
Other including Goods in Transit	111
	5,387
21. Property, Plant and Equipment	
Land and Buildings	
At Fair Value	1,344,829
Less Accumulated depreciation and impairment	538,480
	806,349
Plant and Equipment	
At Fair Value	182,161
Less Accumulated depreciation and impairment	106,050
	76,111
Infrastructure Systems	
At Fair Value	95,198
Less Accumulated depreciation and impairment	42,486
	52,712
Total Property, Plant and Equipment At Net Carrying Value	**935,172**

21. Property, Plant and Equipment - Reconciliations

	Land	Buildings	Work in Progress	Infrastructure Systems	Plant and Equipment	Total
	$000	$000	$000	$000	$000	$000
2005						
Carrying amount at 1 January 2005	-	-	-	-	-	**-**
Amount transferred on 1 January 2005 from Administrative Restructure of Health Services	52,434	605,038	44,511	26,397	74,645	**803,025**
Additions	-	994	38,023	31	8,256	**47,304**
Assets held for sale	(3,315)	(114)	-	-	-	**(3,429)**
Disposals	(1,950)	(166)	-	-	(985)	**(3,101)**
Net revaluation increment less revaluation decrements	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 reporting period	**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(h)].

(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(k)]. Global Valuation Services Pty Ltd is not an employee of the Health Service.

	30 June 2005 $000
22. Non Current Assets (or disposal groups) held for sale	
Assets held for sale	
Land and Buildings	3,429
	3,429
Amounts recognised in equity relating to assets held for sale	
Available for sale financial asset revaluation increments/decrements	691
	691

Land & Buildings held for sale are;
- Dudley, Old Nursing Home
- Taree, Lot 1 Kanagra Drive
- Waratah, Orthopaedic School
- Walcha, Lot 31 & 32 Legge Street

These properties are 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 the assets are available for immediate sale.

23. Restricted Assets

The Health Service's financial statements include the following assets which are restricted by externally imposed conditions, eg. Donor requirements. The asset are only available for application in accordance with the terms of the donor restrictions.

Category	**Brief Details of Externally Imposed Conditions including Asset Category affected**	
Specific Purposes	Condition imposed by the donor	3,529
Perpetually Invested Funds	Original Principal not to be spent	96
Research Grants	Condition imposed by the granting body	11,139
Private Practice Funds	Trust Deed	13,615
Other	Condition imposed by the donor	6,266
		34,645

24. Payables

Current	
Accrued Salaries and Wages	19,603
Payroll Deductions	4,764
Trade Creditors	24,643
Other Creditors	
- Capital Works	86
- Other	14,571
	63,667

	30 June 2005 $000
25. Provisions	
Current Employee benefits and related on-costs	
Employee Annual Leave	51,758
Employee Long Service Leave	13,955
Total Current Provisions	**65,713**
Non Current Employee benefits and related on-costs	
Employee Annual Leave	22,575
Employee Long Service Leave	120,077
Total Non Current Provisions	**142,652**
Aggregate Employee Benefits and Related On-costs	
Provisions - current	65,713
Provisions - non-current	142,652
Accrued Salaries and Wages and on costs (Note 24)	24,367
	232,732
26. Other Liabilities	
Current	
Income in Advance	267
	267
Non Current	
Income in Advance	465
Other	7,686
	8,151

The majority of the income in advance relates to monies originally received from Armidale Private Hospital and the balance at 30th June was $0.480 million. The other major components of the income in advance relates to income from Clinical Drug Trials of $0.064 million, Child Care Fees of $0.019 million & Nursing Home Fees of $0.041 million.

Agreement has been reached with the Department of Health for the repayment of $7.686 million in non interest bearing loans. The loan, first established in 1991/92, will be extinguished over 5 years commencing 2006/07 at the rate of $1.5 million per annum with the last repayment in 2010/11 at $1.686 million.

27. Equity

	Accumulated Funds	Asset Revaluation Reserve	Available for sale reserves	Total Equity
	30 June 2005 $000	30 June 2005 $000	30 June 2005 $000	30 June 2005 $000
Balance at the beginning of the financial reporting period	-	-	-	-
Changes in equity - transactions with owners as owners				
Amount transferred on 1 January 2005 from Administrative Restructure of Health Services	650,635	-	-	650,635
Total	650,635	-	-	650,635
Changes in equity - other than transactions with owners as owners				
Result for the reporting period	6,477	-	-	6,477
Increment/(Decrement) on revaluation of:				
Land and Buildings	-	87,892	691	88,583
Infrastructure Systems	-	26,165	-	26,165
Total	6,477	114,057	691	121,225
Transfers within equity				
Asset revaluation reserve balances transferred to accumulated funds on disposal of asset	1,067	(1,067)	-	-
Total	1,067	(1,067)	-	-
Balance at the end of the financial reporting period	658,179	112,990	691	771,860

The asset revaluation reserve is used to record increments and decrements on the revaluation of non current assets. This accords with Health Service's policy on the "Revaluation of Physical Non Current Assets" and "Investments", as discussed in Note 2(k).

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28. Commitments for Expenditure

	30 June 2005 $000
(a) Capital Commitments	
Aggregate capital expenditure contracted for at balance date but not provided for in the accounts:	
Not later than one year	32,374
Later than one year and not later than five years	1,375
Later than five years	132
Total Capital Expenditure Commitments (including GST)	**33,881**

Of the commitments reported at 30 June 2005 it is expected that $ 0.308 million will be met from locally generated moneys.

(b) Operating Lease Commitments	
Future non-cancellable operating lease rentals not provided for and payable:	
Not later than one year	6,012
Later than one year and not later than five years	5,643
Later than five years	25
Total Operating Lease Commitments (including GST)	**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 $ 4.142 million that are expected to be recoverable from the Australian Taxation Office.

29 Trust Funds

The Health Service holds trust fund moneys of $ 2.999 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
	30 June 2005 $000	30 June 2005 $000	30 June 2005 $000
Cash Balance at the beginning of the financial reporting period	-	-	-
Amount transferred on 1 January 2005 from Administrative Restructure of Health Services	715	240	2,876
Receipts	1,356	249	14,426
Expenditure	792	252	15,819
Cash Balance at the end of the financial reporting period	**1,279**	**237**	**1,483**

30. 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 30th June 2005 number 91 with an estimated value of $29.5 million (101 claims with a estimated value of $32.9 million at 1 January 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. In regard to workers compensation the final hindsight adjustment for the 1998/99 fund year and an interim adjustment for the 2000/2001 fund year were not calculated until 2004/05. As a result, the 1999/2000 final and 2001/02 interim hindsight calculations will be paid in 2005/06.

c) Affiliated Health Organisations

Based on the definition of control in Australian Accounting Standard AASB 127, 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.

31 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
Raffles	25	-	-	25
Functions	48	-	-	48
	73	-	-	73
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
Held in Special Purpose & Trust Fund Pending Purchase	73
	73

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.

	2005 $000
32. Reconciliation Of Net Cost Of Services To Net Cash Flows from Operating Activities	
Net Cash Flows from Operating Activities	58,815
Depreciation	(23,375)
Provision for Doubtful Debts	(198)
Acceptance by the Crown Entity of Employee Superannuation Benefits	(30,393)
(Increase)/ Decrease in Provisions	(15,978)
Increase / (Decrease) in Prepayments and Other Assets	(4,080)
(Increase)/ Decrease in Creditors	(16,984)
Net Gain/ (Loss) on Disposal of Property, Plant and Equipment	67
(NSW Health Department Recurrent Allocations)	(464,624)
(NSW Health Department Capital Allocations)	(34,292)
Net Cost of Services	**(531,042)**

33. 2004/05 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

34 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.

35. 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. 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:

		Fixed interest rate maturing in:					
Financial Instruments	Floating interest rate	I year or less	Over 1 to 5 years	More than 5 years	Non-interest bearing	Total carrying amount as per the Statement of Financial Position	
	30 June 2005 $000	30 June 2005 $000	30 June 2005 $000	30 June 2005 $000	30 June 2005 $000	30 June 2005 $000	30 June 2005 %
Financial Assets							
Cash	11,222	53,000	-	-	76	64,298	5.6%
Receivables	-	-	-	-	44,024	44,024	-
Total Financial Assets	11,222	53,000	-	-	44,100	108,322	
Financial Liabilities							
Payables	-	-	-	-	63,667	63,667	-
Other	-	-	-	-	7,686	7,686	-
Total Financial Liabilities	-	-	-	-	71,353	71,353	

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

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 maximum 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
	30 June 2005 $000	30 June 2005 $000	30 June 2005 $000	30 June 2005 $000	30 June 2005 $000
Financial Assets					
Cash	76	64,222	-	-	64,298
Receivables	21,597	-	6,386	16,041	44,024
Total Financial Assets	21,673	64,222	6,386	16,041	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 $ 0.113 million at balance date.

c) Net Fair Value

As stated in Note 2(w) financial instruments are carried at cost and the resultant values are reported in the Statement of Financial Position and are deemed to constitute net fair value.

d) Derivative Financial Instruments

The Hunter New England Area Health Service 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.