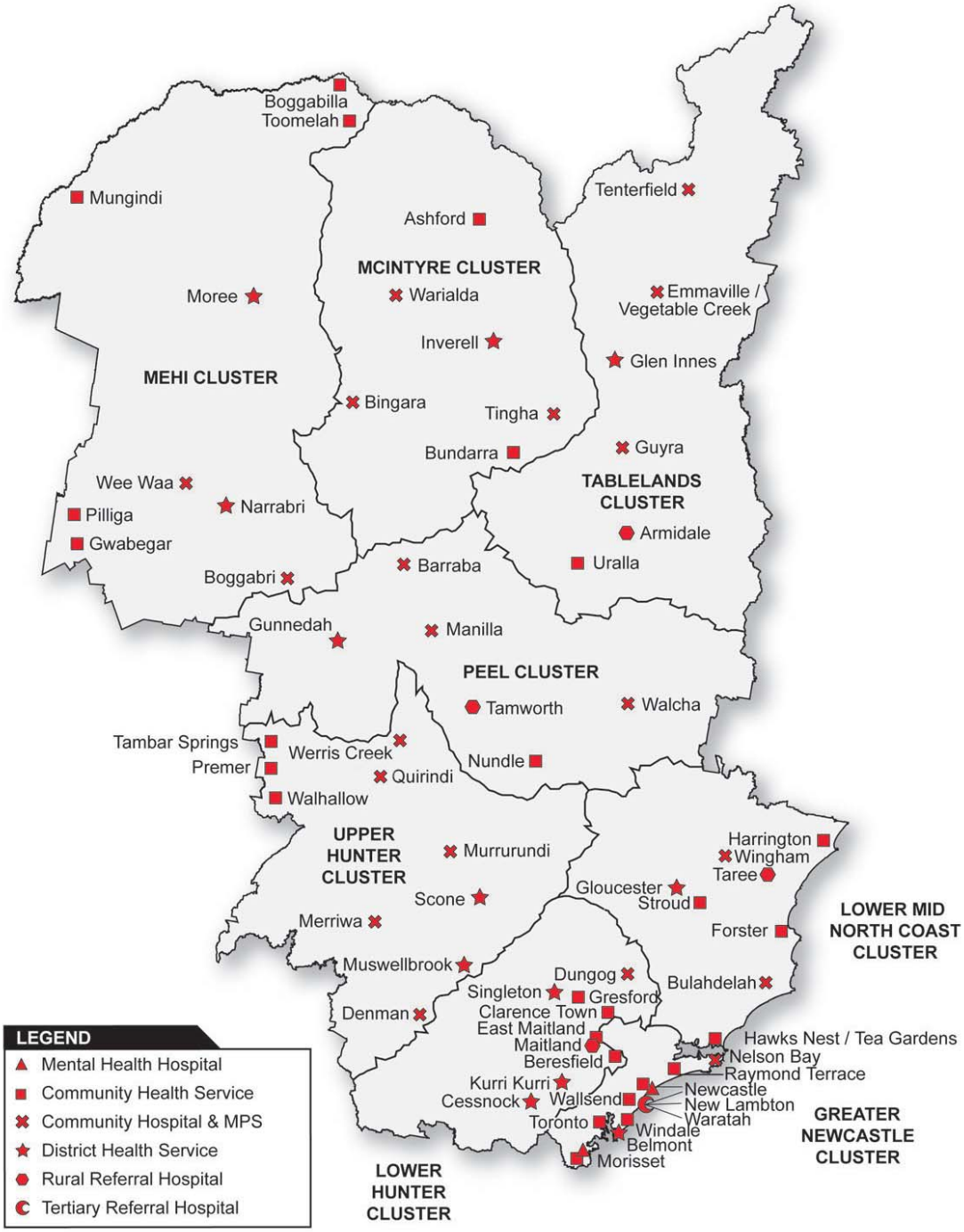
Hunter New England Area Health Service

Annual Report 2007/2008

HUNTER NEW ENGLAND | NSW HEALTH

Map of Hunter New England Health



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All Hunter New England Health hospitals are open 24 hours

Letter to the Minister

November 2008

Professor Debora Picone
Director General
NSW Department of Health
73 Miller Street
NORTH SYDNEY NSW 2060

Dear Professor Picone

I have pleasure in submitting the Hunter New England Area Health Service 2007/08 Annual Report.

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

Dr Nigel Lyons
CHIEF EXECUTIVE

Contents

Highlights and achievements

- Contributed to the reduction of alcohol-related crime in NSW through the implementation of the Alcohol Linking Program.
- Improved access to clinical information and specialist consultations by securing $3 million in funding to provide online access to patient imaging records.
- Opened a $36 million building to house Newcastle Community Health Centre, bringing a comprehensive range of services together on one site.
- Implemented a cultural respect training program to increase the appropriateness and effectiveness of services for the Aboriginal and Torres Strait Islander population; and increase the cultural safety of work sites for Aboriginal and Torres Strait Islander staff.
- Approval received to construct a $8.91 million non-acute mental health facility to provide intensive, short-term rehabilitation for mental health clients on the James Fletcher Campus in Newcastle.
- Partnered University of New England and the University of Newcastle to launch the Joint Medical Program, aimed at addressing the rural and regional medical workforce shortage by providing rural-based medical education for the majority of the Bachelor of Medicine degree.
- Signed a Memorandum of Understanding with Pius X Aboriginal Corporation and the communities of Toomelah and Boggabilla to bring about improved health services to these communities.
- Completed a $10 million project to install air-conditioning in 15 wards of John Hunter Hospital in Newcastle.
- Launched the Rural Stroke Project to the Peel and Mehi Clusters to provide patients with improved access to specialised treatment and education.
- Launched the Hunter New England Aboriginal Health Partnership Strategic Plan 2007-2011.
- Implemented the Aboriginal Employment Strategy 2008-2011.
- Implemented a framework for a multidisciplinary approach supporting adults managing obesity.
- Officially opened the Moree District Health Service Emergency Department.
- Introduced a range of new programs to improve provision of oral health care to children.
- Scored the highest rating for overall patient care in the state in the 2007 NSW Health Patient Survey.
- Moved services from the 99-year-old Tingha Community Hospital building into a new Multi Purpose Service facility.
- Launched the second phase of Australia's largest ever obesity prevention trial – 'Good for Kids, Good for Life' – focussing on encouraging children aged 0-15 years to get active.
- Commenced site works for the redevelopment of Narrabri District Health Service.
- Winner of the 2007 NSW Minister for Health's Award for Aboriginal Health in recognition of our dedication to improving the health of Aboriginal and Torres Strait Islander people.
- Joint winner of the 2007 Prime Minister's Award for Employer of the Year (Large Employer), and national Employer of the Year, for dedication and innovation in the recruitment and retention of staff with a disability.
- Winner of the NSW Minister for Health's Excellence Award for 'Setting them up to succeed' – a program to support International Medical Graduates. This project also took out the Build a Sustainable Health Workforce category.
- Winner of the Clinical Excellence Commission Award for Improvement in Patient Safety for 'Pre-hospital Acute Stroke Triage' – a project with the NSW Ambulance Service to improve outcomes for stroke patients.
- Winner of the NSW Health Hospital Performance Award for Best Performance 2006/2007 Smaller Rural District Hospitals – awarded to Narrabri Hospital.
- Winner of five awards at the 2007 Premier's Public Sector Awards.
- Winner of the 2007 Treasury Managed Fund Risk Management Award for Integrating Risk Management into Organisational Planning.

2007-2008 Snapshot

Population we care for	852,655
Number of people cared for in our emergency departments	361,718
Episodes of care delivered in a hospital setting	186,610
Average length of stay for acute hospital patients (including same day admissions)	3.8 days
Percentage of admissions for same day care (percentage of total admissions)	39.4 per cent
Non-admitted patient services (includes community health and emergency)	2,635,932
Number of babies born	8,759
Percentage of children in the Hunter New England Health region fully immunised at one year (90 per cent NSW)	93 per cent

Message from the Chief Executive

Hunter New England Health is committed to building healthier communities by delivering excellence in healthcare.

During the past year, our skilled and dedicated employees continued their hard work and commitment to providing high quality, safe patient care and improving the health of the people in our communities.

We launched the second phase of Australia's largest ever obesity prevention trial 'Good for Kids, Good for Life', and implemented a framework to provide a multidisciplinary approach to support adults managing obesity and morbid obesity.

Several communities benefited from the completion of major capital works. These included a $10 million project to install air-conditioning at John Hunter Hospital in Newcastle, and two projects to provide local communities with modern integrated health services – a new Multi Purpose Service facility at Tingha and a new $36 million building to house Newcastle Community Health Centre.

We also officially opened the redeveloped Moree District Health Service Emergency Department to provide emergency services to local people in an improved and modern environment.

The redevelopment of Narrabri District Health Service to meet the needs of the community and surrounding region into the future got underway with the commencement of early site works, and we obtained approval to construct a new $8.91 million non-acute mental health facility on the James Fletcher Campus in Newcastle.

We implemented several significant strategies directly aimed at improving the health outcomes and employment opportunities of our Aboriginal and Torres Strait Islander communities and staff. Details of these initiatives are outlined in other sections of this report.

We partnered with the University of New England and the University of Newcastle to launch the Joint Medical Program, with new university medical school places aimed at addressing the medical workforce shortage in rural and regional Australia.

As well, in the interest of providing patients in rural communities with more timely access to specialised stroke treatment and greater access to stroke education, we launched a Rural Stroke Project in the Peel and Mehi Clusters.

This year, as well as winning almost a dozen reputable awards recognising our dedication and innovative approaches to improving health care, Hunter New England Health scored the highest rating for overall patient care of any Area Health Service in the state in the 2007 NSW Health Patient Survey. These results are a credit to our skilled, hard-working and valued staff and evidence of their caring attitude and ongoing dedication to excellence in health care.

This Annual Report provides an overview of the significant work and achievements made by Hunter New England Health during 2007-2008. It also outlines the challenges that we as an organisation are committed to working together with our communities to resolve.

Through our quality people, core values, robust systems, strong partnerships and ongoing sound financial management, we expect to continue these outstanding results for our communities in 2008/2009.

Dr Nigel Lyons
Chief Executive
Hunter New England Health

SECTION 1 - Profile, purpose and goals

Health Service profile

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:

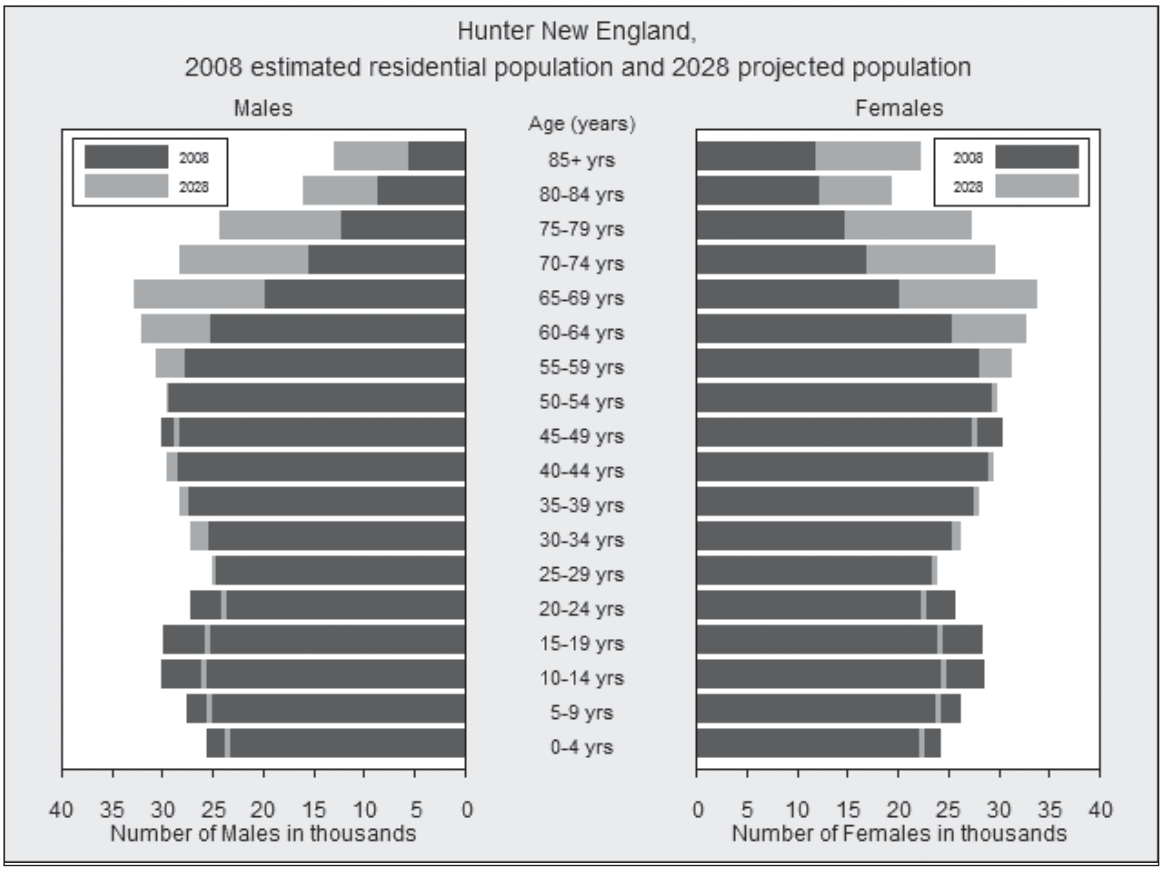
- approximately 14,500 staff (or approx. 10,884 Full Time Equivalents)
- about 1500 medical officers
- more than 1600 volunteers
- an Area Administration office in Newcastle and a Regional Office in Tamworth
- public hospitals/health facilities at: Armidale, Barraba, Belmont, Bingara, Boggabri, Bulahdelah, Cessnock, Denman, Dungog, Glen Innes, Gloucester, Gunnedah, Guyra, Inverell, Newcastle (James Fletcher), New Lambton (John Hunter, John Hunter Children's and Royal Newcastle Centre), Kurri Kurri, Maitland, Manilla, Merriwa, Moree, Morisset, Murrurundi (Wilson Memorial), Muswellbrook, Narrabri, Nelson Bay (Tomaree), Quirindi, Scone (Scott Memorial), Singleton, Taree (Manning), Tamworth, Tenterfield (Prince Albert Memorial), Tingha, Vegetable Creek (Emmaville), Walcha, Waratah (Calvary Mater Newcastle) Warialda, Wee Waa, Werris Creek, and Wingham.
- 57 Community Health Centres

Hunter New England is an area of more than 130,000 square kilometres, 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 the second busiest harbour on the east coast situated at Newcastle
- is the largest coal exporting port in the world

Hunter New England Health's population:

- The Australian Bureau of Statistics has estimated the mid-2008 population of the Hunter New England Health area at 852,655, approximately 12.3 per cent of the population of NSW
- The population is widely distributed across the Area: from a densely populated coastal zone to small rural townships with declining populations
- Modest population growth is projected - 0.55 per cent per annum over the next 10 years (compared with 0.83 per cent in NSW) reaching 900,655 in 2018 and at 0.54 per cent per annum over the next 20 years (compared with 0.77 per cent in NSW) reaching 949,654 in 2028
- The main areas of population growth are the Great Lakes, Port Stephens and Maitland LGAs.
- The Hunter New England Health area Aboriginal and Torres Strait Islander population was 32,889 people as at 30 June 2006. This number represented 22.2 per cent of the state's Aboriginal and Torres Strait Islander population, and 3.9 per cent of the Hunter New England Health population
- There is a high proportion of older people in the Hunter New England Health area - 16.3 per cent aged 65 years and older compared with 13.9 per cent for NSW in year 2008.
- The highest concentrations of people speaking a language other than English are in the Newcastle Local Government Area where they make up nearly 7.2 per cent of the population.
- Newly arrived refugees are increasing in number across the Area. In the past two years about 100 refugees on the VISA 200 and 202 have been settled in Newcastle. These refugees are exclusively from African nations such as The Sudan, Ivory Coast, Burundi, Sierra Leone and Mauritania. The refugee families which have been settled in Tamworth, Armidale and Inverell have come also from African nations. They have been sponsored by local residents or have moved into the area to gain employment.
- Socio-economic disadvantage is spread across the area, particularly where there are pockets of high Aboriginal populations and/or high public housing/low employment areas. The most disadvantaged local government areas (according to Socio Economic Indexes For Areas (SEIFA): provided by ABS) in the Hunter New England Health area are: Inverell, Tenterfield, Glen Innes Severn, Guyra, Liverpool Plains, Gunnedah, Moree Plains, Cessnock and Greater Taree.
- According to the Australian Bureau of Statistics, the mid-2008 population of the Hunter New England Health area aged less than 16 years is 20.5 per cent compared with 20.3 per cent for NSW



Health network

Area Health Clusters

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 determine its boundaries. (See Area Health Service map on inside front cover.)

Mehi Cluster
Covering the local government 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 as 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.

A relationship exists between Murrurundi and Quirindi with a visiting GP service and links with Muswellbrook for access to specialist community-based services. There is a strong relationship between Muswellbrook, Murrurundi, Scone, Denman and Merriwa for service delivery.

Lower Hunter
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. The upper and lower ends of this cluster change to be more rural in nature and programs are modified as required to meet those population requirements.

Acute Hospital Networks

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 the 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, The Royal Newcastle Centre, John Hunter Children's Hospital, Belmont Hospital and the Calvary Mater Newcastle.

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

The Royal Newcastle Centre is located on the Rankin Park campus next to John Hunter Hospital. It includes procedure rooms, consulting rooms for a wide range of ambulatory care (outpatient) services, operating rooms, overnight and day wards. The Royal Newcastle Centre provides treatment for patients in specialities such as orthopaedics, orthopaedic rehabilitation, rheumatology, urology, ophthalmology, dermatology, diabetes, immunology and podiatry. Other clinical services include medical and surgical outpatients, cardiac catheterisation, endoscopy, diagnostic radiology, pathology testing, surgical services, interventional procedures and the Hunter Integrated Pain Service.

John Hunter Children's Hospital (JHCH) is the flagship of Kaleidoscope, an integrated Hunter wide child health service that links a range of community and hospital based services. JHCH is one of three designated Children's Hospitals in NSW and is the hub of one of three training networks for the NSW Institute of Medical Education and Training. The 115-bed facility provides care for those aged from birth (sometimes from 23 weeks gestation) to 18 years throughout Hunter New England Health and other parts of northern New South Wales. Tertiary services at JHCH are provided by specialist paediatric medical, nursing and allied health staff and also by specialists who provide services to adults and children. Services include a Neonatal Intensive Care Unit, general paediatrics and tertiary services, surgery and trauma, adolescent and day stay facilities as well as a comprehensive outpatient service and a school. Community based services are diverse and provide the full range of primary, secondary and tertiary health care for children, young people and families.

Belmont Hospital is a designated medical and surgical district hospital. The hospital provides a range of health care services to the population of Lake Macquarie including general medicine, general surgery, day surgery, coronary care, gynaecology and emergency services. Allied health services are also provided to inpatients when required.

Calvary Mater Newcastle is an affiliated health care organisation owned by Little Company of Mary Health Care Limited. 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. It also has a 24-hour emergency department. Calvary Mater Newcastle is a teaching hospital affiliated with the University of Newcastle.

Maitland Acute Hospital Network

The Maitland Hospital is a rural referral hospital that provides services for the Lower and Upper Hunter communities. Services include emergency, maternal and child health, medical, surgical, and rehabilitation services. Several on-site services such as mental health, dental, dialysis and diagnostic services are centrally managed. The hospital, located approximately 35 minutes from Newcastle, has approximately 150 inpatient beds, four operating theatres, five birthing units and an eight-bed high dependency/coronary care unit.

Manning Acute Hospital Network

Manning Hospital, Taree, is a rural referral hospital that provides a range of services including 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

Incorporating Tamworth Hospital and Armidale Hospital.

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

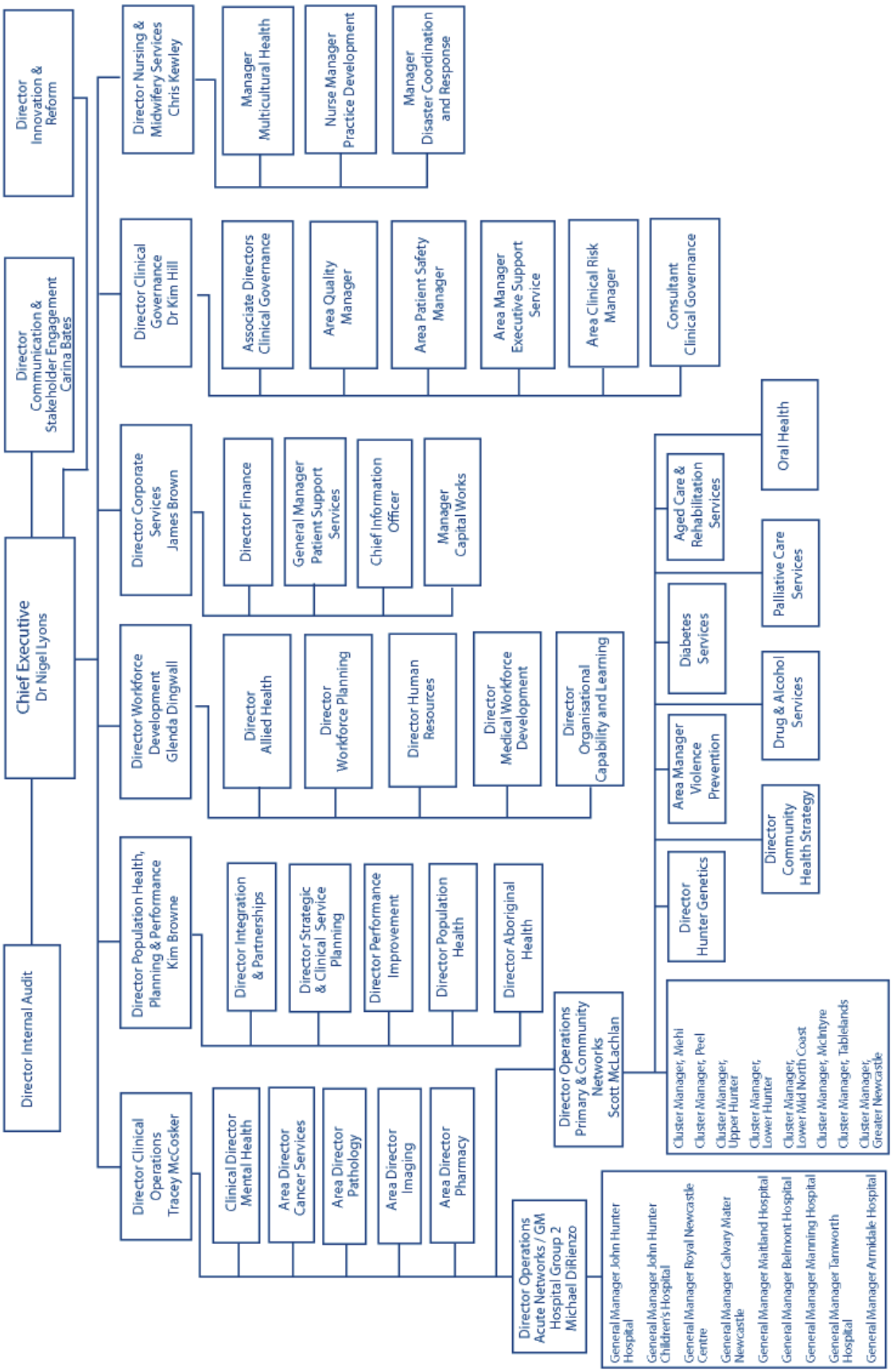
Armidale Hospital is a rural referral hospital that provides a range of services including general medicine, surgery, obstetrics and gynaecology, paediatric, geriatric, anaesthetics and intensive care, dental, mental health and emergency services.

Area Clinical Networks

In addition to the geographic clusters and acute hospital networks, Hunter New England Health has established and continues to develop a number of Area Clinical Networks and Streams.

Area clinical networks and streams are designed to improve co-ordination of service delivery and build staff capacity across the area to ensure equitable provision of high quality, clinically effective care. Area Clinical Networks and streams shift the emphasis from separate institutions to a system of integrated care for the consumer. Hunter New England Health's Children's, Young Persons and Family network, which consists of six streams including Newborn Services, Paediatric Surgery and Trauma, Tertiary Paediatrics, General Paediatrics, Violence Prevention and Child and Family is an example of how Area Clinical Networks will deliver services across the area.

Organisational structure



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 work 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.

Purpose, goals and strategic direction

Hunter New England Health working towards seven strategic directions

Hunter New England Health is committed to the seven strategic directions identified by NSW Health to guide the development and delivery of health services.

The seven strategic directions are:

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

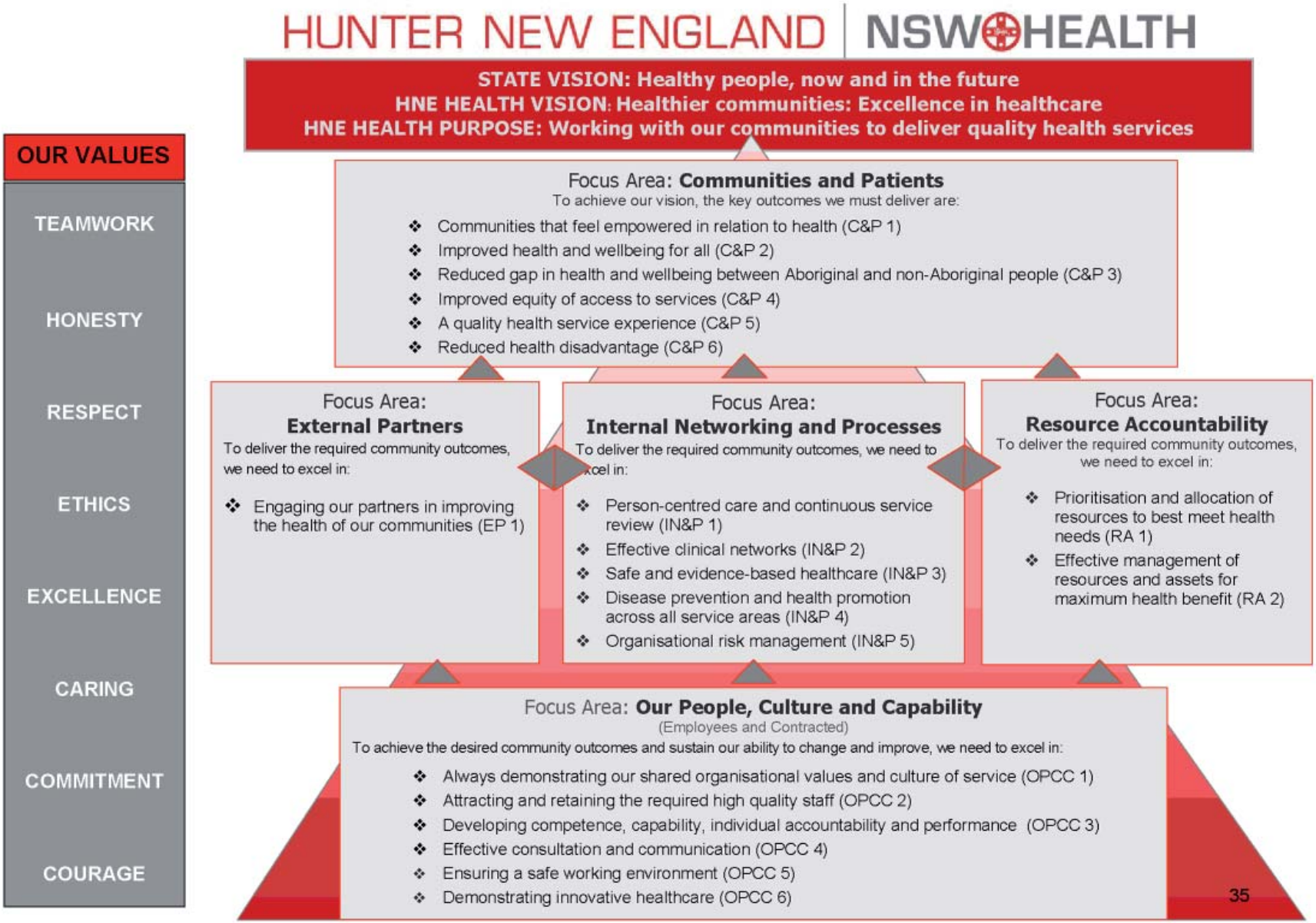
We are working towards achieving the seven strategic directions through the implementation of the Hunter New England Health Strategic Plan, which reflects priorities identified in the NSW State Plan and is closely aligned to the NSW State Health Plan.

Our plan outlines the specific initiatives we will undertake to achieve our vision of Healthier communities: Excellence in healthcare.

Our vision, purpose, key focus areas and strategic objectives are presented in the strategy map on the following page. Our key focus areas are those areas that we consider are critical to achieving our vision. For each key focus area, strategic objectives are identified to ensure the area remains focused on the most important issues and needs.

Hunter New England Health's strategic objectives are grouped into five focus areas:

- Communities and patients (C&P)
- External Partners (EP)
- Internal Networking and Processes (IN&P)
- Resource Accountability (RA)
- Our People, Culture and Capability (OPCC)


HUNTER NEW ENGLAND | NSW HEALTH
STATE VISION: Healthy people, now and in the future
HNE HEALTH VISION: Healthier communities: Excellence in healthcare
HNE HEALTH PURPOSE: Working with our communities to deliver quality health services
OUR VALUES
TEAMWORK
HONESTY
RESPECT
ETHICS
EXCELLENCE
CARING
COMMITMENT
COURAGE
Focus Area: Communities and Patients
To achieve our vision, the key outcomes we must deliver are:
Communities that feel empowered in relation to health (C&P 1)
Improved health and wellbeing for all (C&P 2)
Reduced gap in health and wellbeing between Aboriginal and non-Aboriginal people (C&P 3)
Improved equity of access to services (C&P 4)
A quality health service experience (C&P 5)
Reduced health disadvantage (C&P 6)
Focus Area: External Partners
To deliver the required community outcomes, we need to excel in:
Engaging our partners in improving the health of our communities (EP 1)
Focus Area: Internal Networking and Processes
To deliver the required community outcomes, we need to excel in:
Person-centred care and continuous service review (IN&P 1)
Effective clinical networks (IN&P 2)
Safe and evidence-based healthcare (IN&P 3)
Disease prevention and health promotion across all service areas (IN&P 4)
Organisational risk management (IN&P 5)
Focus Area: Resource Accountability
To deliver the required community outcomes, we need to excel in:
Prioritisation and allocation of resources to best meet health needs (RA 1)
Effective management of resources and assets for maximum health benefit (RA 2)
Focus Area: Our People, Culture and Capability
(Employees and Contracted)
To achieve the desired community outcomes and sustain our ability to change and improve, we need to excel in:
Always demonstrating our shared organisational values and culture of service (OPCC 1)
Attracting and retaining the required high quality staff (OPCC 2)
Developing competence, capability, individual accountability and performance (OPCC 3)
Effective consultation and communication (OPCC 4)
Ensuring a safe working environment (OPCC 5)
Demonstrating innovative healthcare (OPCC 6)
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SECTION 2 - Performance Summary

Strategic Direction 1: Make prevention everybody's business

Performance indicator: Chronic disease risk factors

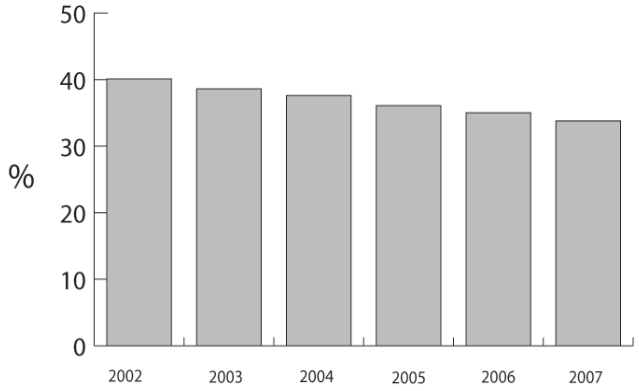
Desired outcome: Reduced prevalence of chronic diseases in adults.

Overall context: The NSW Health Survey includes a set of standardised questions to measure health behaviours.

Alcohol

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

Alcohol - risk drinking behaviour (%)



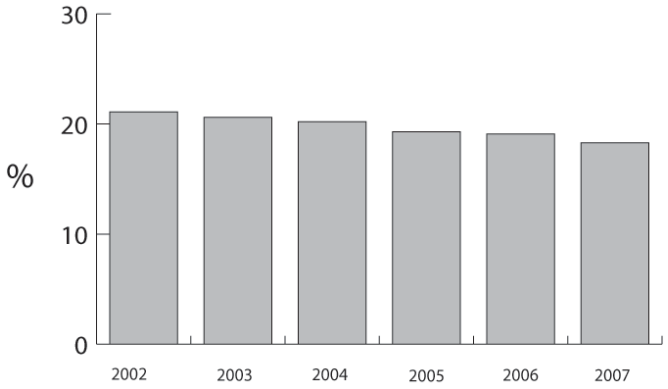
Interpretation: There has been a continued decrease in the number of HNE adults reporting 'at risk' drinking behaviour, dropping from 46 percent in 1997 to 33.8 percent in 2007.

Future initiatives: HNE Health will continue its enhancement of alcohol counselling services, and the implementation of community prevention initiatives including primary prevention initiatives in secondary schools in collaboration with the Department of Education and Training, initiatives in collaboration with NSW Police, and the implementation of enhanced screening and risk management procedures for all patients and clients of Hunter New England Health.

Smoking

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

Smoking - daily or occasionally (%)



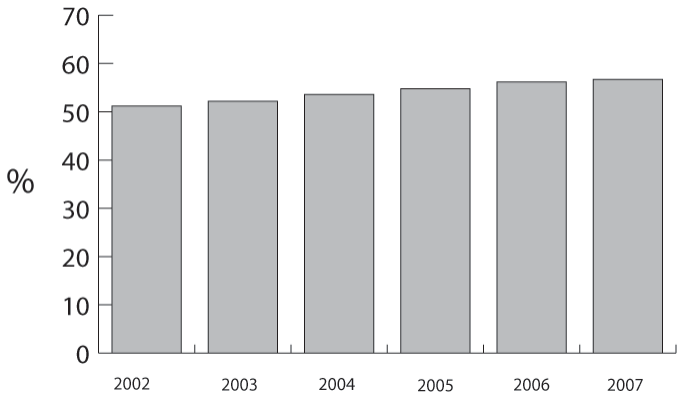
Interpretation: Between 1997 and 2007, the prevalence of daily or occasional smoking among the Hunter New England population has decreased from 24 percent to 18.3 percent.

Future initiatives: Hunter New England Health continues to monitor compliance of the Smoke Free health service policy, introduced in October 2006. 84 percent of inpatients were offered Nicotine Replacement Treatment (NRT) and 500 staff who smoked took up the offer of NRT.

Overweight and obese

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

Overweight or obese (%)



Interpretation: The percentage of overweight or obese people in the Hunter New England region has increased, from 51 percent in 2002 to 56.7 percent in 2007. This is in line with State and national trends of increasing overweight and obesity.

Future initiatives: Hunter New England Health has developed and endorsed a Framework to Support Adults Managing Obesity and Morbid Obesity. 2008/09 initiatives include developing a budget and implementation plan for the introduction of bariatric surgery and weight management clinics. Hunter New England Health also continues to implement the Good For Kids Good For Life program, aimed at preventing children aged 0-15 years from becoming overweight or obese. This program has the potential to impact adult obesity when these children become adults. The program also focuses on parental behaviours.

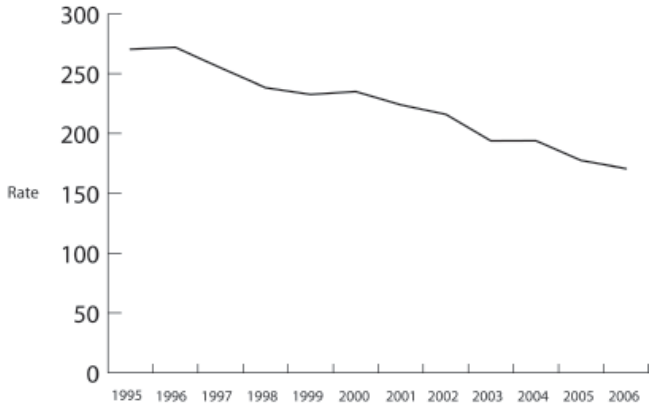
Hunter New England Health has established an Area Prevention Taskforce chaired by the Chief Executive. The purpose of the taskforce is to oversee the implementation of strategies to facilitate the delivery of preventative care on a routine basis by all Hunter New England Health clinicians.

Performance indicator: Potentially avoidable deaths

Desired outcome: Increased life expectancy.

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

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



Interpretation: The rate of potentially avoidable premature deaths has improved consistently over the period 1995 – 2006, dropping from 270.4 per 100,000 population to 170.7.

Future initiatives: Hunter New England Health is working to increase the focus on disease prevention and health promotion through servicing and resourcing strategies. The health service will:

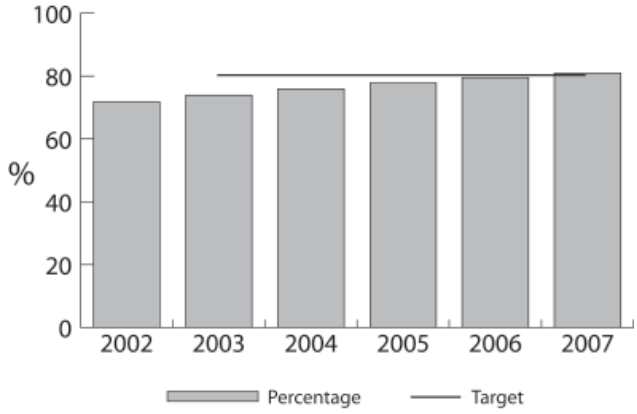
- Develop strategies to address socio-economic causes of ill health, especially for disadvantaged groups and those from culturally and linguistically diverse backgrounds;
- Participate in intersectorial programs and activities that contribute to improved health and wellbeing, for example environmental initiatives and social impact assessments;
- Complete the following Innovation and Reform Projects, including the implementation of solutions: Booked Surgical Patient Journey; Aboriginal Children and Families Project; Patient Co-Design, Manning and John Hunter Emergency Departments; and the Avoidable Admissions Project.

Performance indicator: Adult immunisation

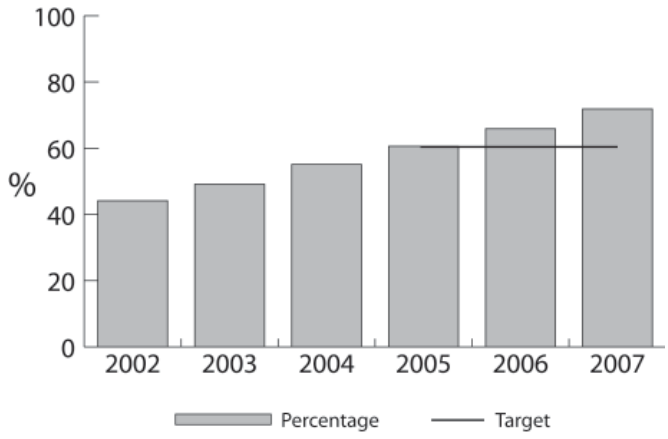
Desired outcome: Reduced illness and death from vaccine-preventable diseases in adults.

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

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



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



Interpretation: Hunter New England Health has exceeded targets in levels of adult immunisation for 2007, with 80.9 percent immunised against influenza and 71.8 immunised against pneumococcal disease.

Future initiatives: Hunter New England Health continues

Strategic Direction 1: Make prevention everybody's business

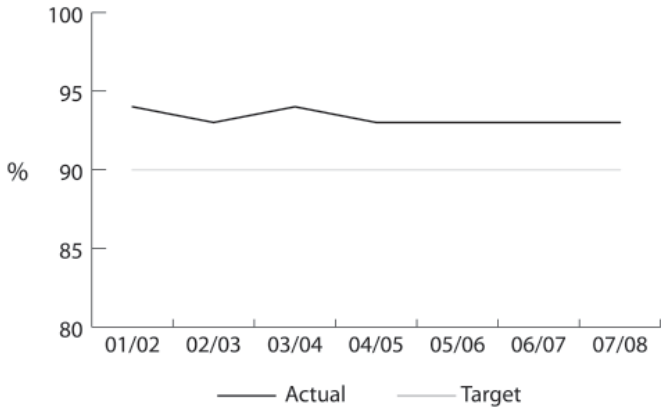
to work with General Practitioners and residential aged care facilities, as well as co-ordinating public awareness campaigns, to improve rates of adult immunisation.

Performance Indicator: Children fully immunised at one year

Desired outcome: Reduced illness and death from vaccine preventable diseases in children.

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

Children fully immunised at 1 year (%)



Interpretation: The rate of children in the Hunter New England Health region fully immunised at 1 year has remained steady at 93 percent, exceeding the target of 90 percent.

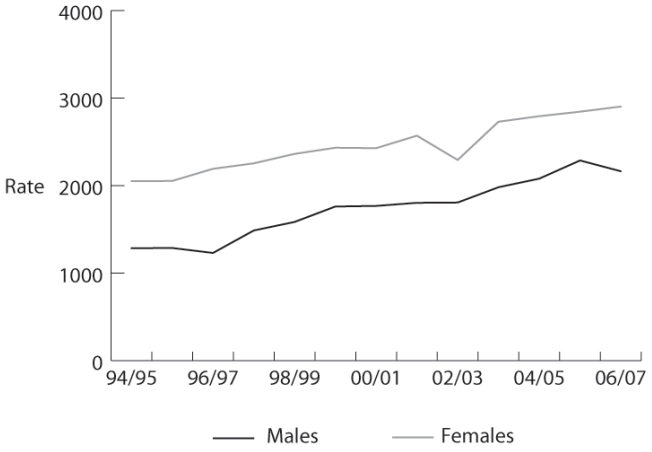
Future initiatives: Hunter New England Health will continue education around immunisation, including opportunities for free immunisation at community health clinics.

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

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

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

Fall injuries - for people aged 65 yrs+ (age standardised hospital separation rate per 100,000 population - excludes day-only stays)



Interpretation: The rate of fall injuries for people aged 65 years and older per 100,000 population has decreased overall from 5130 in 2006 to 5065 in 2007. This includes a slight increase in the rate of falls for the male population.

Future initiatives: A three-year research project led by Hunter New England Health is examining whether the employment of a project officer to work with aged care facilities is effective in reducing the prevalence of falls-related injuries. Hunter New England Health's research project concludes in February 2008 and the results will guide future action for partnerships with the mainly private residential aged care industry.

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

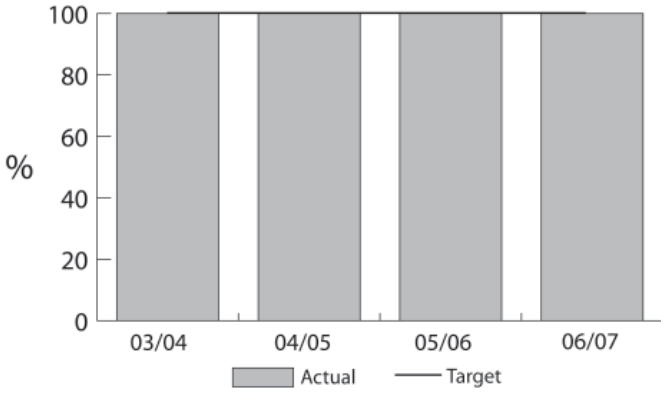
Performance Indicator: Emergency department triage times - cases treated within benchmark times

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

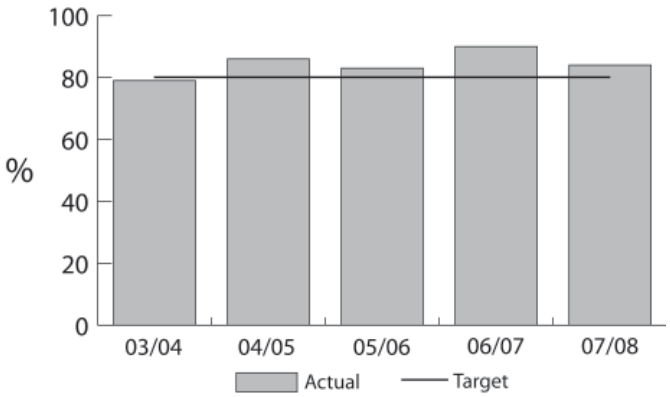
Context: Timely treatment is critical to emergency care. Triage aims to ensure that patients are treated in a timeframe appropriate to their clinical urgency, so that patients presenting to the Emergency Department are seen on the basis of their need for medical and nursing care and classified into one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

Emergency Department - cases treated within Australian College of Emergency Medicine (ACEM) benchmark times (%):

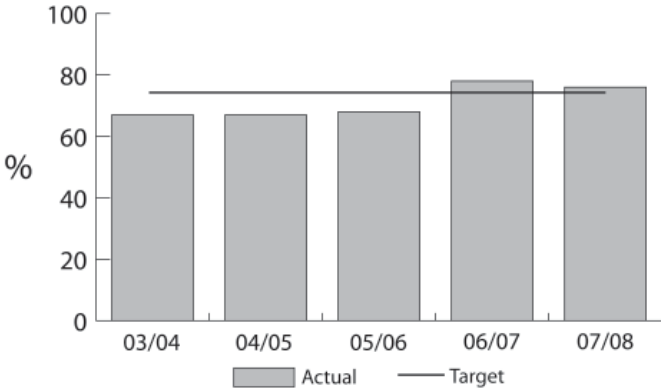
Triage 1 (within 2 minutes)



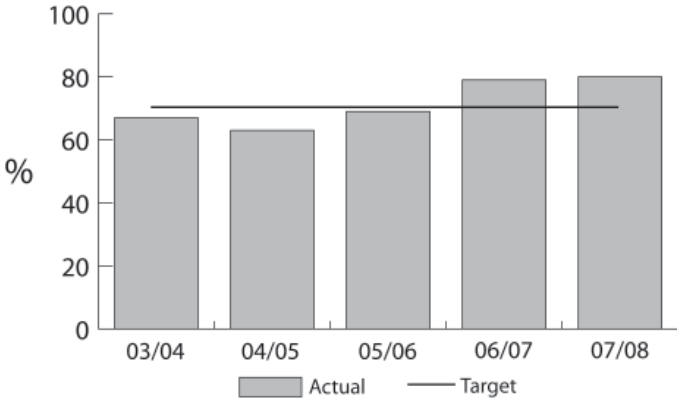
Triage 2 (within 10 minutes)



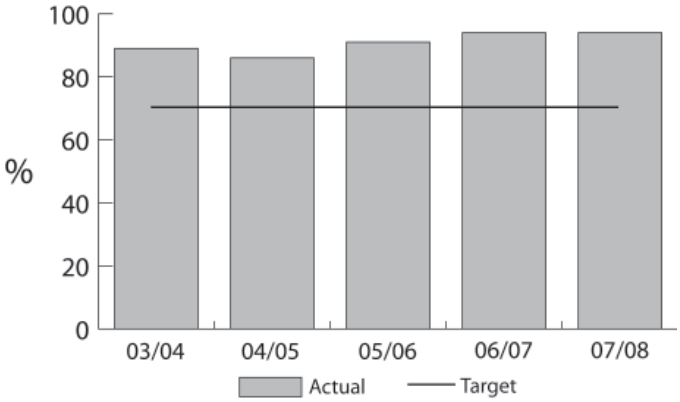
Triage 3 (within 30 minutes)



Triage 4 (within 60 minutes)



Triage 5 (within 120 minutes)



Interpretation: Hunter New England Health has continued to maintain a high level of performance in Emergency Department triage times, exceeding benchmarks in the face of increasing activity.

Future initiatives: Hunter New England Health will develop and implement service plans to increase access to services according to identified priority needs.

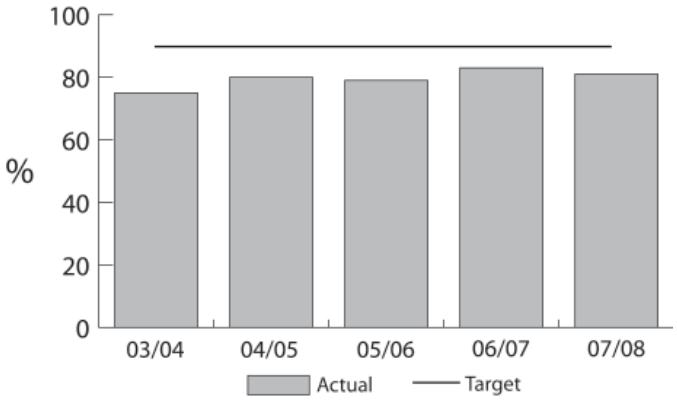
Strategic Direction 2:
Create better experiences for people using health services

Performance indicator: Off stretcher time < 30 minutes

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

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

Off Stretcher time - transfer of care to the Emergency Department < 30 minutes from ambulance arrival (%)



Interpretation: Off Stretcher Time performance has been consistent at the 80 to 84% for the last four years. While this result is under the target of 90% it does represent a result significantly above the State average.

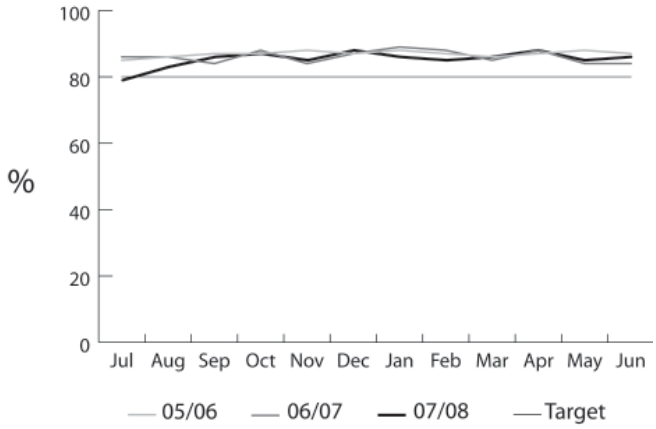
Future initiatives: The main emphasis will be on process improvement facilitated Area and Ambulance management.

Performance indicator: Emergency admission performance – patients transferred to an inpatient bed within eight hours

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

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

Emergency Admission Performance - Emergency Department patients admitted to an inpatient bed within 8 hrs of commencement of active treatment (%)



Interpretation: Hunter New England Health has continued to exceed targets in this category.

Future initiatives: Hunter New England Health will continue to monitor its performance and processes.

The establishment of the John Hunter Hospital Medical Assessment Unit will continue to improve the performance at that hospital.

Focus will be on the Calvary Mater Newcastle performance. The completion of the Hospital Community Home Clinical redesign project will identify and improve Hospital and Community linkages.

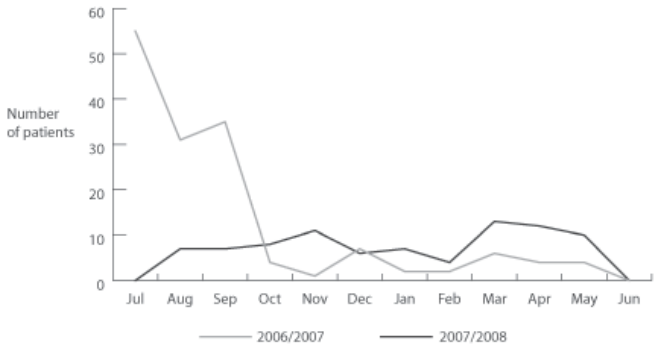
Performance indicator: Booked surgical patients

Desired outcome: Timely treatment of booked surgical patients, resulting in improved clinical outcomes, quality of life and convenience for patients.

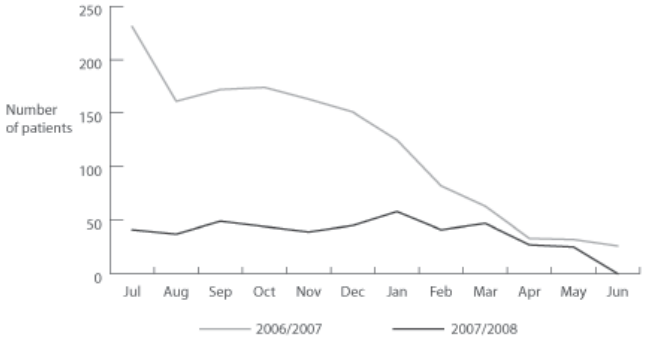
Context: Long wait and overdue patients are those who have not received timely care and whose waits may have adverse effects on the outcomes of their care. The numbers and proportions of long wait and overdue patients represent measures of hospital performance in the provision of elective care. Better management of hospital services helps patients avoid the experience of excessive waits for booked treatment. Improved quality of life may be achieved more quickly, as well as patient satisfaction and community confidence in the health system.

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

Booked surgical patients waiting - Urgency category 3 > 12 months (long waits) (Number)



Booked surgical patients waiting - Urgency category 1 > 30 days (overdues)



Interpretation: Persistent patterns of overdue waits were turned around with Hunter New England Health achieving its target at the end of the financial year

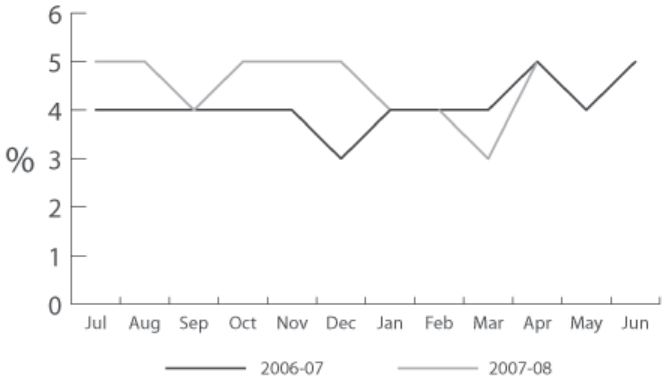
Future initiatives: Further implementation of the Booked Surgical Patient Journey Redesign solutions. Continued weekly monitoring on Key Performance Indicators, including Category 1 Patients greater than 7 days without a Planned Admission Date (PAD). Continue surgeon engagement with regular performance feedback.

Performance indicator: Planned surgery – cancellations on the day of surgery

Desired outcome: Minimised numbers of cancellations of patients from the surgical waiting list on the day of planned surgery, resulting in improved clinical outcomes, greater certainty of care and convenience for patients.

Context: The effective management of elective surgical lists minimises cancellations on a day of surgery and ensures patient flow and predictable access. However, some cancellations are appropriate, being due to acute changes in patients' medical condition.

Planned surgery - cancellations on the date of surgery (%)



Interpretation: Trends in the percentage of cancellations have been consistently above targets for the last two years. Although the number of patients that are cancelled on the date of surgery is low, it is the aim of Hunter New England Health to reduce this further

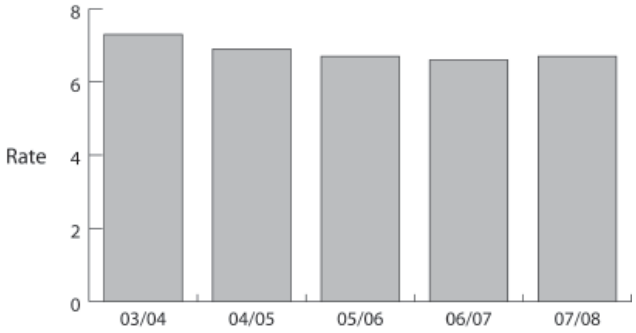
Future initiatives: The Innovations and Reform project "Booked Surgical Patient Journey" is implementing further solutions to improve peri-perative processes. The Booked Surgical Patient Journey Project aims to improve the processes surrounding the care of adults and children as they experience a booked surgical journey in Hunter New England Health

Performance Indicator: Sentinel events

Desired outcome: Reduction of sentinel events, resulting in improved clinical outcomes, quality of life and patient satisfaction.

Context: Sentinel events are incidents agreed as key indicators of system problems by all States and Territories and defined by the Australian Council for Safety and Quality in Healthcare as 'events in which death or serious harm to a patient has occurred'.

Sentinel Events (per 100,000 bed days)



Interpretation: Improved results with targets achieved. Target for 2008 - 2009 set at less than 9.39/100,000 bed days.

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

Future initiatives: Improving the quality and safety of health care in Hunter New England Health has required, among other strategies, the implementation of a comprehensive incident surveillance and reporting system, extensive training in incident prevention and management and rigorous investigation of serious adverse incidents. Area-wide leadership and support to each of these strategies is provided through the Hunter New England Health Clinical Governance Unit.

Hunter New England Health is engaged in the implementation of NSW Health Policy Directives which aim to reduce the incidence of sentinel events including, blood transfusion and wrong site or wrong patient procedures.

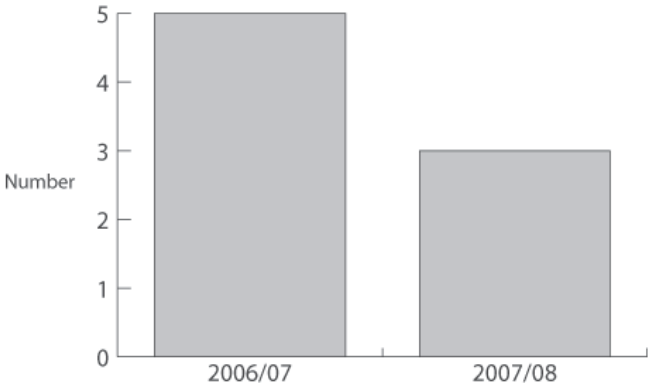
Performance indicator: Incorrect Procedures

Desired outcome: Elimination of incorrect procedures, resulting in improved clinical outcomes, quality of life and patient satisfaction.

Context: Incorrect procedures, though low in frequency, provide insight into system failures that allow them to happen. Health studies have indicated that, with the implementation of correct patient/site/procedure policies, these incidents can be eliminated.

Incorrect procedures – Operating Theatre (number)

Incorrect procedures - Radiology, Radiation Oncology, Nuclear Medicine (number)



Interpretation: Incorrect procedures in operating theatres totalled two in both 2006 -2007 and 2007 -2008. Incorrect procedures for radiation, radiation oncology and nuclear medicine totalled five in 2006 - 2007 and three in 2007 - 2008. This exceeds the target, which remains at one for this period.

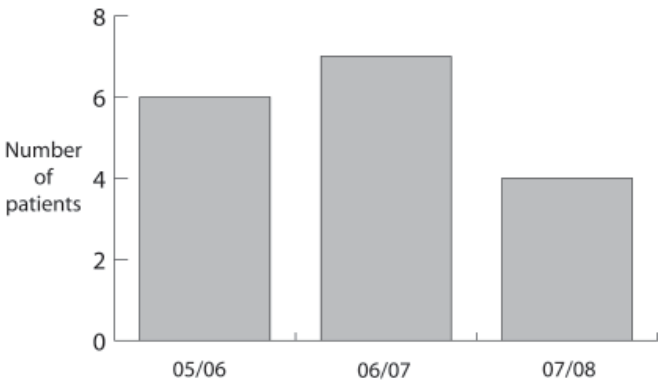
Future initiatives: Hunter New England Health as part of the Patient Safety Program continually looks at the processes around correct patient identification to ensure that the right patient receives the correct procedure.

Performance indicator: Deaths as a result of a fall in hospital

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

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

Deaths as a result of falls in hospitals (number)



Interpretation: The number of deaths as a result of falls in Hunter New England hospitals has fallen from 6 in 2005/06 to 4 in 2007/08.

Future initiatives: Hunter New England Health is committed to a range of programs surrounding health care redesign, improving the quality of care and the patient journey, including measures to track and reduce patient falls. Implementation of the Area wide Falls Strategy continues.

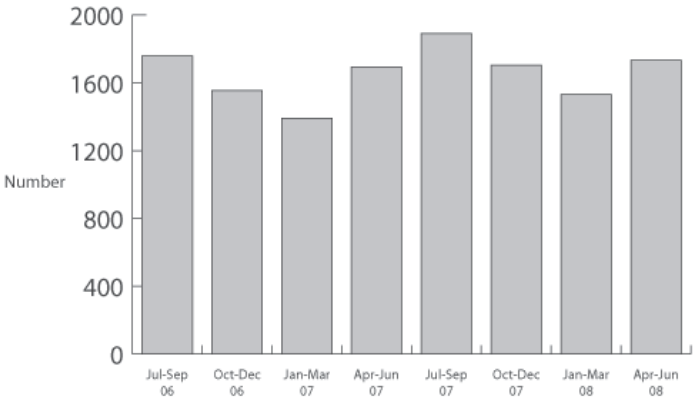
Strategic Direction 3: Strengthen primary health and continuing care in the community

Performance indicator: Avoidable hospital admissions (selected conditions)

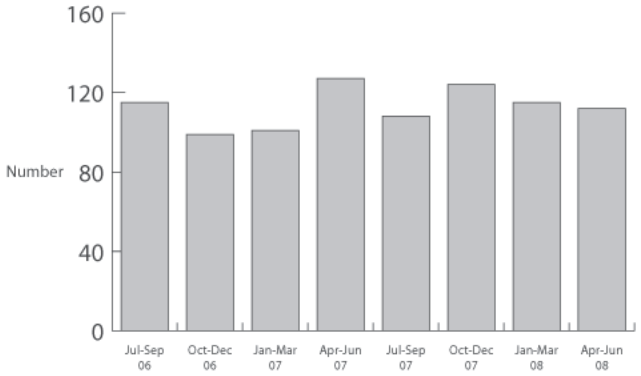
Desired outcome: Numbers of avoidable hospital admissions minimised, resulting in improved health, increased independence, convenience and patient satisfaction, and reduction of unnecessary demand on hospital services.

Context: There are some conditions for which hospitalisation is avoidable through early or more appropriate forms of management, for example by general practitioners, in community health settings, at home, or in outpatient clinics. The conditions of this type included in the indicator are : cellulitis; deep vein thrombosis; community-acquired pneumonia; urinary tract infections; certain chronic respiratory disorders such as emphysema and chronic obstructive pulmonary disorder; bronchitis and asthma; certain blood disorders such as anaemia; and musculo-skeletal disorders such as acute back pain.

Avoidable hospital admissions for conditions that can be appropriately treated in the home – all persons



Avoidable hospital admissions for conditions that can be appropriately treated in the home – Aboriginal persons (including Torres Strait Islander persons)



Interpretation: Across Hunter New England Health there has been on average over the last two years, 566 avoidable admissions per month [with average avoidable Aboriginal admissions of 37/month]. The NSW Health target for avoidable admissions for Hunter New England Health is 376 separations per month. There has not been a substantial shift in the total numbers of avoidable admissions over the last 2 years.

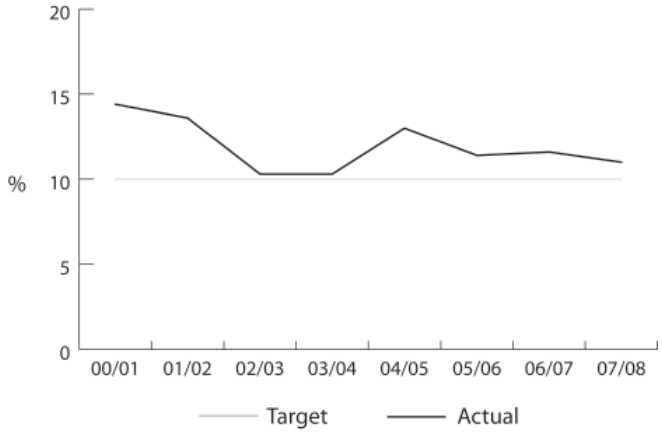
Future initiatives: A range of initiatives have been implemented since April 2008 to further address the targeted Diagnosis Related Groups (DRGs) including increase to Community Acute Post Acute Care Service (CAPAC) type services and a model of care targeted to patients with Chronic Obstructive Pulmonary Disease (COPD) at John Hunter and Manning hospitals. An Innovation and Reform project has commenced to further analyse performance against these targets, improve understanding of the patient groups, current clinical practice and to identify relevant solutions.

Performance indicator: Mental Health acute adult readmission

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

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

Mental Health acute adult readmission - within 28 days to same mental health facility (%)



Interpretation: The rate of mental health acute adult readmission within 28 days in the Hunter New England Health area has dropped slightly to 11 percent.

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

Future initiatives: HNE Mental Health Services as part of its planning processes have developed identified initiatives to address the acute adult readmissions within 28 days such as:

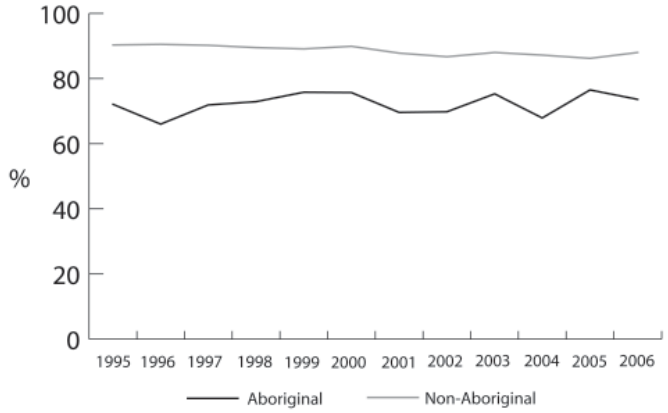
- Developing guidelines, policies and procedures to identify and monitor potentially high risk mental health consumers and ensure risk alerts are in place and monitored appropriately
- Programs to support for carers and family members are to be expanded and improved, particularly in regards to respite care, education and training
- Internal referral and transfer processes to be reviewed between rehabilitation and other mental health services.

Performance indicator: Antenatal visits - confinements where first visit was before 20 weeks gestation

Desired outcome: Improved health of mothers and babies

Context: Antenatal visits are valuable in monitoring the health of mothers and babies throughout pregnancy. Early commencement of antenatal care allows problems to be better detected and managed, and engages mothers with health and related services.

First antenatal visit - before 20 weeks gestation (%)



Interpretation: The percentage of Hunter New England non-Aboriginal mothers seeking first antenatal visits prior to 20 weeks gestation in 2006 increased slightly on the previous year, to 88 percent. Meanwhile for Aboriginal mothers, the rate dropped slightly in the same period to 73.6 percent. In reviewing this data it is pertinent to consider impacting factors such as the complexity of women's social and medical needs, the recruitment of Aboriginal Liaison Officers and midwives to support women and women birthing out of area.

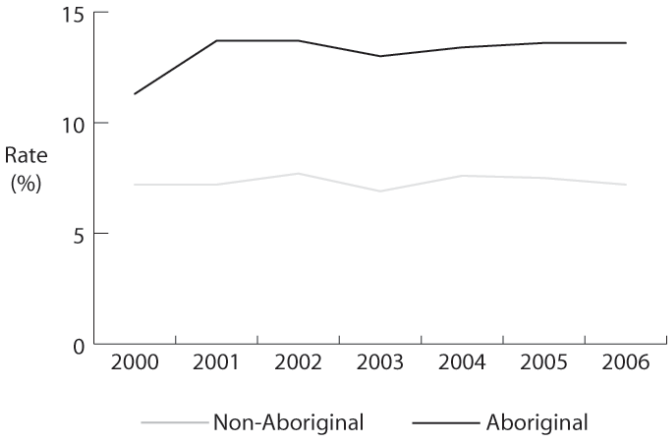
Future initiatives: Hunter New England Health is working to expand the Aboriginal Maternal and Infant Health Service (AMIHS) across the area and to provide access to appropriate antenatal care in the home by midwives and Aboriginal Liaison Officers. Hunter New England Health is also developing relationships with service providers like General Practitioners and Non-Government Organisations to ensure flexible service delivery and community development.

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

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

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

Low birthweight babies - births with birthweight less than 2,500g (%)



Interpretation: The rate of low birth weight babies (less than 2,500g) for Hunter New England women has decreased slightly from 7.5 percent in 2005 to 7.2 percent in 2006. A slight reduction was recorded in the non-Aboriginal population (down to 6.8 per cent), with the rate of low birth weight babies to Aboriginal mothers remaining steady at 13.6 percent.

Future initiatives: Hunter New England Health will continue to work towards reducing the rate of low birth weight babies via improved early identification and intervention programs, as well as strengthened relationships and communication systems between acute facilities and clusters.

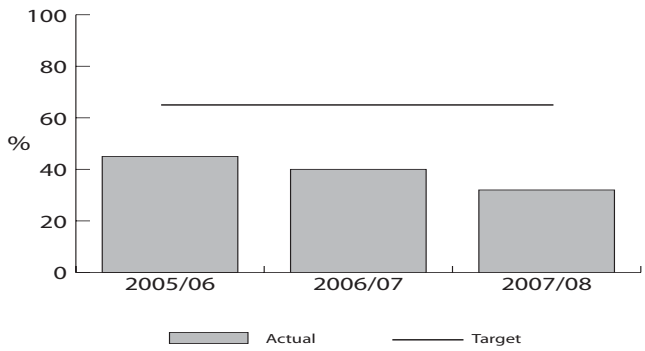
Performance indicator: Postnatal home visits - Families receiving a Families NSW visit within two weeks of the birth

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

Context: The Families NSW program aims to give children the best possible start in life. The purpose is to enhance access to postnatal child and family services by providing all families with the opportunity to receive their first postnatal health service within their home environment, thus providing staff with the opportunity to engage more effectively with families who may not have otherwise accessed services. Families NSW provides an opportunity to identify needs with families in their own homes, and facilitate early access to local support services, including the broader range of child and family health services.

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

Families NSW postnatal universal health home visit (UHHV) (%)



Interpretation: The major factor impacting on families receiving a families NSW visit within 2 weeks of the birth are difficulties with transfer of information of births from maternity hospitals to child and family health nurses

Future initiatives: Maternity services and Hunter New England Health Child and Family Health Nurses (C&FHN) are working together to improve information sharing to ensure that rates show improvement over the next 12 months.

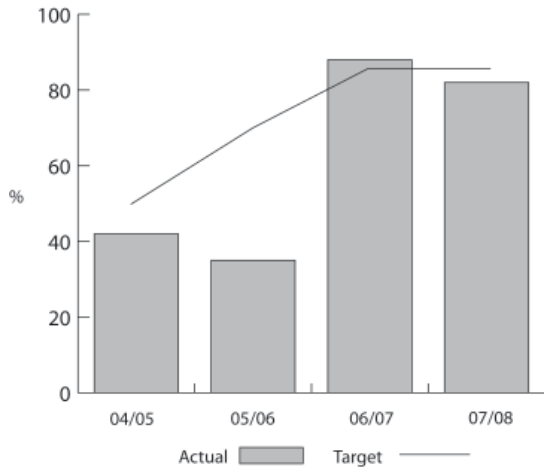
Strategic Direction 4: Build regional and other partnerships for health

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

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

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

Otitis media screening - Aboriginal children aged 0 - 6 years screened (%)



Interpretation: The rate of screening for Otitis Media in Aboriginal children in the Hunter New England Health population dropped slightly to 82 percent in 2007/08, following a remarkable increase in the previous 12 months.

Future initiatives: Hunter New England Health will strive to continue to reduce the gap in health and wellbeing between Aboriginal and non-Aboriginal people. The continued implementation of strategies under the Aboriginal Health Plan will support this goal.

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

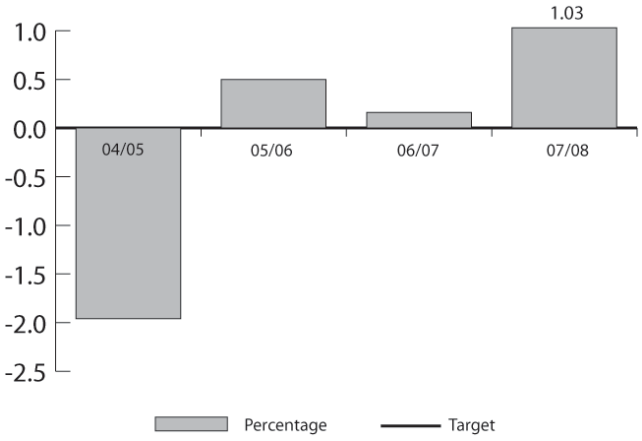
Performance indicator: Net cost of service – General Fund (General) variance against budget

Desired outcome: Optimal use of resources to deliver health care.

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

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

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



Interpretation: Factors that have impacted on this year's performance, including 2005 2006 Treasury Managed Fund Hindsight Benefit, late implementation of the Meal Entertainment Packaging, procurement savings not delivered, unfavourable goods and services, unfavourable overtime costs due to higher than normal sick leave and coverage of vacant essential frontline clinical positions and depreciation favourability

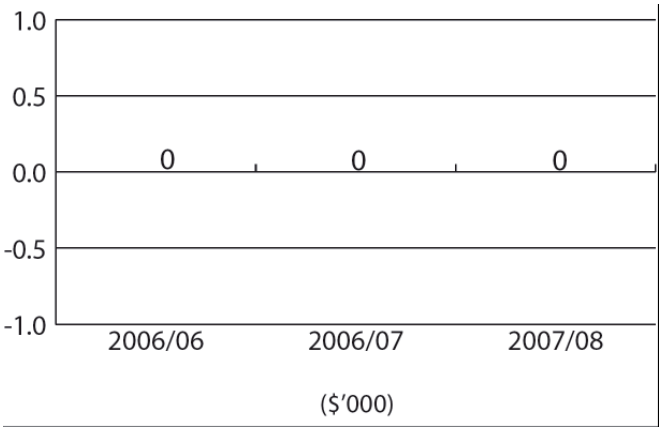
Actions being taken to meet target: Reporting on labour utilisation against affordable budget to be implemented. Cost containment strategies to be in place for all budget holders. Focus on increased revenue opportunities, proactively work to implement any new procurement contracts and a greater focus on increasing the uptake rates for Meal Entertainment and Salary Packaging

Performance indicator: Creditors > Benchmark as at the end of the year

Desired outcome: Payment of creditors within agreed terms.

Context: Creditor management affects the standing of NSW Health in the general community, and is of continuing interest to central agencies. Creditor management is an indicator of a Health Service's performance in managing its liquidity. While health services are expected to pay creditors within terms, individual payment benchmarks have been established for each health service.

Number of Creditors exceeding target days as at the end of year - Creditors exceeding 35 days $('000)



Interpretation: Hunter New England Health continues to meet its targets for this performance indicator

Future initiatives: The Accounts Payable service that manages the function of paying creditors is currently being transferred from Hunter New England Health to the NSW Health service, Health Support. Hunter New England Health will work in a collaborative manner with Health Support to ensure the transition of this service does not impact on creditor performance.

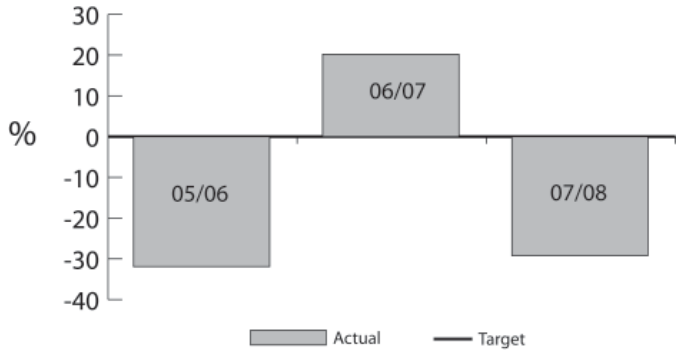
Strategic Direction 5: Make smart choices about the costs and benefits of health services

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

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

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

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



Interpretation: Major factors impacting on performance include the changes in staging and subsequent deferral of purchase of diagnostic equipment and digital scanning proposal for the Calvary Mater Newcastle Public Private Partnerships (PPP), Contractors falling behind in construction, deferring expected purchase of furniture, fittings and equipment for four multipurpose services and the Manning Rural Referral Hospital Emergency Department and the delay in Development Application approval for the James Fletcher Hospital Non Acute Inpatient Unit.

Future initiatives: Delays and impacts have been managed as they have emerged throughout the year. Major works under construction are the Multi Purpose Services located at different sites across the Area, The Manning Rural Referral Hospital Emergency Department, The Calvary Mater Newcastle Public Private Partnership (PPP) and James Fletcher Hospital Non Acute Inpatient Unit. The four projects are proceeding to completion against revised programs with adjusted cash flows.

Strategic Direction 6:
Build a sustainable health workforce

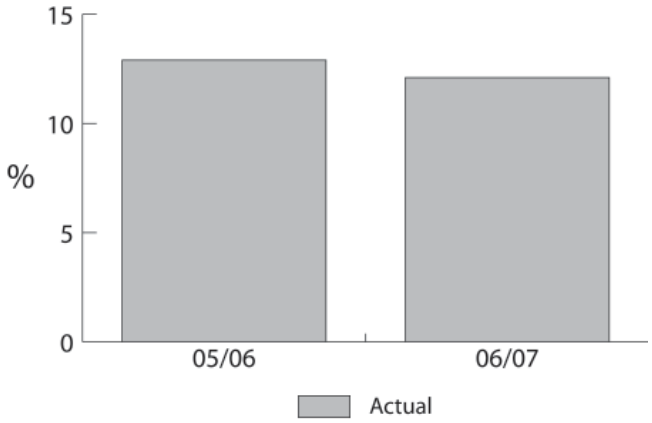
Performance indicator: Staff Turnover

Desired outcome: Staff stability, with minimum unnecessary staff loss, through maintenance of turnover rates within acceptable limits (reducing where necessary).

Context: Human resources represent the largest single cost component for NSW Health Services. High staff turnover rates are associated with increased costs in terms of advertising for and training new employees, lost productivity and potentially a decrease in the quality and safety of services and the level of services provided. Factors influencing turnover include: level of shortage, remuneration and recognition, employer/employee relations and practices, workplace culture and organisational restructure. Monitoring turnover rates over time will enable the identification of areas of concern and development of strategies to reduce turnover.

Note that a falsely inflated turnover rate can be recorded due to the specific requirements of certain services, such as tertiary training hospitals, where staff routinely undertake training for specified set periods before taking up or returning to appointments elsewhere. Also, certain geographic areas can attract overseas nurses who prefer to work only on short-term contracts.

Staff Turnover - Permanent Staff Separation Rates %)



Interpretation: Hunter New England Health only just falls short of the target for staff turnover

Future initiatives: Currently underway is the launch of an e-Exit survey to assist in identification of why staff are leaving to enable measures to be undertaken to resolve issues to assist in future retention.

Values Charter being integrated into Hunter New England Health through Performance Development Reviews and Values and Respectful Workplace workshops to ensure Hunter New England Health is an employer of choice.

A health and wellness strategy and a recruitment and retention strategy are being developed for Hunter New England Health.

Summary Corporate Governance statement

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

The Chief Executive is committed to better practices as outlined in the Guide on Corporate Governance Compendium, issued by NSW Health.

The Chief Executive has practices in place to ensure the primary governing responsibilities of Hunter New England Health Service are fulfilled in respect to:

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

Strategic direction
The Chief Executive has in place processes for the effective planning and delivery of health services to the communities and patients serviced by the public health organisation. This process includes setting of a strategic direction for both the organisation and for the health services it provides.

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

Appropriate communication strategies have been in place during the year to ensure that all employees were aware of the code and successfully completed a Knowledge Assessment.

Risk management
The Chief Executive is responsible for supervising and monitoring risk management by the public health organisation, 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 the public health organisation. This plan enables the management of key risk areas including:
- Leadership and management
- Clinical care
- Safe practice and environment
- Information management
- Workforce, and
- Community expectations.

The Chief Executive has in place a Risk Management Committee, chaired by Vic Lewis, which meets at least quarterly.

Committee structure
The public health organisation 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 or 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. The Health Care Quality Committee is chaired by Kim Hill and meets at least four times per year.

Finance and Resources Committee
The Chief Executive has established a Finance and Resources Committee. The committee is chaired by Nigel Lyons and meets monthly.

Summary Clinical Governance statement

Clinical Governance in Hunter New England Health has responsibility for delivery of Area-wide systems that promote and support clinical excellence and patient safety across patient care and service delivery areas.

Response to patient feedback is an essential part of good clinical governance, and complaints management has paid specific attention to timeliness of acknowledgement and resolution of complaints received from patients and the community. As of June 2008, around 85% of complaints had been resolved within 35 days of receipt, and 81% of complaints were acknowledged within five days, which showed considerable improvement compared with the previous year's performance. The development and wide circulation of a Hunter New England Health Complaints Management Toolkit to support this work received excellent feedback from clinical staff and managers, and is now incorporated into routine information available for their use.

Hunter New England Health participated in the 2007 NSW Health Patient Survey, which sought feedback from patients and carers on their experience of healthcare services, through asking about what patients and carers value. Over 25,000 surveys were mailed to patients within Hunter New England Health who received healthcare during February 2007. An Area Action Plan has been developed to address priority findings of the 2007 survey in relation to emotional support, provision of information and education to patients and patient involvement in their care decisions.

Strong Corporate and Clinical Governance

In 2008, Hunter New England Health was awarded a National Commission on Safety and Quality in Health Care grant to undertake a study into the development of effective of tools in clinical communication. The study is based on trial implementation in Hunter New England Health of the ISBAR (introduction/situation/background/assessment/ recommendation) communication framework. This study, led by Clinical Governance and involving members of the Hunter New England Health Clinical Communications Steering Committee, Clinical Operations, Newcastle and New England Universities and external partners, will undertake this work in the context of inter-hospital transfer of care, and is due to report in 2009.

In 2007, Clinical Governance led a review of the Hunter New England Health approach to clinical ethics management, in consultation with experts in this domain and with NSW Health policies. This resulted in the recently approved Hunter New England Health Clinical Ethics framework, addressing matters such as development of policies and guidelines and the promotion of staff education on clinical ethical issues; monitoring, reporting and evaluation of clinical ethics matters, and facilitation of communication and networking between different sites and services across Hunter New England Health. The new Hunter New England Health Clinical Ethics Committee, reporting to the Chief Executive, provides means for existing expertise concentrated in the larger centres to be shared across Hunter New England Health, and has already endorsed clinical guidelines on organ donation.

Hunter New England Health has been a pilot site for the Collaborating Hospitals Audit of Surgical Mortality (CHASM) initiative of the Clinical Excellence Commission, supported by the Royal Australasian College of Surgeons. This initiative provides peer-review audit of deaths related to surgical care and preliminary information indicates increasing involvement of surgeons in the initiative.

Progress with implementation of the Correct Site/Side/ Procedure Project was made during the year. In particular the results obtained from audits showed increased compliance with the key steps of the time out procedure, and these audit results have been shared with sites and clinical staff to encourage compliance. Similar procedures are in place in non-operating theatre sites such as radiology and dental services.

The New Procedures and Clinical Innovations Committee is now in its second year of operation, having been re-established in line with the redefined Area Health Services and the 2005 NSW Health policy directive last year. The Clinical Governance Intranet Site enables ready access to the new Hunter New England Health policy compliance procedure that advises staff on what is required to progress their application within Hunter New England Health. There is evidence of increasing clinician engagement in this process, with increasing numbers of applications being received by the Committee. New interventional procedures have been assessed and approved through the new procedures, including Medical Thoracoscopy and Intraduodenal Infusion with Duodopa for Treatment of Advanced Idiopathic Parkinson's Disease. The new policy compliance procedure has provided constructive alignment with other relevant Committees including the Research Ethics Committee and Medical and Dental Appointments Advisory Committee, with a view to streamlined approval processes.

During the past year, the core responsibilities for incident management and monitoring have been completed by Hunter New England Health, including review of incidents reported in the Information Management System and root cause analysis of serious incidents to identify any systems issues and prevent any potential recurrence of the incident. Each acute facility and cluster has a designated patient safety officer to support incident management within their area, and to work with clinical staff in these endeavours.

Two high priority patient safety initiatives in 2007-2008 were management of blood transfusion and infection prevention and control. The current BloodWatch initiative focuses on appropriate use of blood products and transfusion practices, based on the contemporary clinical evidence and best practice. The Area-wide implementation of decision support tools such as the Hunter New England Health Transfusion Administration Form and staff in-service on transfusion practice were directed towards achieving the strategy's outcomes. As of June 2008, there has been substantial reduction in both red cell and platelet usage across Hunter New England Health, even though there was at the same time considerable increase in surgical activity.

In relation to infection prevention and control, Hunter New England Health has focused on implementation of NSW Health Infection Control and NSW Health Multi-resistant Organism policy directives. Initiatives directed to improving compliance in key areas such as hand hygiene have been undertaken, including observational audits. Appointment of senior staff in Infection Prevention and Control was completed in 2007-2008, and included the appointment of the Area Clinical Director in Infection Prevention and Control, and the establishment of an Area-wide expert committee.

Since the commencement of an Area-wide strategy for policy management and implementation in mid-2006, good progress has been made and there are reports that organisational capacity to develop, manage and monitor policy has been enhanced. The major focus has been to ensure that all NSW Health Policies and Hunter New England Health Policies, and associated implementation resources, are easily searchable and accessible to staff. Further work will continue through 2008-2009 in linking policy development and clinical guideline development in Hunter New England Health.

During the past year, Hunter New England Health has been awarded a number of accolades in the area of Risk Management. In February 2007, Hunter New England Health received Extensive Achievements (EA) for its approach to risk management, strategic and operational planning during Corporate Accreditation by the Australian Council on Health Care Standards (ACHS). In December 2007, Hunter New England Health was awarded first place in the Treasury Managed Fund (TMF) Risk Management Awards for the NSW Public Sector for its achievements in Integrating Risk

Management into Organisational Planning.

A strong focus for Clinical Governance remains education and capacity development. Quality and safety initiatives and important advice are communicated in Quality Matters, Clinical Governance's monthly newsletter, which commenced in January 2007 and is distributed electronically to over 8000 staff. This publication includes items such as information on NSW Health Safety Alerts, Safety Notices and Safety Information Reports, which are reviewed by senior Clinical Governance staff to ensure actions have been taken to review, assess and mitigate risks, and then communicated through Quality Matters.

In addition, Clinical Governance facilitates access to key quality and safety information sources, such as the Clinical Governance internet/intranet, which is systematically reviewed annually and updated during the year as necessary. Presentations have been made to local seminars and Grand Rounds and feedback about the relevance and value of these sessions has been positive. The 2007 Hunter New England Health Quality Exposition and Scientific Program held in September 2007 in Armidale concentrated on Culture and Communication for Quality, and included eminent speakers such as the Chief Executive of the Greater Metropolitan Clinical Taskforce.

Clinical Governance is based on the principle that everyone engaged in patient care, clinicians and managers alike, are jointly accountable for quality of patient care and standards of care delivery. The role of Clinical Governance in Hunter New England Health is to facilitate the quality and safety agenda across the Area, through expert staff who are geographically located throughout the Area and who support staff of Hunter New England Health to deliver safe and effective health care services.

Hospital activity levels - summary by facility

Activity for year ended 30 June 2008

Facility	Separations YTD	Planned Separations	Planned Sep %	Same Day Separations	Same day Sep %	Daily Average	Total Bed Days (Days episode)
J201 - Armidale and New England Hospital	8,525.	3,765.	44.16 %	3,714.	43.57 %	71.7	26,224.
J202 - Barraba Multi-Purpose Service	367.	41.	11.17 %	38.	10.35 %	4.6	1,694.
J203 - Bingara Multi-Purpose Service	287.	96.	33.45 %	36.	12.54 %	17.9	6,555.
J204 - Boggabri Multi-Purpose Service	87.	27.	31.03 %	10.	11.49 %	1.6	572.
J205 - Glen Innes District Hospital	1,840.	231.	12.55 %	442.	24.02 %	18.6	6,822.
J206 - Gunnedah District Hospital	2,417.	929.	38.44 %	916.	37.90 %	20.8	7,607.
J207 - Guyra and District War Memorial Hospital	293.	27.	9.22 %	117.	39.93 %	3.8	1,382.
J208 - Inverell District Hospital	3,714.	1,090.	29.35 %	1,355.	36.48 %	30.9	11,298.
J211 - Manilla District Hospital	493.	16.	3.25 %	57.	11.56 %	22.1	8,071.
J212 - Moree District Hospital	3,604.	1,602.	44.45 %	1,651.	45.81 %	24.3	8,900.
J213 - Narrabri District Hospital	2,262.	514.	22.72 %	703.	31.08 %	19.6	7,180.
J214 - Prince Albert Memorial, Tenterfield	666.	269.	40.39 %	81.	12.16 %	9.0	3,310.
J215 - Quirindi District Hospital	798.	1.	0.13 %	81.	10.15 %	12.9	4,728.
J216 - Tamworth Base Hospital	18,176.	8,317.	45.76 %	7,024.	38.64 %	207.4	75,903.
J217 - Tingha Hospital	24.	6.	25.00 %		0.00 %	7.8	2,866.
J218 - Vegetable Creek Multi-Purpose Service	34.	10.	29.41 %	7.	20.59 %	1.3	483.
J219 - Walcha Multi-Purpose Service	373.	53.	14.21 %	24.	6.43 %	4.1	1,491.
J220 - Warialda Multi-Purpose Service	430.		0.00 %	20.	4.65 %	16.9	6,200.
J221 - Wee Waa District Hospital	1,089.	326.	29.94 %	265.	24.33 %	8.5	3,128.
J222 - Werris Creek District Hospital	47.	1.	2.13 %		0.00 %	10.4	3,810.
J223 - Bulahdelah District Hospital	406.	3.	0.74 %	20.	4.93 %	6.0	2,200.
J224 - Gloucester Soldier's Memorial Hospital - H	1,397.	682.	48.82 %	656.	46.96 %	18.1	6,629.
J225 - Manning Base Hospital	15,888.	6,480.	40.79 %	6,877.	43.28 %	151.9	55,605.
J226 - Wingham Memorial Hospital	248.	32.	12.90 %	2.	0.81 %	25.3	9,262.
Q101 - Morisset Hospital	103.	2.	1.94 %	3.	2.91 %	117.4	42,977.
Q102 - James Fletcher Hospital	1,762.	3.	0.17 %	82.	4.65 %	76.9	28,162.
Q202 - Cessnock District Hospital	4,151.	1,634.	39.36 %	1,661.	40.01 %	44.1	16,147.
Q203 - Dungog District Hospital	253.	59.	23.32 %	15.	5.93 %	7.3	2,665.
Q205 - Kurri Kurri District Hospital	2,174.	1,538.	70.75 %	1,252.	57.59 %	27.2	9,946.
Q206 - Maitland Hospital	14,136.	2,799.	19.80 %	2,396.	16.95 %	161.2	59,016.
Q208 - Merriwa Multi-Purpose Service	201.	19.	9.45 %	29.	14.43 %	4.4	1,593.
Q209 - Muswellbrook District Hospital	3,417.	1,505.	44.04 %	1,571.	45.98 %	23.3	8,515.
Q210 - Denman Multi-Purpose Service	106.	21.	19.81 %	14.	13.21 %	1.3	490.
Q211 - Calvary Mater Newcastle	12,494.	3,689.	29.53 %	3,350.	26.81 %	162.7	59,533.
Q214 - Belmont Hospital	7,588.	4,098.	54.01 %	2,960.	39.01 %	80.1	29,315.
Q216 - Scott Memorial Hospital, Scone	1,928.	582.	30.19 %	629.	32.62 %	15.8	5,777.
Q217 - Singleton District Hospital	4,472.	1,966.	43.96 %	2,229.	49.84 %	30.7	11,234.
Q219 - Wilson Memorial Hospital, Murrurundi	106.	19.	17.92 %	3.	2.83 %	7.8	2,868.
Q225 - Nelson Bay and District Polyclinic	637.	51.	8.01 %	95.	14.91 %	4.7	1,736.
Q230 - John Hunter Hospital	69,617.	37,681.	54.13 %	33,094.	47.54 %	714.4	261,458.
	186,610.	**80,184.**	**42.97 %**	**73,479.**	**39.38 %**	**2,195.0**	**803,352.**

List of facilities

Tertiary Teaching Hospitals	Address	Phone	Fax
John Hunter	Lookout Road, New Lambton NSW 2305 Locked Bag 1, Hunter Region Mail Centre NSW 2310	(02) 4921 3000	(02) 4921 3999
John Hunter Children's Hospital	Lookout Road, New Lambton NSW 2305 Locked Bag 1, Hunter Region Mail Centre NSW 2310	(02) 4921 3000	(02) 4921 3599
Calvary Mater Newcastle	Edith Street, Waratah NSW 2298 Locked Bag 7, Hunter Region Mail Centre NSW 2310	(02) 4921 1211	(02) 4960 2673
Royal Newcastle Centre	Lookout Road, New Lambton NSW 2305 PO Box 664J, Newcastle NSW 2300	(02) 4921 3000	(02) 4922 3438
Mental Health Hospitals	**Address**	**Phone**	**Fax**
James Fletcher (Newcastle)	72 Watt Street, Newcastle NSW 2300 PO Box 833, Newcastle NSW 2300	(02) 4924 6500	(02) 4924 6687
Morisset	Off Dora Street, Morisset NSW 2264 PO Box 833, Newcastle NSW 2300	(02) 4973 0222	(02) 4973 3442
Rural Referral Hospitals	**Address**	**Phone**	**Fax**
Armidale	Rusden Street, Armidale NSW 2350 Locked Bag 4, Armidale NSW 2350	(02) 6776 9500	(02) 6776 4774
Maitland	550 - 560 High Street, Maitland NSW 2320	(02) 4939 2000	(02) 4939 2270
Tamworth	Dean Street Tamworth NSW 2340 Locked Mail Bag 9783, Tamworth NEMSC NSW 2348	(02) 6767 7700	(02) 6767 8736
Taree - Manning	26 York Street, Taree NSW 2430 PO Box 35, Taree NSW 2430	(02) 6592 9111	(02) 6551 7135
District Health Services	**Address**	**Phone**	**Fax**
Belmont	Croudace Bay Road, Belmont NSW 2280 PO Box 2365, Gateshead DC NSW 2290	(02) 4923 2000	(02) 4923 2106
Cessnock	View Street, Cessnock NSW 2325 PO Box 154, Cessnock NSW 2325	(02) 4991 0555	(02) 4991 0563
Glen Innes	94 Taylor Street, Glen Innes NSW 2370 PO Box 363, Glen Innes NSW 2370	(02) 6739 0200	(02) 6739 0143
Gloucester	Church Street, Gloucester NSW 2422 PO Box 33, Gloucester NSW 2422	(02) 6538 5000	(02) 6538 5001
Gunnedah	Marquis Street, Gunnedah NSW 2380 PO Box 243, Gunnedah NSW 2380	(02) 6741 8000	(02) 6740 2881
Inverell	Swanbrook Road, Inverell NSW 2360 PO Box 279, Inverell NSW 2360	(02) 6721 9500	(02) 6721 9567
Kurri Kurri	Lang Street, Kurri Kurri NSW 2327	(02) 4936 3200	(02) 4936 3239
Manilla	Court Street, Manilla NSW 2346 PO Box 74, Manilla NSW 2346	(02) 6785 4000	(02) 6785 1490
Moree	Alice Street, Moree NSW 2400 PO Box 138, Moree NSW 2400	(02) 6757 0000	(02) 6757 3625
Muswellbrook	Brentwood Street, Muswellbrook NSW 2333 PO Box 120, Muswellbrook NSW 2333	(02) 6542 2000	(02) 6542 2002

List of facilities (continued)

Narrabri	11 Cameron Street, Narrabri NSW 2390 PO Box 324, Narrabri NSW 2390	(02) 6799 2800	(02) 6799 5025
Quirindi	Nowland St, Quirindi NSW 2343 PO Box 120, Quirindi NSW 2343	(02) 6746 0200	(02) 6746 2002
Scone	Stafford Street, Scone NSW 2337	(02) 6540 2100	(02) 6540 2180
Singleton	Dangar Road, Singleton NSW 2330 PO Box 10, Singleton NSW 2330	(02) 6571 9222	(02) 6571 9282
Tomaree Community Hospital	Trevally Street, Nelson Bay NSW 2315 PO Box 344, Nelson Bay NSW 2315	(02) 4984 0700	(02) 4984 0710
Community Hospitals / MPS	**Address**	**Phone**	**Fax**
Barraba Multi Purpose Service	Edward Street, Barraba NSW 2347 PO Box 144, Barraba NSW 2347	(02) 6782 2500	(02) 6782 1808
Bingara Multi Purpose Service	Keera Road, Bingara NSW 2404	(02) 6728 0100	(02) 6724 1708
Boggabri Multi Purpose Service	Wee Waa Street, Boggabri NSW 2382 PO Box 63, Boggabri NSW 2382	(02) 6749 7000	(02) 6743 4274
Bulahdelah Community Hospital	Richmond Street, Bulahdelah NSW 2423 PO Box 67, Bulahdelah NSW 2423	(02) 4997 4477	(02) 4997 4571
Denman Multi Purpose Service	51-53 Ogilvie Street, Denman NSW 2328	(02) 6547 3999	(02) 6547 3903
Dungog Community Hospital	Hospital Road, Dungog NSW 2420	(02) 4995 7000	(02) 4995 7005
Emmaville – Vegetable Creek Multi Purpose Service	13-33 Glen Innes Road, Emmaville NSW 2371	(02) 6734 7900	(02) 6734 7990
Guyra Multi Purpose Service	44-48 Sole Street, Guyra NSW 2365	(02) 6738 4000	(02) 6779 1579
Merriwa Multi Purpose Service	Corner Brisbane Street and Mackenzie Street, Merriwa NSW 2329	(02) 6532 5000	(02) 6532 5005
Murrurundi Community Hospital (Wilson Memorial)	Corner O'Connell and Paradise Roads, Murrurundi NSW 2338	(02) 6546 9000	(02) 6546 9005
Quirindi Community Hospital	Nowland Street, Quirindi NSW 2343 PO Box 120, Quirindi NSW 2343	(02) 6746 0200	(02) 6746 2002
Tenterfield Community Hospital	Naas Street, Tenterfield NSW 2372	(02) 6739 5200	(02) 6736 2960
Tingha Multi Purpose Service	Inverell Road, Tingha NSW 2369	(02) 6723 3900	(02) 6723 3509
Tomaree Community Hospital	Trevally Street, Nelson Bay NSW 2315	(02) 4984 0700	(02) 4984 0710
Walcha Multi Purpose Service	South Street, Walcha NSW 2354 PO Box 73, Walcha NSW 2354	(02) 6774 2366	(02) 6777 1458
Warialda Multi Purpose Service	Long Street, Warialda NSW 2402	(02) 6728 9000	(02) 6729 1208

List of facilities (continued)

Wee Waa Multi Purpose Service	Alma Street, Wee Waa NSW 2388 PO Box 417, Wee Waa NSW 2388	(02) 6795 0400	(02) 6795 4905
Werris Creek Community Hospital	North Street, Werris Creek NSW 2341	(02) 6768 6600	(02) 6768 7775
Wingham Community Hospital	32 Bungay Road, Wingham NSW 2429 PO Box 32, Taree NSW 2430	(02) 6557 3400	(02) 6557 3401
Community Health Centres	**Address**	**Phone**	**Fax**
Armidale CHC	Rusden Street, Armidale NSW 2350	(02) 6776 9600	(02) 6776 4900
Ashford CHC	6 Kneipp Street, Ashford NSW 2361	(02) 6725 4239	(02) 6725 4308
Barraba CHC	Edward Street, Barraba NSW 2347	(02) 6782 2507	(02) 6782 1808
Beresfield CHC	Lawson Street, Beresfield NSW 2322	(02) 4966 1363	No Fax
Bingara CHC	Keera Road, Bingara NSW 2404	(02) 6728 0100	(02) 6724 1708
Boggabilla CHC	74 Merriwa Street, Boggabilla NSW 2409	(07) 4676 2418	(07) 4676 2129
Boggabri CHC	Wee Waa Street, Boggabri NSW 2382	(02) 6749 7000	(02) 6743 4274
Bulahdelah CHC	Cnr Richmond & Crawford Streets, Bulahdelah NSW 2423	(02) 4997 4240	(02) 4997 4993
Bundarra CHC	2 Thunderbolts Way, Bundarra NSW 2359	(02) 6723 7206	(02) 6723 7191
Cessnock CHC	View Street, Cessnock NSW 2325 PO Box 154, Cessnock NSW 2325	(02) 4991 0438	(02) 4991 0584
Clarence Town CHC	Prince Street, Clarence Town NSW 2321	(02) 4996 4450	No Fax
Day Care Centres: Allawah Gardenia Grove Marlin Day Centre Wattlegrove Cottage	 Nash Street, Wallsend NSW 2287 20 Banks Street, East Maitland NSW 2323 Kerrigan Street, Nelson Bay, NSW, 2315 Lowrey Lane, Wallsend NSW 2287	 (02) 4924 6141 (02) 4934 8791 (02) 4984 0730 (02) 4924 6361	 No Fax (02) 4934 8657 No Fax (02) 49246 377
Denman CHC	Ogilvie Street, Denman NSW 2328	(02) 4947 2202	(02) 6547 3903
East Lakes CHC	Cnr South & Cherry Streets, Windale NSW 2306	(02) 4944 5300	(02) 4944 5310
East Maitland CHC	Stronach Avenue, East Maitland NSW 2323	(02) 4931 2000	(02) 4931 2002
Forster CHC	Breeze Parade, Forster NSW 2428 PO Box 448, Forster NSW 2428	(02) 65551800	(02) 6554 8874
Glen Innes CHC	94 Taylor Street, Glen Innes NSW 2370	(02) 6739 0100	(02) 6739 0105
Gloucester CHC (based at Gloucester Hospital)	Church Street, Gloucester NSW 2422 PO Box 33 Gloucester NSW 2422	(02) 6538 5058	(02) 6538 5059
Gresford CHC	Park Street, Gresford NSW 2311	(02) 4938 9207	(02) 4938 9442
Gunnedah CHC	80 Marquis Street, Gunnedah NSW 2380	(02) 6741 8000	(02) 6740 2879
Guyra CHC	44-48 Sole Street, Guyra NSW 2365	(02) 6738 4000	(02) 6779 1579
Gwabegar CHC	Bridge St, Gwabegar NSW 2356	(02) 6849 6100	(02) 6796 4473
Harrington CHC	Pilot Street, Harrington NSW 2727	(02) 6556 1429	No Fax
Hawks Nest/Tea Gardens CHC	Cnr Booner and Tuloa Street , Hawks Nest NSW 2324 PO Box 12, Hawks Nest NSW 2324	(02) 4997 0186	(02) 4997 1528

List of facilities (continued)

Inverell CHC	Swanbrook Road, Inverell NSW,2360	(02) 6721 9600	(02) 6721 9580
Kurri Kurri CHC	Lang Street, Kurri Kurrri NSW 2327 PO Box 154, Cessnock NSW 2325	(02) 4936 3282	(02) 4936 3281
Manilla CHC	Court Street, Manilla NSW 2346	(02) 6785 1490	(02) 6785 1490
Merriwa CHC	McKenzie Street, Merriwa NSW 2329	(02) 6548 2006	(02) 6548 2527
Moree CHC	Alice Street, Moree NSW 2400	(02) 6757 3670	(02) 6757 3697
Morisset CHC	143 Dora Street, Morisset NSW 2264	(02) 4973 3025	(02) 4973 6851
Mungindi CHC	82 St George Street, Mungindi NSW 2406	(02) 6753 2155	(02) 6753 2361
Murrurundi CHC	Cnr O'Connell St and Paradise Rd, Murrurundi NSW 2328	(02) 6546 6106	(02) 6546 6518
Muswellbrook CHC	Brentwood Street, Muswellbrook NSW 2333	(02) 6542 2050	(02) 6542 2005
Narrabri CHC	11 Cameron Street, Narrabri NSW 2390	(02) 6799 2000	(02) 6799 5112
Nelson Bay CHC	Kerrigan Street, Nelson Bay NSW 2315	(02) 49 840730	(02) 4984 0744
Newcastle CHC	670 Hunter Street, Newcastle NSW 2300	(02) 4016 4530	(02) 4016 4535
Nundle CHC	Jenkins Street, Nundle NSW 2340	(02) 6755 8001	(02) 6769 3192
Pilliga/Gwabegar CHC	Dangar Street, Pilliga NSW 2388	(02) 6796 4473	(02) 6769 4473
Premer CHC	Ellerslie Street, Premer NSW 2381	(02) 6744 2366	(02) 6744 2025
Quirindi CHC (based at Quirindi Hospital)	50 Nowland Street, Quirindi NSW 2343	(02) 6746 0200	(02) 6746 0230
Raymond Terrace CHC	Suite 2 / 59 Port Stephens Street, Raymond Terrace NSW 2324	(02) 4987 2078	(02) 4987 1660
Scone CHC	Stafford Street, Sonce NSW 2337	(02) 6540 2136	No fax
Singleton CHC	Boonal Street, Singleton NSW 2330	(02) 6571 9248	
Stroud CHC	Main Street, Stroud NSW 2425	(02) 6558 1011	(02) 6558 2726
Tambar Springs CHC	Merrigula Street, Tambar Springs NSW 2381	(02) 6744 2600	(02) 6744 2025
Tamworth CHC	Johnston House, Johnston Street, Tamworth NSW 2340	(02) 6767 8100	(02) 6766 3967
Taree CHC	64 Pulteney Street, Taree NSW 2430	(02) 6592 9315	(02) 6592 9607
Tenterfield CHC	Naas Street, Tenterfield NSW 2372	(02) 6739 5200	(02) 6736 2960
Toomelah CHC	Building Number 26, Toomelah PO Box 252, Boggabilla NSW 2409	(07) 4671 9701	(07) 4676 2449
Uralla CHC	Corner Bridge and Wood Streets, Uralla NSW 2358	(02) 6776 1201	(02) 6778 3952
Walcha CHC	South Street, Walcha NSW 2354	(02) 6774 2400	(02) 6777 1458
Walhallow CHC	PO Box 3, Caroona NSW 2343	(02) 6747 4853	(02) 6747 4822
Wallsend CHC	15 Nash Street, Wallsend NSW 2287	(02) 4924 6100	(02) 4924 6101
Warialda CHC	Long Street, Warialda NSW 2402	(02) 6728 9000	(02) 6729 1208
Wee Waa CHC	Alma Street, Wee Waa NSW 2388	(02) 6795 0400	(02) 6795 3028
Werris Creek CHC	North Street, Werris Creek NSW 2341	(02) 6768 7380	(02) 6768 7775
Westlakes CHC	James Street, Toronto NSW 2283	(02) 4935 8100	(02) 4935 8163
Western Newcastle CHC	15 Nash Street, Wallsend NSW 2287	(02) 4924 6100	(02) 4924 6101

Strategic and Clinical Services Planning

During 2007/08, Hunter New England Health's Approach to Planning (November 2007) was released. This document aims to define and differentiate the types and levels of planning activities undertaken across Hunter New England Health. At the Area or Corporate level, there are a suite of plans that together provide the overall strategic framework for the provision and development of health services across the Hunter New England area.

Clinical Services Plans
The development of Clinical Services Plans are an important component of that framework and during 2007/08 the following clinical services plans were endorsed and released:

- Aboriginal Health Plan 2007-2011
- Cardiac Services Plan 2008-2012
- Children, Young People and Families Plan 2007-2011
- Critical Care and Emergency Services Plan 2006-2010
- Drug and Alcohol Services Plan 2007-2011
- Renal Services Plan 2007-2011

Most of these plans are aligned with Area Clinical Networks/ Streams.

Health Services Plans
Health Services Plans for Manilla and Werris Creek were also completed this year. Health Services Plans are developed for facilities that are to undergo a major capital redevelopment or refurbishment. Both Manilla and Werris Creek are being redeveloped as Multipurpose Services. Significant work on the development of the Tamworth Health Services Plan was also completed.

Framework Plans
Hunter New England Health has introduced a new planning process – the development of the Framework Plan. Framework Plans are developed to address significant emerging health issues, corporate organisational issues or Area-wide services/service models. They describe the model of service provision for Hunter New England Health in relation to the issue/service – describing the Area's philosophy in relation to the issue/services concerned and the recommended approach/model to be adopted across the Area.

In April, the Hunter New England Health Framework to Support Adults Managing Obesity and Morbid Obesity 2008-2012 was released. The Framework recommends the development of a comprehensive and integrated multidisciplinary approach to managing obesity and morbid obesity. Strategies that focus on building partnerships with general practitioners, private providers, and other government and non-government agencies and community groups are key to the Framework's recommended model of care.

Other Frameworks Plans in development include a Framework to Address Health Inequities and the Primary and Community Health Services Framework.

Progress on Implementing the Area's Strategic Plan
Implementation of A New Direction for Hunter New England Health Service: Strategic Plan Towards 2010 continues with several significant achievements over the past year including:

- Development of proactive planning processes to inform decision making
- A number of clinical initiatives aimed at improving patient safety including patient ID/correct site procedures, the rollout of the NSW Health Surgical Audit Program, introduction of a Death Audit process, reduced rates of inappropriate transfusions and reduced rates of preventable infections in high risk patients.
- Implementation of a Smokefree Health Service – all health campuses across the Hunter New England are now smoke free
- Completion of the Aboriginal Health Plan in consultation and partnership with local Aboriginal people
- Innovation and Reform Unit established
- Funds for Four HealthOne NSW sites secured and planning commenced
- Pandemic Response Planning well underway
- Hunter New England Health Asset Strategic Plan completed
- Aboriginal Employment Strategy completed

Major hospital facilities

John Hunter Hospital incorporating The Royal Newcastle Centre

John Hunter Hospital is a tertiary referral hospital and is the major referral centre for Hunter New England Health. It provides a range of services such as:

- obstetrics and gynaecology
- emergency medicine
- trauma
- cardiology and cardiac surgery
- nephrology and kidney transplant
- anaesthesia and intensive care
- neonatal intensive care
- neurology and neurosurgery
- and a full range of sub-specialty medical and surgical services.

The Royal Newcastle Centre provides treatment for patients in specialties such as:

- orthopaedics and orthopaedic rehabilitation
- rheumatology
- urology
- ophthalmology
- dermatology
- diabetes
- immunology
- podiatry

Other clinical services include:

- medical and surgical outpatients
- cardiac catheterization
- endoscopy
- diagnostic radiology
- pathology testing
- surgical services
- interventional procedures
- Hunter Integrated Pain Service.

Major activities and outcomes:

- Installation of air-conditioning
  Work on a $10 million project to install air conditioning in 15 wards at the John Hunter Hospital and John Hunter Children's Hospital was completed in March 2008.

- Older Person Acute Care Model (OPAC)
  The Division of Medicine at John Hunter Hospital has developed an older person model of care which enhances the care received by older people while inpatients within an acute facility. The OPAC model is a finalist in the NSW Health Awards.

- Caring for people with delirium
  The Division of Medicine has developed a Delirium Alert Protocol for clinical staff to use to prevent the occurrence of Delirium in older persons in the acute care units. This protocol has been developed during the 2007 Delirium research project "Practice Redesign and partnership to Improve Quality of Delirium Care in Older People".

- The Advanced Trainee Program for General Medicine
  In 2007 the Division of Medicine was successful in securing Commonwealth and State Funding for the establishment of a Hunter Network Advanced Trainee Program for General Physicians. The focus of this program is to develop general physicians to meet the rural, regional and metropolitan needs within New South Wales.
  The first advanced trainee from this program will complete their training at the end of 2008 and new recruits will commence in 2009.

- State Wide Cardiology Redesign Project
  The State wide cardiology redesign project continues to be a major initiative in John Hunter Hospital. The most recent initiative involves collaboration between John Hunter Cardiology Department and the NSW Ambulance service, enabling patients with chest pain to access immediate specialist cardiologist consultation and antithrombotic intervention if required.

- Improving access to care for acute stroke patients
  Working in partnership with NSW Ambulance Service and Hunter New England Imaging, John Hunter Hospital developed the Pre-Hospital Acute Stroke Triage (PAST) protocol to reduce pre-hospital and emergency department delays for stroke patients accessing stroke care. This project was awarded a NSW Premier's Public Sector award and an Australian Council on Healthcare Standards (ACHS) Quality Award.

- Aboriginal Health Screening Project
  The Division of Medicine's Nephrology Department has undertaken an area wide project titled Using knowledge to safeguard a nation: A collaborative approach to vascular and renal health in Aboriginal communities within the countries of North Eastern NSW. This project aimed to minimise health disadvantage by identifying patients at risk of vascular and renal disease. This project was awarded the NSW Premiers public sector award and the NSW Aboriginal Health Award.

- Medical Assessment and Coordination Unit (MACU)
  The MACU was established in 2008 to improve access to timely healthcare for elderly patients presenting to inpatient care facilities. The 16 bed inpatient care unit operates 7 days a week to provide comprehensive assessment and intervention for complex elderly patients.

- Emergency Short Stay Unit (ESSU)
  In April 2008 the ESSU was established to treat patients who require an extended period of treatment in the Emergency Department. It is a short stay observation unit for patients who require an extended period of observation and/or investigations.

- NSW Premier's Award for John Hunter Hospital Emergency Department
  In November 2007 the John Hunter Hospital Emergency Department was awarded the NSW Premier's Gold Award for Delivering Better Services.

- Reduction in waiting times for surgery
  As at 30 June 2008, the John Hunter Hospital/Royal Newcastle Centre successfully reduced the number of people waiting for surgery and met all targets for the period. This included reducing the number of patients requiring surgery in 30 days, waiting greater than 30 days to zero and reducing the number patients waiting longer than 365 days for surgery to zero.

- The Organ Donor Collaborative
  John Hunter Hospital has continued to meet all targets within the Australians Donate National Organ Donor Collaborative. This has contributed to the Collaborative increasing the average monthly donation rate over all hospitals to 11.19, an increase of 31.6% over 2005/06.

- Central Sterilising Department Review
  The Central Sterilising Department (CSD) was the subject of review earlier in the year. As a result there has been a significant decrease in reported incidents and improved streamlining of all procedures.

- Ambulatory Care/Referral Management Centre Review
  An extensive consultative process is being conducted and a report prepared to determine what operational, organisational and governance issues need to be addressed to manage our very complex service now and into the future.

- Essentials of Care Program
  The Essentials of Care Program was developed by staff at the Prince of Wales Hospital and is currently being implemented by the Nursing and Midwifery Office throughout NSW public hospitals. It focuses on the development of clinical environments that empower patients, their families and health professionals to work towards a safer and more patient orientated environment. Ward 1 RNC is a pilot site.

- Pandemic Planning - Fever Clinic
  The Royal Newcastle Centre Pandemic Lead Team has developed a plan to enable the activation of a fever clinic as part of its infectious disease emergency response as directed by the NSW Department of Health.

- Power upgrade to John Hunter Hospital/ Royal Newcastle Campus
  Energy Australia undertook work to upgrade the power supply to the campus. The work was undertaken to supply John Hunter Hospital, Royal Newcastle Centre, Hunter Area Pathology Service and Forensic Medicine with stand-alone generators.

Key issues and events:

- **Installation of air-conditioning**
  While the installation of air conditioning at John Hunter Hospital is a major improvement for patients, visitors and staff, the resulting relocation of wards was challenging but also provided opportunities for ward refurbishment and standardisation.

- Emergency department performance
  The main challenge for the John Hunter Hospital Emergency Department was to sustain its current performance to NSW Health benchmarks targets in the face of increasing presentations. The creation of a fast-track area to improve patient throughput, and staff commitment to maintaining a focus and sense of urgency in relation to patient access were significant factors in achieving this goal.

- Laser Safety Course
  The RNC ran a Laser Safety Course for Health Care Professionals in May 2008. It was attended by doctors, nurses and technicians from across Australia. The range of topics covered included laser biophysics, laser science and dosimetry for laser treatments, as well as hazard identification and laser applications in the clinical setting.

- Urological Society of Australia and New Zealand Annual Scientific Meeting
  A number of Royal Newcastle Centre delegates attended this meeting. They were responsible for a presentation on the management of renal colic, a poster presentation on bladder cancer surveillance and another on teaching a rheumatoid arthritic patient how to intermittently self catheterise.

- The “Pit Stop for Youth” Program
  The “Pit Stop for Youth” Program was developed by a group of Royal Newcastle Centre male nurses, to provide education to teenaged boys in years 7-10 to attend self examinations for the early detection of, and intervention for, testicular cancer. The program is ongoing in selected Hunter schools and funding is currently being secured to run a similar program on sexually transmitted diseases.

- Acute General Surgery Unit Introduction
  Introduction of the Acute General Surgery Unit (AGSU) model of care for general surgery patients requiring admission and treatment. This has involved the remodelling of the mode of service provision for the general surgeon group and focuses on providing more timely surgical interventions as required.

- Vascular Angiography Suite
  Commissioning of Vascular Angiography Suite in Royal Newcastle Centre to enable surgeon lead vascular interventional procedures to be conducted. This has also included the introduction of Carotid Stenting.

Future directions:

- John Hunter Hospital is committed to its ongoing contribution to the development of clinical streams within Hunter New England Health and will continue to oversee and provide leadership with the development of the critical care, stroke, cardiology, renal and respiratory clinical streams.

- The future sustainability of the John Hunter Emergency Department’s performance to NSW benchmark targets during winter 2009 and beyond is highly dependent on the efficient use of the Emergency Short Stay Unit (ESSU) and Medical Assessment and Coordination Unit (MACU).

- John Hunter Hospital and the Royal Newcastle Centre participated in the diagnostic and design phase of the Booked Surgical Patient Journey Project began implementing the project solutions. These include the acquisition of a new tracking system for the Clinical Sterilising Department, the development of new operating management governance structures and reporting mechanisms designed to drive efficiency and effectiveness improvements within the operating theatres and a review and redesign of perioperative services delivery.

Community support/volunteers:

The John Hunter Hospital/Royal Newcastle Centre is fortunate to have more than a dozen volunteer organisations working to improve the care and comfort of patients and their families. The largest group, the John Hunter Site Carers, includes more than 160 people, ranging in age from 16 to 90. During the 2007/2008 financial year the Carers donated a total of $260,734.13 in equipment and comforts for patients. As well as fundraising through the sale of handcrafts and other projects, the Carers provide many different services including booking on-site accommodation for relatives, running the gift shop and delivering newspapers and magazines to the wards.

Major hospital facilities

John Hunter Children's Hospital

The John Hunter Children's Hospital is one of three designated children's hospitals in NSW, providing care for those aged from birth (sometimes from 23 weeks gestation) to 18 years throughout Hunter New England Health and other parts of northern New South Wales. Services include:

- a Neonatal Intensive Care Unit
- general paediatrics and tertiary services
- surgery and trauma
- adolescent and day stay facilities
- a comprehensive outpatient service and a school
- a diverse range of community based services providing the full range of primary, secondary and tertiary health care for children, young people and families.

Major activities and outcomes:

Respiratory Medicine

- The paediatric respiratory medicine department cares for patients with long term chronic lung disease such as asthma and cystic fibrosis. This year saw the expansion of support and education to parents through Nurse Asthma Clinics and GP Education programs. A Tracheostomy Team providing co-ordinated care by a multidisciplinary team, including an ENT Specialist has proven successful in providing holistic approach to care for these patients.

Allergy and Immunology

- The trebling in incidence of food allergies in children has placed great demands on paediatric allergy services over the past two years. The service has looked at innovative measures to support patients including temporary engagement of a paediatric allergy Clinical Nurse Consultant and development of an allergy outreach service.

Children's Cancer and Haematology Service

- This year we celebrated the culmination of many years of community fundraising to create a new, state-of-the-art Children's Cancer and Haematology Unit. The new independent Day Unit, separated from hospital wards, is an all encompassing treatment facility where children can present for clinics, procedures and day chemotherapy.

Newborn Services

- Newborn services saw the highest ever level of activity recorded in the Neonatal Intensive Care Unit with over 1100 admissions this year. Our role in the state-wide retrieval service continues to increase and recruitment to the Retrieval Team and training expanded our ability to respond.
- Staff of the nursery, together with other multidisciplinary specialists, delivered an extensive outreach education program in the care of the ex-premature infant throughout New England and Central Coast regions.
- The unit received community and corporate donations resulting in more than $250,000.00 this year to help improve neonatal transport service, cardiac service and parent support facilities. The contributions of Xstrata Coal, JHCH Kids Club, Dorothy Earl, and Variety, the children's charity are commended.
- The nursery saw the completion of Transitional Nurse Practitioner training; three Graduates are now awaiting Nurses Registration Board authorisation. The Unit now has five Nurse Practitioners on staff.

Surgical and Trauma Services

- Demand for Surgical and Trauma services continues to increase. As a consequence of the increase in NICU beds, this year also saw a rise in the number of neonates requiring surgery.
- Existing orthopaedic services were enhanced with the appointment of a paediatric orthopaedic specialist. Collaboration with surgical specialities continues.
- Access to operating theatre time ensured surgical outreach delivered to Maitland and Taree.

Physiotherapy

- The Paediatric Physiotherapy Department became an accredited Ponseti Centre for the management of Congenital Talipes Equinovarus (CTEV) ensuring compliance with international best practice standards which will result in enhanced client outcomes.
- A successful trial of paediatric physiotherapy outreach clinics at Maitland Hospital resulted in establishment of long term service agreements ensuring consistent application of paediatric physiotherapy practices in the southern sector.
- Commenced trial of infant massage classes for parents of NICU babies; developed allied health guidelines for the transition of clients to adult health services and increased access to paediatric physiotherapy services in Port Stephens and Raymond Terrace.

Occupational Therapy

- Activity for the Occupational Therapy team focussed on ensuring equitable access to services and enhancement of assessment tools.
- Members of the team celebrated their role in advocating for an "All Abilities" community playground at Speers Point where children, regardless of their physical, cognitive, medical or behavioural abilities could play on equal terms.

Nutrition and Dietetics

- Conducted multidisciplinary diabetes and cystic fibrosis outreach clinics. Expanded outreach services to NICU and participated with the paediatric allergy team in food allergy outreach education sessions and clinics.
- Staff involved in research into the management of diabetes for children on insulin pump treatment successfully developed an innovative carbohydrate counting program resulting in successful outcomes for patients due to improved compliance.

Speech Pathology

- Inpatient activity has focused on assessment and treatment of speech, language and swallowing disorders for acute and rehabilitation patients.
- Outpatient services provided to specialised client groups including ongoing teaching in specialty areas such as cleft and velopharyngeal incompetence (VPI).

- A new specialist diagnostic procedure, palato-videofluoroscopy (PVF), conducted in conjunction with the paediatric radiologist, offered for children across Northern NSW with (VPI).
- Referrals in infant feeding from Child and Family Health Nurses and Community Lactation Consultants have increased as have referrals from community paediatricians for children with complex dysphagia for children with cardiac anomalies or complex gastroenterological disorders.
- Development of clinical care guidelines for cleft speech and language assessments, resulted in more consistent and evidence based approaches to feeding practices.

Key issues and challenges:

- The increased demand for the services of a paediatric gastroenterologist.
- The increase in birth rate in the region will continue to provide a challenge for delivery of future newborn services.
- The sustainability of surgical and trauma services until appointment of another paediatric surgeon
- Development of resources and protocols for clinical areas experiencing increased patient numbers including food allergies, inflammatory bowel disease, total parenteral nutrition (TPN).
- The need to refurbish or enhance facilities to create safer and more child friendly appropriate environments specific to the needs of children, continues to present challenges.

Future directions:

- Future directions will see continued expansion of regional clinics and growth in delivery of education and continued improvement in programs to prepare patients for transition to adult services.
- An increased role in diversional play for children in Emergency, Intensive Care and Outpatient Clinics. In addition, the paediatric pain team is investigating implementation of a diversion strategy involving virtual reality for children receiving oncology and burn treatment.

Volunteers:

The John Hunter Children's Hospital offers several programs to support patients – Play Therapy, Art Therapy, Ward Grandparent Scheme, the Starlight Express Room and Little Wonders – that rely on the contribution and good will of Volunteers. These programs are vital to our philosophy of providing for the whole wellbeing of the child and their family while in our care. We would like to acknowledge the role volunteers play in delivering these services.

Belmont Hospital

Belmont Hospital is a designated medical and surgical district hospital that provides a range of health care services to the population of Lake Macquarie including:

- general medicine
- general surgery
- day surgery
- coronary care
- gynaecology
- emergency services
- and allied health services for inpatients when required.

In 2007/2008:

- emergency department presentations equated to 22,178, a 10.96 per cent increase on the previous financial year
- surgical cases equated to 4,609, a 12.63 per cent increase
- outpatient activity equated to 13,544, a 10 per cent increase
- inpatient activity also increased by 12 per cent

Major goals and outcomes:

- Refurbishment of the emergency department has improved workflows for clerical and nursing staff, provided new and improved office accommodation for admissions and medical staff, and provided a dedicated area for tutorial/education within the department.
- Relocation of the GP Access After Hours Access Service to the Outpatient Clinic rooms has enabled improved consultation space and necessary dedicated waiting area for emergency department patients.
- Patient accommodation on Level 1 has undergone renovations of bathrooms, aesthetic improvements to patient accommodation and installation of a standardized universal nursecall system.
- To ensure safety of all persons on site, safety enclosures for open balconies have been installed on Level 1 and 3, and fencing has been installed adjacent to the North Block building and carpark area. Suitable pathways have also been constructed between the public bus stop and the hospital to ensure safe access.
- Road signage has been installed on Pacific Highway and Croudace Bay Road to improve public awareness of the location of the hospital.

Key issues and events:

- The Belmont management team was enhanced by the appointment of Manager of Nursing Services Lauren Denny.
- Belmont Hospital celebrated its 40th Birthday on the 2 March 2008.

Future directions:

- Belmont is working toward refurbishment of South Block patient accommodation.
- The hospital continues to stream processes consistent with other sites within the Acute Hospital Network.
- This financial year has seen Belmont achieve all benchmarks including ED triage categories, access performance and waitlist targets and we are working towards continuing to achieve these excellent results.

Major hospital facilities

Community support/volunteers:

- Hospital volunteers donated funds to purchase a Soluscope machine for operating suite, televisions for patient cubicles, patient screens, air conditioning, toaster, lockers, dishwasher, vital signs monitor, bar code scanner, and ring cutter.
- Belmont East Lakes Palliative Care donated furniture and fittings to establish a quiet area for patients' family and friends.
- A community member, Mr Lattimer, donated funds to purchase the following equipment: Vital signs monitor, two bear huggers, six hilite armchairs and a Biphasic Defibrillator AED.
- Swansea Lion's Club donated a Resuscitation Doll.

The Maitland Hospital

The Maitland Hospital is a rural referral hospital that provides services for the Lower and Upper Hunter communities. Services provided include:

- high dependency/coronary care unit
- emergency
- maternal and child health
- medical
- surgical
- rehabilitation services
- mental health
- dental
- dialysis
- diagnostic services

In 2007-2008, the Maitland Hospital experienced an extraordinary growth in emergency department presentations treating 38,981 patients and 12,907 admissions. The maternity unit provided services for women giving birth to a total 1527 newborns, providing antenatal, postnatal and intrapartum care. The facility treated 139,919 non-admitted patients (outpatients) and performed 5175 operations.

Major activities and outcomes:

- Significant improvement in emergency department benchmarks, from 2007 to 2008.
- Improved access for patients waiting for elective surgery. No patients waiting greater than 12 months by June 2008.
- Established additional transitional aged care packages in the community.
- Implemented the Rehabilitation Patient Journey, and established a virtual stroke unit within the medical unit.
- New staff specialist appointed in obstetrics and gynaecology.

Key issues and challenges:

- The emergency department redevelopment is planned to commence in January 2009, with wide consultation and development of plans through 2008.
- Maintaining timely patient access, particularly given the increasing demand for services such as emergency department.
- Managing demand within available resources.

Future directions:

Key issues to be addressed in the future will include:

- Continuing to deliver services whilst the emergency department redevelopment progresses
- Development of a Medical Assessment Unit
- Providing improved outpatient access particularly for orthopaedic patients
- Continued contribution to the development of the Lower Hunter Plan towards 2030
- Rollout of advanced care planning and enablement nursing.

Community support/involvement:

The Maitland Hospital has been fortunate in establishing a Local Health Advisory Committee, which is committed to supporting the organisation in reaching organisation goals.

Several volunteer groups including the Pink Ladies, the Red Cross and the TLC volunteers support The Maitland Hospital. All of these groups contribute to the provision of a large number of volunteer hours for patients.

The facility is enriched by these donations of people's time and energy and grateful for this ongoing support.

Manning Hospital

Manning Hospital, Taree, is a rural referral hospital. Services provided include:

- surgery
- medicine
- critical care
- obstetrics and gynaecology
- paediatrics
- emergency
- oncology
- palliative care
- rehabilitation
- high dependency
- allied health
- mental health

Major activities and outcomes:

- New Emergency Department
  Construction work is well advanced on the new $13.2m Emergency Department which will provide vastly improved facilities for staff and patients including dedicated areas for children, victims of assault and persons with mental illnesses. Completion of stage one of the project is now anticipated for the end of January 2009 and the hospital is well advanced in finalising its commissioning and location plans around that date.

- Renal Services
  Works are well advanced on the establishment of a six chair acute Renal Service on Level 3 of the hospital's general ward block. This project is due for completion in October 2008. In preparation for the service commencing, staff have been recruited and are undergoing training in renal dialysis therapies. This service will particularly benefit those patients who currently need to be transferred to Newcastle to access renal dialysis during periods of acute illness.

- Occupational Health and Safety
  The hospital's commitment to improving safety for its staff remained a high priority during the period and this resulted in a 37 per cent reduction in lost time injuries and a substantial reduction in the hospital's workers compensation premium. Further reductions in injury rates are targeted for the new financial year.

- EQuIP Accreditation
  Manning Hospital was awarded full accreditation by the Australian Council on Healthcare Standards in recognition of its demonstrated commitment to providing quality health services. The hospital has since completed stage one of the next four year EQuIP Accreditation cycle.

- Elective Surgery
  A strong focus was placed upon ensuring all elective surgery patients received their procedure within NSW Health benchmark times. Thanks to the efforts of medical, nursing and administrative staff the hospital was successful in reaching benchmark targets for Category 1, 2 and 3 elective surgery patients.

Key issues and challenges:

- Recruiting to key medical and nursing positions remains a major challenge. In the medical field, the hospital continues to work collaboratively with local medical staff and private hospitals to make positions interesting and inviting for potential applicants.
- A nursing recruitment plan has been developed and updated. A strong focus is now placed on recruiting new graduates and ensuring their safe and effective introduction to the workplace.

Future directions:

- The primary focus of the hospital over the next 12-months will be to bring on line new Emergency Department and the six bed acute Inpatient Renal Unit.

Armidale Hospital

Armidale Hospital is a rural referral hospital. Services provided include:

- general medicine
- surgery
- obstetrics and gynaecology
- paediatric
- geriatric
- anaesthetics and intensive care
- dental
- mental health
- emergency services

Major activities and outcomes:

- Establishment of Armidale as a teaching hospital through the Joint Medical Program (JMP). In January 2008, 64 students commenced study at the University of New England as part of the program. The Joint Medical Program is an expansion of the highly successful University of Newcastle medical program, in partnership with the University of New England, Hunter New England Health and Northern Sydney Central Coast Health.

- Recruitment of many key medical positions including two Staff Specialist Physicians, a Staff Specialist Surgeon and also a Staff Specialist Obstetrician and Gynaecologist and Staff Specialist Surgeon who both have conjoint appointments with the University of New England as part of the Joint Medical Program. We have also appointed a General Surgical Registrar in partnership with John Hunter Hospital.

- A $152,000 upgrade to the teaching facilities at Armidale Hospital to provide JMP students with an appropriate environment to continue their clinical training. Works included an upgraded medical library, modernised seminar room and the addition of videoconferencing equipment in two community health conference rooms, to improve access to electronic teaching programs, computers and literature.

- Achievement of full four-year unconditional accreditation from the Australian Council on Healthcare Standards (ACHS).

- Engagement of a psychogeriatrician service for the northern region to meet increasing demand for services by elderly patients with psychiatric problems. Dr Sid Williams, a psychogeriatrician based in Sydney, made his first monthly visit to Armidale Rural Referral Hospital on 5 September 2007.

- Appointment of Dr Peter Gillies as Director of Medical Services and Sally Bristow as our new Director of Nursing.

Key issues and challenges:

- Managing demand within available resources.
- Number of Junior Medical Officer positions needed in the future to support the specialist workforce.
- Working with the JMP to cater for the educational needs of Year 1 and Year 2 JMP medical students in 2009.
- Preparing for the numerical profile under a new system in November 2008, as changes to standards and criteria will increase the challenges in meeting benchmarks.

Major hospital facilities

Future directions:

- Closer networking with the Tablelands Cluster especially in regards to continuity of patient care and transfers of patients between Armidale and the Tablelands.
- Progress to making Armidale Hospital Intensive Care Unit meet NSW Health Role Delineation Level 4.
- To maintain outreach specialist med clinics to Inverell and Glen Innes.

Tamworth Hospital

Tamworth Hospital is a rural referral hospital. Services provided include:

- medicine
- surgery
- anaesthetics
- dental
- ear, nose and throat
- obstetrics and gynaecology
- cardiology
- emergency
- intensive care
- paediatric
- palliative care
- rehabilitation
- renal
- oncology
- mental health services

Major activities and outcomes:

- Commenced Tamworth Health Services Redevelopment planning.
- Commenced establishment plans for Ronald McDonald House Tamworth.
- Overcame challenge of medical oncology service provision in conjunction with Area Cancer Services.
- Recruited urologist Dr Gias Ahmed, endocrinologist Dr Deepali Shirkhedkar, colorectal surgeon Dr Andrew Zbar, paediatrician Dr Fiona Kay, orthopedic surgeon Dr Rob Sharp, GP anaesthetist Dr Simon Ford and anaesthetist Dr Kondareddy Yatham.
- Achieved full four-year unconditional accreditation from the Australian Council on Healthcare Standards (ACHS).
- Appointed Intensive Care Unit nurse Fiona Ellicott as the Retrieval Team Co-ordinator, to streamline logistics and support the Tamworth Hospital Retrieval Service.
- Employed a record intake of new nurse graduates (20) accepted in the February 2008 intake.
- Established interventional cardiology services, angiograms and stent insertion, at the Tamworth Hospital Cardiac Catheterisation laboratory. A cardiology registrar position was also funded to support new procedures introduced to the service.
- Established a dedicated Acute Stroke Unit in the medical ward, providing four dedicated beds for stroke patients to receive highly-specialised care, including more intensive monitoring, observation and treatment by specialised nursing and allied health staff.
- Tamworth osted the Royal Australasian College of Physicians 2007 FRACP Clinical Examinations.

Key issues and challenges:

- Ongoing medical, nursing and allied health recruitment.
- Medical oncology/radiation oncology service provision.
- Winter bed management.

Future directions:

- Further work on service and facility planning, through the Tamworth Health Services Redevelopment, to deliver health services to serve the community past 2020.

Greater Newcastle Cluster

The Greater Newcastle Cluster includes:

- Tomaree Community Hospital - a 14 bed hospital that provides:
    - 24 hour emergency services for adults and paediatrics
    - inpatient acute care
    - care for adults who are ill but do not require surgery and people recuperating from illness or surgery
    - palliative care
    - respite care for the aged, young and people with disability (Monday to Friday)
    - post natal care for women eligible for early discharge from their obstetric hospital

- Rankin Park Centre – a 40 bed inpatient unit with a day hospital
    - Predominant case mix is debility, stroke, brain injury, amputation and other neurological problems.
    - Day Hospital provides multidisciplinary outpatient services for above patients and significant focus on falls injury prevention, treatment of Parkinson's Disease and Tone and Function clinics.

- Short Term Resident Accommodation Service – a 20 bed in-patient unit located in Belmont Hospital
    - Provides care and accommodation for those people who have been identified as requiring admission to a residential aged care facility.
    - Has a dedicated team of speciality staff who facilitate the admission process and provide support for carers.

- Wallsend Aged Care Facility – a 103 bed aged care facility specialising in patients with challenging behaviours and young people with severe disability.

- Brain Injury Service – located in Newcastle and offers brain injury rehabilitation programs.

- Rankin Park Campus, including:
    - Hunter Prosthetic and Orthotic Service
    - Hydrotherapy pool and gym
    - EDuCARE (Carer Education Service)
    - Aged Care Services

- Community Health Centres at Nelson Bay, Newcastle, Raymond Terrace, Toronto, Wallsend, and Windale that provide a comprehensive range of services. A list of services provided at each centre is available at http://intranet.hne.health.nsw.gov.au/services_and_facilities/

Major activities and outcomes:

- Development of a Wound Management Model of Care that has been recognised at state and national levels.
- The Referral and Information Centre was recognised as the Hunter New England Health Clinical Unit of the Year.
- Rankin Park Centre has significantly improved length of stay.
- Development of a partnership with the Department of Disability, Ageing and Home Care to trial a single point of access for Home and Community Care services.
- Significant development of Community Acute/Post Acute Care and Transitional Aged Care programs to provide alternatives to hospitalisation.

Key issues and challenges:

- Developing a sustainable model of medical management at Tomaree Community Hospital.
- Increasing demand for services across many aspects of the service.

Future directions:

- Further development of the Community Acute/Post Acute Care service to provide acute care in the nursing home setting as well as alternate models of care for conditions where NSW Health has determined conditions being amenable to "hospital avoidance".

Lower Hunter Cluster

The Lower Hunter Cluster includes three district health services/acute hospitals – at Cessnock, Singleton and Kurri Kurri; a community hospital at Dungog; and community health services at East Maitland, Cessnock, Singleton, Kurri Kurri, Dungog and Gresford.

Cessnock District Hospital is an acute facility providing:
- general medicine
- general surgery
- orthopaedics
- urology
- gynaecology
- postnatal
- emergency services
- visiting medical and community health specialist services, allied health services and a range of community health services.

Services at the acute facility at Singleton Hospital include:
- an emergency department
- on-call GP obstetrics
- high dependency/special care unit
- palliative care
- general medical and surgical
- day surgery paediatrics
- pathology
- x-ray
- renal dialysis
- a range of allied and community health services and specialist outreach services.

Geographic Clusters

Kurri Kurri Hospital is an acute and transitional care facility providing:
- general medicine
- general surgery
- ear, nose and throat and ophthamology services
- an emergency department
- a range of allied and community health services and a day respite service.

The community hospital at Dungog provides:
- inpatient medical, post-surgical and postnatal services
- an emergency department
- x-ray and pathology services
- a range of community health services.

A wide range of community health services are provided through the East Maitland Community Health Service, which also provides an outreach service to Beresfield, and at the Gresford Community Health Service.

Major goals and outcomes:

- The Lower Hunter Cluster undertook Organisational Wide Survey by the Australian Council on Health Care Standards, resulting in accreditation status for the next four years. The surveyors congratulated the community health service on the many services that it provided in the community setting, enhancing the potential for participation from people who are reluctant to attend traditional health service settings. Surveyors also commented on the commitment at all levels of the Lower Hunter Cluster to the evaluation and improvement of services across the clinical, support and corporate functions, and commended Cluster educators on their approach to recognise and value knowledge development and generation.

- Cost efficient strategies were implemented in a collaboration between the Lower Hunter Cluster and The Maitland Hospital to enhance patient flow during the busy 2007 winter period. Outcomes included a 19 per cent improvement in The Maitland Hospital's EAP to 84 per cent in two months, despite increased emergency department presentations, and a reduced average length of stay at Kurri Kurri Transitional Care Unit from 149 days to 24 days.

Upper Hunter Cluster

The Upper Hunter Cluster is comprised of nine facilities including Muswellbrook District Health Service, Scone District Health Service, Quirindi Community Hospital, Merriwa Multi Purpose Service, Murrurundi Community Hospital, Denman Multi Purpose Service, Werris Creek Community Hospital and Tambar Springs and Premer Community Health Services. A broad range of services is offered from the cluster's facilities including:

- Aboriginal health services
- Acute medical
- Aged care
- Aged Care Assessment Team (ACAT)
- Audiometry
- Community nursing
- Day care
- Dietetics
- Early childhood service
- Emergency
- Early childhood service
- Foot Care
- High dependency unit
- Mental Health
- Meals on Wheels
- Occupational Health Service
- Occupational Therapy
- Outpatient clinics
- Operating theatre
- Obstetrics
- Oncology
- Physiotherapy
- Psychology
- Paediatric
- Post surgical
- Palliative care
- Pathology
- Respite care
- Renal Dialysis
- Social Work
- Speech Pathology Service
- X-ray

Major activities and outcomes:

- Completion of the first stage of the new Multi Purpose Service at Merriwa.
- Refurbishment of the main elevator at Muswellbrook District Health Service.
- Purchased a state-of-the-art x-ray table for improved patient care at Quirindi District Health Service, with funds donated from the Quirindi District Health Service Ladies Auxiliary.
- Completed the 10,000 Steps Community Challenge, the largest community lifestyle program ever offered to the Upper Hunter and Singleton communities.
- Refurbishment of the Oncology Day Unit at Muswellbrook District Health Service with residents, businesses, sports and community organisations across the Upper Hunter raising $83 000 towards the facility.
- The appointment of a full-time Acute to Community Aged-Care Related Services (ACARS) co-ordinator to help improve post acute care services for the elderly.
- Obtained funding to enhance antenatal services at Muswellbrook and Scone hospitals.
- Increased palliative care nursing staff.
- Undertook engineering upgrades at Murrurundi and Scone hospitals.

Key issues and challenges:

- Visiting Medical Officer, nursing, allied health recruitment in rural setting.
- Identify resources to recruit a Nurse Educator to support staff and provide further health education within the Upper Hunter cluster facilities.

Future directions:

- Development of HealthOne at Quirindi
- Completion of Merriwa as a Multi Purpose Service
- Appointment of OH & S Coordinator for the Cluster
- Service planning for Werris Creek Community Hospital
- Implementation of Aboriginal Health Maternal Infant Support program bases at Quirindi and Muswellbrook

Lower Mid North Coast Cluster

The Lower Mid-North Coast Cluster includes a district health service at Gloucester; community hospitals at Bulahdelah and Wingham; and community health services at Forster, Harrington, Hawkes Nest-Tea Gardens and Stroud.

Gloucester Soldiers Memorial Hospital is an 80-bed campus that includes:

- 20-bed acute ward, which provides a range of services including 24-hour emergency department, medical, surgical, palliative care, limited obstetrics, limited paediatrics, x-ray and physiotherapy
- 15-bed aged care transitional ward
- 25-bed nursing home
- 20-bed hostel
- minor general surgery and ophthalmic (eye) surgery is also undertaken at Gloucester Hospital.

The Bulahdelah Community Hospital is a 12-bed acute medical rural hospital with a two-bed emergency department providing a 24-hour service. The hospital provides aged care, palliative care, medical care, emergency care and radiology.

Wingham Community Hospital includes a 16-bed rehabilitation unit providing rehabilitation and dementia specific care for older persons. Allied health services are provided including physiotherapy, occupational therapy, speech pathology and social work. There are no acute emergency services.

Community-based health centres at Forster, Harrington and Hawkes Nest-Tea Gardens provide a varying range of services including:

- Aboriginal health
- Audiometry
- continence services
- community nursing
- counseling
- diabetic care
- dietetics
- drug and alcohol services
- early childhood services
- footcare
- mental health
- occupational therapy
- oral health
- palliative care
- physiotherapy
- sexual health
- speech pathology
- women's health

Stroud Community Health Centre offers a child and family clinic and a women's health clinic.

Major goals and outcomes:

- Cluster granted four-year accreditation from Australian Council of Health Services with positive comments and results in all clinical areas.
- Acquired 15 aged care licences from Commonwealth - Narraweema Ward, Gloucester Hospital.
- Funding obtained and recruitment of an Aboriginal designated position within the Sexual Assault Service.
- Successful application for funding of a midwife-led antenatal clinic.
- Refurbishment of Gloucester Hospital Emergency Department.
- Recruitment to HealthOne Integrated Clinical Coordinator position for HealthOne Facility Forster-Tuncurry, which is now in consultation stage with internal and external partners.
- Establishment of Heart Failure program, which includes a Heart Failure nurse, Cardiac Liaison position, and an increase to the Community Acute and Post Acute Care team, and has reduced length of stay in acute facilities and reduced presentations.
- Increase in Transitional Aged Care places increasing availability of access to rehabilitation in the home.
- Enhancement of Aged Services Emergency Team to a seven-day service.
- Commencement of Acute to Aged Rehabilitation Care Service.
- Renovation of the Wingham Hospital Hydrotherapy Pool.
- Newly developed care area providing enhanced rehabilitation training facility.
- A donation from Wingham Hospital Auxiliary has allowed the replacement of old hospital beds with electronic ones. The auxiliary also funded a new widescreen TV for the patients lounge.
- The creation of State-wide Eyesight Preschooler Screening Program Coordinator
- Continuation of the Aboriginal Maternal Infant Health Strategy - Pregnancy Care program.

Geographic Clusters

Peel Cluster

The Peel Cluster is comprised of six facilities including Gunnedah District Hospital and Community Health, Walcha MPS, Tamworth Nundle Community Health, Manilla District Hospital and Barraba MPS. A broad range of services is offered from the cluster's facilities including:

- Aged care
- Aged care assessment team (ACAT)
- Audiometry
- Blood bank
- Child and family health
- Continence
- Counselling
- Dietetics
- Health equipment hire and home modifications
- Podiatry and Foot Clinics
- Health promotion
- Immunisation
- Medical services
- Mental health
- Occupational therapy
- Palliative care
- Physiotherapy
- Radiography
- Speech pathology
- Community Nursing
- Cardiac rehabilitation
- Drug and alcohol counselling
- Rehabilitation and therapy services
- Public dental and dental therapy services
- Aboriginal health education
- Aboriginal antenatal clinics
- Aboriginal maternity service
- Clinical psychology
- Diabetic care
- Early childhood services
- Psychiatry
- Sexual assault counselling
- Social work
- Women's health.
- Aboriginal Mother and Babies Service
- Child Development Service
- Family Care Cottage
- Genetic Counselling
- Respiratory Services
- Aboriginal Liaison Officer
- Cardiac and pulmonary rehabilitation program
- Wound care clinic

Major activities and outcomes:

- The Manilla Combined MPS/HealthOne Service procurement Plan and Project Definition Plan were finalised in March 2008. The HealthOne and Community Health Clinical Leader was also appointed.

- Walcha Emergency Department Triage 4 and 5 program
  An innovative program whereby defined triage 4 and 5 after-hours presentations are treated under approved nursing guidelines. Strong community support and GP VMO and nursing commitment means our hard-working rural GPs are supported. The pilot has allowed patients who are classified at the lower clinical priority known as a Level 4 or Level 5 - under the Australian Triage Standards - to be treated quickly through the emergency department by a highly-skilled senior nurse. The model of care recognizes the skills of our nurses and is a strategy aimed at retaining our GP VMOs.

- Manilla Health Service Community Bus
  A new $132,000 state-of-the-art bus with wheelchair access, air-conditioning, more seating and automatic controls is now making life easier for Hunter New England Health staff and members of the community who rely on the service for health-related transport. More than half of the money ($60,000) was raised by an enthusiastic and determined community following.

- The appointment of three new allied health staff, including a new Intern psychologist, physiotherapist and speech pathologist to Gunnedah Community Health Centre.

- Nundle Flu Vax program
  Nundle Nurse Practitioner Sue Denison continued the annual flu vaccination campaign for Nundle residents, in particular those at risk of complications and secondary infections as a result of contracting influenza.

- Aboriginal Liaison Officer Garry Creighton was awarded the Working Together to Make A Difference – Individual Award in recognition of the strong partnerships he has formed between Hunter New England Health and the Aboriginal community.

- Conditional accreditation was awarded to the Peel Cluster by the Australian Council on Healthcare Standards (ACHS) pending compliance with recommendations including fire safety upgrades to the facility.

- Approval of three new community places in the Transitional Aged Care Program, in addition to the 15 that were employed in the 2006/2007 financial year.

- Walcha Aged Care Expo
  Staff and health professionals attended workshops to build on aged care knowledge while Walcha residents were invited to find out more about aged care services in the community at an information night held by Walcha MPS.

- Succession planning meetings with the Barwon Division of General Practice, Rural Doctors Network, Medical Recruitment and the General Managers Peel, Mehi and McIntyre Clusters aimed at joint initiatives to recruit and retain GP VMOs.**Key issues and challenges:**

- Implementing new models of care for avoidable admissions.

- Attracting and retaining staff in health services, given the Cluster's ageing workforce.

Future directions:

- Ongoing planning for a new Multi Purpose Service and HealthOne facility at Manilla, including new models of care which will enhance integration of healthcare with GPs.
- Focus on early intervention and prevention strategies across all age groups.
- Build on internal and external partnerships to improve health outcomes for the Aboriginal community.
- Implement the Community Health Risk Factor Project into sites within the cluster after a successful trial in Gunnedah. The program aims to prevent chronic lifestyle disease through early identification of risk factors relating to smoking, nutrition, alcohol and physical activity.
- Build on relationship with the Division of General Practice and the Rural Doctors Network to develop models for GP retention in the Cluster's communities.

Mehi Cluster

The Mehi Cluster is comprised of nine facilities including Moree District Health Service, Narrabri District Health Service, Wee Waa Community Hospital, Boggabri Multi Purpose Service, Pilliga, Gwabegar, Mungindi, Boggabilla and Toomelah Community Health Services.
A broad range of services is offered from the cluster's facilities including:

- Aboriginal health services, including community midwifery service
- Aboriginal Family Health
- Acute medical
- Aged care
- Aged Care Assessment Team (ACAT)
- Antenatal Transport
- Audiometry
- Community nursing
- Chemotherapy
- Childhood Immunisation
- Day care
- Dietetics
- Diabetes Education
- Drugs and Alcohol Services
- Early childhood service
- Emergency
- Early childhood service
- Foot Care
- Health Education and Promotion
- Home Modifications (visiting service)
- Immunisation
- Maternal and Infant Services
- Mental Health
- Meals on Wheels
- Occupational Health Service
- Occupational Therapy
- Outpatient clinics
- Operating theatre
- Obstetrics
- Paediatric
- PANOC (Child Protection)
- Palliative care
- Pathology
- Physiotherapy
- Psychology
- Post surgical
- Primary Health Care
- Renal Dialysis services
- School-based Programs
- Sexual Assault Service
- Social Work
- Speech Pathology Service
- Visiting Medical Specialist
- Welfare Work
- Well Baby Clinic
- Women's Health
- Wound Care
- X-ray

Emergency Department, and a range of diagnostic imaging (x-ray, CT, mammography and ultrasound) and pathology services are available to non inpatients.

Major activities and outcomes:

- Moree District Health Service presented with a Silver Award in the 2007 Premier's Public Sector Awards, formally recognising achievements in excellence, commitment to quality and the provision of service.
- The official opening of the refurbished Emergency Department at Moree District Health Service. These renovations have achieved an even higher level of commitment and client service to the communities and incorporate improved security systems, a redesigned front reception area and public seating and garden area outside
- Extending the existing paediatric occupational therapy service at Moree Community Health Service from two to five days a week, with the support and fundraising of the local community.
- Moree District Health Service embarked on an innovative training pilot, as the first hospital in the Hunter New England Health region to offer traineeships to Moree senior school students undertaking a Hospital Services Assistant Certificate III.
- The implementation of a new program to educate mothers-to-be about healthy nutritional choices during pregnancy, breastfeeding, and nutrition for infants called Yinaar Gaayili (Mother and child) at Moree Community Health Service.
- Attracting Visiting Medical Officer, Dr Scott Finlay, a General Practitioner and Proceduralist focusing on obstetrics and anesthetics.
- Commencement of early capital works at Narrabri District Health Service, the start of a $41.7 million state-of-the-

art facility which will be developed as an integrated acute, primary and community health care centre on the existing site of the hospital site, together with the co-location of the ambulance service.

- Launch of Narrabri Community Health's "Living Well With Diabetes" program, aimed at helping the growing number of people being diagnosed with Type 2 Diabetes and meeting the individual needs of people who live in Narrabri.
- Upgrade fire detection systems and refurbishment of rooms in Moree District Health Service staff accommodation

Key issues and challenges:

- Recruitment of skilled staff to key areas, including recruitment and retention of nursing staff (specifically registered nurses).
- Continued effects of the drought in rural NSW have the potential to impact service delivery by increasing demand for services such as Mental Health.
- Staff and patient access during construction of a new state-of-the-art facility on the existing Narrabri District Health Service site which remains operational.
- Managing health services and attracting skilled health service staff in a region in a declining population.
- Adapting technology to deliver appropriate health services and to help support workforce shortages

Future directions:

- Ongoing service planning to improve environment for service provision, as allocated funds become available.
- Redevelopment of Narrabri Health campus.
- Improve staff accommodation at Moree District Health Service.
- Establishment of the Aboriginal and Maternal Infant Health Strategy at Narrabri and Wee Waa.
- Improved co-ordination of post acute care services for the elderly, implementing an Acute to Community Aged-Care Related Services.
- Improving performance in surgery services focusing on elective surgical patients.
- Work with staff to enhance antenatal services within the community while supporting the existing birth and parenting classes for Narrabri.
- Developing a strategy to improve community access to services by the implementation of the NSW Rural Hospital and Health Service Program for Wee Waa.

Tablelands Cluster

The Tablelands Cluster comprises a Community Health Centre at Armidale, a Community Health Service at Uralla, a District Health Service at Glen Innes, and Community Hospitals/Multi Purpose Services at Guyra, Tenterfield and Vegetable Creek (Emmaville).
A broad range of services are available at these sites including:

- Medicine
- Acute medical care
- Surgery
- Obstetrics
- Paediatrics
- Accident and emergency
- Outpatient clinics
- Radiology
- Pathology
- Occupational and speech therapy
- Aboriginal health
- Community nursing (including early childhood, diabetes, hearing, home nursing, immunisation, palliative care and women's health)
- Residential aged care
- Counselling (general and mental health)
- PANOC (Physical Abuse and Neglect of Children) service
- Podiatry
- Physiotherapy
- Sexual assault services
- Speech pathology
- Women's health

Major goals and outcomes:

- The Tablelands Cluster undertook an Organisation Wide Survey by the Australian Council on Health Care Standards, resulting in four year unconditional accreditation. The surveyors congratulated all Cluster health sites on the services provided in both community and acute settings. The Cluster was also commended on the involvement of consumers in its Committees and in local planning activities. The surveyors were very impressed by the improvements to the availability of information on patient's rights, and for the assistance given to clients with culturally and linguistically diverse backgrounds.
- A new General Practitioner with surgical credentials was recruited in a succession planning process. He is providing endoscopy services at the Glen Innes Health Service.
- Following a protracted process, Vegetable Creek MPS (Emmaville) was successful in achieving Area of Need approval. The approval will enable Hunter New England Area Health to recruit a General Practitioner who will also provided Visiting Medical Officer services to the Vegetable Creek MPS.
- Telehealth services were established at Armidale Community Health Centre, Glen Innes Hospital, Vegetable Creek MPS and Tenterfield Hospital. This will enable referral hospitals to provide support to General Practitioners in emergency departments, during times of increased acuity. The Telehealth service also provides staff with access to education sessions without having to travel huge distances.

- A Tenterfield Medical Taskforce was established to investigate options for recruiting new General Practitioners to Tenterfield, as well as to increase support, training and education for doctors working in the town. The Medical Task Force draws together key stakeholders from Hunter New England Area Health and Medical Recruitment, as well as from the local community including representatives from Tenterfield Shire Council, the Medical Centre and the Local Health Advisory Committee.

- Tenterfield Health Service was successful in securing the services of a dentist two days per week. The dentist provides services from the refurbished Dental Clinic.

- Tenterfield Community Hospital was successful in receiving funding to refurbish the staff accommodation in the old nurse's home. The staff accommodation underwent a $300,000 overhaul to make the health service a more attractive place to work and visit. Six more rooms were converted to three bigger rooms as part of the Rural Health Minor Works Program.

- A new Refugee Health Nurse was appointed to provide services to the growing refugee population within the Cluster. She is based at Uralla Community Health Centre.

Key Issues and challenges:

- Recruitment of Visiting Medical Officers, as well as nursing and allied health staff in the rural setting.
- Recruitment and retention of a skilled workforce with consideration given to an ageing workforce, succession planning and the provision of service levels that meet the needs of the community.
- The physical facilities of Glen Innes Health Service and Armidale Community Health Centre have been identified as requiring considerable updates, including fire rectification work and refurbishment of the Operating Theatre.

Future directions:

- Endeavour to continue to providing high standard services, in accordance with the state and Hunter New England Health strategic plans.
- Increase employment of Aboriginal staff as opportunities become available.
- Continue to develop a wellness model of health care.
- Continue the emphasis on quality improvement.

McIntyre Cluster

The McIntyre Cluster comprises a District Health Service at Inverell, Community Health Services at Inverell, Bundarra and Ashford, and Community Hospitals/Multi Purpose Services at Tingha, Bingara and Warialda. A broad range of services are available at these sites including:

- Acute medical and surgical care
- Day surgery (Inverell only)
- High dependency
- Palliative care
- Accident and emergency (First Aid Posts at Tingha and Bundarra) (Ashford - CH only)
- Maternity (acute care services only)
- Paediatric (acute care services only)
- A renal dialysis unit (Inverell only)
- Outpatient clinics
- Alcohol and other drugs counselling
- First Aid Posts (Tingha and Bundarra only)
- Needle exchange services
- Aged care beds
- Early childhood nurses
- Baby clinics
- Home nursing
- Dieticians
- Occupational therapy
- Child and adolescent family nurses
- Aboriginal Health
- Asthma and respiratory education
- Audiometry clinic
- Cardiac rehabilitation
- Diversional therapy (incorporating Day Care)
- Dental services (Inverell)
- Mental health service
- Radiography service
- Speech pathology
- Women's health

Major goals and outcomes:

- As part of the NSW Health Rural Hospital and Health Services Program, funding was approved and announced for $26.4 million to progress to completion Multi Purpose Service (MPS) development at Tingha, Bingara and Warialda.

- $5.2 million for a new Tingha Health Service which includes first aid post, a range of primary and community health services, eight residential aged care beds and administration and support services. The new facilities were officially occupied in June 2008.

- $10.6 million for a new Bingara Health Service includes an emergency department, primary and community health services, 14 residential aged care beds, seven acute care beds, ambulance facilities and administration and support services. Staff and patients plan to move into the new facility August 2008.

- $10.6 million for a new Warialda Health Service to include an emergency department, primary and community health services, 15 residential aged care beds, 10 acute care beds, ambulance facilities and administration and support services.

- Capital works funding of $380,000 was received to refurbish the Inverell nurses' home staff accommodation with all works completed.

Geographic Clusters

- Notification of a $250,000 grant from the Commonwealth Department of Health and Ageing has been received for a Palliative Care project in Bingara and Warialda over the next three years. The project has successfully recruited a project officer who is co-ordinating the implementation of best practice guidelines across hospital, hostel and community settings in partnership with McLean Nursing Home.

- Pilot Project, Respecting Patient's Choices - An advance care planning program, has been completed in the Inverell community as the first rural pilot. The target areas for implementation were the acute and community health sectors, residential aged care and community care sectors as well as the wider community. The program provided the Inverell population with an integrated approach to advance care planning by coordinating the implementation, monitoring and evaluation of the Respecting Patient Choices advance care planning program.

- Australian Council on Healthcare Standards EQuIP organisational wide survey was undertaken in July 2007. One year accreditation achieved until June 2009 with another survey scheduled for 11 May 2009.

- The appointment of an Occupational Health and Safety Coordinator across the McIntyre and Tablelands clusters to assist to with compliance to OH&S functions across all sites. Cluster wide Numerical Profile audit scheduled for May 2009 will be a first for the McIntyre Cluster

Key issues and events:

- Support staff and key stakeholders in change management necessary in working towards a new model of service provision with the commencement of the three new MPS at Tingha Bingara and Warialda.
- Recruitment and retention of a skilled workforce with consideration of and aging workforce, succession planning and the provision of a level of services that meet the needs of the community.
- Ongoing support of outreach specialist services to Inverell and the wider McIntyre community. Surgical Services have been boosted under this model with Dr Or providing visiting surgical support on a weekly basis
- Facility Management and Hotel Services now functioning within Hub structure with managers in place

Future directions:

- Consolidation and development of team within the cluster to support and implement Hunter New England vision, purpose and values.
- Successful planning, building and transition into new multipurpose facilities at Tingha, Bingara and Warialda.
- Continue to promote and raise profile of primary health care.
- Close working ties continue to be developed with the New England Division of GPs to provided additional outreach services to communities within the McIntyre Cluster.
- Consolidation of the Hub and Spoke model of care, with the planned commencement of two visiting physicians.
- Cluster wide role being develop for Staff Educator, in addition to the OHS coordinator.
- Successful Australian Council Health Standards EQuIP Accreditation planned for May 2009.

Mental Health Services

Hunter New England Mental Health provides integrated mental health services in geographically based teams and specialist streams for child and adolescent, neuropsychiatry, acute adult, rehabilitation and older persons.

Major goals and outcomes:

- New Area Director, Dr Dinesh Arya, commenced 21 April 2008.
- Service Director Specialist Mental Health Services for Older People appointed in 2008.
- 2008/2009 Operational Plan developed and signed off.
- Completion of a clinical redesign project to develop and implement an integrated dodel of care in the service delivery of adult community and inpatient mental health services across Hunter New England Health.
- Development of Model of Care for Acute Adult Services.
- Roll out of an electronic community health information system completed in December 2007, which enables community mental health staff to now complete clinical documentation electronically.
- Expansion of drought relief.
- Progress on mental health website to use it effectively for communicating across the Area Health Service.
- Further implementation of Mental Health key performance indicators and utilisation by clinical services.
- Transition of long stay dementia units into Transitional Behavioural Assessment and Intervention Service (known as T-Basis).
- Pandemic preparedness and disaster planning operations.
- Implementation of a process for continuous monitoring and monthly reporting of performance.
- Implementation of an Interagency Action Plan to ensure all mental health providers (governmental, private and non-governmental) are working collaboratively.
- Service remains focused on quality improvement with finalists in five Quality Award categories.

Key issues and events:

- Change management process for relocation of acute mental health services from James Fletcher Hospital to the Mater campus.
- Recruiting staff for new units.
- Developing a model of care for integrated mental health services.
- Planning for future of services currently delivered at Morisset Hospital.

Future directions:

- Review of continuum of care processes to ensure delivery of better integrated mental health care that is focused on empowering consumers, based on evidence and on minimising waste.
- Move of mental health inpatients and associated specialist mental health services from James Fletcher Hospital to the mater campus.
- Construction of non-acute unit at James Fletcher Hospital site.
- Recruitment of additional skilled mental health professionals for both acute inpatient services at the mater campus and non-acute inpatient unit at James Fletcher Hospital.
- Development of a model of care for services in Greater Newcastle.
- Planning for future of services currently based at Morisset Hospital.
- Review of service model of care to ensure better integration and improved continuity of care for the consumer
- Planning and development of a Psychiatric Emergency Care Centre with four short stay inpatient beds.
- Focus on better integration with primary care, including primary care mental health consultation liaison.
- Focus on developing and strengthening interagency relationships within the rural and remote sector to ensure better provision of mental health care to people living in rural and remote communities.
- Ensuring full staffing, particularly in rural and remote mental health services.
- Development of Mental Health and Drugs and Alcohol Clinical network.
- Supporting further development of skilled non-government organisations (NGO) workforce to meet mental health needs of mental health consumers who are supported by various NGOs within Hunter New England.

Nursing and Midwifery

Hunter New England Health Nursing and Midwifery undertakes a broad range of activities in several sectors: Clinical Practice and Policy, Practice Development, Workforce and Career Development, Recruitment and Retention, Nurse Strategy Fund Management and Professional Development.

Major activities and outcomes:

Clinical Practice and Policy

- Scholarships
  Two NSW Nursing and Midwifery Office Clinical Innovations Scholarships were awarded, totalling $20,000.

- Practice Development School Participation
  Hunter New England Health continues to support the attendance of clinicians at the five-day Developing a Culture of Effectiveness Workshop hosted by the International Practice Development Collaborative to enhance their skills in developing practice within their teams. Participants included Senior Nurse Managers, Nurse Unit Managers, Clinical Nurse Consultants and Nurse Educators. The skills acquired at this school will be vital in the implementation of the Essentials of Care program.

- One hundred nurses and midwives from across the area attended the Fourth Annual Innovations in Clinical Practice Showcase in Tamworth as part of International Nurses and Midwives Days celebrations. This year's celebrations also featured an enhanced Poster Presentation Section. The Showcase also featured the launch of HNE Handover: Journal of Hunter New England Nursing and Midwifery

– a peer reviewed monograph that is the result of the collaboration between Hunter New England Health, The University of Newcastle and The University of New England. Handover features articles that inform clinical nursing and midwifery practice within Hunter New England Health and is part of the work that is being undertaken to promote writing for publication among clinicians. The work is supported by workshops for neophyte authors and for those interested in developing their skills in critical review.

- Nursing and Midwifery Big Day Out
  The Big Day Out (BDO) was a new, innovative way of conducting the annual Nursing and Midwifery Planning Day. The BDO format allowed for a range of different approaches to suit the topic and the participants, and was designed to yield a variety of useful and supported outcomes. The outcomes of the day will be used to provide support and guidance to the strategic framework for Nursing and Midwifery in Hunter New England Health.

- Hunter New England Health Breastfeeding Summit
  More than 70 nurses, midwives, community group representatives and specialist staff from across the Area met to discuss improved ways to boost the number of women who take up and continue the healthy practice, by locally implementing the NSW Health policy, Breastfeeding: Promotion, Protection and Support. Staff shared their knowledge of successful initiatives aimed at boosting breastfeeding rates in the Area.

Nursing workforce

- Bower Bird Information Services continues to provide support for internet advertising access for nursing, midwifery and allied health positions.

- With the introduction of the Health Training Package considerable work is being undertaken in the Trainee Enrolled Nurse Program with Hunter New England Health and TAFE NSW to coordinate the new training package requirements within the health service.

- The Reasonable Workloads initiative implementation continues to be supported across the Area. All facilities are monitoring their nursing workloads in accordance with NSW Health directives.

- Hunter New England Health actively participates in the Vocational Education Training in Schools program. We have 22 trainees currently employed as Assistant in Nursing and undertaking the Certificate III in Aged Care or the Certificate III in Hospital Services Assistant as part of their school studies. This year, four students will complete the Cert III Aged Care and transition into the Trainee Enrolled Nurse Program.

- Nurse Reconnect and Mental Health Reconnect continues to attract employees. Midwifery Reconnect will be launched in November 2007. Reconnect is an initiative of the NSW Department of Health and provides nurses and midwives wishing to re enter the workforce with a supported clinical placement to meet their learning needs.

- Inception of the combined clinical placement meeting of universities, TAFE NSW and NSW Health Service representatives has been instrumental in developing stronger relationships and partnerships for improvements to the clinical placement system and enhancement of the student journey.

Professional Development

- CEC Clinical Leadership Program: The second year of the CEC Clinical Leadership Program is coming to a close with the majority of applications coming from Nursing and Midwifery.

- Rural Nursing and Midwifery Exchange Program continued for the Rural areas of Hunter New England Health for 2007/2008. Nurses and midwives from rural and remote areas have undertaken a variety of professional development and training opportunities in a range of specialties. There are also many opportunities for nurses and midwives to work in other services and facilities to update their current knowledge and experience. Funding allows registered nurses, midwives and enrolled nurses to be provided with accommodation, travel and registration/ fees for courses.

- Clinical Nurse/Midwife Specialist Application Review: Hunter New England Health Nursing and Midwifery Service has finalised the review of the applications and appointment process for the Clinical Nurse/Midwife Specialist qualification. When completed, this will allow for a transparent process to be implemented area wide to accommodate people wishing to regrade to CNS/CMS.

- Perioperative Endorsed Enrolled Nurse Program: One cohort of Endorsed Enrolled Nurse completed The College of Nursing Perioperative Nurse Program.

- Clinical Nurse/Midwife Consultant Network: More than 100 Clinical Nurse/Midwife Consultants, Nurse Practitioners and Nurse/Midwife Educators attended the Professional Day. The Area Director of nursing and Midwifery services addressed the seminar and participants experienced a range of workshops aimed at enhancing Clinical Leadership skills. Networking days and activities were also provided for Cancer Nurses, Continence Advisors and Discharge Planners.

Key issues and challenges:

- Nurse Practitioner Implementation
  Hunter New England Health currently has 13 authorised Nurse Practitioners and 12 nurses and midwives in transitional roles preparing for nurse practitioner authorisation. There are currently nine Nurse Practitioners working under guidelines that allow them to extend their practice and offer an independent service to their patients. One Hunter New England Health nurse was authorised this year as the first Hepatology Nurse Practitioner in NSW.

- Modelling Care Initiatives
  Hunter New England Health is an active participant in the Modelling of Care (MoC) work being undertaken by NSW Health. The original work of the MoC project was to

explore and develop innovative modelling of nursing care delivery and organisation that would facilitate best clinical practice and outcomes, and develop new and emerging roles and partnerships within nursing and health care.

- Eighty nurses and midwives attended the third Hunter New England Health Annual Innovations in Clinical Practice Showcase. Judges from University of New England were impressed by the range and quality of initiatives showcased at this event. Presentations on innovations in care have also been presented at other forums, including the NSW Nursing and Midwifery Peak Forum, and NSW Nursing and Midwifery Innovations Showcase held in Sydney.
- A Nursing and Midwifery annual strategic planning day was held in Tamworth in May 2008. Planning has been aligned to the NSW Nursing and Midwifery Strategic Directions Plan 2008-2010.

Future directions:

- The Essentials of Care program will be implemented to improve patient safety and outcomes through the implementation of a state wide framework focusing on the essentials of nursing and midwifery care. It helps to enhance the experiences of patients, families and carers, as well as staff involved in health service delivery.
- There has been a major recruitment and retention campaign during 2007-2008, particularly to secure quality employees in our high area needs of midwifery and community nursing.

Disaster Management Unit

The Hunter New England Health Disaster Management unit provides direction and assistance in developing Emergency Procedure/Disaster Plans for all units, while implementing and providing specialised disaster training in the form of numerous courses to staff members at all levels. The Unit also acts as the liaison between external emergencies services, local governments, the NSW Counter Disaster Unit and other Functional Areas.

Major activities and outcomes:

- Hunter New England Area Healthplan (a supporting plan to the NSW Healthplan and local District Plans) has been completed. The plan is currently processing through approval and endorsement before implementation.
- Local Emergency Risk Management Process continues across all three districts (Hunter Central Coast, Peel and Lower Mid North Coast), with Hunter New England Health representation on these committees.
- Hunter New England Health Pandemic Plan and attachments continue to be developed by the Disaster Management Unit and all facilities/units.
- Emergo Train System Implementation Process across Hunter New England Health continues. John Hunter, Tamworth Hospital and Calvary Mater Newcastle have conducted Emergo Train Exercises with reports submitted to NSW Health.
- Newcastle Central Business District Evacuation Planning Committee - Hunter New England Health on committee, with plan currently in the community education phase. An extensive website is under development.
- Recover, an online database containing all facilities critical standard operating procedures, has been implemented in Hunter New England Health.
- Chemical material risk assessment planning has been conducted for all Hunter New England Health northern cluster facilities with NSW Fire Brigade and plans implemented.
- Post Disaster Survey conducted following Hunter Storms. The report was submitted as required and recommendations continue to be implemented.
- The Hunter New England Health Disaster Unit organised and conducted the Australian Emergency Coordinators Conference on the 15 and 16 November 2007 with approximately 120 people attending.
- Pandemic Exercises
    - Exercise Ring Around the Rosie March 2008 - tested the ability to implement and conduct a mass vaccination (plans were tested and revised according to outcomes)
    - Exercise Enza - Ability for facilities to implement enhanced triage and screening stations against a pandemic influenza case definition (continues to be conducted across 39 facilities)

Key issues and challenges:

- A key challenge for the Disaster Management Unit is the geographical size of the area and the amount and varied type of facilities involved. The Unit has planned to recruit a Disaster Coordinator to cover the Mehi, Mcintyre, Tablelands and Peel Clusters.
- The Biopreparedness Officer position is funded by NSW Multicultural Health Service and funding is evaluated on a regular basis. The challenge arises in maintaining the position with an individual who is seconded from another area.

Future directions:

- Pandemic Planning and Exercises continue to be developed, implemented and conducted throughout the area.
- Strategic Disaster Education Framework to be implemented and further staff to be trained in Disaster Management.
- Emergo Train Exercises are currently scheduled for Moree District Health Service and The Maitland Hospital in 2008. Further hospitals will be scheduled to conduct these exercises in 2009.

Other health services

Multicultural Health Service

The Multicultural Health Unit assists Hunter New England Health to ensure that people from diverse cultural and linguistic backgrounds receive equity of access to public health services, culturally and linguistically appropriate health care and information about their health, so that they can make informed decisions.

The unit provides a range of services including:
- Health Care Interpreter Service
- NSW Rural Health Care Interpreter Service
- Multicultural Health Liaisons
- health education and advice to Hunter New England Health staff on multicultural health issues.

Major activities and outcomes:

- Ensuring that all newly arrived refugees have their full course of immunisations through the on arrival health clinics.
- The establishment of automatic referral and treatment regime for all diagnosed with infectious disease within the on-arrival refugee clinics.
- The establishment of special optometry clinics for refugees to run concurrently with immunisation clinics.
- The review of all cases where people who said they needed an interpreter and did not have one provided in the emergency Departments at John Hunter Hospital and Calvary Mater Hospital, to establish the reason or reasons for the hospitals' non-compliance.
- Hunter New England Health Interpreting Service provided the interpreting service in 42 languages for 473 people completing the NSW Health Patient Survey.
- A partnership was formed between the Area, Sydney IVF Clinic Newcastle, and the Legal Aid Commission of NSW- Coffs Harbour Office that we will provide interpreting services to the organisations.
- An agreement with NSW Police Force to post information about the Multicultural Health Unit Interpreting Service on its website.
- Involvement of Hunter New England Health interpreters in the development of a training package for translators, interpreters and bilingual workers. The package is being produced by Government Skills Australia, commissioned by the Department of Education and Workplace Relations.
- Development of a protocol for the Royal Newcastle Centre to ensure that patients with interpreters are seen within half an hour of the time for which they are booked. More still needs to be achieved to ensure that interpreters are used by health professionals in a timely cost-effective manner.
- Establishment of a monthly report provided to the Health Service's Area Executive Team to gauge the performance of each emergency department across the Area on their use of interpreters.

Key issues and challenges:

- Maintaining the standard of the interpreting service and reviewing the way the service is utilised by health professionals without impacting on access for any particular language or cultural group.
- The ongoing need to find and train African bilingual people as interpreters. There are only two Pular interpreters available across the whole of Australia.
- The need to influence mainstream services to ensure that the new directions and new strategies across all sectors include provision of service to CALD patient/ clients.
- The need to find measures which appropriately reflect the health status, health care and needs of CALD patients/ clients.
- The need to ensure services are available in all parts of the Area, including refugees settled in regional areas.

Future directions:

- To pursue through the patient safety officers and the Multicultural Advisory Committee, the mandatory recording of place of birth on all IMMS and RCA reports so that the statistics for NESB can be compared with the ESB clients.
- To establish an education program within the Mental Health Service which will upskill interested mainstream psychologists and psychiatrists working within the area health service so they are more confident and competent to handle issues of torture and trauma with their clients.
- To pursue a drive to attract more CALD community members onto Multicultural Access Committees.

Drug and Alcohol Clinical Services

Drug and Alcohol Clinical Services provide early intervention, referral and treatment for drug and alcohol dependence area wide.

Services operate under the umbrella of harm minimisation and include the

- Central Intake Telephone Service. This is the first point of contact for Drug and Alcohol Clinical Services and is located at Tamworth, Taree and Belmont. It provides Drug and Alcohol information, brief assessments and interventions, Drug and Alcohol assessment appointments, and referral to appropriate services (government and non-government) for people requiring assistance with drug and alcohol issues.
- Harm Minimisation Program engages clients to assist them to deal with problems related to their drug use. Primary outlets are located at Newcastle, Taree and Tamworth with outreach to various locations. Vending machines as well as partnerships with government and non-government organisations to operate as secondary outlets increase access to this service. Needle Syringe Programs reduce the sharing of injecting equipment and the potential transmission of blood borne infectious diseases.
- Aboriginal Drug and Alcohol Service provides appropriate conduits into Drug and Alcohol treatment facilitated by Aboriginal staff. Services are currently located at Tamworth and Moree. It is proposed to develop this model area wide.
- Drug and Alcohol Community counsellors seek to provide supportive contemporary interventions to clients in varying levels of dependency. Services are provided from the majority of community health centres throughout Hunter New England Health.
- Withdrawal Management including inpatient, community and home detoxification. Inpatient detoxification is available in selected hospitals by prior arrangement with drug and alcohol services. The Lakeview Detoxification Service is a stand-alone 12-bed residential facility for people 16 years and over. Community Detoxification Services involves withdrawal-supported management by registered nurses and the patient's General Practitioner and can occur within the patient's home or as an outpatient.
- Pharmacotherapy is a voluntary treatment program for opiate dependant people. Treatment options include Methadone, Biodone, Buprenorphine and Suboxone. Public clinics are located at Tamworth, Taree, Cessnock and Newcastle.
- MERIT is the Magistrates' Early Referral into Treatment program that provides the opportunity for some defendants with drug problems to work on a voluntary basis towards rehabilitation as part of the bail process. Services are located at Newcastle and Tamworth and provide outreach to courts at various locations.
- Consultation Liaison Services, which includes a pilot trial of designated staff at John Hunter Hospital as well as staff from DACS to provide an in-reach service into selected public hospitals across HNE.

Major goals and outcomes:

- Appointment of manager, recruitment of staff, and commencement of Aboriginal Drug and Alcohol Service.
- Aboriginal Drug and Alcohol Service qualitative needs analysis commenced.
- Area-wide merge of Harm Minimisation Program completed and manager appointed.
- Installation of vending machines in selected rural locations to increase access to injecting equipment – 24 hour service.
- Extra places at Newcastle Pharmacotherapy and continued work with local hospitals and community pharmacies, across the area has increased access to treatment.
- Area-wide review of pharmacotherapy services completed.
- Commencement of Staff Specialist for Pharmacotherapy.
- Phase 1 Stimulant Treatment Program evaluation completed June 2008.
- Development of electronic community health information system reports for Stimulant Treatment Program to collect key performance indicators for pilot project and overcome different area health anomalies in documentation requirements for inter area health service pilot (St. Vincent's Hospital and Newcastle).
- Upgrade of two additional beds at Lakeview inpatient unit to meet demand for medical detoxification service.
- Review of statewide guidelines for withdrawal management and development of Area-wide guidelines.
- Postgraduate training position implemented.
- Held a two day Area-wide planning day for staff that included conference presentations on transferring research into practice, quality improvement processes, Mental Health Drug and Alcohol Office update and Overview Indigenous Plan, showcase of Drug and Alcohol Clinical Service research and projects.
- Held an Area-wide workshop to develop strategies for the operational plan for Drug and Alcohol Clinical Services.
- Received new funding for the establishment of cannabis clinics, and a pilot program- Pathways from Emergency Department to Drug and Alcohol Treatment – Consultation Liaison at John Hunter Hospital

Other health services

Key issues and challenges:

- Lack of GP prescribers for Pharmacotherapy Treatment Program, especially in rural areas
- Numbers of current GP prescribers across the area who are planning to retire in next few years
- Recruitment to vacant positions in rural areas
- Successful liaison with Mental Health Services to include Drug and Alcohol in term rotations for registrars

Future directions:

- Electronic Medical Record: rollout of shared access with generalist services to improve continuity of care for patients; standardisation of clinical note templates; implementation of organisational structure in preparation for merged databases; and standardisation of activity templates to improve reporting requirements.
- Rollout of online web-based orientation program for staff.
- Commencement of Mental Health registrar positions in Drug and Alcohol.
- Rollout of Hunter New England Health Withdrawal Management guidelines adapted from NSW Health guidelines.
- Assistance with rollout of NSW Health Nursing and Midwifery Clinical Guidelines - Identifying and Responding to Drug and Alcohol Issues.
- Implementation and evaluation of pilot program Pathways from Emergency Department to Drug and Alcohol Treatment – Consultation Liaison.
- Commencement of Pharmacotherapy Treatment Program clinical leadership team.
- A focus on strategies to address issues relating to GP providers and access to Pharmacotherapy Treatment Program including:
  - Increased focus on stability assessment and moving stable Pharmacotherapy Treatment Program clients to community pharmacies.
  - Increase access to Pharmacotherapy Treatment Program in rural areas by increasing availability of remote prescribing.
  - Establish a working party to review recommendations from Area-wide wide review of Pharmacotherapy Services and implement approved strategies.
- Phase 2 Stimulant Treatment Program evaluation to commence 1 August 2008.
- Implementation of pharmacotherapy treatment drug trial for selected clients that meet the criteria.
- Successful submissions for research projects to be undertaken include:
  - Implementation of a Randomised Controlled Trial of Intramuscular Droperidol for Rapid Sedation of Aggressive and Agitated Psychostimulant – Associated Delirium.
  - Treatment Outcomes Profile – take part in inter AHS validation of tool for use in Australian Drug and Alcohol services.
  - Hepatitis C Project – better provision of Hepatitis C treatment in Opioid Treatment Services settings.

Population Health

Major activities and outcomes:

- The Population Health teams have continued their focus on ensuring that services are culturally appropriate. Each team has committed to an active process of making its services culturally appropriate and ensuring they contribute to addressing the health disadvantage of Aboriginal and Torres Strait Islander residents of Hunter New England Health region.
- The formation of the Area Prevention Taskforce ensures the continuation of the team's work to include prevention in the routine work of the health service. The taskforce will provide direction and leadership for this work. The Health Promotion teams work over the past year has focused on supporting inpatient services to provide smoking care to smokers in the context of Hunter New England Health Smoke-free sites. Additionally the team has worked to reduce falls injury in older people. A successful partnership with EduCARE has seen 22 new Active Over 50s leaders trained throughout the area, a key strategy to give older people an opportunity to exercise to reduce falls injury.
- HIV and related health promotion programs have developed a multi-strategic approach to reducing the prevalence of sexually transmitted diseases, HIV and other blood borne infections by building the capacity of youth services across Hunter New England and general practitioners in the New England area through the Divisions of General Practice. The team continues to develop its relationship with the Aboriginal community in Tamworth and Armidale.
- Schools-based health promotion continues to be a focus of work by the Capacity Building team. A previous schools-based resilience program undertaken by the team demonstrated a reduction in risk behaviours (tobacco, alcohol and marijuana use) among students attending three regional high schools within the Area. The team, in collaboration with the Department of Education, will commence roll out of the project to three remote high schools within the Area in October 2008.
- Liveable Communities (improving health through modifying environmental risks to health) continues to be a successful area of work for the unit. Current collaboration with Maitland City Council on the development of the Lochinvar area will form the basis for future work across the Area.

- The Health Protection team continues to play a leadership role in supporting the Area Disaster Committee in preparing for public health disasters and an influenza pandemic. A major accomplishment was a large health workers perception survey across all categories of staff that would be expected to respond during a protracted health disaster. The findings from this survey, which enjoyed an excellent response rate, are forming the basis of planning, education and communication initiatives throughout the Hunter New England Health region.

- The public health preparedness team successfully conducted a national survey of knowledge, perceptions and likely responses to prescribed pandemic containment measures with important recommendations for Area, State and Commonwealth communication strategies.

- Tobacco Control targets were successfully accomplished. A comprehensive review of the NSW Health Drinking Water monitoring database was completed in partnership with the NSW Health Water Unit. This has served as a key risk assessment submission into the Ministerial Enquiry into rural water utilities. All environmental health regulatory targets are on track.

- Our Area continues to excel in immunisation coverage for children with rates exceeding both NSW and Australian performance in all age groups. Our Area successfully conducted Australia's first large pandemic mass vaccination clinic offering influenza vaccination using the pandemic plan for all resident of Aberdeen with very important lessons for Hunter New England Health and NSW Health.

- This year, the Surveillance and Monitoring team has continued its focus on providing timely population level health intelligence data across a wide range of areas including demographic, health status and health determinant measures to describe the health of residents of the Hunter New England region. These indicators were captured in the Health of Hunter New England electronic resource (HHNEe-R), an internet-based resource that is continuously updated. The team has also collaborated with staff from the NSW Health Survey Program to ensure minimisation of duplication of work in the area of health behaviour survey data analysis. Information sessions regarding the resource were held for Hunter New England Health units and non-government organisations.

- The Surveillance and Monitoring Unit has also implemented a program of data analysis to inform understanding of the health issues of the Aboriginal and Torres Strait peoples of the region. Using seeding funds obtained in 2007 from the University of Newcastle, the Health Intelligence unit has developed a clearinghouse of population health information on the Aboriginal and Torres Strait Islander peoples of Hunter New England. This work has been done in collaboration with the HNE Aboriginal Health and Hunter New England Health Planning units.

- In addition to provision of data, the Surveillance and Monitoring team also provided an information service, Statistical, Application Development and CATI Survey support for the HNE Population Health team. The team provided complex data management and analysis for a large variety of services including the Alcohol Linking project, 'Good for Kids', Influenza Tracking, Pandemic Planning, Balanced Scorecard indicators, and the One Stop Shop intervention project in disadvantaged schools. In addition, the team also provided training in statistics, CATIs and the SAS statistical software package across the area. A total of 20 different CATI surveys were undertaken in 2007-2008 (an average of a survey every three weeks) with over 6,400 interviews completed.

- 'Good For Kids. Good For Life' - Australia's largest ever obesity prevention trial in children aged 0 to 15 years has:
    - Won two major awards - the NSW Health Award for Aboriginal Health and the University of NSW Research Centre for Primary Health Care and Equity Health Impact Assessment Award.
    - Provided training in healthy eating to over 65 per cent of schools.
    - Registered over 100 schools as 'Crunch&Sip' schools with more than 17,000 students receiving drink bottles.
    - Contacted 100 per cent of preschools and long day care services and given feedback on current nutrition practices and support to implement best practice.
    - Involved 217 sports clubs in the Good Sports Program.
    - Completed the Good for Kids Aboriginal communities consultation report and started rolling out intervention strategies.
    - Recruited 27 community service organisations to the vulnerable families program and organisational managers have completed baseline organisational evaluation telephone interviews.
    - Conducted 15 'Healthy Living for Families' training sessions for over 150 participants including family support workers, case managers, playgroup coordinators, early intervention workers, group facilitators and supervisors.
    - Commenced Phase 2 of the 'Good for Kids' advertising campaign on 22 June - Get active, get out and play, one hour a day / reduce small screen recreation.
    - Developed Healthier Choices Catering Policy Compliance Procedure and supporting resources and piloted the catering policy within the Hunter New England Health Area Administration building
    - Developed and signed-off service agreements with five Divisions of General Practice to help practices to assess children's weight status, advise and refer.
    - Finalised dissemination priorities for the 'Good for Kids' program and assigned authors to research outputs.
    - Conducted a baseline survey of parents to assess the efficacy of the second phase of the social marketing campaign.
    - Had two PhD Students awarded scholarships to work on the 'Good for Kids' program.

Other health services

Key issues and challenges:

- The initiative to improve the cultural appropriateness of our services requires an extended and ongoing commitment to service assessment and redesign.
- Although by two years of age Aboriginal and Torres Strait Islander immunisation coverage rates approach those of non-Indigenous children, the key challenge remains to close this gap in the first year of life in each local government area.
- The engagement of clinicians in the Area Preventive Care initiative will be a key determinant of its success.

Aboriginal Health

Major activities and outcomes:

- Hunter New England Health is committed to improving the health and education status of Aboriginal children through the implementation of an effective Otitis Media screening program of Aboriginal children across area. Hunter New England Health achieved 97 per cent for 2007/08 across the area, this was an excellent performance from all staff across the area.
- Hunter New England Health, Pius X Aboriginal Corporation, and the Aboriginal Communities of Toomelah and Boggabilla for the first time have signed a Memoriam of Understanding for the delivery of health services within these two communities. This is an important step for all parties, recognising the vital role community and individuals play in health care and service delivery. The development of a joint action plan has been a priority closely followed by implementation.
- Healthy lifestyle groups focusing on physical activity, nutrition and healthy weight, have been facilitated under different program names and in different formats, across the area. The programs are run through the Aboriginal Health Service or in partnership with local Aboriginal Community Controlled Health Services, or the local Division of General Practice or in collaboration with local Elders Groups. Key programs such as Good for Kids Good for Life and Healthy for Life also operate within Hunter New England Health area.
- The Journey of Aboriginal Children and their Families project commenced in June. The program is a collaborative clinical redesign project being undertaken across Hunter New England Health and the North Coast Area Health Service. The aim is to gain insight to improve the journey of an Aboriginal child and their family after a decision is made to transfer the child's health care from a lower level of care in their local community, to a higher level of care outside their local community. Work has commenced on the first stage which involves detailed project, communication, and consumer engagement planning. Guiding principles for a best practice model of culturally appropriate care and support will be developed by working with targeted Aboriginal communities and health care workers. Current initiatives will be highlighted to ensure the project builds on the existing commitment to quality patient care.
- A two-day health promotion training workshop was held at Tamworth in June to learn about strategic planning for health promotion, which was attended by 35 Aboriginal Health staff from across the area. Presenters included Shane Hearn and Marilyn Wise from the University of Sydney who challenged staff to look differently at the work they do to implement strategies which will enhance health and well-being in a more strategic manner. We look forward to seeing more partnerships which better address physical and cultural barriers to health, which will help to close the health gap.

Key issues, challenges and future directions:

- The Aboriginal Health Partnership Strategic Plan 2007 – 2012 was launched in March. An Aboriginal Health Balanced Scorecard and Annual Operational Plan has been loaded onto the Performance Gateway and allows access into critical information on how well we are performing. This Balanced Scorecard links our performance management to our strategic direction, so we achieve our vision of closing the 17 year life expectancy gap between Aboriginal and non-Aboriginal Australians. It also ensures there is transparency in performance reporting within an accountable reporting framework. Key focus areas include access to culturally sensitive services, expanding work within and across an integrated chronic disease strategy, building capacity of our workforce and strengthening of partnerships.
- Training has been implemented to reduce diabetes-related lower-limb amputations for Indigenous people through multi-disciplinary care, self-managed care, capacity-building in indigenous communities and best practice for Aboriginal Health Workers (AHW). AHWs from Hunter New England Health and Aboriginal Medical Services attended a two day Indigenous Diabetes Foot Program at Tamworth in June. The program provided AHWs with excellent educational resources including a CD-rom, posters, and assessment tools. The educational tools are designed to encourage Indigenous people with diabetes, Indigenous Health Workers and other health professionals, to become more actively involved with the management of the diabetic foot. With better understanding of the management and early identification of foot conditions, the expectation is to prevent foot ulceration and amputation.

Dental Health

Major activities and outcomes:

- The service achieved 177,037 occasions of service for the 2007/2008 year through its 23 sites.
- In August 2007, the Newcastle Dental Clinic moved to the present site at the Newcastle Community Health Centre in Hunter Street.
- The Oral Health Contact Centre commenced operations on 12 November 2007 as a collaboration between Hunter New England and North Coast Area Health Services. It provides a single point of contact for all requests for care for two Area Health Services and has the ability to appoint or wait list requests for all clinics throughout the Hunter, New England and North Coast regions.
- February 2008 saw the launch of a range of new child programs across Hunter New England Health, with an emphasis on responsibility for good dental health and preventive care. "Super Smiles" targets school-aged children, "Better Smiles" provides a managed care program for more at-risk children, whilst "Little Smiles" and "First Smiles" focus on education, prevention, and referral strategies for those under five years of age.
- The service was successful in recruiting a key senior clinician in the Tablelands Cluster. This dentist will assist provide clinical guidance and direction for the Area-wide service.

Key issues and challenges:

- The service receives in excess of 4,500 request for care per month. In the 2007/08 financial year there were a total of 54,467 requests for care predominately through our call centre operation. The call centre triages calls and either makes the appropriate appointment or waitlists patients according to need.
- Recruitment remains challenging. Strategies are in place to retain staff through education and peer reviews which ensure clinicians remain current in their knowledge and skills. A number of recently recruited dentists are overseas-trained with current Australian Dental Council qualifications. Sponsorship of candidates is becoming more frequent. In the past 12 months Hunter New England Oral Health has recruited to positions in Taree, Upper Hunter, and Maitland, Newcastle and Armidale.
- We are developing preventive dental health programs to address the needs of small communities. We hope to launch a new program in the next six months that will target children in small communities especially those with a high indigenous population.

Future directions:

- Commonwealth targets, funding, and priorities will be a focus for the next twelve months. Plans are in place to enhance clinical services at a number of sites.
- With Commonwealth funding, the State has agreed to have a key focus on addressing the dental needs of those with chronic disease. The service will redirect efforts to providing care to this target group.
- There will be continued progressive implementation of digital imaging and work bench computerisation.

Diabetes Services

While the Hunter area holds the largest number of people with diabetes, and has for some years shown the biggest growth in people with Type 1 diabetes, Type 2 diabetes is widespread and increasing throughout Australia.

Hunter New England Health provides adult diabetes services in a variety of community based settings in all clusters. Multi-disciplinary staff include doctors, nurses and dietitians, along with dedicated diabetes services, generalist community health and hospital based staff who provide education, monitoring of patient progress and referral to specialist services.

These services complement a range of services provided for children and adolescents with diabetes at John Hunter Children's Hospital in Newcastle and services provided by GP practices.

Hunter New England Health's Diabetes Clinical Stream has now been established to oversee and direct diabetes-related clinical activities through a Clinical Service Plan, which will refocus diabetes services in Hunter New England Health to ensure a sharing of specialist diabetes expertise.

The stream structure aims to provide a cohesive and well-supported diabetes service resulting in more equitable access to treatment and education, especially to rural and Aboriginal communities and increased support and training opportunities for all staff. It will also promote integration with the GP sector and closer links with other groups that provide diabetes management in the community.

Major activities and outcomes:

- Diabetes Stream Leadership Group established and Diabetes Clinical Service Plan developed.
- Diabetes staff initiated a Clinical Attachment Program in partnership with GP Access, which gives GPs the opportunity to be attached to Newcastle Diabetes to learn more about managing the condition on their return to their own practice.
- Development of education sessions for GPs to improve their management of diabetes, with presentations by staff specialist, nurses and dietitians in various locations.
- Development by Diabetes staff of a 'Carers Package of Education in Managing Diabetes' that is delivered to

external non-health groups of staff who have a caring role with diabetes clients.

- Enhancement of the Nurse Education Program provided to nurses and other health professionals external to Hunter New England Health. This program has been run in the Newcastle area and also at Foster this year. Tamworth Diabetes Centre also runs this program in their surrounds.
- Professional development opportunities for staff across the area through attendance at conferences, a variety of workshops and professional forums held in locations across the Area and videoconferencing to other sites.
- Staff participation in diabetes camps conducted by Diabetes Australia.
- Development of career pathways for diabetes dietitians through the new Allied Health Award.
- Collaboration with John Hunter Children's Hospital paediatric diabetes services to continue to devise strategies to enhance the transition process to adult services.
- Successful submission by senior dietitian and staff specialist for $15,000 grant to undertake a research into the benefits of cognitive screening in people with diabetes.
- Successful application by senior nurse for $5000 grant to trial group based diabetes program in the Mehi Cluster.
- Key issues and challenges:
- Effective communication with all diabetes staff and generalist staff doing diabetes related activities about issues related to the Diabetes Stream and Clinical Service Plan

Future directions:

- Public sector diabetes services will move more to dealing with high risk and complex patients, while the GP sector addresses the needs of those at lower risk of complications.
- The use of Telehealth video and teleconference technology will become the norm to facilitate the sharing of specialist expertise with those in rural and remote locations.
- • Implementation of the Clinical Service Plan over the next five years means greater collaboration and education of other stakeholders dealing with diabetes, especially GPs and practice nurses.
- Staff education and training regarding use of insulin pumps and new medications as they become more widely used.

Allied Health

Major activities and outcomes:

- Implementation of a work redesign project with a focus on Allied Health Assistants to provide better support to the existing workforce and grow additional positions. Fourteen Assistants, drawn from physiotherapy, hydrotherapy, occupational therapy, dietetic and multidisciplinary services from various clinical settings are participating in the project. An innovation grant through the Australian Flexible Learning Framework was used to develop an e-recognition pathway and the on-line program will be completed in mid October 2008. Participants who complete the e-recognition tool and assessment activities, and meet the criteria for the competencies, will be awarded the Certificate IV in Allied Health Assistance (Generic). If the evaluation is positive, the e- recognition system has potential for broad application nationally.
- Area Allied Health was successful in obtaining an additional grant of $980,000 over three years to develop a rural locum program for dietetics, psychology and social work services. This complements the funding received last year for occupational therapy, physiotherapy and speech pathology. Ten permanent reliever positions are operational - two each in dietetics, occupational therapy, physiotherapy and speech pathology, and one each in psychology and social work. These positions provide continuity of services for clients whilst staff are absent from the workplace. Many rural services have benefited from access to these positions resulting in a very positive client experience.
- Continued support of the physiotherapy rotation program to fill vacant positions whilst recruitment activity is in train. This initiative enhances continuity of service for existing clients, and improves access to services for new clients. This has allowed services to be maintained in Tamworth, Taree, Moree, Muswellbrook and Maitland in a time a general shortage of physiotherapists.
- Progression of a Memorandum Of Understanding (MOU) with the Hunter Central Coast DADHC to improve the service experience of people with a disability. The MOU defines roles and responsibilities, referral pathways, management of clients involved with both agencies and a series of activities for on-going collaboration and service improvement.
- Funding from the NSW Institute of Rural Clinical Services and Teaching was obtained in 2007 to strengthen rural allied health services through professional development processes. The project conducted a needs analysis across all services which identified the key issues from clinician and management perspectives. Multiple strategies were developed and an implementation plan will rollout over the next year. Strategies have been developed in partnership with Organisational Development and Learning, Clinical Networks and streams, and professional networks. Strategies include multidisciplinary, management and profession specific skill sets.
- A lead role in a national study on staffing level standards for tertiary hospitals, in conjunction with the Health Round Table. The objective is to develop evidence based guidelines for staff ratios by client group (casemix group) for inpatient services. The methodology has been

designed through the Health Round Table to rigorously explore this national project.

- Expansion of the innovative Home Enteral Nutrition Program LMNC and Calvary Mater services.
- Conducted an Area-wide Annual Allied Health Research Forum in March 2008 to showcase current research projects and to stimulate additional research uptake. The forum was available by videoconference to five other locations across the Area. In June 2008, a Data Mining Workshop was held with expert input by Professor Irwin Epstein from The Hunter College, New York.
- In November 2007, the Industrial Relations Commission of NSW brought down the NSW Health Service Health Professional (State) Award. The award introduced new career pathways for senior clinicians, student educators rural staff and health professional educators. Translation of 18 profession groups to the new Award was achieved through an Area-wide process. Over 1200 translations were considered, with initial translations being finalised in June 2008.

Future directions:

- Further exploration of recruitment / retention and contingency strategies for difficult to fill positions. Implement strategies for allied health staffs including improved career structures and incentives.
- Further enhancement of the professional supports to rural clinicians through improved access to professional development programs, clinical supervision and other professional supports.
- Progress work redesign - increased Allied Health Assistant roles across the Area and exploration of advanced / extended practice for the professionals.
- Explore innovative contributions reducing the gap in health status between Aboriginal and non-Aboriginal populations and other populations with poorer health outcomes.
- Implementation of standardised outcome indicators in data collections for each profession.

Networking

ACN: Aged Care and Rehabilitation Services

The Aged Care and Rehabilitation Service (ACARS) Clinical Network oversees aged care and rehabilitation services across the spectrum of primary through to acute care services. The ACARS Clinical Network aims to provide strategic leadership, support and direction for aged care and rehabilitation services within Hunter New England Health. The Clinical Network is lead by Clinical Leader for Aged Care, Dr John Ward and Clinical Leader for Rehabilitation Services, Dr Michael Pollack.

Hunter New England Health's specialised ACARS include services such as:

- Aged Care Assessment Teams
- Aged Care Services in Emergency Teams
- Acute to Aged Related Care Services
- Transitional Aged Care Program
- Carer Education and Support Services
- Commonwealth Carer Respite and Carelink
- Home and Community Care Services
- Dementia and Psychogeriatric Services
- Geriatrician and Rehabilitation Staff Specialists
- NSW State Government Residential Aged Care Facilities
- Multi Purpose Services
- Inpatient, Outpatient and Community Rehabilitation Services
- Brain Injury Service
- Spinal Cord Injury Service
- Amputee Services

With the number of older people in our population increasing, it is anticipated that demand for health, aged care and rehabilitation services will also increase. Aged care and rehabilitation services are currently provided by both generalist and specialist health care teams in acute hospitals, residential aged care facilities, community health centres and in the home. General Practitioners provide health services in the primary health care setting and are important partners along with health services in the provision of care for older people and people with a disability.

Major activities and outcomes:

- Involvement with the Older Persons Model of Care project. This is a high-level, evidence based, integrated aged and chronic disease model of care that will support the needs of the Hunter New England region for the next 10-15 years.
- Involvement with the Maitland Rehabilitation Patient journey project and facilitation of potential slow stream rehabilitation pilots at smaller sites.
- Roll out of the Longer Stay Older Patients Initiative – allocation of funds to sites to enhance or commence Aged Care Services in Emergency Teams and Acute to Aged Related Care Services.
- Assistance with funding submissions and establishment of new positions at various sites across the Area, such as Spinal Cord Injury Clinical Care Co-ordinator at Tamworth, Dementia/Delirium Clinical Nurse Consultant at Tamworth, Rehabilitation Nurse Practitioner at Inverell and Dementia Nurse in Newcastle.
- Assistance with planning and funding submissions for additional Transitional Aged Care Program places within the Greater Newcastle, Peel, Lower Mid North Coast and Lower Hunter Clusters.
- Assistance with funding submission for additional high care aged care places at Gloucester.
- Assistance with funding submissions for Department of Veterans Affairs Innovative Grants and oversight of successful projects.
- Data collection and oversight.
- Strengthening links across the area between specialist aged care and rehabilitation staff and generalist staff caring for older people and people with a disability.
- Identifying workforce issues and potential strategies for dealing with staffing needs.
- Promoting and providing professional development and clinical support opportunities for staff across the area.
- Development of a comprehensive community dementia service for Greater Newcastle Cluster.
- Introduction of enablement nursing to Maitland Hospital
- Completion of recruitment in Geriatric Medicine in Greater Newcastle Cluster.
- Introduction of falls injury prevention programs in the residential aged care sector.
- Support for Advance Care Planning in residential aged care.
- Establishment of Aged Care Advisory Committees in Lower Hunter Cluster and Calvary Mater Newcastle.
- Streaming of rehabilitation programs at Rankin Park Centre.
- Development of the Continuing Professional Development Unit at Rankin Park Centre.
- Development of Bone Protection Program at John Hunter Hospital.
- Commencement of on-line education program for GPs in Aged Care.
- Membership on a range of state advisory groups and committees.
- Review and development of aged care and rehabilitation type policies.
- Facilitated the development of the HNE Carer Action Plan.

Key issues and challenges:

- Improving relationships, referral information and care coordination with GPs and other aged care and rehabilitation service providers.
- Attracting and retaining medical, allied health and nursing staff.
- Changing attitudes regarding the care of older people and people with a disability within the health system.
- Improving access to multidisciplinary care.
- Dealing with the greater demand generally on aged care and rehabilitation services in acute and community settings, including general practice.

Future directions:

- In July 2007, Hunter New England Health launched the Aged Care and Rehabilitation Services Plan, which sets the direction and priorities for aged care/ rehabilitation services in the Hunter New England Health region over the next five years. The plan was devised in consultation with clinicians, managers, relevant service providers and consumers. It aims to improve opportunities for people to remain as independent and healthy as possible, and with the ability to participate in community life. Strategic actions and initiatives to be implemented are identified in the plan. These actions and initiatives aim to build on the strengths of Hunter New England Health's aged care and rehabilitation services by enhancing the delivery and quality of those services. An integral part of this plan is improving relationships, referral information and care coordination with GPs and other service providers.
- Roll out of clinician support and education programs, dealing with the care needs of aged and disabled people in hospital and in the community.
- Ongoing networking of aged care and rehabilitation services to improve the co-ordination of service delivery, and facilitate patient access to these services, as well as aiming for a more seamless and efficient patient journey.
- Introducing 'enablement nursing' to all hospitals, in order to up skill acute care staff so they can assist and enable patients to be as independent as possible.
- Developing comprehensive assessment tools for use across the Area.
- Expanding exercise options for older people.
- Developing a policy for the management of sarcopenic obesity in hospitals.
- Developing a program for the assessment and management of people with dementia and difficult behaviours.
- Developing a closer relationship with Specialist Mental Health Services for Older People.

Area Cancer Network

Hunter New England Health is committed to improving the cancer patient's experience of care, through improved coordination and delivery of cancer services across the Area.

The Clinical Cancer Network was established to ensure all people in the Hunter New England Health area have access to a range of high quality services and best practice care irrespective of where they enter the health system.

Major activities and outcomes:

- Leadership committee
  The Network Leadership Committee provides the over-arching leadership for the strategic development of the Cancer Clinical Network through the implementation of the Area Cancer Services Plan. The Cancer Clinical Streams and Tumour Council provide input into the Leadership Committee.
- Introduction of clinical streams
  The Cancer Network consists of six clinical streams. Each stream provides a central reference point for policy, planning, service development and resource initiatives related to services within that stream. The focus areas include workforce planning, resource recommendations, accreditation, tumour group development and communication across the network.
- Establishment of Tumor Groups and the Tumour Council
  The Tumour Council is the strategic committee consisting of representatives from each tumour group. The Tumour Council provides an opportunity for clinical leaders to establish a critical mass of opinion to highlight operational or systemic issues impacting on the care and management of cancer patients. The overall objective of the Tumour Council is to identify these issues and, through the Cancer Clinical Network structure, affect change. The tumour groups oversee the development of formalised, area-wide, site-specific clinical groups and Multi-Disciplinary Teams (MDTs); standards of care, both clinical and organisational, for managing patients with cancer; processes to facilitate equitable access to best practice care for all; formal inter-Area and intra-Area linkages and collaborations with appropriate facilities and providers to ensure access to the full range of cancer services required.
- Consolidation of Multi-Disciplinary Teams
  Multi-Disciplinary Teams (MDTs) consist of medical and other health care professionals who meet to plan treatment and care for patients with complex needs or who may require more than one form of treatment. The MDT will discuss appropriate treatment options which lay the basis for recommendations for the patient's treatment plan.
- Introduction of the Quality Use of Chemotherapy Committee
  The Quality Use of Chemotherapy Committee (QUCC) was formed to establish processes to standardise

chemotherapy prescribing, treatment guidelines and protocols, the implementation of new chemotherapy regimes and the evaluation of outcomes of chemotherapy use. The QUCC is a sub-committee of the Area Quality Use of Medicine Committee.

- Development of the Palliative Care Plan
  The Palliative Care Stream is developing a plan to set the direction of Palliative Care service delivery across the Area. It will provide a framework for the future direction of Palliative Care Services and will articulate priority strategies for action over the next five years. The Palliative Care Stream is linked to the Clinical Cancer Network.

- Establishment of the Cancer Clinical Network News
  A newsletter – Cancer Clinical Network News - was launched to update stakeholders about the activities and outcomes of work undertaken by the Cancer Clinical Network.

- Establishment of CanNET, a Cancer Australia initiative, within Hunter New England Health in October 2007
  CanNET was established is to bring together public and private cancer services, general practitioners, and all other cancer support services in the northern New South Wales region, into one network of services. Northern New South Wales means the regions that make up the North Sydney Central Coast, Hunter New England and North Coast Area Health Services. The project aims to make it easier for persons affected by cancer, who need cancer diagnostic and treatment services, to access what they need, when they need it, in the best way possible. CanNET NSW is jointly funded by the Australian Government and the Cancer Institute NSW. This project is part of a national network.

- Expansion of the QUICA Touch program at the Calvary Mater Newcastle
  The QUICA Touch allows oncology patients to be comprehensively screened and treated for pain, distress, anxiety and depression using a touch-screen program. The system generates a one-page alert for the oncologist who, at a quick glance, can review the results and suggested action regarding referral for psychological support.

- Tamworth Medical Oncology
  Actively pursuing the transition of Tamworth Medical Oncology services from reliance on an external provider to provision internally by Hunter New England Health.

Key issues and challenges:

- The burden of an increasing ageing population the projected increase in the cancer incidence, coupled with the medical workforce issues of recruitment and retention of experienced staff, all combine to create a unique set a of challenges for the clinical cancer network. One specific challenge is the development of a regional oncology centre in Tamworth to meet the needs of the population, which requires the recruitment of a permanent medical oncologist as a first step towards a regional centre.

Future directions:

- The Cancer Clinical Network will drive the continued development of an integrated and coordinated approach to cancer care, through the further consolidation of the cancer streams and tumour groups.

- Further development of relationships with North Coast and Northern Sydney Central Coast Area Health Services within CanNET. In particular, to establish an online services directory for clinicians and consumers listing all cancer services across the network, establish projects to facilitate better care coordination for patients and referral pathways, continue professional development opportunities for clinicians, facilitate more timely access to services by patients and reduce need to travel for some patients.

Paediatric Services

Paediatric services in NSW are networked to ensure high quality clinical care is available as close as possible to home for all children. The focus is a shared approach to service development with common guidelines for care, accompanied by staff training and development.

Networking clearly links each local paediatric unit with one or two of the specialist Children's Hospitals in NSW ensuring the quality of care provided locally is enhanced by the support available from the Children's Hospitals, such as:

- specialist clinical outreach services
- shared treatment protocols and guidelines
- staff rotation between services
- professional training and development opportunities
- support in times of peak demand
- smoother transfer and referral of patients between services

Kaleidoscope

Kaleidoscope in Greater Newcastle, incorporating John Hunter Children's Hospital (JHCH) and Community Child and Youth Health services, is the tertiary referral centre for the Hunter New England Clinical Network for Children, Young people and Families facilitating an integrated system for the care of children and young people in Hunter New England Area Health Service.

Kaleidoscope acts as an umbrella organisation that integrates a range of health care services designed to meet the every-changing health needs of babies, children, young people and their families.

As a strategic partner of Kaleidoscope, the Northern Child Health Network works collaboratively with the Children, Young People and Families Clinical Network to advocate for child health issues on a statewide platform. This partnership ensures that issues effecting children and access to service provision across geographical boundaries can be advocated collectively to NSW Health.

Children, Young People and Family Clinical Network

The Children, Young People and Families (CYP&F) Clinical Network formed in March 2007, built on the existing networks developed by Kaleidoscope, the Northern Child Health Network (NCHN) and the preliminary work of the Northern (New England) Child Health Expert Working Group.

The CYP&F Clinical Network links primary, secondary and tertiary health services in a coordinated manner and aims to support clinicians in providing high quality, effective clinical care.

This year saw final appointments and consolidation of a leadership group ensuring a sound governance framework in which to undertake area wide initiatives.

Major activities and outcomes:

The activities of the Children Young People and Families Clinical Network reported below, highlight the many achievements made possible through partnership and a willingness to share expertise and knowledge. With a focus on ensuring provision of safe and appropriate care provided close to home these activities reinforce the clinical improvements that can result from networking.

- Outreach clinics from JHCH to Tamworth expanded to include two new specialities - Neurology and Paediatric Respiratory and Cystic Fibrosis.
- Provision of paediatric medical service assessed at all Hunter New England Health facilities providing inpatient or emergency care to children and young people.
- Role delineation reviews undertaken of Warialda, Tenterfield, Glen Innes, Armidale, Inverell, Taree in child protection and sexual assault
- Newborn Services multi-disciplinary workshops held in Muswellbrook, Tamworth, Taree, Moree, Armidale and Newcastle.
- Purchase of Neopuffs for all Hunter New England Health facilities that provide maternity services.
- Development of a Paediatric Planned Admission Booklet, resulting from participation in the Booked Surgical Patient Journey project.
- 'Unplanned Admission booklet' commenced.
- Comprehensive orientation program for newly appointed paediatricians within Hunter New England Health introduced at JHCH.
- Introduced Rural New Street Adolescent and Family Counselling State-wide Service.
- Developing standardised CHIME activity templates for Child & Family Health Nursing and Violence Prevention staff.
- Increased number of Aboriginal Child Sexual Assault Counselling positions.
- Recruitment of long term Violence Prevention Counselling positions in rural areas.
- Implementing state-wide Joint Investigation Response Team recommendations.
- Introduction of StEPS Vision screening program
- Conducted three 'Paediatric Emergency Care for Rural GP's' workshops in Gloucester, Narrabri and Glen Innes.
- Implemented the Supporting Allied Health Professionals Working with Children project
- Developing several area-wide policies, most significantly, the Safety and Security of Children and Escalation of Care policies and policy compliance procedures.
- IMET training rotations for paediatric trainees to Maitland, Gosford, Tamworth and Lismore.
- Inclusion of Neonatal Intensive Care Unit guidelines and protocols on Kaleidoscope website.

The leadership group of the Children, Young People and Families Clinical Network has also this year developed a comprehensive plan outlining the strategic direction for the development of services over the next five years. The Plan is consistent with National, State and Area objectives and specifically the NSW State Plan and the NSW State Health Plan.

Future directions:

- Identifying priority issues and facilitating support for management for operational matters.
- Meeting increasing demands for allergy and immunology, gastroenterology, autism, and surgical services.
- Strengthening leadership across the Area in community based children's and young people's health services.
- Strengthen relationship with Clinical Governance Unit and improve review systems for area wide IIMS, RCA's and Death Reviews.
- Increasing attention to Aboriginal Child Health.
- Strengthening the relationships with Critical Care Network, Maternity Network and Mental Health Services.
- Centralising Violence Prevention and Care processes
- Development of Violence Prevention and Care Stream governance.
- Liaise with John Hunter Intensive Care Unit to develop a dedicated Paediatric Intensive Care Unit.

SECTION 4: Health Support Services

Financial Services

Major activities and outcomes:

In 2007/2008, Financial Services continued to work towards a fully integrated and transparent budget throughout Hunter New England Health and communication processes that ensured:

- Budgets for all Hunter New England Health cost centres and units were constructed using common principles and techniques.
- Activity and expenditure patterns were matched to ensure stronger cash management.
- The guidelines and directives of the NSW Department of Health were incorporated into budget projections.
- There was acceptance and sign off of the budget by the responsible cost centre manager.
- The reporting structure and financial performance was supported by reporting systems and techniques.

Reporting responsibilities to the NSW Department of Health were routinely achieved and were supported by quality analysis. Revenue growth targets were exceeded throughout the area and this was made possible by ongoing business process reviews of revenue functions. The combination of this growth and operating expenditure controls ensured Hunter New England Health maintained creditor payment targets in line with the NSW Department of Health benchmark. No creditors exceeded the benchmark of 35 days.

Accounts payable, purchasing, warehouse and some financial accounting functions transitioned to the Health Support Service Centre in Newcastle.

Future directions:

- There will be an increased focus on cash management to maintain Hunter New England Health's financial position.
- Ongoing collaborative approach with Health Support Services to ensure the transition of services achieves all of the stated goals and objectives.

Hotel Services

Major activities and outcomes:

- Hotel Services has achieved a comprehensive area-wide service with the successful merger of patient support services. This has resulted in the standardisation of our practices in cleaning and food services which has contributed to a better outcome for clinical services.
- Hotel Services has continued to focus on the areas of Governance, with the establishment of Governance Committees in Food, Waste and Security.
- Hotel Services is currently working towards successful implementation of the revised Cleaning Standards for Public Health Organisations.
- During the year, Hotel Services subsidiary, HNE Clinical Technology, won contracts with both the Calvary Mater Newcastle and Honeywell to supply biomedical engineering services for the existing medical equipment and the new equipment purchased under the public-private partnership. The services are being provided under service level agreements with KPIs prescribed and being met.
- HNE Clinical Technology has continued to consolidate its service in the Mehi, McIntyre, Tablelands and Peel Clusters with the introduction of its equipment management database for the management of maintenance to all medical equipment, and the recruitment of staff to fill some vacancies.

Key issues and events:

- The development of a model for transition to HealthSupport continues to be a primary focus for the Hotel Services Unit.
- Hotel Services is currently working closely with the Mehi, McIntyre, Tablelands, Peel, Lower Mid North Coast Clusters to standardise Hotel Services procedures and practices.
- Hotel Services conducted two internal patient satisfaction surveys, the results of exceeding Area Benchmarks with satisfaction rates being increased from 88 per cent in 2007 to 91 per cent in 2008 and scoring as high as 96 per cent in one category.
- Hotel Services has continued to meet the external requirements to maintain HACCP and ISO 9001 certification in food services management.
- HNE Clinical Technology has recently been reviewed by Engineers from Sydney, Melbourne and Adelaide under the College of Biomedical Engineers Peer Networking Program. The review involved completion of a self-assessment questionnaire, followed by a two-day site visit by the engineers. During the visit the reviewers interviewed staff, customers and the hotel services manager. The summation on the final afternoon indicated that the reviewers found many of HNE Clinical Technology's practices to be benchmarks to which other services should aspire.

Future directions:

- During 2008/2009, Hotel Services are expected to transition to HealthSupport Services. As such, one of the major priorities for Hotel Service included the development of a comprehensive Service Partnership Agreement with the Area Health Service. The model for the provision of services post-transition is currently being developed in consultation with the Area Health Service.
- The focus for Hotel Services post-transition will be the generation of efficiency savings through the delivery of a state-wide service, in line with the mission of HealthSupport Services which is "providing high quality cost-effective corporate and business services in new and different ways".

Information Technology and Telecommunications

Major activities and outcomes:

- Commenced implementation of area-wide records storage plan.
- Implemented Stage 1 of information system for oncology services.
- Planned network upgrade to support implementation of Picture Archiving System for Medical Imaging.
- Upgraded PC fleet to new standard (5,500 devices).

Key issues and events:

- Completed implementation of Community Health Information System across Area Health Services.
- Completed implementation of Operating Theatre and Emergency Department Information Systems at all sites.
- Completed migration of all users to single domain (7,000 users).
- Commissioned remote (700 users) and mobile access (300 users) services.

Future directions:

- Continue rollout of Electronic Medical Record to all sites and commence implementation of new modules.
- Continue improvements to Help Desk and After Hours Service.
- Improve printer management.
- Develop and implement plan for data storage.

Area Facilities Management Unit

Major activities and outcomes:

- Major fire works completed at Cessnock Hospital.
- Lift upgrade Muswellbrook Hospital, as well as renovations made to accommodate a Chemotherapy Clinic. In addition, work was undertaken for fire isolation of the centre stairwell at the facility, and monitoring of exit and emergency lighting at across the campus.
- High voltage electrical substation and main switchboard upgrade to Tamworth Hospital.
- Upgraded the accommodation buildings at Moree, Tenterfield and Walcha health services.
- Significant repair work was undertaken, with an extension added to Toomelah Clinic.
- Commenced construction of the new two-story equipment store at Tamworth Hospital.
- Completion of the fire ring mains at Scone and Murrurundi Hospitals.
- Minor refurbishment of Muswellbrook maternity workstation.
- Upgrade of the electrical supply to Cessnock Hospital.

Future directions:

The Area Facilities Management Unit will assist staff at Hunter New England Health sites to reduce and manage their physical risks. The unit will also continue to improve the physical environment of Hunter New England Health facilities by maintenance, refurbishments and the capital works program.

Communication Services

Hunter New England Health's Communication Unit is responsible for promoting the work, values and achievements of the organisation. Key functions of the unit include media relations, developing and implementing communication strategies to support the work of the Area, developing internal publications, implementing corporate campaigns and events, and overseeing content for the organisation's internet and intranet. The Communication Unit also supports the organisation's community engagement efforts and groups.

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

- Help instil consumer confidence in the Area's ability to deliver quality healthcare to the communities it serves
- Facilitate media access to timely, accurate information about the health service and broader public health issues
- Maintain the health service's duty of care to patients as set out in the Privacy and Personal Information Protection Act 1998 and the Health Records and Information Privacy Act 2002
- Support staff in the delivery of health care services to the community.
- Help ensure consumers and community groups are informed and have opportunity for involvement in the planning and delivery of health care services.

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

The Communication Unit provides communication services for the entire Hunter New England Health region and has staff based at multiple locations within the area.

Health Support Services

Population Health, Planning and Performance

Performance Improvement Unit

In 2007/08 the Performance Improvement Unit continued to provide on time and high quality information and data to support decisions of Hunter New England Health's Area Executive Team, managers and staff.

In the interest of continually improving our service, a major upgrade of IT infrastructure to support Business Objects reporting was undertaken. This has vastly improved the turnaround times of data extractions and provided a quantum improvement in reporting response times for users.

There has been considerable activity to further roll out the Balanced Scorecard to facilities and units, networks and streams. Access to Balanced Scorecard performance reports has been enhanced through the development of the Performance Gateway portal on the Hunter New England Health Intranet. This also provides staff with easy access to a range of other performance management tools and resources.

Implementation commenced of a new costing system that will improve the depth and timeliness of health product costing. This is part of a state wide initiative which will standardise approaches to costing across all Area Health Services.

Hunter New England Human Research Ethics Committee

The Hunter New England Human Research Ethics Committee (HNEHREC) is the sole Human Research Ethics Committee for Hunter New England Health and has been established to review research:

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

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

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

From the period July 2007 to June 2008, 169 applications for ethical approval for human research were submitted, where:

- 47 were reviewed by the Clinical Trials Subcommittee and HNEHREC;
- 39 were reviewed by the Rural Research Methods Support Group and HNEHREC; and
- 83 were reviewed by HNEHREC.

In October 2007, five member of the Hunter New England Human Research Ethics Committee or its subcommittees and two members of staff attended the NHMRC's National Research Ethics Conference and its training days.

Participation in the NSW System for Single Ethical and Scientific Review of Multi Centre Research

In July 2007, the NSW Health System for Single Ethical and Scientific Review of multicentre research commenced. The Hunter New England Human Research Ethics Committee was accredited as a lead Human Research Ethics Committee in both the areas of clinical research and general research. It reviewed 44 applications for Human Research projects in its capacity as a Lead HREC during the year. Furthermore, Hunter New England Health has authorised 20 human research projects where the ethics review has been undertaken by another NSW Health Lead Human Research Ethics Committee.

Human Resources

Major events and outcomes:

- Code of Conduct e-package launched 1 August 2007. The system automatically collects data to monitor compliance.
- e-Exit survey launched 1 February 2008 including an automated mail out process inviting terminating employees to participate.
- Attendance and absence strategy developed and launched December 2007. Existing data capitalise upon with the development of dedicated reporting related to the strategy to assist monitoring and analysis of data and trends.
- Values charter further integrated within the organisation through people related functions such as performance development review and the conduct of Values and respectful Workplace workshops.
- A recruitment advertising strategy implemented to maximise cost effective attraction of applicants and reduce overall costs.
- Recruitment and selection training reviewed and updated. On-line training package in final development stage for launch in January 2009.
- Automated Post Appointment e-survey implemented to gather feedback on new employee's experience of the recruitment and selection process to assist in identifying opportunities for enhancement in our processes.
- Standardised Performance Development and Review process developed and access to associated tools and resources provided via Hunter New England Health Intranet.
- Human Resources (HR) Intranet site developed and

launched June 2008. This provides ready access for all staff to an extensive suite of tools, resources, policies and guidelines to assist them in people related matters.

- Standardised approach to induction developed and launched through existing e-platform.
- Orientation Guide redeveloped and published to reflect shift in direction and structure of Hunter New England Health. New format developed to link with planned update of Corporate Orientation program and Induction processes and mandatory training requirements.

Future directions:

- Develop an organisation-wide health and wellness strategy.
- Enhance capacity to utilise data gathered from people related measurement systems to guide strategic planning and action.
- Organisation wide Staff Perception Survey to be implemented.
- Implement blended learning package for Recruitment and Selection.
- Implement e-recording of Performance Development Reviews to enable organisation wide reporting and monitoring of participation rates.
- Continue development of resources to add to the HR Intranet site.
- Develop and implement organisation wide strategy to further embed Hunter New England Health values within the organisation.
- Implement Respectful Workplace Policy and Guidelines.

Hunter Area Pathology Service

Hunter Area Pathology Service (HAPS) has continued to provide service Pathology throughout the Newcastle and Hunter region with laboratories at John Hunter, Mater, Belmont, Maitland, Cessnock and Singleton Hospitals.

HAPS Staff Specialists provide a clinical consultative service to private and public clinicians.

- Increased test activity by 9.4% overall, of which 5.4% came from private referrals.
- Increased staffing levels by 6%.
- Completed the year within budget after investing $2 million in capital equipment involved with patient testing.

Major goals and outcomes:

- Continue to provide accurate, timely and cost effective service Pathology.
- Achievement of International Standards Organisation (ISO) 9000 accreditation.
- Creation of the HAPS website (http://www.haps.nsw.gov.au/).
- Establishment of a state of the art Quality Management System.
- Successful supervision of registrars through appropriate Royal College of Pathologists of Australasia (RCPA) college exams.
- Continuing delivery of the Newcastle University undergraduate medical pathology course.
- Mentoring of higher degree students.
- Expansion of our clinical service using cutting edge technology.
- Participation in outreach programs for educational and clinical support.
- Establishment of a support centre for patients with auto-immune diseases.
- Extension of the courier service to include Scone and Muswellbrook.
- Establishment of a patient specimen collection service in Muswellbrook.
- Provision of the “Pathology Forum” education sessions.
- Implementation of automated high throughput genetic analysis for familial cancer syndromes-State Referral Centre.
- New diagnostic tests for meningitis.
- Assisted Pathology New England to gain their National Association of Testing Authorities Australia (NATA) accreditation.
- User driven test expansion—Tuberculum Bacillus (TB) screening—Interferon Gold.

Key issues and events:

- Implementation of Pathology North, a NSW Health initiative. Pathology North is a cluster of pathology laboratories from Royal North Shore, Gosford, Taree, Tamworth, Armidale, Glenn Innes, Inverell, Tweed, Lismore, Coffs and Grafton hospitals.
- Commissioning of the Inductively Coupled Plasma-Mass Spectrometry (ICP-MS) for the analysis of trace metals in all matrices.
- Commissioning of high throughput Chemistry and Haematology analysers.
- Commissioning of a PC3 containment facility.
- Facilitation of applied research with clinical departments — ICU/inflammatory response study.

Future directions:

- Integration of Pathology North into Hunter New England Health.
- Recruit into vacant Pathologist positions.
- Workforce planning, technical, scientific and medical.
- Expansion of Molecular Haematology testing - JAK2.
- Implementation of micro array analysis for routine Cytogenetics.
- Increase HAPS market share with private referrers.
- Increase industrial/OHS testing—drugs of abuse testing.

Health Support Services

Hunter New England Imaging and Breastscreen NSW Hunter New England

Number of examinations across all imaging sites: 360,000.
This includes:

CT Scans	27,500
Ultrasound	21,000
MRI7	200
Angiography	2,200
Diagnostic Mammograms	2,500
*Screening Mammograms	36,230
*Breast Recall Assessments	1,876
Fluoroscopy	3,000

* BreastScreen NSW Hunter New England

Major goals and outcomes:

- BreastScreen NSW Hunter New England Assessment Data Audit - April 2008.
- BreastScreen NSW Hunter New England Assessment Team Site visit June 2008. The outcome of this visit will be known November 2008.
- Implementation of four new Mammography machines (one digital, three analogue) for the Newcastle BreastScreen Service in June 2008.
- Implementation of Computed Radiography (CR) on three of the new analogue mammography machines in June 2008.
- Transition of breast cancer screening services within Hunter New England Imaging.
- Transition of Imaging services across Hunter New England Area Health Service into Hunter New England Imaging in June 2008.
- Improvement in the BreastScreen NSW Hunter New England biannual breast screening participation rate for women aged between 50 and 69 years. This rate has increased from 61.9 per cent to 62.5 per cent.
- Improvement in the BreastScreen NSW Hunter New England screening to assessment rate. The target set was for 90 per cent of patients to attend their assessment within 28 days of screening. This was achieved in May and June 2008.
- Acquired funding under the Department of Broadband, Communication and Digital Economy (Clever Networks Program) for the rollout of PACS (Picture Archival Communication System) and RIS (Radiology Information System) across Hunter New England Area Health Service. This includes 23 new sites, plus 12 existing sites.
- Procurement and installation of a 64 Slice CT Scanner at The Maitland Hospital.
- Procurement and installation of a new general x-ray room at Tenterfield Hospital.
- Establishment of a networked radiographer relief service across Scone, Muswellbrook, Singleton and Maitland.
- Renewal of contracts for the provision of radiology services in Peel, Tablelands, McIntyre and Mehi Clusters.
- Secured Commonwealth funding for a new PET/CT in the redeveloped Calvary Mater Newcastle Hospital.
- Overflow reporting system established to maintain report turnaround times.
- Renovation to several Hunter New England Imaging Departments to improve waiting and reception areas for patients and staff.
- All sites of Hunter New England Imaging registered for mandatory accreditation of its radiology services with the Health Insurance Commission (HIC).

Key issues and events:

- Invitation to apply for a Medicare eligible MRI Unit Newcastle/Maitland/Hunter Region – proposal by Hunter New England Imaging for this MRI to be located at Calvary Mater Newcastle Hospital.
- Establishment of an Echo Cardiology Service in the Radiology Department at The Maitland Hospital.
- RANZCR (Royal Australian New Zealand College of Radiologists) Accredited Registrar Training Program – successful site visit and subsequent achievement of continued accreditation of registrar training program.

Future directions:

- Implementation of the Clever Networks Program involving rollout of PACS/RIS to 23 sites across Hunter New England Area Health Service.
- Replace one MRI Unit at John Hunter Hospital.
- Implementation of PET/CT in the redeveloped Calvary Mater Newcastle Hospital.
- Implementation of PACS and soft copy reading for mammography.
- Implementation of CR (Computed Radiography System) on mobile breast cancer screening units based in Newcastle - late 2008 or early 2009.
- Target further improvement in biannual breast screening participation rate.
- Procure a new prone biopsy table for BreastScreen NSW Hunter New England - late 2008.
- Creation of a metro-rural medical imaging education network providing internally developed online education resources primarily aimed at the education needs of radiographers and remote x-ray operators.

- Installation of OPG (Orthopantomogram) x-ray machines at Maitland and Cessnock Hospitals.
- Installation of direct digital radiography equipment and a 64 slice CT scanner as part of the Calvary Mater redevelopment project.
- Replacement of an ultrasound machine at Manning Hospital.
- Review of service hours to better meet the changing workload profiles at particular sites.
- Introduction of lymphoscintigraphy examinations in the redeveloped Calvary Mater Newcastle.
- Implementation of new BreastScreen NSW Hunter New England Management Structure.
- Recruitment to the role of Clinical Director, Nuclear Medicine, Hunter New England Imaging.
- Development of Hunter New England Imaging and BreastScreen NSW Hunter New England Website
- Investigate potential for digital dictation of imaging reports.
- Implement an appropriate document management system for Imaging.

Pharmacy Services

The Area Pharmacy Service was implemented following the merger of pharmacy services across the Area during 2007/08.

This amalgamation is bringing 13 separate pharmacy services/ departments, including mental health pharmacy services, and over 110 pharmacy staff together under one line management structure to ensure best possible pharmacy service delivery to the patient care facilities across Hunter New England Health.

The pharmacy services offer administrative and distribution services, and quality and safe use (or medication management) advice in the large metropolitan and rural referral hospitals as well as in smaller rural sites. Clinical pharmacy services are also provided in a range of specialties including paediatrics, oncology, renal medicine, immunology and infectious diseases, aged care, intensive care, cardiology and general medicine. Clinical pharmacy services are limited in the more rural and remote sites.

The use of technology is important to service delivery with the drug list and usage information for all sites across Hunter New England Health available electronically. The use of tele-health strategies for service delivery is being explored.

The Directors of Pharmacy within these pharmacy departments assist in overseeing and advising on the quality and safe use of medicines which comprises more than $42 million of the Area's budget expenditure.

The Area Pharmacy Service is part of the Clinical Operations portfolio and reports to Director of Clinical Operations Tracey McCosker.

Major goals and outcomes:

- Appointment of the Area Director of Pharmacy in December 2007.
- Appointment of new Directors of Pharmacy for John Hunter Hospital (who also oversees the pharmacy service provision to the John Hunter Children's Hospital, Royal Newcastle Centre and Rankin Park Unit) and Armidale Hospital.
- Commissioning of a new Pharmacy Department at Manning Rural Referral Hospital.
- Participation in NSW Health recruitment and retention strategies including the continuation of six pharmacist intern training positions within the Area Health Service and the NSW Health Pharmacist ReConnect Pilot Program.
- Establishment of a clinical pharmacist position for the Short Term Residential Assessment Service at Belmont Hospital.
- Expansion of the clinical pharmacy service at John Hunter Hospital for Emergency Department and Medical Admissions as a seven-day service.
- Supervision of numerous pharmacy undergraduate and masters students from the Universities of Newcastle, Sydney and Charles Sturt.
- Hunter New England Health Quality Award in 2007 for the Tamworth Rural Referral Hospital Pharmacy Department – entitled Clinical Pharmacy by Remote – which extended clinical pharmacy services via remote technology from Tamworth to Tenterfield.
- John Hunter Hospital Charitable Trust funding ($15,500) for a Pharmacist Prescribing Project within the Surgical Admissions Clinic – Pharmacists Improving Patient Outcomes in the Perioperative Service (PIPOPS)
- Development of a new clinical form aimed at streamlining the medication admission history taking and medication reconciliation processes in particular for patient admission and discharge.
- Successful liaison with pharmaceutical company representatives to ensure cost-effective medicines being available to treat the patients of Hunter New England Health.
- Along with Clinical Governance, establishment of the Area Quality Use of Medicines Committee for Hunter New England Health.

Health Support Services

Key issues and events or challenges:

- Increased demand for clinical pharmacy services in a climate of pharmacist workforce shortages in rural and remote NSW.
- Commissioning a new pharmacy satellite within the Mental Health Capital Works program on the Calvary Mater Newcastle site.
- Providing clinical training opportunities for the pharmacy students of the local Masters of Pharmacy degree at the University of Newcastle.
- Building and maintaining a trained and competent pharmacy workforce.
- Hold a forum for Directors of Pharmacy in September 2008 to assist in the planning for future development and connectivity of the Area Pharmacy Service.

Future directions:

- Review of pharmacy services across Hunter New England Health in order to establish a service plan for the next five years, including recommendations regarding the delivery of clinical pharmacy service to the more rural and remote facilities of Hunter New England Health.
- Enhance the professional support to rural pharmacy staff via collaboration with the Society of Hospital Pharmacists of Australia to offer professional development education sessions via video-conferencing facilities.
- Development of a pharmacy workforce plan that will ensure enough trained and competent staff, continue work with NSW Health on recruitment and retention strategies, as well as developing a localised marketing strategy for attracting more pharmacists to Hunter New England Health.
- Developing a plan for key/priority pharmacy and quality use of medicines research in collaboration with the University of Newcastle.

Strategic profile of the Health Service workforce

Major events/activities/or outcomes for recruitment and retention:

- A new position was created and filled to support the recruitment and retention of clinical staff working in rural non-acute facilities.
- A survey of International Medical Graduates (IMGs) engaged by Hunter New England Health to identify ways that the Area Health Service can better support IMGs.
- An implementation review of the 2007 Re-credentialing and Appointment process for senior medical practitioners has been undertaken so that lessons can be learnt for future projects.
- The centralised Staffing Services Unit has significantly improved the support provided to Hunter New England Health emergency departments requiring locum doctors to fill their medical rosters.
- In a number of facilities, reliance on locum doctors has reduced as a result of filling of permanent vacancies, and improved rostering arrangements.
- A new web-based system has been developed and implemented to assist in the management of clinical privileges of senior medical officers

Key issues/challenges during this period:

- A significant review of the appointment and credentialing processes for senior medical officers has commenced.
- Recommendations have been put in place following an audit of medical practitioners who have conditional registration with the NSW Medical Board.

Future directions/plans for 07/08 and beyond.

The Medical Workforce Unit is working toward completion of the following projects and strategy implementation over the 2008/09 financial period:

- Completion of the review and audit of the Area's processes for the appointment and credentialing of Senior Medical Officers will ensure that the Area's processes are best practice.
- Improved governance and management structures will be implemented to ensure that the reputation of the Area Junior Medical Officer Training Network is one of the best in the state.
- The process to appoint and credential approximately 100 rural Visiting Medical Officers will be completed.
- Improved support for International Medical Graduates engaged across the Area will be undertaken.

Executive Reports

Nigel Lyons
Chief Executive

Key responsibilities:

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

Significant achievements in reporting year:

- Contributed effectively to corporate planning and policy development.
- Provided concise, accurate and timely advice to the Director General and other senior officers and the Minister as appropriate.
- Ensured achievement of agreed program targets and outcomes through appropriate resource, staff management and continuous improvement strategies.
- Provided leadership and effectively managed employee relations issues.
- Met statutory and professional obligations relating to external reporting, probity and ethical behaviour.
- Management of issues as required within and across Government.
- Took responsibility for ensuring high level client and community engagement.
- Ensured risk management is an integral part of the Hunter New England Health organisation and culture.
- Modelled, lead, promoted and encouraged an organisation and culture that embraces the values of Hunter New England Health in every day decision making and in interactions with colleagues, staff, customers and the community.
- Led Hunter New England Health to a high standard, meeting all performance targets, with the exception of General Fund.
- Made a significant contribution at a NSW Health level.
- Established the Joint Medical Program in partnership with the University of New England, the University of Newcastle and Northern Sydney Central Coast Health.
- Appointed Director of the Hunter Valley Research Foundation.
- Appointed to the NSW Rural and Remote Health Priority Taskforce.
- Member of the Sustainable Access Health Priority Taskforce.
- Member Management Board NSW Institute of Medical Education and Training.

Executive Reports

Kim Browne
Director Population Health, Planning and Performance

Key responsibilities:

Provide leadership and support for Hunter New England Health in the development, implementation, monitoring and evaluation of a strategic approach to health service delivery. This includes service development, performance improvement and population health approaches, Aboriginal health, research governance and research ethics, and partnerships with GPs, NGOs and other government and health service organisations. The directorate aims to build the capacity of the health service and other community organisations and agencies to effectively meet the needs of our staff, patients and communities by working closely with internal and external stakeholders.

Significant achievements in reporting year:

- Completion and launch of Aboriginal Health Partnership Strategic Plan, jointly with Aboriginal Community Controlled Health services in our region.
- Development of Performance Gateway portal on the intranet, providing access to a wide range of performance management reports, tools and resources.
- Establishment of HealthOne Program coordinating structure across the area including appointment of clinical integration coordinators at each of the four sites and advancement of capital works planning.
- Signing of a MOU for joint health service delivery to the communities of Toomelah and Boggabilla, with Pius X AMS
- Establishment of a number of shared service projects between health-funded NGOs and Hunter New England Health
- Formation of the Area Prevention Taskforce and the Area Aboriginal and Torres Strait Islander Strategic Leadership Committees
- Transfer to routine business of Area SmokeFree Policy implementation, with particular success in improving care of inpatients who smoke
- Completion of multiple clinical services plans, framework plans, local plans to inform capital works, and planning guidelines
- Establishment of Partnership with New England General Practice Division to increase access to Sexual Health Services
- Conduct of Ring-of-Rosies vaccination exercise for pandemic preparedness
- Comprehensive review of the NSW Health Drinking Water monitoring database in partnership with the NSW Health Water Unit.
- Development of the “HNE Aboriginal and Torres Strait Islander Health InfoNet”, a clearinghouse of health information to assist service development and research for Aboriginal people of HNE
- Successfully completed first year as an accredited lead Human Research Ethics Committee
- Identification of and progress by the General Practice Advisory Committee on three strategic priority areas of concern: mental health, integrated primary care and education and training for undergraduate, postgraduate and procedural GPs.
- Another successful year at the NSW Aboriginal Health Awards
- Achievement of highest child immunisation rates in NSW
- Achieved 97 per cent of Area target for Otitis Media screening of Aboriginal Children aged 0-6 years
- Major upgrade of IT infrastructure to support Business Objects reporting - vastly improved reporting response times for users.

Tracey McCosker
Director Clinical Operations

Key responsibilities:

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

Significant achievements in reporting year:

- Improved access to services
- Access block performance maintained on benchmark
- Benchmarks for waiting time for elective surgery
- Off stretcher for ambulance patients improved
- ED triage category benchmarks achieved
- Improved integration of Acute and Primary and Community services
- Progressing the implementation of the Booked Surgical and the Adult Community Mental Health Clinical Redesign projects
- Commencement of the ED Co-design at John Hunter and Manning Hospitals
- Commencement of the review of Ambulatory Care Centre in Royal Newcastle Centre
- Executive sponsor for Cardiac Stream and Cancer Area Clinical Network
- Introduction of the Joint Medical Program in the Hunter New England Health area.

Dr Dinesh Arya
Area Director Hunter New England Mental Health

Key responsibilities:

- Responsible for the overall management of all mental health services across Hunter New England Health. Hunter New England Mental Health provides integrated mental health services in geographically based teams and specialist streams for Child and Adolescent, Neuropsychiatry, Acute Adult, Rehabilitation and Older Persons.
- Providing leadership and direction to all services of Hunter New England Mental Health

- Providing a focus on clinical redesign programs and embedding a quality, safety and reduction of waste culture within the service.

Significant achievements in reporting year:

- Review of progress of initiatives within the Operational Plan and development of processes for implementation and continuous evaluation of planning initiatives.
- Development and review of potential risks for the Risk register
- Review and revision of management structure and the committee structure.
- Focus on improving communication, including reformatting the service newsletter to focus on review of performance and opportunities for improvement. Improved communication also through use of website, Director's blog site and a repository for documents available for consultation and discussion
- Development of facility plan for future of services currently based at the Morisset Hospital.
- Overseeing mental health facility development initiatives including move of inpatient mental health and other associated services from James Fletcher Hospital to the mater campus and development and construction of a new non-acute inpatient unit at James Fletcher Hospital.
- Overseeing the NSW Health Milestones Projects and Interagency Action Plan
- Expanded promotion prevention and early intervention initiatives such as the drought support program in rural and remote areas.
- Development of an aboriginal mental health workforce through trainee positions.
- Promotion of Mental Health General Practice Consultation Liaison to provide better increased mental health support to GPs.

Michael Di Rienzo
Director Operations – Acute Networks

Key responsibilities:

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

Significant achievements in reporting year:

- Better than benchmark performance in emergency department triage and emergency admission performance despite significant increase in Emergency Department presentations.
- Improved waiting list performance with both Category 1 - 30 days and Category 3 greater than 12 months waiting lists reduced to zero and significant improvement in Category 2 - 90 days waiting list.
- Continued reduction in length of stay for the acute hospitals
- Roll out of clinical redesign projects including Booked surgical patient, Maitland Rehabilitation and Emergency Co design projects.
- Further roll out of clinical networks and streams including critical care, stroke and renal.
- Completion of design and development of the new emergency department at Manning Rural Referral Hospital, the extensions to the Maitland emergency department and the Manning Acute Dialysis Unit.

Scott McLachlan
Director Primary and Community Networks

Key responsibilities:

- Managing and leading the improvement of primary health care services, service redesign and ensuring integration across networks to achieve quality care delivery
- Managing and leading the eight operational Clusters across the Area that entail community health services, Community and District Hospitals and Multi Purpose Services.
- Overseeing Area wide services such as Drug and Alcohol, Oral Health, and Genetics
- Leading Clinical Networks and Streams such as Aged Care and Rehabilitation, Palliative Care, Violence Prevention and Chronic Disease
- Working with key stakeholders, including General Practice, and other government departments to enable integrated primary care approaches and develop working partnerships in order to benefit the community.
- Actively participating in the community consultation process to ensure communities have key role in the planning and delivery of health services.
- Contributing to and enhancing strategic planning and policy development across the division.
- Developing innovative service models to ensure resources are appropriately utilised and place Hunter New England Health as a leader in the delivery of Primary Health Care Services.

Significant achievements in reporting year:

- All Clusters have achieved ACHS Accreditation and all aged care services have received Commonwealth Accreditation.
- Construction close to completion for 4 Multi Purpose Services (MPS) and approval for other facilities to develop plans for both minor and major capital works.
- Opening of new Community Health Centre in Newcastle
- Commencement of capital works for a new Narrabri

Hospital

- Development of Area-wide service plans for Diabetes and Drug & Alcohol which look at the challenges over the next five years and changing service needs over this time.
- Development of an innovative model of care for older persons and chronic disease through a major redesign project.
- Development of plans for four new Integrated Primary Health Care Services (HealthOne) that will integrate services between a number of service providers at Quirindi, Manilla, Forster / Tuncurry and Raymond Terrace.
- Implementation of several new telehealth models of care supporting rural communities through the use of technology to access specialist services.
- Significant expansion of the Community Health clinical information system CHIME to enable clinicians to make evidence-based decisions on their models of care.

Dr Kim Hill
Director Clinical Governance

Key responsibilities:

The Director Clinical Governance is responsible for directing, managing and leading the implementation of Area-wide systems that promote clinical excellence and patient safety, to continuously improve the quality of health care services, to promote high standards of care and to create an environment of excellence in clinical care.

Significant achievements in reporting year:

- Progressive implementation of the Hunter New England Health Quality and Patient Safety Framework, including the establishment of specialist Area-wide expert groups that promote clinician engagement, and the identification of clinical leaders for each of these areas
- Executive sponsor of Area-wide initiatives in key quality areas including Infection Prevention and Control, Safe Use of Medicines, Correct Side/Site Surgery and Transfusion Medicine
- Leadership of clinical communication strategies in Hunter New England Health, including of the team that received the Australian Commission on Safety and Quality in Healthcare grant to study standardised communication tools in the context of inter-hospital transfer
- Implementation of the Hunter New England Health Clinical Ethics Framework that incorporates policy development, staff education and evaluation of clinical ethics matters and requirements with an Area-wide perspective and the establishment of an Area Clinical Ethics Committee with clinical and executive membership
- Leadership of the team whose strategy delivered significant improvement in timeliness of acknowledgement and resolution of complaints received from patients and the community
- Development of the Hunter New England Health process to action and manage recommendations from the 2007 NSW Health Patient Survey, incorporating consultation with staff and the Area Health Advisory Committee
- Implementation of the Hunter New England Health policy compliance procedure for introduction, monitoring and evaluation of new interventional procedures and clinical practice innovation, including alignment of the process with other relevant committees such as Research Ethics and the Medical and Dental Appointments Advisory Committee
- Provision of valued professional development initiatives, references and resources for safety and quality for Hunter New England Health staff, including the second Annual Hunter New England Health Quality Exposition and Scientific Program, continued monthly publication of Clinical Governance Newsletter “Quality Matters”, and revision and maintenance of the Clinical Governance web portal via both the Hunter New England Health intranet and internet
- Implementation of performance management for senior Clinical Governance staff and formalisation of staff establishment and reporting relationships consistent with portfolio responsibilities
- Partnership with other Area executive directors in integrated risk management initiatives, including development of routine reporting to Area Executive and as designated point of contact between Hunter New England Health and NSW Health in relation to risk management
- Continued implementation of the Area-Wide policy management framework, resulting in improved mechanisms to monitor and manage policy implementation and preliminary work on alignment of policy development and clinical guideline development

Chris Kewley
Area Director of Nursing and Midwifery

Key responsibilities:

To assist and advise the Chief Executive on:

- Development and management of an appropriately resourced, qualified and competent nursing and midwifery workforce
- Professional development needs aligned to changing practice models and evidenced based care
- Recruitment and retention issues
- Emerging state (NaMo), national and international professional nursing and midwifery trends and initiatives
- The judicious use of nurse strategy funding aligned to local and state strategic initiatives
- Tertiary education partnerships, education and research
- Disaster exercise planning, execution and business continuity
- Multicultural and refugee service planning, monitoring and facilitation of the Ethnic Affairs Priority Statement (EAP)
- Facilitation of Area executive duties related to service plans, networks and clinical streams

Significant achievements in reporting year:

- The portfolio has performed to a high standard throughout the year in partnership with clinical operations, clinical governance, workforce development and various NSW Health Department services.

- The nursing and midwifery workforce has remained reasonably stable with positions actively recruited (PAR) below the state average. The number of new graduates indicating HNE as their preferred employer continues to increase yearly along with a 21% overall increase in new graduate numbers. The Trainee Enrolled Nursing program in the rural and remote areas with its foci on locally "growing and keeping our own" has performed strongly with an 80% local retention rate. Early entrance programs are yielding a high return on investment through an increased emphasis on Vocational Education Training for years 11 and 12. VET course entrant numbers focusing on certificate 3 in either Aged Care or Acute Care have returned a 50% increase for the past year. The benefit of early pathway entrance is evident through 60% of nurses that graduated in 2006/07 had entered via a VET course.

- This past year has seen a major emphasis on strengthening our partnership with the tertiary education sector. A Nursing and Midwifery Leadership Council has been established bringing together a collaborative consisting of Hunter New England Area Health, The University of Newcastle, University of New England and TAFE NSW. The Council has a mandate to engage and support nurses and midwives in clinically grounded research and scholarship.

- The portfolio has lead and monitored in partnership with the Public Health Unit 36 disaster exercises and participated in a number of major high risk social gatherings including the Tamworth Music Festival, World Youth Day and City to Surf.

- The multicultural and refugee services have had a busy year with significant success. A special optometry clinic has been established to run concurrently with the immunisation clinics and an automatic referral and treatment regime for all diagnosed with infectious diseases has also been established within the on arrival refugee clinics. The interpreter service provided interpreting service in 42 languages for 473 people.

James Brown
Director, Corporate Services

Key responsibilities:

Leadership and Management of the following portfolios:
- Finance
- Information Management and Technology
- Corporate Risk
- Capital Works
- Mater PPP Project
- Property Management
- Shared Corporate Services, including
    - Logistics
    - Hotel Services
    - Facilities Management
    - Food Services
    - Linen Services
    - Security Services

Significant achievements in reporting year:

- Successfully initiated the services component of the Mater Public Private Partnership (P.P.P.) - first Health P.P.P. in the State.
- Mater P.P.P. construction progressing on time and on budget
- Opening in November 2007 of the 2nd access road to the Rankin Park campus which has been a specific objective since commencement of the Newcastle strategy in 2000.
- Completion of air-conditioning of all John Hunter Hospital wards in March 2008
- Opening of Tingha MPs and Stage 1 of Merriwa MPS in June 2008
- Construction of the Paediatric Oncology Day Unit at John Hunter Hospital
- Staff accommodation improvements at Moree, Tenterfield and Manning Hospitals
- Commencement of project planning for Manilla MPS and Narrabri Hospital Redevelopment
- Asset Strategic Plan was completed and submitted to NSW Health
- During the year, Hotel Services subsidiary, HNE Clinical Technology, won contracts with both the Calvary Mater Newcastle Hospital and Honeywell to supply biomedical engineering services for the existing medical equipment and the new equipment purchased under the public-private partnership.
- Revenue growth targets were exceeded throughout the area and this was made possible by ongoing business process reviews of Revenue functions.
- Accounts Payable, Purchasing, Warehouse and some Financial Accounting functions transitioned to Health Support Service Centre Newcastle.
- Completed Clinical Systems implementations as planned.

Glenda Dingwall
Acting Director Workforce Development

Key responsibilities:
- Provide high level, strategic advice to the CE on all Workforce matters
- Provide leadership and management of the following portfolio areas:
    - Workforce Planning
    - Workforce Development and strategy
    - Allied Health
    - Human resource strategy, services and employee/ industrial relations
    - Organisational change and workforce capabilities and development

Significant achievements in reporting year:

- Implementation of a work redesign project with a focus on Allied Health Assistants providing support to the existing professional workforce.

- Developed a rural local program for dietetics, psychology and social work services, complementing the funding received last year for occupational therapy, physiotherapy and social work services.
- Allied Health undertook a lead role in a national study on staffing level standards for tertiary hospitals, in conjunction with the Health Round Table, to develop evidence based guidelines for staff ratios.
- Pilot Implementation of the HNEH Organisational Capability Framework
- Deployment of Area learning content management system including its use in the Area PI project, Advanced Care Planning and the Area leadership Capability strategy.
- Design endorsement and initial deployment of Area Management and Leadership Frameworks including support programs.
- Delivered a second CEC Clinical Leadership Program.
- Code of Conduct e-package launched 1 August 2007. The system automatically collects data to monitor compliance.
- Attendance and Absence Strategy developed and launched December 2007.
- A recruitment advertising strategy implemented to maximize cost effective attraction of applicants and reduce overall costs.
- Hunter New England Health awarded Prime Minister's award for both Employer of the Year and Large Employer of the Year recognizing excellence in the employment of people with disability for the second year running.
- Integration/partnering of Workforce Planning with Clinical Services Planning
- Lead role in Pandemic Influenza Workforce Taskforce
- Designed/delivered Workforce Planner Capability Program
- HNE strong contributor to statewide workforce strategy and initiatives
- Implemented Area Wide Junior Medical Officer training network
- Undertook re-credentialing of Staff Specialists employed by HNEH.
- Developed and implemented electronic system to manage Clinical Privileges
- Employed additional resources to address recruitment challenges in Emergency Departments and rural communities.

Carina Bates
Director Communication and Stakeholder Engagement

Key responsibilities:

- Promote the work, achievements and values of Hunter New England Health, and
- Provide strategic direction for Hunter New England Health's internal and external communication initiatives, including
    - media relations
    - special publications
    - corporate campaigns and events
    - internal communication campaigns
    - strategic content for the organisation's internet and intranet
    - the organisation's community engagement principles.

Significant achievements in reporting year:

- Promoted and supported the implementation of new and improved health services across Hunter New England Health, including the establishment of John Hunter Hospital's Medical Assessment Unit; the construction of several Multi Purpose Service facilities in the region; and capital works and enhancements at Belmont, Moree, Tamworth, Armidale, Maitland, Manning and many other acute and community health facilities.
- Promoted preventative health messages to the broader community to help address major health issues such as adult and childhood obesity, chronic disease, falls, cancer and other conditions.
- Supported local health services and teams in promoting health awareness events and activities to local communities.
- Developed an improved format for the Area Managers Forum, which brings together approximately 125 of Hunter New England Health's most senior managers, including clinician managers, to share and discuss solutions to strategic issues affecting the health service and the communities we serve.
- Developed a new and enhanced process for recognising the outstanding achievements of Hunter New England Health staff, health care units and support units via the 2008 Staff Achievement Awards.
- Developed the Hunter New England Health Community Engagement Tool-Kit to help Health Service Managers and the organisations community engagement groups strengthen their efforts and outcomes.
- Supported the goals of a range of other Hunter New England Health service units through internal and external communication strategies and results.
- Promoted and supported multiple emergency and pandemic response planning exercises, including Ring O' Rosies and Exercise Forrest Gump.

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

X540 - Hunter New England

	June -03	June -04	June -05	June -06	June -07	June -08
Medical	564	630	687	726	797	**888**
Nursing	3,794	3,901	4,526	4,638	4770	**4,877**
Allied Health	662	737	829	842	872	**877**
Other Prof. & Para professionals	365	326	336	306	308	**306**
Oral Health Practitioners & Therapists	114	98	110	120	111	**116**
Corporate Services	680	655	589	521	525	**453**
Scientific & technical clinical support staff	502	506	647	686	719	**730**
Hotel Services	1,070	1,039	1,168	1,176	944	**926**
Maintenance & Trades	201	184	206	205	197	**205**
Hospital Support Workers	955	1,064	1,346	1,369	1396	**1,519**
Other	41	44	42	37	40	**44**
Total	8,948	9,183	10,485	10,626	10,679	**10,939**
Medical, nursing, allied health, other health professionals & oral health practitioners as a proportion of all staff	67.1	67.5	68.0	68.9	71.0	**71.2**

Source: Health Information Exchange & Health Service local data
Note: 2004 corporate service FTE increased by 24 to reflect transfer of FTEs resulting for Health Service amalgamations

Notes:

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

Equal Opportunity Employment

Equal Employment Opportunity outcomes for 2007/2008:

The primary focus in 2007/2008 has been the Aboriginal Employment Strategy launched in March 2008. Other outcomes were:

- EEO Advisory Committee formed.
- Rotation commenced for existing apprentices with a disability to ensure that apprentices are given extensive development opportunities in their trade across different work sites.
- Placement of four apprentices with a disability into apprenticeships for electrical, painter, carpenter, fitter/machinist.
- Commenced rollout of Aboriginal Cultural Respect workshops.
- Commencement of fourteen Aboriginal traineeships including placements at Guyra, Inverell, Wallsend. Walcha, Manilla, Moree, Taree and Waratah.
- Placement of four Aboriginal trainees with a disability within Hunter New England Health in partnership with Castle Personnel.
- Review of EEO Management Plan completed 07/09.
- Gold sponsor of the Hunter Indigenous Jobs Market (Held 1 November 2007).
- STEP contract with DEWR secured to assist the Aboriginal employment program across Hunter New England Health. Fifty five Aboriginal people employed in2007/2008. Hunter New England Health now employs three hundred Aboriginal people in total.
- Survey of Aboriginal staff was conducted to gather information to further develop career opportunities.
- Introduction of Mentoring Program for all Aboriginal trainees.
- Consultation undertaken with community and providers of Australian Government Services to determine ways to attract Aboriginal people to Hunter New England Health vacancies.
- Pre-vocational course for Aboriginal Trainee Enrolled Nurses, conducted at Newcastle TAFE 2006/0707 used as a pilot model for TAFE system.
- Establishment of an EEO Intranet site as a component of the Human Resources Intranet.
- Formed Aboriginal Health Worker Competency Steering Committee.
- Formed an Aboriginal Cultural Respect Steering Committee.
- Regular attendance and input into local and state-wide EEO external Network meetings Eg: Newcastle Anti Discrimination Board, Aboriginal Employment Interagency, Newcastle Disability Forum, NSW EEO Practitioners Association, Indigenous Jobs Market Executive Committee.
- Employment of two Aboriginal Nurse Cadets.
- Employed five Aboriginal Trainee Enrolled Nurses in 2007/2008.
- Respectful workplace training conducted to support related guidelines/policies that have now been developed.

Planned outcomes 2008/2009:

- Collect qualitative information on workplace equity issues (from Staff Opinion Survey, Exit Survey, Staff Consultative Committees, Career Development forums and Staff Development forums). Develop strategies to address any equity issues identified through these sources.
- Collect qualitative information on flexible work practices.
- All staff resurveyed for their EEO statistics.
- Creation and implementation of a Equity and Diversity Balance Scorecard that lists diversity aims, goals and targets across the organisation in the areas of gender, cultural/ethnic diversity, disability, and mature age. The scorecard would aim to increase management accountability.
- Strategies developed to ensure that EEO objectives and success stories are shared across Hunter New England Health and with external stakeholders to promote Hunter New England Health as a values based culture that supports diversity.
- Development and implementation of a Disability Employment Strategy.
- Conduct a series of Cultural Diversity Employee Forums/Roundtables to gather face-to-face feedback and practical ideas for increasing awareness of cultural diversity within Hunter New England Health from staff.
- Commence Planning for EEO Management Plan 2010-2012.

Aboriginal and Torres Strait Islander

- Ongoing consultation with community and internal/external stakeholders regarding Aboriginal employment.
- Provide Hunter New England Health managers with training/education and information to assist them in employing and retaining Aboriginal staff in permanent positions e.g.: toolkit for managers with Indigenous employees in their unit and management support.
- Develop and implement protocols that ensure that an Aboriginal Person participates on all selection committees where the candidate list includes an Identified Aboriginal applicant.
- Develop processes to assist and educate managers to prepare job descriptions in plain English and ensure that selection criteria is worded to encourage Aboriginal people to apply.
- Develop policies and tools to ensure that the performance agreements of managers include objectives related to supporting and progressing Aboriginal employment within their units.
- Conduct a survey of Aboriginal Staff to assess perceptions regarding career opportunities.
- Explore options for the provision of an Aboriginal Employee Assistance Program (EAP) counsellor.
- Develop and implement local programs to celebrate NAIDOC Week, National Sorry Day and other key events of significance for Aboriginal people, and provide opportunities for all staff to participate Hunter New England Health's site and Community events.

Trends in the representation of EEO target groups in %

EEO target group	% of Total Staff				
	Benchmark or target	2005	2006	2007	2008
Women	50%	76%	76%	77%	77%
Aboriginal people & Torres Strait Islanders	2%	1.8%	1.8%	1.9%	1.95%
People whose first language was not English	20%	4%	5%	7%	8%
People with a disability	12%	3%	3%	3%	3%
People with a disability requiring work-related adjustment	7%	1%	0.9%	0.9%	0.7%

Trends in the distribution of EEO Target Groups

EEO Target Group	Distribution Index				
	Benchmark or target	2005	2006	2007	2008
Women	100	88	88	86	
Aboriginal people & Torres Strait Islanders	100	80	81	81	
People whose first language was not English	100	119	118	112	
People with a disability	100	99	99	98	
People with a disability requiring work-related adjustment	100	97	96	96	

Note: A distribution index of 100 indicates that the centre of the distribution of the EEO Groups across salary levels is equivalent to other staff. Values less than 100 means the EEO groups tend to be more concentrated at lower salary levels than is the case for other staff. The more pronounced this tendency is, the lower the index will be. In some cases the index may be more than 100, indicating that the EEO group is less concentrated at lower salary levels.

Hunter New England Health will continue to work with Castle Personnel and other Providers to identify further opportunities to place people with a disability into employment in Hunter New England Health.

Progress made in implementing disability plan under the Disability Services Act

Equal Employment Opportunity

- Continue to implement proactive strategies to increase the representation of staff with disabilities at Hunter New England Health and to broaden the range of occupations **within which** they are employed
- Further promote Hunter New England Health's commitment as an EEO employer, particularly to people with a disability.
- Consultation with staff with a disability to identify and address workplace issues and concerns
- Two Hunter New England Health employees with a disability to represent the organisation at the Department of Premier and Cabinet's Disability Employment Strategy consultative forums.
- Consultation with Hunter New England Health staff with disabilities (or with expertise in disability issues) to assist the Health Service in developing and implementing good equity practice.
- An email network for staff with disabilities to be established to promote more effective communication and consultation. (Steps to be taken to ensure full confidentiality of participants in the network.)

Occupational Health and Safety

Hunter New England Health is committed to achieving the safest workplace possible for its employees.

Occupational Health and Safety data for the 2007/2008 year gives an indication of our commitment to achieving this goal.

Strategies are in place to achieve further improvements in the future.

	Yr. 2005/2006	Yr 2006/2007	Yr 2007/2008
No. of claims per 100 FTE	824	808	828
Cost of Claims	11999	10923	8275
Accident Type:			
Bite	4	0	6
Body Stress	451	452	461
Exposure	36	19	37
Fall/Slip	119	162	151
Objects - hit	87	91	79
Objects - move	15	12	9
Other	4	1	3
Unknown	45	18	23
Vehicle	63	52	59
Total	824	807	828
Occupational Groups:			
General admin	89	84	98
Hotel Services	227	211	202
Maintenance	21	18	23
Medical	9	11	10
Medical Support	67	73	77
Nursing	411	410	418
Total	824	807	828

There were no prosecutions of the Area Health Service under the OHS Act during the 2007/2008 year.

(Data source: GIO database - Magellan)

Teaching and training initiatives

Allied Health

- Successfully submitted a request for funding from the NSW Rural Institute of Clinical Services and Teaching for a grant to strengthen rural allied health services through professional development processes. The project conducted a needs analysis across all services which identified the key issues from clinician and management perspectives. Multiple strategies were developed and an implementation plan will roll out over the next year.

- Conducted the annual Area-wide Research Forum in March 2008 to showcase current research projects and to stimulate additional research uptake.

- Conducted a Data Mining Workshop in June 2008 with expert input provided by Professor Irwin Epstein from The Hunter College, New York.

- Professions conducted numerous annual professional development days and inservices, attracting high levels of participation. This included webcasting for remote staffs and videoconferencing support for profession specific clinical interest groups.

- Maintenance of clinical teaching programs for undergraduate and post graduate tertiary programs. An honorary professional educator appointment with the University of Newcastle's School of Physiotherapy commenced in early 2008.

Medical

- Programs presented by the Centre for Medical Professional Development include:
    - Professional Development Programme for Northern Fellows – Royal Australasian College of Physicians – November 2007
    - Work/Life Balance for Doctors – Cognitive Institute – November 2007
    - Teaching on the Run continues to be rolled out across Hunter New England Health with approximately 100 attendances by clinicians. Teaching on the Run has also been facilitated on behalf of General Practice Training - Valley to Coast with many GPs from the Hunter attending.
    - Finance Education for Medical Clinician Managers that has been delivered in the Hunter region and Tamworth.
    - The AMC Programme continues to provide specialised education, support and mentoring for the AMC Graduates

- A DVD about the program to support overseas trained Australian Medical Council graduates undertaking an internship. The DVD, called "Setting them up to Succeed", has been produced and now been distributed to NSW Department of Health, NSW Australian Curriculum Framework Steering Committee and the Institute of Medical Education and Training. The Hunter New England Health program has been a model for other Area Health Services and this DVD is aimed to disseminate the model.
- The Hospital Skills Program to support the career development of career medical officers will be managed by the Centre for Medical Professional Development. A Medical Education Support Officer has been appointed and the recruitment of an Area Director of Clinical Training is about to commence. This project is a collaboration of Hunter New England Area Health Service, the Institute of Medical Education and Training and NSW Health.

- An area-wide network to support the development of approximately 160 junior doctors has been established. This has included the recruitment of eight "rural preferential recruits" to be based in Tamworth.

- During 2008 Teaching on the Run – Module 1: Clinical (Bedside) Teaching and Module 2: Teaching a Skill was rolled out to Interns and RMO1s. These sessions are conducted every month over two evenings, with attendees encouraged to become facilitators of these courses for their peers. At this stage Hunter New England Health has four PGY2s in training to become Teaching on the Run facilitators.

Nursing and Midwifery:

- Nurse and Midwife Strategy Reserve Funding continue to support professional development programs for Nurses and Midwives across all geographical locations in the Area Health Service.

- Annual Professional Development conferences focus on Clinical Innovations and Professionalism. This aims to support and promote research to lead and inform changes to practice within the clinical area.

- Monthly clinical updates which use videoconference and web streaming has been facilitated since March 2007. This enables access to regular ongoing professional development and Evidence Guided practice for clinicians across the area health service and particularly in rural areas.
"Take the Lead" Project has commenced in HNEH with 8 NUM's being identified as "champions". The project between the NSW Health Nursing and Midwifery Office, Health Services Performance Improvement Branch aimed at strengthening the roles of Nursing and Midwifery Unit Mangers across NSW.

- Continuing the role out and support Clinical Supervision across the Area Health Service for Nursing and Midwifery Clinicians and Managers.

- Clinical leadership program - 13 Nurses and Midwives were selected to participate in the first CEC clinical leadership state-wide program for 2007.

- Clinical Placements - Implementation of a new Clinical placement process and database base will enable the Area Health Service to support Undergraduate Nursing and Midwifery Students to develop clinical skills in our facilities and specialty areas.

- School Based Trainees have commenced in various locations across the area health service with a total of 22 Trainee Assistants in Nursing, who will also complete their HSC. This strategy of 'grow your own' aims to give senior school students and opportunity to gain a qualification whilst completing their HSC and provide them with a starting point to a career in health.

- Development of the Nursing and Midwifery Leadership Council in partnership with the Universities and TAFE will provide strategic direction to the profession and inform both clinical practice and curriculum development.

- Support for clinicians undertaking education in practice development. There have been 20 staff attend five day workshops and facilitation of ongoing support through the creation of a network of practice development facilitators.

Nursing and Midwifery Research

- Nurses and Midwives in the Area Health Service have been successful at attaining two NSW Health NaMO Innovations Scholarships totaling $20,000 to support the research of clinically based innovative projects.

- Pressure Ulcer Prevention Project funded through Nurse Strategy Reserve Funding. The project aims to provide Hunter New England Health care practitioners, its consumers and the community with a system to predict, prevent and manage pressure ulcers.

Hunter Medical Research Institute

The Hunter Medical Research Institute (HMRI) is a partnership between Hunter New England Health, the University of Newcastle and the community.

Ten years ago, HMRI was a revolutionary new model for health and medical research for a new century. Today it is the third largest medical research institute in New South Wales.

HMRI brings medical researchers and clinical researchers together to collaborate and share resources, assisting them to translate their research from the laboratory to the clinic to improve the community's health.

Researchers are working at multiple levels to develop better methods of treatment, diagnosis and disease prevention, and to translate discoveries into commercial products and better health outcomes.

HMRI receives funding through the NSW Health Capacity Building Infrastructure Grants Program and from the Office for Science and Medical Research through the Medical Research Support Program. This supports essential research infrastructure in the form of staff salaries, equipment and facilities and has resulted in the enhancement of our region's research capacity.

Researchers work across seven programs:
- Brain and mental health
- Cancer
- Cardiovascular health
- Information based medicine
- Public health and health behaviour
- Pregnancy and reproduction and
- Viruses, Infection/Immunity, Vaccines and Asthma (VIVA).

HMRI achievements:

- In August 2007 HMRI was recognised with the President's Award from the Hunter Business Chamber in recognition of its contribution to the economic growth of the Hunter region. This is a significant achievement for HMRI's partners, Hunter New England Health, the University of Newcastle and the community.

- HMRI implemented a new strategic plan, themed "Building Research Distinction and Healthier Communities" in 2007.

- HMRI awarded a record $475,000 in grants and prizes to the Hunter's leading health and medical researchers from corporate and community donations in November 2007, and a total $1.524 million in the 2007-08 financial year.

- In March 2008 HMRI marked its tenth anniversary. In ten years HMRI has grown from 100 affiliated health and medical researchers to more than 600.

- In May 2008 HMRI announced the appointment of APP Corporation Pty Ltd as Project Director for the joint HMRI and University of Newcastle research facility. The facility will support the continued growth of HMRI, which is already the third largest institute of its kind in NSW. It will attract leading researchers, clinicians, and the best doctors and health specialists to the Hunter, ensuring that our community receives the best health care.

- HMRI's Tenth Anniversary Ball held in June 2008 raised an impressive $126,000 for health and medical research in the Hunter. For more information visit www.hmri.net.au.

Research achievements 2007-08:

- The Hunter Medical Research Institute (HMRI) was involved in an international study into genetic factors behind breast cancer which has brought researchers a step closer to identifying genetic risk factors for breast cancer in the general population. It also raises the possibility of individually tailoring screening and treatment to women who are at an increased risk of breast cancer.

Research

- Researchers from the University of Newcastle and Hunter New England Health showed that a commonly available antibiotic can improve the quality of life of patients with difficult asthma, and may also generate significant health care savings. Results of a study published in the American Journal of Respiratory and Critical Care Medicine indicate that macrolide antibiotics could prove a successful therapy in conjunction with current asthma treatment. This finding is significant because 5 to 10 per cent of asthma cases are considered difficult and these account for 50 per cent of asthma treatment and health care costs.

- The HMRI Stroke Research Group at John Hunter Hospital, together with the Royal Melbourne Hospital, demonstrated that clot busting (thrombolysis) treatment can be effective when administered up to six hours after a stroke. When administered in the first few hours after stroke, thrombolysis has been shown to improve health outcomes by dissolving blood clots in the brain, preventing stroke damage and disability. Previously, this treatment had not been proved effective beyond three hours. The results of this study could increase the number of stroke patients benefiting from clot busting treatments to 5,000 a year.

- Researchers from Hunter New England Health and the University of Newcastle discovered that male babies born prematurely are more vulnerable to cardiovascular complications than female babies. This finding may explain why male babies born prematurely are twice as likely to die as female babies in the first 72 hours of life. It could also lead to new ways of treating premature babies throughout the world.

Solutions for Health: 10 years of HMRI

- In 2008 HMRI celebrated 10 years of supporting health and medical research in the Hunter. During that time researchers from Hunter New England Health and the University of Newcastle:

- Developed a foetal test which can identify women who will not deliver. This test is particularly important in rural Australia as it can rule out the need to transfer women over long distances to a larger hospital, saving health care dollars and avoiding unnecessary disruption to the woman and her family.

- Identified that the optimal dose of corticosteroids for treating asthma was lower than current Australian guidelines. Adoption of recommendations for a lower prescribed dose will lead to savings for the Commonwealth Government of $6 million per annum. This is also positive for the bone density of asthma patients as long-term high doses of steroid medication can reduce bone density, increasing the risk of bone fracture in old age.

- Investigated the prevalence and impact of incontinence, which has led to hospital intervention strategies for elderly patients and new mothers. Incontinence affects nearly four million Australians, 70 per cent of whom are women. It costs around $1.5 billion each year in Australia.

Official overseas travel for Health Service staff

Name and position	Place and purpose of visit	Cost	Met from
Melba Mensch Dietitian	Christchurch, New Zealand: 3 September to 7 September 2007. Attendance at Australian Diabetes Society and Australian Diabetes Educators Association Annual Scientific Meeting .	$1,580	General funds
Annabel Thurlow Clinical Nurse Consultant	Christchurch, New Zealand: 3 September to 7 September 2007. Attendance at Australian Diabetes Society and Australian Diabetes Educators Association Annual Scientific Meeting.	$1,529	General funds
Judith Henderson Director of Physiotherapy	Auckland and Wellington, New Zealand: 19 November to 23 November 2007. Attendance at Health Round Table Consortium NAHBC meeting, also hospital site visits	$1,425	General funds
Rosanne Leahey Project Officer	Boston, USA: 26 November to 14 December 2007. Beacon Site Demonstration Study Tour.	$8,608	General funds
Branka Barac Clinical Educator	Paris, France: 20 April to 25 April 2007. International Forum on Quality and Safety in Health Care. Invited to present a poster on Human Factors Course with Hunter New England Health	$5,175	General funds
Carolyn Ripper Aboriginal Birthing Service Coordinator	Glasgow, Scotland: 2 June to 5 June 2007. Attendance at International Midwives Congress.	$3,909	General funds
Anne Saxton Service Manager	Glasgow, Scotland: 2 June to 5 June 2007. Attendance at International Midwives Congress.	$3,750	General funds
Rebecca Hemmings Oncology Trials Data Manager	Wellington, New Zealand: 1 July to 5 July 2008. Attendance at Australian New Zealand Breast Cancer Trials Group Scientific Meeting.	$2,406	General funds
Jennifer Keller Clinical Nurse Consultant	Christchurch, New Zealand: 31 July to 5 August 2007. Attendance at TBI Functional Rehabilitation Conference.	$2056	Special Purpose and Trust (SP&T)
Santiago Vazquez Hospital Scientist	Santiago de Compostella & Barcelona, Spain and Nice, France: 27 August to 21 September 2007. Visit various laboratories / hospitals and attend International Congress of Therapeutic Drug monitoring and Toxicology, Nice.	$9,306	SP&T
Carolyn Slattery Health Promotion Officer	Auckland, New Zealand: 4 September to 7 September 2007. Attendance at Oceanic Tobacco Control Conference, presenting a paper at the conference.	$3,657	SP&T
Megan Freund Post Doctoral Research Fellow	Auckland, New Zealand: 4 September to 7 September 2007. Attendance at Oceanic Tobacco Control Conference	$2661	SP&T
Karen Gillham Service Director	Auckland, New Zealand: 4 September to 7 September 2007. Attendance at Oceanic Tobacco Control Conference. Presented a paper at conference.	$2661	SP&T

Official Overseas Travel

Official overseas travel for Health Service staff

Name and position	Place and purpose of visit	Cost	Met from
Margaret Terry Service Director	Auckland, New Zealand: 4 September to 7 September 2007. Attendance at Oceanic Tobacco Control Conference.	$1956	SP&T
Vanessa McDonald Clinical Nurse Consultant	Stockholm, Sweden: 13 September to 21 September 2007. Attendance at European Respiratory Society Congress.	$3,485	SP&T
Edouard Tursan Despaignet Service Director, Surveillance and Monitoring	Rome, Italy: 19 October to 31 October 2007. Attendance at 5th International Conference on Behavioural Risk Factor Surveillance	$8,434	SP&T
Charles Gruszynski Senior Hospital Scientist, Clinical Chemistry	Hamilton, New Zealand: 12 February to 16 February 2008. Attendance at NZ Trace Elements Group Conference 2008.	$2,314	SP&T
Bruce Tually General Manager	Atlanta, USA and Vienna, Austria: 1 April to 10 April 2008. CLSI Leadership Conference and Pharma Conference	$10,329	SP&T
Nicholas Hille Senior Medical Physicist	New Orleans and Knoxville, USA: 13 June to 22 June 2008. Attendance at Society of Nuclear Medicine Conference 2008, also factory and clinical site visits.	$5,073	SP&T
Zenobia Haffajee Technical Officer, Immunohistochemistry laboratory	Penang, Malaysia: 20 June to 28 June 2008. Attendance at the Fourth APSMI Annual Meeting.	$2,872	SP&T
Joanne Brown Manager, Clinical Information	Auckland, New Zealand: 7 October to 10 October 2007. Attendance at HIMAA Conference.	$2,896	SP&T
Christopher Kurtz Project Manager	Hong Kong, Hong Kong: 17 May to 24 May 2008. Attendance at HIMSS Asia Pacific 2008.	$3,678	SP&T

Working with clinicians and the community

The Area Health Advisory Council provides strategic advice to Hunter New England Health in a range of areas, such as policy development, workforce planning and service planning. It has a key role in ensuring that the views of clinicians, communities and patients are heard and given due consideration in decision making, particularly in relation to the quality and accessibility of health services.

The Council was established in 2005 and is appointed by the NSW Minister for Health. It has 13 members with either experience as a clinician or in community representation.

To help enhance their understanding of the issues and opportunities facing local health services and local community, the Council visits approximately six local health services each year to get a first-hand look at key achievements and issues of concern.

During the 2007/2008 financial year, the Council visited Armidale, Muswellbrook, Inverell, Newcastle, Tamworth and Scone.

At each of the meetings, the Council makes a point of scheduling time in the agenda to talk with local clinicians as well as representatives from Hunter New England Health's community engagement groups (Local Health Advisory Committees and Community Forums on Health).

The sessions provide clinicians and community groups with an opportunity to raise any concerns or issues they're facing, and share any things about the local health service that they're particularly proud of. These discussions also help identify ways the Area Health Service can enhance communication and interaction with clinical staff and the broader community.

The members are:

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

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

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

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

Ms Deborah Hogan is a registered nurse. She has a Master of Management in Community Management. Ms Hogan has worked in the disability sector for 16 years. She is operations manager for non-profit organisation Hunter Integrated Care inc. which provides services to frail aged people, people with a disability and carers. Ms Hogan resides in Singleton.

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

Ms Janice McKay is member of the Committee of Asthma NSW – Hunter Branch. She has recently held the position of Clinical Psychologist Children's Cancer and Haematology Service, John Hunter Childrens Hospital. Ms McKay's qualifications include honours in psychology. She resides in Jewells and is an advocate for mental health services.

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

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

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

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

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

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

Our Community

Community activity

Engagement Framework
Developing a framework for community and clinical engagement over Hunter New England Health's enormous geographic area with many sectional interest groups has been a challenging task. 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).

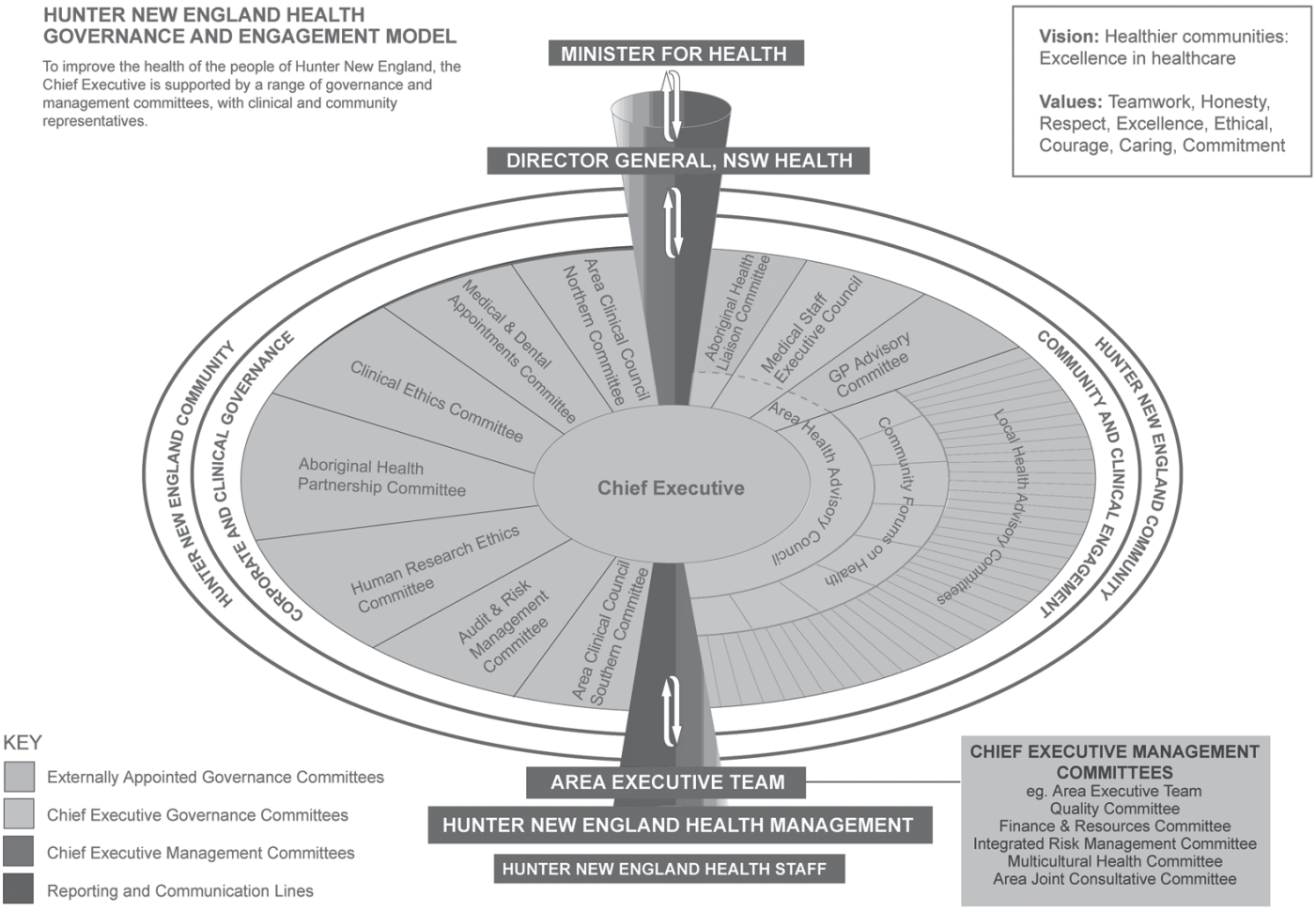
The model has been developed taking into account:

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



Patient Satisfaction

Hunter New England Health scored the highest rating for overall patient care of any area health service in NSW in the 2007 NSW Health Patient Survey.

The results of the survey were published on 1 June 2008 and showed that 90.6 per cent of patients surveyed in the Hunter New England region rated their care as 'excellent', 'very good', or 'good', which is higher than the state average of 88.1 per cent.

In addition, 66.4 per cent of those surveyed said they would 'definitely' recommend Hunter New England Health to family and friends. This is the second highest advocacy rating in NSW and also above the state average of 62.4 per cent.

Respondents were asked questions about eight core dimensions of patient care including access; information and education provided; physical comfort; co-ordination of care; emotional support; continuity and transition; respect for patient preferences; and support for family and friends.

Hunter New England Health received highest marks for overall patient care among community health patients, day only inpatients, outpatients and paediatric inpatients. The health service also scored higher than the state average across all dimensions of care. It received the highest proportion of positive ratings on information and education, co-ordination of care and respect for patient preferences than any other health service.

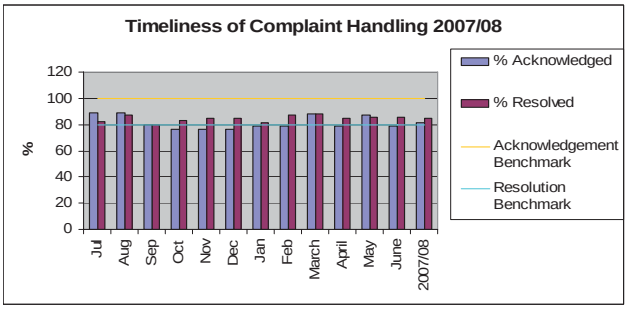
Complaints Management

Complaints management has been one of the highest priorities for review during 2007-2008. Since December 2005, the Incident Information Management System has provided the database for complaints received. During the past year, 2305 complaints were recorded, compared with 1940 complaints in 2006/07 and 1310 complaints in 2005/06.

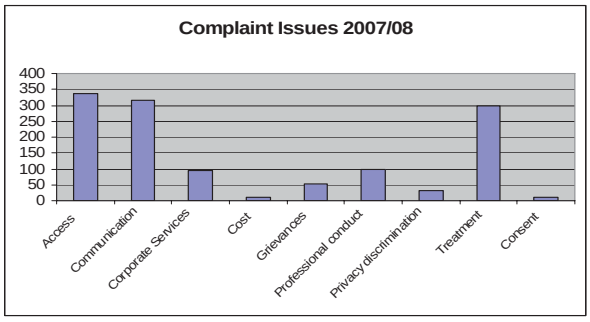
In 2007-2008, there has been continued improvement in complaint handling performance compared to the previous year, with 85% complaints resolved within 35days and 81% complaints acknowledged within five days of receipt.

The three main issues raised in complaints received are about Access (27%), Communication (25%) and Treatment (24%).

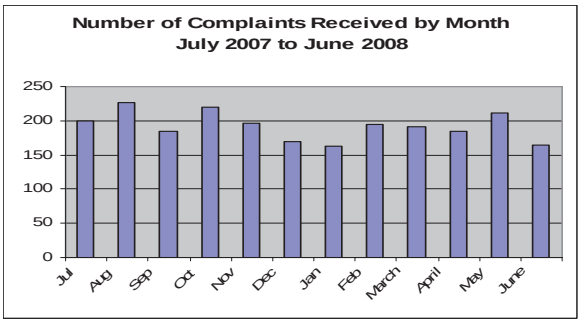
Complaint Handling Timeframes 2007/08



Complaints by Issue 2007/2008



Complaints by Month 2007/08



Note: The total number of complaints and total number of complaint issues will not be the same as complaints can have more than one issue coded, nor have all complaints had the complaint issue coded in IIMS therefore.

Links with GPs

General Practice Liaison and Integration

GP Access After Hours

Five GP Access After Hours clinics operated by GP Access (formerly the Hunter Urban Division of General Practice) have continued to provide services from Hunter New England Health premises. These clinics are at Maitland, Belmont and John Hunter Hospitals, and Toronto and Newcastle Community Health Centres. They provide a comprehensive after hours GP service (including clinic consultations, home visits, telephone advice and patient transport to the clinic) that aims to meet the population need for urgent GP care after hours. The 30 June 2008 marked the end of the 2006-2008 Funding Agreement between GP Access, the Commonwealth Department of Health and Ageing and Hunter New England Area Heath Service. During the term of this Agreement more than 262,000 occasions of service were provided, including more than 96,000 patients seen via a clinic consultation, over 164,000 callers managed by the call centre and 859 patients seen via a home visit. In 2007-2008, over 88,400 people obtained telephone advice and more than 49,200 people attended GP clinics.

Compared to 2006-2007 clinic and call centre activity rose by 4.83% and 16% respectively. Overall the clinic performance benchmark (per cent of patients seen within 30 minutes of their scheduled appointment time) has been maintained for 2007/08 at around 90 per cent. GP participation while below the peak of 256 in June 2006 has risen from a low in December 2007/January 2008 of 234 and stabilised at 241 as at 30 June 2008.

A total of 81 per cent (365) of Hunter urban region GPs are now set up for messaging with, on average, 73 per cent of GPAAH consultation summaries being sent electronically per day rather than posted or faxed.

General Practice Advisory Committee

The General Practice Advisory Committee provides strategic advice to the Chief Executive and Area Executive Team on issues relating to aspects of general practice primary care and its relationship to the wider health service. It is comprised of representatives of the five Divisions of General Practice, Hunter New England Health, University of Newcastle and GP Training Providers. An agreed Liaison Framework between Divisions of General Practice in the Hunter New England Region and Hunter New England Health, signed in November 2006, formally acknowledges the commitment to work together. The committee has maintained its focus on the three key strategic areas: mental health, integrated primary care and training and education; that were identified and prioritised for attention by the group until the end of 2008.

There are a number of projects and initiatives that are underway across the Area that involve the Divisions and local General Practitioners. Significant amongst these are the four HealthOne NSW projects that are progressing at Manilla, Quirindi, Raymond Terrace and Forster-Tuncurry. Other integrated primary care initiatives are underway or being considered at Cessnock and Gunnedah. In addition, the Divisions and GPs have been involved throughout the year in a range of service planning and clinical framework developments. Consultation has also occurred with the NSW Rural Doctors Network concerning medical workforce recruitment and retention issues in rural areas.

Links with Non-Government Organisations

Non government organisations (NGOs) play an important role in the delivery of services to improve the health of the people residing within Hunter New England Health area.

The diversity of services provided by NGOs includes drug and alcohol, oral health, HIV/AIDS, health transport, palliative care volunteers, women's health, community services, mental health, aged/disabled and carers.

The NSW Health NGO Policy Framework defines NGOs as *'self-governing, independent, not for profit, duly incorporated organisations that provide a range of services to the people of NSW, including health and health-related services. NGOs often receive all or part of their funding from Government agencies and, in addition, many NGOs gain income through other activities, including fees for service, membership fees and donations, as well as public and corporate fund raising. NGOs include:*

- *Peak NGO bodies, which provide coordination, resources and advocacy on behalf of their members and member service users. They organise training, seminars and regular conferences and other activities that enhance and develop the capacity of their members to provide services. Peak bodies also promote information exchange between their members and across sectors.*
- *State-wide NGOs, which deliver services across NSW.*

As stated above, an NGO must be an entity where the principal objective is not the generation of a profit (AASB136 Impairment of Assets, Aus para 6.2). Such organisations may have minor operations that could be regarded as for profit, but classification should be based on a consideration of the main activities of the entity (NSW Treasury, Accounting Policy – Distinguishing For Profit from Not-For-Profit Entities, December 2005)."

In conjunction with NSW Health, the Hunter New England Health NGO Program was responsible for the management of

Links with Non-Government Organisations

NGO grants including negotiation of Funding and Performance Agreements (FPAs), payment, monitoring, performance review and support provision to over 50 health funded projects with a total funding of $5,347,158.

Major achievements of the 2007-2008 funding period:

- Hunter New England Health NGO Program Unit was formally established in November 2007.
- NGO Forum meetings are now held in both Hunter and New England parts of the area.
- Development of Area Health policies on :
    - provision of Area Accommodation for Community Purposes
    - staff participation in Community Organisations
    - Non Government Organisation Grant Program management to strengthen the system for working in partnership with the NGOs.
- A seminar on “Effective Communication Processes in Aboriginal Communities” was held in December 2007.
- The review of the Information Handbook for health funded NGOs. The updated version is to be distributed in September 2008.
- Provision of input into the development of Memorandum of Understanding between the Palliative Care Volunteer NGOs and Hunter New England Health Palliative Care Clinical Services.
- A number of shared service projects between health funded NGOs and Hunter New England Health services took place during the year:
    - Dungog Community Linen Service : a purpose built laundry set up by Dungog Hospital, Dungog & District Neighbour Care and Dungog Palliative Care Volunteers
    - Healthy Budget Bites Program : inexpensive healthy eating options program conducted by Cessnock Hospital Community Dietitian and Coalfields Healthy Heartbeat
    - Shared care project of ACON Hunter, Karumah Inc and HNEAHS Sexual Health and Immunology Units.
    - Development of a shared-care model between HNE Mental Health Clinical Services and Mental Health NGOs.

Non-Government Organisations - Grants

Mental Health Program

Name	Funded by	Project	Amount	Review date
Association of Relatives and Friends of People Who Have a Mental Illness (ARAFMI)	DOH	Mutual support services for families and carers of people with a mental illness.	$62,500 Base Grant	June 2010
	HNE Mental Health	Carers Support	$53,597	June 2008
Armidale & District Services Inc	HNE Mental Health	To increase access of Aboriginal individuals, their families and communities of Armidale and neighboring districts to culturally appropriate mental health services.	$53,700	Expired
Billabong Clubhouse Inc:	DOH	A Clubhouse psychosocial model of community support and rehabilitation for people with mental illness.	$286,000	June 2011
Hunter Joblink:	HNE Mental Health	Vocational training and supported employment service for people with mental illness/psychiatric disability.	$75,036	June 2008
Kaiyu Enterprises - Lake Macquarie Clubhouse	DOH	A Clubhouse psychosocial model of community support and rehabilitation for people with mental illness.	$200,000	June 2010
Life Without Barriers	HNE Mental Health	Sport and recreational opportunities for people with a mental illness	$54,669	June 2008
Psychiatric Rehabilitation Association	HNE Mental Health	Community Rehabilitation Program for people with serious and persistent mental illness through a range of social and rehabilitation practices.	$350,525	June 2008
Pius X Aboriginal Corporation	HNE Mental Health	To increase access of Aboriginal individuals, their families and communities of Moree and neighboring districts to culturally appropriate mental health services.	$107,400	June 2011
Richmond Fellowship	HNE Mental Health	Supported accommodation service for people with mental illness/psychiatric disability.	$1,173,104	June 2008
Schizophrenia Fellowship	DOH	Community development project to ensure sustainable support groups	$74,000	June 2009

Non-Government Organisations - Grants

Drug and Alcohol Program

Name	Funded by	Project	Amount	Review date
DREAMS-Mercy Community Care	DOH	A residential rehabilitation service for Women and their children	$139,999	Expired June 2008
McAuley Outreach - Mercy Community Care	DOH	Support services for parents with young children who have drug and alcohol problems	$191,700	June 2011
Newcastle Youth Service	DOH	Youth networking, streetwork/needle exchange, education and counseling for young people aged 12 – 24	$112,500	June 2009
Salvation Army - Miracle Haven	DOH	A residential rehabilitation service for those affected by alcohol and other drugs.	$382,978	June 2010
Salvation Army - The ARK	DOH	A work skills, vocational and life skills training project.	$62,780	June 2009
St Vincent de Paul – Freeman House	DOH	A residential rehabilitation treatment place.	$106,225	June 2009
Tamworth Homeless Men's Support Group Inc	Area Health	Provision of one (1) MERIT emergency bed	$6,500	June 2008
Upper Hunter Drug & Alcohol Services	DOH	Community development, education, information and counseling in Drug and Alcohol for Upper Hunter.	Base Grant $146,400	June 2011
	Area Health	Magistrate Early Referral Into Treatment (MERIT) $100,000, METHADONE $30,000	$130,000	June 2008
We Help Ourselves	DOH	Seven (7) MERIT) designated beds.	$176,295	June 2008

HIV / AIDS Program

Name	Funded by	Project	Amount	Review date
AIDS Council of NSW Inc (ACON)	DOH	Provide case management and referral services to people (HIV/AIDS affected) presenting with a range of needs including accommodation	$118,300	June 2010
Karumah Inc.	DOH	A drop-in day centre for people who are HIV positive, their friends, families and carers.	$132,600	June 2011

Oral Health

Name	Funded by	Project	Amount	Review date
Biripi AMS	Area Oral Health	Provision of adult dental treatment to the Aboriginal community	$54,500	June 2009

Aged and Disabled / Carers Program

Name	Funded by	Project	Amount	Review date
Mercy Community Care	DOH	Provision of home nursing, day centre activities, counselling and support for aged and frail people and their carers.	$202,900	June 2011
Families Supporting Families	DOH	Carers Café project for families of children with disabilities	$3,300	June 2009
Singleton Uniting Church-	DOH	Celebrate Disability Project for children with disabilities	$2000	June 2009

Community Services, Women's Health and Health Transport

Name	Funded by	Project	Amount	Review date
Asthma Foundation of NSW	DOH	Asthma education programs throughout the Hunter Region for groups who have a role in the care of people with asthma.	$56,200	June 2009
CARELINK	DOH	A support service for Cancer and Palliative Care patients, their carers and significant others, who reside in the Upper Hunter Region.	$30,400	June 2009
Community Transport of Port Stephens	DOH	Provision of health related transport	$19,800	June 2011
Dungog Shire Palliative Care Volunteers	DOH	Support services for people with a terminal illness and their carers.	$15,400	June 2010
DURRI Aboriginal Corporation	Area Health	Men's Health Projects	$118,749	June 2008
Family Planning NSW	Funded by DOH, supported by Area Health	Provision of reproductive preventive and sexual health promotion interventions for specific population groups	$41,300	June 2010
Hunter Volunteer Centre Inc	Area Health	To provide referral and resourcing of volunteers to HNE Health and health related NGOs	$20,000	June 2008
Hunter Women's Centre	DOH	Projects include: - Counselling Service - Health promotion and Group work - Medical and nurse clinical services	$356,4000	June 2010
Inverell HACC Services Inc	DOH	Provision of individual transport to severely transport disadvantaged people within the Inverell HACC sub-region.	$13,600	June 2011
Lifeline Newcastle & Hunter	DOH	24hrs /7day Telephone Crisis Counseling and Associated Welfare Services.	$74,000	June 2011
Lifeline Tamworth	DOH	24 hour telephone counselling service accessible to New England and North West communities.	$22,600	June 2011
Make Today Count	DOH	Support services for people suffering life-threatening illness, their families and carers, and bereavement support.	$36,900	June 2009
Manning Valley & Area Community Transport	DOH	Provision of health related transport	$20,600	June 2011
Merriwa & District Community Care Inc	DOH	Provision of health related transport	$6900	June 2011
Samaritan Foundation - Coalfields Healthy Heartbeat	DOH	Heart health promotion within Cessnock LGA	$65,500	June 2010
Singleton Community Development Organisation	DOH	Coordination of palliative care volunteers within the Singleton, Kurri Kurri & Cessnock LGAs	$60,000	June 2010
Singleton HACC Services	DOH	Provision of health related transport	$16,400	June 2011
Tamworth Homeless Housing Support Group Inc	DOH	Brokerage/outreach service for homeless men 18 years and over.	$25,400	June 2011
TLC Volunteers – former Maitland Volunteer Palliative Care Service	DOH	Support services for patients whose cancer or other life threatening illness no longer responding to curative treatment	$50,300	June 2009
TRANSCARE (Former Upper Hunter Community Care Inc)	DOH	Provision of health related transport	$6,900	June 2011
Wee Waa & District HACC Assoc Inc	DOH	Provision of health related transport	$24,000	June 2011

Our Community

Our Volunteers

Hunter New England Health is supported by approximately 1,600 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.

Donations and Charitable Fundraising

Donations and charitable fundraising provide an important source of supplementary revenue for health services and equipment across the region. This significant figure reflects the generosity which is inherent in communities across our Area, and Hunter New England Health would like to acknowledge the goodwill of a number of businesses, organisations, community groups and individuals who contributed to this amount.

Hunter New England Health received $5.1 million from donations in the 2007/08 Financial Year. The largest beneficiary of these funds in the most recent financial year was the Paediatric Oncology Unit at John Hunter Children's Hospital, located on the Rankin Park campus.

Hunter New England Health received $80 000 from charitable fundraising in the 2007/08 Financial Year. This fundraising was in accordance with the requirements of the Charitable Fundraising Act.

SECTION A – NEW FOI APPLICATIONS

How many FOI applications were received, discontinued or completed?		NUMBER OF FOI APPLICATIONS					
		PERSONAL		OTHER		TOTAL	
		2006/07	2007/08	2006/07	2007/08	2006/07	2007/08
A1	New	9	6	5	11	14	17
A2	Brought forward	2	0	0	2	2	2
A3	**Total to be processed**	11	6	5	13	16	19
A4	Completed	11	4	3	6	14	10
A5	Discontinued	1	2	1	4	2	6
A6	**Total processed**	12	6	4	10	16	16
A7	Unfinished (carried forward)	0	0	2	3	2	3

SECTION B – DISCONTINUED APPLICATIONS

Why were FOI applications discontinued?		**NUMBER OF DISCONTINUED FOI APPLICATIONS**					
		PERSONAL		**OTHER**		**TOTAL**	
		2006/07	2007/08	2006/07	2007/08	2006/07	2007/08
B1	Request transferred out to another agency (s.20)	0	0	0	0	0	0
B2	Applicant withdrew request	1	1	1	1	2	2
B3	Applicant failed to pay advance deposit (s.22)	0	0	0	1	0	1
B4	Applicant failed to amend a request that would have been an unreasonable diversion of resources to complete (s.25(1)(a1))	0	1	0	2	0	3
B5	**Total discontinued**	1	2	1	4	2	6

Note: If request discontinued for more than one reason, select the reason first occurring in the above table. The figures in B5 should correspond to those in A5.

Freedom of Information

SECTION C – COMPLETED APPLICATIONS

What happened to completed FOI applications?		NUMBER OF COMPLETED FOI APPLICATIONS					
		PERSONAL		**OTHER**		**TOTAL**	
		2006/07	2007/08	2006/07	2007/08	2006/07	2007/08
C1	Granted or otherwise available in full	1	1	0	5	1	6
C2	Granted or otherwise available in part	2	3	0	1	2	4
C3	Refused	3	0	2	0	5	0
C4	No documents held	5	0	1	0	6	0
C5	**Total completed**	11	4	3	6	14	10

Note: A request is granted or otherwise available in full if all documents requested are either provided to the applicant (or the applicant's medical practitioner) or are otherwise publicly available. The figures in C5 should correspond to those in A4.

SECTION D – APPLICATIONS GRANTED OR OTHERWISE AVAILABLE IN FULL

How were the documents made available to the applicant?		NUMBER OF FOI APPLICATIONS (GRANTED OR OTHERWISE AVAILABLE IN FULL)					
		PERSONAL		OTHER		TOTAL	
		2006/07	2007/08	2006/07	2007/08	2006/07	2007/08
All documents requested were: D1	Provided to the applicant	n/a	1	n/a	5	n/a	6
D2	Provided to the applicant's Medical Practitioner	n/a	0	n/a	0	n/a	0
D3	Available for inspection	n/a	0	n/a	0	n/a	0
D4	Available for purchase	n/a	0	n/a	0	n/a	0
D5	Library material	n/a	0	n/a	0	n/a	0
D6	Subject to deferred access	n/a	0	n/a	0	n/a	0
D7	Available by a combination of any of the reasons listed in D1 - D6 above	n/a	0	n/a	0	n/a	0
D8	**Total granted or otherwise available in full**	n/a	1	n/a	5	n/a	6

Note: The figures in D8 should correspond to those in C1.

SECTION E – APPLICATIONS GRANTED OR OTHERWISE AVAILABLE IN PART

How were the documents made available to the applicant?	NUMBER OF FOI APPLICATIONS (GRANTED OR OTHERWISE AVAILABLE IN PART)					
	PERSONAL		OTHER		TOTAL	
	2006/07	2007/08	2006/07	2007/08	2006/07	2007/08
Documents made available were: E1 Provided to the applicant	n/a	3	n/a	1	n/a	4
E2 Provided to the applicant's Medical Practitioner	n/a	0	n/a	0	n/a	0
E3 Available for inspection	n/a	0	n/a	0	n/a	0
E4 Available for purchase	n/a	0	n/a	0	n/a	0
E5 Library material	n/a	0	n/a	0	n/a	0
E6 Subject to deferred access	n/a	0	n/a	0	n/a	0
E7 Available by a combination of any of the reasons listed in E1-E6 above	n/a	0	n/a	0	n/a	0
E8 Total granted or otherwise available in part	n/a	3	n/a	1	n/a	4

Note: The figures in E8 should correspond to those in C2.

SECTION F – REFUSED FOI APPLICATIONS

Why was access to the documents refused?	NUMBER OF REFUSED FOI APPLICATIONS					
	PERSONAL		**OTHER**		**TOTAL**	
	2006/07	2007/08	2006/07	2007/08	2006/07	2007/08
F1 Exempt	3	0	2	0	5	0
F2 Deemed refused	0	0	0	0	0	0
F3 Total refused	3	0	2	0	5	0

Note: The figures in F3 should correspond with those in C3.

Freedom of Information

SECTION G – EXEMPT DOCUMENTS

Why were the documents classified as exempt? (identify one reason only)	NUMBER OF FOI APPLICATIONS (REFUSED OR ACCESS GRANTED OR OTHERWISE AVAILABLE IN PART ONLY)					
	PERSONAL		**OTHER**		**TOTAL**	
	2006/07	2007/08	2006/07	2007/08	2006/07	2007/08
Restricted documents:	n/a	0	n/a	0	n/a	0
G1 Cabinet documents (Clause 1)						
G2 Executive Council documents (Clause 2)	n/a	0	n/a	0	n/a	0
G3 Documents affecting law enforcement and public safety (Clause 4)	n/a	1	n/a	0	n/a	0
G4 Documents affecting counter terrorism measures (Clause 4A)	n/a	0	n/a	0	n/a	0
Documents requiring consultation:	n/a	0	n/a	0	n/a	0
G5 Documents affecting intergovernmental relations (Clause 5)						
G6 Documents affecting personal affairs (Clause 6)	n/a	0	n/a	1	n/a	1
G7 Documents affecting business affairs (Clause 7)	n/a	0	n/a	0	n/a	0
G8 Documents affecting the conduct of research (Clause 8)	n/a	0	n/a	0	n/a	0
Documents otherwise exempt:	n/a	0	n/a	0	n/a	0
G9 Schedule 2 exempt agency						
G10 Documents containing information confidential to Olympic Committees (Clause 22)	n/a	0	n/a	0	n/a	0
G11 Documents relating to threatened species, Aboriginal objects or Aboriginal places (Clause 23)	n/a	0	n/a	0	n/a	0
G12 Documents relating to threatened species conservation (Clause 24)	n/a	0	n/a	0	n/a	0
G13 Plans of management containing information of Aboriginal significance (Clause 25)	n/a	0	n/a	0	n/a	0

Why were the documents classified as exempt? (identify one reason only)	NUMBER OF FOI APPLICATIONS (REFUSED OR ACCESS GRANTED OR OTHERWISE AVAILABLE IN PART ONLY)					
	PERSONAL		**OTHER**		**TOTAL**	
	2006/07	2007/08	2006/07	2007/08	2006/07	2007/08
G14 Private documents in public library collections (Clause 19)	n/a	0	n/a	0	n/a	0
G15 Documents relating to judicial functions (Clause 11)	n/a	0	n/a	0	n/a	0
G16 Documents subject to contempt (Clause 17)	n/a	0	n/a	0	n/a	0
G17 Documents arising out of companies and securities legislation (Clause 18)	n/a	0	n/a	0	n/a	0
G18 Exempt documents under interstate FOI Legislation (Clause 21)	n/a	0	n/a	0	n/a	0
G19 Documents subject to legal professional privilege (Clause 10)	n/a	0	n/a	0	n/a	0
G20 Documents containing confidential material (Clause 13)	n/a	0	n/a	0	n/a	0
G21 Documents subject to secrecy provisions (Clause 12)	n/a	0	n/a	0	n/a	0
G22 Documents affecting the economy of the State (Clause 14)	n/a	0	n/a	0	n/a	0
G23 Documents affecting financial or property Interests of the State or an agency (Clause 15)	n/a	0	n/a	0	n/a	0
G24 Documents concerning operations of agencies (Clause 16)	n/a	2	n/a	0	n/a	2
G25 Internal working documents (Clause 9)	n/a	0	n/a	0	n/a	0
G26 Other exemptions (eg., Clauses 20, 22A and 26)	n/a	0	n/a	0	n/a	0
G27 Total applications including exempt documents	n/a	3	n/a	1	n/a	4

Note: Where more than one exemption applies to a request select the exemption category first occurring in the above table. The figures in G27 should correspond to the sum of the figures in C2 and F1.

Freedom of Information

SECTION H – MINISTERIAL CERTIFICATES (S.59)

How many Ministerial Certificates were issued?		NUMBER OF MINISTERIAL CERTIFICATES	
		2006/07	2007/08
H1	Ministerial Certificates issued	0	0

SECTION I – FORMAL CONSULTATIONS

How many formal consultations were conducted?		NUMBER	
		2006/07	2007/08
I1	Number of applications requiring formal consultation	n/a	0
I2	Number of persons formally consulted	n/a	0

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

SECTION J – AMENDMENT OF PERSONAL RECORDS

How many applications for amendment of personal records were agreed or refused?		NUMBER OF APPLICATIONS FOR AMENDMENT OF PERSONAL RECORDS	
		2006/07	2007/08
J1	Agreed in full	0	0
J2	Agreed in part	0	0
J3	Refused	0	0
J4	**Total**	0	0

SECTION K – NOTATION OF PERSONAL RECORDS

How many applications for notation of personal records were made (s.46)?		NUMBER OF APPLICATIONS FOR NOTATION	
		2006/07	2007/08
K1	Applications for notation	0	0

SECTION L – FEES AND COSTS

What fees were assessed and received for FOI applications processed (excluding applications transferred out)?	ASSESSED COSTS		FEES RECEIVED	
	2006/07	2007/08	2006/07	2007/08
L1 All completed applications	$ n/a	$1910	$1080	$1910

SECTION M – FEE DISCOUNTS

How many fee waivers or discounts were allowed and why?	NUMBER OF FOI APPLICATIONS (WHERE FEES WERE WAIVED OR DISCOUNTED)					
	PERSONAL		OTHER		TOTAL	
	2006/07	2007/08	2006/07	2007/08	2006/07	2007/08
M1 Processing fees waived in full	0	0	0	0	0	0
M2 Public interest discount	0	0	0	0	0	0
M3 Financial hardship discount – pensioner or child	1	0	0	0	0	0
M4 Financial hardship discount – non profit organisation	0	0	0	0	0	0
M5 Total	1	0	0	0	0	0

SECTION N – FEE REFUNDS

How many fee refunds were granted as a result of significant correction of personal records?	NUMBER OF REFUNDS	
	2006/07	2007/08
N1 Number of fee refunds granted as a result of significant correction of personal records	0	0

Freedom of Information

SECTION O – DAYS TAKEN TO COMPLETE REQUEST

How long did it take to process completed applications? (Note: calendar days)		NUMBER OF COMPLETED FOI APPLICATIONS					
		PERSONAL		**OTHER**		**TOTAL**	
		2006/07	2007/08	2006/07	2007/08	2006/07	2007/08
O1	0-21 days – statutory determination period	n/a	1	n/a	1	n/a	2
O2	22-35 days – extended statutory determination period for consultation or retrieval of archived records (S.59B)	n/a	0	n/a	0	n/a	0
O3	Over 21 days – deemed refusal where no extended Determination period applies	n/a	3	n/a	5	n/a	8
O4	Over 35 days – deemed refusal where extended determination period applies	n/a	0	n/a	0	n/a	0
O5	**Total**	n/a	4	n/a	6	n/a	10

Note: Figures in O5 should correspond to figures in A4.

SECTION P – PROCESSING TIME: HOURS

How long did it take to process completed applications?		NUMBER OF COMPLETED FOI APPLICATIONS					
		PERSONAL		**OTHER**		**TOTAL**	
		2006/07	2007/08	2006/07	2007/08	2006/07	2007/08
P1	0-10 hours	n/a	4	n/a	5	n/a	9
P2	11-20 hours	n/a	0	n/a	1	n/a	1
P3	21-40 hours	n/a	0	n/a	0	n/a	0
P4	Over 40 hours	n/a	0	n/a	0	n/a	0
P5	**Total**	n/a	4	n/a	6	n/a	10

Note: Figures in P5 should correspond to figures in A4.

SECTION Q – NUMBER OF REVIEWS

How many reviews were finalised?		NUMBER OF COMPLETED REVIEWS	
		2006/07	2007/08
Q1	Internal reviews	2	1
Q2	Ombudsman reviews	0	1
Q3	ADT reviews	0	0

SECTION R – RESULTS OF INTERNAL REVIEWS

What were the results of internal reviews finalised?

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

Freedom of Information

2007/08 Summary of FOI requests

There were 16 FOI applications during 2007/08, which was the same number as in 2006/07. While the total FOI applications remained the same there was a shift between personal and non-personal applications, with an increase in non-personal applications to 10 applications in 2007/08 compared to 4 applications in the previous year. There were 6 personal applications for 2007/08 compared to 12 personal applications in the previous year.

No applications under FOI were refused in 2007/08 with full or part access granted for those completed. In 2007/08 a total of 6 applications were discontinued at the request of the applicant or due to failure to pay the fee or amend the application that would have been an unreasonable diversion of resources.

One applicant lodged a request for an Internal Review, and the outcome of this review was that the original determination was upheld. In 2007/08 one applicant complained to the Ombudsman for an external review of the determination. This application was part of a state-wide application to all Area Health Services. All but one of the non-personal applications were from the Media or Members of Parliament.

GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDITOR'S REPORT

Hunter New England Area Health Service and controlled entity

To Members of the New South Wales Parliament

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

Auditor's Opinion

In my opinion, the financial report:

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

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

Chief Executive's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

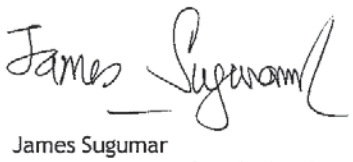
My opinion does *not* provide assurance:

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

Independence

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

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



James Sugumar
Director, Financial Audit Services

1 December 2008
SYDNEY

HUNTER NEW ENGLAND
NSW HEALTH

Certification of Parent/Consolidated Financial Statements
For Period Ended 30 June 2008

Pursuant to Section 45F of the *Public Finance and Audit Act, 1983*, I state that to the best of my knowledge and belief:

1) The financial report has been prepared in accordance with:
   - Australian Accounting Standards
   - *Public Finance and Audit Act 1983*
   - *Public Finance and Audit Regulations 2005*
   - *Health Services Act 1997 and its Regulations*
   - the Accounts and Audit Determination
2) The financial report exhibits a true and fair view of the financial position and the financial performance of the Hunter New England Area Health Service.
3) There are no circumstances which would render any particulars included in the financial report to be misleading or inaccurate.

Nigel Lyons

Chief Executive

Date 10.11.08

Mark Jeffrey

Director of Finance

Hunter New England Area Health Service
Operating Statement for the year ended 30 June 2008

PARENT					CONSOLIDATION		
Actual 2008 $000	Budget 2008 $000	Actual 2007 $000		Notes	Actual 2008 $000	Budget 2008 $000	Actual 2007 $000
			Expenses excluding losses				
			Operating Expenses				
-	-	-	Employee Related	3	904,961	891,648	839,976
904,961	891,648	839,976	Personnel Services	4	-	-	-
67,130	61,379	59,476	Visiting Medical Officers		67,130	61,379	59,476
391,930	375,451	376,343	Other Operating Expenses	5	391,930	375,451	376,343
54,452	58,667	52,023	Depreciation and Amortisation	2(i), 6	54,452	58,667	52,023
9,528	9,478	8,132	Grants and Subsidies	7	9,528	9,478	8,132
4,225	4,225	431	Finance Costs	8	4,225	4,225	431
91,018	91,698	82,040	Payments to Affiliated Health Organisations Recurrent	9	91,018	91,698	82,040
71,330	71,330	-	Payments to Affiliated Health Organisations Non recurrent		71,330	71,330	-
4,423	4,423	7,356	Payments to Affiliated Health Organisations Capital		4,423	4,423	7,356
1,598,997	**1,568,299**	**1,425,777**	**Total Expenses excluding losses**		**1,598,997**	**1,568,299**	**1,425,777**
			Revenue				
204,612	187,094	187,035	Sale of Goods and Services	10	204,612	187,094	187,035
6,581	5,195	6,575	Investment Revenue	11	6,581	5,195	6,575
46,470	44,211	40,532	Grants and Contributions	12	26,100	23,683	22,389
12,571	11,936	11,933	Other Revenue	13	12,571	11,936	11,933
270,234	**248,436**	**246,075**	**Total Revenue**		**249,864**	**227,908**	**227,932**
(486)	(661)	10,448	Gain/(Loss) on Disposal	14	(486)	(661)	10,448
(1,414)	(1,125)	(37)	Other Gains/(Losses)	15	(1,414)	(1,125)	(37)
1,330,663	**1,321,649**	**1,169,291**	**Net Cost of Services**	33	**1,351,033**	**1,342,177**	**1,187,434**
			Government Contributions				
			NSW Department of Health				
1,183,307	1,183,307	1,112,935	Recurrent Allocations	2(d)	1,183,307	1,183,307	1,112,935
			NSW Department of Health				
40,363	60,218	49,017	Capital Allocations	2(d)	40,363	60,218	49,017
			(Asset Sale Proceeds transferred to the				
-	-	(27,859)	NSW Department of Health)		-	-	(27,859)
			Acceptance by the Crown Entity of				
-	-	-	Employee Benefits	2(a)(ii)	20,370	20,528	18,143
1,223,670	**1,243,525**	**1,134,093**	**Total Government Contributions**		**1,244,040**	**1,264,053**	**1,152,236**
(106,993)	**(78,124)**	**(35,198)**	**RESULT FOR THE YEAR**		**(106,993)**	**(78,124)**	**(35,198)**

Hunter New England Area Health Service
Balance Sheet as at 30 June 2008

PARENT					CONSOLIDATION		
Actual 2008 $000	Budget 2008 $000	Actual 2007 $000		Notes	Actual 2008 $000	Budget 2008 $000	Actual 2007 $000
			ASSETS				
			Current Assets				
66,156	65,651	71,144	Cash and Cash Equivalents	18	66,156	65,651	71,144
47,942	37,110	38,491	Receivables	19	47,942	37,110	38,491
5,167	4,889	4,889	Inventories	20	5,167	4,889	4,889
2,244	2,716	2,716	Non Current Assets Held for Sale	23	2,244	2,716	2,716
121,509	**110,366**	**117,240**	**Total Current Assets**		**121,509**	**110,366**	**117,240**
			Non-Current Assets				
204	1,660	1,660	Receivables	19	204	1,660	1,660
906,398	799,222	822,494	- Land and Buildings	21	906,398	799,222	822,494
81,844	111,956	81,651	- Plant and Equipment	21	81,844	111,956	81,651
73,895	46,499	48,738	- Infrastructure Systems	21	73,895	46,499	48,738
1,062,137	957,677	952,883	Total Property, Plant and Equipment		1,062,137	957,677	952,883
1,062,341	**959,337**	**954,543**	**Total Non-Current Assets**		**1,062,341**	**959,337**	**954,543**
1,183,850	**1,069,703**	**1,071,783**	**Total Assets**		**1,183,850**	**1,069,703**	**1,071,783**
			LIABILITIES				
			Current Liabilities				
89,300	62,465	67,051	Payables	25	89,300	62,465	67,051
3,494	1,103	1,277	Borrowings	26	3,494	1,103	1,277
269,633	261,257	254,145	Provisions	27	269,633	261,257	254,145
2,341	3,318	3,319	Other	28	2,341	3,318	3,319
364,768	**328,143**	**325,792**	**Total Current Liabilities**		**364,768**	**328,143**	**325,792**
			Non-Current Liabilities				
72,792	74,079	4,750	Borrowings	26	72,792	74,079	4,750
6,911	10,278	5,915	Provisions	27	6,911	10,278	5,915
420	435	435	Other	28	420	435	435
80,123	**84,792**	**11,100**	**Total Non-Current Liabilities**		**80,123**	**84,792**	**11,100**

Hunter New England Area Health Service
Statement of Recognised Income and Expense for the year ended 30 June 2008

PARENT					CONSOLIDATION		
Actual 2008 $000	Budget 2008 $000	Actual 2007 $000		Notes	Actual 2008 $000	Budget 2008 $000	Actual 2007 $000
111,061	-	-	Net Increase/(Decrease) in Property, Plant and Equipment Asset Revaluation Reserve		111,061	-	-
111,061	**-**	**-**	**TOTAL INCOME AND EXPENSE RECOGNISED DIRECTLY IN EQUITY**		**111,061**	**-**	**-**
(106,993)	**(78,124)**	**(35,198)**	Result for the Year		**(106,993)**	**(78,124)**	**(35,198)**
4,068	**(78,124)**	**(35,198)**	**TOTAL INCOME AND EXPENSE RECOGNISED FOR THE YEAR**		**4,068**	**(78,124)**	**(35,198)**
			EFFECT OF CHANGES IN ACCOUNTING POLICIES AND CORRECTION OF ERRORS				
-	-	(5,956)	Accumulated Funds Reserves		-	-	(5,956)
-	**-**	**(5,956)**	**TOTAL EFFECT OF CHANGES IN ACCOUNTING POLICIES AND CORRECTION OF ERRORS**		**-**	**-**	**(5,956)**

The accompanying notes form part of these Financial Statements

Hunter New England Area Health Service
Cash Flow Statement for the year ended 30 June 2008

PARENT					CONSOLIDATION		
Actual 2008 $000	Budget 2008 $000	Actual 2007 $000		Notes	Actual 2008 $000	Budget 2008 $000	Actual 2007 $000
			CASH FLOWS FROM OPERATING ACTIVITIES				
			Payments				
-	-	-	Employee Related		(865,166)	(864,809)	(804,359)
(120,447)	(121,420)	(106,365)	Grants and Subsidies		(120,447)	(121,420)	(106,365)
(3,761)	(3,761)	-	Finance Costs		(3,761)	(3,761)	-
(1,344,174)	(1,348,146)	(1,270,973)	Other		(479,008)	(483,337)	(466,614)
(1,468,382)	**(1,473,327)**	**(1,377,338)**	**Total Payments**		**(1,468,382)**	**(1,473,327)**	**(1,377,338)**
			Receipts				
203,720	193,954	192,708	Sale of Goods and Services		203,720	193,954	192,708
5,438	4,296	5,611	Interest Received		5,438	4,296	5,611
83,970	91,384	75,989	Other		83,970	91,384	75,989
293,128	**289,634**	**274,308**	**Total Receipts**		**293,128**	**289,634**	**274,308**
			Cash Flows From Government				
1,183,307	1,183,307	1,112,935	NSW Department of Health Recurrent Allocations		1,183,307	1,183,307	1,112,935
40,363	60,218	49,017	NSW Department of Health Capital Allocations		40,363	60,218	49,017
1,223,670	**1,243,525**	**1,161,952**	**Net Cash Flows from Government**		**1,223,670**	**1,243,525**	**1,161,952**
48,416	**59,832**	**58,922**	**NET CASH FLOWS FROM OPERATING ACTIVITIES**	33	**48,416**	**59,832**	**58,922**
			CASH FLOWS FROM INVESTING ACTIVITIES				
2,572	459	7,350	Proceeds from Sale of Land and Buildings, Plant and Equipment and Infrastructure Systems		2,572	459	7,350
(55,358)	(64,042)	(68,632)	Purchases of Land and Buildings, Plant and Equipment and Infrastructure Systems		(55,358)	(64,042)	(68,632)
(52,786)	**(63,583)**	**(61,282)**	**NET CASH FLOWS FROM INVESTING ACTIVITIES**		**(52,786)**	**(63,583)**	**(61,282)**
			CASH FLOWS FROM FINANCING ACTIVITIES				
1,124	-	1,207	Proceeds from Borrowings and Advances		1,124	-	1,207
(1,742)	(1,741)	(1,500)	Repayment of Borrowings and Advances		(1,742)	(1,741)	(1,500)
(618)	**(1,741)**	**(293)**	**NET CASH FLOWS FROM FINANCING ACTIVITIES**		**(618)**	**(1,741)**	**(293)**
(4,988)	**(5,492)**	**(2,653)**	**NET INCREASE / (DECREASE) IN CASH**		**(4,988)**	**(5,492)**	**(2,653)**
71,144	**71,143**	**73,797**	Opening Cash and Cash Equivalents		**71,144**	**71,143**	**73,797**
66,156	**65,651**	**71,144**	**CLOSING CASH AND CASH EQUIVALENTS**	18	**66,156**	**65,651**	**71,144**

The accompanying notes form part of these Financial Statements

Hunter New England Area Health Service
Program Statement of Expenses and Revenues
for the Year Ended 30 June 2008

SERVICE'S EXPENSES AND REVENUES	Program 1.1 *		Program 1.2 *		Program 1.3 *		Program 2.1 *		Program 2.2 *		Program 2.3 *		Program 3.1 *		Program 4.1 *		Program 5.1 *		Program 6.1 *		Non Attributable		Total	
	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007
	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
Expenses excluding losses																					----	----		
Operating Expenses																					----	----		
Employee Related	72,507	74,206	5,116	4,825	95,115	80,429	76,032	69,119	339,754	315,317	56,432	49,817	104,454	96,733	108,719	105,809	12,441	10,452	34,391	33,269	----	----	904,961	839,976
Visiting Medical Officers	637	792	1	7	5,108	3,236	9,783	8,587	33,630	30,395	11,235	9,731	3,365	3,025	2,799	3,091	182	204	390	408	----	----	67,130	59,476
Other Operating Expenses	17,697	16,935	1,112	1,028	41,030	36,160	29,498	25,223	198,565	194,994	41,307	40,520	18,527	19,803	33,860	33,813	4,212	3,312	6,122	4,555	----	----	391,930	376,343
Depreciation and Amortisation	3,202	3,117	165	171	6,480	5,668	5,205	4,884	22,280	22,150	5,207	4,836	5,558	4,699	5,541	5,856	223	253	591	389	----	----	54,452	52,023
Grants and Subsidies	4,763	2,926	81	57	196	583	10	108	61	519	11	119	4,180	3,573	169	218	55	16	2	13	----	----	9,528	8,132
Finance Costs	305	30	22	2	478	39	386	29	1,694	142	355	28	418	37	466	116	58	4	43	4	----	----	4,225	431
Payments to Affiliated Health Organisations	3,014	1,457	-	-	37,304	19,034	17,344	6,740	78,188	44,179	7,646	4,430	-	-	13,013	7,417	3,384	2,531	6,878	3,608	----	----	166,771	89,396
Other Expenses																					----	----	-	-
Total Expenses excluding losses	102,125	99,463	6,497	6,090	185,711	145,149	138,258	114,690	674,172	607,696	122,193	109,481	136,502	127,870	164,567	156,320	20,555	16,772	48,417	42,246	-	-	1,598,997	1,425,777
Revenue																					----	----		
Sale of Goods and Services	4,303	3,360	279	120	15,920	11,065	12,649	11,242	106,226	107,290	15,833	13,870	6,488	6,296	38,305	30,010	463	188	4,146	3,594	----	----	204,612	187,035
Investment Revenue	824	950	18	13	487	1,152	159	574	1,329	1,849	241	244	244	393	1,911	583	295	386	1,073	431	----	----	6,581	6,575
Grants and Contributions	1,405	1,517	62	31	2,368	1,899	805	711	4,997	5,320	867	419	883	705	6,847	4,408	5,371	5,053	2,494	2,326	----	----	26,099	22,389
Other Revenue	1,105	1,631	56	32	896	683	291	305	3,161	4,520	644	260	754	896	4,304	2,397	684	772	677	437	----	----	12,572	11,933
Total Revenue	7,637	7,458	415	196	19,671	14,799	13,904	12,832	115,713	118,979	17,585	14,793	8,369	8,290	51,367	37,398	6,813	6,399	8,390	6,788	-	-	249,864	227,932
Gain / (Loss) on Disposal	(29)	626	(1)	34	(58)	1,138	(46)	981	(200)	4,449	(46)	971	(50)	944	(49)	1,176	(2)	51	(5)	78			(486)	10,448
Other Gains / (Losses)	(73)	(2)	(5)	-	(197)	(5)	(127)	(3)	(600)	(16)	(172)	(5)	(82)	(2)	(131)	(4)	(18)	-	(9)	-			(1,414)	(37)
Net Cost of Services	94,590	91,381	6,088	5,860	166,295	129,217	124,527	100,880	559,259	484,284	104,826	93,722	128,265	118,638	113,380	117,750	13,762	10,322	40,041	35,380	-	-	1,351,033	1,187,434
Government Contributions																							1,244,040	1,152,236
RESULT FOR THE YEAR																							(106,993)	(35,198)

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

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

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

1 The Health Service Reporting Entity

The **Hunter New England Area** Health Service was established under the provisions of the Health Services Act with effect from 1 January 2005.

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

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

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

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

As a consequence the values in the annual financial statements presented herein consist of the Health Service (as the parent entity), the financial report of the special purpose entity Division and the consolidated financial report of the economic entity. Notes capture both the parent and consolidated values with notes 3, 4 12, 25, 27 and 33 being especially relevant.

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

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

These financial statements have been authorised for issue by the Chief Executive on**Monday 10th November, 2008.**

2 Summary of Significant Accounting Policies

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

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

The consolidated entity has a deficiency of working capital of $243.3m (2007 $208.6m). Notwithstanding this deficiency the financial report has been prepared on a going concern basis because the entity has the support of the NSW Department of Health.

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

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

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

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

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

a) Employee Benefits and Other Provisions

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

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

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

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

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

ii) Long Service Leave and Superannuation

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

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

The Health Service's liability for the closed superannuation pool schemes (State Authorities Superannuation Scheme and State Superannuation Scheme) is assumed by the Crown Entity. The Health Service accounts for the liability as having been extinguished resulting in the amount assumed being shown as part of the non-monetary revenue item described as "Acceptance by the Crown Entity of Employee Benefits". Any liability attached to Superannuation Guarantee Charge cover is reported in Note 25, "Payables".

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

iii) Other Provisions

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

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

b) Insurance

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

c) Finance Costs

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

d) Income Recognition

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

Sale of Goods and Services

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

Patient Fees

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

Investment Revenue

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

Debt Forgiveness

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

Use of Hospital Facilities

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

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

Use of Outside Facilities

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

Grants and Contributions

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

NSW Department of Health Allocations

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

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

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

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

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

f) Inter Area and Interstate Patient Flows

Inter Area Patient Flows

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

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

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

Inter State Patient Flows

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

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

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

g) Acquisition of Assets

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

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

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

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

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

h) Plant & Equipment and Infrastructure Systems

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

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

i) Depreciation

Depreciation is provided for on a straight line basis for all depreciable assets so as to write off the depreciable amount of each asset as it is consumed over its useful life to the Health Service. Land is not a depreciable asset.

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

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

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

j) Revaluation of Non Current Assets

Physical non-current assets are valued in accordance with the NSW Department of Health's "Valuation of Physical Non-Current Assets at Fair Value" policy. This policy adopts fair value in accordance with AASB116, "Property, Plant & Equipment" and AASB140, "Investment Property". Investment property is separately discussed at Note 2(o)
Property, plant and equipment is measured on an existing use basis, where there are no feasible alternative uses in the existing natural, legal, financial and socio-political environment. However, in the limited circumstances where there are feasible alternative uses, assets are valued at their highest and best use.

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

The Health Service revalues Land and Buildings and Infrastructure at minimum every three years by independent valuation and with sufficient regularity to ensure that the carrying amount of each asset does not differ materially from its fair value at reporting date. The last revaluation for assets assumed by the Area as at 1st July 2007 was completed on 31st March 2008 and was based on an independent assessment.

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

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

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

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

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

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

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

k) Impairment of Property, Plant and Equipment

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

l) Assets Not Able to be Reliably Measured

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

m) Restoration Costs

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

n) Non Current Assets (or disposal groups) Held for Sale

The Health Service has certain non-current assets (or disposal groups) classified as held for sale, where their carrying amount will be recovered principally through a sale transaction, not through continuing use. Non-current assets (or disposal groups) held for sale are recognised at the lower of carrying amount and fair value less costs to sell. These assets are not depreciated while they are classified as held for sale.

o) Investment Properties

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 does not have any property that meets the definition of Investment Property.

p) Intangible Assets

The Health Service recognises intangible assets only if it is probable that future economic benefits will flow to the Health Service and the cost of the asset can be measured reliably. Intangible assets are measured initially at cost. Where an asset is acquired at no or nominal cost, the cost is its fair value as at the date of acquisition. All research costs are expensed. Development costs are only capitalised when certain criteria are met.

The useful lives of intangible assets are assessed to be finite. Intangible assets are subseguently measured at fair value only if there is an active market. As there is no active market for the Health Service's intangible assets, the assets are carried at cost less any accumulated amortisation. The Health Service's intangible assets are amortised using the straight line method based on the useful life of the asset for both internally developed assets and direct acquisitions. In general, intangible assets are tested for impairment where an indicator of impairment exists. However, as a not-for-profit entity the Health Service is effectively exempted from impairment testing (see Note 2[k]).

q) Maintenance

The costs of maintenance are charged as expenses as incurred, except where they relate to the replacement of a component of an asset in which case the costs are capitalised and depreciated.

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 Department of Health.

t) Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the operating statement when impaired, derecognised or through the amortisation process.

Short-term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

u) Investments

Investments are initially recognised at fair value plus, in the case of investments not at fair value through profit or loss, transaction costs. The Hunter New England Area Health Service determines the classification of its financial assets after initial recognition and, when allowed and appropriate, re-evaluates this at each financial year end.

* *Fair value through profit or loss* - The Hunter New England Area Health Service subsequently measures investments classified as "held for trading" or designated upon initial recognition "at fair value through profit or loss" at fair value. Financial assets are classified as "held for trading" if they are acquired for the purpose of selling in the near term. Derivatives are also classified as held for trading. Gains or losses on these assets are recognised in the operating statement.

  The Hour-Glass Investment facilities are designated at fair value through profit or loss using the second leg of the fair value option i.e. these financial assets are managed and their performance is evaluated on a fair value basis, in accordance with a documented risk management strategy, and information about these assets is provided internally on that basis to the agency's key management personnel.

  The risk management strategy of the Health Service has been developed consistent with the investment powers granted under the provision of the Public Authorities (Financial Arrangements) Act. T Corp investments are made in an effort to improve interest returns on cash balances otherwise available whilst also providing secure investments guaranteed by the State market exposures.

  The movement in the fair value of the Hour-Glass Investment facilities incorporates distributions received as well as unrealised movements in fair value and is reported in the line item 'investment revenue'.

* *Held to maturity investments* – Non-derivative financial assets with fixed or determinable payments and fixed maturity that the Hunter New England Area Health Service has the positive intention and ability to hold to maturity are classified as "held to maturity". These investments are measured at amortised cost using the effective interest method. Changes are recognised in the operating statement when impaired, derecognised or though the amortisation process.

* *Available for sale investments* - Any residual investments that do not fall into any other category are accounted for as available for sale investments and measured at fair value directly in equity until disposed or impaired, at which time the cumulative gain or loss previously recognised in equity is recognised in the operating statement. However, interest calculated using the effective interest method and dividends are recognised in the operating statement.

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

The fair value of investments that are traded at fair value in an active market is determined by reference to quoted current bid prices at the close of business on the balance sheet date.

v) Impairment of financial assets

All financial assets, except those measured at fair value through profit and loss, are subject to an annual review for impairment. An allowance for impairment is established when there is objective evidence that the entity will not be able to collect all amounts due.

For financial assets carried at amortised cost, the amount of the allowance is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate. The amount of the impairment loss is recognised in the operating statement.

When an available for sale financial asset is impaired, the amount of the cumulative loss is removed from equity and recognised in the operating statement, based on the difference between the acquisition cost (net of any principal repayment and amortisation) and current fair value, less any impairment loss previously recognised in the operating statement.

Any reversals of impairment losses are reversed through the operating statement, where there is objective evidence, except reversals of impairment losses on an investment in an equity instrument classified as "available for sale" must be made through the reserve. Reversals of impairment losses of financial assets carried at amortised cost cannot result in a carrying amount that exceeds what the carrying amount would have been had there not been an impairment loss.

w) De-recognition of financial assets and financial liabilities

A financial asset is derecognised when the contractual rights to the cash flows from the financial assets expire; or if the agency transfers the financial asset:

* where substantially all the risks and rewards have been transferred; or
* where the Health Service has not transferred substantially all the risks and rewards, if the entity has not retained control.

Where the Health Service has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the Health Service's continuing involvement in the asset.

A financial liability is derecognised when the obligation specified in the contract is discharged or cancelled or expires.

x) Payables

These amounts represent liabilities for goods and services provided to the Health Service and other amounts. Payables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method. Short-term payables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

Payables are recognised for amounts to be paid in the future for goods and services received, whether or not billed to the Health Service.

y) Borrowings

Loans are not held for trading or designated at fair value through profit or loss and are recognised at amortised cost using the effective interest rate method. Gains or losses are recognised in the operating statement on derecognition.

The finance lease liability is determined in accordance with AASB 117 Leases

z) Equity Transfers

The transfer of net assets between agencies as a result of an administrative restructure, transfers of programs/functions and parts thereof between NSW public sector agencies is designated as a contribution by owners and is recognised as an adjustment to "Accumulated Funds".

Transfers arising from an administrative restructure between Health Services/Government Departments are recognised at the amount at which the asset was recognised by the transferor Health Service/Government Department immediately prior to the restructure. In most instances this will approximate fair value. All other equity transfers are recognised at fair value.

The Statement of Recognised Income and Expense does not reflect the Net Assets or change in equity in accordance with AASB 101 Clause 97.

aa) Trust Funds

The Health Service receives monies in a trustee capacity for various trusts as set out in Note 31. As the Health Service performs only a custodial role in respect of these monies, and because the monies cannot be used for the achievement of the Health Service's own objectives, they are not brought to account in the financial statements.

ab) Budgeted Amounts

The budgeted amounts are drawn from the budgets agreed with the NSW Health Department at the beginning of the financial reporting period and with any adjustments for the effects of additional supplementation provided.

ac) Emerging Asset

The Health Services's emerging interest in the **Mater Public Private Partnership Funding** has been valued in accordance with the Department of Health's policy for *Accounting for Privately Financed Projects* . This policy required the Health Services to initially determine the estimated written down replacement cost by reference to the project's historical cost escalated by a construction index and the system's estimated working life. The estimated written down replacement cost was then allocated on a systematic basis over the concession period of **25** years using the annuity method and the Government Bond rate of **5.63%** at commencement of the concession period.

ad) Summary of Capital Management

With effect from 1 July 2008 project management for all capital projects over $10M will be provided by Health Infrastructure, a division of the Health Administration Corporation created with the purpose of managing and coordinating approved capital works projects within time, budget and quality standards specified by the Department. Capital charging will also be introduced (see note 38, Post Balance Date Events) and will guide Health Services in the management of capital and subsequent budget impact when planning facility redevelopments and assessing the ongoing importance of under utilised land and buildings.

PARENT 2008 $000	PARENT 2007 $000		CONSOLIDATION 2008 $000	CONSOLIDATION 2007 $000
		3. Employee Related		
		Employee related expenses comprise the following:		
		Salaries and Wages	664,421	609,844
		Awards	33,956	37,819
		Superannuation - defined benefit plans	20,370	18,143
		Superannuation - defined contributions	55,775	51,053
		Long Service Leave	27,142	23,601
		Annual Leave	68,875	65,962
		Sick Leave and Other Leave	18,206	16,535
		Redundancies	(25)	1,189
		Workers Compensation Insurance	15,972	15,623
		Fringe Benefits Tax	269	207
-	**-**		**904,961**	**839,976**
		The following additional information is provided:		
		Employee Related Expenses capitalised - Land and Buildings	24	408
		Employee Related Expenses capitalised - Plant and Equipment		
		4. Personnel Services		
		Personnel Services comprise the purchase of the following:		
664,421	609,844	Salaries and Wages		
33,956	37,819	Awards		
20,370	18,143	Superannuation - defined benefit plans		
55,775	51,053	Superannuation - defined contributions		
27,142	23,601	Long Service Leave		
68,875	65,962	Annual Leave		
18,206	16,535	Sick Leave and Other Leave		
(25)	1,189	Redundancies		
15,972	15,623	Workers Compensation Insurance		
269	207	Fringe Benefits Tax		
904,961	**839,976**		**-**	**-**
		The following additional information is provided:		
24	408	Personnel Services Expenses capitalised - Land and Buildings		
		Personnel Services Expenses capitalised - Plant and Equipment		
		5. Other Operating Expenses		
5,443	7,922	Blood and Blood Products	5,443	7,922
19,094	15,240	Domestic Supplies and Services	19,094	15,240
40,939	38,176	Drug Supplies	40,939	38,176
10,133	9,445	Food Supplies	10,133	9,445
8,675	8,823	Fuel, Light and Power	8,675	8,823
31,982	36,069	General Expenses (See (b) below)	31,982	36,069
14,012	10,975	Hospital Ambulance Transport Costs	14,012	10,975
6,735	5,423	Information Management Expenses	6,735	5,423
1,637	1,680	Insurance	1,637	1,680
77,664	74,324	Allocation for Inter Area Patient Outflows, NSW (see (d) below)	77,664	74,324
10,469	10,005	Interstate Patient Outflows (see (e) below)	10,469	10,005
		Maintenance (See (c) below)		
11,209	12,266	Maintenance Contracts	11,209	12,266
11,912	11,482	New/Replacement Equipment under $10,000	11,912	11,482
9,396	9,720	Repairs	9,396	9,720
53,545	51,309	Medical and Surgical Supplies	53,545	51,309
6,279	6,256	Postal and Telephone Costs	6,279	6,256
4,115	3,972	Printing and Stationery	4,115	3,972
2,468	2,396	Rates and Charges	2,468	2,396
7,011	6,243	Rental	7,011	6,243
39,651	38,222	Special Service Departments	39,651	38,222
10,351	7,179	Staff Related Costs	10,351	7,179
1,882	1,699	Sundry Operating Expenses (See (a) below)	1,882	1,699
7,328	7,517	Travel Related Costs	7,328	7,517
391,930	**376,343**		**391,930**	**376,343**

PARENT 2008 $000	PARENT 2007 $000		CONSOLIDATION 2008 $000	CONSOLIDATION 2007 $000
		(a) Sundry Operating Expenses comprise:		
-	393	Contract for Patient Services	-	393
1,882	1,699	Isolated Patient Travel and Accomodation Assistance Scheme	1,882	1,699
1,882	**2,092**		**1,882**	**2,092**
		(b) General Expenses include:-		
1,608	1,378	Advertising	1,608	1,378
643	613	Books, Magazines and Journals	643	613
		Consultancies		
1,794	1,045	- Operating Activities	1,794	1,045
89	41	- Capital Works	89	41
1,356	1,509	Courier and Freight	1,356	1,509
158	182	Auditor's Remuneration - Audit of financial reports	158	182
67	226	Auditor's Remuneration - Other Services	67	226
17	-	Data Recording and Storage	17	-
1,048	467	Legal Services	1,048	467
836	5,923	Membership/Professional Fees	836	898
6,923	6,862	Motor Vehicle Operating Lease Expense - minimum lease payments	6,923	6,862
		Other Motor vehicle expenses	4,388	4,186
1,945	1,630	Other Operating Lease Expense - minimum lease payments	1,945	1,630
15	13	Payroll Services	15	13
331	314	Quality Assurance/Accreditation	331	314
41	-	Translator Services	41	15
		(c) Reconciliation Total Maintenance		
		Maintenance expense - contracted labour and other (non employee		
30,461	31,266	related), included in Note 5	30,461	31,266
10,227	9,449	Employee related/Personnel Services maintenance expense included in Notes 3 and 4	10,227	9,449
40,688	**40,715**	Total maintenance expenses included in Notes 3, 4 and 5	**40,688**	**40,715**
		(d) Details of the Allocations applied to Inter Area Patient Outflows, NSW on an Area basis as accepted by the NSW Department of Health are as follows:-		
5,383	6,047	Children's Hospital Westmead	5,383	6,047
464	355	Greater Southern	464	355
1,435	1,350	Greater Western	1,435	1,350
7,953	7,511	North Coast	7,953	7,511
24,539	22,637	Northern Sydney Central Coast	24,539	22,637
20,235	19,836	South East Illawarra	20,235	19,836
9,376	9,540	Sydney South West	9,376	9,540
8,279	7,048	Sydney West	8,279	7,048
77,664	**74,324**	*Total*	**77,664**	**74,324**
		(e) Expenses for Interstate Patient Flows are as follows:-		
751	577	Australian Capital Territory	751	577
426	649	Northern Territory	426	649
8,669	6,908	Queensland	8,669	6,908
541	303	South Australia	541	303
(333)	797	Tasmania	(333)	797
191	660	Victoria	191	660
224	111	Western Australia	224	111
10,469	**10,005**	**Total**	**10,469**	**10,005**

PARENT			CONSOLIDATION	
2008 $000	**2007 $000**		**2008 $000**	**2007 $000**
		6. Depreciation and Amortisation		
34,359	32,153	Depreciation - Buildings	34,359	32,153
17,303	17,553	Depreciation - Plant and Equipment	17,303	17,553
2,790	2,317	Depreciation - Infrastructure Systems	2,790	2,317
54,452	**52,023**		**54,452**	**52,023**
		7. Grants and Subsidies		
8,894	7,921	Non Government Voluntary Organisations	8,894	7,921
634	211	Other	634	211
9,528	**8,132**		**9,528**	**8,132**
		8. Finance Costs		
		Finance Lease Interest Charges		
464	431	Interest on Bank Overdrafts and Loans	464	431
3,761	-	Other Interest Charges	3,761	-
4,225	**431**	Total Finance Costs	**4,225**	**431**
		9. Payments to Affiliated Health Organisations		
		(a) Recurrent Sourced		
91,018	82,040	Calvary Mater Newcastle	91,018	82,040
		(b) Non Recurrent		
71,330	**-**	Calvary Mater Newcastle	71,330	**-**
		(c) Capital Sourced		
4,423	7,356	Calvary Mater Newcastle	4,423	7,356
166,771	**89,396**		**166,771**	**89,396**

PARENT 2008 $000	PARENT 2007 $000		CONSOLIDATION 2008 $000	CONSOLIDATION 2007 $000
		10. Sale of Goods and Services		
		(a) Sale of Goods comprise the following:-		
3,943	3,837	Sale of Prosthesis	3,943	3,837
		(b) Rendering of Services comprise the following:-		
93,198	83,046	Patient Fees [see note 1(c)]	93,198	83,046
1,647	1,440	Staff-Meals and Accommodation	1,647	1,440
33,638	30,050	Infrastructure Fees - Monthly Facility Charge [see (d) below]	33,638	30,050
5,010	3,246	- Annual Charge	5,010	3,246
3,482	3,366	Car Parking	3,482	3,366
740	702	Child Care Fees	740	702
3,458	402	Clinical Services (excluding Clinical Drug Trials)	3,458	402
6,537	1,681	Commercial Activities	6,537	1,681
266	249	Fees for Medical Records	266	249
29,762	34,167	Allocation from Inter Area Patient Inflows, NSW (see (c) below)	29,762	34,167
-	1,096	Linen Service Revenues - Other Health Services	-	1,096
3	1,568	Linen Service Revenues - Non Health Services	3	1,568
735	742	Meals on Wheels	735	742
11,701	11,137	Services Provided to Non NSW Health Organisations	11,701	11,137
233	179	PADP Patient Copayments	233	179
3,465	2,717	Patient Inflows from Interstate	3,465	2,717
502	464	Pharmacy Sales	502	464
6,292	6,946	Other	6,292	6,946
204,612	**187,035**		**204,612**	**187,035**
		(c) Details of the Allocation received for Inter Area Patient Flows, NSW on an Area basis as accepted by the NSW Department of Health are as follows:-		
590	412	Greater Southern	590	412
4,478	3,654	Greater Western	4,478	3,654
11,174	9,427	North Coast	11,174	9,427
9,827	8,767	Northern Sydney Central Coast	9,827	8,767
1,028	1,670	South East Illawarra	1,028	1,670
1,360	8,743	Sydney South West	1,360	8,743
1,305	1,494	Sydney West	1,305	1,494
29,762	**34,167**	**Total**	**29,762**	**34,167**
		(d) Revenues from Patient Inflows from Interstate are as follows:-		
363	246	Australian Capital Territory	363	246
84	133	Northern Territory	84	133
2,151	1,435	Queensland	2,151	1,435
44	238	South Australia	44	238
50	13	Tasmania	50	13
689	492	Victoria	689	492
84	160	Western Australia	84	160
3,465	**2,717**	**Total**	**3,465**	**2,717**
		11. Investment Revenue		
5,438	5,611	Interest	5,438	5,611
1,091	942	Lease and Rental Income	1,091	942
52	22	Royalties	52	22
6,581	**6,575**		**6,581**	**6,575**

PARENT			CONSOLIDATION	
2008 $000	2007 $000		2008 $000	2007 $000
		12. Grants and Contributions		
679	533	Clinical Drug Trials	679	533
6,523	7,285	Commonwealth Government grants	6,523	7,285
115	100	Commonwealth Teaching Hospital grants	115	100
5,148	3,426	Industry Contributions/Donations	5,148	3,426
4,850	4,400	Cancer Institute grants	4,850	4,400
6,738	19	NSW Government grants	6,738	19
20,370	18,143	Personnel Services - Superannuation Defined Benefits	-	-
843	1,741	Research grants	843	1,741
1,204	4,885	Other grants	1,204	4,885
46,470	**40,532**		**26,100**	**22,389**
		13. Other Revenue		
		Other Revenue comprises the following:-		
20	13	Bad Debts recovered	20	13
175	271	Commissions	175	271
616	-	Conference and Training Fees	616	-
48	48	Sale of Merchandise, Old Wares and Books	48	48
9,507	9,759	Treasury Managed Fund Hindsight Adjustment	9,507	9,759
2,205	1,842	Other	2,205	1,842
12,571	**11,933**		**12,571**	**11,933**
		14. Gain/(Loss) on Disposal		
16,946	38,481	Property Plant and Equipment	16,946	38,481
14,235	12,173	Less Accumulated Depreciation	14,235	12,173
2,711	**26,308**	**Written Down Value**	**2,711**	**26,308**
1,943	32,956	Less Proceeds from Disposal	1,943	32,956
(768)	**6,648**	**Gain/(Loss) on Disposal of Property Plant and Equipment**	**(768)**	**6,648**
473	2,500	Assets Held for Sale	473	2,500
755	6,300	Less Proceeds from Disposal	755	6,300
282	**3,800**	**Gain/(Loss) on Disposal of Assets Held for Sale**	**282**	**3,800**
(486)	**10,448**	**Total Gain/(Loss) on Disposal**	**(486)**	**10,448**
		15. Other Gains/(Losses)		
(1,414)	(37)	Impairment of Receivables	(1,414)	(37)
(1,414)	**(37)**		**(1,414)**	**(37)**

Hunter New England Area Health Service
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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	2,300	10,803	5,014	18,117
Contributions recognised in amalgamated balance as at 30 June 2007 which were not expended in the current reporting period	4,080	23,957	5,015	33,052
Total amount of unexpended contributions as at balance date	6,380	34,760	10,029	51,169

Comment on restricted assets appears in Note 24

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.

Hunter New England Area Health Service
Notes to and forming part of the Financial Statements
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PARENT			CONSOLIDATION	
2008 $000	**2007 $000**		**2008 $000**	**2007 $000**
		18. Cash and Cash Equivalents		
17,156	1,144	Cash at bank and on hand	17,156	1,144
49,000	70,000	Short Term Deposits	49,000	70,000
66,156	**71,144**		**66,156**	**71,144**
		Cash & cash equivalent assets recognised in the Balance Sheet are reconciled at the end of the financial year to the Cash Flow Statement as follows:		
66,156	71,144	Cash and cash equivalents (per Balance Sheet)	66,156	71,144
66,156	**71,144**	Closing Cash and Cash Equivalents (per Cash Flow Statement)	**66,156**	**71,144**

Refer to Note 37 for details regarding credit risk, liquidity risk and market risk arising from financial instruments.

PARENT 2008 $000	PARENT 2007 $000		CONSOLIDATION 2008 $000	CONSOLIDATION 2007 $000
		19. Receivables		
		Current		
16,790	10,259	(a) Sale of Goods and Services	16,790	10,259
1,035	778	Leave Mobility	1,035	778
6,848	7,839	NSW Health Department	6,848	7,839
7,772	7,600	Debtors GST	7,772	7,600
1,952	1,397	Expense / Payments	1,952	1,397
10,556	9,094	Other Debtors	10,556	9,094
44,953	36,967	**Sub Total**	44,953	36,967
(830)	(569)	Less Allowance for impairment	(830)	(569)
44,123	36,398	**Sub Total**	44,123	36,398
3,819	2,093	Prepayments	3,819	2,093
47,942	**38,491**		**47,942**	**38,491**
		(b) Movement in the allowance for impairment Sale of Goods & Services		
(310)	(543)	Balance at 1 July	(310)	(543)
254	152	Amounts written off during the year	254	152
47	(233)	Amounts recovered during the year	47	(233)
301	(81)	Increase/(decrease) in allowance recognised in profit or loss	301	(81)
(357)	**(310)**	Balance at 30 June	**(357)**	**(310)**
		(c) Movement in the allowance for impairment Other Debtors		
(259)	(213)	Balance at 1 July	(259)	(213)
853	73	Amounts written off during the year	853	73
214	46	Amounts recovered during the year	214	46
1,067	119	Increase/(decrease) in allowance recognised in profit or loss	1,067	119
(473)	**(259)**	Balance at 30 June	**(473)**	**(259)**
(830)	**(569)**		**(830)**	**(569)**
		Non Current		
262	263	(a) Sale of Goods and Services	262	263
32	1,441	Leave Mobility	32	1,441
294	1,704	**Sub Total**	294	1,704
(90)	(44)	Less Allowance for impairment	(90)	(44)
204	**1,660**		**204**	**1,660**
		(b) Movement in the allowance for impairment Sale of Goods & Services		
(44)	(211)	Balance at 1 July	(44)	(211)
-	167	Amounts written off during the year	-	167
46	(167)	Amounts recovered during the year	46	(167)
46	-	Increase/(decrease) in allowance recognised in profit or loss	46	-
(90)	**(44)**	Balance at 30 June	**(90)**	**(44)**
		(c) Sale of Goods and Services Receivables (Current and Non Current) include:		
1,006	1,222	Patient Fees - Compensable	1,006	1,222
389	213	Patient Fees - Ineligible	389	213
9,199	9,087	Patient Fees - Other	9,199	9,087
10,594	**10,522**		**10,594**	**10,522**

Details regarding credit risk, liquidity risk and market risk, including financial assets that are either past due or impaired are disclosed in Note 37.

PARENT 2008 $000	PARENT 2007 $000		CONSOLIDATION 2008 $000	CONSOLIDATION 2007 $000
		20. Inventories		
		Current - at cost		
2,617	2,504	Drugs	2,617	2,504
2,318	2,139	Medical and Surgical Supplies	2,318	2,139
219	241	Food and Hotel Supplies	219	241
3	3	Engineering Supplies	3	3
10	2	Other including Goods in Transit	10	2
5,167	**4,889**		**5,167**	**4,889**
		21. Property, Plant and Equipment		
		Land and Buildings		
1,569,385	1,413,918	At Fair Value	1,569,385	1,413,918
662,987	591,424	Less Accumulated depreciation and impairment	662,987	591,424
906,398	**822,494**	Net Carrying Amount	**906,398**	**822,494**
		Plant and Equipment		
201,179	197,924	At Fair Value	201,179	197,924
119,335	116,273	Less Accumulated depreciation and impairment	119,335	116,273
81,844	**81,651**	Net Carrying Amount	**81,844**	**81,651**
		Infrastructure Systems		
117,219	94,400	At Fair Value	117,219	94,400
43,324	45,662	Less Accumulated depreciation and impairment	43,324	45,662
73,895	**48,738**	Net Carrying Amount	**73,895**	**48,738**
1,062,137	**952,883**	**Total Property, Plant and Equipment At Net Carrying Amount**	**1,062,137**	**952,883**

PARENT AND CONSOLIDATED

22. Property, Plant and Equipment - Reconciliations

	Land	Buildings	Work in Progress	Leased Buildings	Plant and Equipment	Infrastructure Systems	Other Leased Assets	Total
	$000	$000	$000	$000	$000	$000	$000	$000
2008								
Carrying amount at start of year	**70,895**	**717,501**	**34,098**	**-**	**81,651**	**48,738**	**-**	**952,883**
Additions	315	465	44,579		9,804	193		**55,356**
Reclassifications to Intangibles								
Recognition of Assets Held for Sale	-	-	-	-	-	-	-	**-**
Disposals	(224)	(125)	-	-	(2,362)	-	-	**(2,711)**
Administrative restructures - transfers in/(out)	-	-	-	-	-	-	-	**-**
Net revaluation increment less revaluation decrements recognised in reserves	39,032	53,163	-	-	-	18,866	-	**111,061**
Impairment losses (recognised in "other gains/losses)	-	-	-	-	-	-	-	**-**
Depreciation expense	-	(34,359)	-	-	(17,303)	(2,790)	-	**(54,452)**
Reclassifications	190	24,371	(43,503)	-	10,054	8,888	-	**-**
Carrying amount at end of year	**110,208**	**761,016**	**35,174**	**-**	**81,844**	**73,895**	**-**	**1,062,137**

	Land	Buildings	Work in Progress	Leased Buildings	Plant and Equipment	Infrastructure Systems	Other Leased Assets	Total
	$000	$000	$000	$000	$000	$000	$000	$000
2007								
Carrying amount at start of year	**78,202**	**715,322**	**36,808**	**-**	**89,236**	**51,178**	**-**	**970,746**
Additions	-	339	52,745	-	15,508	40	-	**68,632**
Reclassifications to Intangibles								
Recognition of Assets Held for Sale	(581)	(1,498)	-	-	-	(130)	-	**(2,209)**
Disposals	(6,916)	(15,073)	(241)	-	(2,812)	(1,265)	-	**(26,307)**
Administrative restructures - transfers in/(out)	-	(884)	-	-	(5,072)	-	-	**(5,956)**
Net revaluation increment less revaluation decrements recognised in reserves	-	-	-	-	-	-	-	**-**
Impairment losses (recognised in "other gains/losses)	-	-	-	-	-	-	-	**-**
Depreciation expense		(32,152)	-	-	(17,554)	(2,317)	-	**(52,023)**
Reclassifications	190	51,447	(55,214)	-	2,345	1,232	-	**-**
Carrying amount at end of year	**70,895**	**717,501**	**34,098**	**-**	**81,651**	**48,738**	**-**	**952,883**

Above categories and transaction type should be deleted if not applicable.

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

(ii) Land and Buildings were valued by Global Valuation Services Pty Ltd **(FRICS, FVLE Val & Econ Registered Number 27)** on 1 July 2007 [see note 2(j)]. Global Valuations Services is / is not an employee of the Health Service.

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PARENT			CONSOLIDATION	
2008 $000	2007 $000		2008 $000	2007 $000
		23. Non Current Assets held for sale		
		Assets held for sale		
2,114	2,586	Land and Buildings	2,114	2,586
130	130	Plant and Equipment	130	130
-	-	Infrastructure systems	-	-
-	-	Other	-	-
2,244	**2,716**		**2,244**	**2,716**
		Amounts recognised in equity relating to assets held for sale		
-	-	Property, plant and equipment asset revaluation increments/decrements	-	-
425	619	Available for sale financial asset revaluation increments/decrements	425	619
-	-	Other	-	-
425	**619**		**425**	**619**

Land, Buildings And Infrastructure held for sale are;

Land, Lot 1 Kanagra Drive Taree
Land, Lot 1 to 12 Singleton
Land, Buildings and Infrastructure Walcha
Land & Buildings, 40 Henry Street Barraba
Land & Buildings, 82 George Street Mungindi
Land, Buildings and Infrastructure, 10 Warialda Rd Inverell - Lot 4 DP17592

These Assets 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 assets are available for immediate sale.

PARENT				CONSOLIDATION	
2008 $000	2007 $000			2008 $000	2007 $000

24. Restricted Assets

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

		Category	Brief Details of Externally Imposed Conditions including Asset Category affected		
6,380	5,955	Specific Purposes	Condition Imposed by Donor	6,380	5,955
19	18	Perpetually Invested Funds	Original principal not to be spent	19	18
15,631	15,720	Research Grants	Condition imposed by granting body	15,631	15,720
19,110	16,305	Private Practice Funds	Trust Deed	19,110	16,305
10,029	7,191	Other (List Major Items)	Condition Imposed by Donor	10,029	7,191
51,169	**45,189**			**51,169**	**45,189**

PARENT			CONSOLIDATION	
		25. Payables		
2008 $000	**2007 $000**		**2008 $000**	**2007 $000**
		Current		
-	-	Accrued Salaries and Wages	24,019	17,622
-	-	Payroll Deductions	1,579	4,520
25,598	22,142	Accrued Liability - Purchase of Personnel Services	-	-
25,745	26,300	Creditors	25,745	26,300
1,310	1,335	Taxation Payables - Goods and Services Tax	1,310	1,335
		Other Creditors		
4,623	1,244	- Capital Works	4,623	1,244
2,824	1,561	- Intra Health Liability	2,824	1,561
29,200	14,469	- Other	29,200	14,469
89,300	**67,051**		**89,300**	**67,051**

Details regarding credit risk, liquidity risk and market risk, including a maturity analysis of the above payables are disclosed in Note 37.

		26. Borrowings		
		Current		
1,663	1,277	Other Loans and Deposits	1,663	1,277
1,831		Calvery Mater Newcastle	1,831	
3,494	**1,277**		**3,494**	**1,277**
		Non Current		
4,038	4,750	Other Loans and Deposits	4,038	4,750
68,754	-	Calvery Mater Newcastle	68,754	-
72,792	**4,750**		**72,792**	**4,750**

Other loans still to be extinguished represent monies to be repaid to NSW Health Department, $3.9m,
Health Support, $1.8m, and Calvary Mater Newcastle Hospital Public, Private Partnership, liability to Novacare, $70.6m.
Final repayment of the NSW Health Department loan is scheduled for 2010/11.
Final repayment of the Health Support loan is scheduled for 2012/13
Final repayment to Novacare for Calvary Mater Newcastle Hospital PPP Liability is scheduled for 2032/33.

		Repayment of Borrowings (excluding Finance Leases)		
3,494	1,277	Not later than one year	3,494	1,277
13,378	4,750	Between one and five years	13,378	4,750
59,414	-	Later than five years	59,414	-
76,286	**6,027**	Total Borrowings at face value (excluding Finance Leases)	**76,286**	**6,027**

Details regarding credit risk, liquidity risk and market risk, including a maturity analysis of the above payables are disclosed in Note 37.

PARENT			CONSOLIDATION	
2008 $000	**2007 $000**		**2008 $000**	**2007 $000**
		27. Provisions		
		Current Employee benefits and related on-costs		
-	-	Annual Leave - Short Term Benefit	62,810	59,128
-	-	Annual Leave - Long Term Benefit	44,923	42,825
-	-	Long Service Leave - Short Term Benefit	15,015	13,880
-	-	Long Service Leave - Long Term Benefit	146,885	138,312
269,633	254,145	Provision for Personnel Services Liability	-	-
269,633	**254,145**	**Total Current Provisions**	**269,633**	**254,145**
		Non Current Employee benefits and related on-costs		
-	-	Long Service Leave - Conditional	6,911	5,915
6,911	5,915	Provision for Personnel Services Liability	-	-
6,911	**5,915**	**Total Non Current Provisions**	**6,911**	**5,915**
		Aggregate Employee Benefits and Related On-costs		
269,633	254,145	Provisions - current	269,633	254,145
6,911	5,915	Provisions - non-current	6,911	5,915
-	-	Accrued Salaries and Wages and on costs (Note 25)	25,598	22,142
25,598	22,142	Accrued Liability - Purchase of Personnel Services (Note 25)	-	-
302,142	**282,202**		**302,142**	**282,202**

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PARENT			CONSOLIDATION	
2008 $000	**2007 $000**		**2008 $000**	**2007 $000**
		28. Other Liabilities		
		Current		
2,341	3,319	Income in Advance	2,341	3,319
2,341	**3,319**		**2,341**	**3,319**
		Non Current		
420	435	Income in Advance	420	435
420	**435**		**420**	**435**

The major components of Income in Advance as at the 30 June 2008 relates to rent in advance received from Armidale Private Hospital $0.4million, Deposit on the sale of David Maddison $0.6million, DVA COPS Brokerage $0.3million, Armidale AMS Grant $0.2million, Compacks Fundings $0.2million, TACP $0.2million HMRI Accomodation $0.1million, Health for Life DHA Gunnedah $0.1million, MDT Lung Cancer Prj - Cancer Institute $0.1million and Mammography Grants received from Cancer Institute $0.1million.

29. PARENT AND CONSOLIDATION

Equity	Accumulated Funds		Asset Revaluation Reserve		Available for Sale Reserves		Total Equity	
	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000
Balance at the beginning of the financial year	622,930	661,970	111,342	113,745	619	330	734,891	776,045
Correction of errors (specify)							-	-
Restated Opening Balance	622,930	661,970	111,342	113,745	619	330	734,891	776,045
Changes in equity - transactions with owners as owners								
Increase/(Decrease) in Net Assets from Administrative Restructure	-	(5,956)	-	-	-	-	-	(5,956)
Total	622,930	656,014	111,342	113,745	619	330	734,891	770,089
Changes in equity - other than transactions with owners as owners								
Result for the year	(106,993)	(35,198)	-	-	-	-	(106,993)	(35,198)
Correction of errors (specify)								
Increment/(Decrement) on Revaluation of:								
Land and Buildings	-	-	39,032	-	-	-	39,032	-
Plant and Equipment	-	-	53,163	-	-	-	53,163	-
Infrastructure Systems	-	-	18,866	-	-	-	18,866	-
Increment/(Decrement) on revaluation of available for sale financial assets	-	-	-	-	-	-	-	-
Transfer to Result for Year on disposal of available for sale financial assets	-	-	-	-	-	-	-	-
Total	(106,993)	(35,198)	111,061	-	-	-	4,068	(35,198)
Transfers within equity								
Asset revaluation reserve balances transferred to accumulated funds on disposal of asset	(451)	2,114	645	(2,403)	(194)	289	-	-
Total	(451)	2,114	645	(2,403)	(194)	289	-	-
Balance at the end of the financial year	515,486	622,930	223,048	111,342	425	619	738,959	734,891

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

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PARENT 2008 $000	PARENT 2007 $000	30. Commitments for Expenditure	CONSOLIDATION 2008 $000	CONSOLIDATION 2007 $000
		(a) Capital Commitments		
		Aggregate capital expenditure for the acquisition of land and buildings, plant and equipment, infrastructure and intangible assets, contracted for at balance date and not provided for:		
15,223	35,246	Not later than one year	15,223	35,246
803	990	Later than one year and not later than five years	803	990
-	-	Later than five years	-	-
16,026	**36,236**	**Total Capital Expenditure Commitments (including GST)**	**16,026**	**36,236**

Of the commitments reported at 30 June 2008 it is expected that **$0.4m** will be met from locally generated moneys.

(b) Operating Lease Commitments
Commitments in relation to non-cancellable operating leases are payable as follows:

8,751	8,711	Not later than one year	8,751	8,711
13,414	12,021	Later than one year and not later than five years	13,414	12,021
36,524	44,532	Later than five years	36,524	44,532
58,689	**65,264**	**Total Operating Lease Commitments (including GST)**	**58,689**	**65,264**

The operating lease commitments above are for motor vehicles, information technology, equipment including personal computers, medical equipment and other equipment

(c) Contingent Asset related to Commitments for Expenditure
The total of "Commitments for Expenditure" above, i.e. **$74.4m** million as at 30 June 2008 includes input tax credits of **$6.6m** that are expected to be recoverable from the Australian Taxation Office.

PARENT 2008 $000	PARENT 2007 $000	30. Commitments for Expenditure (Continued)	CONSOLIDATION 2008 $000	CONSOLIDATION 2007 $000

(d) Calvary Mater Newcastle Hospital Public, Private Partnership (PPP)

In 2005-06, the Health Administration Corporation entered into a contract with a private sector provider, Novacare Project Partnership for financing, design, construction and commissioning of a new Mater Hospital, a mental health facility and refurbishment of existing buildings, and facilities management and delivery of ancillary non-clinical services on the site until November 2033. The redevelopment will be completed in three stages. Stage 1 was completed on 9 January 2008 and full service commencement is anticipated in mid 2009.

When Stage 1 construction was completed in January 2008, the Hunter New England Area Health Service (HNEAHS) transferred the Mater hospital to Calvary Mater Newcastle and recognised the transfer as a grant expense of $71.33m. The recognition is based on the fact that services are delivered by Little Company of Mary Health Care being a Third Schedule Hospital health care provider which is outside the accounting control of either HNEAHS or the Department. After completion of the Project, HNEAHS will transfer the other parts of the new Hospital and will recognise the transfer of a grant expense of

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

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

An estimate of the commitments is as follows:

2,008 $000	2,007 $000	(e) Capital Commitments – New Mental Health Building and Refurbished	2,008 $000	2,007 $000
4,253	1,401	Not later than one year	4,253	1,401
29,315	26,156	Later than one year and not later than five years	29,315	26,156
89,818	97,230	Later than five years	89,818	97,230
123,386	**124,787**	**Total Capital Expenditure Commitments (including GST)**	**123,386**	**124,787**
		(ii) Other Expenditure Commitments – Redevelopment of new Mater Hospital		
18,856	8,426	Not later than one year	18,856	8,426

PARENT AND CONSOLIDATION

31 Trust Funds

The Health Service holds trust fund moneys of **$2.6** million which are used for the safe keeping of patients' monies, deposits on hired items of equipment and Private Practice Trusts. These monies are excluded from the financial statements as the Health Service cannot use them for the achievement of its objectives. The following is a summary of the transactions in the trust account:

	Patient Trust		Refundable Deposits		Private Practice Trust Funds	
	2008 $000	**2007 $000**	**2008 $000**	**2007 $000**	**2008 $000**	**2007 $000**
Cash Balance at the beginning of the financial reporting period	**1,346**	**1,119**	**315**	**274**	**739**	**891**
Receipts	261	1,695	1,055	788	49,694	44,001
Expenditure	177	1,467	928	747	49,714	44,153
Cash Balance at the end of the financial reporting period	1,430	1,347	442	315	719	739

32 Contingent Liabilities

a) Claims on Managed Fund

Since 1 July 1989, the Health Service has been a member of the NSW Treasury Managed Fund. The Fund will pay to or on behalf of the Health Service all sums which it shall become legally liable to pay by way of compensation or legal liability if sued except for employment related, discrimination and harassment claims that do not have statewide implications. The costs relating to such exceptions are to be absorbed by the Health Service. Open public liability claims against the Health Service at 30 June 2008 numbered 67 with an estimate value of $43.8m (81 claims with an estimate value of $39.7 million at 30 June 2007). As such, since 1 July 1989, apart from the exceptions noted above no contingent liabilities exist in respect of liability claims against the Health Service. A Solvency Fund (now called Pre-Managed Fund Reserve was established to deal with the insurance matters incurred before 1 July 1989 that were above the limit of insurance held or for matters that were incurred prior to 1 July 1989 that would have become verdicts against the State. That Solvency Fund will likewise respond to all claims against the Health Service.

b) Workers Compensation Hindsight Adjustment

Treasury Managed Fund normally calculates hindsight premiums each year. However, in regard to workers compensation the final hindsight adjustment for the 2001/02 fund year and an interim adjustment for the 2003/04 fund year were not calculated until 2007/08. As a result, the 2002/03 final and 2004/05 interim hindsight calculations will be paid in 2008/09.

c) Affiliated Health Organisations

Based on the definition of control in Australian Accounting Standard AASB127, Affiliated Health Organisations listed in Schedule 3 of the Health Services Act, 1997 are only recognised in the Department's consolidated Financial Statements to the extent of cash payments made.

However, it is accepted that a contingent liability exists which may be realised in the event of cessation of health service activities by any Affiliated Health Organisation. In this event the determination of assets and liabilities would be dependent on any contractual relationship which may exist or be formulated between the administering bodies of the organisation and the Department.

d) Contingent Liabilities include, a. Bank Guarantee - Fisher & Paykel Australia for sublease of Belford Place Cardiff, $126k.
b. Claim by Calvary Retirement Community Cessnock Limited re payment of redundancies for staff previously transferred from Hunter New England Area Health Service, $330k.

Hunter New England Area Health Service
Notes to and forming part of the Financial Statements
for the Year Ended 30 June 2008

PARENT 2008 $000	PARENT 2007 $000		CONSOLIDATION 2008 $000	CONSOLIDATION 2007 $000
		33. Reconciliation Of Net Cash Flows from Operating Activities To Net Cost Of Services		
48,416	58,922	Net Cash Flows from Operating Activities	48,416	58,922
(54,452)	(52,023)	Depreciation	(54,452)	(52,023)
(307)	354	Provision for Doubtful Debts	(307)	354
-	-	Acceptance by the Crown Entity of Employee Superannuation Benefits	(20,370)	(18,143)
(16,484)	(15,840)	(Increase)/ Decrease in Provisions	(16,484)	(15,840)
8,547	5,402	Increase / (Decrease) in Prepayments and Other Assets	8,547	5,402
(92,227)	(14,602)	(Increase)/ Decrease in Creditors	(92,227)	(14,602)
(486)	10,448	Net Gain/ (Loss) on Sale of Property, Plant and Equipment	(486)	10,448
(1,183,307)	(1,112,935)	(NSW Health Department Recurrent Allocations)	(1,183,307)	(1,112,935)
(40,363)	(49,017)	(NSW Health Department Capital Allocations)	(40,363)	(49,017)
(1,330,663)	**(1,169,291)**	**Net Cost of Services**	**(1,351,033)**	**(1,187,434)**

34. 2007/08 Voluntary Services

It is considered impracticable to quantify the monetary value of voluntary services provided to the health service. Services provided include:

. Chaplaincies and Pastoral Care -	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

PARENT AND CONSOLIDATED

35 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.

36 Budget Review - Parent and Consolidated

Net Cost of Services
The actual Net Cost of Services was unfavourable to budget by $8.9m. This was due primarily to higher than anticipated salaries and wages and goods and services costs, offset by higher than anticipated infrastructure fee , patient fee and user charges revenues.

Result for the Year
The actual result for the year was unfavourable to budget by $28.9m. This was due to lower than anticipated capital allocations from NSW Department of Health, $20.0m, and unfavourable net cost of services, $8.9m, as noted above.

Assets and Liabilities
Current Assets were higher than budget by $11.1m due to higher than anticipated debtors and prepayments.

Non Current Assets were higher than budget by $103m due to an asset revaluation and lower than anticipated capital expenditure.

Current Liabilities were higher than budget by $34.8m due to higher than anticipated Provisions for Leave Liabilities and creditor balances.

Non Current Liabilities were lower than budget by $2.8m due to lower than anticipated Provisions for Leave Liabilities.

Cash Flows

The actual Net Cash flows from Operating Activities were lower than budget by $11.4m. This was primarily due to lower than anticipated NSW Health Capital Allocations.

PARENT AND CONSOLIDATED
Budget Review - Parent and Consolidated Continued

Movements in the level of the NSW Department of Health Recurrent Allocation that have occurred since the time of the initial allocation on 1st July 2007 are as follows:

		$000
Initial Allocation		1,070,003
Award Increases (Including Special Project Award Increases)		33,955
Special Projects;		
ESWL	1,840	
High Cost Drugs	1,540	
National Drug Diversion Prg 2	1,348	
Ill Drugs Needles & Syringes	893	
Aboriginal Health Enhancement	791	
Drug Summit 3	604	
AIDS	509	
AHCA Pathways Home	502	
HASI - Housing	497	
State Immunisation	472	
C/W Geriatric Assessment	387	
Mental Health Enhancement	356	
Aboriginal Child Mat	(789)	
Managed Fund Insurance	(1,729)	
Other	1,224	8,447
Other;		
Inter Area Patient Flows	47,902	
VMO / Rural Doctors Increase	4,220	
Newcastle Mater Hospital PPP	3,846	
Costs incurred for Drug Herceptin	2,100	
Nursing Strategies Allocation Approval 2007	2,069	
Additional Acute Hospital Beds	1,789	
Procurement Savings reversal	1,601	
Newcastle Community Health Centre	1,534	
Newcastle Mater Hospital PPP	1,335	
Clinical Service Redesign Program	1,150	
Long Stay Older Patients Initiatives	1,116	
First State Superannuation	987	
Tamworth Interventional Cardiology Service	900	
Medical Retrieval Services	810	
Emergency Specialist Position	720	
Compulsory Third Party Insurance	(3,100)	
Other	1,925	70,902
Balance as per Operating Statement		**1,183,307**

Note 37 Financial Instruments

The Health Service's principal financial instruments are outlined below. These financial instruments arise directly from the Health Service's operations or are required to finance its operations. The Health Service does not enter into or trade financial instruments, including derivative financial instruments, for speculative purposes.

The Health Service's main risks arising from financial instruments are outlined below, together with the Health Service's objectives, policies and processes for measuring and managing risk. Further quantitative and qualitative disclosures are included throughout this financial report.

The Chief Executive has overall responsibility for the establishment and oversight of risk management and reviews and agrees policies for managing each of these risks. Risk management policies are established to identify and analyse the risk faced by the Health Service, to set risk limits and controls and monitor risks. Compliance with policies is reviewed by the Audit Committee/Internal auditors on a continuous basis.

a) Financial Instrument Categories

PARENT AND CONSOLIDATED

		Total carrying amounts as per the Balance Sheet	
		2008 $000	2007 $000
Financial Assets			
Class:	Category		
Cash and Cash Equivalents (Note 18)		66,156	71,144
Receivables at Amortised Cost (Note 19)1		37,475	31,071
Total Financial Assets		103,631	102,215
Financial Liabilities			
Borrowings (Note 26)		76,286	6,027
Payables (Note 25)2		87,990	65,716
Total Financial Liabilities		164,276	71,743

Notes

1 Excludes statutory receivables and prepayments (ie not within scope of AASB 7)

2 Excludes unearned revenue (ie not within scope of AASB 7)

b) **Credit Risk**

Credit risk arises when there is the possibility of the Entity's debtors defaulting on their contractual obligations, resulting in a financial loss to the Entity. The maximum exposure to credit risk is generally represented by the carrying amount of the financial assets (net of any allowance for impairment).

Credit risk arises from financial assets of the Entity i.e receivables. No collateral is held by the Entity nor has it granted any financial guarantees.

Credit risk associated with the Health Service's financial assets, other than receivables, is managed through the selection of counterparties and establishment of minimum credit rating standards. Authority deposits held with NSW Tcorp are guaranteed by the State.

Cash

Cash comprises cash on hand and bank balance deposited in accordance with Public Authorities (Financial Arrangements) Act approvals. Interest is earned on daily bank balances at rates of approximately 7.42% in 2007/08 compared to 6.34% in the previous year.

Receivables - trade debtors

All trade debtors are recognised as amounts receivable at balance date. Collectability of trade debtors is reviewed on an ongoing basis. Procedures as established in the NSW Department of Health Accounting Manual and Fee Procedures Manual are followed to recover outstanding amounts, including letters of demand. Debts which are known to be uncollectable are written off. An allowance for impairment is raised when there is objective evidence that the entity will not be able to collect the amounts due. The evidence includes past experience and current and expected changes in economic conditions and debtor credit ratings. No interest is earned on trade debtors.

The Health Service is not materially exposed to concentrations of credit risk to a single trade debtor or group of debtors. Based on past experience, debtors that are not past due (2008:$26.4m; 2007: $22.4) are not considered impaired and together these represent 70% of the total trade debtors
In addition Patient Fees Compensables are frequently not settled with in 6 months of the date of the service provision due to the length of time it takes to settle legal claims.
Most of the Health Services' debtors are Health Insurance Companies or Compensation Insurers settling claims in respect of inpatient treatments. There are no debtors which are currently not past due or impaired whose terms have not been renegotiated.

		$000	
2008	**Total**	**Past due but not impaired**	**Considered impaired**
<3 months overdue	6,770	6,506	264
3 months - 6 months overdue	2,729	2,662	67
> 6 months overdue	1,576	987	589
2007			
<3 months overdue	3,246	3,246	-
3 months - 6 months overdue	1,726	1,602	124
> 6 months overdue	3,653	3,164	489

The ageing analysis excludes statutory receivables, as these are not within the scope of AASB 7.

The only financial assets that are past due or impaired are 'sales of goods and services' in the 'receivables category of the balance sheet. Patient Fees Ineligibles represent the majority of financial assets that are past due or impaired.

c) **Liquidity risk**

Liquidity risk is the risk that the Health Service will be unable to meet its payment obligations when they fall due. The Health Service continuously manages risk through monitoring future cash flows and maturities planning to ensure adequate holding of high quality liquid assets. The objective is to maintain a balance between continuity of funding and flexibility through effective management of cash, investments and liquid assets and liabilities.

The Health Service's exposure to liquidity risk is significant but is mitigated by financial support from the Department.

During the current and prior year, there were no defaults or breaches on any loans payable. No assets have been pledged as collateral. The Health Service's exposure to liquidity risk is deemed insignificant based on prior periods' data and current assessment of risk noting that the NSW Department c Health has indicated its ongoing financial support for the Hunter New England Area Health Service which is deemed to be a going concern.

The liabilities are recognised for amounts due to be paid in the future for goods or services received, whether or not invoiced. Amounts owing to suppliers (which are unsecured) are settled in accordance with the policy set by the NSW Department of Health. If trade terms are not specified, payment is made no later than the end of the month following the month in which an invoice or a statement is received.

The table below summarises the maturity profile of the Health Service's financial liabilities together with the interest rate exposure.

Maturity Analysis and interest rate exposure of financial liabilities

	$'000								
	Interest Rate Exposure					Maturity Dates			
	Fixed Interest Rate	Variable Interest Rate	Nominal Amount [1]	Variable Interest Rate	Non - Interest Bearing	< 1 Yr	1-5 Yr	> 5Yr	Weighted Average Effective int rate
2008	%	%	$	$000	$000	$000	$000	$000	%
Payables:					87,990				-
Borrowings:									
Other Loans and Deposits	76,286					3,494	13,378	59,414	6%
	76,286	-	-	-	87,990	3,494	13,378	59,414	
2007									
Payables:					65,716				-
Borrowings:									
Other Loans and Deposits	6,027					1,277	4,750	-	6%
	6,027	-	-	-	65,716	1,277	4,750	-	

Notes:
[1]The amounts disclosed are the contractual undiscounted cash flows of each class of financial liabilities, therefore the amounts disclosed above will not reconcile to the balance sheet in respect of non interest bearing loans negotiated with the NSW Department of Health.

d) **Market risk**

Market risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in market prices. The Health Service's exposures to market risk are primarily through interest rate risk on the Health Service's borrowings and other price risks associated with the movement in the unit price of the Hour Glass Investment facilities. The Health Service has no exposure to foreign currency risk and does not enter into commodity contracts.

The effect on profit and equity due to a reasonably possible change in risk variable is outlined in the information below, for interest rate risk and other price risk. A reasonably possible change in risk variable has been determined after taking into account the economic environment in which the Health Service operates and the time frame for the assessment (i.e. until the end of the next annua reporting period). The sensitivity analysis is based on risk exposures in existence at the balance sheet date. The analysis is performed on the same basis for 2007. The analysis assumes that all other variables remain constant.

Interest rate risk

Exposure to interest rate risk arises primarily through the Health Service's interest bearing liabilities.

However, Health Services are not permitted to borrow external to the NSW Department of Health (Sustainable Energy Development Authority loans which are negotiated through Treasury excepted) Both SEDA and NSW Department of Health loans are set at fixed rates and therefore are generally not affected by fluctuations in market rates. For financial instruments a reasonably possible change of +/-1% is consistent with trends in interest. The Health Service's exposure to interest rate risk is set out below.

$'000

		-1%		+1%	
	Carrying Amount	**Profit**	**Equity**	**Profit**	**Equity**
2008					
Financial assets					
Cash and cash equivalents	66,156	(662)		662	
2007					
Financial assets					
Cash and cash equivalents	71,144	(711)		711	

Note 38 Post Balance Date Events

With effect from 1 July 2008 a policy of capital charging is to be introduced across NSW Health in which each Health Service will be charged the current cost of holding Land, Buildings, Infrastructure Systems and Leasehold Improvements. In economic terms a capital charge is the opportunity foregone from holding ar asset. The charge will be introduced with only 25% budget impact in 2008/09 increasing in steps of 25% each year until the charge and the budgeting impact are fully applied in 2012/13
It is not yet possible to estimate the impact of the change on the financial statements.

END OF AUDITED FINANCIAL STATEMENTS

GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDITOR'S REPORT

Hunter New England Area Health Service Special Purpose Service Entity

To Members of the New South Wales Parliament

I have audited the accompanying financial report of the Hunter New England Area Health Service Special Purpose Service Entity, which comprises the balance sheet as at 30 June 2008, the income statement, statement of recognised income and expense and cash flow statement for the year then ended, a summary of significant accounting policies and other explanatory notes.

Auditor's Opinion

In my opinion, the financial report:

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

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

The Chief Executive's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

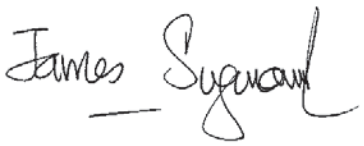
My opinion does *not* provide assurance:

- about the future viability of the Hunter New England Area Health Service Special Purpose Service Entity,
- that it has carried out its activities effectively, efficiently and economically, or
- about the effectiveness of its internal controls.

Independence

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

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



James Sugumar
Director, Financial Audit Services

1 December 2008
SYDNEY

HUNTER NEW ENGLAND
NSW HEALTH

Certification of Special Purpose Entity
For Period Ended 30 June 2008

Pursuant to Section 45F of the *Public Finance and Audit Act, 1983*, I state that to the best of my knowledge and belief:

1) The financial report has been prepared in accordance with:
   - Australian Accounting Standards
   - *Public Finance and Audit Act 1983*
   - *Public Finance and Audit Regulations 2005*
   - *Health Services Act 1997 and its Regulations*
   - the Accounts and Audit Determination
2) The financial report exhibits a true and fair view of the financial position and the financial performance of the Hunter New England Area Health Service Special Purpose Service Entity.
3) There are no circumstances which would render any particulars included in the financial report to be misleading or inaccurate.

Nigel Lyons
Chief Executive
Date 10.11.08

Mark Jeffrey
Director of Finance

Income Statement of Hunter New England Area Health Service
Special Purpose Service Entity for the Year Ended 30 June 2008

	2008 $000	2007 $000
Income		
Personnel Services	904,961	839,976
Acceptance by the Crown Entity of Employee Benefits	20,370	18,143
Total Income	**925,331**	**858,119**
Expenses		
Salaries and Wages	682,627	626,380
Awards	33,956	37,818
Defined Benefit Superannuation	20,370	18,143
Defined Contribution Superannuation	55,775	51,053
Long Service Leave	27,142	23,601
Annual Leave	68,875	65,962
Sick Leave and Other Leave		
Redundancies	(25)	1,189
Workers Compensation Insurance	15,972	15,623
Fringe Benefits Tax	269	207
Grants & Subsidies	20,370	18,143
Total Expenses	**925,331**	**858,119**
Result For The Year	**-**	**-**

The accompanying notes form part of these Financial Statements.

Balance Sheet of Hunter New England Area Health Service
Special Purpose Service Entity as at 30 June 2008

	Notes	2,008 $000	2,007 $000
ASSETS			
Current Assets			
Receivables	2	295,231	276,288
Total Current Assets		**295,231**	**276,288**
Non-Current Assets			
Receivables	2	6,911	5,915
Total Non-Current Assets		**6,911**	**5,915**
Total Assets		**302,142**	**282,203**
LIABILITIES			
Current Liabilities			
Payables	3	25,598	22,143
Provisions	4	269,633	254,145
Total Current Liabilities		**295,231**	**276,288**
Non-Current Liabilities			
Provisions	4	6,911	5,915
Total Non-Current Liabilities		**6,911**	**5,915**
Total Liabilities		**302,142**	**282,203**
Net Assets		**0**	**0**
EQUITY			
Accumulated funds			
Total Equity		**0**	**0**

The accompanying notes form part of these Financial Statements

Statement of Recognised Income and Expense of Hunter New England Area Health Service Special Purpose Service Entity for the Year Ended 30 June 2008

	2008 $000	2007 $000
Total Income and Expense Recognised Directly in Equity		
Result for the Year		
Total Income and Expense Recognised for the year		

The accompanying notes form part of these Financial Statements

Cash Flow Statement of Hunter New England Area Health Service Special Purpose Service Entity for the Year Ended 30 June 2008

	2008 $000	2007 $000
Net Cash Flows from Operating Activities	0	0
Net Cash Flows from Investing Activities	0	0
Net Cash Flows from Financing Activities	0	0
Net Increase/(Decrease) in Cash	0	0
Closing Cash and Cash Equivalents	0	0

The Hunter New England Special Purpose Service Entity does not hold any cash or cash equivalent assets and therefore there are nil cash flows.

The accompanying notes form part of these Financial Statements.

Hunter New England Area Health Service Special Purpose Service Entity
Notes to and forming part of the Financial Statements
for the Year Ended 30 June 2008

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

a) Hunter New England Area Health Services Special Purpose Entity

The Hunter New England Special Purpose Service Entity *"the Entity"* , is a Division of the Government Service, established pursuant to Part 2 of Schedule 1 to the Public Sector Employment and Management Act 2002 and amendment of the Health Services Act 1997. It is a not-for-profit entity as profit is not its principal objective. It is consolidated as part of the NSW Total State Sector Accounts. It is domiciled in Australia and its principal office is at New Lambton, New South Wales.

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

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

The financial report was authorised for issue by the Chief Executive Officer on **Monday 10th November, 2008.**

b) Basis of Preparation

This is a general purpose financial report prepared in accordance with the requirements of Australian Accounting Standards, the requirements of the Health Services Act 1997 and its regulations including observation of the Accounts and Audit Determination for Area Health Services and Public Hospitals.

Generally, the historical cost basis of accounting has been adopted and the financial report does not take into account changing money values or current valuations. However, certain provisions are measured at fair value. See note (j).

The accrual basis of accounting has been adopted in the preparation of the financial report, except for cash flow information.

Management's judgements, key assumptions and estimates are disclosed in the relevant notes to the financial report.

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

c) Comparative Information

The financial statements and notes comply with Australian Accounting Standards which include AEIFRS. Comparative figures are, where appropriate, reclassified to give meaningful comparison with the current year.

d) New Australian Accounting Standards Issued But Not Effective

No new or revised accounting standards or interpretations are adopted earlier than their prescribed date of application. Set out below are changes to be effected, their date of application and the possible impact on the financial report of the Hunter New England Special Purpose Service Entity

e) Income

Income is measured at the fair value of the consideration received or receivable. Revenue from the rendering of personnel services is recognised when the service is provided and only to the extent that the associated recoverable expenses are recognised.

f) Receivables

A receivable is recognised when it is probable that the future cash inflows associated with it will be realised and it has a value that can be measured reliably. It is derecognised when the contractual or other rights to future cash flows from it expire or are transferred.

Receivables are non-derivative financial assets with fixed or deteminable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the operating statement when impaired, derecognised or through the amortisation process.

Short term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

If there is objective evidence at year end that a receivable may not be collectable, its carrying amount is reduced by means of an allowance for impairment and the resulting loss is recognised in the income statement. Receivables are monitored during the year and bad debts are written off against the allowance when they are determined to be irrecoverable. Any other loss or gain arising when a receivable is derecognised is also recognised in the income statement.

g) Impairment of Financial Assets

As both receivables and payables are measured at fair value through profit and loss there is no need for annual reviews for impairment.

h) De-recognition of Financial Assets and Financial Liabilities

A financial asset is derecognised when the contractual rights to the cash flows from the financial assets expire; or if the agency transfers the financial asset:

* where substantially all the risks and rewards have been transferred; or
* where the Entity has not transferred substantially all the risks and rewards, if the Entity has not retained control.

Where the Entity has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the Entity's continuing involvement in the asset

A financial liability is derecognised when the obligation specified in the contract is discharged or cancelled or expires.

i) Payables

Payables include accrued wages, salaries and related on costs (such as payroll deduction liability, payroll tax, fringe benefits tax and workers' compensation insurance) where there is certainty as to the amount and timing of settlement.

A payable is recognised when a present obligation arises under a contract or otherwise. It is derecognised when the obligation expires or is discharged, cancelled or submitted.

Payables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method. Short term payables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial. Payables are recognised for amounts to be paid in the future for goods and services received, whether or not billed to the Entity.

j) Employee Benefit Provisions and Expenses

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

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

All Annual Leave employee benefits are reported as "*Current*" as there is an unconditional right to payment. Current liabilities are then classified as "*Short Term*" and "Long Term" based on past trends and known resignations and retirements. Anticipated payments to be made in the next 12 months are reported as "*Short Term*". On costs of 17% are applied to the value of leave payable at 30 June 2008, such on costs being consistent with actuarial assessment. (comparable costs for 30 June 2007 were 21.7% which, in addition to the 17% increase, also included the impact of awards immediately payable at 30 June 2007).

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

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

ii) Long Service Leave and Superannuation

Long Service Leave employee leave entitlements are dissected as "Current" if there is an unconditional right to payment and "Non-Current" if the entitlements are conditional. Current entitlements are further dissected between "Short Term" and "Long Term" on the basis of anticipated payments for the next 12 months. This in turn is based on past trends and known resignations and retirements.

Long Service Leave provisions are measured on a short hand basis at an escalated rate of 8.1% above the salary rates immediately payable at 30 June 2008 (also 8.1% at 30 June 2007) for all employees with five or more years of service. Actuarial assessment has found that this measurement technique produces results not materially different from the estimate determined by using the present value basis of measurement.

The Entity's liability for the closed superannuation pool schemes (State Authorities Superannuation Scheme and State Superannuation Scheme) is assumed by the Crown Entity. The Entity accounts for the liability as having been extinguished resulting in the amount assumed being shown as part of the non-monetary revenue item described as "Acceptance by the Crown Entity of Employee benefits". Any liability attached to Superannuation Guarantee Charge cover is reported in Note 3, "Payables".

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

Notes to and forming part of the Financial Statements for the Year Ended 30 June 2008

	2008 $000	2,007 $000
2. RECEIVABLES		
Current		
Accrued Income - Personnel Services Provided	295,231	276,288
Non-Current		
Accrued Income - Personnel Services Provided	6,911	5,915
Total Receivables	**302,142**	**282,203**

Details regarding credit risks, liquidity risk and market risks are disclosed in Note 5

3. PAYABLES		
Current		
Accrued Salaries and Wages and On Costs	24019	17,623
Payroll deductions	1579	4,520
Total Payables	**25,598**	**22,143**

Details regarding credit risks, liquidity risk and market risk are disclosed in Note 5

4. PROVISIONS		
Current Benefits and Related On Costs		
Annual Leave - Short Term Benefit	62810	59,128
Annual Leave - Long Term Benefit	44923	42,825
Long Service Leave - Short Term Benefit	15015	13,880
Long Service Leave - Long Term Benefit	146885	138,312
Total Current Provisions	**269,633**	**254,145**
Non-Current Employee Benefits and Related On Costs		
Long Service Leave - Conditional	6911	5,915
Total Non-Current Provisions	**6,911**	**5,915**
Aggregate Benefits and Related On Costs		
Provision - Current	269,633	254,145
Provision - Non-Current	6,911	5,915
Accrued Salaries and Wages and On Costs	25,598	22,143
Total	**302,142**	**282,203**

Note 5 Financial Instruments

The Entity's financial instruments are outlined below. These financial instruments arise directly from the Entity's operations or are required to finance its operations. The Entity does not enter into or trade financial instruments, including derivative financial instruments for speculative purposes.

The Chief Executive has overall responsibility for the establishment and oversight of risk management and reviews and agrees policies for managing each of these risks. The Entity carries minimal risks within its operation as it carries only the value of employee provisions and accrued salaries and wages offset in full by accounts receivable from the Parent Entity. Risk management policies are established by the Parent Entity to identify and analyse the risk faced by the Entity, to set risk limits and controls and monitor risks. Compliance with policies is reviewed by the Audit Committee/Internal auditors of the Parent Entity on a continous basis.

a) **Financial Instruments Categories**

		Total carrying amounts as per the Balance Sheet	
		2008 $000	2007 $000
Financial Assets			
Receivables at Amortised Cost[1] (note 2)		302,142	282,203
Total Financial Assets		302,142	282,203
Financial Liabilities			
Class:	Category		
Payables (Note 3)[1]		25,598	22,143
Total Financial Liabilities		25,598	22,143

1Excludes statutory receivables and prepayments, i.e. not within the scope of AASB 7.

b) **Credit Risk**

Credit risk arises when there is the possibility of the Entity's debtors defaulting on their contractual obligations, resulting in a financial loss to the Entity. The maximum exposure to credit risk is generally represented by the carrying amount of the financial assets (net of any allowance for impairment).

Credit risk arises from financial assets of the Entity i.e receivables. No collateral is held by the Entity nor has it granted any financial guarantees.

Receivables - trade debtors

Receivables are restricted to accrued income for personnel services provided and employee leave provisions and are recognised as amounts receivable at balance date. The parent entity of the Hunter New England Health Service Special Purpose Service Entity is the sole debtor of the Entity and it is assessed that there is no risk of default. No accounts receivables are classified as "Past Due but not Impaired" or "Considered Impaired".

c) **Liquidity Risk**

Liquidity risk is the risk that the Entity will be unable to meet its payment obligations when they fall due. No such risk exists with the Entity not having any cash flows. All movements that occur in Payables are fully offset by an increase in Receivables from the Hunter New England Area Health Service parent entity.

d) **Market Risk**

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. The Entity's exposures to market risk are considered to be minimal and the Entity has no exposure to foreign currency risk and does not enter into commodity contracts.

Interest rate risk

Exposure to interest rate risk arises primarily through interest bearing liabilities.

However the Entity has no such liabilities and the interest rate is assessed as Nil. Similarly it is considered that the Entity is not exposed to other price risks.

e) **Fair Value**

Financial instruments are generally recognised at cost.

The amortised cost of financial instruments recognised in the balance sheet approximates fair value because of the short term nature of the financial instruments.

Note 6 Related Parties

The Hunter New England Area Health Service is deemed to control the Hunter New England Health Service Special accordance with Australian Accounting Standards. The controlling entity is incorporated under the Health Services Act 1997.
Transactions and balances in this financial report relate only to the Entity's function as provider of personnel services to the controlling entity. The Entity's total income is sourced from the Hunter New England Area H Cash receipts and payments are effected by the Hunter New England Health Service on the Entity's behalf.

Note 7 Post Balance Date Events

No post balance date events have occurred which warrant inclusion in this report.

END OF AUDITED FINANCIAL STATEMENTS