DEPARTMENT OF
HEALTH

Department of Health

Annual Report 2015-16

NORTHERN TERRITORY GOVERNMENT

www.health.nt.gov.au

Acknowledgement

The Department acknowledges the contributions of the many people who have assisted in the production of this report, providing content, images and their time. Images have come from many sources, with special acknowledgment to the Interactive Communications and Development Unit.

NORTHERN TERRITORY GOVERNMENT

DEPARTMENT OF HEALTH

Chief Executive Officer (Acting)

Postal Address:
PO Box 40596
CASUARINA NT 0811

The Honourable Natasha Fyles MLA
Minister for Health
Parliament House
DARWIN NT 0800

Dear Minister

RE: 2015-16 Department of Health Annual Report

I am pleased to present you with the 2015-16 Annual Report for the Department of Health. The report has been prepared in accordance with the provisions of section 28 of *the Public Sector Employment and Management Act* and section 12 of the *Financial Management Act*, for presentation to the Northern Territory Legislative Assembly.

The report provides information about the Northern Territory public health system and includes financial and non-financial reports for the:

- Department of Health
- Top End Health Service
- Central Australia Health Service

Pursuant to my responsibilities as an Accountable Officer under the *Public Sector Employment and Management Act*, *the Financial Management Act* and *the Information Act*, I advise that to the best of my knowledge and belief:

a) proper records of all transactions affecting the agency and its employees were kept and all employees under my control observe the provisions of the *Public Sector Employment and Management Act*, *the Financial Management Act*, *the Financial Management Regulations* and the Treasurer's Directions
b) procedures within the agency afford proper internal control, and a current description of such procedures is recorded in the Department's Accounting and Property Manual, which has been prepared and updated in accordance with the Financial Management Act
c) there is no indication of fraud, malpractice, major breaches of legislation or delegation, major error in, or omission from, the accounts and records
d) in accordance with the requirements of section 15 of the *Financial Management Act*, the internal audit capacity available to the agency was adequate and the results of all internal audits were reported to the Audit Committee and the Chief Executive
e) the financial statements included in this annual report have been prepared from proper accounts and records and are in accordance with the Treasurer's Directions
f) all Employment Instructions issued by the Commissioner for Public Employment have been satisfied
g) all public sector principles have been upheld and no significant failures to uphold them have occurred.

Yours sincerely

J. M. Anderson

Janet Anderson PSM
27 September 2016

Purpose of report

The Department of Health Annual Report 2015-16 provides detailed information about the Northern Territory (NT) Health System and its financial and non-financial performance for the 2015-16 year. It includes reports for the:

- Department of Health
- Top End Health Service
- Central Australia Health Service

All three entities report against their strategic plans and agreed budget program outputs with their associated key performance indicators.

Pursuant to section 28 of the *Public Sector Employment and Management Act* and section 12 of the *Financial Management Act*, the report has been prepared for the Minister of Health to submit to the NT Legislative Assembly. It has also been prepared to provide information to other stakeholders about the primary functions of the Department, the performance of the NT Health System and to report significant activities undertaken during the year. Other stakeholders include the healthcare industry, the community, other government agencies and employees.

Throughout this report the terms NT Health and NT Health System are used to describe the public health system in the Northern Territory and are inclusive of the Department of Health, Top End and Central Australia Health Services.

Under the current Administrative Arrangements the Department of Health has responsibility for administering 32 pieces of legislation, 23 Acts and nine Regulations. This legislation is listed in Appendix A.

Acknowledgement to traditional owners

The Department of Health respectfully acknowledges the traditional owners and custodians of the lands and seas on which we work. We show our recognition and respect for Aboriginal people, their culture, traditions and heritage by working towards improving Aboriginal health and wellbeing.

Throughout this report the term Aboriginal should be taken to include Torres Strait Islander people.

Publishing/Copyright and Contact

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Introduction

Chief Executive Officer's Report

Professor Len Notaras AM

Having spent over two years in the role of Chief Executive of the Department of Health I have been fortunate enough to have been party to what could reasonably be described as some of the most significant and exciting changes ever to occur in Territory health.

We have, of course, seen the establishment of two new health services, the Top End Health Service (TEHS) and the Central Australia Health Service (CAHS), which sit alongside the Department of Health. It is now two years since the *Health Service Act 2014* brought both the Services into existence. It is highly encouraging to note the pace with which the two services have continued to evolve.

Recently, I had the privilege of signing the 2016-17 Service Delivery Agreements (SDA) between the Department, as the System Manager, and the Chairs of both the TEHS and CAHS Boards. The SDAs detail the services that the Health Services will deliver, the funding for those services and the agreed performance measures. There is no doubt the seamless transition of almost all services from the Department to the new entities has played a significant part in the establishment of what are already two extremely robust health services.

I would like to thank Michael Kalimnios (Chief Operating Officer, TEHS), Sue Korner (Chief Operating Officer, CAHS) and their respective leadership teams, for their strong collaborative efforts over the last 12 months.

It isn't, however, just the development of the new Health Services that has made the last 12 months so exciting. One of the truly forward looking initiatives currently occurring is the construction of the 116-bed Palmerston Regional Hospital. Work is now well advanced on the $150 million project. Once fully operational in 2018, the Palmerston Regional Hospital will significantly reduce pressure on waiting times at Royal Darwin Hospital. It will also mean the people of Palmerston and Darwin's rural area will enjoy more timely access to hospital treatment. From our perspective we are concentrating on the commissioning phase of the new hospital to ensure that everything – including the staffing and equipment – is in place and ready for the first patients in 2018.

While work continues on this major initiative, the $64 million upgrade of Royal Darwin Hospital (RDH) has now passed the half-way mark. Once completed the upgrade will see enhanced paediatrics facilities, new out-patients and pre-admission services and a relocated allied health unit along with a new front entrance and lobby.

RDH is not the only Territory hospital being upgraded. Both Alice Springs Hospital (ASH) and Gove District Hospital (GDH) will benefit from major enhancement works funded in part by the Australian Government. GDH will receive a $10.7 million Emergency Department upgrade and ASH a $5.3m clinical services building.

Over and above the work occurring in our urban centres there is also plenty of activity in health facilities in the more remote corners of the Territory. The NT is currently managing $50 million in Federal funding for the construction of seven new remote health centres and the upgrading of three existing clinics.

We are currently moving towards a sweeping change on the information technology (IT) front with the development and implementation of a five year, $186 million program to replace our core clinical systems across the Northern Territory. This will be the largest ICT reform ever undertaken within the Northern Territory public sector. The Core Clinical Systems Renewal Program (CCSRP) will transform our service provision across the Territory allowing access to critical clinical information

at the point of service. The CCSRP will replace four existing and ageing clinical information systems with a single end-to-end information system. It will make the Territory the first jurisdiction in Australia where public health clinicians will be able to electronically access client records regardless of their geographic location.

In my role as Community Champion for the communities of Ramingining and Millingimbi I visited these two communities and witnessed first-hand not only the great work that our health staff undertake daily, but also the enthusiasm of community members for local initiatives that will provide economic and social benefits. Planning is underway on a range of exciting initiatives that will take shape in coming months. Participating in the community champion program has proven to be a rewarding experience for me and one that I shall remember for years to come.

Everything I have seen over the past 12 months has again affirmed that over 6500 staff across the NT public health system are our greatest asset and the reason Territorians continue to enjoy access to such a high level of health care. This is confirmed for me every day; every time I visit a Territory health facility, no matter where it might be. In the context of the unique challenges of delivering health services in the Territory, the commitment and professionalism of staff shines through, and deserves acknowledgement.

With respect to the achievements of our staff I would like to list some of the highlights over the year in review:

Local and national awards won by staff in 2015-16 include:

Clinical/Professional Recognition

- **2015 Fullbright postgraduate scholarship**
  Dr Robert Marshall
- **2016 Fullbright Professional Scholarship in Non-Profit Leadership**
  Hichem Demortier, NCCTRC
- **2015 Sidney Sax medal**
  Professor Len Notaras AM
- **2015 AIM NT Manager of the Year**
  Nicholas Coatsworth
- **Member of the Order of Australia, Australia Day Honours**
  Dr Brian Spain, RDH
- **2015 Menzies medallion**
  Dr Vicki Krause, Centre for Disease Control
- **2016 Guild Intern of the Year, Pharmacy Guild of Australia**
  Jessica Cahill, ASH
- **2016 Medal for Clinical Services in Rural and Remote Areas, Royal Australasian College of Physicians**
  Dr Stephen Brady, ASH
- **2015 Remote Health Professional of the Year, CRANAplus conference**
  Sandra McElligott, CAHS
- **Excellence in Mentoring, 2015 CRANAplus Conference**
  Pauline Rubin, CAHS
- **2015 Telstra Health RDAA-ACRRM Rural Registrar of the Year Award**
  Dr Sarah Koffmann
- **Aboriginal and Torres Strait Islander Health Medal of the Royal College of Surgeons**
  Dr Jacob Jacob, ASH
- **Advanced Accredited Practicing Dietician by Dietitians Association**
  Louise Moodie, RDH Dietetics Manager
- **2016 Australia's Midwife of the Year**
  Jenny Kenna, ASH

2015 Medical Education and Training Centre NT Junior Doctor and Clinical Educator of the Year Awards:

- **NT Junior Doctor of the Year**
  Dr Cameron Spenceley, ASH
- **NT Clinical Educator of the Year**
  Dr Mary Wicks, ASH

2015 NT ATSIHP Excellence awards:

- **New Practitioner Category**
  Kylie (Helen) Parry winner,
  Adelaide River Health Centre, TEHS
- **Remote Practitioner Category**
  Helen Lalara highly commended,
  Angurugu Health Centre, TEHS
- **Urban Practitioner Category**
  Natasha Tatipata, winner, Clinic 34

Training Awards

2016 GTNT Awards:

- **GTNT School Based Apprentice of the Year, GTNT Indigenous Apprentice of the Year**
  Allana Neave
- **GTNT Supervisor of 'he Year**
  Anthony Sievers, Manager Alcohol and Other Drugs

Leadership Achievements

- **2015 OCPE Future Leaders Graduates**
  Anita Maertens
  Brendon Sherratt
  Helen Judd
  Trish Pini

I would like to thank each and every one of you for your dedication and enthusiasm. I would also like to thank the Chair and members of the Top End and Central Australia Health Service Boards respectively for their willingness to work in a collaborative and productive manner with the Department during the last 12 months. Thank you also to our Non-Government Organisation partners who play such a vital role alongside public and private health services in meeting the community's health care needs.

The year in review was a time of tight fiscal challenges that required strategic expenditure decisions and disciplined management and performance monitoring across the public health system. 2016-17 will see a continuation of the need for all of us to be diligent in ensuring that we maximise the resources allocated to us and use them in an accountable, effective and efficient manner for the benefit of Territorians.

Chief Health Officer's Report

Professor Dinesh Arya

The Office of the Chief Health Officer (CHO) continues to experience a high level of activity in line with the statutory legislated and representational functions of the CHO. Collaboration within the NT and across other jurisdictions, along with representation on significant national committees is an essential function of the CHO and ensures that responses to public health and protection issues as well as disaster responses are seamlessly coordinated amongst day-to-day business.

In the role of Chief Health Officer I have worked closely with the Centre for Disease Control and Environmental Health branch across the domains of health protection and public health. Dr Vicki Krause and Mr Xavier Schobben have provided effective leadership in assisting with projects of public health significance. These have included specific projects in relation to immunisation, infectious disease control, environmental health and monitoring, water safety and possible contamination of food sources. These projects have required development of health solutions with cross-sector agency engagement and working with government and non-government health services, land councils, communities and other stakeholders.

Acting on identified elevated levels of minerals and chemicals in waterways has been another major project involving the CHO and cross-sector engagement. The Centre for Disease Control, Environmental Health, Department of Lands, Mines and Energy and Department of Primary Industry and Fisheries have worked together to investigate the human health impact of heavy metals that were identified in some waterways and aquatic life in the Borroloola region. This investigation resulted in a public health campaign about safe levels of consumption for fish and other aquatic life. Concern in relation to reports of elevated lead levels in children in some specific communities was investigated using a science-based methodology to explore potential causes and provide guidance for a population health approach to managing this problem. Dr Steven Skov provided effective leadership for both projects.

Per- and poly-fluoroalkyl substances (PFAs) are an emerging problem nationally and these chemicals have been found in waterways and aquatic species including Rapid and Ludmilla creeks. Environmental Health, in collaboration with a number of universities, and the Larrakia Nation is currently contributing to a national scientific based investigation. The Australian Defence Force, NT Airports and NT Emergencies Services are key partners along with other jurisdictions, agencies, stakeholders and community.

Infectious diseases issues are an ongoing concern for the CHO. Zika virus has gained a foothold internationally and I have worked closely with the Centre for Disease Control and the Entomology Branch to monitor for mosquito borne infectious diseases, working with other jurisdictions and the Australian government and engaging in prevention activities and responses.

I am proud to acknowledge that the NT has also taken a lead role in the control of a Syphilis outbreak, with NT experts contributing to the response across Northern Australia as well as making contributions towards the Communicable Disease National Framework and Implementation Plan.

With the Australian Government approving changes to regulation of cannabis cultivation, it is also timely to acknowledge the work of the Medicines and Poisons Control Unit and the Alcohol and Other Drugs Directorate, along with the Department of the Chief Minister. Together, we are working to predict and plan legislative changes to safeguard against potential dangers and anticipate requirements for medical use of cannabis.

The Chief Health Officer is also responsible for managing epidemics and pandemics, and planning is well underway to ensure that we are able to respond effectively to a potential influenza pandemic, should this occur.

Chief Nursing and Midwifery Officer's Report

Heather Keighley

A/Chief Nursing and Midwifery Officer

The Chief Nursing and Midwifery Officer (CNMO) provides NT wide professional leadership, advice and support to all nurses and midwives working in the NT, drawing on best practice and evidence based standards to continually build and improve the sustainability of the Territory's nursing and midwifery workforce. As the incoming incumbent into this position, I would like to acknowledge the work of Dr Robyn Aitken, who held this position from January 2014 until midway through this financial year. Dr Aitken is now the Executive Director, Clinical Support, Education and Public Health Services, and she continues to play a significant role in professional leadership for nurses and midwives.

The Office of the Chief Nursing and Midwifery Officer (OCNMO) works with the operational units of the Department of Health, Top End Health Service and Central Australia Health Service to improve service delivery within NT Health. Representing the nursing and midwifery profession locally, nationally and internationally, the OCNMO has jurisdictional links with other health service providers and is an important link between NT Health as the largest employer of nurses and midwives in the Territory and the tertiary education sector, locally and nationally.

Recognising Excellence in NT Nursing and Midwifery

Each year, the OCNMO works in partnership with key stakeholders to deliver the NT Nursing and Midwifery Excellence Awards. Now in its 13th year, these prestigious awards are a wonderful opportunity to recognise and reward excellence in nursing and midwifery.

Hosted during May 2016, these awards were celebrated with three main events: an official launch hosted in Alice Springs, a Professional Education Day (Symposium) and Gala Dinner, both hosted in Darwin.

Coinciding with the International Day of the Midwife on 5 May 2016, the official launch saw more than 100 people attend the event. Each category was strongly contested this year, making the task of determining the award finalists a difficult job for selection panels.

Celebrations continued on 7 May, where more than 400 nurses, midwives, their colleagues, friends and family travelled from across the Territory to witness the moment award recipients were announced. Thirteen awards were presented, all received by passionate and dedicated individuals who have gone beyond usual expectations to deliver excellent care to people living across the Territory.

Held at the Darwin Convention Centre on 9 May 2016, the Professional Education Day (Symposium): Colliding Cultures in Health Care, saw participants learn new strategies to operate safely and provide culturally-appropriate health care in the NT. Jointly sponsored by the NT Department of Health and the Australian Nursing and Midwifery Federation NT, this full-day professional development event focused on the challenges nurses and midwives face working in the multicultural, multilingual, and multidisciplinary NT environment. Participants were from a range of nursing and midwifery health disciplines and represented the Top End and Central Australia.

Diana Baseley – Nurse/Midwife of the Year

The Nursing and Midwifery Excellence Awards are the annual opportunity to reward outstanding achievements of nurses and midwives working across the NT. The award recipients this year were:

Award Category	Recipient
Nurse/Midwife of the Year	Diana Baseley: Maternity Unit, Alice Springs Hospital (CAHS)
NT Administrator's Medal for Lifetime Achievement in Nursing/Midwifery	Sandra McElligott: Remote Women's Health Educator (CAHS)
1st Year Graduate Nurse/Midwife of the Year	Ingrid Potgieter: Alice Springs Hospital (CAHS)
Excellence in Aged, Disability and Residential Nursing	Rosemary Jeffery: Alzheimer's Australia (NGO)
Excellence in Nursing/Midwifery Education, Research and Innovation	Gina Majid: Paediatrics Ward, Royal Darwin Hospital (TEHS)
Excellence in Enrolled Nursing	Kay Stevens: Rehabilitation Ward, Royal Darwin Hospital (TEHS)
Excellence in Nursing/Midwifery Hospital Care	Lea Davidson: Preventable Chronic Disease Unit, Alice Springs Hospital (CAHS)
Excellence in Nursing/Midwifery Leadership	Diana Baseley: Maternity Unit, Alice Springs Hospital (CAHS)
Excellence in Alcohol and Other Drugs Nursing	Kim Meighan: Alcohol and Other Drugs, Nhulunbuy (TEHS)
Excellence in Mental Health Nursing	Kym Richardson: Adult Community Mental Health (MHAT), Top End Mental Health Service (TEHS)
Excellence in Midwifery	Katie Michell: Midwifery and Women's Health Outreach Team, Yulara, (CAHS)
Excellence in Nursing/Midwifery Community Health	Emma Louise Corcoran: Flynn Drive Primary Health Care (CAHS)
Excellence in Remote Health Nursing/Midwifery	E. Ann Sanotti: Nyrippi Primary Health Care Clinic (CAHS)

Developing a Sustainable Workforce

Substantial progress has been made this year towards meeting the target of 25 nurse practitioners in the Territory by the end of the 2016 calendar year. At April 2016, 21 nurse practitioners were endorsed in the NT and an additional 12 Nurse Practitioner candidates are undertaking study. Of the currently endorsed Nurse Practitioner and Nurse Practitioner candidates, 16 are working remote, outreach remote or in Aboriginal Community Controlled Health Services. There are currently four designated Nurse Practitioners in NT Health and five positions currently being assessed for implementation. The OCNMO is supporting work implementation groups and developing the governance framework to comply with Nursing and Midwifery Board of Australia requirements for all Nurse Practitioners in the NT.

The OCNMO also maintained focus on streamlining processes to recruit new graduates with support provided in their first year of practice as a nurse or midwife. This year, 94 grants were awarded for the Nursing and Midwifery Studies Assistance and Grants Scheme, three of which were provided for the Ministerial Nurse Practitioner Scholarships. Overall, the grants totalled $95,170 and were used to support accredited postgraduate tertiary study in priority health areas, including primary health care, child health, chronic disease, renal, remote and Aboriginal health, mental health and midwifery. Aboriginal and non-Aboriginal Territorians were also supported to commence studies in undergraduate Bachelor of Nursing, Bachelor of Midwifery and Diploma of Enrolled Nursing courses.

With remote area nurses' safety and wellbeing front of mind, the OCNMO conducted a peer and stakeholder review to determine current issues and areas for improvement for nurses working in remote locations. The Department has now collated all feedback and is working with partners/service providers to identify and recommend changes.

Midwifery in the Northern Territory

Since September 2015, the OCNMO has been working on a national research project, commissioned by the Australian Health Ministers' Advisory Council (AHMAC) to evaluate cultural competence in maternity care for Aboriginal women. The project is raising awareness and organisational knowledge of cultural competence and provides guidance in cultural security of maternity services in Australia.

At the start of 2016, the OCNMO implemented a policy to improve access for Territory women to long acting reversible contraception. The OCNMO hosted an accredited workshop to support local nurses and midwives to develop advanced practice skills in this area.

Led by the OCNMO and in partnership with the University of South Australia and the Society for Ultrasound in Medicine, the NT is proactively involved in providing ultrasound training for midwives operating in remote services. A training workshop for new and currently accredited midwives is planned for November 2016 to improve access to this service for remote women and accurately estimate their date of birth.

In partnership with the National Perinatal Epidemiology and Statistics Unit the OCNMO hosted a workshop for maternity stakeholders in the NT to classify different maternity models of care. Two NT Hospitals, Alice Springs and Royal Darwin participated in the national pilot program for this system. For the first time in Australia, this will enable recording of maternity models of care, data that have not been captured before.

Jenny Kenna recipient of the Australia's Midwife of the Year award with her Award nominators Jarl and Chris Le Page and baby Thomas

Chief Psychiatrist's Report

Dr Peggy Brown

I was pleased to take up the part-time role of the NT Chief Psychiatrist in November 2015.

The focus of the role is to provide expert specialist advice to the Chief Executive Officer, NT Health Leaders, Health Services, Government and the private and non-government sector on the clinical care and treatment of persons with a mental illness, ensuring compliance with the *NT Mental Health and Related Services Act* and providing advice on mental health legislation. Working collaboratively with health services, my role is also to contribute to quality and safety programs relevant to mental health care and to monitor the standards of mental health care provided in the NT, in line with the System Manager function.

Areas of focus in the initial eight months have included contributions to the NT Law Reform Commission's review of the interaction between people with mental health issues and the criminal justice system, the Senate Inquiry into Indefinite Detention of People with Cognitive or Psychiatric Impairment, and consideration of the policy provisions underpinning mental health legislation changes around Australia over the past decade.

The approved procedures underpinning the implementation and administration of the *Mental Health and Related Services Act* have been recently updated and set the basis for the continued monitoring of compliance with the Act. I anticipate that monitoring of clinical standards and the effectiveness of quality and safety provisions within the mental health program will be an ongoing area of focus, along with performance monitoring arrangements in line with the System Manager role. Enhancing the input from those with lived experience of mental illness to policy and planning initiatives and emphasising cultural safety and security in service delivery will also be a priority.

I have been pleased to represent the NT in a range of national mental health forums and committees at a time of significant mental health reform nationally, and in particular to ensure that the issues of service delivery to rural and remote areas and to Aboriginal Territorians is given appropriate consideration at this level.

I would like to thank my colleagues for the very warm welcome they have extended to me in joining the mental health team in the Territory, and for their support as I have advanced my knowledge of the service system.

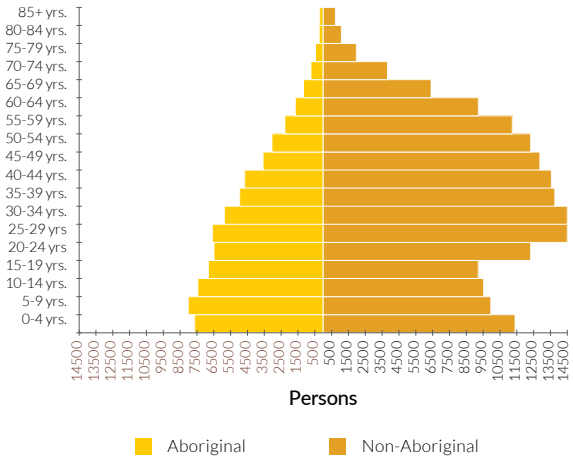
Delivering health in the NT context

Our Population

The NT has distinctive population characteristics compared with other Australian states. Geographically, the NT is the third largest of the states and territories, covering approximately 18% of the Australian land mass, yet it has only 1% of the national population. The population density of 0.2 people per square kilometre is the lowest of any state or territory. As of June 2015, the estimated resident population was 244,600, meaning that there was an annual growth rate of 0.4% since June 2014 which, in that year, was the lowest among states and territories. Over the previous five years the NT population increased by 13,020 (5.6%) with an average annual growth rate of 1.1%. The NT also has a relatively young population, with a median age of 32 years, compared with the national median age of 37 years. Males outnumber females, with 112 males for every 100 females.

Two further characteristics of the NT population are the high proportion of Aboriginal people and the geographic distribution of the population. There was estimated to be 71,870 Aboriginal residents, as of June 2015, which was 29.4% of the total NT population and 10.3% of the total Australian Aboriginal population. The geographic distribution of the Aboriginal population is different from the non-Aboriginal population. The highest proportion of Aboriginal residents (58.3%) lives in 'very remote' areas, including in discrete Aboriginal communities and regional towns. By contrast the majority of the non-Aboriginal population (71%) live in an area covering the greater Darwin area including Darwin city, Palmerston city and Litchfield Shire. The NT Aboriginal population is generally younger than the non-Aboriginal population (Figure 1).

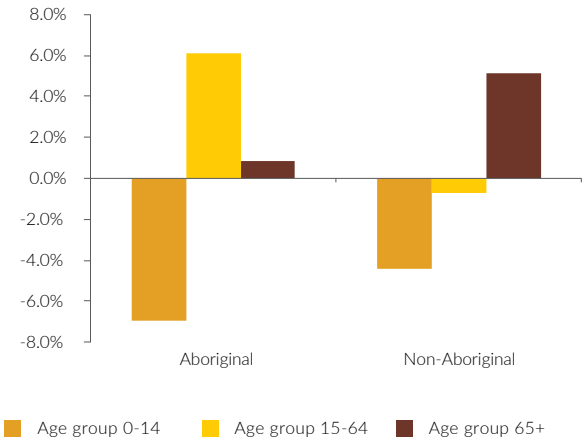
Figure 1: Population distribution by age group and Aboriginal status, Northern Territory, 2015



Source: Department of Health, 2015, 'Northern Territory Resident Population Estimates by Age, Sex, Indigenous Status and Health Districts (1971-2015)', prepared by Health Gains Planning. File updated on 20 June 2016, using ABS Estimated Resident Population.

While the NT has historically had the youngest population among all states and territories, falling fertility rates, improved life expectancy and reduced interstate migration has meant that the proportions of different age groups are changing. The proportion of NT persons aged 65 years and over increased from 3.0% in 1995 to 6.9% in 2015, an increase which is the greatest among all jurisdictions. By contrast, during the same period, the proportion of children aged less than 15 years fell in both the Aboriginal and non-Aboriginal populations (Figure 2).

Figure 2: Population change (%) by broad age group, NT Aboriginal and non-Aboriginal populations, 1995-2015



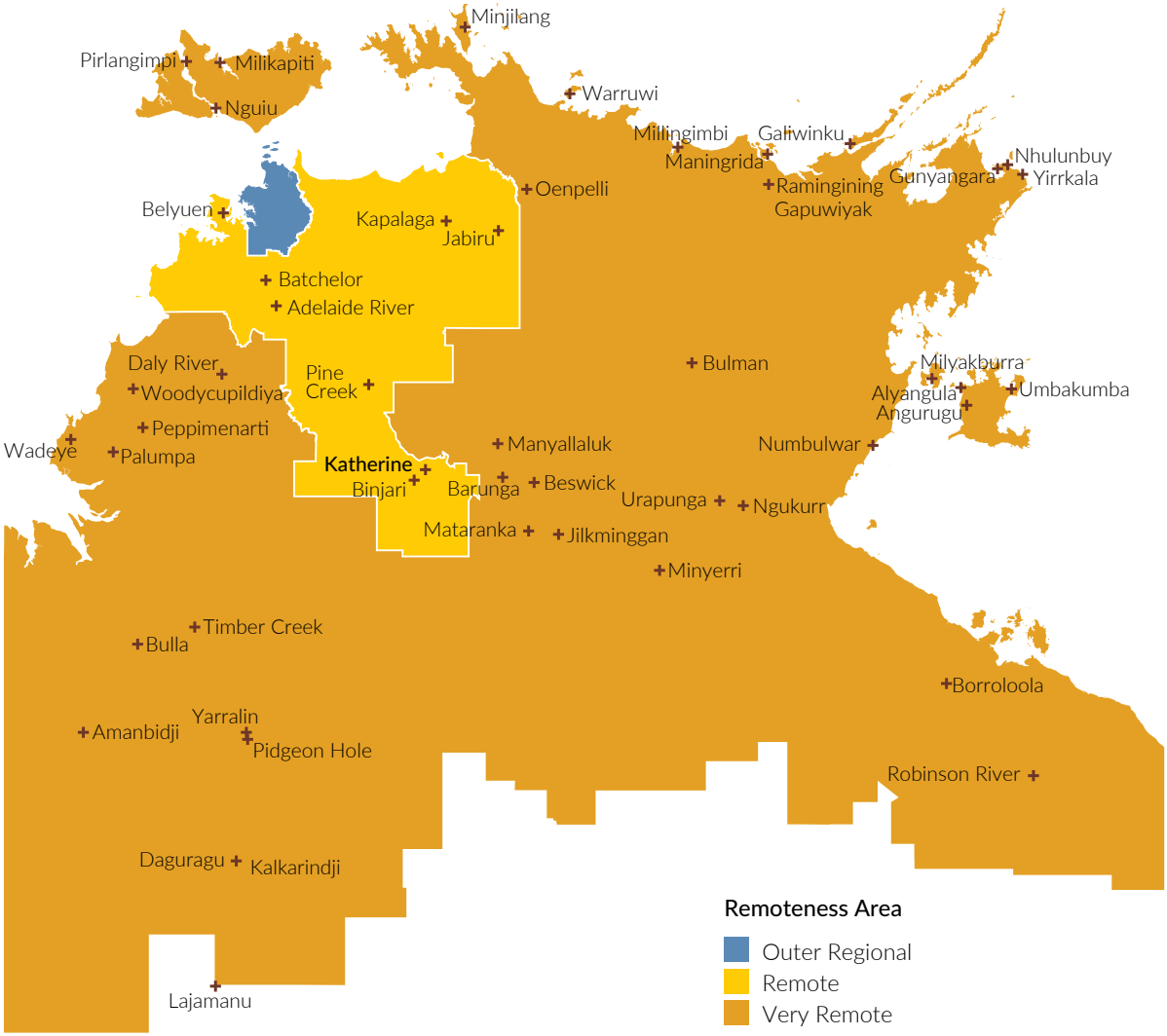
Source: Department of Health, 2015, 'Northern Territory Resident Population Estimates by Age, Sex, Indigenous Status and Health Districts (1971-2015)', prepared by Health Gains Planning. File updated on 20 June 2016, using ABS Estimated Resident Population.

NT health regions

Top End Health Service

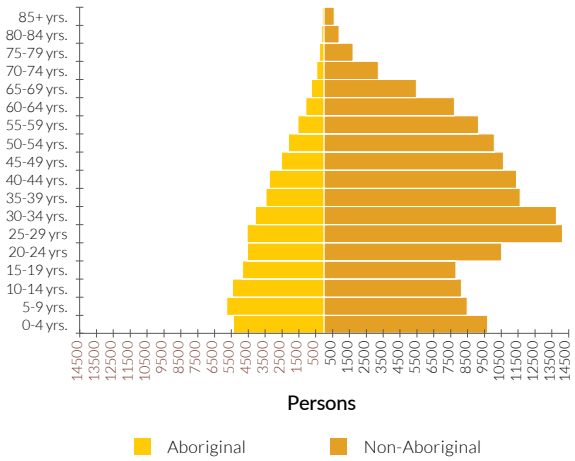
The TEHS region covers 35.3% (475,338 km²) of the total area of the Northern Territory. The TEHS region includes the Darwin, East Arnhem and Katherine districts. As of June 2015 the resident population of the TEHS region was 195,330, representing 80% of the total NT population. Almost three quarters (141,850, 72.6%) of TEHS residents reside within the Darwin Urban area, of which the majority are non-Aboriginal (89.2%). The distribution of the TEHS Aboriginal population varies within regions, with Darwin Rural (12,650, 79.1%) having the largest proportion, followed by East Arnhem (11,360, 66.0%), Katherine (11,010, 54.4%), and Darwin Urban (15,270, 10.8%).

Map 1: Top End Health Service (TEHS) region



Source: Department of Health, 2015. Map created using ABS 2011 Census Geography.

Figure 3: Top End Health Service - population distribution by age groups and Aboriginal status



Source: Department of Health, 2015, 'Northern Territory Resident Population Estimates by Age, Sex, Indigenous Status and Health Districts (1971-2015)', prepared by Health Gains Planning. File updated on 20 June 2016, using ABS Estimated Resident Population.

Figure 4: Central Australia Health Service - population distribution by age group and Aboriginal status

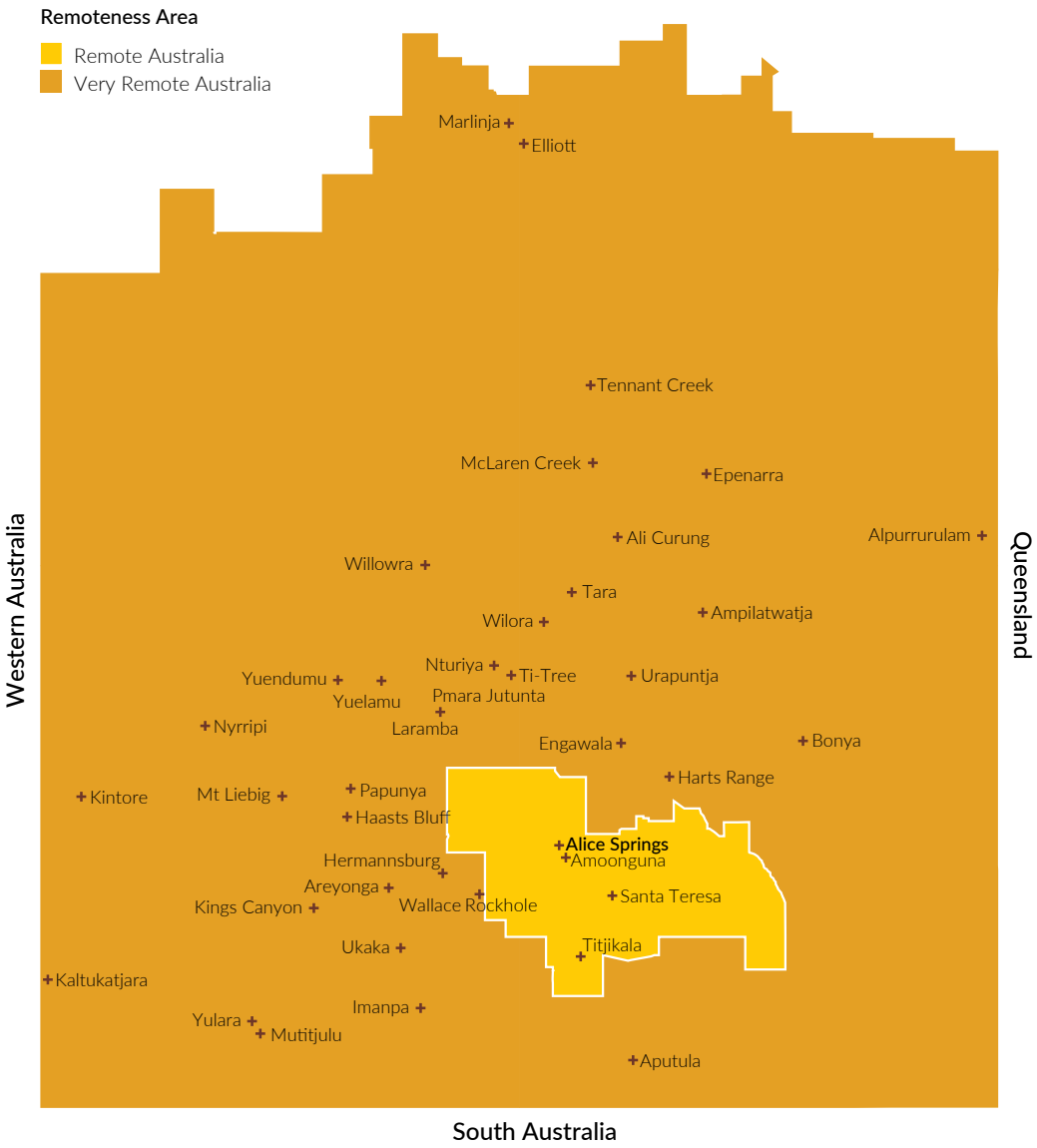
Source: Department of Health, 2015, 'Northern Territory Resident Population Estimates by Age, Sex, Indigenous Status and Health Districts (1971-2015)', prepared by Health Gains Planning. File updated on 20 June 2016, using ABS Estimated Resident Population.

Central Australia Health Service

The CAHS region covers two-thirds (64.7%) of the total area of the Northern Territory, and includes 20.1% of the total NT population. As of June 2015, the CAHS region had an estimated resident population of 49,270 people, of whom 43.8% (21,570) were Aboriginal. The majority of the non-Aboriginal CAHS population reside in Alice Springs (83.2%). Of Aboriginal residents, 48.1% live in discrete communities within the Alice Springs Rural area, 30.3% reside in the Alice Springs Urban area and the remaining 21.7% live in the Barkly area.

Map 2: Central Australia Health Service (CAHS) region

Source: Department of Health, 2015. Map created using ABS 2011 Census Geography.



Our Health

The health needs within a population are a result of a mixture of the age and sex profile of the population and are influenced by a number of potentially modifiable risk factors which impact on the development of various conditions. The health needs are then modified by access and quality of health care services. For the NT Aboriginal population in particular, a range of historical, social, economic and environmental factors contribute to increased health risks and poorer health outcomes. The following section provides recently available information on three important issues for the health of Territorians – key pregnancy measures (tobacco and alcohol use and low birth weight), early childhood development and the future demand for renal replacement therapy.

Tobacco and alcohol use in pregnancy and trends in low birth weight

Tobacco and alcohol use during pregnancy can have adverse health effects on women and infants. In the NT, smoking status during pregnancy is collected in the NT Midwives Collection. Smoking status is self-reported, and is recorded as having smoked during the first 20 weeks gestation and after 20 weeks gestation. Between 2000 and 2014, the proportion of NT Aboriginal mothers who reported smoking at any time during pregnancy increased by 5.8% to 2013 before a small decline in 2014 (Figure 5). While encouraging, it is too early to assess whether the 2014 result is a turning point ahead of a sustained reduction. For NT non Aboriginal mothers there has been a sustained decrease in smoking, with a total 11.6% reduction (Figure 5).

Self-reported alcohol consumption during pregnancy is collected at the first antenatal visit and again at 36 weeks gestation. The proportion of Aboriginal and non Aboriginal mothers who reported drinking alcohol at their first antenatal visit decreased between 2000 and 2014, with a reduction of 3% and 7.6% in the proportions respectively (Figure 6).

Low birth weight is defined as weight at birth of less than 2500 grams, and is associated with a range of short and long term adverse outcomes. During the period from 2000 to 2014, the proportion of low birth weight Aboriginal and non-Aboriginal babies has seen little changed at approximately 14% and 6% respectively (Figure 7).

Figure 5: Self-reported maternal smoking during pregnancy as a proportion of NT mothers, 2000 to 2014

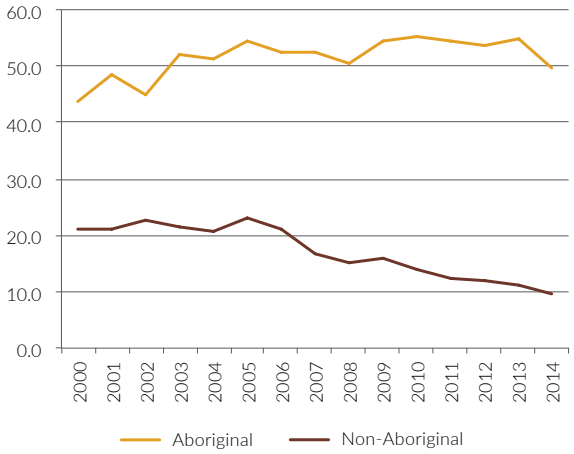


Figure 6: Self-reported maternal drinking during pregnancy, as a proportion of NT mothers, 2000 to 2014

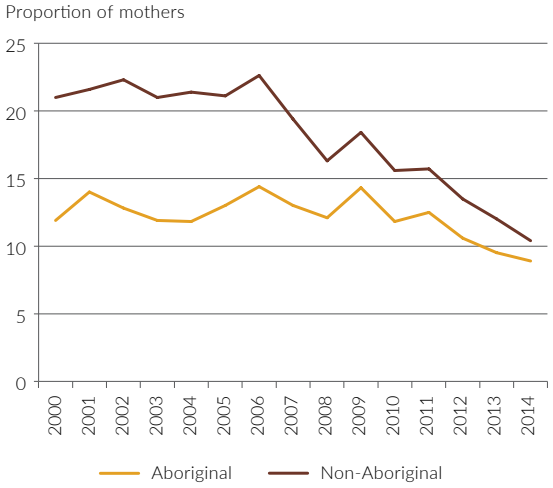
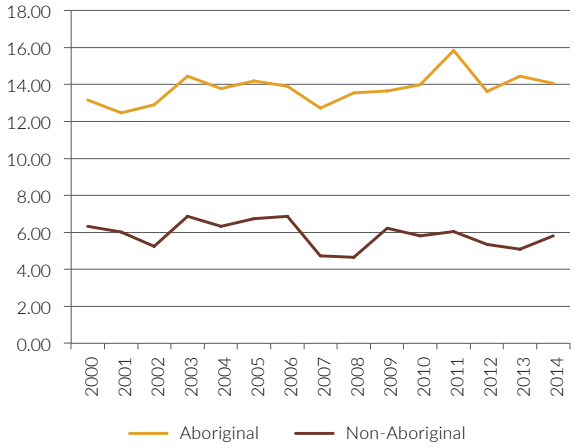


Figure 7: Proportion of low birth weight NT live born babies by Aboriginal status, 2000 to 2014



Childhood Developmental Outcomes

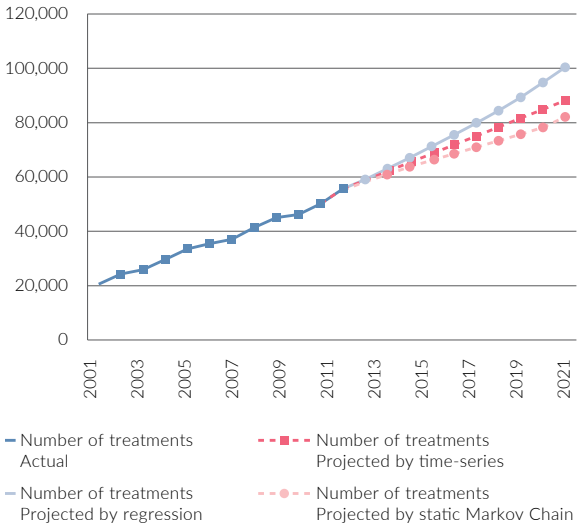
A range of social, individual, health and family factors influence early development of children. A new teacher rated measure of children's readiness for school, the Australian Early Development Census (AEDC), was introduced in 2009 for assessment of all Australian children in their first few months of school. The census is conducted every three years. The AEDC assesses five domains of a child's development including social, physical and cognitive development. A research project was undertaken as a collaboration between the Department of Health and Menzies School of Health Research, which examined the influence of fourteen separate explanatory factors on the AEDC results.

The results confirmed the substantial gap between NT Aboriginal and non-Aboriginal children, but more importantly highlighted that much of this difference is explained by the combination of health and social factors, such as gestational age, education level of the mother or whether a child had attended day care or pre-school. The results are important in informing initiatives to overcome disadvantage among all NT children through addressing modifiable risks such as optimising birth outcomes, access to early childhood programs and targeted support for young or poorly educated mothers. A study such as this also highlights the emerging capacity in the NT to examine a range of factors affecting childhood development through the linkage of administrative data sets. The investigators in the project have been given further approval to extend the study by also including hospital, primary care, youth justice, education and child protection data.

Renal Demand

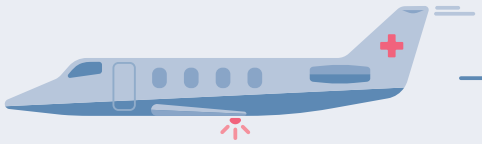
Across Australia, demand for renal replacement therapy services has been growing at a substantial rate over the last decade. Health service funders are faced with increasing service delivery costs and investment requirements. In the five-year period from 2007 to 2011, the number of dialysis patients increased by 27% in the NT. Same day haemodialysis (HD) now comprises close to 50% of total NT public hospital admissions and in recent years the number of NT patients with end-stage kidney disease (ESKD) using palliative care has doubled. From 2001 to 2012, the number of HD treatments in the NT increased, on average, by around 3,200 per year. In a NT Department of Health report, three separate methods were used to determine renal demand projections - linear regression, an autoregressive integrated moving average time series model and a static Markov chain model. The projections for the number of facility based HD treatments estimate a further increase of between 41% and 70% from 2013 to 2022. The projected average annual increase of HD treatments through this period ranged from 2,700 using the Markov chain model, through 3,300 using the time-series model, to 4,600 using the linear regression model (Figure 8). This type of projection analysis is not only important in planning future dialysis services but is also important in monitoring the effectiveness of a range of strategies to slow the development of end stage kidney disease through improved management of diabetes and high blood pressure in primary care services. The results also provide impetus for the long term goal of preventing end stage kidney disease.

Figure 8: Demand projections for facility-based haemodialysis treatments, using three statistical models, NT 2013 - 2022



Source: You JQ et al. Renal Replacement Therapy Demand Study, Northern Territory, 2001 to 2022, Department of Health, Darwin, 2015

NT Health Snapshot

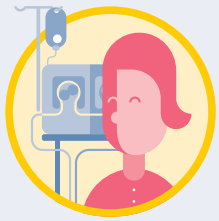


Number of public hospital admissions (excluding dialysis)

74,168

Number of emergency department presentations

144,517



Number of episodes of haemodialysis

74,191

Number of babies born

3,331

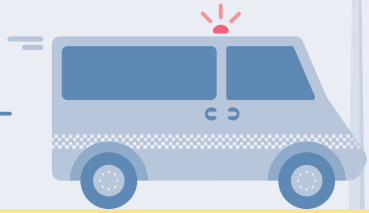
Number of heart attacks

540

Number of admissions for injuries and poisonings

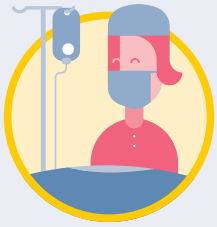
10,976

Number of episodes of Telehealth *provider only | **2,207**



Number of patients attended by St John Ambulance — **46,614**

Number of aeromedical retrievals | **5,496**



Number of gall bladders removed (cholecystectomies)

1,333

Number of admissions with diagnosis of Chronic Obstructive Pulmonary Disease (COPD)

1,125

Number of admissions with mental health diagnosis

3,282

Number of admissions involving a surgical procedure

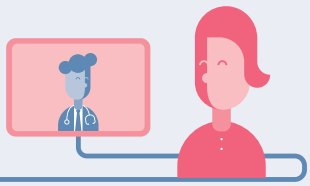
12,931

Number of pathology tests

1,427,094

Number of NT residents enrolled in national My Health Record

37,535



Number of specialist outreach services provided to remote communities

6,852

The Northern Territory Health System

Since 1 July 2014, the public health system in the Northern Territory has comprised three entities: the Department of Health as System Manager, the Top End Health Service (TEHS) and the Central Australia Health Service (CAHS). The purchaser/provider model of health service delivery is still evolving in the Northern Territory, as responsibilities for a range of public health programs and activities transition to the health services where local decisions and knowledge will guide and lead improved service delivery and better client outcomes.

The NT Health System is challenged by demographic and geographic factors which include:

- Large, sparsely populated areas
- High levels of chronic disease and co-morbidity
- An ageing population and the accompanying burden of disease
- Social and economic disadvantage with particular links to remoteness

The NT Health System covers 1.35 million square kilometres and employs approximately 6648 staff (Full Time Equivalent as at 30 June 2016).

Over 43% of the NT population reside in remote or very remote areas. There are over 600 communities and remote outstations in the NT, all with small populations, and the system experiences high fixed and unit costs associated with the challenges of the above factors.

There are 85 remote primary health care centres, 52 of which are operated by the NT Government and 33 by Aboriginal Community Controlled Health Organisations.

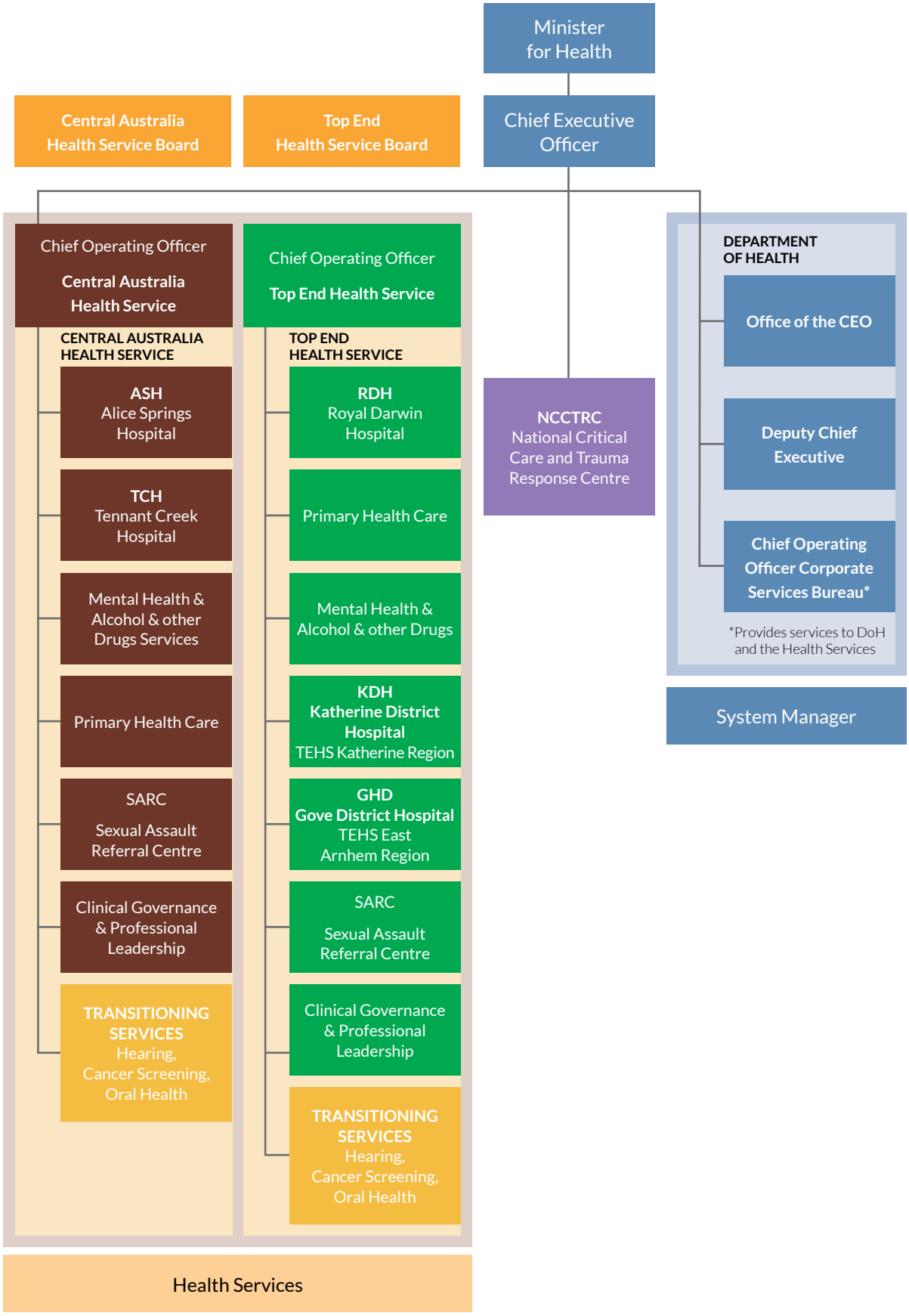
The overall development, management and performance of the public health system in the NT is the responsibility of the Department of Health. As System Manager, the Department is responsible for Territory wide system planning, capital works and monitoring/managing the performance of the Health Services and the public health system as a whole. The Department is also responsible for policy advice and intergovernmental relations.

Each Health Service is an autonomous entity responsible for the provision of health services as set out in its Service Delivery Agreement with the Department. The two Health Services are each governed by a Health Service Board and are accountable to the Chief Executive Officer NT Department of Health through SDAs and regular performance reporting. The Health Services and the Department are working collaboratively to build a cohesive and integrated health system that meets the needs of Territorians and to achieve better health outcomes.

Further devolution, structural and governance changes will occur in 2016-17, with the following services transitioning from the Department to the Health Services:

- Oral Health Services
- Hearing Health Services
- Cancer Screening Services

Department of Health Functional Chart



Our leaders

Professor Len Notaras AM

Chief Executive Officer

Professor Len Notaras AM is the Chief Executive Officer of the NT Department of Health, the largest single employer in the Northern Territory. He was appointed to this position in April 2014, having spent the previous five years as Executive Director of the National Critical Care and Trauma Response Centre (NCCTRC). Professor Notaras was a strategic founder of the centre, and retains overarching responsibility for the organisation.

Prior to this, Professor Notaras spent 15 years at RDH, first as Medical Superintendent (1994-2001) and then as General Manager (2001-2009). During this time, RDH dealt with a number of crises, including the evacuation of East Timor in 1999, the Bali bombings in 2002, the 2004 Indian Ocean tsunami, the Ashmore Reef incident in 2009 and the retrieval and treatment of then President of Timor-Leste Dr Jose Ramos-Horta following the assassination attempt on his life in 2008. In 2002, RDH received nearly 100 victims of the Bali bombings, 70 of whom were critically injured. For his service in jointly coordinating the medical assistance provided by the RDH to the victims of the bombings, Professor Notaras was appointed a Member of the Order of Australia in 2003.

Professor Notaras holds a Bachelor of Medicine, Bachelor of Law and Arts, Bachelor of Commerce, Masters in History and Masters in Hospital Management. In 2005, Professor Notaras was presented with the Best Individual Contribution to HealthCare in Australia Award during the AMA National Conference.

In 2010, Professor Notaras negotiated and coordinated the NCCTRC deployment of the Australian Medical Assistance Team (AUSMAT) to Pakistan following devastating floods. The group treated more than 11,000 people during the 10 week deployment. Professor Notaras led the NCCTRC through the AUSMAT response to Typhoon Haiyan which devastated part of the Philippines in November 2013.

In 2008 Professor Notaras received an honorary doctorate in Science from Charles Darwin University in recognition of his contribution to the medical field in the NT and in 2015, he was honoured by Flinders University with the title of professorial fellow in the faculty of Medicine, Nursing and Health Sciences.

Professor Notaras was directly involved in the development of the NT Clinical School, and, as a member of the NT Medical Board and former Chair of the NT Pharmacy Board, played a key role in negotiating changes to legislation. Professor Notaras was Chair of the NT Radiographers Board, an inaugural member of the Australian Council for Safety and Quality in healthcare, and a long serving board member of Australia's premier health care standards organisation, the Australian Council on Healthcare Standards. In 2015, Professor Notaras was awarded the Prestigious Sidney Sax Medal for his contribution to healthcare in the NT and Australia.

Janet Anderson

Deputy Chief Executive

Janet Anderson was appointed as the Deputy Chief Executive of the NT Department of Health in November 2015. Janet has worked in the public health sector for over 25 years and has held executive positions at regional, state and Commonwealth levels. Immediately before coming to the NT, she spent nearly four years as First Assistant Secretary in the Commonwealth Department of Health, with responsibility for acute care policy, planning and service development. Prior to that, Janet worked in the New South Wales Department of Health, filling executive roles with responsibilities spanning primary health care, community engagement, strategic planning, funding strategies and inter-government relations. In 2009, Janet was awarded the Public Service Medal (in the Australian Honours system) for her contributions to health policy.

Lisa Watson

Chief Operating Officer

Corporate Services Bureau

Lisa Watson commenced with the Department of Health in August 2015. With a career spanning 20 years in the NT Public Service in Alice Springs and Darwin, Lisa has held Senior Executive Management roles at Power and Water Corporation, Department of Housing and Department of Infrastructure. Lisa has led various corporate services branches, implementing shared service delivery models with a strong focus on customer service and corporate governance.

Lisa's experience is supported by a Bachelor of Business Management and certification in Prosci's Change Management Methodology. Lisa is a Graduate of the University of Adelaide's Professional Management Program, and has also undertaken the Australian Institute of Company Directors Course.

Michael Kalimnios

Chief Operating Officer
Top End Health Service

Michael Kalimnios commenced as Chief Operating Officer (COO) in TEHS in January 2015. Prior to this role, Michael was the Chief Finance Officer and Acting Executive Director, Funding, Performance and Corporate with the Department of Health since November 2012. Michael is a Chartered Accountant and has worked in senior roles within the public health sector for more than twenty years.

Sue Korner

Chief Operating Officer
Central Australia Health Service

Sue Korner is a long term Alice Springs local with a wealth of experience having worked in leadership roles in the health sector – including acute, public health and primary health care – in Central Australia for more than 29 years. Sue brings to the role a strong understanding of the health care needs and expectations of Central Australians. Appointed to the role of COO Central Australia Health Service in September 2014, Sue has responsibility for ensuring successful health service delivery in Central Australia. Prior to moving into the role of COO, Sue was Acting Chief Executive Officer (CEO) of the Northern Territory Medicare Local. She has held a number of senior positions within the Department of Health including Central Australia Health Services Regional Director, and served as CEO for the Central Australia Division of Primary Health Care and also as CEO of General Practice Network Northern Territory. Sue was a member of the Central Australia Hospital Network Governing Council and the CAHS Board until her appointment as COO. She is a graduate of the Northern Territory University NT Public Sector Executive Management Program and is a member of the Australian Institute of Company Directors.

Department of Health

Overview of the Department

Our Vision

Healthy Territorians engaged and living in healthy communities

Our Mission

We promote, protect and improve the health and wellbeing of all Territorians in partnership with individuals, families and the community

Our Values

We are driven by public service values: commitment to service, ethical practice, respect, accountability, impartiality and diversity

Our Role

The Department has a key leadership role in shaping and enhancing the performance outcomes of the NT Health System. The Department works closely with Top End and Central Australia Health Services to better integrate and coordinate patient care, to facilitate greater local control and decision making and to drive greater efficiency and effectiveness in our public hospitals and primary health care. The Department sets the service standards for the health services against which performance is monitored. This lead role is consistent with the National Health Reform Agreement which requires all jurisdictions to establish system managers with system wide responsibilities. The Department is responsible for territory wide health planning, managing capital works, developing system wide policy and for the collection and reporting on the performance of the public health system.

The Department is represented on a number of national and interjurisdictional committees and working groups including the Australian Health Ministers' Advisory Council and Principal Committees and contributes to national discussions on health reform. The Department is also a member of the Australian Commission on Safety and Quality in Health Care interjurisdictional committee, the Greater Northern Australia Training Network, the Northern Territory Aboriginal Health Forum and the North Australia Health Round Table.

Our Structure

The structure of the Department is still evolving as it continues to transition to the health service purchaser/provider delivery model for the NT. In 2015-16, the Department created the new senior executive role of Deputy Chief Executive.

In addition, the position of Executive Director, Corporate Support Bureau, was retitled to Chief Operating Officer, Corporate Support Bureau.

These positions are integral to the role of Health System Manager and support the health service framework and purchaser-provider model of health service delivery.

At the end of the 2015-16 year the Department's functional units include:

- The Office of the Chief Executive
- The Office of the Deputy Chief Executive
- Corporate Services Bureau
- Clinical Support, Education and Public Health Services
- Policy, Strategy and Performance
- Territory Wide Services
- National Critical Care and Trauma Response Centre

Office of the Chief Executive

The Office of the Chief Executive plays a vital role in providing high level executive support services and coordination of information and activities across the Agency, with the Minister's Office and other key external stakeholders. These services are delivered through the Executive Services Division.

It consists of the following functions:

- Legal Services
- Risk and Audit
- Ministerial Liaison
- Media and Corporate Communications
- Disaster Coordination
- Information and Privacy

Office of the Deputy Chief Executive

The Deputy Chief Executive's (DCE) portfolio has a key leadership role in shaping and enhancing the performance outcomes of the Northern Territory (NT) Health System. The DCE's portfolio works closely with Top End and Central Australia Health Services to plan services and better integrate and coordinate patient care, and to drive greater efficiency and effectiveness in our public hospitals and primary health care.

The DCE portfolio currently comprises the following areas:

- Clinical Support, Education and Public Health Services Division
- Office of Aboriginal Health Policy and Engagement

- Office of Disability
- Strategy and Reform
- Territory Wide Services.

Corporate Services Bureau

The Corporate Services Bureau (CSB) is a client focussed provider of corporate functions supporting the Health Services and System Manager in the delivery of improved health outcomes. The CSB provides strategic leadership and service delivery of centralised corporate support functions to its clients, with an emphasis on efficiency, innovation and service excellence.

It consists of the following functions:

- Data Management and System Reporting
- Financial Services, including Activity Based Funding and Pensioner and Carer Concession Scheme
- Strategic Procurement and Contracting
- Human Resources Management
- Information Systems and Services
- Infrastructure Services, including Corporate Support Services
- Grants Management

Clinical Support, Education and Public Health Services

The Clinical Support, Education and Public Health Services division comprises a range of functions including clinical system-wide policies and strategies, health workforce reform, disease control, environmental health, mental health and alcohol and other drugs.

It consists of the following functions:

- Chief Health Officer/Chief Medical Officer
  - Centre for Disease Control
  - Environmental Health
  - Medical Education and Training Centre
  - Clinical Policy and Strategy
  - Clinical Safety and Quality
  - Principal Allied Health Advisor
- Office of the Chief Nursing and Midwifery Officer
- Office of the Chief Psychiatrist
  - Mental Health Directorate
  - Alcohol and Other Drugs Directorate

Policy, Strategy and Performance

Policy, Strategy and Performance contains functions that support and align with health system reform and performance.

It consists of the following functions:

- Aboriginal Health Policy and Engagement
- Population Needs, Health Gains Planning and Evaluation
- System Performance
- Commissioning Service Innovation/Reform
- Strategic Policy and Intergovernmental Relations

Territory Wide Services

Territory Wide Services encompasses a range of primary health care and specialist services across urban and remote settings, including oral health, hearing health and cancer screening services. It also includes policy and strategy units addressing men's health, women's health, child and youth health, nutrition and physical activity, chronic conditions and health promotion.

It consists of the following functions:

- Office of Disability
- Office of the Public Guardian[#]
- Health Development
- Cancer Screening*
- Oral Health*
- Hearing Health*
- Urban Primary Health Care grants

[#] The Office of the Public Guardian is being transferred to an independent office

* Cancer Screening, Oral Health and Hearing Health services are in the process of transitioning to the Health Services.

National Critical Care and Trauma Response Centre

The National Critical Care and Trauma Response Centre is a key element of the Australian Government's disaster and emergency medical response to incidents of national and international significance. The NCCTRC is focused on enhancing Australia's capacity to provide clinical and academic leadership in disaster and trauma care and provides internationally unique education, training and exercising capacity. The NCCTRC also supports an enhanced surge capacity for RDH to provide a rapid response in the event of a mass casualty incident in the region. The RDH Trauma Service, managed by the NCCTRC, maintains level two accreditation from the Royal Australian College of Surgeons, while contributing to locally and nationally relevant research projects.

NT Health Strategic Plan

NT Health Strategic Planning Framework

The Northern Territory's public health system is informed and guided by the Northern Territory Health Strategic Plan 2014-17 and the Northern Territory Government's *Framing the Future* document. *Framing the Future* seeks to build a 'Strong Society'; a society that values an individual's right to freedom and equitable access, that supports the most vulnerable and is safe for all. The Department and Health Services are working together to build a strong health system that will support the most health vulnerable members of our society and facilitate expanded health services and access. The NT Health Strategic Plan recognises the unique features and challenges of health service delivery in the Northern Territory and articulates the health priorities. The seven priorities for the NT Health System are:

1. Promote and protect health and wellbeing

Encourage the adoption of healthy behaviours, controlling the spread of disease, preventing harm and injury and working across sectors to influence the social determinants of health.

2. Deliver appropriate care to vulnerable people and populations

Improving health outcomes for people and populations who are vulnerable using a holistic, person centred approach across the lifespan.

3. Improve Aboriginal health outcomes

Closing the gap in health and wellbeing between Aboriginal and non-Aboriginal Australians.

4. Better coordinate care and integrate care

Integrating planning and service provision to improve pathways of care for patients and consistency in health standards and delivery.

5. Strive for clinical and corporate excellence

Driving a systematic, evidence based approach to maintaining and improving the quality and safety of patient care underpinned by transparent, accountable and effective clinical and corporate governance structures.

6. Build a highly skilled and culturally responsive workforce

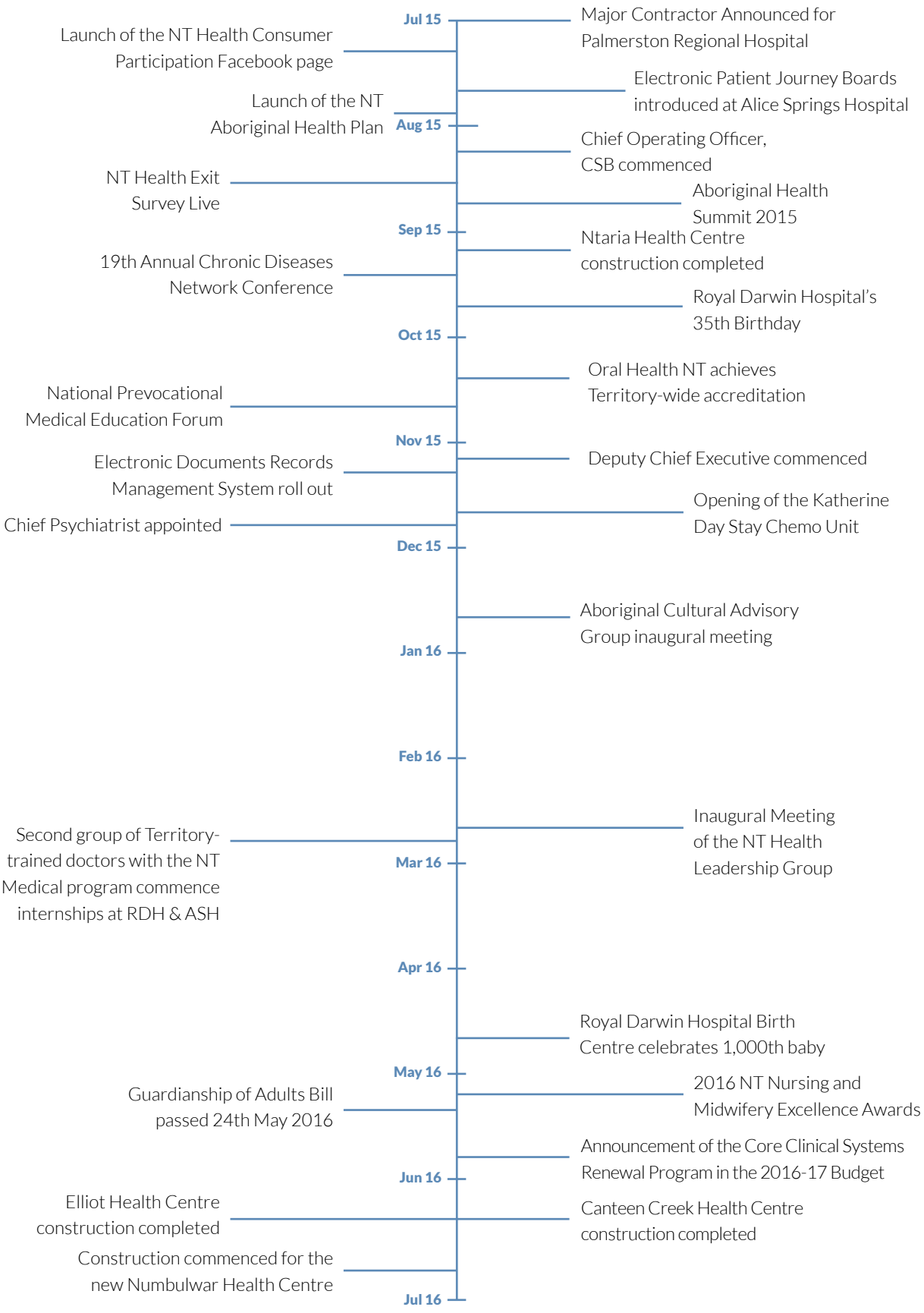
Building local capacity and strategically recruit, develop and retain a culturally safe and highly skilled health workforce.

7. Drive financial sustainability

Putting the health system on a path to financial sustainability through the provision of efficient, appropriate and cost effective services.

The NT faces unique challenges in health service delivery. It has one of the highest infant mortality rates in Australia and is confronted every day by the tyranny of distance. Similar to national and international trends, the NT deals with an increased burden of chronic diseases in society, and a shift from acute care on an episodic basis to the management of chronic, complex health conditions. Technology will continue to provide new ways to deliver health services and potentially to mitigate cost challenges. Improved integration and coordination of care is a high priority, supported by contemporary clinical systems. It is clear that an adaptive approach is needed: to shape policy, revisit funding models, review regulatory provisions and identify community driven tailored solutions, in order to meet current and future community and consumer needs.

NT Health 2015-16 Highlights



Highlights

Core Clinical System Renewal Program

An announcement and funding to replace four ageing health information systems with one integrated fit for purpose system has been welcomed by all health practitioners. The Northern Territory Government announced the allocation of $186 million in the 2016-17 Health Budget towards a project to renew the ageing core clinical systems currently utilised across the NT Health System.

Extensive clinical engagement and research was undertaken in 2015-16 to ensure the design specifications align with clinicians' needs.

The Core Clinical Systems Renewal Program (CCSRP) will be the largest investment in ICT ever in the NT and the single greatest reform of NT public health information systems in the last 20 years. The project, scheduled to run over the next five years will see the four existing health information systems replaced with one contemporary system improving efficiency and patient experience, with essential clinical information being available at point of care delivery.

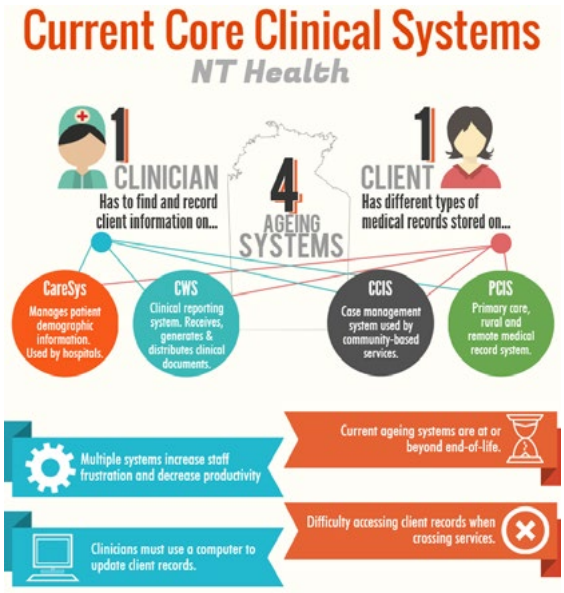
The CCSRP will enhance patient centred care by:

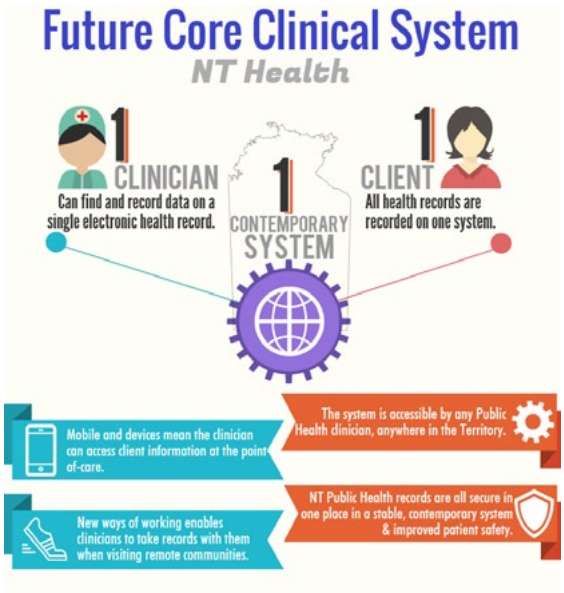
- Enabling a single electronic medical record across all health systems
- Integrating core client systems
- Improving access to core clinical information to improve mobility

The NT will be the first jurisdiction to implement an integrated client-centric patient information system where location is no barrier to accessing centralised client records.

Core Clinical Systems

NT Health





Pathways to Community Control

NT Heath continues to work in partnership with key stakeholders to advance and support Aboriginal community control in the planning, development and management of remote primary health care services. Stakeholders include the Australian Government, the Aboriginal Medical Service Alliance Northern Territory, the Primary Health Network of the NT (NT PHN), the Northern Territory Government, Aboriginal communities and where they exist, local Aboriginal Medical Services.

In July 2016, the Milingimbi Primary Health Care centre successfully transitioned to Aboriginal community control. At 30 June 2016 there were 33 Aboriginal community controlled primary health centres. In the coming year the West Arnhem and Alyawarra regions will be a focus for progress towards community control.

Palmerston Hospital

Palmerston Regional Hospital under construction

Construction of the NT's sixth public hospital, the Palmerston Regional Hospital is now well advanced. The hospital will be the first new public hospital built in the NT in nearly 40 years and is due for completion in early 2018. When fully commissioned, the hospital will provide 116 beds as well as outpatient services for people in the rapidly expanding area of Palmerston and surrounding rural districts. The facility will include a 24/7 accident and emergency service, low complexity elective surgery, low acuity hospital services and maternity services, linked with the community midwifery program operating from the RDH. Additionally, rehabilitation and geriatric evaluation and management services will be available. The Palmerston Regional Hospital will be a welcome additional health facility for the growing NT population.

Expanding Health Services Facilities in Aboriginal Communities

Significant work continues on the construction or redevelopment of a number of remote health centres as part of the Australian Government funded $50.29 million Health and Hospitals Fund Regional Priority program to build seven new NT remote health centres and upgrade four existing health centres. In 2015-16 three new centres were completed, at Elliott, Ngukurr and Canteen Creek and the centres at Papunya, Titjikala and Docker River were upgraded. The centre upgrades include modern emergency rooms, ambulance bay, and extensive refurbishment of the Papunya health centre.

Construction is well underway at Umbakumba on Groote Eylandt and Numbulwar community to construct two more new health centres. The Umbakumba project is due for completion in January 2017. The $6 million project is a tripartite Regional Partnership Agreement between the Australian Government, the Northern Territory Government and the Groote Eylandt Bickerton Island Enterprise.

Once complete, both new health centres will feature improved clinical and patient facilities and include a state of the art emergency room, dental room and clinic room.

Newly completed Health Clinic at Elliott

Adult Guardianship

The *Guardianship of Adults Act* 2016 passed the Legislative Assembly on 24 May 2016 and was assented to on 7 June 2016. This Act brings the NT into line with other jurisdictions by introducing a contemporary framework of 'best interest' decision-making for adults with impaired decision-making capacity.

The Guardianship of Adults Act will:

- transfer guardianship review jurisdiction from the Local Court to the Northern Territory Civil and Administrative Tribunal
- establish an independent statutory officer as the Public Guardian
- establish an independent Office of the Public Guardian
- introduce comprehensive guardianship principles.

Telehealth

Use of Telehealth technology has been expanding within NT Health in part as a result of the PATS Telehealth Project. The project has resulted in more remote and regional Territorians receiving the medical advice they need without having to travel to major centres. Within the limited scope of the project, patient consultations with doctors using Telehealth technology rose from approximately 200 a year to more than 1,000. Patients can now be seen via the video technology for a range of health conditions including renal, cardiac, burns and dermatology. The use of Telehealth has not only resulted in significant savings and less travel for patients, but has also allowed family members and clinic staff to be a part of the consultation.

In 2015-16, Telehealth NT also implemented Tele-Sonography in BreastScreen NT and the Obstetrics and Gynaecology unit in RDH.

Telehealth consultation

Territory Pathology

In September 2015 the five public pathology laboratories located at RDH, ASH, GDH, Katherine and Tennant Creek hospitals became a single entity known as Territory Pathology. The formation of Territory Pathology marked a new era in public pathology in the NT where on site pathology testing at each of the hospitals is complemented by provision of services in the areas of forensic medicine, public health and to Aboriginal community health clinics across the Territory.

Territory Pathology has approximately 127 FTE staff, performing over 1,000,000 tests per annum, at an annual growth rate of 3%. The testing is performed in the areas of histology, microbiology, haematology, transfusion medicine, chemistry, serology and molecular testing for infectious agents. This year Territory Pathology hosted four registrar training positions in pathology and provided tertiary education at Charles Darwin University in Medical Laboratory Science and Medicine. Territory Pathology also achieved the delivery of secure electronic messaging of pathology results to external clients, established electronic pathology ordering, and delivered a transparent billing model for pathology testing.

National Critical Care and Trauma Response Centre

The NCCTRC continues to develop its national and regional response capability as a hub of evidence based emergency care, research and education, which is readily available to respond to major health incidents. In 2015-16:

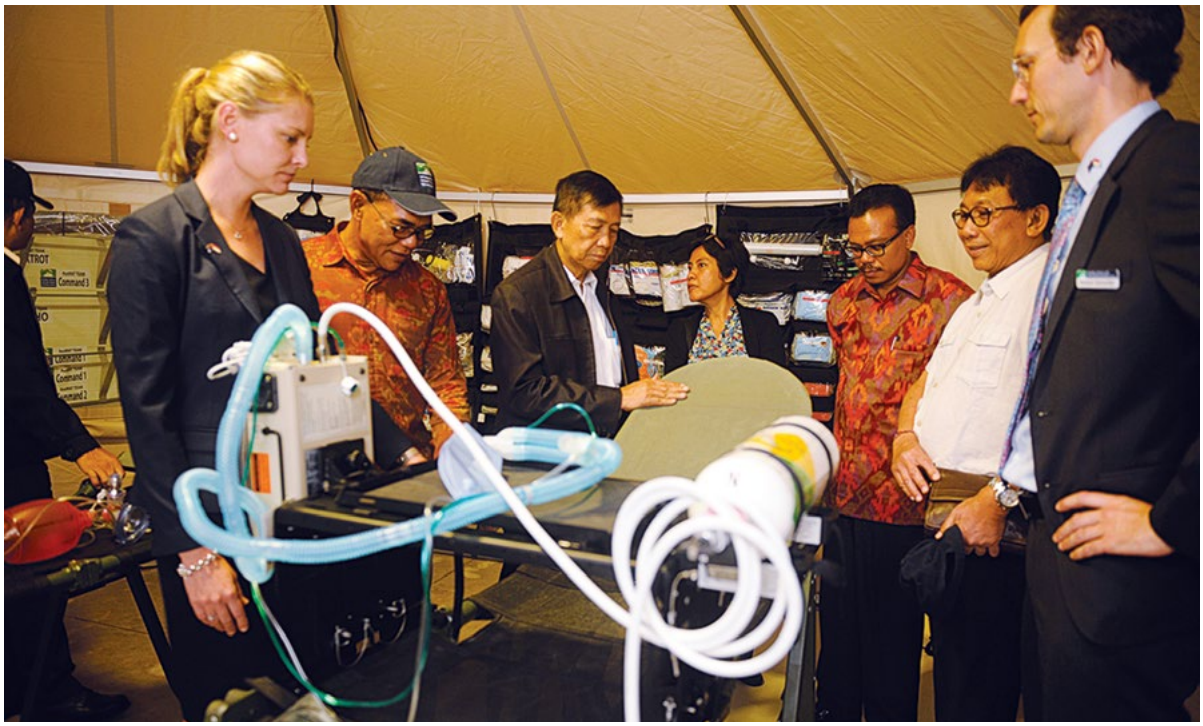
- The NCCTRC coordinated the Australian Medical Assistance Team (AUSMAT) response to Tropical Cyclone Winston in Fiji from the tasking order on 22 February 2016 to the end of the deployment on 15 March 2016. This very successful deployment allowed a team of 21 AUSMAT members to support the Fijian Ministry of Health through three mobile primary health care teams, ongoing support to the Emergency Operations Centre and public health surveillance. In addition to the recognition from the Fijian Government, the AUSMAT team integrated seamlessly in the broader response of the Australian Government.

- In collaboration with the World Health Organisation (WHO), the NCCTRC delivered the inaugural Emergency Medical Team Coordination Cell course. The selection of the NCCTRC to deliver this training is testimony to Australian Medical Assistance Teams being one of the world benchmarks for emergency medical teams.
- The NCCTRC trained 895 participants in its core fields of expertise. This included training of AUSMAT members for deployment, training of Northern Territory health and emergency personnel for improved local disaster response through Major Incident Medical Management Support (MiMMS) and Hospital MiMMS, and trauma related courses.
- A research agenda around the wellbeing and performance of field workers was developed by the NCCTRC, which builds on existing heat management research. This agenda will expand and include other determinants of quality of care in sudden onset disasters.
- The NCCTRC undertook a review of its clinical governance. This review led to establishing a Medical Director position to complement the existing Nursing Director position, and provide medical leadership and support to the Disaster, Education and Research teams.

National Disability Reform

As part of the reform in the delivery of disability services, the National Disability Insurance Scheme (NDIS) is a new way for people with disability to access their supports with increased choice and control. The Barkly region of the NT was a trial site for this new approach and has provided valuable lessons that will continue to inform the transition of the full scheme of the NDIS. On 5 May 2016, the NT and the Australian Government signed the *Bilateral Agreement between the Commonwealth and the Northern Territory: Transition to a National Disability Insurance Scheme (NDIS)*. The transition will commence on 1 July 2016 and will continue through to 30 June 2019.

Providing practical and expert support to the disability reform agenda locally, a Ministerial Advisory Council on Disability Reform was established consisting of service providers, people with a disability and carers. The Advisory Council met four times during 2015/16, discussing a range of matters including the NDIS, public transport, multipurpose taxi accessibility issues, Parap Pool redevelopment accessibility concerns, and changes to NT guardianship legislation.



The Governor of Bali His Excellency Mr Made Mangku Pastika and a delegation of health officials visited the National Critical Care and Trauma Response Centre in May 2016.

Priorities for 2016-17

Palmerston Regional Hospital

The Palmerston Regional Hospital project has moved into the operational commissioning phase and 2016-17 will see the project team focus on progressing preparations to be service ready for the hospital opening. Areas of particular focus include: service delivery models and preparation for the opening of clinical and non-clinical services; workforce strategies to ensure the hospital is appropriately staffed; input into hospital infrastructure and ICT design by clinical staff to ensure the hospital is fit for purpose; and financial modelling for the hospital. This work will also include the development of comprehensive communication and change management strategies aimed at staff and the community.

The Palmerston Regional Hospital will be the first new public hospital built in the NT in 40 years and is due for completion in early 2018. The 116 bed facility will be an important additional facility within the Top End Health Service.

Strategic Information Management Initiatives

The Core Clinical Systems Renewal Program (CCSRP) will be a focus for the Department in the coming year. The $186 million project, replacing four ageing public health computer systems with a single contemporary system and facilitating access to patient information at the point of care will complete the procurement stage in 2016-17. Implementation planning will commence shortly after confirmation of the selected vendor. The system is set to change the current work practices and ultimately facilitate seamless accessing and updating of patient information at the point of care.

Other important information management projects progressing in the coming year include:

- the National Telehealth Connection Service will be implemented, allowing expanded access to NT Health Telehealth services network for Aboriginal controlled medical services, interstate service providers and other key stakeholders
- implementation of a new eCredentialling system, improving employee screening, practitioner credentialing and assignment of appropriate scopes of clinical practice
- the eProcurement Project's Supply Chain Management software will be delivered
- the Electronic Document Records Management system will continue to be rolled out across business units, with the next major rollout being the System Manager Division in the second quarter of 2017
- the Enterprise Master Person Index project will be implemented for patients and providers
- an Information Security and Access Framework will be progressively rolled out across NT Health
- a new hospital billing system (eBilling) will be implemented, improving efficiency of revenue management in Territory public hospitals.

Disability Services

The transition to the NDIS in the NT, commencing 1 July 2016, will feature continued roll out in the Barkly region through participant engagement, planning and market development. Further participant phasing will commence in East Arnhem and for supported accommodation services in the Darwin region from 1 January 2017. The transition of all existing NT specialist disability clients will be completed by June 2019 and is expected to benefit around 6,500 people with a disability when the full scheme has been implemented.

Purchasing health services for better health outcomes

In 2016-17 the Department and Health Services will continue to work in partnership to improve the NT Health System. The Department, as System Manager, will monitor Health Service performance against a suite of 24 key performance indicators, including new measures for:

- mental health seclusion rates
- the proportion of Aboriginal patients that discharged or left hospital against medical advice
- Telehealth occasions of service
- the percentage of discharge summaries dispatched to a patient's health care practitioner within 48 hours
- the prevalence of Aboriginal children diagnosed with moderate hearing impairment.

Other work in 2016-17 will include increasing the effectiveness and transparency of the purchaser/provider model in the SDAs and supporting the Health Services to provide services that are sustainable and value for money. This will include transitioning oral health, hearing health and cancer screening service provision units from the System Manager to the Health Services.

The 2016-17 year will be challenging for NT Health, with the System Manager and the Health Services each implementing strategies to improve efficiency against a backdrop of increasing demands across all areas of service delivery.

Adult Guardianship

Following the commencement of the *Guardianship of Adults Act 2016*, priorities for the Department in 2016-17 will be:

- Implement the *Guardianship of Adults Act 2016*, and the appointment of an independent Public Guardian
- Creation of a new Office of the Public Guardian supported by the Department of Health, but independent of the Chief Executive Officer's direction
- Conduct a comprehensive community education and awareness campaign on the new legislation to ensure key stakeholders, advocates, guardians and the general public understand the new contemporary decision making framework of the Act

Neuro-surgical and cardio thoracic services

Funding has been provided to establish local cardio thoracic and neuro-surgical services for Territorians, with the services being delivered from the RDH. Previously, patients requiring these medical services needed to travel interstate. Development of the services will take time to ensure the services are sustainable and meet all quality and safety requirements.

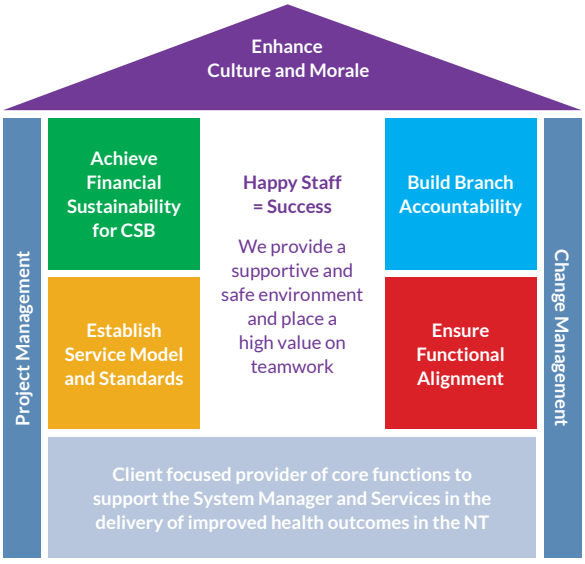
National Health Reform

The Australian Government and all States and Territories will continue work to implement changes and reforms to the public health system in accordance with the *Heads of Agreement between the Commonwealth and the States and Territories on Public Health Funding*. This work includes:

- implementing changes to public hospital funding arrangements including a cap on activity based funding
- development of new models of care for patients with chronic and complex disease. These will be part of bilateral agreements on coordinated care or as part of the Health Care Homes implementation
- incorporating safety and quality into hospital pricing and funding

Corporate Services Bureau Strategy

The Corporate Services Bureau (CSB) Strategy was launched throughout January 2016. The five priority projects: Enhance Culture and Morale; Achieve Financial Sustainability for CSB; Build Branch Accountability; Establish Service Model and Standards; and Ensure Functional Alignment are being completed in a structured project management approach, and tracked through a centralised CSB Project Management Office. Implementation of the Strategy is progressing positively, and will continue throughout the 2016-17 financial year.



Corporate governance

In a year of further maturing of the NT Health System, the system leaders have remained focussed on robust, fit for purpose corporate governance. 2015-16 saw the establishment of the NT Health Leadership Group. This group provides informed strategic stewardship, direction and clinical and corporate governance to the NT Health System. It aims to ensure:

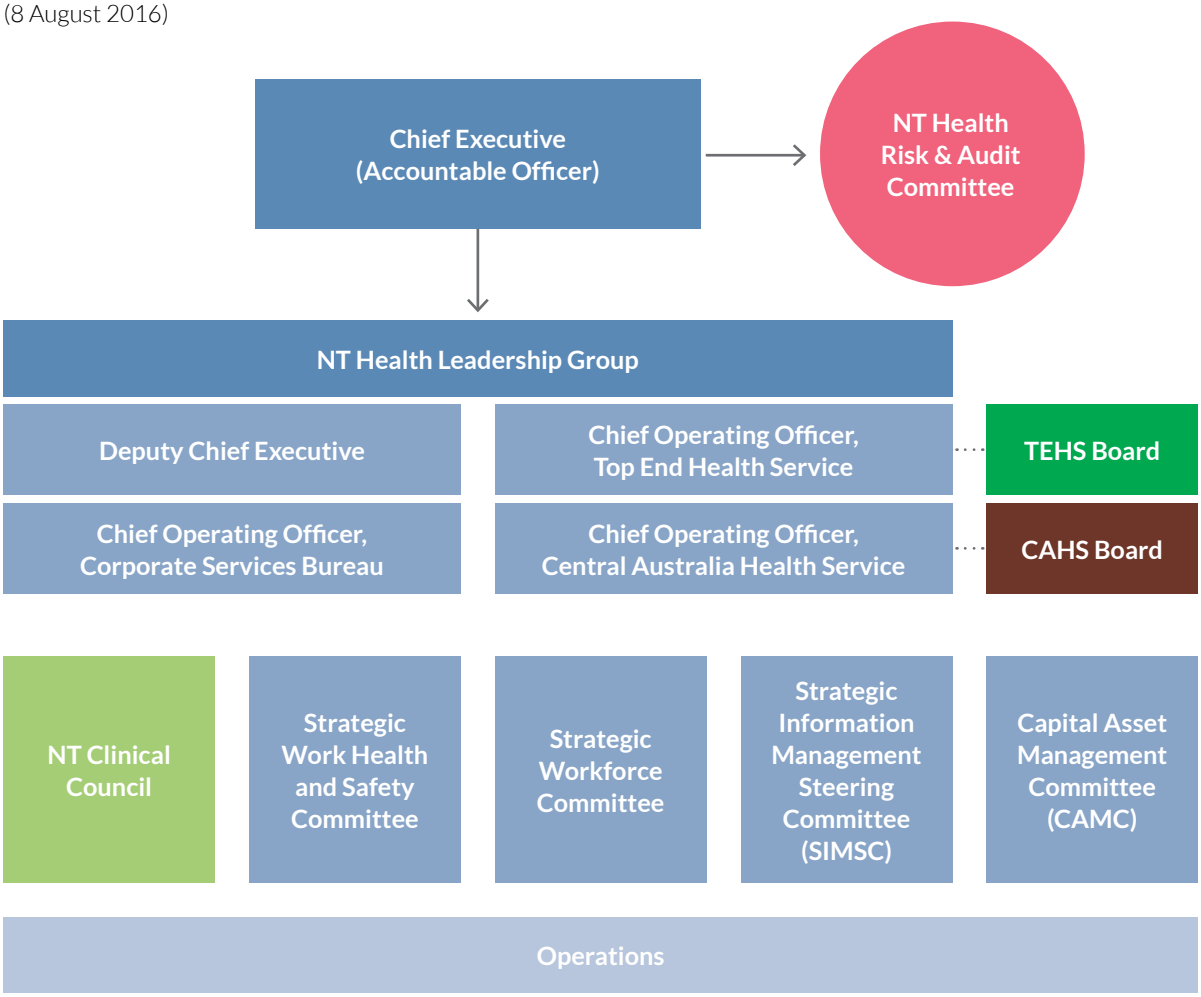
- the effective and efficient use of resources
- sustainable, safe, and accessible delivery of health services
- health provision in the right place at the right time
- services meeting the current and emerging needs of Territorians.

The Leadership Group (diagram below) is supported by a number of standing committees whose focus is on key areas of organisational and clinical governance.

The Department continues to strengthen its governance through review, system improvements and initiatives that enhance its capacity to meet its fiduciary, regulatory and other corporate responsibilities.

NT Health Governance framework

(8 August 2016)



Key Committees and Councils

NT Health Leadership Group

The NT Health Leadership Group is a key forum underpinning corporate and clinical governance in the NT Health System. It provides strategic leadership, stewardship, direction, clinical and corporate governance to the public health system in the NT. The members are:

Prof Len Notaras (Chair)	Chief Executive Officer, DoH
Ms Janet Anderson	Deputy Chief Executive, DoH
Ms Lisa Watson	Chief Operating Officer, CSB
Mr Michael Kalimnios	Chief Operating Officer, TEHS
Ms Sue Korner	Chief Operating Officer, CAHS
Ms Jan Currie (Secretariat)	Senior Director, Office of the CE

Risk and Audit Committee

The Risk and Audit committee is an independent advisory committee whose primary purpose is to advise the Chief Executive Officer on the effectiveness of NT Health's systems, processes, controls and culture for managing risk and complying with its governance obligations.

The Risk and Audit Committee has a broad mandate that covers a wide range of activities including fraud prevention strategies, financial and non-financial performance, compliance requirements and other audit and assurance activities not directly related to the financial report.

In understanding the importance placed on internal audit, the 2015-16 audit program has resulted in approximately 200 days of audit-related effort by the external service provider. The 2015-16 internal audit programs were integrated into the advancement of NT Health and provided an audit focus on operational performance, not just the performance of controls.

The Risk and Audit Committee consists of the following members and they met five times in 2015-16.

Voting members

Professor Villis Marshall	Chair
Major General Michael Krause	Voting Member
Mr Antoni Murphy	Voting Member
Ms Janet Anderson	Voting Member & Deputy Chief Executive DoH

Ex-officio non-Voting members

Iain Summers	External Member
Jan Currie	Senior Director, Office of the Chief Executive
Lisa Watson	Chief Operating Officer (CSB)
Michael Martin	Board Member TEHS
Graham Symons	Board Member CAHS
Yvonne Sundmark	Director Risk & Audit Services (DRAS)

Capital Asset Management Committee

The Capital Asset Management Committee is the chief decision making body for the NT Health Infrastructure Program. It is responsible for providing advice, monitoring progress and monitoring risks in the program, and supports the System Manager to meet responsibilities outlined in the *Health Services Act 2014* and other relevant legislation.

Established in January 2015, the Committee meets on a quarterly basis to review the allocation of resources or program issues that are unable to be resolved at division or health service levels. Members of this group include the Chief Operating Officers of the Department, TEHS, CAHS and the Senior Director of Infrastructure and Services.

Strategic Human Resource Management Committee

In 2015-16 the Department reviewed the Strategic Human Resource Management Committee to align with the New Service Framework. The NT Health Strategic Human Resource Governance Committee provides strategic decision making, oversight and centralised coordination for the Department of Health, TEHS and CAHS in strategic HR governance, planning, risk management, workplace culture, organisational values and legislative requirements.

In accordance with its legislated functions, the committee provides system wide governance, analysis and decision making on human resource management and supports the NT Health Leadership Group in:

- meeting its specific HR legislative and regulatory responsibilities
- leading the development and implementation of an enterprise-level workforce planning framework
- providing a forum for discussion on state, national and international health workforce reform and organisational capability development trends
- undertaking Risk Assessment and managing and mitigating HR risk
- oversight of the linkages between organisational strategy, planning and HR strategic planning
- analysing workforce related data, including labour force trends, at industry and jurisdictional level.

The Strategic Human Resource Management Committee met four times during 2015-16.

NT Health Strategic Work Health and Safety Committee

The NT Health Strategic Work Health and Safety Committee provides strategic advice, oversight and centralised coordination of the NT Health's safety management system. Its function is to provide strategic direction on work health and safety issues across NT Health and to ensure that it:

- meets its legislative responsibilities
- addresses work health and safety performance and risk management issues
- leads the implementation of the Work, Health and Safety Strategy and the Musculoskeletal Injury Prevention Strategy.

During the year a review of the Committee was undertaken to align it with the New Service Framework which resulted in revised Terms of Reference and membership. In 2015-16 the committee met three times.

Risk and Audit

The Agency's risk management framework complies with the *Financial Management Act* and is in line with the Australian/New Zealand Risk Management Standard As/NZ ISO31000 and its Risk Management Policy.

This framework guides internal control systems that enable management and control of risk exposures consistent with the level of risk management maturity of the Agency.

In 2015-16 this was supported by:

- ongoing consideration of risk management processes as part of the planning and decision making processes
- periodic review of the risk profile and risk management processes
- an audit and assurance program aligned with the risk profile.

Internal audit activities undertaken by the Risk and Audit Committee in the 2015-16 contributed to informing both corporate and clinical governance structures and processes. The audit program examines processes, practices and internal controls in areas not covered by any other audit engagements.

The audit program for 2015-16 included the following audit topics:

Electronic Medication Management Application 'eMMa' Post Implementation Review

Electronic management systems can reduce medication errors through improved prescription legibility, dose calculation and clinical decision support, and enables best practice information to be more readily available to prescribers and improves linkages between clinical information systems.

As part of the ongoing commitment to developing e-health initiatives, the Australian and NT Governments implemented the electronic medication management solution (eMMa) through the MedChart Medication Management Solution into the acute wards of NT public hospitals and Remote Health Centres. The objective of this audit was to examine the post-implementation of the eMMa system against four key areas: Project Governance, Business Readiness, Project Management and Benefits and Outcomes Management.

Selection, Letter of Offers and Contract of Employment of NT Health Medical Officers

Following a selection process, the Letter of Offer and Contract for Medical Officers is the primary document for establishing the employment relationship and outlining terms, conditions and role expectations. It is therefore essential that selection process, Letters of Offer and Contracts issued to medical staff are consistent and comply with relevant policy and legislation. This audit examined the processes and controls in place to select, offer and prepare contracts for Medical Officers. Focus was placed on examining the consistency and integrity of the selection process, as well as value for money considerations.

Visiting Medical Officers

There is a need for completeness and consistency in developing and managing Visiting Medical Officer contracts to ensure appropriate recruitment decisions. This audit examined the processes and controls in place to select, credential, offer and prepare contracts for Visiting Medical Officers. Focus was on examining the consistency and integrity of the selection process and final contracts, as well as value for money considerations.

Nurse initial screening and ongoing monitoring of professional practice

Nursing and midwifery are professions regulated under the Nursing and Midwifery Board of Australia. Ensuring a safe and effective nursing and midwifery workforce relies on processes that ensure employed nurses and midwives possess and maintain qualifications and experience relevant to their intended roles and responsibilities. Robust processes for initial screening and ongoing monitoring of compliance with professional regulation, and occupational health and safety requirements reduce risk to public safety. The objective of this audit was to examine the consistency of the initial screening of nursing and midwifery staff and the ongoing monitoring of professional practice and continuing professional development to provide assurance that a consistent process is being used in all appointments of nursing and midwifery staff.

Patient Assistance Travel - Evacuation

A decision to transport a patient to a regional area comes with a significant cost in resources, both physical and financial. Medical professionals need to ensure that the right balance of patient safety and effective use of resources when considering a medical evacuation. Due to the significant distances to health facilities throughout the Northern Territory, the use of air travel is often necessary for patients accessing health care that is not available locally. The objective of this audit was to examine the processes applied by clinicians and other staff when deciding when and where to evacuate patients, transfer to interstate hospitals or the retrieval of patients from the site of the accident/Health Centre or an intrastate hospital to another NT hospital.

Information and Privacy

The Information and Privacy Unit manages formal applications to access information under the freedom of information provisions of the *Information Act* (the Act) for NT Health and ensures the Department complies with the requirements of the Act. Information requests fall into three category types: access to information (for personal or government information); correction of personal information; and privacy complaints. The unit assists staff, members of the public and other organisations to access government and personal information. The unit provides educational sessions across the Department and advice to departmental staff on their responsibilities in accordance with the Act.

Applications to Access Information	2014-15	2015-16
Applications lodged during the year	128	168
Applications granted in full	71	121
Applications granted in part	14	10
Applications refused in full	15	13
Applications transferred	4	4
Applications withdrawn	24	10
Applications outstanding at end of year	7	10

Correction of personal information

In the 2015-16 reporting period, the unit received three applications to correct personal information held by the department. All applications were investigated with corrections made to all applicants' personal information.

Privacy complaints

The unit provides advice and assistance to staff and members of the public on issues of privacy protection. The unit investigates complaints regarding alleged breaches of privacy under section 104 of the Act and responds to issues raised by the Office of the Information Commissioner in relation to privacy complaints and privacy protection issues more generally. In the 2015-16 reporting period one privacy complaint was made.

Third party consultations

In the 2015-16 reporting period, the unit received three third party consultation requests from external parties seeking support for the release of government information. The unit supported the release of all information in consultation with the relevant program areas.

Clinical governance

Ensuring safe and high quality healthcare in the NT requires effective clinical governance. System wide clinical governance is monitored through Service Delivery Agreements with both Health Services, and is underpinned by the *NT Health Clinical Safety and Quality Governance Framework*.

A review of clinical governance is planned for 2016-17 to develop a formal strategy to enhance safety and quality across NT Health. This will align with the Australian Commission on Safety and Quality in Health Care's work to develop a national approach to clinical governance. In addition in 2015–16, a range of tools were developed to support the management of complaints and adverse incidents. New eLearning modules are in development to support staff in the use of the incident information management system (RiskMan).

NT Clinical Council

The NT Clinical Council comprises senior clinicians and provides informed strategic advice to the executive of the NT Department of Health and the two Health Services. In 2015–16 there were three clinical council meetings and two forums convened by the Council.

The focus of the council meetings was on reviewing clinical performance information. The Clinical Council also reviewed the Clinical Risk Register and recommendations from Internal Audits with a clinical focus.

The two Clinical Council Forums (one in Top End and the other in Central Australia) provided an opportunity for wider discussion about clinical priorities and opportunities to promote the clinical practice improvement agenda. The forum topic this year was *'Understanding and reducing complexity in Healthcare'*. Recommendations from the forums included that a structured project approach to the rollout of Telehealth was required to build on the success of the pilot projects, and educational material should be developed for clinicians to assist in their understanding of "counting and coding" to ensure the sustainability of the NT Health System.

Clinical Networks

NT wide clinical networks have been established for cancer care, NT blood wastage management, rehabilitation and renal care. The networks escalate issues to the Clinical Council where appropriate. The focus of the networks is to increase the level of clinician engagement and cooperation in the planning and development of services across NT and to find ways to better coordinate the delivery of services in a culturally safe manner. A maternity care network suspended activities so that members could instead participate in health service specific maternity services review programs. The intention is to address operational matters and then reconvene once new structures are established.

The NT Cancer Care Network achieved the following outcomes in 2015-16:

- input and discussions with Cancer Australia regarding their *Regional Cancer Services* report and involvement in Phase 2 of their project *Best practice cancer care in Regional Australia*
- preliminary discussions regarding the NT implementation of the national Optimal Care Pathways for Cancer
- formation of a data collection working group investigating possible establishment of clinical cancer registries in the NT
- improved liaison with the Cancer Care coordinators
- benchmarking of local Allied Health services in cancer against comparable hospitals to identify Allied Health Service gaps.

The NT Rehabilitation Health Network (NTRHN) achieved the following outcomes in 2015-16:

- the development of a Rehabilitation Strategy 2016-2020, with actions and outcome measures for the five year life of the Strategy
- development of outcome measures to evaluate the progress of the NTRHN
- formation of a Stroke working group.

Sentinel Events

Sentinel events are unanticipated events in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness.

There are eight nationally endorsed sentinel event categories. The Department provides data on the eight nationally defined sentinel events and submits this to the Report on Government Services. The following table indicates the occurrence of sentinel events in NT hospitals 2010-11 to 2015-16. Incident data specific to each Health Service (categorised according to Incident Severity Rating (ISR)) is reported in their respective chapters.

Northern Territory Sentinel Events 2010–11 to 2015–16

Sentinel Event	2010–11	2011–12	2012–13	2013–14	2014-15	2015-16
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function						
Suicide of a patient in an inpatient unit[1]				1		
Retained Instruments or other material after surgery requiring re operation or further surgical procedure	2		1	1		
Intravascular gas embolism resulting in death or neurological damage					1	
Haemolytic blood transfusion reaction resulting from ABO incompatibility						
Medication error leading to the death of a patient reasonable believed to be due to incorrect administration of drugs						
Maternal death associated with pregnancy, birth and the puerperium[2]					1	
Infant discharge to wrong family or infant abduction						
Total	**2**	**0**	**1**	**2**	**2**	**0**

Notes:
[1] Does not include Mental Health clients who take own leave and/or suicide
[2] Change to Maternal sentinel event definition and adoption of the WHO definition of maternal death as: *'the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.'* endorsed by AHMAC November 2014.

Coroner Recommendations

Under the *NT Coroner's Act*, the coroner's office investigates reportable deaths on behalf of the community.

A reportable death means the death may be any of the following:

- appears to have been unexpected, unnatural or violent
- appears to have resulted, directly or indirectly from an accident or injury
- occurred during an anaesthetic or as a result of an anaesthetic and is not due to natural causes
- occurred when a person was held in, or immediately before death, was held in care or custody
- was caused or contributed to by injuries sustained while the person was held in custody
- of a person whose identity is unknown
- in certain other circumstances

This year as a result of coronial recommendations the Department has:

- established a Senior Officials Alcohol Working Group across whole of government to consider and discuss key issues associated with alcohol use in the NT and to develop and implement actions to address alcohol use and misuse
- appointed a Clinical Director of Alcohol Mandatory Treatment (AMT) who oversees medical service provision across all AMT services
- developed an AMT client treatment plan for use in the Patient Care Information System that facilitates the uploading of AMT treatment plans for clients with chronic conditions which will create its own set of alerts and reminders regarding client care, and ensure appropriate client record access.

Consumer Feedback

The Department is committed to ensuring consumers have easy access to the provision of feedback on their experience with the NT Department of Health. In 2015-16 five complaints were received at the System Manager level. Most of these were related to access. Four of the complaints have been resolved with one complaint still under investigation.

In line with providing appropriate and easy access to the provision of feedback, the Department has been developing a culturally appropriate survey tool to capture patient experience within the health services. The tool uses spoken language and to date survey questions have been translated into a range of languages including 15 Aboriginal languages. The survey pilot is due for roll out in late 2016.

Credentialing, regulation of registration and accreditation

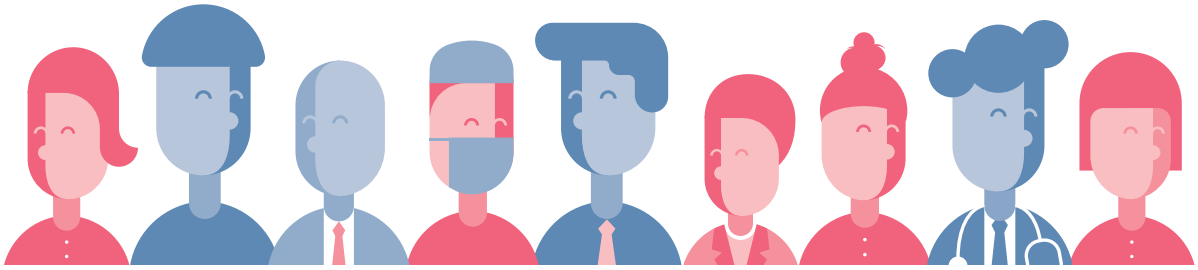
The Department is currently working on an e-credentialing system that will allow the Department to monitor in real time health practitioners' credentials, to screen new and continuing employees, and to record scopes of clinical practice. The system will link to the health professional regulation authority Australian Health Practitioners' Regulation Authority, and provide increased rigour in relation to health professional registration, accreditation and compliance with regulation standards.

Health service accreditation

The Department of Health requires all health services to maintain accreditation under the Australian Health Service Safety and Quality Accreditation Scheme against the ten National Safety and Quality Health Service Standards.

Both TEHS and CAHS hospitals have maintained their accreditation in 2015-16.

Our people



Human Resources (HR) Services assists the Department in the management and support of the human capital within the NT Health System. It promotes best practice management of our people and develops and implements strategies to build workforce capacity and workplace satisfaction.

The HR Policy Unit develops and maintains all HR related policies and maintains the HR Service Centre intranet page, a one-stop shop where all HR related information, including HR policies, guidelines, forms, delegations and related information can be found.

Within the New Service Framework, the Chief Executive Officer of the Department retains overall responsibility for all staff employed. Accordingly, this section contains HR related information on all staff employed in the public health system.

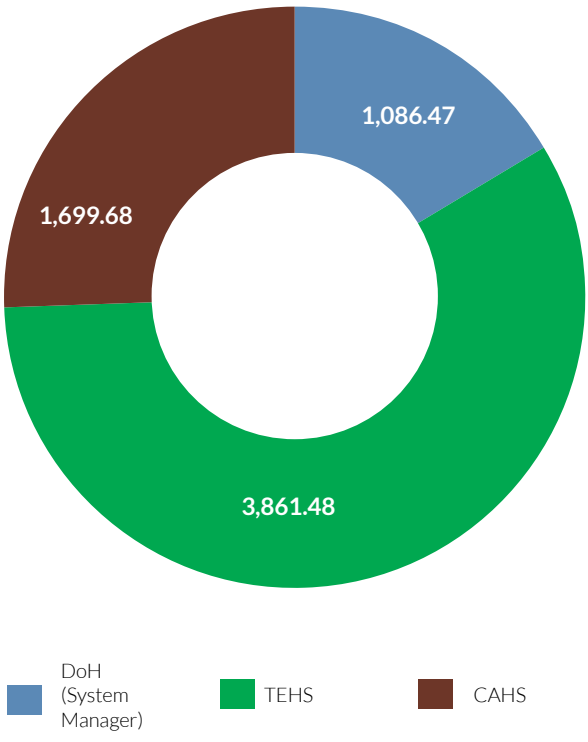
Our Workforce Profile

As of 30 June 2016, the full time equivalent staff (FTE) was 6648, an increase of 325 or 5.1% on the previous year

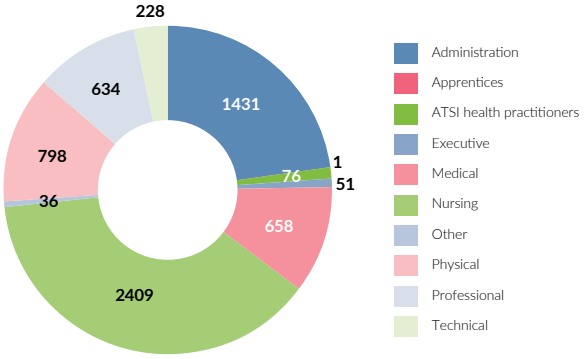
The Health System has undergone and continues to undergo restructuring associated with the New Service Framework. This has seen a shift of staff from the Department to the Health Services. The annual numbers reflect this as the Department number has dropped while TEHS and CAHS have increased 8.3% and 3.5% respectively with an annual overall system growth of 5.1%. The most significant service to move to the health services in 2015-16 was Alcohol and Other Drug Services. The TEHS FTE number further increased by the transfer of NT Pathology staff for the creation of a Territory Wide Service, Territory Pathology. As of 30 June 2016, the FTE was 6,648 compared with 6,323 in the previous year. The breakdown by stream across NT Health, and for the Department as System Manager is illustrated in the figures below. The breakdown by stream for TEHS and CAHS is illustrated in their respective sections.

The major factor contributing to the overall 5.1% increase were staff employed to address increased inpatient demand at NT acute care facilities. This demand has seen inpatient activity grow by 4% at TEHS and 3% at CAHS. Additional staff were also employed to open an extended medical emergency unit at Royal Darwin Hospital and a project team created to deliver the new Palmerston Regional Hospital.

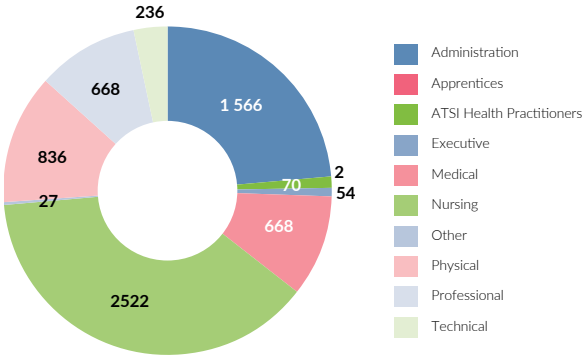
NT Health Staff (FTE) as at 30 June 2016



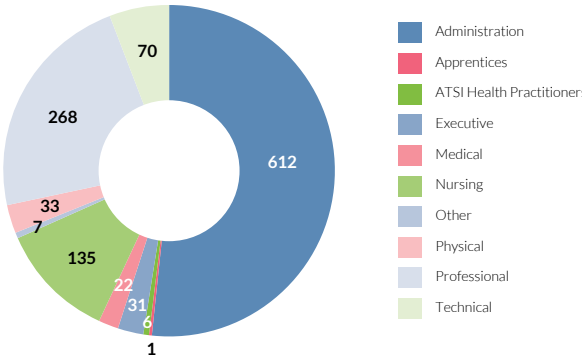
NT Health Workforce Profile (FTE) at 30 June 2015 (incl. DoH/ TEHS/CAHS)



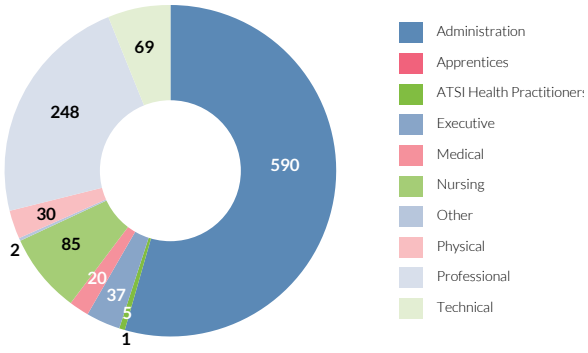
NT Health Workforce Profile (FTE) at 30 June 2016 (incl. DoH/ TEHS/CAHS)



DoH (System Manager) Workforce Profile (FTE) at 30 June 2015



DoH (System Manager) Workforce Profile (FTE) at 30 June 2016



Aboriginal Health Workforce

NT Health's priority to make a difference for Aboriginal people and communities has, in part, been responded to through a range of workforce strategies that encourage and provide opportunities for Aboriginal people to take up a fulfilling career in health.

Strengthening links between education, employment and development for the NT Health Aboriginal workforce with career pathways informed by workforce planning indicators continues to be a priority. Key initiatives that highlight NT Health's continued investment in growing the NT Health Aboriginal workforce include:

- *NT Health Special Measures Plan 'Priority Consideration for Aboriginal Applicants' [the Plan].* Commenced in January 2015, the Plan enables preference in recruitment to be given to Aboriginal applicants for all NT Health advertised vacancies. There is continued improvement in this area with Aboriginal employees currently representing 8.1% of the NT Health workforce across a range of positions, a 1% increase on the previous year.
- The *Back on Track (BoT)* project aims to increase the number of Aboriginal people employed within the Department and is aligned with Government's target of increasing Aboriginal employment to 16% under the Northern Territory Public Sector (NTPS) Indigenous Employment and Career Development Strategy 2015-2020. In 2015-16, the *BoT* project was expanded to include both clinical and non-clinical positions across the health services.

Indigenous Cadetship Support

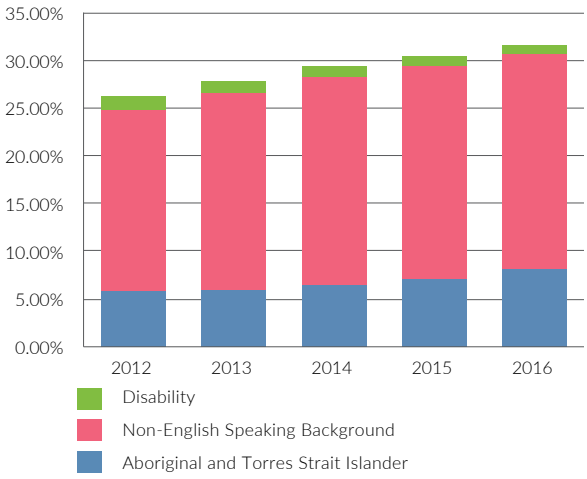
The Indigenous Cadetship Support Program, funded by the Australian Government, supports Aboriginal persons studying undergraduate degrees full time at a recognised tertiary institution. Students undertake work placements every year as part of the program. In 2015-16 NT Health cadets accounted for nearly half of the cadets across the NTPS, and as at 30 June 2016, NT Health supported 41 cadets at undergraduate level study in the following areas - Medicine, Nursing, Midwifery, Social Work, Psychology, Health Services, Occupational Therapy, Speech Pathology, Dietetics and Nutrition, Exercise and Sport Science, Media and Communication/ Law, Humanitarian and Community Services.

At the end of the reporting period 14% had completed their degrees and 68% remained active. Of the six cadets that completed in 2015, four are ongoing employees across Social Work, Psychology, Nursing and Medicine. One of the cadets has continued on to further education in the field of Medicine.

Workforce Diversity

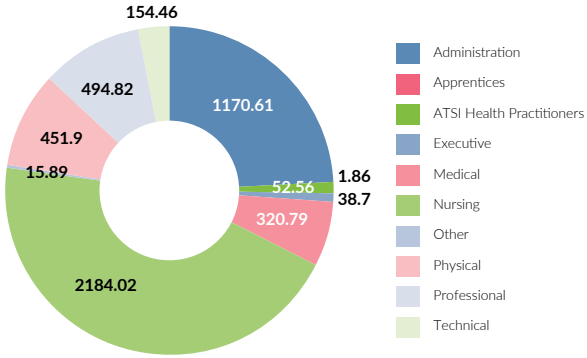
Overall, the Department and Health Services reported an increase in cultural diversity during 2015-16, with an additional 89 employees identifying as Aboriginal and a small increase in staff from non-English speaking backgrounds. Increased workforce diversity is an ongoing goal. Workforce profiles are illustrated in the figures below.

NT Health workforce diversity

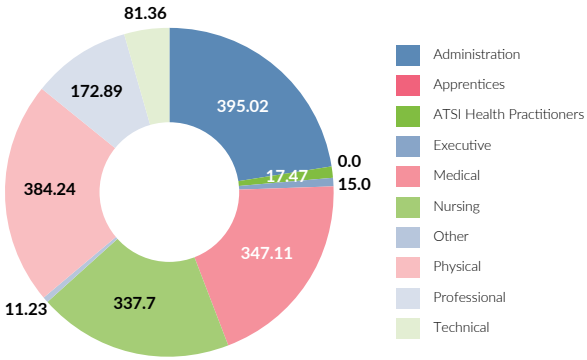


94 women hold Executive leadership roles across the NT Health System

NT Health female workforce



NT Health male workforce



Simplified Recruitment Initiative

On 1 June 2015 NT Health implemented the Whole of Government Simplified Recruitment Initiative in line with NTPS requirements to streamline the recruitment process for NT Health positions. The designed outcomes of this initiative include:

- a simplified recruitment processes
- consistency across NTPS agencies
- fair and transparent processes
- courtesy and respect towards applicants
- assessment of applicants' suitability based on proven capabilities
- information about the reasons for selecting successful applicants.

One of the outcomes of this initiative is improved timeliness, with 40% of recruitment being completed within a six week timeframe and 34% within a six to nine week timeframe.

Workforce Development

Early Careers

The Department employs a number of strategies to engage and support new employees through the early stages of their career, with the intention of retaining those participants into the future.

These programs include:

- Group Training Northern Territory hosted Trainees (full time and school based)
- Medical Interns (managed by Top End Health Service)
- Nurse Graduate Program
- Aboriginal and Torres Strait Islander Health Practitioner Scholarships
- School Work Experience
- Cadetships
- NTG Traineeships and Indigenous Traineeships Programs (including School based traineeships)

Additionally, the following programs are part of whole of government initiatives in which NT Health participates:

- Entry Level Recruitment for Administrative and Professional roles
- Indigenous Employment Program
- Vacation Students
- Graduates

Apprenticeships (includes Traineeships)

During the 2015-16 period, NT Health employed 20 apprentices who were enrolled in Vocational Education and Training programs in Business (Certificate IV, III, II); Community Services (Certificate II); Population Health (Certificate IV) and Kitchen Operations (Certificate II). Of these:

- 75% of the apprentices identified as Indigenous and 40% of these students remain active.
- ten students were in Alice Springs, seven students located in Darwin and three in Tennant Creek.
- 11 of the Indigenous trainees were undertaking School Based Traineeships
- the Department hosted 11 Indigenous trainees under third party hosting arrangements with Group Training NT in the fields of Community Services and Dental Assistance.

Student initiatives

In partnership with NT PHN, the Department conducted a number of school based visits to promote health related careers and employment opportunities. The visits included a guest health medical cadet speaking to the students about career pathways and practical health related exercises.

Staff from Alcohol and Other Drugs and Nursing/Midwifery attended careers expos in Darwin promoting health careers and healthy living. Participants were able to experience *'drinking goggles'*, apparatus that mimics the impacts of alcohol use.

The Department visited eight schools and saw approximately 339 students in conjunction with the NT PHN to promote health related careers.

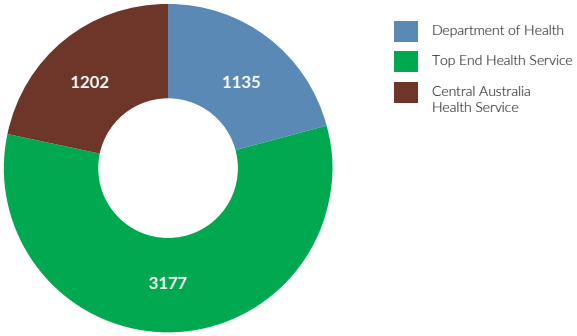
Workforce Learning and Development

Recognising that a key element of a sustainable, capable workforce is continuous learning and keeping abreast of contemporary practices, the Department invests heavily in upskilling, knowledge transfer and clinical and professional development. It recognises the importance of developing leadership and management capability as an important component to meeting the health challenges of the future.

A range of corporate and clinical training opportunities, both face to face and online are provided. This year a comprehensive suite of core essential management short courses were offered across the Territory. 5,514 staff completed a management short course in 2015-16. The suite of tailored short course available to staff included:

- Appropriate Workplace Behaviours – Staff
- Appropriate Workplace Behaviours – Managers
- Managing Under Performance
- The Essentials of Management
- Performance Management and the Art of Giving and Receiving Feedback
- Finance for Cost Centre Managers
- Managing Procurement Part 1
- Managing Procurement Part 2
- Recruitment and Selection

NT Health Short Course Attendance by Agency 2015-16



Cultural development programs included:

- Aboriginal Cross Cultural Awareness Program
- Cultural Capability Development for Managers
- Cultural Considerations for Policy and Strategic Program Developers

628 staff attended cultural development programs

The eLearning site, `*MyLearning*` enables staff to access online courses from a central portal 24 /7 with an internet connection. eLearning is considered to be an important platform enabling staff based in regional and remote areas to gain increased access to training. In 2015-16, 97 online courses were made available, spanning a range of corporate and clinical topics. The MyLearning site was upgraded during 2015-16, which improved system functionality and user experience, including improved mobile device functionality and enhanced resources and activities for educators and participants.

A multi disciplinary face to face orientation program continues to be provided to all new starters which provides an overview of the NT Health System and covers mandatory reporting requirements, workplace behaviours and expectations, key corporate information and other relevant information for new employees. This program is now complemented by a self-paced online orientation program available at all regional health sites

Leadership

Leadership in the NT Health System directly and indirectly affects the quality of patient care and consequently the effectiveness of the system as a whole. Research indicates leadership affects people, their satisfaction, trust in management, commitment, individual and team effectiveness and ultimately individual and collective performance.

Given the strong evidence base for developing health leaders, the Department is committed to improving the leadership capability of staff and contributing to positive organisational cultural change. The Department recognises that a positive learning and development culture is vital in assisting to attract staff to the NT, retaining existing employees and maintaining engagement.

Fifty-four staff completed NT Health's 'Leading the Way' and 'Building Our Leaders Leadership and Development Programs'. A further 59 health leaders commenced the leadership programs in January 2016. To date NT Health has had 256 leaders complete these contemporary 12 month tailored leadership development programs. In 2015-16, a further 23 staff were supported to participate in across government leadership development programs, including Indigenous specific Leadership Development programs.

375 Aboriginal staff participated in face to face short course training programs

Human Resource Management

Human Resource actions in accordance with the *Public Sector Employment and Management Act* (PSEMA) are outlined in Appendix C.

Workplace Health and Safety

The Department of Health is committed to providing a safe environment for all stakeholders. There has been a focus on training employees to further develop risk management skills. Training activities include:

- facilitating face-to-face short training on topics including aggression minimisation, emergency management, work health and safety refresher training
- manual handling training delivered face to face across the NT.

A broad cross-section of work health and safety modules was compiled into an e-learning platform. The uptake has been well received. Moving to an e-learning environment has promoted consistent content and seen efficiencies by allowing employees to promptly complete training in remote locations. The work has been acknowledged by the broader Northern Territory government with the establishment of a dedicated portal accessible to all Northern Territory employees.

Building on the success of previous years the annual Workplace Safety Leaders competition was held during Safe Work Month in October receiving a broad cross-section of applications highlighting activities and the promotion of WHS across Departmental workplaces. The Palmerston Community Care Centre was presented with the award for 2015.

Managing aggression

There were 315 incidents of aggression reported by staff in 2015-16. The vast majority of reports were from the nursing workforce and the total number is an increase on the previous year. The increased number of reports is attributed to staff's increased confidence and understanding of the RiskMan reporting process and the training and awareness raising provided. Increased reporting provides the opportunity for the Department to have a greater understanding of aggression; where it is occurring and how and why. This will allow targeted responses to reduce incidents of aggression. Emphasis continues on staff training and education to better identify and minimise aggression in the workplace.

Workers' Compensation

In accordance with the *Return to Work Act 2015*, the Department provides access to compensation to workers who have suffered an injury that arises out of, or in the course of employment. A high level of support is also provided to injured workers to assist them in staying at, or getting back to work.

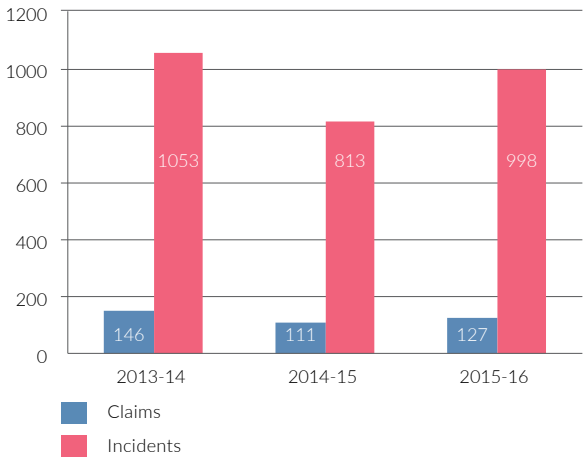
During the financial year 2015-16, 127 new workers' compensation claims from a total of 998 reportable incidents were lodged. Annual claims cost $7,672,815.

Claim costs increased by 12.79% and are attributed to increased costs of services and an increase in the claims settled. The Department continues to work closely with TIO, the appointed provider of claims management services for the NT government to improve claim management and outcomes. This includes enhancements to communication between the Department and TIO and weekly meetings to discuss management of cases, particularly lengthy claims.

The Department is committed to providing effective risk management, injury prevention strategies and rehabilitation programs for employees sustaining work related injuries, as well as improving return to work strategies.

Workers' compensation incidents and claims from 2013-14 to 2015-16 are illustrated in the figure below.

Workers' compensation incidents and claims



People Matter Survey

The People Matter Staff Survey, a two yearly capture of how employees are feeling and what is on their minds was rolled out again in 2016. Preliminary results indicate NT Health achieved an overall response rate of 32%, up on 2014's response rate of 25%. The survey results provide a valuable insight to employee perceptions of the organisational climate and performance, and the drivers for strengthening employee engagement and workplace outcomes. Findings of the 2016 survey are due to be released late in August 2016.

Outputs and performance

This section describes the Department's performance against outputs identified in Budget Paper 3.

- Output groups
  - Territory Wide Primary Health Care
  - Pensioner Concessions
  - Disease Prevention and Health Protection
  - Community treatment and Extended Care
  - Corporate and Governance
  - National Critical Care and Trauma Response
  - Health services
- Department of Health Snapshot of Costs

Output Groups

The Department of Health's financial and activity reporting is based on an output structure as presented in the NT Government's Budget Paper 3. This structure is characterised by seven outputs for 2015-16: Territory Wide Primary Health Care; Pensioner Concessions; Disease Prevention and Health Protection; Community Treatment and Extended Care; Corporate and Governance; National Critical Care and Trauma Response and Health Services.

Territory Wide Primary Health Care

Territory Wide Primary Health Care encompasses a range of primary health care and specialist services across urban and remote settings, including oral health, hearing health and cancer screening services. It also includes policy and strategy units addressing men's health, women's health, child and youth health, nutrition and physical activity, chronic conditions and health promotion. In 2015-16 output group services were exclusively delivered by Oral Health Services NT (OHSNT) and Health Development Branch which manages hearing health.

OHSNT provides quality, client focused oral health services to eligible Territorians, including emergency care, diagnostic, restorative, preventive, oral hygiene services, oral health promotion and dental prosthetic services. The Health Development Branch collaborates with key stakeholders to develop and facilitate the implementation of evidence based health promotion and prevention practice in the NT. Health Development also manages Hearing Health NT; develops policy advice; provides training, evaluation and monitoring services and tools.

Territory Wide Primary Health Care is also delivered through the Specialist Services Branch, which manages Cancer Screening Services - BreastScreenNT, CervicalScreenNT and BowelScreenNT. Specialist Services also manages the Urban Primary Health Care Grants Program and the NT Government's responsibility for the National Health Direct Australia telephonic and digital triage, information and referral services. Specialist Services provides functional management support for the Office of the Public Guardian.

Pensioner Concessions

Provides assistance to eligible Territorians to maintain their financial independence through concessions that assist with the cost of living and to provide an incentive for senior Territorians to remain in the NT.

Concessions provided under the scheme include subsidies for electricity/alternative energy, local council property rates, water rates, sewerage rates, garbage charges, motor vehicle registration, drivers licence, spectacles, travel and public transport.

Disease Prevention and Health Protection

- **Disease Control**

The Centre for Disease Control (CDC) is responsible for the development and implementation of the NT's immunisation program, and provides advice and education to health staff and the public on immunisation. Surveillance for more than 90 notifiable diseases and mounting the necessary public health responses, including the management of outbreaks, also forms part of its core business. CDC provides clinical services, including screening and contact tracing, for sexual health, blood-borne viruses, tuberculosis, leprosy and other mycobacterial diseases. CDC's role includes policy and clinical guideline development for these diseases.

- **Environmental Health**

The Environmental Health Branch has a Territory wide commitment to reducing the amount of disease in the community caused by physical, chemical, biological and radiological factors in the environment and provides opportunities for improved health outcomes and working towards health promoting environments. Environmental Health is encompassed within the broader area of public health and the Environmental Health Branch is involved

in the assessment, correction, control, and prevention of environmental factors adversely affecting human health.

Community Treatment and Extended Care

- **Alcohol and Other Drugs Directorate**

The Alcohol and Other Drugs Directorate facilitates the strategic policy and planning agenda for alcohol and other drugs in the NT in partnership with health services, clinicians and consumers. The Directorate aims to minimise harm associated with the use of alcohol, tobacco and other drugs, through a range of prevention, education, treatment and community action initiatives.

- **Disability Services**

Disability Services provides specialist disability support services for people with disability in the NT. The Office of Disability provides key functions that support people with disability including: information and referral services; disability service provision including case management, specialist allied health and behaviour support services; Disability Equipment Program; Seating Equipment Assessment and Technical Service; grants and service funding; policy and planning at an NT and national level, and the Northern Territory Companion Card. It is also responsible for the NT policy and service role in the NDIS reform.

The Office of Disability works in partnership with a number of key stakeholders as part of undertaking the above key functions, these include: people with disability and their families and carers; non-government disability service providers; local government; peak bodies; advocates; NT Government agencies; Australian Government agencies; and the National Disability Insurance Agency.

- **Mental Health Directorate**

The Mental Health Directorate facilitates the strategic policy and planning agenda for mental health in the NT in partnership with health services, clinicians, consumers and their carers. The Directorate forms part of the Department of Health's planning, policy and performance function. The Directorate also has responsibility for monitoring the implementation of mental health legislation, NGO service development and coordinates monitoring and reporting progress on all National Mental Health Strategy initiatives.

Corporate and Governance

- **Corporate and Governance**

The System Manager's strategic focus and leadership role, providing system wide policy and plans, risk mitigation and regulation to deliver efficient and sustainable health services as outlined in service agreements.

- **Shared Services Provided**

Reflects the Department's service delivery of centralised corporate support functions to its clients in areas such as Human Resource management, ICT systems and services, procurement and contracting, finance services and data management and system reporting.

National Critical Care and Trauma Response

The NCCTRC provides a national and regional response to major health incidents utilising evidence based emergency care, research and education. Increased capacity to deliver training and emergency response activity is evidenced by investments in resources such as a mobile laboratory, morgue, infectious diseases management capability and a water filtration system.

In collaboration with the Australian Government, the NCCTRC works to enable the reception and management of local, national and international victims of disaster. Disaster preparedness is prioritised though training and education and demonstrated though the coordination of AUSMAT responses and delivery of the Emergency Medical Team Coordination Cell course in conjunction with the World Health Organization.

Health Services

As outlined in Service Delivery Agreements, the Department purchases services from each health service under the New Service Framework. This output group shows a measure of acute health care delivered by CAHS and TEHS in Weighted Activity Units.

Department of Health – Key Performance Indicators

Territory Wide Primary Health Care

Outcome: Strengthened capability of Territorians to maintain and improve health.

Territory Wide Primary Health Care

Provide support for an integrated Territory-wide primary health care service including reporting, policy, planning, grant management and legislative support.

	Actual				2015-16		2016-17 Budget
	2011-12	2012-13	2013-14	2014-15	Budget	Actual	
Territory Wide Primary Health Care							
Percentage of non-government organisation grant recipients' satisfaction with grant management[1]	n/a	n/a	n/a	n/a	n/a	n/a	80%
Oral health occasions of service[2,3]	45 206	45 547	51 988	50 808	47 770	51 429	48 900
Percentage of remote Indigenous children (from total assessed) diagnosed with moderate/severe/ profound hearing impairment[2]	14.8%	11.8%	10.0%	9.20%	10.0%	10.4%	9.6%

[1] New measure.

[2] Measure originally presented under Primary Health Care Output groups in TEHS and CAHS sections of BP3 due to expected transition of services from the Department to the Health Services. Transition to the Health Services delayed until 2016-17.

[3] Incorrect reporting of 2014-15 data in 2014-15 Annual Report due to software technical fault.

Pensioner Concessions

Outcome: Eligible Territorians are assisted to maintain their financial independence.

Pensioner Concessions

Administer subsidies to Territory residents who are classified as eligible persons.

	Actual				2015-16		2016-17 Budget
	2011-12	2012-13	2013-14	2014-15	Budget	Actual	
Pensioner Concessions							
Pensioner Concession Recipients	24 759	26 189	27 181	24 878	26 083	24 765	24 800

Disease Prevention and Health Protection

Outcome: The capacity of individuals, families and communities is strengthened to improve and protect their health through promotion and prevention strategies, and appropriate interventions that minimise harm from disease and the environment.

Environmental Health

Provide education, statutory surveillance and monitoring, and complaint resolution relating to physical, chemical, biological and radiological agents in the environment. Manage environmental health standards, environmental health impact assessment, sanitation and waste management, water quality, food safety, radiation protection and poisons control.

Disease Control

Deliver disease prevention and early intervention services, immunisation, disease surveillance and management, screening services, contact tracing for mycobacterial diseases, HIV/AIDS and sexually transmitted infections, and environmental management of mosquito-borne diseases.

	Actual				2015-16		2016-17 Budget
	2011-12	2012-13	2013-14	2014-15	Budget	Actual	
Disease Prevention and Health Protection							
Environmental Health							
Authorities issued	4 036	3 628	4 318	4 211	4 000	4 032	4 050
Environmental health complaints investigations initiated within one working day of notification	98%	99%	98%	98%	98%	98%	98%
Disease Control							
Notification of HIV	18	30	22	12	26	28	20
Occasions of service at Clinic 34 in Darwin and Alice Springs	12 146	11 270	9 292	7 741	10 500	12 201	10 500
Proportion of notified cases of exotic mosquito-borne diseases for which the place of infection was ascertained within two days	n/a	n/a	99%	99%	100%	97%	100%
Children fully immunised: - at age 12 months	92%	91%	91%	91%	90%	93%	93%
- at age 2 years[1]	95%	93%	93%	87%	93%	89%	88%
People completing treatment for tuberculosis	94%	100%	100%	100%	95%	100%	100%
Units of sterile injecting equipment distributed through the Needle and Syringe Program[2]	n/a	n/a	n/a	n/a	n/a	n/a	480,000
People living with HIV who receive Anti-Retroviral Therapy[2]	n/a	n/a	n/a	n/a	90%	97.9%	90%

[1] The decrease reflects a lag in uptake and reporting practices due to revised definition of 'fully immunised' at two years to include the measles, mumps, rubella, varicella vaccine.

[2] New measure.

Community Treatment and Extended Care

Outcome: The capacity of individuals, families and communities is strengthened to improve and protect their health and wellbeing through community-based strategies and appropriate interventions that minimise harm.

Alcohol and Other Drugs

Provide support for an integrated Territory wide service to reduce harm attributable to the use and misuse of alcohol, tobacco and other drugs, including reporting, policy, planning, grant management and legislative support.

Disability Services

Deliver community and professional support services to people with a disability, including community care and support, in-home support, community access, supported accommodation and respite care.

Mental Health

Provide support for an integrated Territory wide mental health service including reporting, policy, planning, grant management and legislative support.

	Actual				2015-16		2016-17 Budget
	2011-12	2012-13	2013-14	2014-15	Budget	Actual	
Community Treatment and Extended Care							
Alcohol and Other Drugs							
Average daily bed usage at Sobering Up Shelters[1]	56%	59%	63%	51%	60%	48%	50%
Closed episodes in non-government treatment services[2,3]	2 573	2 521	3 295	3 466	3 200	3 776	3 546
Completed closed episodes in non-government treatment services[2,3]	1 692	1 516	1 847	1 653	1 770	2 087	1 910
Disability Services							
Clients accessing full-time accommodation services	178	186	195	195	195	198	198
Clients accessing community support services[4]	2 471	2 731	2 626	2 669	2 775	n/a	2 800
Clients accessing professional support services[5]	6 438	6 278	6 410	6 065	6 400	6 513	6 000
Occasions clients access professional support services[6]	54 515	52 322	57 800	59 127	58 800	65 150	55 000

[1] The decrease is due to Temporary Beat Locations and Alcohol Protection Orders in Alice Springs, Tennant Creek and Katherine. Service capacity at Sobering Up Shelters has reduced to reflect demand.

[2] An episode of alcohol and other drugs treatment is a 'period of contact, with defined dates of commencement and cessation' (National Health Data Dictionary). A closed episode of treatment is one where there is a valid date of cessation. A completed closed episode is one where there is a valid date of cessation and the reason for cessation is 'treatment completed.

[3] The increase is largely due to a significant increase in remote-based activity by a single agency.

[4] Acutal data for 2015-16 unavailable until 2017.

[5] Intake aligned with preparations for NDIS.

[6] The variations reflect the transition of clients to full scheme NDIS commencing July 2016.

Corporate and Governance

Outcome: Effective and efficient performance of the health system.

Corporate and Governance

Provide leadership and strategic management that ensures the health system meets its service and quality objectives, and identifies and mitigates risk. Deliver Territory-wide strategy, policies and plans to ensure an equitable and integrated system. Ensure fair, evidence-based and sustainable purchase-of-service agreements with healthcare providers and systems to deliver appropriate services to Territorians.

Shared Services Provided

Provide quality client-focussed shared services to the Health Services and the System Manager including finance, human resource, ICT, infrastructure, procurement and performance reporting, to contribute to the efficient delivery of health outcomes.

	Actual				2015-16		2016-17 Budget
	2011-12	2012-13	2013-14	2014-15	Budget	Actual	
Corporate and Governance							
Corporate and Governance							
Corporate risks ranked as 'extreme' that have a risk mitigation plan in place within 30 days of the initial risk assessment[1]	n/a	n/a	n/a	100%	100%	100%	100%
Delivery of health literacy and cultural security training program for staff	n/a	n/a	n/a	n/a	50	50	50
Shared Services provided							
Availability of major enterprise clinical information systems to Health Services	n/a	n/a	99.97%	99.98%	99.50%	99.40%	99.50%
Percentage of signed service standards with Health Services[2]	n/a	n/a	n/a	n/a	n/a	n/a	100%
Health Services satisfaction with corporate support services provided[2]	n/a	n/a	n/a	n/a	n/a	n/a	75%

[1] Includes only those risks overseen by the Department of Health.

[2] New Measure.

National Critical Care and Trauma Response

Outcome: High-quality and efficient emergency medical response services to the north Australian and South East Asian regions.

National Critical Care and Trauma Response

Provide emergency medical response across the north of Australia and within the South East Asian region including training and research services.

	Actual				2015-16		2016-17 Budget
	2011-12	2012-13	2013-14	2014-15	Budget	Actual	
National Critical Care and Trauma Response							
Training participants[1]	n/a	n/a	1 030	991	695	895	695
Response to local, national and international deployment requests[2]	n/a	n/a	n/a	n/a	n/a	100%	100%

[1] The National Critical Care and Trauma Response Centre (NCCTRC) is benchmarked to train 695 participants. Training of extra participants occurred due to increased efficiencies in the NCCTRC, and several training programs (Clinical Team Leader and Surgical Anaesthetics training), some of which received additional funding.

[2] New measure .

Health Services

Outcome: The best possible health of Territorians in the Top End and Central Australia is achieved and maintained through high quality, safe and efficient services.

Top End and Central Australia Health Services

Provide the range of acute to primary health care services in hospitals, health centres and in the home.

	Actual				2015-16		2016-17 Budget
	2011-12	2012-13	2013-14	2014-15	Budget	Actual	
Health Services							
Top End and Central Australia Health Services							
Total Weighted Activity Units [1]	n/a	n/a	124673	129 557	138 730	149 656	153 160

[1] All Budget and Actual figures calculated in version 15 of the activity-based funding model.

Department of Health - snapshot of costs

Financial results for 2015-16 against agreed targets based on output groups in Budget Paper 3 are presented in the table below. The Department's financial performance is provided in greater detail in the Department of Health's Financial Reports section.

	2015-16		2016-17	
	(a)	(b)	(c)	(c) – (a)
Business Line	Budget	Actual	Budget	Note
	$000	$000	$000	
Territory Wide Primary Health Care	**64 929**	**44 759**	**32 868**	1
Territory Wide Primary Health Care	64 929	44 759	32 868	
Pensioner Concessions	**28 841**	**27 087**	**29 530**	
Pensioner Concessions	28 841	27 087	29 530	
Disease Prevention and Health Protection	**26 586**	**26 342**	**21 446**	
Environmental Health	5 547	6 078	4 675	2
Disease Control	21 039	20 264	16 771	
Community Treatment and Extended Care	**168 660**	**141 115**	**134 074**	
Alcohol and Other Drugs	71 460	28 946	41 134	3
Disability Services	88 133	103 765	85 636	
Mental Health	9 067	8 404	7 304	
Corporate and Governance	**86 292**	**106 832**	**95 381**	
Corporate and Governance	43 506	64 046	51 330	4
Shared Services Provided	42 786	42 786	44 051	
National Critical Care and Trauma Response	**10 579**	**9 749**	**10 262**	
National Critical Care and Trauma Response	10 579	9 749	10 262	
Health Services	**942 684**	**1 034 819**	**1 102 357**	5
Top End and Central Australia Health Services	942 684	1 034 819	1 102 357	
Total Expenses	**1 328 571**	**1 390 703**	**1 425 918**	
Appropriation				
Output	1 010 764	1 020 500	1 054 350	
Capital	6 292	410	31 679	
Commonwealth	44 218	57 064	54 720	

Notes

[1] The decrease relates to the transfer of primary health care grants and oral, hearing and cancer screening service delivery functions to the Health Services, partially offset by the timing of additional Commonwealth and external funding.

[2] The decrease mainly reflects a reduction in Commonwealth and external funding as well as efficiencies.

[3] The decrease is due to the transfer of the Alcohol and Other Drugs program to the Health Services, partially offset in 2015-16 by one off funding for a disability services hub.

[4] The increase is mainly due to additional Commonwealth and external funding, partially offset in 2016-17 by a cross agency transfer to reflect project management arrangements for the Core Clinic Systems Renewal Program.

[5] The increase is due to additional Commonwealth and demand growth funding and the transfer of functions to the Health Services.

Performance, achievements and outcomes

The Department is proud of its achievements during 2015-16 and its commitment and progress to meet the objectives outlined in the *Northern Territory Health Strategic Plan 2014-2017*. Key achievements, milestones and developments are listed under each Strategic Objective below. Across the Strategic Objectives, this section also addresses priorities which were identified in last year's report.

Strategic Objective 1:

Promote and protect health and wellbeing

Encouraging the adoption of healthy behaviours, controlling the spread of disease, preventing harm and injury and working across sectors to influence the social determinants of health

BreastScreenNT

In 2015-16, a total of 5700 women across the NT received free screening mammograms. Screening sites included Casuarina, Palmerston and Alice Springs. The BreastScreenNT bus provided screening at Jabiru, Katherine, Tennant Creek, Darwin City, Bagot Community, Darwin Prison, Inpex Work Site, Belyuen, Daly River, Bathurst Island and Kalkarindji. The BreastScreenNT bus is a Territory and Australian Government initiative enabling breast screening services to be provided in remote parts of the NT.

BreastScreenNT Bus at Bagot Community

Nutrition and Physical Activity Strategy

The Nutrition and Physical Activity Strategy unit funded the Heart Foundation NT to deliver the *'Live Lighter'* social marketing campaign across the NT for the three year period 2014-15 to 2016-17. *'Live Lighter'* is a mass media campaign that aims to raise awareness of the risks associated with overweight and obesity.

Promoting Healthy Childhood

In 2015-16 the Child Health Strategy Unit developed the *Healthy Under Five Kids Parenting with Families* program (HU5KPF) that builds on the existing program delivered by health services. HU5KPF is a universal standardised child and family health program for all families with children 0-5 years of age. It is anticipated the program will be implemented in NT Government primary health care centres by the end of 2017, following a six month pilot in ten communities planned for the second part of 2016.

In 2015-16, the Child Youth Health Strategy Unit completed the development of a system that will enable monitoring, evaluation and reporting of key child health outcomes, including coverage of the *Healthy Under 5 Kids Program* across NT Government primary health care services in remote communities. *The Healthy Under 5 Kids Program* comprises a series of key child health checks that facilitate the prevention, early detection, intervention and treatment of common conditions that cause morbidity and early mortality as well as prompting early referral for the management of more serious or chronic conditions. This program is delivered by health providers in the remote communities.

The Pregnant & Parenting Program *Young Mothers are Strong Mothers* was developed as a collaboration between the Health and Education departments. The program will commence a 12 month pilot from the Department of Education's Palmerston Children and Families Centre from July 2016. The *Young Mothers are Strong Mothers* is a collaborative and flexible approach to engaging young mothers into learning as early in their pregnancy as possible. The program aims to combine clients into peer groups and create a safe, physical space that can offer child care, parenting education, life skills and a range of support services to create a 'foundation' of learning.

Chronic Conditions

The Chronic Conditions Network continues to deliver an annual conference for practitioners focusing on preventing and managing chronic conditions. The 19th Chronic Diseases Network (CDN) was held on 24-25 September 2015 at the Darwin Convention Centre. With the theme: *Connecting the Care across the Lifespan*, the 214 conference delegates gathered to showcase their projects and programs, which covered clinical chronic care, prevention, early detection and the management of chronic conditions in children, adults and the ageing population.

The majority of conference delegates were from the NT (166 delegates) with the remaining 48 delegates attending from other states and territory. Consistent with previous years, the 2015 conference had a high proportion (28% - 60 delegates) of attendance by Aboriginal health professionals. At this conference, a number of Aboriginal staff and groups were awarded CDN awards to recognise their excellent contribution to chronic care. Among these were the Santa Teresa team, awarded the Health Promotion and Program Delivery Award, Mr David Adams awarded the male Aboriginal Health and Leadership Award, Miss Emslie Dianne Lankin awarded the female Aboriginal Health and Leadership Award, Ms Grace Daly awarded the Continuous Quality Improvement Award, and Dr Lawurrpa Maypilama awarded the Lifetime Achievement Award.

Andrea Martin and her painting on renal disease

Partnering with Consumers and Strong Voices Toolkits

In 2015-16, two toolkits were developed to increase consumer participation in the planning, design, delivery, monitoring and evaluation of health services. *Partnering with Consumers for Success: A toolkit to assist NT Health to increase consumer engagement* is for departmental and health service staff. *Strong Voices: A toolkit to strengthen and support consumer representatives engaged in NT Health activities* is a toolkit for consumer representatives engaged in NT Health activities.

Medical Entomology

In 2015-16, the Department's Medical Entomology team achieved the following:

- Salt marsh mosquito numbers remained relatively low in Darwin urban, except for high numbers recorded in October and December, triggered by high tides and rain. A total of 16 successful aerial survey and control operations were carried out, with a total of 2112 hectares treated.
- Ross River virus cases remained below the five year mean, except for September and October with high case numbers recorded coinciding with high salt marsh mosquito numbers.
- In 2015-16, a total of 80 overseas acquired dengue cases were recorded in the NT, however the NT remained exotic vector free. The exotic dengue vector, *Aedes aegypti* was detected in October, December 2015 and January 2016 in Department of Agriculture and Water Resources routine surveillance traps at the Darwin International airport; and measures occurred to ensure the vector didn't establish. The exotic Asian Tiger mosquito was also detected at East Arm Wharf in August 2015. All incursions were responded to with enhanced surveillance and control as per protocol.
- To increase risk awareness in remote communities of Murray Valley encephalitis, public awareness campaigns took place in February 2016. Messages were delivered in language, on radio and on social media across the NT.
- Establishment of a routine exotic vector mosquito surveillance program at Port Melville, in response to the port being declared a first port of entry for international vessel movement. The program commenced in November

2015, enabling early detection and control of exotic dengue mosquito incursions.

- Responded to 16 malaria cases notified in the NT.

Disease Control

- Needle and Syringe Program

The Northern Territory Needle and Syringe Program distributed more than 500,000 units of sterile injecting equipment in 2015-16 in order to prevent blood borne virus transmission and injecting-related injury and disease. This year also saw important amendments to the Authorisation of Classes of Persons to Supply Hypodermic Syringes and Needles under the Misuse of Drugs Act. Amendments are expected to significantly increase access to harm reduction services among priority populations including Aboriginal people, people in remote areas, homeless people, and people experiencing access barriers to existing Needle and Syringe services.

- Prevention of congenital syphilis

In response to the current outbreak of Syphilis in some regions of the NT, outbreak response teams from CDC have been working together with primary health care providers and other organisations to improve testing and treatment for Syphilis. In 2015 there were no cases of congenital Syphilis.

- Rheumatic Heart Disease

The Rheumatic Heart Disease (RHD) Control Program continued its efforts to reduce the recurrences of acute rheumatic fever and reduce the burden of RHD amongst the people of the NT. Positive networking and collaboration with RHD Australia (RHD National Coordination Unit) has been maintained, and reporting capabilities for the NT RHD Register and the NT RHD Control Program have improved. In accordance with the NT *Notifiable Diseases Act*, rheumatic fever continues to be notified through the NT RHD Register.

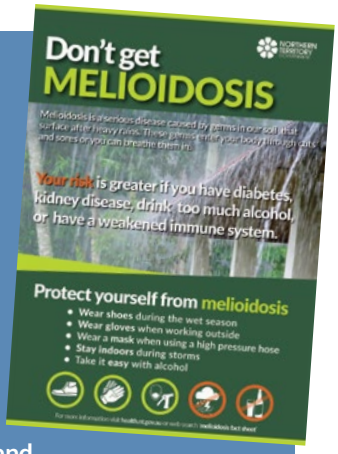
- Tuberculosis

Tuberculosis (TB) is a condition of significant public health importance in the NT in both urban centres and remote communities. In 2015-16 the Tuberculosis Unit supported intensive TB treatment and conducted extensive contact tracing as well as screening of at risk groups for TB to identify and treat those with latent TB infection to prevent progression to active TB.

Providing timely diagnosis and directly observed treatment for all cases of TB in the NT has resulted in nearly 100% treatment completion of all cases.

- Crusted Scabies

Crusted scabies was made a notifiable disease in 2015-16. This will further improve the identification, treatment and long-term management of the debilitating condition for individuals and communities.



Melioidosis

In 2015-16 the Centre for Disease Control in partnership with local health care providers, services and industries intensified efforts to increase melioidosis awareness and prevention messages. New factsheet and poster resources were developed aimed at people with low English literacy. Radio announcements on local radio in local Indigenous languages, provided greater education for people with melioidosis and a 'Shoe Art Project' was initiated. This project combined education with the provision of shoes to vulnerable populations. Raising and maintaining awareness about melioidosis in the population is a continuous process requiring innovation and the ability to reach those most at risk.

- Better health outcomes through immunisation

Together with health clinics, schools, general practice and Aboriginal Controlled Community Health Organisations, the Immunisation Unit has worked to maintain high immunisation coverage rates in infants, children, school aged children and older people in the NT. This has been achieved through the continued development of policy, education and programs to protect Territorians against vaccine preventable diseases.

During 2016, health providers and the general public were assisted to provide catch up immunisations and to ensure data in the Australian Childhood Immunisation Register was correct with the introduction of the Commonwealth *No Jab No Pay* policy.

As of March 2016, immunisation coverage rates for all children in the NT remain high and are comparable with the national average. Immunisation coverage rates for Aboriginal children in the NT also remain high and continue to be above the national average.

- Herpes Zoster

From 1 November 2016, the national immunisation program will introduce herpes zoster for people aged 70 years. There will be a national catch up program for people aged 71-79 years of age. The immunisation unit will provide education and assistance to implement this important vaccine program

The NT has the highest prevalence of hepatitis B in Australia and 60% of people living with chronic hepatitis B are Aboriginal people. The Sexual Health and Blood Borne Virus Unit coordinated the development of an NT Hepatitis B Action Plan in conjunction with hospital specialists, primary health care agencies and community organisations. The key elements of the plan are to increase the number of people receiving treatment for chronic hepatitis B infection and increase vaccination coverage for people over the age of 25 years. Actions under the plan include

- **Provision of free hepatitis B vaccine for all Aboriginal adults up to the age of 50 years who have not been previously vaccinated or infected,**
- **Delivery of training and accreditation workshops in Central Australia and the Top End in the treatment of hepatitis B for doctors, nurses and Aboriginal Health Practitioners.**
- **Developing a data merging exercise to provide primary health care agencies with a resource that will allow them to see the proportions of people in their communities in need of various elements of hepatitis B care and to identify specific actions needed for each individual patient.**

Strategic Objective 2:

Deliver appropriate care to vulnerable people and populations

Improving health outcomes for people and populations who are vulnerable using a holistic, person centred approach across the lifespan

Sporting Activity Access Grant

In 2015-16, the Department developed a one-off Sporting Activity Access Grant worth $30,000 with the aim of providing funding to an organisation to improve access to a sporting and/or recreational activity for people with disability. The successful applicant was Total Recreation who proposed an initiative called *'Futs for All.'* Futsal is a modified form of soccer and has been identified as a sport that Territorians with a disability would benefit most from. It is a group sport that has strong social links to the community and will provide inclusive pathways for players with an intellectual disability to connect with the community. The *'Futs for All'* program aims to assist athletes with a disability achieve a level of fitness and skill to reach the eligibility criteria to compete in the International Association of Sport Global Games to be held in Brisbane 19 October 2019. The Games are the world's largest elite sporting event for athletes with an intellectual disability.

NT Health Response to the *NT Domestic and Family Violence Reduction Strategy*

NT Health has collaborated on the implementation of the Family Safety Framework, an action based integrated service response operating in Darwin, Katherine, Nhulunbuy, Alice Springs, Tennant Creek and Yuendumu. Seventy-six NT Health staff attended Family Safety Framework training across the NT.

NT Health staff referred 53 people at high risk of domestic and family violence to the Family Safety Framework. The Department has strengthened the focus on mandatory reporting at NT Health orientation sessions for clinical staff, to raise awareness of their responsibilities. In 2015-16 two professional development days were held on this issue with 68 attending.

Health and Justice Partnership

The CAHS and the Central Australian Women's Legal Service (CAWLS) have entered into a new partnership aimed at meeting the needs of patients presenting as having experienced domestic and family violence.

The Health and Justice Partnership is a collaborative practice model providing an integrated response between medical services, ASH, Flynn Drive Renal Dialysis Unit and CAWLS. It focuses on maximising client capacity by providing legal information and support while addressing and managing identified social needs.

The Australian Government has identified that female clients are at higher risk of becoming victims or are already victims of family violence in Central Australia and need to access legal intervention while also securing alternative social and health supports in a confidential space. The *"wrap around service"* aims to offer this holistic and collaborative service on site or by an on call service at each of our health services.

L-R Larissa Ellis, Sue Korner, Kim Raine and Janet Taylor signing the partnership agreement

Healthy School Age Kids Program

In 2015-16, the Child Youth Health Strategy Unit commenced adapting the Healthy School Aged Kids Program for children 5–14 years. The Healthy School Aged Kids (HSAK) Program is an evidence based population health program for school-age children in remote areas of the Northern Territory. The aim of the program is *'To improve the health, well-being and learning outcomes of school age children living in remote communities of the NT'*. The Program consists of three components: Health Promotion in the school and community setting; Integration of other services and programs for school age children and student health screening.

Community Paediatrics Program

In coordination with the Health Services and the Office of Disability, the Community Paediatrics Program continues to develop and implement early diagnosis strategies and monitoring programs for children with cerebral palsy, including the NT Cerebral Palsy Hip Surveillance Program. This program monitors children with cerebral palsy for early indicators of progressive hip displacement. This is achieved through a recall system which provides timely x-ray assessment and orthopaedic referral if required.

In January 2016, a pilot project commenced to collect childhood injury data from the emergency department of the RDH. Following 12 months of data collation and entry, the data will be analysed and interpreted, with injury information including the cause of injuries to be shared with outside agencies such as Kidsafe NT. This data will assist in directing the development of preventative measures.

Healthy Skin Program

In August 2015, the CDC published the *Healthy Skin Program; Guidelines for Community Control of Scabies, Skin Sores, Tinea and Crusted Scabies in the Northern Territory.* This publicly available document will assist health practitioners with diagnosis and management of scabies, skin sores, tinea and crusted scabies in the Northern Territory.

Alcohol and Other Drugs

The Department's Alcohol and Other Drugs Directorate achieved the following in 2015-16:

- Funding for Barkly Region Alcohol and Drug Abuse Advisory Group facilitated the establishment of *"High Risk Youth Substance Misuse Service"* which opened in February 2016. The service was developed in response to the growing number of young people in the region with substance misuse problems. This new service provides 12 beds, 24 hour 7 day a week care in a residential setting to clients aged 10 to 17 years who are affected by volatile substances, drug and/or alcohol abuse and misuse.
- Launch and promotion of *Tackling Ice in the NT*– the whole of government Northern Territory Ice Action plan in February 2016 (www.breaktheice.nt.org.au).

- Contributed towards the *Draft National Ice Action Strategy, National Drug Strategy 2016-2025* and the *National Alcohol Strategy 2016-2025*.
- Supported enactment of *Alcohol Mandatory Treatment Regulations* in March 2016 to provide a new pathway for medical practitioners to refer clients into AMT for assessment and treatment.
- Development of strategies to improve efficiency of Alcohol Mandatory Treatment and commissioning of an external review of Alcohol Mandatory Treatment due for completion in early 2017.
- Engaging the community and relevant partners in service planning to optimise service integration and delivery and to test the effectiveness of approaches.
- Volatile substance abuse prevention initiatives including the continued roll out of low aromatic fuel across the NT to reduce the incidence of petrol sniffing, implementation of a new volatile substance abuse management plan by Kalano Community Association and reviewing and updating existing volatile substance abuse management plans for Galiwinku, Gapuwiyak, Ramingining and Wugularr/Beswick communities.

Readiness for NDIS transition

In 2015-16, the Department has been realigning current disability service planning processes and eligibility criteria for disability services to be better positioned to meet the eligibility criteria and support planning operations of the NDIS. This includes working closely with clients currently in receipt of supports and developing new processes providing them with increased opportunity to exercise choice and control in relation to provider choice.

The Department has also undertaken a project to review and streamline information in the Community Care Information System in order to align information with the NDIS. A template has been developed and is currently being implemented to better support NDIS information requirements as part of the transition process.

Northern Territory Disability Services Awards

The Northern Territory Disability Services Awards recognise disability support workers, operational staff and mainstream businesses that have demonstrated outstanding commitment to improving the lives of people with disability and to creating opportunities for their participation in the community. The Awards promote the value of a professional disability workforce in the Northern Territory and acknowledge mainstream businesses that make a positive contribution to people with disability. In 2015 there were seven categories as well as the overall award. The recipients of the 2015 Awards were announced on 10 November 2015 and include 2015 Overall Award for Excellence - Vanessa Adzaip; other awardees are summarised below.

Award	Recipient/Organisation
Emerging leader	Shannon Hallatt, OT for Kids
Excellence in Improving Participation	Total Recreation
Excellence in Promoting Community Awareness	Barkly Regional Arts
Excellence in Innovation	Henbury School
Outstanding Disability Service Employee	Mavis White, Somerville Community Services
Outstanding Business and Community Initiative Award	HPA - Helping People Achieve
Excellence in Improving Learning and Development	Vanessa Adzaip, DeafNT and Deaf Children Australia

Vanessa Adzaip - 2015 Overall Award for Excellence

Young Carers Awards

The Department's Office of Disability sponsors the Young Carers Award as part of the NT Young Achievers Awards to recognise the achievements and positive contributions of young Territorians aged between 14 and 27 years. At the Awards Presentation in

April 2016 Bethany O'Shea was announced as this year's recipient. Bethany has been a carer for her Mum who suffers from mental illness and diabetes, and for her younger sister, who also has diabetes. During her school holidays, Bethany assists Carers NT by taking young carers on outings to provide some respite from their caring role.

Strategic Objective 3:

Improve Aboriginal health outcomes

Closing the gap in health and wellbeing between Aboriginal and non-Aboriginal Australians

Aboriginal Health Plan

The *Northern Territory Aboriginal Health Plan 2015-2018* was launched in July 2015. The Health Plan sets out the Department's strategic directions to improve the health and wellbeing of Aboriginal Territorians. The Aboriginal Health Plan is based on four strategic directions which aim to improve Aboriginal health service delivery; build effective partnerships, deliver culturally secure and safe services for Aboriginal people and strengthen the Aboriginal health workforce.

Statement of Commitment

The *Statement of Commitment to Making a Difference to Aboriginal Health and Wellbeing* was signed by the Chief Executive Officer and the Minister for Health in July 2015. The Statement of Commitment is a pledge to make a difference to Aboriginal health and wellbeing by acknowledging and respecting the interest of Aboriginal people as Australia's first peoples. It underpins NT Health's engagement with, and delivery of services to Aboriginal people, their families, carers and communities.

Aboriginal Cultural Security Framework

The *Northern Territory Aboriginal Cultural Security Framework 2016-2026* was signed in June 2016. The Framework builds on the *Aboriginal Cultural Security Policy* developed in 2007 that articulates the importance of culture in improving the health outcomes of Aboriginal people and communities.

The Framework will assist NT Health staff to consider and implement cultural security initiatives through priority action areas including; workforce, communication, whole of organisation approach, leadership, consumer and community participation, quality improvement, planning, research and evaluation. Through structured action across these priorities, NT Health will improve access and equity to health services for Aboriginal Territorians.

Aboriginal Health Innovations Sponsorship Fund

In 2015-16 the Aboriginal Health Innovations Sponsorship Fund supported 13 projects totalling $100,000 across NT Health including the development of the hearing health hip-hop promotion video with young people at Canteen Creek, development of a health literacy practice resource and medication support for renal patients.

National Aboriginal Health Summit

The Department of Health and the Aboriginal Medical Services Alliance NT successfully co-hosted the third National Aboriginal Health Summit in Darwin in July 2015. The Summit bought together health and mental health Ministers and leaders in the Aboriginal health and mental health portfolios to discuss activity aimed at improving health outcomes for Aboriginal people. A number of issues were identified and the Department is undertaking a number of measures in response to these issues. This includes:

- development of a central online resource portal for Aboriginal health policies, frameworks and relevant information
- finalisation of the Aboriginal and Torres Strait Islander Health Practitioner Cultural Statement.
- development and implementation of the Northern Territory Mental Health Service Strategic Plan 2015-2021 and the Northern Territory Suicide Prevention Strategic Action Plan 2015-2018
- continuation of the support for the "Pathways to Community Control"
- maintaining strategic partnerships with the National Aboriginal and Torres Strait Islander Health Workforce Working Group

Evaluating Organisational Cultural Competence in Maternity Care

The Department is leading a national research project commissioned by AHMAC, *Evaluating Organisational Cultural Competence in Maternity Care for Aboriginal and Torres Strait Islander Women*. This project will provide a baseline 'stocktake' of self-assessed organisational cultural competence in participating maternity services across Australia. At the same time it is expected that awareness and organisational knowledge of cultural competence will be increased and participating organisations will have the opportunity to assess current strengths and areas for improvement. The project is due for completion by the end of 2016.

Improving Health Outcomes

Improvement in oral health significantly contributes to better health outcomes for Territorians

Oral Health Services Northern Territory and Anyinginyi Health Aboriginal Corporation formed a joint collaborative working group known as *Dental Connect*. The two organisations meet quarterly to discuss all aspects of oral health and how to most effectively and efficiently deliver services in the Barkly region. This has resulted in efficiencies in scheduling of dental visits to the various dental facilities in the Barkly region and in patient referral processes.

Throughout 2015-16 an additional 600 days of clinical services were provided to eligible children living in remote NT communities. This is in addition to NTG funded services. The year has also seen enhanced clinical and preventive oral health services delivered to Aboriginal children throughout the Territory under the National Partnership Agreement - Northern Territory Remote Aboriginal Investment. In addition, The National Partnership Agreement - On Adult Public Dental Services commenced 1 July 2015. This Agreement is facilitating short term employment of dental teams to supplement the workforce, and increase clinical services to eligible adult clients, with a focus on remote communities.

OHSNT has continued its valued partnership with Australian Football League Northern Territory for another four years. The key element of the agreement is to increase the opportunity for improving oral health literacy and clinical outcomes by providing increased access to Aboriginal teenagers through the Michael Long Learning and Leadership Centre.

A partnership between Child Australia (Bagot Community) and the Department, utilising an Indigenous Liaison Officer has resulted in a marked increase in primary school children having completed comprehensive dental examinations.

The Hearing Health Program implemented the Hip Hop Project in Canteen Creek in June 2016 in collaboration with the Indigenous Hip Hop Projects (IHHP) and local community organisations within Canteen Creek in the Barkly Region. The Canteen Creek community are extremely proud of the video and the program has received very positive feedback. The video can be accessed on YouTube through the IHHP channel.

A major software development project commenced for the build and implementation of the Hearing Health Information Managements System (HHIMS). HHIMS will support integrated business capabilities that translate to less chronic ear disease and improved hearing in Aboriginal children. HHIMS will deliver a hearing health record and clinical data repository for specialist (Ear, Nose and Throat surgeons), audiology, specialist nurse, neonatal hearing screening (NHS) and hearing health work units. Clinical reports are distributed to stakeholders based on electronic data from assessments/treatments provided by specialist personnel. In addition, the HHIMS will include administration modules to strategically manage, integrate and deploy resources and streamline reporting.

Strategic Objective 4:

Better coordinate and integrate care

Integrating planning and service provision to improve pathways of care for patients and consistency in health standards and delivery

Territory Pathology

The implementation of Territory Pathology reflects a transition from five independent laboratories to an integrated network, facilitating better coordination and integration of care through a single public pathology service. Other outcomes include improved clinical

governance and the standardisation of systems and processes resulting in improved service quality.

Strategic Information Technology Projects

Major projects successfully delivered in 2015-16 include:

- the Primary Care Information System and the MedChart Primary Care Module was rolled out to all Top End Renal Services providing management of priority client information
- pathology bulk billing in the Acute Care Information System receives direct revenue from Medicare, providing a processing, claiming and receiving loop cycle
- patient Journey Boards were deployed in RDH and ASH providing clinical logistics support
- the three year project *'My eHealth Record transition to the national My Health Record'* (M2N Project) was completed on 30 June 2016 and has delivered capability to send summaries of important health information to the national My Health Record system
- Hospital Dashboards which provide hospital management with near real time operational information to show current hospital capacity and activity against national targets.
- continued roll out of the Electronic Document Records Management system, with 108,000 electronic records now created or revised.
- completed a major ICT upgrade program including commissioning new server infrastructure for CareSys and Clinical Workstation.

Strategic Information Management Committee

During 2015-16, the SIMSC met its aims and objectives by endorsing a range of priority ICT investment proposals and business cases, provided advice and guidance to the newly established ICT Project Boards and regularly monitored the progress of in-flight ICT projects for Top End and Central Australia Health Services and the Department of Health.

Of note is SIMSC's involvement to progress the Enterprise Master Person Index project, a foundation component for TEHS and CAHS ICT architecture that supports operational clinical information systems, and will be a key element for delivery of the Core Clinical Systems Renewal Program.

Reversible Contraception Program

The Office of the Chief Nursing and Midwifery Office implemented a policy and supportive educational program for nurses and midwives to improve access to long acting reversible contraception for Territory women.

Maternity Models of Care

In partnership with the National Perinatal Epidemiology and Statistics Unit, the OCNMO hosted a workshop for maternity stakeholders in the NT to classify different maternity models of care. ASH and RDH participated in the national pilot program. For the first time in Australia, this will enable recording of maternity models of care, data that has never been captured before.

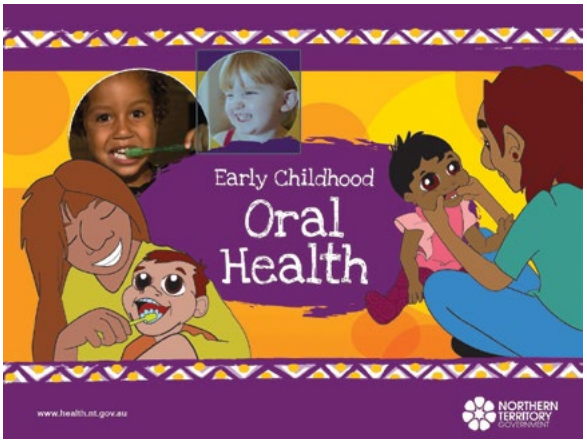
Community Morgue Agreements

The NT Government and the Australian Government have committed $5 million to build new and upgrade existing remote NT morgues over the next two years. A Project Control Group comprising representatives from the Department of Local Government and Community Services, Infrastructure and Health has been established to plan and oversee the work.

Strategic Objective 5:

Strive for clinical and corporate excellence

Driving a systematic, evidence based approach to maintaining and improving the quality and safety of patient care underpinned by transparent, accountable and effective clinical and corporate governance structures



Oral Health

Oral Health Services NT achieved accreditation with the Australian Council of Healthcare Standards in November 2015. Accreditation is mandatory for all public dental services and OHSNT met all core actions in the process receiving positive feedback regarding workplace culture, consistency in staff practices across sites, risk management and evaluation processes.

OHSNT continues to strive towards maintaining the best possible outcomes in all aspects of quality and safety for clients, and ensure staff utilise a system that plans, evaluates and drives quality initiatives across the services

A new dental truck, which arrived in Alice Springs in September 2015, is the latest addition to the OHSNT mobile fleet servicing the Barkly and Central Australia region. The truck was specifically designed to cope with the harsh demands of the Northern Territory – rough dirt roads, long distances, extreme heat and extreme cold. Additionally, a new dental engineering workshop was completed in December 2015. Externally funded, the workshop is co-located with the dental clinic at Alice Springs Flynn Drive campus.

Palmerston Dental Clinic underwent an upgrade in early 2016. The renovation included a fully functioning dental technician workshop that provides on-site prosthetic services for Palmerston clients. At the same time improvements were made to the client waiting room, multipurpose staff room and increased storage capacity in the clinical and reception areas. Remote Health centre upgrades this year included new dental clinics at Elliot, Docker River, Ngukurr and renovations to the clinic at Maningrida.

Quality Improvement Program Planning System

The Health Promotion Strategy Unit (HPSU) continues to administer, update and implement the Quality Improvement Program Planning System (QIPPS) that is utilised by NT Health staff, including TEHS and CAHS primary health care teams, to plan and evaluate health promotion programs and projects. With a view to quality and system improvement, each year users and stakeholders of the system are surveyed. This year's survey indicated that QIPPS is a valued component of health promotion planning and evaluation within NT Health. Most respondents preferred to use QIPPS together with other program planning tools. Key barriers to routine use of QIPPS, included it being a time intensive tool and a perceived lack of system support. Most respondents indicated they want more leadership and support to use QIPPS within teams. As a result of the survey QIPPS Business rules are currently being finalised and work continues with the QIPPS system owner to customise the system to better meet NT Health needs.

The HPSU facilitated a Health Promotion Continuous Quality Improvement 3 day workshop in Darwin that was attended by 20 participants. A similar workshop is planned in Alice Springs in the later part of 2016.

Health Gains Planning

Health Gains Planning (HGP) has continued to produce evidence based, high quality information to inform departmental policy development and service planning. Much of this work is published either as departmental reports or as peer-review journal articles. Some examples of new publications are:

- *Injuries in the Northern Territory, 1997-2011*
- *Renal Replacement Therapy Demand Study, Northern Territory, 2001 to 2022*
- *Early influences on developmental outcomes among children, at age five, in Australia's Northern Territory*

During 2015-16, HGP has also contributed to a range of collaborative research projects. This has included data linkage studies in the areas of early child development, renal disease and the influence of staff turnover on the quality of health care.

Injury Prevention and Safety Promotion

Injury causes substantial death, disability and costs to the health care system in the NT. In 2015-16 the Centre for Disease Control coordinated various activities in the NT to promote injury prevention.

Significant campaigns included:

- annual fireworks community safety campaign for Territory Day 2015
- promotion of stinger safety messages over the wet season
- support of Water Safety Week 21-28 September 2015.

The Department continues to play a crucial role in multi sector partnerships by providing public health, research and evaluation expertise as well as access to and analysis of injury data.

Environmental Sustainability

The Department is committed to developing new buildings and substantial facility extensions and infrastructure that are environmentally sustainable and energy efficient. This is facilitated through compliance with the Building Code of Australia's (BCA) Section J which details the energy efficiency requirements for buildings. The BCA Section J has not been widely adopted in the Northern Territory, however the Department of Health has proactively promoted compliance through its briefing requirements.

Attention is paid to both passive and active control measures to ensure the internal and surrounding climate remain within efficient and comfortable conditions. This cannot always be achieved, particularly in existing and old buildings where passive energy saving elements were not accommodated in the original facilities design and are now difficult to incorporate. In these cases, energy efficiency measures are incorporated actively into fixtures, fittings and equipment which incrementally reduce the Department of Health's energy requirements. An example of this is the replacement of fluorescent tubes with LED lights and improved air-conditioning control through recent projects at Royal Darwin Hospital. The Palmerston Regional Hospital will be the largest BCA Section J compliant facility the Department of Health has delivered on.

Stakeholder Engagement

The Department is currently developing culturally appropriate patient experience survey tool for use across NT Health services, to meet national accreditation requirements and increase the accessibility and useability of feedback mechanisms for consumers.

This continued focus will ensure the availability of multiple avenues for consumers to provide direct feedback to assist in the continuous improvement of operational health service delivery.

Particular focus has been given to identifying a tool that can be easily accessed by those consumers who are the least likely to provide feedback, such as Aboriginal and Torres Strait Islander persons and consumers from culturally and linguistically diverse backgrounds.

Service Delivery Agreements

The 2015-16 Service Delivery Agreements were developed in the context of the New Service Framework, the strategic objectives of the *NT Health Strategic Plan 2014-17* and the parameters of the NT Health Performance Charter.

A suite of 22 key performance indicators were used to measure and monitor Health Service performance and to address and improve accountability in the delivery of publicly funded health services. A summary of all performance measure outcomes can be found in each Health Service's respective section. In 2015-16 the System Manager:

- used monthly performance reports and meetings with Health Service Executives to monitor and manage Health Service performance and reporting requirements against the 2015/16 SDA
- held formal performance mid-year and year-end review meetings with the Health Service Boards and Health Service Executives to review the levels of performance improvement, service delivery and financial performance expected of the Health Services, including consumer feedback reports
- monitored and maintained focus on improving Aboriginal health outcomes using the 2015/16 SDA key performance indicators, in particular reports on adult health check coverage rates, the number of patients with a chronic disease management plan, anaemia and type II diabetes diagnosis rates, and the number of Aboriginal Health Practitioner FTEs employed by the Health Services
- provided the Health Service Boards improved transparency in decision-making processes for the type, volume and mix of health services purchased in the 2016-17 SDAs
- developed the 2016-17 SDAs to include more detailed information and visibility of the cost effectiveness of health services in acute care settings
- provided oversight in the development and pilot of the TEHS Integrated Health Care Framework to support delivery of integrated care initiatives

- introduced five new key performance indicators in the 2016-17 SDAs to extend performance monitoring: mental health seclusion rates; discharge summaries dispatched within 48 hours; discharged or left against medical advice; Telehealth occasions of service; and prevalence of children diagnosed with moderate hearing impairment
- reviewed and prioritised potentially preventable hospitalisations performance reporting in 2016-17 to support work being undertaken for the Heads of Agreement on Public Hospital Funding

Strategic Objective 6:

Build a highly skilled and culturally responsive workforce

Building local capacity and strategically recruit, develop and retain a culturally safe and highly skilled health workforce

Aboriginal Health Workforce

In 2015-16 the Department of Health awarded four scholarships for Aboriginal people studying the Certificate IV Aboriginal and Torres Strait Islander Primary Health Care Practice. The scholarships aim to increase the Aboriginal and Torres Strait Islander Health Practitioner workforce and contribute to improved health outcomes for Aboriginal Territorians.

NT Health continued its cultural development program titled *Walking in Two Worlds*. Designed for Aboriginal staff to gain a greater understanding of how Government works, and navigation of the health systems.

NT Health continued its suite of cultural development programs including an exciting new program piloted in 2014-15, titled Walking in Two Worlds. This program is designed for Aboriginal staff to gain a greater understanding of how Government works, and navigation of the health systems.

Each year the Department sponsors the annual Aboriginal and Torres Strait Islander Health Practitioner Excellence Awards. This year Ms Sarah Bukulatjpi was recognised for her work and received the 2015 legend award. Ms Bukulatjpi, a staff member at the Ngalkanbuy Health Service was recognised for work on improving health outcomes in her home community of Galiwin'ku. Sarah's work included introducing new systems within the chronic conditions program and developing an educational app, first launched in late 2014. Sarah is also passionate about working with individuals experiencing mental health issues.

Ms Sarah Bukulatjpi receives her award from Minister John Elferink

Aboriginal Staff Development

NT Health is also committed to the management capability development of Aboriginal staff as part of the Indigenous Employment and Career Development Strategy 2015-2020. The table below details Aboriginal staff participation in the suite of short courses offered by the Department.

Aboriginal Staff Participation in Employee Development Training Courses (short courses only)

Agency Name	Aboriginal or Torres Strait Islander	Not Aboriginal or Torres Strait Islander	Not Stated	Total
Department of Health	147	788	200	**1135**
Top End Health Service	139	2147	891	**3177**
Central Australia Health Service	89	810	303	**1202**
Grand Total	**375**	**3745**	**1394**	**5514**

In 2015-16 the Minister for Health expanded the *Back on Track* (BoT) Project to include Aboriginal health workforce (both clinical and non-clinical) across health services. The BoT project aims to increase the number of Aboriginal people employed within the Department and is aligned with the Chief Minister's target of increasing Aboriginal employment across the Northern Territory Public Sector.

NT Health staff participated in OCPE's Lookrukin Indigenous Women's Leadership Development Program. This unique personal and professional development programs designed for NTPS Indigenous women provides an opportunity for participants to gain the knowledge and skills necessary to increase their effectiveness in their current position and to improve their career progression. The Lookrukin Indigenous Women's Leadership Program ran from March until November 2015, with five NT Health participants – two from Top End Health Service and three from the Department of Health. During the Lookrukin Indigenous Women's Leadership Program participants undertake the Diploma of Management through Charles Darwin University.

NT Health Graduates in the Lookrukin Womens Leadership program

Alcohol and other Drugs Workforce Development

Alcohol and Other Drugs Workforce Development continued to provide accredited apprenticeships and Certificate II, III, IV and Diploma qualifications in Alcohol and other Drugs to high school students and health workers in community and frontline related services

Nurse Practitioners

Substantial progress has been made towards meeting the target of 25 nurse practitioners operating in the NT by the end of 2016 calendar year, with 21 nurse practitioners endorsed in the NT as at April 2016.

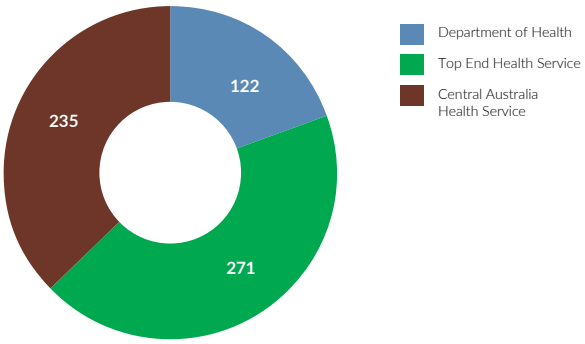
Cultural Awareness

Aboriginal cultural awareness and enhanced skill development continues to be a key learning and development priority for the Department.

In 2015-16, 628 employees attended Aboriginal cultural development programs to develop their skills, knowledge and attitudes in working effectively with Aboriginal staff and clients to improve health outcomes and the consumer experience. The following Aboriginal cultural development programs were available to staff:

- Aboriginal Cross Cultural Awareness Program (ACAP)
- Cultural Capability Development for Managers
- Cultural Considerations for Policy and Strategic Program Developers

NT Health ACAP Attendance by Agency 2015-16



Other training programs provided to support staff in their professional roles included:

- The accredited Healthy Smiles Oral Health and Fluoride Varnish Information for Health professionals program.
- Health Promotion - 4 day Short course *
- Social Media -1 day workshop*

* These courses were also made available to non-Government organisations and Aboriginal Controlled Medical Services.

The Health Promotion short course aims to increase staff's knowledge of health promotion principles and theories and build their skills in planning and evaluating health promotion programs and projects.

Student Support and Traineeships

Ninety four study assistance grants were awarded to students undertaking postgraduate and undergraduate tertiary study in a range of nursing and midwifery courses.

The Department hosted 24 James Cook University final year dental students for their long term placements, eight students in Darwin and four in Alice Springs. All students undertake a remote placement and actively participate in all clinical collaboratives and professional development opportunities.In addition, four oral health therapy students from the University of Melbourne participation in a three week clinical placement in the Top End.

In 2010, The Department successfully developed and introduced the Certificate III Dental Assisting training program to address the increasing difficulty of recruiting Dental Assistants in the NT. Training has progressed well, with the completion rate of trainees being over 90% and has expanded to include mature age trainees. In 2015-16, the program was upgraded to meet Australian Skills Quality Authority Standards.

Professional Practice Supervision (PPS)

The Department implemented the Professional Practice Supervision (PPS) program across the Health Services. PPS includes formal, regular and structured activities to support and facilitate an environment for health professional growth. Implementation of the program was supported by a PPS Framework and PPS Implementation Guide and Resource

Remote Area Nurse Safety

A review of Remote Area Nurse Safety commenced in 2015-16. Phone interviews and focus groups were conducted with stakeholders to determine current issues, areas of concern and identify improvements. All information has been gathered and the outcome of the review is due in the second half of 2016.

Health Literacy and Cultural Safety

The Department, in partnership with Charles Darwin University (CDU) School of Health held the inaugural "Effective Communication: improving health literacy and cultural safety in health care" pilot workshops in Darwin and Alice Springs 21-22. The aim of the training is to help increase staff awareness and understanding of the importance of effective communication and improving our own health literacy to assist our consumers to better engage with service providers. It further acknowledges that health literacy cannot be effectively addressed without also addressing the key elements of communication and cultural safety. The workshops were attended by a total of 50 staff and trials will be continued and evaluated in the upcoming year.

Strategic Objective 7:

Drive financial sustainability

Putting the health system on a path to financial sustainability through the provision of efficient, appropriate and cost effective services

Financial sustainability and growing demand

The economic burden associated with the growing demand for health services, while not unique to the NT, represents a considerable financial challenge to the Department. Changing demographics, adoption of new technologies, service expansion and innovation all contribute to the demand on fiscal resources. The Department has prioritised financial sustainability in the *NT Health Strategic Plan 2014 17* to ensure that the NT health system is well positioned to deliver an integrated service and to improve the efficiency and effectiveness of primary care thus making the best use of hospital resources.

In 2015-16 the Budget and Finance Branch undertook a range of activities to improve financial management within the Department of Health and the broader health system. These included:

- a new set of budget guidelines and principles to improve the budget setting process

- a new Service Delivery Agreement finance notification process to ensure health services have transparent and timely budget advice. The new process also ensures clear alignment of budget numbers between the key three areas of Department of Treasury and Finance, System Manager and the Health Services
- a new forecasting methodology to better inform on projected revenue and expenditure performance
- new high level reporting that facilitates the provision of accurate and timely financial advice to senior management
- creation of a Master Map of Revenue Standard Classifications in Health, which will assist to achieve greater accuracy, and thereby revenue reporting on which management decisions are made.
- a new hospital billing system is at the User Acceptance Testing stage, with 'go live' scheduled for early 2016-17. Delivery of this fully integrated system will enable hospitals to better manage patient billing and improve revenue reporting.

Activity Based Funding

The Department continues to provide ongoing clinical documentation education to service providers in the NT to ensure ongoing accurate measurement of activity in the Health Services. Accurate collection and costing of clinical activity will continue to be a key driver of improvements to the provision of cost effective quality health care.

Procurement and Contracting

The Corporate Services Bureau commenced the project *"Establish Service Model and Service Standards"* which is underpinned by a relationship model of consultation and collaboration. The overall aim is to be a client focused provider of core functions to support the delivery of improved health outcomes in the Northern Territory.

To support more efficient and contestable system-wide procurement and contracting processes, the Department:

- progressed the development of a department-wide Spend Analysis/Category Taxonomy to identify spend categories. This will enable the identification of efficiencies through analysis of high volume and high value vendor payments to improve alignment with the Health Services' procurement requirements.
- implemented service efficiencies through economies of scale and a more visible mechanism of accountability for the use of public pathology services through the newly integrated Territory Pathology. The development of a costing model and national billing follows best practice of analysing demand.

Grants management

The Department continues to promote financial sustainability and transparency through the implementation of improvements for the management of grants to external service providers. The departmental governance, policy and procedures for grants have been in use since December 2014 and are to be reviewed to align with Whole of Government principals announced in October 2015 and continued grants reforms inclusive of system and policy.

A review of the Grant Management System (GMS) and the Integrated Grants Management Framework (IGMF) training modules has been completed and the training modules have been updated. Training is available for Department and external service providers.

The Department has been developing a system for grant management that has been in production since March 2015 which is being used by Alcohol and Other Drugs. The GMS allows external service providers to apply for grants and submit performance and financial reporting directly into the system.

Appendix B lists grant and subsidy payments managed by the Department's Grants Administration Unit during 2015-16.

Major Works and Infrastructure

Refurbishment and redevelopment works have occurred at both Royal Darwin and Alice Springs Hospitals in 2015-16 and are outlined in each Health Services respective sections. Completion and construction of remote health centres is detailed in Highlights 2015-16.

Financial statements

Department of Health

Department of Health

Financial Performance

For the year ended 30 June 2016

Overview

The Department of Health's financial performance is reported in three financial statements: the Operating Statement, the Balance Sheet, and the Cash Flow Statement. These statements and the accompanying notes have been prepared in accordance with the Northern Territory Government's financial management framework and relevant Australian accounting standards. The financial statements include financial data from the 2015-16 financial year and comparative data from 2014-15.

The 2015-16 financial performance for the Department had minor variations from the budgeted targets for both expenses and revenue and continues the Department's strong emphasis in resource management.

Main results at a glance

- The Department reported an operating surplus of $6.5 million.
- The equity position decreased by $3.8 million from 2014-15 to $23.8 million in 2015-16.
- Expenses were contained within 0.4% of budget targets.
- Revenue earned was within 0.04% of budget targets.

Operating Statement

Operating Statement Summary	2015-16 $000	2014-15 $000	Variation $000	Variation %
Operating Revenue	1 397 246	1 307 082	90 164	6.90%
Operating Expenditure	(1 390 702)	(1 331 692)	(59 010)	4.43%
Surplus/(Deficit)	6 544	(24 610)	31 154	

In 2015-16 the Department's operating statement showed a surplus result of $6.5 million. The full year operating surplus exclusive of depreciation expenditure (which is not revenue funded) was $11.2 million. The surplus result was due to a one off funding issue with the Commonwealth.

Operating Revenue

The Department's principal source of revenue is output revenue provided by the Northern Territory Government to fund core health services across the Northern Territory. The majority of the Department's remaining revenue came from the Commonwealth in the form of Activity Based Funding (ABF), National Partnership Payments (NPP), Specific Purpose Payments (SPP) and grant funding.

Operating Expenditure

In 2015-16 the Department incurred expenses of $1.4 billion, an increase of 4.43% on the previous financial year. The increase was mainly due to additional funding provided to the Health Services under the purchaser provider arrangement. This included additional Commonwealth revenue for National Health Reform, Indigenous Australian Health Program, Indigenous Teenage Sexual Health and Parent Support and Northern Territory Remote Aboriginal Investment.

Balance Sheet

Balance Sheet Summary	2015-16 $000	2014-15 $000	Variation $000	Variation %
Assets	44 344	60 341	(15 997)	(26.51%)
Liabilities	(20 544)	(32 704)	12 160	(37.18%)
Equity	23 800	27 637	(3 837)	

In 2015-16 the Department's equity position decreased by $3.8 million. The decrease was primarily a result of the transfer of the Alcohol and Other Drugs program to the Top End Heath and Central Australia Health Services.

Statement of Cash Flows

Cash Flow Statement Summary	2015-16 $000	2014-15 $000	Variation $000	Variation %
Cash at beginning of reporting period	18 301	26 202	(7 901)	(30.15%)
Receipts	1 407 144	1 325 421	81 723	6.17%
Payments	(1 410 767)	(1 379 583)	(31 184)	2.26%
Equity injections	1 634	46 321	(44 687)	(96.47%)
Equity withdrawals	-	(59)	59	(100.00%)
Cash at end of reporting period	16 312	18 301	(1 989)	

The cash flow statement shows the Department's cash receipts and payments for the financial year. The statement incorporates expenses and revenues from the operating statement, after the elimination of all non-cash transactions, with cash movements from the balance sheet.

Summary

Budget Target Summary	2016 Final Budget $000	2016 Actual $000	Variation $000	Variation %
Operating Revenue	1 397 825	1 397 246	(579)	(0.04%)
Operating Expenses	(1 396 207)	(1 390 702)	5 505	0.40%
Surplus/(Deficit)	1 618	6 544	4 926	

The Department's performance in both revenue generation and expenditure control show a result that had minor variations from planned targets. Expenditure across the Department was well managed coming within 0.4% of the annual budget target.

CERTIFICATION OF THE FINANCIAL STATEMENTS

We certify that the attached financial statements for the Department of Health have been prepared from proper accounts and records in accordance with the prescribed format, the *Financial Management Act* and Treasurer's Directions.

We further state that the information set out in the Comprehensive Operating Statement, Balance Sheet, Statement of Changes in Equity, Cash Flow Statement, and notes to and forming part of the financial statements, presents fairly the financial performance and cash flows for the year ended 30 June 2016 and the financial position on that date.

At the time of signing, we are not aware of any circumstances that would render the particulars included in the financial statements misleading or inaccurate.

Prof Len Notaras AM
Accountable Officer
31 / 8 /2016

Anthony Hendry
A/Chief Finance Officer
31 / 8 /2016

DEPARTMENT OF HEALTH

COMPREHENSIVE OPERATING STATEMENT

For the year ended 30 June 2016

	Note	2016	2015
		$000	$000
INCOME			
Grants and subsidies revenue			
Current		257 799	213 567
Capital		410	0
Appropriation			
Output		1 020 500	985 167
Commonwealth		57 064	47 136
Sales of goods and services		46 678	45 999
Interest revenue		16	18
Goods and services received free of charge	4	11 233	14 526
Gain on disposal of assets	5	4	0
Other income		3 542	669
TOTAL INCOME	3	**1 397 246**	**1 307 082**
EXPENSES			
Employee expenses		128 809	138 579
Administrative expenses			
Purchases of goods and services	6	537 563	504 879
Repairs and maintenance		583	667
Depreciation and amortisation	10, 11	4 679	4 549
Other administrative expenses[1]		11 401	15 098
Grants and subsidies expenses			
Current		678 346	645 437
Capital		10 825	0
Community service obligations		18 496	22 483
TOTAL EXPENSES	3	**1 390 702**	**1 331 692**
NET SURPLUS/(DEFICIT)		**6 544**	**(24 610)**
OTHER COMPREHENSIVE INCOME			
Items that will not be reclassified to net surplus/deficit			
Transfer from reserves		0	221
Changes in asset revaluation surplus		943	1 038
TOTAL OTHER COMPREHENSIVE INCOME		**943**	**1 259**
COMPREHENSIVE RESULT		**7 487**	**(23 351)**

[1] Includes DCIS service charges.

The Comprehensive Operating Statement is to be read in conjunction with the notes to the financial statements.

DEPARTMENT OF HEALTH

BALANCE SHEET

As at 30 June 2016

	Note	2016	2015
		$000	$000
ASSETS			
Current Assets			
Cash and deposits	7	16 312	18 301
Receivables	8	3 790	2 410
Inventories	9	434	127
Prepayments		1 364	3 858
Total Current Assets		**21 900**	**24 696**
Non-Current Assets			
Advances and investments		300	300
Property, plant and equipment	10, 11	22 144	35 345
Total Non-Current Assets		**22 444**	**35 645**
TOTAL ASSETS		**44 344**	**60 341**
LIABILITIES			
Current Liabilities			
Payables	12	5 393	15 919
Provisions	13	11 928	12 743
Total Current Liabilities		**17 321**	**28 662**
Non-Current Liabilities			
Provisions	13	3 224	4 042
Total Non-Current Liabilities		**3 224**	**4 042**
TOTAL LIABILITIES		**20 544**	**32 704**
NET ASSETS		**23,800**	**27 637**
EQUITY			
Capital		252 974	264 298
Asset revaluation surplus	14	2 550	1 607
Accumulated funds		(231 725)	(238 268)
TOTAL EQUITY		**23 800**	**27 637**

The Balance Sheet is to be read in conjunction with the notes to the financial statements.

DEPARTMENT OF HEALTH

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2016

	Note	Equity at 1 July	Comprehensive result	Transactions with owners in their capacity as owners	Equity at 30 June
		$000	$000	$000	$000
2015-16					
Accumulated Funds		(238 471)	6 544		(231 928)
Changes in accounting policy		203			203
Correction of prior period errors					
Transfers from reserves					
Other movements directly to equity					
		(238 269)	6 544		(231 725)
Asset Revaluation Surplus	14	1 607	943		2 550
Capital – Transactions with Owners					
Equity injections					
Capital appropriation		76 265		509	76 774
Equity transfers in		616 122		2 028	618 150
Other equity injections		182 519		1 125	183 645
Specific purpose payments					
National partnership payments		3 504			3 504
Commonwealth – capital					
Equity withdrawals					
Capital withdrawal		(118 895)			(118 895)
Equity transfers out		(495 217)		(14 986)	(510 203)
		264 299		(11 324)	252 974
Total Equity at End of Financial Year		**27 638**	**7 486**	**(11 324)**	**23 800**
2014-15					
Accumulated Funds		(213 862)	(24 609)		(238 471)
Changes in accounting policy					
Correction of prior period errors					
Transfers from reserves		(18)	221		203
Other movements directly to equity					
		(213 880)	(24 388)		(238 268)
Asset Revaluation Surplus	14	569	1 038		1 607
Capital – Transactions with Owners					
Equity injections					
Capital appropriation		75 036		1 229	76 265
Equity transfers in		613 814		2 308	616 122
Other equity injections		137 947		44 572	182 519
Specific purpose payments					
National partnership payments		2 984		520	3 504
Commonwealth – capital					
Equity withdrawals					
Capital withdrawal		(118 835)		(59)	(118 894)
Equity transfers out		(493 562)		(1 655)	(495 218)
		217 383		46 915	264 298
Total Equity at End of Financial Year		**4 072**	**(23 350)**	**46 915**	**27 637**

The Statement of Changes in Equity is to be read in conjunction with the notes to the financial statements.

DEPARTMENT OF HEALTH

CASH FLOW STATEMENT

For the year ended 30 June 2016

	Note	2016	2015
		$000	$000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Receipts			
Grants and subsidies received			
Current		257 799	213 567
Capital		410	0
Appropriation			
Output		1 020 500	985 167
Commonwealth		57 064	47 136
Receipts from sales of goods and services		71 351	79 533
Interest received		16	18
Total Operating Receipts		**1 407 140**	**1 325 421**
Operating Payments			
Payments to employees		(134 231)	(139 764)
Payments for goods and services		(560 986)	(570 304)
Grants and subsidies paid			
Current		(678 346)	(645 437)
Capital		(10 825)	0
Community service obligations		(22 884)	(21 409)
Total Operating Payments		**(1 407 271)**	**(1 376 914)**
Net Cash From/(Used in) Operating Activities	15	**(132)**	**(51 493)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Investing Receipts			
Proceeds from asset sales	5	4	0
Total Investing Receipts		**4**	**0**
Investing Payments			
Purchases of assets		(3 496)	(2 669)
Total Investing Payments		**(3 496)**	**(2 669)**
Net Cash From/(Used in) Investing Activities		**(3 492)**	**(2 669)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Financing Receipts			
Equity injections			
Capital appropriation		509	1 229
Commonwealth appropriation		0	520
Other equity injections		1 125	44 572
Total Financing Receipts		**1 634**	**46 321**
Financing Payments			
Repayment of borrowings			
Finance lease payments			
Equity withdrawals		0	(59)
Total Financing Payments		**0**	**(59)**
Net Cash From/(Used in) Financing Activities		**1 634**	**46 262**
Net increase/(decrease) in cash held		(1 989)	(7 900)
Cash at beginning of financial year		18 301	26 202
CASH AT END OF FINANCIAL YEAR	7	**16 312**	**18 301**

The Cash Flow Statement is to be read in conjunction with the notes to the financial statements.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

INDEX OF NOTES TO THE FINANCIAL STATEMENTS

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

1. OBJECTIVES AND FUNDING

The Department of Health's mission is to improve the health status and wellbeing of all people in the Northern Territory.

The Department is predominantly funded by, and is dependent on, the receipt of Parliamentary appropriations. The financial statements encompass all funds through which the agency controls resources to carry on its functions and deliver outputs. For reporting purposes, outputs delivered by the agency are summarised into several output groups. Note 3 provides summary financial information in the form of a Comprehensive Operating Statement by output group.

2. STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

a) Statement of Compliance

The financial statements have been prepared in accordance with the requirements of the *Financial Management Act* and related Treasurer's Directions. The *Financial Management Act* requires the Department of Health to prepare financial statements for the year ended 30 June based on the form determined by the Treasurer. The form of agency financial statements is to include:

(i) a Certification of the Financial Statements;

(ii) a Comprehensive Operating Statement;

(iii) a Balance Sheet;

(iv) a Statement of Changes in Equity;

(v) a Cash Flow Statement; and

(vi) applicable explanatory notes to the financial statements.

b) Basis of Accounting

The financial statements have been prepared using the accrual basis of accounting, which recognises the effect of financial transactions and events when they occur, rather than when cash is paid out or received. As part of the preparation of the financial statements, all intra-agency transactions and balances have been eliminated.

Except where stated, the financial statements have also been prepared in accordance with the historical cost convention.

The form of the agency financial statements is also consistent with the requirements of Australian Accounting Standards. The effects of all relevant new and revised Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that are effective for the current annual reporting period have been evaluated.

The following new and revised accounting Standards and interpretations were effective for the first time in 2015-16:

AASB 1048 Interpretation of Standards This reflects amended versions of Interpretations arising in relation to amendments to AASB 9 Financial Instruments and consequential amendments arising from the issuance of AASB 15 Revenue from Contracts with Customers. The Standard does not impact the financial statements.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

AASB 2013-9 Amendments to Australian Accounting Standards [Part C Financial Instruments] Part C of this Standard amends AASB 9 Financial Instruments to add Chapter 6 Hedge accounting and makes consequential amendments to AASB 9 and numerous other Standards. The Standard does not impact the financial statements.

AASB 2014-8 Amendments to Australian Accounting Standards arising from AASB 9 This Standard makes amendments to AASB 9 Financial Instruments (December 2009) and AASB 9 Financial Instruments (December 2010). These amendments arise from the issuance of AASB 9 Financial Instruments in December 2014. The Standard does not impact the financial statements.

AASB 2015-3 Amendments to Australian Accounting Standards arising from the withdrawal of AASB 1031 Materiality The Standard completes the withdrawal of references to AASB 1031 in all Australian Accounting Standards and Interpretations, allowing the Standard to effectively be withdrawn. The Standard does not impact the financial statements.

AASB 2015-4 Amendments to Australian Accounting Standards – Financial Reporting Requirements for Australian Groups with a Foreign Parent Amendments are made to AASB 128 Investments in Associates and Joint ventures to require the ultimate Australian entity to apply the equity method in accounting for interests in associates and joint ventures, if either the entity or the group is a reporting entity, or both the entity and group are reporting entities. The Standard does not impact the financial statements.

AASB 2014-1 Amendments to Australian Accounting Standards (Part E - Financial Instruments) Part E of this Standard defers the application date of AASB 9 Financial Instruments to annual reporting periods beginning on or after 1 January 2018. The Standard does not impact the financial statements.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

The following Standards and interpretations are likely to have an insignificant impact on the financial statements for future reporting periods, but the exact impact is yet to be determined:

Standard/Interpretation	Effective for annual reporting periods beginning on or after
AASB 9 Financial Instruments (December 2014), AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)	1 January 2018
AASB 15 Revenue from Contracts with Customers, AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	1 January 2018
AASB 1056 Superannuation Entities	1 July 2016
AASB 14 Regulatory Deferral Accounts	1 January 2016
AASB 1057 Application of Accounting Standards	1 January 2016
AASB 2014-1 Amendments to Australian Accounting Standards [Part D Consequential arising from AASB 14 Regulatory Deferral Accounts]	1 January 2016
AASB 2014-3 Amendments to Australian Accounting Standards - Accounting for Acquisitions of Interests in Joint Operations [AASB 1 and AASB 11]	1 January 2016
AASB 2014-16 Amendments to Australian Accounting Standards - Agriculture: Bearer Plants [AASB 101,116, 117, 123, 136, 140 and 141]	1 January 2016
AASB 2015-5 Amendments to Australian Accounting Standards - Investment Entities: Applying the Consolidation Exception [AASB 10, 12 and 128]	1 January 2016
AASB 2015-9 Amendments to Australian Accounting Standards - Scope and Application Paragraphs [AASB 8, 133 and 1057]	1 January 2016
AASB 2015-10 Amendments to Australian Accounting Standards - Effective Date of Amendments to AASB 10 and AASB 128	1 January 2016
AASB 2016-1 Amendments to Australian Accounting Standards- Recognition of Deferred Tax Assets for Unrealised Losses [AASB 112]	1 January 2017

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

The following Standards and interpretations are expected to have a potential impact on the financial statements for future reporting periods:

Standard/Interpretation	Effective for annual reporting periods beginning on or after	Impact
AASB 2015-6 Amendments to Australian Accounting Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities [AASB 10, 124 and 1049]	1 July 2016	New note disclosure to include remuneration of Key Management Personnel (KMP) and related party transactions.
2016-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107	1 January 2017	New disclosure on the reconciliation of the changes in liabilities arising from financing activities
AASB 16 Leases	1 January 2019	Reclassification of operating leases greater than 12 months to finance lease reporting requirements
AASB 9 Financial Instruments	1 January 2018	Simplified requirements for classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier as opposed to only when incurred
AASB 15 Revenue from Contracts with Customers	1 January 2018	Requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.
AASB 2014-1 Amendments to Australian Accounting Standards [Part E Financial Instruments]	1 January 2018	Amends various AAS's to reflect the deferral of the mandatory application date of AASB 9
AASB 2014-4 Amendments to Australian Accounting Standards - Clarification of Acceptable Methods of Depreciation and Amortisation [AASB 116 and AASB 138]	1 January 2016	Provides additional guidance on how the depreciation or amortisation of property, plant and equipment and intangible assets should be calculated and clarifies that the use of revenue-based methods to calculate the depreciation of an asset is not appropriate.
AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	1 January 2017	Amends the measurement of trade receivables and the recognition of dividends.
AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9	1 January 2018	Amends various AAS's to reflect the changes as a result of AASB 9

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Standard/Interpretation	Effective for annual reporting periods beginning on or after	Impact
AASB 2014-9 Amendments to Australian Accounting Standards - Equity Method in Separate Financial Statements [AASB 1, 127 and 128]	1 January 2016	Allows an entity to account for investments in subsidiaries, joint ventures and associates in its separate financial statement at cost or using the equity method.
AASB 2015-1 Amendments to Australian Accounting Standards - Annual Improvements to Australian Accounting Standards 2012-14 Cycle [AASB 1, 2, 3,5, 7, 11, 110, 119, 121, 133, 134,137 and 140]	1 January 2016	The amendments include AASB 5 change in methods of disposal; AASB 7 Servicing contracts and applicability of the amendments to AASB 7 to condensed interim financial statements; AASB 119 Discount rate: regional market issue and AASB 134 Disclosure of information elsewhere in the interim financial.

c) Reporting Entity

The financial statements cover the Department as an individual reporting entity.
The Department of Health ("the Department") is a Northern Territory department established under the *Interpretation Act Administrative Arrangements Order*.

The principal place of business of the Department is: Health House, 87 Mitchell Street, Darwin NT 0800.

d) Agency and Territory Items

The financial statements of the Department include income, expenses, assets, liabilities and equity over which the Department has control (Agency items). Certain items, while managed by the agency, are controlled and recorded by the Territory rather than the agency (Territory items). Territory items are recognised and recorded in the Central Holding Authority as discussed below.

Central Holding Authority

The Central Holding Authority is the 'parent body' that represents the Government's ownership interest in Government-controlled entities.

The Central Holding Authority also records all Territory items, such as income, expenses, assets and liabilities controlled by the Government and managed by agencies on behalf of the Government. The main Territory item is Territory income, which includes taxation and royalty revenue, Commonwealth general purpose funding (such as GST revenue), fines, and statutory fees and charges.

The Central Holding Authority also holds certain Territory assets not assigned to agencies as well as certain Territory liabilities that are not practical or effective to assign to individual agencies such as unfunded superannuation and long service leave.

The Central Holding Authority recognises and records all Territory items, and as such, these items are not included in the agency's financial statements. However, as the agency is

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NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

accountable for certain Territory items managed on behalf of Government, these items have been separately disclosed in Note 21 – Schedule of Administered Territory Items.

e) Comparatives

Where necessary, comparative information for the 2014-15 financial year has been reclassified to provide consistency with current year disclosures.

f) Presentation and Rounding of Amounts

Amounts in the financial statements and notes to the financial statements are presented in Australian dollars and have been rounded to the nearest thousand dollars, with amounts of $500 or less being rounded down to zero. Figures in the financial statements and notes may not equate due to rounding.

g) Changes in Accounting Policies

There have been no changes to accounting policies adopted in 2015-16 as a result of management decisions.

h) Accounting Judgments and Estimates

The preparation of the financial report requires the making of judgments and estimates that affect the recognised amounts of assets, liabilities, revenues and expenses and the disclosure of contingent liabilities. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Judgments and estimates that have significant effects on the financial statements are disclosed in the relevant notes to the financial statements. Notes that include significant judgments and estimates are:

- Employee Benefits – Note 2(w) and Note 13: Non-current liabilities in respect of employee benefits are measured as the present value of estimated future cash outflows based on the appropriate Government bond rate, estimates of future salary and wage levels and employee periods of service.
- Property, Plant and Equipment – Note 2(r): The fair value of land, building, infrastructure and property, plant and equipment are determined on significant assumptions of the exit price and risks in the perspective market participant, using the best information available.
- Contingent Liabilities – Note 18: The present value of material quantifiable contingent liabilities are calculated using a discount rate based on the published 10-year Government bond rate.
- Allowance for Impairment Losses – Note 2(s), Note 8: Receivables and Note 16: Financial Instruments. The allowance represents debts that are likely to be uncollectible and are

DEPARTMENT OF HEALTH
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considered doubtful. Debtors are grouped according to their aging profile and history of previous financial difficulties.

- Depreciation and Amortisation – Note 2(l), Note 10: Property, Plant and Equipment.

i) Goods and Services Tax

Income, expenses and assets are recognised net of the amount of Goods and Services Tax (GST), except where the amount of GST incurred on a purchase of goods and services is not recoverable from the Australian Tax Office (ATO). In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables are stated with the amount of GST included. The net amount of GST recoverable from, or payable to, the ATO is included as part of receivables or payables in the Balance Sheet.

Cash flows are included in the Cash Flow Statement on a gross basis. The GST components of cash flows arising from investing and financing activities, which are recoverable from, or payable to, the ATO are classified as operating cash flows. Commitments and contingencies are disclosed net of the amount of GST recoverable or payable unless otherwise specified.

j) Income Recognition

Income encompasses both revenue and gains.

Income is recognised at the fair value of the consideration received, exclusive of the amount of GST. Exchanges of goods or services of the same nature and value without any cash consideration being exchanged are not recognised as income.

Grants and Other Contributions

Grants, donations, gifts and other non-reciprocal contributions are recognised as revenue when the agency obtains control over the assets comprising the contributions. Control is normally obtained upon receipt.

Contributions are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

Appropriation

Output appropriation is the operating payment to each agency for the outputs they provide and is calculated as the net cost of agency outputs after taking into account funding from agency income. It does not include any allowance for major non-cash costs such as depreciation.

Commonwealth appropriation follows from the Intergovernmental Agreement on Federal Financial Relations, resulting in Specific Purpose Payments (SPPs) and National Partnership (NP) payments being made by the Commonwealth Treasury to state treasuries, in a manner similar to arrangements for GST payments. These payments are received by the Department of Treasury and Finance on behalf of the Central Holding Authority and then on-passed to the relevant agencies as Commonwealth appropriation.

Revenue in respect of appropriations is recognised in the period in which the agency gains control of the funds.

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Sale of Goods
Revenue from the sale of goods is recognised (net of returns, discounts and allowances) when:

- the significant risks and rewards of ownership of the goods have transferred to the buyer;
- the agency retains neither continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold;
- the amount of revenue can be reliably measured;
- it is probable that the economic benefits associated with the transaction will flow to the agency; and
- the costs incurred or to be incurred in respect of the transaction can be measured reliably.

Rendering of Services
Revenue from rendering services is recognised by reference to the stage of completion of the contract. The revenue is recognised when:

- the amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and
- it is probable that the economic benefits associated with the transaction will flow to the entity.

Interest Revenue
Interest revenue is recognised as it accrues, taking into account the effective yield on the financial asset.

Goods and Services Received Free of Charge
Goods and services received free of charge are recognised as revenue when a fair value can be reliably determined and the resource would have been purchased if it had not been donated. Use of the resource is recognised as an expense.

Disposal of Assets
A gain or loss on disposal of assets is included as a gain or loss on the date control of the asset passes to the buyer, usually when an unconditional contract of sale is signed. The gain or loss on disposal is calculated as the difference between the carrying amount of the asset at the time of disposal and the net proceeds on disposal. Refer also to Note 5.

Contributions of Assets
Contributions of assets and contributions to assist in the acquisition of assets, being non-reciprocal transfers, are recognised, unless otherwise determined by Government, as gains when the agency obtains control of the asset or contribution. Contributions are recognised at the fair value received or receivable.

Administered Income
The Department collects taxes, fines and regulatory fees on behalf of the Territory. The Department does not gain control over assets arising from these collections, consequently no income is recognised in the Department's financial statements. Accordingly, these amounts are disclosed as income in Note 21 Schedule of Administered Territory Items.

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NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

k) Repairs and Maintenance Expense

Funding is received for repairs and maintenance works associated with agency assets as part of output appropriation. Costs associated with repairs and maintenance works on agency assets are expensed as incurred.

l) Depreciation and Amortisation Expense

Items of property, plant and equipment, including buildings but excluding land, have limited useful lives and are depreciated or amortised using the straight-line method over their estimated useful lives.

Amortisation applies in relation to intangible non-current assets with limited useful lives and is calculated and accounted for in a similar manner to depreciation.

The estimated useful lives for each class of asset are in accordance with the Treasurer's Directions and are determined as follows:

	2016
Buildings	50 Years
Sheds / Demountables	10 - 20 Years
Plant and Equipment (refer below)	
Computer Hardware	3 - 6 Years
Office Equipment	5 - 10 Years
Medical Equipment	5 - 15 Years
Furniture and Fittings	10 Years
Catering Equipment	5 - 15 Years
Laundry Equipment	5 - 15 Years

Assets are depreciated or amortised from the date of acquisition or from the time an asset is completed and held ready for use.

m) Interest Expense

Interest expenses include interest and finance lease charges. Interest expenses are expensed in the period in which they are incurred.

n) Cash and Deposits

For the purposes of the Balance Sheet and the Cash Flow Statement, cash includes cash on hand, cash at bank and cash equivalents. Cash equivalents are highly liquid short-term investments that are readily convertible to cash.

o) Inventories

Inventories include assets held either for sale (general inventories) or for distribution at no or nominal consideration in the ordinary course of business operations.

General inventories are valued at the lower of cost and net realisable value, while those held for distribution are carried at the lower of cost and current replacement cost. Cost of inventories includes all costs associated with bringing the inventories to their present location

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and condition. When inventories are acquired at no or nominal consideration, the cost will be the current replacement cost at date of acquisition.

The cost of inventories are assigned using a mixture of first-in, first out or weighted average cost formula or using specific identification of their individual costs.

Inventory held for distribution is regularly assessed for obsolescence and loss.

p) Receivables

Receivables include accounts receivable and other receivables and are recognised at fair value less any allowance for impairment losses.

The allowance for impairment losses represents the amount of receivables the agency estimates are likely to be uncollectible and are considered doubtful. Analyses of the age of the receivables that are past due as at the reporting date are disclosed in an aging schedule under credit risk in Note 16 Financial Instruments. Reconciliation of changes in the allowance accounts is also presented.

Accounts receivable are generally settled within 30 days and other receivables within 30 days.

q) Prepayments

Prepayments represent payments in advance of receipt of goods and services or that part of expenditure made in one accounting period covering a term extending beyond that period.

r) Property, Plant and Equipment

Acquisitions

All items of property, plant and equipment with a cost, or other value, equal to or greater than $10 000 are recognised in the year of acquisition and depreciated as outlined below. Items of property, plant and equipment below the $10 000 threshold are expensed in the year of acquisition.

The construction cost of property, plant and equipment includes the cost of materials and direct labour, and an appropriate proportion of fixed and variable overheads.

Complex Assets

Major items of plant and equipment comprising a number of components that have different useful lives, are accounted for as separate assets. The components may be replaced during the useful life of the complex asset.

Subsequent Additional Costs

Costs incurred on property, plant and equipment subsequent to initial acquisition are capitalised when it is probable that future economic benefits in excess of the originally assessed performance of the asset will flow to the agency in future years. Where these costs represent separate components of a complex asset, they are accounted for as separate assets and are separately depreciated over their expected useful lives.

Construction (Work in Progress)

As part of the financial management framework, the Department of Infrastructure is responsible for managing general government capital works projects on a whole of Government basis. Therefore appropriation for all agency capital works is provided directly to the Department of Infrastructure and the cost of construction work in progress is recognised

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NOTES TO THE FINANCIAL STATEMENTS
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as an asset of that Department. Once completed, capital works assets are transferred to the agency.

s) Revaluations and Impairment

Revaluation of Assets
Subsequent to initial recognition, assets belonging to the following classes of non-current assets are revalued with sufficient regularity to ensure that the carrying amount of these assets does not differ materially from their fair value at reporting date:

- land;
- buildings;
- infrastructure.

Plant and equipment are stated at historical cost less depreciation, which is deemed to equate to fair value.

Impairment of Assets
An asset is said to be impaired when the asset's carrying amount exceeds its recoverable amount.

Non-current physical and intangible agency assets are assessed for indicators of impairment on an annual basis or whenever there is indication of impairment. If an indicator of impairment exists, the agency determines the asset's recoverable amount. The asset's recoverable amount is determined as the higher of the asset's depreciated replacement cost and fair value less costs to sell. Any amount by which the asset's carrying amount exceeds the recoverable amount is recorded as an impairment loss.

Impairment losses are recognised in the Comprehensive Operating Statement. They are disclosed as an expense unless the asset is carried at a revalued amount. Where the asset is measured at a revalued amount, the impairment loss is offset against the asset revaluation surplus for that class of asset to the extent that an available balance exists in the asset revaluation surplus.

In certain situations, an impairment loss may subsequently be reversed. Where an impairment loss is subsequently reversed, the carrying amount of the asset is increased to the revised estimate of its recoverable amount. A reversal of an impairment loss is recognised in the Comprehensive Operating Statement as income, unless the asset is carried at a revalued amount, in which case the impairment reversal results in an increase in the asset revaluation surplus. Note 14 provides additional information in relation to the asset revaluation surplus.

t) Assets Held for Sale

Assets and disposal groups are classified as held for sale if their carrying amount will be recovered through a sale transaction or a grant agreement rather than continuing use. Assets held for sale consist of those assets that management has determined are available for immediate sale or granting in their present condition and their sale is highly probably within one year from the date of classification.

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NOTES TO THE FINANCIAL STATEMENTS
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These assets are measured at the lower of the asset's carrying amount and fair value less costs to sell. These assets are not depreciated. Non-current assets held for sale have been recognised on the face of the financial statements as current assets.

u) Leased Assets

Leases under which the agency assumes substantially all the risks and rewards of ownership of an asset are classified as finance leases. Other leases are classified as operating leases.

Finance Leases
Finance leases are capitalised. A lease asset and lease liability equal to the lower of the fair value of the leased property and present value of the minimum lease payments, each determined at the inception of the lease, are recognised.

Lease payments are allocated between the principal component of the lease liability and the interest expense.

Operating Leases
Operating lease payments made at regular intervals throughout the term are expensed when the payments are due, except where an alternative basis is more representative of the pattern of benefits to be derived from the leased property. Lease incentives under an operating lease of a building or office space is recognised as an integral part of the consideration for the use of the leased asset. Lease incentives are to be recognised as a deduction of the lease expenses over the term of the lease.

v) Payables

Liabilities for accounts payable and other amounts payable are carried at cost, which is the fair value of the consideration to be paid in the future for goods and services received, whether or not billed to the agency. Accounts payable are normally settled within 30 days.

w) Employee Benefits

Provision is made for employee benefits accumulated as a result of employees rendering services up to the reporting date. These benefits include wages and salaries and recreation leave. Liabilities arising in respect of wages and salaries, recreation leave and other employee benefit liabilities that fall due within twelve months of reporting date are classified as current liabilities and are measured at amounts expected to be paid. Non-current employee benefit liabilities that fall due after twelve months of the reporting date are measured at present value, calculated using the Government long-term bond rate.

No provision is made for sick leave, which is non-vesting, as the anticipated pattern of future sick leave to be taken is less than the entitlement accruing in each reporting period.

Employee benefit expenses are recognised on a net basis in respect of the following categories:

- wages and salaries, non-monetary benefits, recreation leave, sick leave and other leave entitlements; and
- other types of employee benefits.

As part of the financial management framework, the Central Holding Authority assumes the long service leave liabilities of Government agencies, including Department of Health and as such no long service leave liability is recognised in agency financial statements.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

x) Superannuation

Employees' superannuation entitlements are provided through the:

- Northern Territory Government and Public Authorities Superannuation Scheme (NTGPASS);
- Commonwealth Superannuation Scheme (CSS); or
- non-government employee-nominated schemes for those employees commencing on or after 10 August 1999.

The agency makes superannuation contributions on behalf of its employees to the Central Holding Authority or non-government employee-nominated schemes. Superannuation liabilities related to government superannuation schemes are held by the Central Holding Authority and as such are not recognised in agency financial statements.

y) Contributions by and Distributions to Government

The agency may receive contributions from Government where the Government is acting as owner of the agency. Conversely, the agency may make distributions to Government. In accordance with the *Financial Management Act* and Treasurer's Directions, certain types of contributions and distributions, including those relating to administrative restructures, have been designated as contributions by, and distributions to, Government. These designated contributions and distributions are treated by the agency as adjustments to equity.

The Statement of Changes in Equity provides additional information in relation to contributions by, and distributions to, Government.

z) Commitments

Disclosures in relation to capital and other commitments, including lease commitments are shown at Note 17.

Commitments are those contracted as at 30 June where the amount of the future commitment can be reliably measured.

aa) Financial Instruments

A financial instrument is a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

Financial assets and liabilities are recognised on the Balance Sheet when the agency becomes a party to the contractual provisions of the financial instrument. The agency's financial instruments include cash and deposits; receivables; advances; investments loan and placements; payables; advances received; borrowings and derivatives.

Due to the nature of operating activities, certain financial assets and financial liabilities arise under statutory obligations rather than a contract. Such financial assets and liabilities do not meet the definition of financial instruments as per AASB 132 Financial Instruments Presentation. These include statutory receivables arising from taxes including GST and penalties.

Exposure to interest rate risk, foreign exchange risk, credit risk, price risk and liquidity risk arise in the normal course of activities. The agency's investments, loans and placements, and borrowings are predominantly managed through the Northern Territory Treasury

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Corporation adopting strategies to minimise the risk. Derivative financial arrangements are also utilised to manage financial risks inherent in the management of these financial instruments. These arrangements include swaps, forward interest rate agreements and other hedging instruments to manage fluctuations in interest or exchange rates.

Classification of Financial Instruments

AASB 7 Financial Instruments: Disclosures requires financial instruments to be classified and disclosed within specific categories depending on their nature and purpose.

Financial assets are classified into the following categories:

- financial assets at fair value through profit or loss;
- held-to-maturity investments;
- loans and receivables; and
- available-for-sale financial assets.

Financial liabilities are classified into the following categories:

- financial liabilities at fair value through profit or loss (FVTPL); and
- financial liabilities at amortised cost.

Financial Assets or Financial Liabilities at Fair Value through Profit or Loss

Financial instruments are classified as at FVTPL when the instrument is either held for trading or is designated as at FVTPL.

An instrument is classified as held for trading if it is:

- acquired or incurred principally for the purpose of selling or repurchasing it in the near term with an intention of making a profit; or
- part of a portfolio of identified financial instruments that are managed together and for which there is evidence of a recent actual pattern of short-term profit-taking; or
- a derivative that is not a financial guarantee contract or a designated and effective hedging instrument.

A financial instrument may be designated as at FVTPL upon initial recognition if:

- such designation eliminates or significantly reduces a measurement or recognition inconsistency that would otherwise arise; or
- the instrument forms part of a group of financial instruments, which is managed and its performance is evaluated on a fair value basis, in accordance with a documented risk management or investment strategy, and information about the grouping is provided internally on that basis; or
- it forms part of a contract containing one or more embedded derivatives, and AASB 139 Financial Instruments: Recognition and Measurement permits the contract to be designated as at FVTPL.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
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Financial Liabilities at Amortised Cost

Financial instrument liabilities measured at amortised cost include all advances received, finance lease liabilities and borrowings. Amortised cost is calculated using the effective interest method.

Note 16 provides additional information on financial instruments.

Held-to-Maturity Investments

Non-derivative financial assets with fixed or determinable payments and fixed maturity dates that the entity has the positive intent and ability to hold to maturity are classified as held-to-maturity investments. Held-to-maturity investments are recorded at amortised cost using the effective interest method less impairment, with revenue recognised on an effective yield basis.

Loans and Receivables

For details refer to Note 2(p), but exclude statutory receivables.

Available-for-Sale Financial Assets

Available-for-sale financial assets are those non-derivative financial assets, principally equity securities that are designated as available-for-sale or are not classified as any of the three preceding categories. After initial recognition available-for-sale securities are measured at fair value with gains or losses being recognised as a separate component of equity until the investment is derecognised or until the investment is determined to be impaired, at which time the cumulative gain or loss previously reported in equity is recognised in the Comprehensive Operating Statement.

bb) Fair Value Measurement

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

Fair value measurement of a non-financial asset takes into account a market participant's ability to generate economic benefits by using the asset in its highest and best use or by selling it to another market participant that would use the asset in its highest and best use. The highest and best use takes into account the use of the asset that is physically possible, legally permissible and financially feasible.

When measuring fair value, the valuation techniques used maximise the use of relevant observable inputs and minimise the use of unobservable inputs. Unobservable inputs are used to the extent that sufficient relevant and reliable observable inputs are not available for similar assets/liabilities.

Observable inputs are publicly available data that are relevant to the characteristics of the assets/liabilities being valued. Observable inputs used by the agency include, but are not limited to, published sales data for land and general office buildings.

Unobservable inputs are data, assumptions and judgments that are not available publicly, but are relevant to the characteristics of the assets/liabilities being valued. Such inputs include internal agency adjustments to observable data to take account of particular and potentially unique characteristics/functionality of assets/liabilities and assessments of physical condition and remaining useful life.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
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All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the following fair value hierarchy based on the inputs used:

Level 1 – inputs are quoted prices in active markets for identical assets or liabilities;

Level 2 – inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly; and

Level 3 – inputs are unobservable.

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

3. COMPREHENSIVE OPERATING STATEMENT BY OUTPUT GROUP

		Territory-Wide Primary Health Care		Pensioner Concessions		Disease Prevention and Health Protection		Community Treatment and Extended Care		Corporate and Governance		National Critical Care and Trauma Response		Health Services		Total	
	Note	2016	2015	2016	2015	2016	2015	2016	2015	2016	2015	2016	2015	2016	2015	2016	2015
		$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
INCOME																	
Taxation revenue																	
Grants and subsidies revenue																	
Current		2 118	2 067	0	0	4 592	4 898	907	2 210	5 923	9 849	601	393	243 658	194 150	257 799	213 567
Capital		410	0	0	0	0	0	0	0	0	0	0	0	0	0	410	0
Appropriation																	
Output		0	0	0	0	0	0	0	0	1 020 500	985 167	0	0	0	0	1 020 500	985 167
Commonwealth		9 107	9 348	0	0	6 427	5 949	16 711	15 026	950	750	10 216	9 413	13 653	6 650	57 064	47 136
Sales of goods and services		468	622	0	0	265	264	14	102	2 790	2 710	350	744	42 791	41 557	46 678	45 999
Interest revenue		0	0	0	0	0	0	0	0	16	18	0	0	0	0	16	18
Goods and services received free of charge	4	894	14 526	0	0	0	0	0	0	10 339	0	0	0	0	0	11 233	14 526
Gain on disposal of assets	5	0	0	0	0	4	0	0	0	0	0	0	0	0	0	4	0
Other income		16	0	2 354	0	152	152	835	(12)	184	527	0	0	0	0	3 542	669
TOTAL INCOME		**13 014**	**26 563**	**2 354**	**0**	**11 440**	**11 263**	**18 467**	**17 326**	**1 040 702**	**999 021**	**11 168**	**10 550**	**300 101**	**242 357**	**1 397 246**	**1 307 082**
EXPENSES																	
Employee expenses		25 920	25 255	596	377	17 890	17 603	26 724	41 479	51 418	47 048	6 177	6 728	85	88	128 809	138 579
Administrative expenses																	
Purchases of goods and services	6	8 922	11 835	882	108	5 724	7 445	5 733	10 793	33 479	47 309	3 104	3 358	479 718	424 031	537 563	504 879
Repairs and maintenance		0	3	0	0	0	0	0	0	583	664	0	0	0	0	583	667
Depreciation and amortisation	10, 11	2 123	2 484	1	1	28	29	47	68	2 257	1 770	222	197	0	0	4 679	4 549
Other administrative expenses[1]		16	14 552	2	0	14	4	27	509	11 259	31	60	2	24	0	11 401	15 098
Grants and subsidies expenses																	
Current		7 760	20 110	7 110	7 018	2 686	3 023	97 758	95 417	7 836	9 452	186	0	555 009	510 418	678 346	645 437
Capital		0	0	0	0	0	0	10 826	0	0	0	0	0	0	0	10 825	0
Community service obligations		0	0	18 496	22 483	0	0	0	0	0	0	0	0	0	0	18 496	22 483
Interest expenses																	
TOTAL EXPENSES		**44 741**	**74 239**	**27 087**	**29 987**	**26 342**	**28 104**	**141 115**	**148 266**	**106 832**	**106 274**	**9 749**	**10 285**	**1 034 836**	**934 537**	**1 390 702**	**1 331 692**
NET SURPLUS/(DEFICIT)		**(31 727)**	**(47 676)**	**(24 733)**	**(29 987)**	**(14 902)**	**(16 841)**	**(122 648)**	**(130 940)**	**933 870**	**892 747**	**1 419**	**265**	**(734 735)**	**(692 180)**	**6 544**	**(24 610)**
OTHER COMPREHENSIVE INCOME																	
Items that will not be reclassified to net surplus/deficit																	
Transfer from Reserves		0	0	0	0	0	0	0	0	0	221	0	0	0	0	0	221
Correction of prior period errors		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Changes in asset revaluation surplus		0	0	0	0	0	0	0	0	943	1 038	0	0	0	0	943	1 038
TOTAL OTHER COMPREHENSIVE INCOME		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**943**	**1 259**	**0**	**0**	**0**	**0**	**943**	**1 259**
COMPREHENSIVE RESULT		**(31 727)**	**(47 676)**	**(24 733)**	**(29 987)**	**(14 902)**	**(16 841)**	**(122 648)**	**(130 940)**	**934 813**	**894 006**	**1 419**	**265**	**(734 735)**	**(692 180)**	**7 487**	**(23 351)**

[1] Includes DCIS service charges.

This Comprehensive Operating Statement by output group is to be read in conjunction with the notes to the financial statements.

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

	2016	2015
	$000	$000

4. GOODS AND SERVICES RECEIVED FREE OF CHARGE

Corporate and information services	11 233	14 526
Total Goods and Services Received Free of Charge	**11 233**	**14 526**

5. GAIN ON DISPOSAL OF ASSETS

Net proceeds from the disposal of non-current assets	4	0
Less: Carrying value of non-current assets disposed	(0)	(0)
Total Gain on Disposal of Assets	**4**	**0**

6. PURCHASES OF GOODS AND SERVICES

The net surplus has been arrived at after charging the following expenses:

Goods and services expenses:		
Property maintenance	5 515	2 597
General property maintenance	949	1 492
Power	1 035	1 416
Water and sewerage	123	182
Accommodation	1 145	1 390
Advertising [1]	27	29
Agent service agreements	475 943	424 355
Audit fees	406	364
Bank charges	14	25
Client travel	336	235
Clothing	75	49
Communications	1 372	1 833
Consultant fees [2]	1 062	2 955
Consumables/general expenses	1 894	1 377
Cross border patient charges	51	1 082
Document production	411	458
Entertainment/hospitality	65	119
Food	163	525
Freight	147	216
IT charges	7 876	10 044
IT consultants	10 678	12 547
IT hardware and software expenses	6 482	5 257
Insurance premium	1	4
Laboratory expenses	160	122
Legal expenses [3]	2 671	8 324
Library services	1 435	1 327
Marketing and promotion [4]	702	1 358
Medical/dental supply and services	5 124	7 070
Membership and subscriptions	476	246
Motor vehicle expenses	2 364	3 260
Office requisites and stationery	459	654
Official duty fares	2 202	4 943

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

	2016	2015
	$000	$000
Other equipment expenses	1 548	2 641
Recruitment expenses [5]	223	890
Reg/advisory boards/committees	519	562
Relocation expenses	75	82
Training and study expenses	2 872	3 416
Transport equipment expenses	135	217
Travelling allowance	938	1 122
Unallocated corporate credit card expenses	(111)	93
Goods and services costs allocation	0	1
Total Purchases of Goods and Services	**537 563**	**504 879**

[1] Does not include recruitment, advertising or marketing and promotion advertising.
[2] Includes marketing, promotion and IT consultants.
[3] Includes legal fees, claim and settlement costs.
[4] Includes advertising for marketing and promotion but excludes marketing and promotion consultants' expenses, which are incorporated in the consultant category.
[5] Includes recruitment-related advertising costs.

7. CASH AND DEPOSITS

Cash at bank	16 307	18 300
Cash on hand	6	1
Total Cash and Deposits	**16 312**	**18 301**

8. RECEIVABLES

Current

Accounts receivable	993	1 089
Less: Allowance for impairment losses	(170)	(66)
	823	1 023
GST receivables	2 928	1 387
Other receivables	39	0
Total Receivables	**3 790**	**2 410**

9. INVENTORIES

Inventories Held for Distribution

At current replacement cost	434	127
Total Inventories	**434**	**127**

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

	2016	2015
	$000	$000
10. PROPERTY, PLANT AND EQUIPMENT		
Land		
At fair value	1 310	2 686
Buildings		
At fair value	16 528	33 779
Less: Accumulated depreciation	(9 782)	(15 143)
	6 746	18 636
Plant and Equipment		
At fair value	40 848	37 198
Less: Accumulated depreciation	(25 301)	(21 718)
Less: Accumulated impairment loss	(1 459)	(1 457)
	14 088	14 023
Total Property, Plant and Equipment	**22 144**	**35 345**

Property, Plant and Equipment Valuations

The latest independent revaluations were undertaken by the Australian Valuation Office (AVO) as at 30 June 2011 for the Bachelor Central Australian Campus and Hong Street Flats. The fair value of these assets was determined based on any existing restrictions on asset use. Where reliable market values were not available, the fair value of these assets was based on their depreciated replacement cost. Refer to Note 11: Fair Value Measurement of Non-Financial Assets for additional disclosures.

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

10. PROPERTY, PLANT AND EQUIPMENT (continued)

2016 Property, Plant and Equipment Reconciliations

A reconciliation of the carrying amount of property, plant and equipment at the beginning and end of 2015-16 is set out below:

	Land	Buildings	Plant and Equipment	Total
	$000	$000	$000	$000
Carrying Amount as at 1 July 2015	2 686	18 636	14 023	35 345
Additions			3 496	3 496
Disposals				
Depreciation		(451)	(4 228)	(4 679)
Additions/(Disposals) from administrative restructuring				
Additions/(Disposals) from asset transfers	(1 377)	(11 438)	(143)	(12 958)
Revaluation increments/(decrements)				
Impairment losses			(2)	(2)
Impairment losses reversed				
Other movements			943	943
Carrying Amount as at 30 June 2016	**1 310**	**6 746**	**14 088**	**22 144**

10. PROPERTY, PLANT AND EQUIPMENT (continued)

2015 Property, Plant and Equipment Reconciliations

A reconciliation of the carrying amount of property, plant and equipment at the beginning and end of 2014-15 is set out below:

	Land	Buildings	Plant and Equipment	Total
	$000	$000	$000	$000
Carrying Amount as at 1 July 2014	2 566	19 315	13 459	35 340
Additions			2 669	2 669
Disposals				
Depreciation		(878)	(3 671)	(4 549)
Additions/(Disposals) from administrative restructuring			(421)	(421)
Additions/(Disposals) from asset transfers	120	199	1 794	2 113
Revaluation increments/(decrements)				
Impairment losses			(28)	(28)
Impairment losses reversed				
Other movements			221	221
Carrying Amount as at 30 June 2015	**2 686**	**18 636**	**14 023**	**35 345**

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

11. FAIR VALUE MEASUREMENT OF NON-FINANCIAL ASSETS

a) Fair Value Hierarchy

Fair values of non-financial assets categorised by levels of inputs used to compute fair value are:

	Level 1	Level 2	Level 3	Total Fair Value
	$000	$000	$000	$000
2015-16				
Asset Classes				
Land (Note 10)			1 310	1 310
Buildings (Note 10)			6 746	6 746
Plant and Equipment (Note 10)			14 088	14 088
Total			**22 144**	**22 144**
2014-15				
Asset Classes				
Land (Note 10)			2 686	2 686
Buildings (Note 10)			18 636	18 636
Plant and Equipment (Note 10)			14 023	14 023
Total			**35 345**	**35 345**

There were no transfers between Level 1 and Levels 2 or 3 during 2015-16.

b) Valuation Techniques and Inputs

Valuation techniques used to measure fair value in 2015-16 are:

	Level 2 Techniques	Level 3 Techniques
Asset Classes		
Land		Cost approach
Buildings		Cost approach
Plant and Equipment		Cost approach

There were no changes in valuation techniques from 2014-15 to 2015-16.

Level 2 fair values of land and buildings were based on market evidence of sales price per square metre of comparable land and buildings.

Level 3 fair values of specialised buildings and infrastructure were determined by computing their depreciated replacement costs because an active market does not exist for such facilities. The depreciated replacement cost was based on a combination of internal records of the historical cost of the facilities, adjusted for contemporary technology and construction approaches. Significant judgement was also used in assessing the remaining service potential of the facilities, given local environmental conditions, projected usage, and records of the current condition of the facilities.

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

c) Additional Information for Level 3 Fair Value Measurements

(i) Reconciliation of Recurring Level 3 Fair Value Measurements

	Land	Buildings	Plant and Equipment
	$000	$000	$000
2015-16			
Fair value as at 1 July 2015	2 686	18 636	14 023
Additions			3 496
Disposals	(1 377)	(11 438)	(143)
Transfers from Level 2			
Transfers to Level 2			
Depreciation		(451)	(4 228)
Gains/losses recognised in net surplus/deficit			(2)
Gains/losses recognised in other comprehensive income			943
Fair value as at 30 June 2016	**1 310**	**6 746**	**14 088**
2014-15			
Fair value as at 1 July 2014	2 566	19 315	13 459
Additions	120	199	4 463
Disposals			(421)
Transfers from Level 2			
Transfers to Level 2			
Depreciation		(878)	(3 671)
Gains/losses recognised in net surplus/deficit			(28)
Gains/losses recognised in other comprehensive income			221
Fair value as at 30 June 2015	**2 686**	**18 636**	**14 023**

(ii) Sensitivity analysis

Unobservable inputs used in computing the fair value of buildings include the historical cost and the consumed economic benefit for each building. Given the large number of agency buildings, it is not practical to compute a relevant summary measure for the unobservable inputs. In respect of sensitivity of fair value to changes in input value, a higher historical cost results in a higher fair value and greater consumption of economic benefit lowers fair value.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

	2016	2015
	$000	$000
12. PAYABLES		
Accounts payable	3 464	3 368
Accrued expenses	1 929	8 163
Other payables	0	4 388
Total Payables	**5 393**	**15 919**
13. PROVISIONS		
Current		
Employee benefits		
Recreation leave	8 413	8 732
Leave loading	1 837	1 879
Other employee benefits	56	197
Other current provisions		
Other provisions - includes provisions for Superannuation and Fringe Benefits Tax payable	1 621	1 935
	11 928	12 743
Non-Current		
Employee benefits		
Recreation leave	3 224	4 042
Total Provisions	**15 151**	**16 785**

The Agency employed 1 082 employees as at 30 June 2016 (1 184 employees as at 30 June 2015).

14. RESERVES

Asset Revaluation Surplus

(i) Nature and purpose of the asset revaluation surplus

The asset revaluation surplus includes the net revaluation increments and decrements arising from the revaluation of non-current assets. Impairment adjustments may also be recognised in the asset revaluation surplus.

(ii) Movements in the asset revaluation surplus		
Balance as at 1 July	1 607	569
Increment/(Decrement) – administrative restructuring	943	1 038
Balance as at 30 June	**2 550**	**1 607**

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

15. NOTES TO THE CASH FLOW STATEMENT

Reconciliation of Cash

The total of agency 'Cash and deposits' of $16 312 recorded in the Balance Sheet is consistent with that recorded as 'Cash' in the Cash Flow Statement.

Reconciliation of Net Surplus/(Deficit) to Net Cash from Operating Activities

	2016 $000	2015 $000
Net Surplus/(Deficit)	6 544	(24 610)
Non-cash items:		
Depreciation and amortisation	4 679	4 550
Asset write-offs/write-downs	2	29
(Gain)/Loss on disposal of assets	(4)	0
Changes in assets and liabilities:		
Decrease/(Increase) in receivables	(1 380)	9 450
Decrease/(Increase) in inventories	(307)	16
Decrease/(Increase) in prepayments	2 494	(2 501)
Decrease/(Increase) in other assets		
(Decrease)/Increase in payables	(10 526)	(38 215)
(Decrease)/Increase in provision for employee benefits	(1 320)	(202)
(Decrease)/Increase in other provisions	(313)	(10)
(Decrease)/Increase in other liabilities		
Net Cash from Operating Activities	**(132)**	**(51 493)**

Non-Cash Financing and Investing Activities

Non cash transfers

During the financial year the Agency transferred in the 175 Bees Creek Road buildings and land from the Department of Correctional Services ($1.26 million) and acquired other buildings with an aggregate fair value of $0.76 million by non-cash asset transfers from the Department of Infrastructure.

16. FINANCIAL INSTRUMENTS

A financial instrument is a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Financial instruments held by the Department of Health include cash and deposits, receivables, payables and finance leases. The Department of Health has limited exposure to financial risks as discussed below.

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

a) Categorisation of Financial Instruments

The carrying amounts of the agency's financial assets and liabilities by category are disclosed in the table below.

2015-16 Categorisation of Financial Instruments

	Fair value through profit or loss						
	Held for trading	Designated at fair value	Held to maturity investments	Financial assets - Loans and receivables	Financial assets - available for sale	Financial Liabilities - amortised cost	**Total**
	$000	$000	$000	$000	$000	$000	$000
Cash and deposits		16 312					16 312
Receivables[1]				862			862
Advances				300			300
Investments loans and placements							
Other financial assets							
Interest rate swaps							
Total Financial Assets		**16 312**		**1 162**			**17 474**
Deposits held[1]							
Payables[1]		5 393					5 393
Advances							
Loans							
Finance Lease Liabilities							
Interest rate swaps							
Total Financial Liabilities		**5 393**					**5 393**

1.Total amounts disclosed exclude statutory amounts

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

2014-15 Categorisation of Financial Instruments

	Fair value through profit or loss						
	Held for trading	Designated at fair value	Held to maturity investments	Financial assets - Loans and receivables	Financial assets - available for sale	Financial Liabilities - amortised cost	**Total**
	$000	$000	$000	$000	$000	$000	$000
Cash and deposits		18 301					18 301
Receivables				2 410			2 410
Advances				300			300
Investments loans and placements							
Other financial assets							
Interest rate swaps							
Total Financial Assets		**18 301**		**2 710**			**21 011**
Deposits held[1]							
Payables[1]		15 919					15 919
Advances							
Loans							
Finance Lease Liabilities							
Interest rate swaps							
Total Financial Liabilities		**15 919**					**15 919**

1. Total amounts disclosed exclude statutory amounts

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

b) Credit Risk

The agency has limited credit risk exposure (risk of default). In respect of any dealings with organisations external to Government, the agency has adopted a policy of only dealing with credit worthy organisations and obtaining sufficient collateral or other security where appropriate, as a means of mitigating the risk of financial loss from defaults.

The carrying amount of financial assets recorded in the financial statements, net of any allowances for losses, represents the agency's maximum exposure to credit risk without taking account of the value of any collateral or other security obtained.

Receivables

Receivable balances are monitored on an ongoing basis to ensure that exposure to bad debts is not significant. A reconciliation and aging analysis of receivables is presented below.

Internal Receivables	Aging of Receivables	Aging of Impaired Receivables	Net Receivables
	$000	$000	$000
2015-16			
Not overdue	18		18
Overdue for less than 30 days	26		26
Overdue for 30 to 60 days	0		0
Overdue for more than 60 days	0		0
Total	**44**		**44**

Reconciliation of the Allowance for Impairment Losses	
Opening	0
Written off during the year	0
Recovered during the year	0
Increase/(Decrease) in allowance recognised in profit or loss	0
Total	**0**

2014-15			
Not overdue	9		9
Overdue for less than 30 days	13		13
Overdue for 30 to 60 days	0		0
Overdue for more than 60 days	(98)		(98)
Total	**(76)**		**(76)**

Reconciliation of the Allowance for Impairment Losses	
Opening	0
Written off during the year	0
Recovered during the year	0
Increase/(Decrease) in allowance recognised in profit or loss	0
Total	**0**

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

External Receivables	Aging of Receivables	Aging of Impaired Receivables	Net Receivables
	$000	$000	$000
2015-16			
Not overdue	278		278
Overdue for less than 30 days	17		17
Overdue for 30 to 60 days	173		173
Overdue for more than 60 days	520	170	350
Total	**988**	**170**	**818**
Reconciliation of the Allowance for Impairment Losses			
Opening		66	
Written off during the year		(4)	
Recovered during the year			
Increase/(Decrease) in allowance recognised in profit or loss		108	
Total		**170**	
2014-15			
Not overdue	1 724		1 724
Overdue for less than 30 days	716		716
Overdue for 30 to 60 days	22		22
Overdue for more than 60 days	90	66	24
Total	**2 552**	**66**	**2 486**
Reconciliation of the Allowance for Impairment Losses			
Opening		41	
Written off during the year		(13)	
Recovered during the year			
Increase/(Decrease) in allowance recognised in profit or loss		38	
Total		**66**	

c) Liquidity Risk

Liquidity risk is the risk that the agency will not be able to meet its financial obligations as they fall due. The agency's approach to managing liquidity is to ensure that it will always have sufficient liquidity to meet its liabilities when they fall due.

The following tables detail the agency's remaining contractual maturity for its financial assets and liabilities.

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

2016 Maturity analysis for financial assets and liabilities

	Variable Interest Rate			Fixed Interest Rate					
	Less than a Year	1 to 5 Years	More than 5 Years	Less than a Year	1 to 5 Years	More than 5 Years	Non Interest Bearing	Total	Weighted Average
	$000	$000	$000	$000	$000	$000	$000	$000	%
Assets									
Cash and deposits	52						16 260	16 312	1.96
Receivables							862	862	
Advances							300	300	
Investment, loans and placements									
Total Financial Assets	**52**						**17 422**	**17 474**	
Liabilities									
Deposits held								0	
Payables							5 393	5 393	
Advances								0	
Total Financial Liabilities							**5 393**	**5 393**	

2015 Maturity analysis for financial assets and liabilities

	Variable Interest Rate			Fixed Interest Rate					
	Less than a Year	1 to 5 Years	More than 5 Years	Less than a Year	1 to 5 Years	More than 5 Years	Non Interest Bearing	Total	Weighted Average
	$000	$000	$000	$000	$000	$000	$000	$000	%
Assets									
Cash and deposits	36						18 265	18 301	2.25
Receivables							2 410	2 410	
Advances and Investment							300	300	
Total Financial Assets	**36**						**20 975**	**21 012**	
Liabilities									
Deposits held								0	
Payables							15 919	15 919	
Advances								0	
Total Financial Liabilities							**15 919**	**15 919**	

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. It comprises interest rate risk, price risk and currency risk.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

(i) Interest Rate Risk

The Department of Health has very limited exposure to interest rate risk as agency financial assets and financial liabilities, with the exception the State Pool account with the Reserve Bank of Australia, are non-interest bearing.

Market Sensitivity Analysis
Changes in the variable rates of 100 basis points (1 per cent) at reporting date would have the following effect on the agency's profit or loss and equity.

	Profit or Loss and Equity	
	100 basis points increase	100 basis points decrease
	$000	$000
30 June 2016		
Financial assets – cash at bank	8	(8)
Net Sensitivity	**8**	**(8)**
30 June 2015		
Financial assets – cash at bank	8	(8)
Net Sensitivity	**8**	**(8)**

(ii) Price Risk

The Department of Health is not exposed to price risk as the Department of Health does not hold units in unit trusts.

(iii) Currency Risk

The Department of Health is not exposed to currency risk as the Department of Health does not hold borrowings denominated in foreign currencies or transactional currency exposures arising from purchases in a foreign currency.

e) Net Fair Value

The fair value of financial instruments is determined on the following basis:

- the fair value of cash, deposits, advances, receivables and payables approximates their carrying amount, which is also their amortised cost;
- the fair value of derivative financial instruments are derived using current market yields and exchange rates appropriate to the instrument; and
- the fair value of other monetary financial assets and liabilities is based on discounting to present value the expected future cash flows by applying current market interest rates for assets and liabilities with similar risk profiles.

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

For financial instruments measured and disclosed at fair value, the following table groups the instruments based on the level of inputs used.

2016	Total Carrying Amount	Net Fair Value Level 1	Net Fair Value Level 2	Net Fair Value Level 3	Net Fair Value Total
	$000	$000	$000	$000	$000
Financial Assets					
Cash and deposits	16 312	16 312			16 312
Receivable	862	862			862
Advances and Investments	300	300			300
Total Financial Assets	**17 474**	**17 474**			**17 474**
Financial Liabilities					
Deposits held	0	0			0
Payable	5 393	5 393			5 393
Finance lease liabilities	0	0			0
Total Financial Liabilities	**5 393**	**5 393**			**5 393**

2015	Total Carrying Amount	Net Fair Value Level 1	Net Fair Value Level 2	Net Fair Value Level 3	Net Fair Value Total
	$000	$000	$000	$000	$000
Financial Assets					
Cash and deposits	18 301	18 301			18 301
Receivables	2 410	2 410			2 410
Advances and Investments	300	300			300
Total Financial Assets	**21 012**	**21 012**			**21 012**
Financial Liabilities					
Deposits held	0	0			0
Payables	15 919	15 919			15 919
Finance lease liabilities	0	0			0
Total Financial Liabilities	**15 919**	**15 919**			**15 919**

There were no changes in valuation techniques during the period.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

	2016		2015	
	Internal	External	Internal	External
	$000	$000	$000	$000

17. COMMITMENTS

(i) Capital Expenditure Commitments

Capital expenditure commitments primarily related to the purchase of plant and equipment. Capital expenditure commitments contracted for at balance date but not recognised as liabilities are payable as follows:

Within one year	0	0	0	0
Later than one year and not later than five years	0	0	0	0
Later than five years	0	0	0	0
	0	**0**	**0**	**0**

(ii) Operating Lease Commitments

The agency leases property under non-cancellable operating leases expiring from 3 to 5 years. Leases generally provide the agency with a right of renewal at which time all lease terms are renegotiated. The agency also leases items of plant and equipment under non-cancellable operating leases. Future operating lease commitments not recognised as liabilities are payable as follows:

Within one year	0	103	0	191
Later than one year and not later than five years	0	29	0	132
Later than five years	0	0	0	0
	0	**132**	**0**	**323**

(iii) Other Expenditure Commitments

Other non-cancellable expenditure commitments not recognised as liabilities are payable as follows:

Within one year	0	82 372	0	68 981
Later than one year and not later than five years	0	16 314	0	16 929
Later than five years	0	0	0	0
	0	**98 686**	**0**	**85 909**

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

18. CONTINGENT LIABILITIES AND CONTINGENT ASSETS

a) Contingent Liabilities

The Department of Health had no contingent liabilities as at 30 June 2016 or 30 June 2015.

b) Contingent Assets

The Department of Health had no contingent assets as at 30 June 2016 or 30 June 2015.

19. EVENTS SUBSEQUENT TO BALANCE DATE

No material events have arisen between the end of the financial year and the date of this report that require adjustment to, or disclosure in these financial statements.

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

20. WRITE-OFFS, POSTPONEMENTS, WAIVERS, GIFTS AND EX GRATIA PAYMENTS

	Agency		Agency		Territory Items		Territory Items	
	2016	No. of Trans.	2015	No. of Trans.	2016	No. of Trans.	2015	No. of Trans.
	$000		$000		$000		$000	
Write-offs, Postponements and Waivers Under the *Financial Management Act*								
Represented by:								
Amounts written off, postponed and waived by Delegates								
Irrecoverable amounts payable to the Territory or an agency written off	4	3	8	5				
Losses or deficiencies of money written off								
Public property written off	2	3	28	38				
Waiver or postponement of right to receive or recover money or property								
Total Written Off, Postponed and Waived by Delegates	**6**	**6**	**36**	**43**				
Amounts written off, postponed and waived by the Treasurer								
Irrecoverable amounts payable to the Territory or an agency written off	0	0	5	1				
Losses or deficiencies of money written off								
Public property written off								
Waiver or postponement of right to receive or recover money or property								
Total Written Off, Postponed and Waived by the Treasurer	**0**	**0**	**5**	**1**				
Write-offs, Postponements and Waivers Authorised Under Other Legislation [(a)]								
Gifts Under the *Financial Management Act*								
Gifts Authorised Under Other Legislation								
Ex Gratia Payments Under the *Financial Management Act*								

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

21. SCHEDULE OF ADMINISTERED TERRITORY ITEMS

The following Territory items are managed by the Department of Health on behalf of the Government and are recorded in the Central Holding Authority (refer Note 2(d)).

	2016	2015
	$000	$000
TERRITORY INCOME AND EXPENSES		
Income		
Grants and subsidies revenue		
Capital	0	775
Fees from regulatory services	402	208
Other income	0	12
Total Income	**402**	**995**
Expenses		
Central Holding Authority income transferred	402	995
Total Expenses	**402**	**995**
Territory Income less Expenses	**0**	**0**
TERRITORY ASSETS AND LIABILITIES		
Assets		
Grants and subsidies receivable	0	0
Other receivables	0	0
Total Assets	**0**	**0**
Liabilities		
Central Holding Authority income payable	0	0
Unearned Central Holding Authority income	0	0
Total Liabilities	**0**	**0**
Net Assets	**0**	**0**

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

22. BUDGETARY INFORMATION

Comprehensive Operating Statement	2015-16 Actual	2015-16 Original Budget	Variance	Note
	$000	$000	$000	
INCOME				
Grants and subsidies revenue				
Current	257 799	203 166	54 633	1
Capital	410	0	410	2
Appropriation				
Output	1 020 500	1 010 764	9 736	
Commonwealth	57 064	44 218	12 846	1
Sales of goods and services	46 678	47 077	(399)	
Interest revenue	16	0	16	3
Goods and services received free of charge	11 233	14 690	(3 457)	4
Gain on disposal of assets	4	0	4	5
Other income	3 542	226	3 316	6
TOTAL INCOME	**1 397 246**	**1 320 141**	**77 105**	
EXPENSES				
Employee expenses	128 809	137 787	(8 978)	
Administrative expenses				
Purchases of goods and services	537 563	551 554	(13 991)	
Repairs and maintenance	583	1 554	(971)	1
Depreciation and amortisation	4 679	4 607	72	
Other administrative expenses	11 401	14 690	(3 289)	7
Grants and subsidies expenses				
Current	678 346	586 670	91 676	1
Capital	10 825	8 235	2 590	8
Community service obligations	18 496	23 474	(4 978)	9
TOTAL EXPENSES	**1 390 702**	**1 328 571**	**62 131**	
NET SURPLUS/(DEFICIT)	**6 544**	**(8 430)**	**14 974**	
OTHER COMPREHENSIVE INCOME				
Items that will not be reclassified to net surplus/deficit				
Change in asset revaluation	943	0	943	10
TOTAL OTHER COMPREHENSIVE INCOME	**943**	**0**	**943**	
COMPREHENSIVE RESULT	**7 487**	**(8 430)**	**15 917**	

Notes:
The following note descriptions relate to variances greater than 10 per cent or where multiple significant variances have occurred.

1. Original budget is subject to significant variation during the year due to restructures and timing of Commonwealth funding.
2. Capital grant received for dental equipment.
3. State Pool account interest received.
4. Fees reduction was due to CPI and the transfer of property from notional to actual billing.
5. Gain on disposal of plant and equipment.
6. Recoveries from external bodies.
7. Fees reduction was due to CPI and the transfer of property from notional to actual billing.
8. Community Hub grant to Carpentaria Disability Services.
9. Timing of Community Service Obligations payments.
10. Capitalisation of assets coded to expenditure in prior year.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Balance Sheet	2015-16 Actual	2015-16 Original Budget	Variance	Note
	$000	$000	$000	
ASSETS				
Current assets				
Cash and deposits	16 312	25 620	(9 308)	1
Receivables	3 790	11 858	(8 068)	2
Inventories	434	143	291	3
Prepayments	1 364	1 357	7	
Total current assets	**21 900**	**38 978**	**(17 078)**	
Non-current assets				
Advances and investments	300	300	0	
Property, plant and equipment	22 144	35 957	(13 813)	2
Total non-current assets	**22 444**	**36 257**	**(13 813)**	
TOTAL ASSETS	**44 344**	**75 235**	**(30 891)**	
LIABILITIES				
Current liabilities				
Payables	5 393	54 131	(48 738)	2
Provisions	11 928	12 901	(973)	
Total current liabilities	**17 321**	**67 032**	**(49 711)**	
Non-current liabilities				
Provisions	3 224	4 096	(872)	2
Total non-current liabilities	**3 224**	**4 096**	**(872)**	
TOTAL LIABILITIES	**20 544**	**71 128**	**(50 584)**	
NET ASSETS	**23 800**	**4 107**	**19 693**	
EQUITY				
Capital	252 974	233 217	19 757	
Reserves	2 550	569	1 981	4
Accumulated funds	(231 725)	(229 679)	(2 046)	
TOTAL EQUITY	**23 800**	**4 107**	**19 693**	

Notes:
The following note descriptions relate to variances greater than 10 per cent or where multiple significant variances have occurred.

1. Predominantly due to the settlement of payables.
2. Original budget is subject to significant variation during the year due to restructures and timing of Commonwealth funding.
3. Increase in dental inventory held.
4. Transfer in of Aranda House and capitalisation of assets coded to expenditure in prior year.

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

Cash Flow Statement	2015-16 Actual	2015-16 Original Budget	Variance	Note
	$000	$000	$000	
CASH FLOWS FROM OPERATING ACTIVITIES				
Operating receipts				
Grants and subsidies received				
Current	257 799	203 166	54 633	1
Capital	410	0	410	2
Appropriation				
Output	1 020 500	1 010 764	9 736	
Commonwealth	57 064	44 218	12 846	1
Receipts from sales of goods and services	71 351	47 303	24 048	3
Interest received	16	0	16	4
Total operating receipts	**1 407 140**	**1 305 451**	**101 689**	
Operating payments				
Payments to employees	(134 231)	(137 787)	3 556	
Payments for goods and services	(560 986)	(553 108)	(7 878)	
Grants and subsidies paid				
Current	(678 346)	(586 670)	(91 676)	1
Capital	(10 825)	(8 235)	(2 590)	5
Community service obligations	(22 884)	(23 474)	590	
Total operating payments	**(1 407 271)**	**(1 309 274)**	**(97 997)**	
Net cash from/(used in) operating activities	**(132)**	**(3 823)**	**3 691**	
CASH FLOWS FROM INVESTING ACTIVITIES				
Investing receipts				
Proceeds from asset sales	4	23	(19)	6
Total investing receipts	**4**	**23**	**(19)**	
Investing payments				
Purchases of assets	(3 496)	(6 315)	2 819	7
Total investing payments	**(3 496)**	**(6 315)**	**2 819**	
Net cash from/(used in) investing activities	**(3 492)**	**(6 292)**	**2 800**	
CASH FLOWS FROM FINANCING ACTIVITIES				
Financing receipts				
Equity injections				
Capital appropriation	509	6 292	(5 783)	7
Other equity injections	1 125	1 500	(375)	1
Total financing receipts	**1 634**	**7 792**	**(6 158)**	
Financing payments				
Equity withdrawals	0	0	0	
Total financing payments	**0**	**0**	0	
Net cash from/(used in) financing activities	**1 634**	**7 792**	**(6 158)**	
Net increase/(decrease) in cash held	(1 989)	(2 323)	334	
Cash at beginning of financial year	18 301	27 943	(9 642)	
CASH AT END OF FINANCIAL YEAR	**16 312**	**25 620**	**(9 308)**	

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

Notes:
The following note descriptions relate to variances greater than 10 per cent or where multiple significant variances have occurred.

1. Original budget is subject to significant variation during the year due to restructures and timing of Commonwealth funding.
2. Capital grant received for dental equipment.
3. GST refunds.
4. State Pool account interest received.
5. Community Hub grant to Carpentaria Disability Services.
6. Gain on disposal of plant and equipment.
7. Reduction due to transfer of Core Clinical system replacement budget and saving measures.

DEPARTMENT OF HEALTH

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

23. ADMINISTERED TERRITORY ITEMS

In addition to the specific departmental operations which are included in the financial statements, the Department administers or manages other activities and resources on behalf of the Territory such as Grants and Subsidies Revenue. The transactions relating to these activities are reported as administered items in this note.

Administered Territory Items	2015-16 Actual	2015-16 Original Budget	Variance	Note
	$000	$000	$000	
TERRITORY INCOME AND EXPENSES				
Income				
Fees from regulatory services	402	126	276	1
Total income	**402**	**126**	**276**	
Expenses				
Central Holding Authority income transferred	402	126	276	1
Total expenses	**402**	**126**	**276**	
Territory income less expenses	**0**	**0**	**0**	
TERRITORY ASSETS AND LIABILITIES				
Assets				
Grants and subsidies receivable	0	0	0	
Royalties and rent receivable	0	0	0	
Other receivables	0	0	0	
Total assets	**0**	**0**	**0**	
Liabilities				
Central Holding Authority income payable	0	0	0	
Unearned Central Holding Authority income	0	0	0	
Total liabilities	**0**	**0**	**0**	
Net assets	**0**	**0**	**0**	

Notes:
The following note descriptions relate to variances greater than 10 per cent or where multiple significant variances have occurred.
1. Increase in license fees received.

Top End Health Service

Foreword - Board Chair

Annette Burke

Board Chair

In its second year of operation, the Top End Health Service Board has consolidated the work achieved by the Top End Health Service in 2014-15 to provide a more efficient and effective delivery of health care, by moving towards an integrated health service framework to ensure patient focussed outcomes.

In collaboration with the Executive Management Team, the Board has worked to progress the 2014-17 Strategic Plan through business plan priorities established for 2015-16. Several of these projects culminated in the development of new Frameworks as a basis for ongoing business activity, while others will be further developed in 2016-17. The Strengthening Workforce Culture project and the resulting Action Plan, was one that the Board was pleased to be involved in through the workshops that were held.

Strategic oversight and monitoring of the Strategic Plan by the Board has assisted TEHS to gain significant improvements in most of the performance areas as reported in the Service Delivery Agreement. These include:

- The Extended Emergency Medicine Unit (EEMU), commissioned in March 2015 which has improved flow through the RDH Emergency Department, and investment in the Hybrid Operating Suite, increasing the precision and throughput of surgery services;
- optimising funding sources, which has seen improvement in private patient election and subsequent revenue to support health services;
- strengthening governance frameworks to improve performance and accountability throughout TEHS; and
- reducing elective surgery long waits which continue on a pathway of reduction.

Building on this, further improvement is expected towards the achievements of the SDA targets.

The Board also worked to establish Regional Community Advisory Groups, as part of a greater community and consumer engagement strategy. The establishment of these groups now provides an important avenue for the community to be involved in the strategic planning process and we look forward to their input.

Committees established in the previous year, including the Finance, Risk and Audit Committee, the Community and Consumer Engagement Committee, and the Safety and Quality Committee are working well to advise the Board and assist the Board as a whole to monitor and manage its obligations. A new Governance Committee established during the year completes the governance structure and will complement the work of the other Committees.

Board members continue to expand their knowledge and understanding of the wide range of services provided throughout the Top End, through interactions such as visiting regional centres, hosting meetings with service providers and attending presentations. A recent example is provided through the Board involvement in judging of the Quality Awards, with an exceptional range of entries providing wonderful insight into both the services and the staff of TEHS.

On behalf of the Board I would like to thank TEHS staff for their continuing hard work and dedication throughout 2015-16 and beyond, towards improving health outcomes in the Top End community.

The Year in review - Chief Operating Officer

Michael Kalimnios

Chief Operating Officer

Top End Health Service (TEHS) is an independent body corporate and operates under the direction of the TEHS Board.

In 2015-16, our total TEHS Operating Budget was $790.153 million, which delivered:

- 82 601 - Hospital admissions
- 144 134 - Outpatient occasions of service
- 90 288 - Emergency Department presentations
- 347 566 - Community occasions of service (combined urban and remote)
- 11 541 – Aged Care occasions of service
- 5 152– Community Mental Health occasions of service

These services were delivered across the Top End in Royal Darwin Hospital, Katherine Hospital, Gove District Hospital and our Community and Primary Health Care Clinics.

In July 2015, TEHS embarked on the 2015-16 Business Improvement Program, comprising six major projects including:

1) Improving Patient Flow
2) Improving Elective Surgery Access
3) Strengthening Workforce Culture and Capacity
4) Delivering Integrated Care (Service Integration and PHC Accreditation)
5) Corporate and Clinical Governance
6) Revenue Optimisation

This ambitious program of work also marked the beginning of a change journey, upon which TEHS staff across all sectors were led to think differently about the way in which we work. In just one year, we have started to take a truly patient-centred approach by putting the needs of our patients at the centre of everything we do. We are also looking at TEHS as a whole, and identifying opportunities to work together across the service rather than just focusing on the individual areas in which we work.

Just twelve months later I am pleased to say that we have made very good progress with all of our projects. We have:

- completed the diagnostic process for improving patient flow and elective surgery access and commenced the implementation of specific strategies which are already making positive progress and improvements in these areas.
- conducted 52 organisational culture workshops involving over 700 staff and management from across the Top End to gain insight about today's workforce culture, about how we can improve, and to develop a TEHS Culture Charter that explicitly sets out TEHS values and behaviours based on learnings from those workshops.
- developed the TEHS Aboriginal Workforce Recruitment and Retention Strategy which will assist us to take practical steps to improve our success in recruiting and retaining Aboriginal and Torres Strait Islanders as valued members of our TEHS workforce.
- developed the TEHS Integrated Health Care Framework that we will apply to all of our projects, service and program planning and development activities moving forward
- commenced the process of achieving accreditation of our Primary Health Care services against the national standards.
- developed the TEHS Corporate Governance Framework and the TEHS Clinical Governance Framework which will serve as key foundation documents that outline how TEHS is controlled, and accountable for its performance.
- increased patient related revenue generation by $5M (26%)

In 2015-16, TEHS has successfully improved its high quality of service, ensuring that the care we deliver considers a patient's full range of needs, while rising to the challenges and increasing demands for services across the Top End.

None of our achievements would be possible without the participation, energy and willingness of our staff to get involved and help us make positive changes for TEHS, and I know that every member of our staff has played some part in helping us to progress these projects. I would like to take this opportunity to thank each and every one of them for their commitment and input in helping to make TEHS a better place for our patients, their families, carers and the community, and for all of us who work at TEHS. I look forward to 2016-17 as we continue upon this journey of *building better care, better health and better communities together.*

Role and function

The Top End Health Service (TEHS) works with key stakeholders to build better care, better health and ultimately better communities across the Top End. TEHS is a statutory body under the Northern Territory Health Services Act 2014. Its role is to ensure the provision of health services in the Top End as outlined in the Service Delivery Agreement with the Department of Health. TEHS is governed by a Board and the legislated roles and responsibilities of the TEHS Board include:

- Governance of the service
- Provision of strategic direction for the service
- Monitoring performance of the service against the SDA
- Engaging and working collaboratively with key stakeholders
- Community leadership functions including promoting appropriate culture and values of the service
- Leading community engagement by the service
- Understanding the health needs of the region
- Leading systemic improvements in communication between the service and its community

- **Team work and trust, respecting, valuing and acknowledging everyone's input, skills and experience**
- **Excellence and equity, striving to provide health care that is equitable, accessible and based on need**
- **Honesty and accountability, taking individual and collective accountability for our actions successes and mistakes**
- **Service and innovation, going the extra distance to deliver high quality services to our clients and consumers**

Our Vision

Building better care, better health, better communities together

Our Mission

We promote, protect and improve the health and wellbeing of all Top End Territorians in partnership with individuals, families and the community to ensure the delivery of the best and most appropriate evidence based care

Our Values

The values of TEHS are embodied in the services provided through:

Highlights 2015-16

Hybrid Operating Theatre Suite commissioned

In partnership with the National Critical Care and Trauma Response Centre, Darwin's first Hybrid Operating Theatre was opened at the RDH in October 2015. This technology provides shorter operating times, superior accuracy and faster recovery for patients undergoing surgery for specific head and neck, vascular, urology, orthopaedics and severe injury procedures.

Operating Theatre, Royal Darwin Hospital

Royal Darwin Hospital Redevelopment

Royal Darwin Hospital is halfway through a $64 million upgrade, which will, on completion, provide substantial improvement to the emergency department, main entrance and surrounds, outpatient clinics and the paediatric ward

Opening of the Medical Day Stay Unit in Katherine Hospital

With the assistance of Australian Government funding and in partnership with the Alan Walker Cancer Care Centre, patients in the Katherine region can now receive low risk cancer treatments in Katherine, treatments which would have previously required travel to Darwin or another major urban centre.

Opening of the Medical Day Stay Unit in Katherine Hospital

Redeveloped Staff Accommodation on the Gove District Hospital Campus

Significant redevelopment work has been completed for the staff accommodation at GDH. The existing quarters have now been converted into contemporary studio units, providing staff with comfortable, safe accommodation.

Youth Inpatient (YIP) service

A new mental health service and facility for vulnerable youth commenced in February 2016. This service and facility provides an age appropriate tailored setting for young people to access and receive mental health treatment.

Inaugural TEHS Quality Awards

Held in June 2016 as part of TEHS Quality week, the Quality Awards highlighted the innovative and quality committed culture of TEHS.

Transition of Alcohol and Other Drugs

The addition of Alcohol and Other Drugs to the existing Top End Mental Health Service portfolio from 1 July 2015 has strengthened the service TEHS provides to its patients requiring treatment and awareness for alcohol and drug addiction.

Louise O'Riordan at the Inaugural TEHS Quality Awards

Other highlights

In 2015-16 the TEHS Board endorsed six business priorities supporting the TEHS Strategic Plan.

Each business priority was addressed with a project methodology and included extensive diagnostic work to identify areas of focus. The work undertaken on all priorities has seen significant outcomes for TEHS during 2015-16, with further work to be covered in the 2016-17 TEHS Board approved business priorities.

TEHS 2015-16 Business Priorities

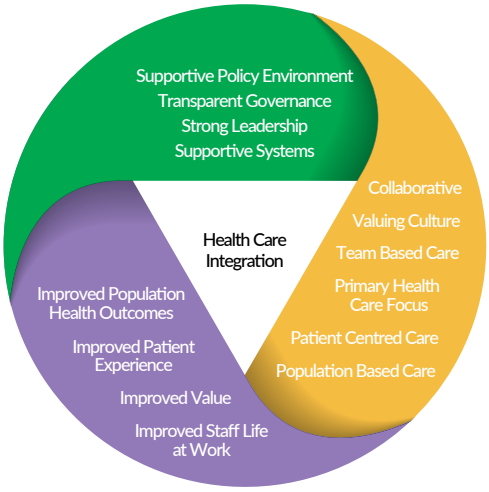
1 **Improving Patient Flow** – Focus on patients receiving the right care, in the right place at the right time. A number of strategies have been identified to improve a patient's journey through the hospital system. This work will continue into 2016-17.

2 **Improving Elective Surgery Access** – Focus on elective surgical and procedural patients being given the right treatment as soon as possible and going home in a timely way. This work will also continue into 2016-17.

3 **Strengthen Workforce Culture & Capacity** –This priority's focus was to seek feedback and ascertain the existing TEHS workforce culture in order to position the service to lead, manage, deliver and change in the future. The priority also focussed on growing and retaining the Aboriginal workforce to strengthen our culture and to increase capacity for high quality care.

This has been an extensive body of work and will continue as a priority in 2016-17.

4 **Deliver Integrated Care** – Focus on the development of a Service Integration Framework for application to new and existing health services to enhance patient experience and satisfaction. The Framework has been developed and will now be applied to selected services in 2016-17.



5 **Governance** – Corporate and clinical governance frameworks have now been established.

6 **Revenue Optimisation** – focused on the different funding sources available to the health service and the extent to which these can be optimised given the population demographics and service models in place. This analysis has assisted with enhancing knowledge of services provided and strategies to maximise eligible funding.

Strategic priorities 2016-17

The TEHS Board has approved eight business priorities for 2016-17. This includes continuation of work on the priorities for 2015-16. These include, *Improving Patient Flow and Elective Surgery Access* (now merged as the one priority due to commonality with patient flow issues) and *Strengthening Workforce Culture and Capacity.*

1. **Improving Patient Flow and Elective Surgery Access** – Continuing the work that commenced in the 2015-16 business priorities. This priority work will focus on implementing identified strategies to improve patient journeys through the hospital environment and ensure that surgery and procedures are received in the recommended times.
2. **Strengthening Workforce Culture and Capacity** – Continuing the work from 2015-16, the key findings from the organisational culture workshops and surveys will be published together with action plans to address areas for improvement. TEHS will launch management and leadership training programs for all levels of employees.
3. **Maternity Services Integration** – Using the Service Integration Framework developed in the 2015-16 business priority work, maternity services across primary care and hospital settings will be integrated on a patient centred model to ensure that women get the required care when and where they need it.
4. **Renal Services Integration** – Using the Service Integration Framework developed in the 2015-16 business priority work, the growing renal services area will be integrated across primary and hospital care settings, effectively utilising the Territory Government's 2016-17 increased renal service funding.
5. **Ambulatory Care** – This priority focuses on the improved coordination and scheduling of specialist outreach services together with greater utilisation of Telehealth technology, minimising the inconvenience of travel for patients attending specialist outpatient clinics. With the redeveloped outpatients department at RDH expected to be delivered early 2016-17, a new operating model will also be delivered, improving responsiveness and scheduling for appointments and clinics.
6. **Palmerston Regional Hospital Service Commissioning** – The commissioning of the Palmerston Regional Hospital is an exciting opportunity for TEHS to provide services to the population of the Top End and specifically Palmerston. TEHS is responsible for commissioning services in the Palmerston Regional Hospital. This requires intensive work to ensure that services are effectively modelled, planned, resourced and co-ordinated, not only for the Palmerston Regional Hospital but other services operating within Top End Health Service.
7. **Discharge Summaries** –The production of a discharge summary for patients leaving hospital is a significant factor in a patient's ongoing wellbeing, providing crucial information for primary health care practitioners about treatment and consequential issues such as medications. Timely production of discharge summaries is therefore, a quality health indicator and an area the TEHS hospitals are constantly seeking to improve.
8. **Financial Sustainability** – Following on from the revenue optimisation priority work in 2015-16, TEHS is committed to developing a platform for long term financial sustainability. As a largely cost driven industry, public health services have contemporary models available to better measure efficiency and effectiveness of delivery. A by-product of pursuing long term financial sustainability in the public health setting is better measurement and information about services, ultimately delivering better considered services.

Other 2016-17 Priorities

Redevelop Emergency Department Gove District Hospital

Work has already commenced to redevelop the Emergency Department at Gove District Hospital. The redevelopment is due for completion in early 2017.

Royal Darwin Hospital Redevelopment

The redeveloped areas of Royal Darwin Hospital will be completed in 2016-17.

Cardio Thoracic and Neuro-surgical Service

Planning work has commenced for the delivery of this complex surgery that Territorians currently have to travel interstate to receive. Making this service sustainable at a local level will take some time and preparation to ensure the quality and safety aspects of the services provided are delivered to a high standard.

PET Scanner

The recent Australian Government commitment to providing funding for a PET scanner and cyclotron infrastructure provides a boost to cancer patient services, research and training opportunities in the Top End. TEHS will be assessing operating model options during 2016-17.

Our leaders

Top End Health Service Board

In line with legislation, the Top End Health Service (TEHS) Board must have at least five, but not more than nine members. Currently, the Board consists of eight members, with the following changes in Board membership during the past year:

- Richard Harding resigned effective 30 August 2015;
- the appointments of Graeme Lewis and Dr Max Chalmers expired on 30 June 2015;
- Dr Sarah Giles and Professor Alan Cass were appointed from 1 July 2015; and
- Amin Islam was appointed from 1 January 2016.

TEHS Board (Left to Right): back: Trish Angus, Connie Jape, Dr Sarah Giles, Michael Martin; Front: Prof Alan Cass, Diane Walsh (Deputy Chair), Annette Burke (Chair), Amin Islam.

Annette Burke,
Board Chair

Annette Burke is Chair of the Top End Health Service Board. She is also on the Cancer Council NT Board and the Cancer Council Australia National Board. Annette has a Master in Education, an MBA, is a Fellow of the Australian Rural Leadership Foundation and a Companion to the Charles Darwin University.

Annette arrived in the NT in 1991 and became an Alderman on Palmerston Council a couple of months later, then was Mayor from 1997 to 2007. More recently, Annette worked for four years in the Middle East for the Abu Dhabi Government as Curriculum Manager of the Centre of Excellence and later as Director of Executive Education for the Abu Dhabi Chamber of Commerce and established the first business women's mentoring group in the Middle East.

Following this, on her return to Australia, Annette was Chair of the Charles Darwin University Foundation Board.

Diane Walsh,
Board Deputy Chair

Diane Walsh was formerly a school teacher and is a graduate of the Australian Institute of Company Directors. She is a member of the Consumers Health Forum and has served in consumer health and governance roles such as the Medicare Australia Stakeholder Consultative Group and the Therapeutic Goods Committee for over 14 years. She chairs the NPS Medicines Wise Consumer Advisory Group and is Director and Deputy Chair, NT PHN.

Diane was Chair of the General Practice Network Northern Territory Board from 2009 until its wind-up following the formation of the Northern Territory Medicare Local and on the Governing Council of the Top End Hospital Network.

Trish Angus,
Board Member

Trish Angus has a Master in Tropical Health and several nursing qualifications. She has undertaken courses or programs such as the Australian Institute of Company Directors; Australian and New Zealand School of Governance Executive Fellows Program; NTPS Executive Development Program and the London Kings Fund Executive Fellows Program.

Trish was born in Katherine and grew up in the NT. Trish retired in May 2012 after 26 years of service in the NT Public Service (NTPS) and holding a number of senior executive policy, legislation and program development roles in the fields of health, housing, human services, local government policy and Aboriginal affairs.

Trish is also a CareFlight Board Director; Indigenous Business Australia Board Director; Voyages Indigenous Tourism Australia Board Director, Charles Darwin University Vice Chancellor's Indigenous Advisory Council Member; Sydney University Ethical Investment Committee Member; and Mutitjulu Foundation Board Director.

Michael Martin,
Board Member, Chair Finance Risk and Audit Committee

Michael Martin has been in the Territory since 1978 and experienced a successful executive career in the Northern Territory Public Service between 1978 and 2006. He started a successful consultancy business in 2007 and is Managing Director of THEM P/L which has a range of Territory clients.

Michael is a Fellow of CPA Australia, Graduate Member of the Australian Institute of Company Directors, a graduate of ANU and holds tertiary qualifications from ANU, Canberra University and the University of Queensland.

Michael is a Board member of Mt Isa Aboriginal Community Controlled Health Service known as Gidgee Healing, as well as NT Build and the NT Remuneration Tribunal.

Connie Jape,
Board Member

Connie Jape is the Director of the independent retail store Jape Furnishing Superstore and franchise outlet Forty Winks Darwin. Connie was born in Timor Leste and educated in Singapore. She has been in the Territory since 1981.

Connie has served as a board member for the Chamber of Commerce NT.

Dr Sarah Giles,

Board Member, Chair Safety and Quality Committee

Dr Sarah Giles is currently working as a GP and as Senior Medical Officer Health Systems with Danila Dilba Health Service, with responsibility for quality and safety. Sarah graduated in Medicine from Adelaide University in 1981 and became a Fellow of the Royal Australian College of General Practice in 2010. She has been a general practitioner in Darwin since 1997.

Sarah is the medical member of both the Winston Churchill Memorial Trust NT Regional Committee and the Top End Community Visitor Panel. Sarah chaired the NT Health Minister's Advisory Council between 2009 and 2012.

Professor Alan Cass,

Board Member

Professor Alan Cass is Director of the Menzies School of Health Research in Darwin. Having trained as a renal physician, Alan completed a PhD at Menzies and worked as a renal physician in Darwin from 1998 to 2002. He undertook a Harkness Fellowship in Health Care Policy at Harvard Medical School, before returning to head the Renal and Metabolic Division at the George Institute for Global Health at Sydney University. In 2012, he returned to Darwin as Menzies Director.

Alan has pursued a research career with a particular interest in the prevention and management of chronic disease and Indigenous health.

Amin Islam,

Board Member

Amin Islam is a Fellow Chartered Accountant and a member of the Australian Institute of Company Directors. He was a former partner of Ernst & Young and Managing Director of Merit Partners Pty Ltd. He was an authorised auditor for Northern Territory Government and Australian National Audit Office.

His involvement in the health sector is via auditing, budgeting, management accounting and corporate advice and as Board Member of Health NGOs.

Amin served as a president of the CPA Australia (NT). He was also a Board member of the Heart Foundation NT and lectured at the Charles Darwin University on a part time basis.

Board meeting attendance is indicated in the following table.

Board meeting attendance 2015-16

Board Member	Meetings Attended
Annette Burke	11
Diane Walsh	11
Trish Angus	10
Michael Martin	10
Connie Jape	10
Dr Sarah Giles	12
Prof Alan Cass	11
Amin Islam *	6*
Total Meetings	12/6*

*commenced January 2016

Board Activities 2015-16

After entering into the formal Service Delivery Agreement (SDA) for 2015-16 with the Department of Health, the Board and the Department met regularly to monitor performance in line with targets. The 2016-17 SDA between the Board and the Department of Health was signed on 28 June 2016. TEHS committee structures and processes support operations and assist the Board discharge its accountabilities under the SDA. Committee attendances are in the table below.

Board Committee meeting attendances 2015-16

Board Member	Finance Risk & Audit	Community & Consumer Engagement	Safety and Quality	Governance
Annette Burke	7	4	4	
Diane Walsh	1	7	6	2
Trish Angus	7	2		2
Michael Martin	10	7		
Connie Jape	1	4	4	
Dr Sarah Giles	1		6	
Prof Alan Cass	10		1	2
Amin Islam *	6*			
Total Meetings	12	8	6	2

*commenced January 2016

Non member | Non member or change in membership | Member

A fourth Board Committee was established during the year, and TEHS Board Committees now include:

- Finance, Risk and Audit
- Community and Consumer Engagement
- Quality and Safety
- Governance

As part of its consumer engagement strategy, the Board has established Regional Community Advisory Groups (RCAG) for:

- East Arnhem
- Katherine
- Darwin
- Palmerston and Rural

A fifth RCAG for Top End Remote is in the process of being established. RCAG provide an important mechanism for the community to provide input and feedback on local health service provision.

Executive team

Michael Kalimnios,

Chief Operating Officer

Michael commenced as the Chief Operating Officer in TEHS in January 2015. Prior to this role, Michael was the Chief Finance Officer and Acting Executive Director, Funding, Performance and Corporate with the Department of Health. Michael is a Chartered Accountant and has worked in senior roles within the public health sector for more than twenty years.

Michael is supported in the operation of TEHS by the Strategic Executive Team and an Operational Executive team (tabled below).

Each service in TEHS is represented on the Operational Executive Team (East Arnhem Region, Katherine Region, Royal Darwin Hospital, Darwin Region and Strategic Primary Health Care, and Mental Health and Alcohol and Other Drugs). The Strategic Executive team consists of executive professional and clinical leadership roles.

Strategic Executive Team

Chief Operating Officer	Michael Kalimnios
Assistant Chief Operating Officer	Allison Grierson
Executive Director Medical Services*	Dr Charles Pain
Executive Director of Nursing and Midwifery	Val Tuckett
Executive Director Allied Health	Renae Moore
Executive Director People and Culture #	Peter Boyce
Chief Finance Officer	Brigid Bourke

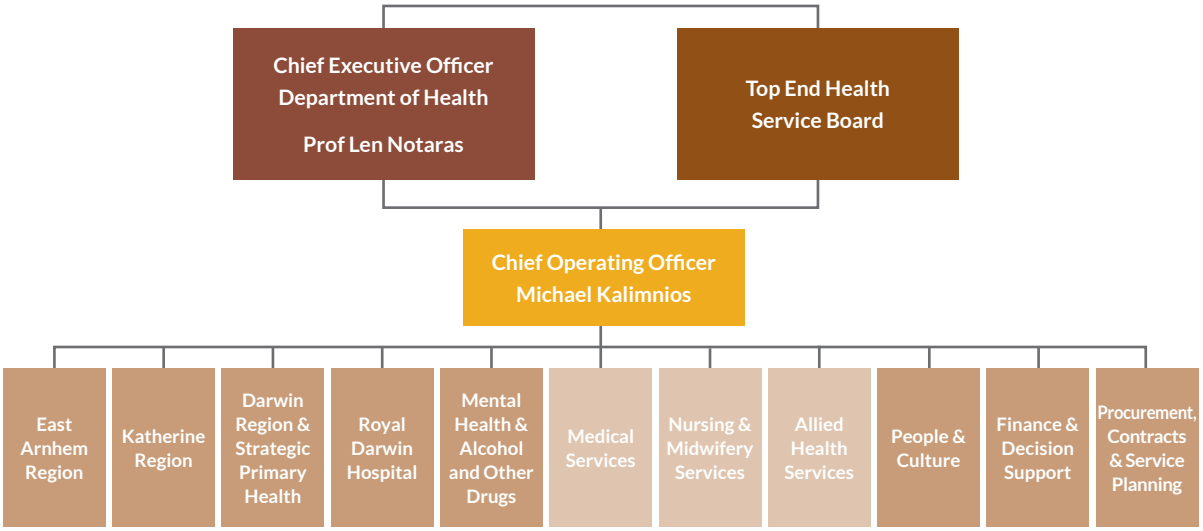
* Dr Pain commenced 20-06-16. Previously Dr Dinesh Arya and Dr Sara Watson performed in this role.

Peter Boyce commenced 27-06-16. Previously Louise Oriti performed the role.

Operational Executive Team

Chief Operating Officer	Michael Kalimnios
Assistant Chief Operating Officer	Allison Grierson
Senior Director Operations RDH	Emma Reid
General Manager – Palmerston Regional Hospital Service Commissioning	Sharon Sykes
General Manager East Arnhem Region	Lisa Pullen
General Manager Katherine Region	Angela Brannelly
General Manager Darwin Region & Strategic PHC	Dr Christine Connors
General Manager Top End Mental Health and Alcohol and Other Drugs Service	Richard Campion
Chief Finance Officer	Brigid Bourke

Top End Health Services



Health Service structure

TEHS is a statutory body under the Northern Territory *Health Services Act 2014*. Its role is to ensure the provision of health services in the Top End as outlined in the Service Delivery Agreement with the Department of Health.

TEHS encompasses:

- Royal Darwin Hospital
- Katherine Region
- East Arnhem Region
- Darwin Region and Strategic Primary Health Care
- Mental Health and Alcohol and Other Drugs Services
- Aged Care Services

The Top End region covers 35.3% (475,338 square kilometres) of the Northern Territory. It has an estimated resident population of 195,330 people (as of June 2015), which represents 80% of the total Northern Territory population. Of this population, 72.6% live in the Greater Darwin area with the balance residing in Katherine, Nhulunbuy and the remote areas of the Top End. 26% of the Top End region population indentify as Aboriginal people.

Royal Darwin Hospital

Royal Darwin Hospital operates with 371 beds and provides a broad range of services in all specialty areas to the Greater Darwin population as well as serving as a referral centre to the Top End of the Northern Territory, Western Australia and South East Asia.

RDH is currently the only public hospital facility providing health care services to the population of Darwin and is also the location of Australia's National Critical Care and Trauma Response Centre. This results in primary and secondary catchments that are reliant on RDH to provide health care services.

In addition to a range of medical, surgical, maternal, paediatric and emergency services, the hospital offers comprehensive diagnostic radiology and pathology facilities to support the delivery of inpatient and non admitted clinical services.

RDH is the largest teaching hospital in the Northern Territory and is affiliated with Flinders University, University of Sydney, Charles Darwin University and participates in research projects in a variety of fields with the Menzies School of Health Research.

During 2015-16, significant redevelopment works commenced on the RDH campus. Following the completion of the extended emergency and surgical physical capacity in late 2014-15, the Hybrid Operating Theatre Suite was commissioned in October 2015. The Hybrid Theatre complements the trauma and other specialist services provided by RDH. The $64 million redevelopment of the RDH main block will focus on the emergency department, main entry, outpatients area and the paediatric ward.

Much of the TEHS business priority work during 2015-16 has been hosted at RDH, building the 'one service, multi-site' philosophy of TEHS, investing in better patient flow models throughout the Top End.

Katherine Region

The Katherine region covers an area of approximately 340,000 square kilometres between the borders of Western Australia and Queensland, extending south to Dunmarra and Pine Creek to the north. The population of the Katherine region is approximately 19,000 of which 48% identify as Aboriginal. Katherine, the third largest town in the Northern Territory is home to approximately 10,600 people. The region attracts a significant tourist population, with an annual tourist presence of more than 500,000 visitor nights.

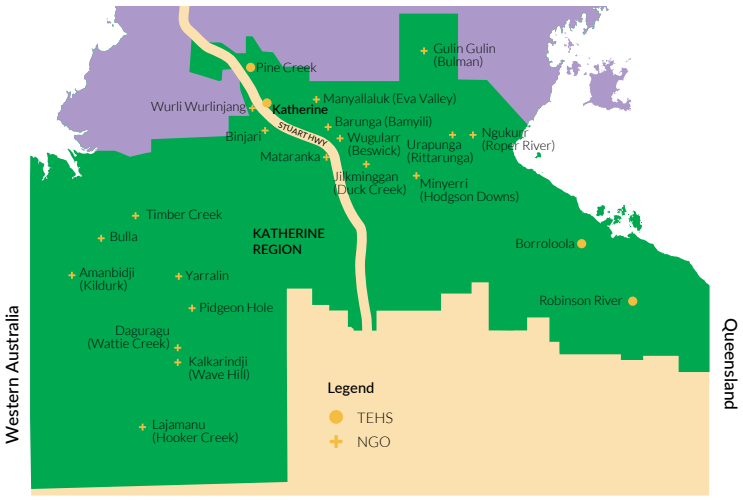
TEHS operates several primary health care clinics in the Katherine region as well as the Katherine Hospital located in the town of Katherine. The Katherine Hospital operates with 60 overnight beds, primarily serving the needs of the region. Katherine Hospital provides general medical, surgical, maternity and a range of specialist medical and allied health services. The emergency department provides 24 hour emergency care to Katherine and surrounding communities. Katherine Hospital also offers a number of non-admitted services.

During 2015-16, the medical day stay unit commenced operation in partnership with the Alan Walker Cancer Care Centre, providing an alternative setting for the treatment of specific cancers and reducing travel required by patients located in the Katherine Region. Katherine Region primary health care centres are listed in the table below.

Katherine Region Primary Health Care Centres

	Referral Centre
Pine Creek	Katherine Hospital
Royal Darwin Hospital	
Borroloola	
Robinson River	
Katherine Urban	
Katherine West*	Royal Darwin Hospital
Sunrise Health Service*	
Wurli-Wurlinjang Health Service*	

*in partnership with NGOs



East Arnhem Region

The East Arnhem region is located in the far north of the NTand covers an area of approximately 41,000 square kilometres extending west to Milingimbi and south to Numbulwar.

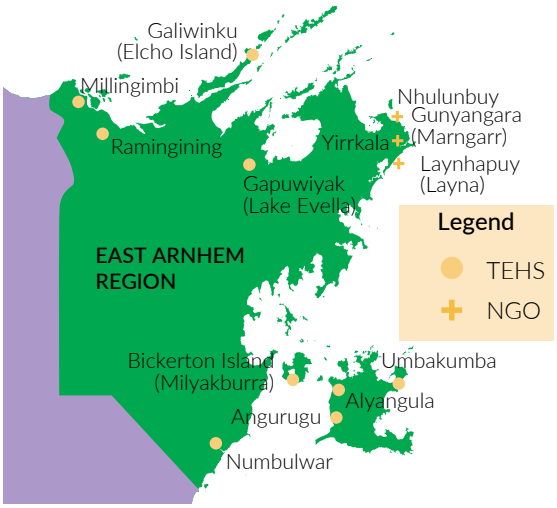
East Arnhem region encompasses the towns of Nhulunbuy on the Gove Peninsula, Alyangula on Groote Eylandt, Milingimbi, Elcho Island and the major Aboriginal communities on the mainland.

The East Arnhem region accounts for 3% of the Northern Territory's population. Throughout the region, there are in excess of 100 homelands and outstations that are almost exclusively Aboriginal in population and range from 30 to 200 people.

TEHS operates several primary health care clinics in the East Arnhem region as well as the GDH located in the town of Nhulunbuy (tabled below). The GDH operates with 30 beds and provides a range of medical, surgical, paediatric, respite and maternity services. It is the referral centre for approximately 15 remote community primary health care clinics that refer patients to the hospital for outpatient and specialist care. GDH provides a mortuary for the region and the hospital stores building doubles as the community cyclone shelter.

During 2015-16, staff accommodation located on the hospital campus was renovated to provide safe, secure and contemporary studio units and the redevelopment of the emergency department commenced. This redevelopment is the culmination of two years of planning with the Australian Government's Health and Hospital Fund. Building works have also begun on the new Umbakumba health clinic.

Following a thorough scoping process, operation of the Millingimbi Primary Health Centre transitioned to Miwatj Health Aboriginal Corporation from 1 July 2016.



East Arnhem Primary Health Care Centres

		Referral Centre
East Arnhem North	Ramingining	Gove District Hospital
	Milingimbi	
	Gapuwiyak	
	Marthakal Homelands*	Royal Darwin Hospital
	Miwatj* (Yirrkala, Galiwinku)	
	Laynhapuy Homelands*	
East Arnhem South	Umbakumba	
	Angurugu	
	Alyangula	
	Numbulwar	

*in partnership with NGOs

Darwin Region and Strategic Primary Health Care

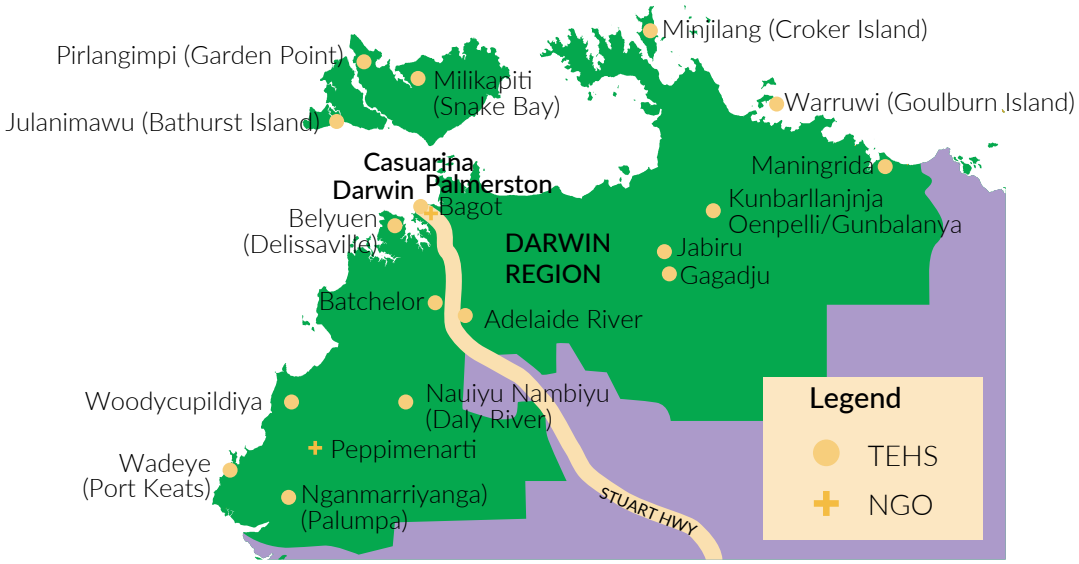
TEHS provides a broad range of primary health care through three distinct settings:

- Urban Primary Health Care
- Remote Primary Health Care
- Prison Primary Health Care

The size and mix of services provided by the TEHS Primary Health Care Centres (tabled below) vary according to the size and health needs of the population and access to alternative services. Visiting or outreach services are also provided to small communities and outstations in very remote areas where a permanent primary health care service cannot be provided.

The key range of primary health care services provided includes:

- Clinical Services - primary clinical care, clinical prevention, rehabilitation and clinical support systems
- Health Promotion Services – health public policy, community action and development, health information, education, skills development and education
- Community Engagement, Control and Cultural Safety Services – engaging clients with their health, community participation, community control, governance and cultural safety
- Corporate Services and Infrastructure – staff training and support, management systems, human resource services, infrastructure and access to systems and services external to the service
- Advocacy, Knowledge, Research and Policy Development



Darwin Region Primary Health Care Centres

		Referral Centre
Top End West	Wadeye	Royal Darwin Hospital
	Nauiyu Nambiyu (Daly River)	
	Batchelor	
	Adelaide River	
	Peppimenarti*	
Top End Central	Jalanimawu (Bathurst Island)	
	Pirlangimpi	
	Belyuen	
Top End West Arnhem	Minjilang	
	Warruwi	
	Gunbalanya	
	Jabiru	
	Maningrida	
	Malabam*	
Urban Primary Health Care	Casuarina Community Care Centre	
	Palmerston Community Clinic	
Prison Health Services	Darwin Correctional Centre	
	Police Watch House (Darwin and Katherine)	

*in partnership with NGOs

Mental Health and Alcohol and Other Drugs Services

Mental Health Services and Alcohol and Other Drugs Services are specialist TEHS clinical services that provide a multi-disciplinary approach to treatment and therapeutic intervention for individuals experiencing a mental illness, mental health problems or addiction in the Top End. The service provides a comprehensive range of clinical services, including assessment, treatment and intervention to consumers of all ages that present with moderate to severe illness and health problems in a variety of settings including, in-patient, out-patient and mandated treatment settings.

Access to services is based on assessment of clinical need, which incorporates consideration and assessment of risk. Services have a recovery focus with an emphasis on rehabilitation and relapse prevention.

The inclusion of the Alcohol and Other Drugs service with the Mental Health Service portfolio from July 2015 has strengthened the service for patients requiring treatment and information regarding drug addiction.

In February 2016, the Youth Inpatient (YIP) Mental Health ward opened on the Royal Darwin Hospital campus, providing an appropriate and safe setting for young people receiving mental health treatment.

Emma Reid, General Manager Top End Mental Health Services at the Opening of the Youth Inpatient (Yip) Service

Palmerston Regional Hospital

Palmerston Regional Hospital is expected to start providing services in mid-2018. This is an exciting opportunity for health services in the Top End as well for the people of Palmerston and outer Darwin areas. In the time leading up to the commissioning of the hospital work is required to not only complete the infrastructure but also to ensure that service models and staff are in place to have a functioning hospital.

In 2015-16, the PRH project moved into the Operational Commissioning phase and 2016-17 will see the project team focus on progressing preparations to be service ready for the hospital opening. The PRH Operational Commissioning Team are working as part of Top End Health Service on strategies to ensure safe, quality service delivery at the new hospital. Areas of particular focus include: service delivery models and preparation for the opening of clinical and non clinical services; workforce strategies to ensure the hospital is appropriately staffed; input into hospital infrastructure and ICT design by clinical staff to ensure the hospital is fit for purpose; and financial modelling for the hospital. This work will also include the development of comprehensive communication and change management strategies aimed at staff and the community.

The PRH building is due for completion in early 2018, with a 116 bed facility providing low acuity hospital services closer to home for the Palmerston region community. Population and health data have been used to design the services at the hospital to meet the future needs of the local community. There will be a 24/7 low acuity emergency facility, low complexity elective surgery and maternity services linking in with the community midwifery program run from the RDH. Additionally, rehabilitation and geriatric services for the Top End will be delivered in new purpose built patient areas. The PRH will be a key service within TEHS and assisting to lessen the patient activity pressures on RDH.

Strategic planning framework and directions

The TEHS Strategic Plan 2014-17 drives the activities and business priorities of the Health Service. The strategies and actions presented in the plan translate and integrate with the priorities and strategic directions articulated by NT Health, aligning the focus of TEHS with Territory wide health system planning, and building a platform for health service provision that is cohesive and integrated across the Northern Territory.

The core goal of the framework is to deliver responsive, effective and efficient health services with a focus on consistently providing high quality, patient centred care and getting the best value for every health dollar spent.

Building better care, better health, better communities together

TEHS strategies and key actions reflect a commitment to equitable access to affordable health care that responds to the unique health needs of Territorians in the Top End with a focus on fostering a culture of innovation and continuous improvement.

The Strategic Directions in the plan are supported by the 2015-16 and 2016-17 TEHS business priorities (table below):

Strategic Direction	2015-16 Business Priorities	2016-17 Business Priorities
1. Foster a culture that promotes ownership of performance	Strengthen Workforce Culture & Capacity	Strengthening Workforce Culture & Capacity
2. Promote a culture of innovation	Improving Patient Flow Improving Elective Surgery Access	Improving Patient Flow & Elective Surgery Access
3. Provide safe and quality healthcare services	Governance Deliver Integrated Care	Discharge Summaries
4. Provide affordable and efficient healthcare	Revenue Optimisation Improving Patient Flow Improving Elective Surgery Access	Financial Sustainability Improving Patient Flow & Elective Surgery Access Ambulatory Care
5. Ensure equitable access to healthcare services	Deliver Integrated Care Improving Elective Surgery Access	Maternity Services Integration Renal Services Integration Ambulatory Care Palmerston Regional Hospital Service Commissioning
6. Build a sustainable and quality workforce	Strengthen Workforce Culture & Capacity	Strengthening Workforce Culture & Capacity Palmerston Regional Hospital Service Commissioning

Service Delivery Agreement

Each year the TEHS Board enters a Service Delivery Agreement with the Department of Health as the Health System Manager, detailing resourcing and performance targets to be met throughout the year. The SDA enhances performance accountability for performance in TEHS and focusses the service on the best use of limited resources to deliver services to the Top End community.

The Board endorsed six business priorities for 2015-16, which not only supported the strategic direction of TEHS but drove improvements against the SDA key performance indicators.

- The improving patient flow and access to elective surgery priorities have seen improvements in the indicators for Emergency Department departures within four hours. Contributors to this include:
  - the introduction of the Extended Emergency Medicine Unit (EEMU)
  - the commissioning of the Hybrid Operating Theatre Suite.

The Hybrid Operating Theatre Suite has enhanced surgical services, both elective and emergency with improved precision and throughput capability. Investment in the EEMU and the Hybrid Operating Suite were strong recommendations to the System Manager for the improvement of services and performance. Work throughout 2015-16 has identified other changes in practice that has further improved performance against access and surgery targets.

- The Board's revenue optimisation business priority has improved TEHS' resource capacity to deliver health services through increasing the election of patients to utilise their private health insurance and boosting the TEHS strategic funding profile to focus on better measurement of activity for maximum gain.
- The establishment of clear governance frameworks for TEHS (also a Board business priority) has improved the accountability for SDA performance indicators throughout TEHS.
- Significant progress has been made with setting the foundation for the TEHS culture and improving Aboriginal Health Practitioner recruitment and retention through the *Strengthening Workforce Culture and Capacity* business priority.

(L-R) Deputy Chair Diane Walsh, Chair Annette Burke and Chief Executive Prof Len Notaras signing the 2016-17 SDA, June 2016

Clinical governance

During 2015-16 TEHS established a Clinical Governance framework as part of its Corporate Governance Framework. The framework articulates the TEHS approach to ensuring that the services it delivers are safe and of high quality and set, manage, monitor and seek to improve TEHS' performance in delivering safe, high quality care.

Safety and quality

The TEHS Service Delivery Agreement includes safety and quality indicators which are closely monitored.

	Actual				2015-16		2016-17 Budget
	2011-12	2012-13	2013-14	2014-15	Budget	Actual	
Safety and Quality							
Staphylococcus Aureus Bacteraemia (SAB) Infections[1]	1.50	1.01	1.09	0.76	1.07	0.75	1.07
Hand hygiene compliance	n/a	64.6%	70.6%	76.4%	70.0%	81.8%	75.0%
Potentially preventable hospitalisations[2]	n/a	7.80%	7.9%	8.1%	9.1%	6.8%	9.1%
Discharge summaries dispatched within 48 hours[3]	n/a	n/a	n/a	n/a	n/a	n/a	95.0%
Inpatients who discharged from hospital or left hospital against medical advice[3]	n/a	n/a	n/a	n/a	n/a	n/a	9.1%

[1] Revised data for 2014-15, previously only reported until May 2015.
[2] Historical data reprocessed due to new definitions of PPH.
[3] New measure in SDA.

Access

The following access indicator is outlined in the TEHS SDA.

	Actual				2015-16		2016-17 Budget
	2011-12	2012-13	2013-14	2014-15	Budget	Actual	
Access							
Telehealth Occasions of service[1]	n/a	n/a	n/a	n/a	n/a	n/a	1 040

[1] New measure in SDA.

Incident management

Incidents or near misses that have potential to harm consumers or carers and staff are reported via an online based integrated risk management system. Incidents are severity rated and high level incidents are escalated to ensure appropriate notification and action to reduce the likelihood of reoccurrence. Incidents that are rated at a lower level are trended and targeted action plans are developed and implemented.

Reported incidents and near misses are across a range of clinical care delivery processes and outcomes, including, but not limited to:

- Medication administration, adverse drug reaction, dispensing and prescribing
- Consent
- Consumer falls
- Clinical handover, including discharge summaries and referrals
- Pressure injuries
- Healthcare associated infections
- Complication eg. bleeding
- Consumer identification
- Care and response to deteriorating consumer
- Blood and blood products
- Security
- Access and delays to care and diagnostics
- Equipment availability

Incident Severity Rating (ISR)	2015-16
ISR1 incident is where there is death or permanent loss or reduction of functioning where the person is unlikely to recover from the reduction or loss of function, and it is not as a direct result of their natural disease progression or co-morbidities	11
ISR2 incident is where there is significant harm or impact on the person/s involved, though any loss or reduction in functioning is temporary and a full recovery to pre incident level is expected, and it is not as a direct result of their natural disease progression or co-morbidities	79
ISR3 incident is where harm has occurred which may require a higher level of care or observation, but did not have a loss or reduction of function as a result of the incident	2,300
ISR4 incident is where harm is minimal and not requiring additional level of care	2,492
ISR5 is an incident that did not cause harm and includes near misses	2,173
Total	**7,065**

ISR1 excludes 9 alleged suicide in the community with service contact within 12 months prior to the date of death

TEHS Safety and Quality Awards

The inaugural TEHS Safety and Quality awards in 2015-16 highlighted the commitment of TEHS staff to service innovation, improvement and high quality outcomes for patients across a wide range of areas.

Consumer Feedback

TEHS is committed to providing care that is responsive to patient needs and the availability of consumer feedback is valuable in assisting with this process.

In the 2015-16 financial year, the Health Service recorded 482 complaints and 192 compliments. Complaint data is similar to last financial year but there have been twice as many compliments this year. 192 in 2015-16 compared with 80 compliments in 2014-15.

Training has been provided to staff to increase recording of consumer feedback and improve data accuracy in the consumer feedback database.

Themes are identified with each complaint recorded so we can assess areas where service improvements are required (table below). Communication/Information and Treatment were the most common issues in 2015-16.

Complaints 2015-16

Theme	2015-16
Access	97
To facility, to subsidies, refusal to admit or treat, service availability, waiting list delays	
Treatment	132
Co-ordination, diagnosis, delay, unexpected outcome, wrong/inappropriate, inadequate consultation, no/inappropriate referral, withdrawal of, excessive rough/painful, infection control, private/public election	
Communication – information	145
Attitude/manner, inadequate information provided, incorrect/misleading information provided, special needs not considered	
Environment/Management	58
Administrative process, cleanliness and hygiene of facility, physical environment of facility, staffing and rostering, statutory obligations/accreditation	
Consent and Decision Making	13
Consent not obtained or inadequate, involuntary admission or treatment, uninformed consent	
Medical Records	9
Access to/transfer of records, record keeping	
Fees/Cost	7
Billing practices, cost of treatment, financial consent	
Medication	29
Administering, dispensing, prescribing and supply/storage/security of medications	
Reports	6
Access to/transfer of records, record keeping	
Discharge and Transfers	26
Inadequate discharge, information on follow up care not provided	
Professional Conduct	8
Unsatisfactory professional conduct	
Grievances	2
Inadequate of no response, complaint information not provided. Reprisal/ retaliation as a result of complaint lodged	

Our people

Workforce profile

From 1 July 2015, AOD transitioned from Territory Wide Services within the Department to TEHS. This transfer increased the workforce of TEHS by an additional 80 full time equivalents. A further transfer of Specialist Outreach travel co-ordination in December 2015 increased the workforce by another 9 full time equivalents. In addition the NT Pathology Network commenced operation on 1 July 2015. The Network combined the pathology staff from TEHS facilities and CAHS facilities in the one structure. The NT Pathology Network is hosted within TEHS but reports and is accountable to the Department of Health. Approximately 111 full time equivalents from across TEHS transferred to the NT Pathology Network.

TEHS made significant investments throughout 2015-16 to strengthen its workforce culture and capacity. The need to focus strategically on the role and contribution of TEHS people and culture was identified as a key component of TEHS 2015-16 Business Improvement Program. By building a strong, dedicated and capable workforce and influencing a workplace culture that inspires and motivates positive performance, TEHS has significantly strengthened its capacity to lead, manage, deliver and sustain the range of improvements planned across the organisation.

Throughout 2015-16 the TEHS Executive worked closely with staff to gain an understanding of the existing organisational culture and the type of culture staff want for the future. This involved staff at all levels from a range of locations and settings clarifying and confirming the organisation's values and expected behaviours and determining a course of action to strengthen TEHS organisational culture for the future.

A series of actions were identified to assist with bringing about the required cultural change which will be implemented in 2016-17 under the *'Shaping TEHS Organisational Culture Framework'*. A key component of this is an organisational culture learning and development program that will support managers to build their capacity to engage with staff in dialogues about values, culture, behaviours and how they link to and support the delivery of TEHS' business priorities.

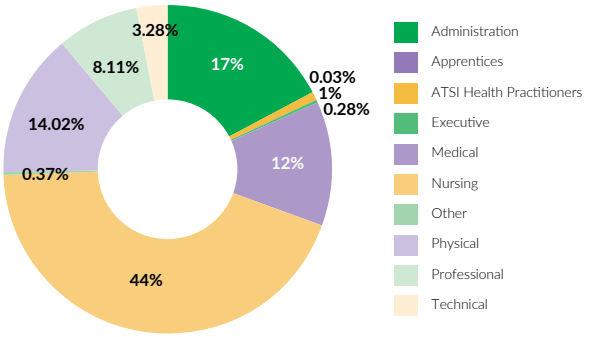
During 2015-16 TEHS also developed an *Aboriginal and Torres Strait Islander Workforce Recruitment and Retention Strategy* to assist with increasing the number of Aboriginal staff working in TEHS and to encourage them to stay working at TEHS long term. By developing the Aboriginal workforce TEHS hopes to have a dual impact on Aboriginal health and wellbeing by providing opportunities for Aboriginal people to become health professionals and leaders, who in turn will enable TEHS to provide more culturally appropriate and tailored care to Aboriginal patients, their families, carers and communities. The Strategy sets out the fundamental principles that underpin Aboriginal workforce recruitment and retention, and draws together a collection of practical strategies and initiatives aligned to three key action areas:

- **Workforce Environment** – creating a culturally safe and competent workplace that supports the needs and expectations of Aboriginal and Torres Strait Islander staff.
- **Attraction and Recruitment** – attracting and recruiting Aboriginal and Torres Strait Islander people at all levels to work at TEHS.
- **Retention and Career** – supporting and enhancing the employment continuity and career development of Aboriginal and Torres Strait Islander staff.

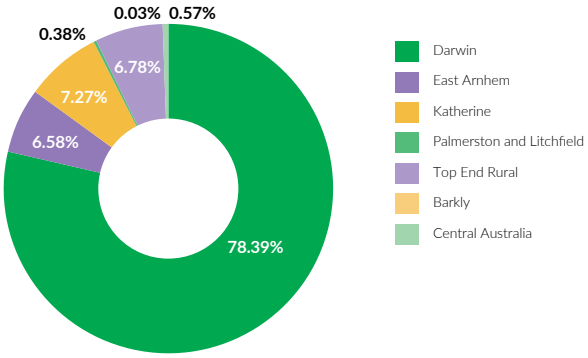
Juliette Chula and Bronwyn Nankervis

L -R: Val Tuckett, Renae Moore, Brigid Bourke, Angela Brannelly, Lisa Pullen at the Executive Strengthening Workforce Culture and Capacity (SWCC) Workshop

TEHS full-time equivalents by classification as at 30 June 2016 (Pay 27)



TEHS full-time equivalent staff by region as at 30 June 2016 (Pay 27)



TEHS full-time equivalents by classification variance from 2014-15 to 2015-16

Classification Stream	TEHS full-time equivalents 2014-15	TEHS full-time equivalents 2015-16	NT Pathology Network 2015-16	Total FTE paid from TEHS 2015-16	Variation
Nursing	1,562.70	1,682.90	1.26	1,684.16	7.77%
Administration	553.19	658.71	8.89	667.6	20.68%
Physical	508.97	541.56	-	541.56	6.40%
Professional	260.55	246.93	66.19	313.12	20.18%
Medical	448.41	452.57	10.95	463.52	3.37%
Technical	110.92	84.28	42.27	126.55	14.09%
Executive	12.80	11.00	-	11.00	-14.06%
Other	15.00	15.43	-	15.43	2.87%
Aboriginal Health Practitioners	40.98	38.54	-	38.54	-5.95%
Total	**3,513.52**	**3,731.92**	**129.56**	**3,861.48**	**9.90%**

Bush medicine

Outputs and performance

TEHS' financial and activity reporting is based on an output structure as presented in the NT Government's Budget Paper 3 and TEHS SDA.

The defined output groups for 2015-16 are:

- Top End Hospitals
- Community Treatment and Extended Care
- Primary Health Care
- Top End Wide Support Services

Top End Health Service – Key Performance Indicators

Top End Hospitals

Outcome: Improvement and maintenance of the health and wellbeing of those in the community who require acute or specialist care.

Top End Hospitals

Provide admitted, non admitted and emergency services.

	Actual				2015-16		2016-17 Budget
	2011-12	2012-13	2013-14	2014-15	Budget	Actual	
Top End Hospitals							
Top End Health Service weighted activity units (WAU)[1,2]	n/a	n/a	82049	84267	89704	98 566	100 537
Average length of stay[3]	6.1	6.1	6.0	6.0	5.5	5.3	5.4
Elective surgery wait times[4,5]:							
category 1: percentage of patients waiting longer than the clinically recommended time	10.0%	16.5%	5.5%	2.4%	0%	4.7%	0%
category 2: percentage of patients waiting longer than the clinically recommended time	25.6%	18.1%	41.0%	43.0%	2.4%	43.0%	2.4%
category 3: percentage of patients waiting longer than the clinically recommended time	7.0%	11.8%	19.8%	23.5%	2.4%	27.6%	2.4%
Emergency department presentations departing within 4 hours[5]	61.8%	61.8%	58.5%	60.8%	78.0%	65.0%	78.0%

[1] The 2015-16 Budget figure (as at June SDA variation), and Actual figures have been (re)calculated using version 15 of the activity- based funding (ABF) model to enable comparison. The 2016-17 Budget figure has been recalculated in version 15 to reflect projected growth against actual 2015-16 ABF activity.

[2] Activity detail by service stream is available in the relevant service delivery agreement at the Department of Health website: http://health.nt.gov.au/Publications/Corporate_Publications/index.aspx.

[3] The average number of days in a hospital for patients who stay at least one night.

[4] Definition reworded.

[5] At the time of publication, the 2016-17 figure mirrored the target for the key performance indicator in the 2015-16 Service Delivery Agreement and was subject to negotiations. Health Services use funding provided to improve the performance to achieve targets.

Community Treatment and Extended Care

Outcome: Strengthened capacity of individuals, families and communities to improve and protect their health through strategies and appropriate interventions that minimise harm.

Mental Health

Provide specialist mental health services including assessment, case management and treatment.

Aged Care

Provide services to support senior Territorians to live in the community, along with hospital care and assessment for residential care.

Alcohol and Other Drugs

Support community development, education and training, intervention, treatment and care options to reduce harm attributable to the use and misuse of alcohol, tobacco and other drugs.

	Actual				2015-16		2016-17 Budget
	2011-12	2012-13	2013-14	2014-15	Budget	Actual	
Community Treatment and Extended Care							
Mental Health							
Individuals receiving community-based public mental health services[1,2]	5 009	5 355	5 306	5 306	5 500	5 152	5 500
Individuals under 18 receiving community-based public mental health services[1]	958	1 155	1 022	978	1 100	921	1 200
Post-discharge community mental health care[3,4]	40.4%	44.5%	43.5%	49.3%	70.0%	60.2%	70.0%
28-day mental health re-admissions[3,5]	10.3%	11.3%	10.9%	7.9%	10.0%	11.3%	10.0%
Aged Care							
Aged care occasions of service[6]	7 727	7 524	8 338	9 049	9 700	11 541	11 300
Aged Care Assessment Program clients receiving timely intervention in accordance with priority at referral[3]	80.2%	93.0%	92.6%	92.8%	85.0%	94.4%	85.0%
Alcohol and other Drugs							
Closed episodes in government treatment services[7,8]	761	869	892	790	960	1 038	1 013
Completed closed episodes in government treatment services[7,8]	241	388	372	361	421	442	438
Number of referrals to assessment for mandatory treatment[7,9]	n/a	n/a	279	329	396	376	324
Number of Treatment Orders commenced[7,10]	n/a	n/a	174	197	256	197	180

[1] Community-based public mental health services include all mental health services provided by government (excluding government-funded non-government organisations) dedicated to the assessment, treatment, rehabilitation or care of non-admitted patients.

[2] The variation in 2015-16 reflects a decline in the number of referrals to community treatment and extended care services.

[3] 2015-16 data until March only available at time of report.

[4] The measure indicates the proportion of separations from mental health service organisations' acute care units for which a community service contact was recorded in the seven days immediately following that separation.

[5] The measure indicates the percentage of separations from the mental health services' acute mental health inpatient units that results in unplanned re-admission to the same or another public acute mental health inpatient unit within 28 days of discharge.

[6] The increase reflects a 2015-16 Budget underestimate.

[7] Data has been recalculated to reflect transition of the function to the Health Services. Variations to previously reported data may have occurred in this process.

[8] An episode of alcohol and other drugs treatment is a 'period of contact, with defined dates of commencement and cessation' (National Health Data Dictionary). A closed episode of treatment is one where there is a valid date of cessation. A completed closed episode is one where there is a valid date of cessation and the reason for cessation is 'treatment completed'.

[9] The decrease reflects the effect of Temporary Beat Locations in Katherine on reducing access to alcohol.

[10] The decrease reflects fewer referrals to assessment for mandatory treatment.

Primary Health Care

Outcome: The capability of Territorians to maintain and improve health is strengthened through education, prevention, early intervention and access to culturally appropriate assessment, treatment and support services.

Remote Primary Health Care

Provide primary health care services delivered by government health centres located in remote communities.

Urban Primary Health Care

Provide primary health care services delivered by government health services located in urban centres.

Top End Wide Community Services

Provide community care services through hearing, oral and cancer screening specialists across the Top End.

	Actual				2015-16		2016-17 Budget
	2011-12	2012-13	2013-14	2014-15	Budget	Actual	
Primary Health Care							
Remote Primary Health Care							
Episodes of health care services in government-managed remote health centres[1,2]	221 797	224 952	233 256	240 077	232 000	289 818	232 864
Aboriginal adult health check coverage[2,3]	24%	39%	52%	61%	65%	66%	70%
Proportion of screened Indigenous children under 5 years with anaemia[2,4]	22%	16%	19%	15%	n/a	15%	n/a
Proportion of screened Aboriginal children between 6 months and 5 years of age who have been checked for anaemia[2,4,5]	82%	84%	84%	84%	n/a	88%	n/a
Proportion of remote Aboriginal women who attended their first antenatal visit in the first trimester of their pregnancy[2,3,5]	50%	50%	50%	54%	50%	56%	60%
Proportion of remote Aboriginal clients aged 15 years and over with type II diabetes and or coronary heart disease with a chronic disease management plan[2,3,5]	68%	71%	77%	85%	68%	82%	85%
Proportion of remote Aboriginal clients aged 15 years and over with type II diabetes who have had an HbA1c test[2,4,5]	68%	76%	84%	90%	n/a	95%	n/a
Proportion of remote Aboriginal clients aged 15 years and over with type II diabetes whose latest HbA1c measurements are lower than or equal to 7 per cent[2,4,5]	37%	38%	40%	38%	n/a	44%	n/a
Urban Primary Health Care							
Community health occasions of service – urban[6]	97 682	106 412	112 067	107 332	110 000	109 721	110 000
Prison health episodes of care	n/a	n/a	42 889	46 535	46 000	48 025	46 000

[1] Health care services are defined as client-related occasions of health surveillance, primary treatment, chronic disease management, palliative care and maternal and child health.
[2] 2015-16 Actual data includes East Arnhem Communicare data not previously reported.
[3] Budget figures realigned with SDA targets.
[4] Definition refers to twelve month reporting period. SDA targets not aligned with twelve month definition.
[5] New measure in BP3. Backcast data provided.
[6] Community health occasions of service in child and family health, general community health, palliative care, school screening service (school-entry age), nutrition services and women's health services as provided by government managed urban-based community health care centres.

Top End Wide Support Services

Outcome: Safe, efficient, effective and accessible public health services to Top End residents.

Top End Wide Support Services

Support health service delivery, including corporate governance, safety and quality, health service development and planning, human resources, workforce development, finance, infrastructure and project management, and support to the Health Service Board.

	Actual				2015-16		2016-17 Budget
	2011-12	2012-13	2013-14	2014-15	Budget	Actual	
Top End-Wide Support Services							
Complaints to the Health and Community Services Complaints Commissioner responded to within timeframes set	n/a	n/a	n/a	n/a	100%	100%	100%
Incident recommendations followed up within timeframes set	n/a	n/a	n/a	n/a	100%	100%	100%

Medical students in training

Top End Health Service - snapshot of costs

Financial results for 2015-16 against agreed targets based on output groups in Budget Paper 3 are presented in the table below. Top End Health Service's financial performance is provided in greater detail in the TEHS Financial Reports section.

	2015-16		2016-17	
	(a)	(b)	(c)	(c) – (a)
Business Line	Budget	Actual	Budget	Note
	$000	$000	$000	
Top End Hospitals	**493 844**	**546 674**	**527 053**	1
Top End Hospitals	493 844	546 674	527 053	
Community Treatment and Extended Care	**33 055**	**51 032**	**44 363**	2
Mental Health	31 074	34 459	30 976	
Aged Care	1 981	3 601	1 370	
Alcohol and Other Drugs		12 972	12 017	
Primary Health Care	**70 180**	**109 674**	**112 447**	3
Remote Primary Health Care	55 851	96 046	80 257	
Urban Primary Health Care	14 329	13 628	14 125	
Top End-Wide Community Services			18 065	
Top End-Wide Support Services	**137 972**	**152 272**	**169 572**	4
Top End-Wide Support Services	137 972	152 272	169 572	
Total Expenses	**735 051**	**859 652**	**853 435**	
Income	**715 451**	**794 984**	**830 938**	5
SURPLUS (+)/DEFICIT (-) BEFORE INCOME TAX	**-19 600**	**-64 669**	**-22 497**	

Notes

1 The variations mainly relate to additional Commonwealth and external funding in 2015-16 and demand growth funding in 2016-17.

2 The variations mostly reflect the transfer of the Alcohol and Other Drugs program from the Department of Health from 2015-16, partially offset in 2016-17 by the cessation of the Commonwealth funded Aged Care Assessment program.

3 The variation in 2015-16 mainly relates to additional Commonwealth funding and the transfer of remote primary health care grants from the Department of Health. The increase in 2016-17 is mostly due to the transfer of oral, hearing and cancer screening service delivery functions from the Department of Health, partly offset by the timing of Commonwealth funding.

4 The variation in 2015-16 mainly relates to additional ambulance services and Commonwealth funding as well as increased depreciation. The increase in 2016-17 is mostly due to additional Commonwealth funding, additional repairs and maintenance funding, as well as increased depreciation.

5 This includes depreciation expense which is not revenue funded

Performance, achievements and outcomes

This section reports on the performance, achievements and outcomes for TEHS against the six Strategic Directions identified in the *TEHS Strategic Plan 2014-17*.

Strategic Direction 1:

Foster a culture that promotes ownership of performance

Service Delivery agreements

TEHS' SDA with the System Manager (Department of Health) enables both parties to work together towards optimal health outcomes. This agreement outlines the performance measures against which delivered services are assessed. TEHS participates in monthly performance meetings with the System Manager as well as providing quarterly performance reports.

Strengthening Workforce Culture

The strengthening workforce culture priority work is identifying strategies to achieve a cultural shift based on patient centred care that will improve accountability and ownership throughout TEHS. To date an "as is" cultural survey has been conducted with an action plan to reach a "to be" culture throughout 2016-17 and onwards, commencing with the launch of the TEHS Organisational Culture Charter.

Corporate and Clinical Governance Frameworks

The completion of the Corporate and Clinical Governance Frameworks during 2015-16 has provided transparency for TEHS staff regarding organisational structures and reporting frameworks.

Strategic Direction 2:

Promote a culture of innovation

Hybrid Operating Theatre Suite

The inclusion of a hybrid operating theatre suite in the new theatre space commissioned in October 2015, has enhanced TEHS' surgical capacity to deal in a more timely way with complex surgeries, increasing theatre capacity and better surgical outcomes for patients.

Improving Patient Flow

TEHS has analysed current practices and looked to other health services for the best contemporary models to implement and improve a patient's journey through TEHS. This has included:

- "home for lunch" and "home to family" launches aiming for a consistent discharge by 11am each day
- live updating of the Expected Date of Discharge – allowing for better bed management planning and certainty for patients
- Patient Journey boards installed throughout Royal Darwin Hospital – with mobile tablets for updating – providing up to date status on admitted patients in the hospital.

Royal Darwin Hospital Redevelopment

The $64 Million redevelopment of Royal Darwin Hospital has provided an excellent opportunity to improve the patient experience at Royal Darwin Hospital and also update areas in line with contemporary hospital models. The redevelopment has already delivered the hybrid operating theatre suite, Extended Emergency Medicine Unit and throughout 2016-17 will complete the new paediatrics ward, outpatients department and main entrance.

Strategic Direction 3:

Provide safe and quality healthcare services

Service Integration Framework

In 2015-16, TEHS focussed on the development of a Service Integration Framework for application to new and existing health services to enhance patient experience and satisfaction. The Framework has been developed and will now be applied to maternal and renal services in 2016-17. This Framework underpins the "One Service Multi-Campus" principle with patient centred care as the main tenet.

Primary Health Care Accreditation

Work commenced during 2015-16 on preparing primary health care clinics in TEHS for inclusion in health service accreditation. This initiative has been welcomed and embraced by primary health care clinics as an essential part of the quality healthcare that they provide.

Discharge Summaries

In 2016-17, TEHS will focus extensively on the timely provision of discharge summaries. This is a key health service safety and quality measure to ensure continuity of care for our patients.

Strategic Direction 4:

Provide affordable and efficient healthcare services

Revenue Optimisation

Under the National Health Reform Agreement, TEHS is obliged to optimise its funding/revenue opportunities to maximise the extent to which it can provide health services. TEHS mainly does this through Medicare from the Australian Government (in the outpatient and primary health care setting), private health insurance and compensation schemes (in the admitted patient setting) and activity based funding from the Australian Government and Territory Government (in the emergency department, outpatient and admitted patient settings). During 2015-16, an extensive review was conducted for TEHS, looking at the best mix of these funding mechanisms and recognition of all activity to provide the maximum funding and therefore, health services. During 2016-17 TEHS will focus on financial sustainability to ensure that the health service is adaptive to funding changes and can manage these with fiscal responsibility.

Strategic Direction 5:

Ensure equitable access to healthcare services

Improving Elective Surgery Access

TEHS is focussed on Improving Elective Surgery Access with patients being given the right treatment as soon as possible and going home in a timely way. Much of the work achieved in 2015-16, involved analysis of the current state of elective surgery access to identify ways forward to meet clinically recommended timeframes. With a focus on surgery as a service across all facilities in TEHS, the following initiatives are in place:

- dedicated surgery waitlist auditing and scheduling
- implementation of increased liaison resources
- trial of ten-hour shifts to maximise theatre resources and throughput.

While elective surgery wait times have improved during 2015-16, there are still a number of improvements to be implemented for a TEHS wide co-ordinated and sustainable surgery service.

Strategic Direction 6:

Build a sustainable and quality workforce

Strengthening Workforce Culture & Capacity

In 2015-16, workshops were held across TEHS to seek feedback and ascertain existing workforce culture. Seven hundred participants were surveyed to define the current state culture, identify the desired future culture and develop an action plan to reach this future state. A TEHS organisational charter has been developed, along with Middle, Senior and Executive Manager training and toolkits.

Palmerston Hospital Commissioning

Due to open in May 2018, the Palmerston Hospital presents an exciting opportunity to build a sustainable and quality workforce across the Darwin/Palmerston region. To ensure that the hospital can be effectively commissioned, extensive work is required in service planning and planning and recruiting the workforce to deliver these services, along with the logistics of integrating two closely located facilities.

Financial statements

Top End Health Service

Top End Health Service

Financial Performance

For the year ended 30 June 2016

Overview

The 2015-16 financial statements for the Top End Health Service (TEHS) have been prepared in accordance with the Northern Territory Government's financial management framework and relevant Australian accounting standards.

The financial performance for TEHS in 2015-16 and comparative financial information for 2014-15 are reported in three financial statements: the Operating Statement, the Balance Sheet and the Cash Flow Statement.

Financial performance at a glance

Key results at year end for TEHS include:

- The entity reported an operating deficit of $64.7 million
- The equity position improved by $35.7 million from 2014-15
- Expenses incurred were within 5.7% of budget targets
- Revenue earned was within 0.4% of budget targets

Operating Statement

Operating Statement Summary	2015-16 $000	2014-15 $000	Variation $000	%
Operating revenue	794 984	754 532	40 451	5.36%
Operating expenditure	-859 652	-751 621	-108 031	14.37%
Net deficit / surplus	**-64 669**	**2 911**	**-67 580**	

In 2015-16 TEHS returned a $64.7 million deficit. Deficit results are expected in Northern Territory Government agencies as the Northern Territory Government accounting framework does not fund non-cash expenses such as depreciation and the carry forward of unspent funds from prior periods.

The budgeted deficit for 2015-16 was $15.3 million. The difference between the final budgeted deficit and the actual outcome was predominately a result of a prior year accrual adjustment of $11.6 million, $3 million of unfunded costs relating to the construction of the new Palmerston Hospital and employment growth.

Operating Revenue

TEHS is predominantly funded by and is dependent on the receipt of Territory funded National Health Reform payments paid through the Department of Health (DoH). The majority of the remaining revenue came from the Australian Government in the form of Activity Based Funding, National Partnership Payments and grant funding.

Operating Expenditure

In 2015-16 TEHS incurred expenses of $859.7 million, an increase of 14.37% from 2014-15. The increase predominantly relates to an additional $53.8 million of employee expenses and $42.9 million in purchases of goods and services which is indicative of the increase in activity, the transition of services from DoH to TEHS, as well as the increased cost of service delivery in the health and welfare sector.

Balance Sheet

Balance Sheet Summary	2015-16 $000	2014-15 $000	Variation $000	%
Assets	601 063	558 629	42 434	7.60%
Liabilities	-131 775	-125 007	-6 768	5.41%
Equity	469 288	433 622	35 666	

In 2015-16 the equity position of TEHS increased by $35.7 million. The increase is primarily comprised of a $20 million equity injection from Department of Treasury and Finance and a $56.1 million of assets transferred in from Department of Infrastructure offset by the operating deficit during the financial year.

Statement of Cash Flows

Cash Flow Statement Summary	2015-16 $000	2014-15 $000	Variation $000	%
Cash at beginning of reporting period	**29 470**	**17 771**	**11 700**	**65.84%**
Receipts	818 354	764 525	53 829	7.04%
Payments	-861 349	-745 423	-115 926	15.55%
Equity injections	20 000	2 637	17 363	658.44%
Equity withdrawals	-810	-10 040	9 230	-91.93%
Cash at end of reporting period	**5 666**	**29 470**	**-23 804**	

The Cash Flow Statement shows TEHS cash receipts and payments for the financial year. The statement incorporates expenses and revenues from the Operating Statement, after the elimination of all non-cash transactions, with cash movements from the Balance Sheet. The net result is a decrease in TEHS cash balances of $23.8 million over the financial year, mainly due to the significant increase in operating payments.

Summary

Summary	2015-16 Final Budget	2015-16 Actual	Variation $000	%
Operating revenue	798 195	794 984	-3 211	0.40%
Operating expenditure	-813 508	-859 652	-46 144	5.67%
Net deficit / surplus	**-15 313**	**-64 669**	**-49 355**	

TEHS performance in both revenue generation and expenditure control show a result that had minor variation from planned targets. Revenue across TEHS was well managed coming within 0.4% of the annual budget target.

Auditor-General

Independent Auditor's Report to the Minister for Health

Top End Health Service

I have audited the accompanying financial report of Top End Health Service which comprises the balance sheet as at 30 June 2016, the comprehensive operating statement, the statement of changes in equity and the cash flow statement for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and the certification of the financial statements by the Accountable Officer.

The Accountable Officer's Responsibility for the Financial Report

The Accountable Officer of the Department of Health is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and for such internal control as the Accountable Officer determines is necessary to enable the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error.

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. Those 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 control relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Accountable Officer, 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

In my opinion the financial report gives a true and fair view of the financial position of Top End Health Service as at 30 June 2016, and of its financial performance and its cash flows for the year then ended in accordance with Australian Accounting Standards.

Julie Crisp
Auditor-General for the Northern Territory
Darwin, Northern Territory

29 September 2016

TOP END HEALTH SERVICE
FINANCIAL REPORT

CERTIFICATION OF THE FINANCIAL STATEMENTS

We certify that the attached financial statements for the Top End Health Service have been prepared from proper accounts and records in accordance with the prescribed format, the *Financial Management Act* and Treasurer's Directions.

We further state that the information set out in the Comprehensive Operating Statement, Balance Sheet, Statement of Changes in Equity, Cash Flow Statement, and notes to and forming part of the financial statements, presents fairly the financial performance and cash flows for the year ended 30 June 2016 and the financial position on that date.

At the time of signing, we are not aware of any circumstances that would render the particulars included in the financial statements misleading or inaccurate.

J. M. Anderson

Janet Anderson

Accountable Officer

8 / 9 /2016

Michael Kalimnios

Chief Operating Officer

8/9/ 2016

Brigid Bourke

Chief Finance Officer

8/9 2016

TOP END HEALTH SERVICE
COMPREHENSIVE OPERATING STATEMENT
For the year ended 30 June 2016

	Note	2016	2015
		$000	$000
INCOME			
Grants and subsidies revenue			
Current		445 505	399 111
Sales of goods and services		340 069	335 171
Gain on disposal of assets	4	4	0
Other income		9 405	20 250
TOTAL INCOME	3	**794 984**	**754 532**
EXPENSES			
Employee expenses		483 157	429 395
Administrative expenses			
Purchases of goods and services	5	295 674	252 727
Repairs and maintenance		19 372	25 158
Depreciation and amortisation	9	25 671	21 667
Other administrative expenses		1 890	3 378
Grants and subsidies expenses			
Current		31 800	17 784
Capital		1 901	1 323
Interest expenses		188	189
TOTAL EXPENSES	3	**859 652**	**751 621**
NET SURPLUS/(DEFICIT)		**(64 669)**	**2 911**
OTHER COMPREHENSIVE INCOME			
Items that will not be reclassified to net surplus/deficit			
Transfers from reserves		0	(45)
Changes in asset revaluation surplus		22 581	(48 395)
TOTAL OTHER COMPREHENSIVE INCOME		**22 581**	**(48 440)**
COMPREHENSIVE RESULT		**(42 088)**	**(45 529)**

The Comprehensive Operating Statement is to be read in conjunction with the notes to the financial statements.

TOP END HEALTH SERVICE
BALANCE SHEET
As at 30 June 2016

	Note	2016	2015
		$000	$000
ASSETS			
Current Assets			
Cash and deposits	6	5 666	29 470
Receivables	7	35 288	40 040
Inventories	8	7 794	6 129
Prepayments		5 792	5 621
Total Current Assets		**54 540**	**81 260**
Non-Current Assets			
Property, plant and equipment	9,10	546 523	477 368
Total Non-Current Assets		**546 523**	**477 368**
TOTAL ASSETS		**601 063**	**558 628**
LIABILITIES			
Current Liabilities			
Deposits held		2 076	1 736
Payables	11	71 321	65 860
Borrowings and advances	12	45	41
Provisions	13	39 148	36 119
Other liabilities	14	0	2 520
Total Current Liabilities		**112 590**	**106 276**
Non-Current Liabilities			
Borrowings and advances	12	3 749	3 635
Provisions	13	15 436	15 095
Total Non-Current Liabilities		**19 186**	**18 730**
TOTAL LIABILITIES		**131 775**	**125 006**
NET ASSETS		**469 288**	**433 622**
EQUITY			
Capital		382 436	304 682
Asset revaluation surplus	15	174 460	151 880
Accumulated funds		(87 608)	(22 940)
TOTAL EQUITY		**469 288**	**433 622**

The Balance Sheet is to be read in conjunction with the notes to the financial statements.

TOP END HEALTH SERVICE
STATEMENT OF CHANGES IN EQUITY
For the year ended 30 June 2016

	Note	Equity at 1 July	Comprehensive result	Transactions with owners in their capacity as owners	Equity at 30 June
		$000	$000	$000	$000
2015-16					
Accumulated Funds		(22 913)	(64 669)	0	(87 581)
Changes in accounting policy		0	0	0	0
Correction of prior period errors		0	0	0	0
Transfers from reserves		(27)	0	0	(27)
Other movements directly to equity		0	0	0	0
		(22 940)	(64 669)	0	(87 608)
Asset revaluation surplus	15	151 880	22 581	0	174 460
Capital – Transactions with Owners					
Equity injections					
Capital appropriation		0	0	0	0
Equity transfers in		369 140	0	61 066	430 205
Other equity injections		27 123	0	20 000	47 123
Specific purpose payments		0	0	0	0
National partnership payments		0	0	0	0
Commonwealth – capital		0	0	0	0
Equity withdrawals					
Capital withdrawal		(90 188)	0	(810)	(90 998)
Equity transfers out		(1 393)	0	(2 502)	(3 895)
		304 682	0	77 754	382 436
Total Equity at End of Financial Year		**433 622**	**(42 088)**	**77 754**	**469 288**
2014-15					
Accumulated Funds		(25 824)	2 911	0	(22 913)
Changes in accounting policy		0	0	0	0
Correction of prior period errors		0	0	0	0
Transfers from reserves		18	(45)	0	(27)
Other movements directly to equity		0	0	0	0
		(25 806)	2 866	0	(22 940)
Asset revaluation surplus	15	200 275	(48 395)	0	151 880
Capital – Transactions with Owners					
Equity injections					
Capital appropriation		0	0	0	0
Equity transfers in		350 957	0	18 183	369 140
Other equity injections		24 486	0	2 637	27 123
Specific purpose payments		0	0	0	0
National partnership payments		0	0	0	0
Commonwealth – capital		0	0	0	0
Equity withdrawals					
Capital withdrawal		(80 148)	0	(10 040)	(90 188)
Equity transfers out		(1 327)	0	(66)	(1 393)
		293 968	0	10 714	304 682
Total Equity at End of Financial Year		**468 437**	**(45 529)**	**10 714**	**433 622**

The Statement of Changes in Equity is to be read in conjunction with the notes to the financial statements.

TOP END HEALTH SERVICE
CASH FLOW STATEMENT
For the year ended 30 June 2016

	Note	2016	2015
		$000	$000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Receipts			
Grants and subsidies received			
Current		445 505	399 111
Receipts from sales of goods and services		372 505	370 818
Total Operating Receipts		**818 010**	**769 929**
Operating Payments			
Payments to employees		(491 721)	(423 563)
Payments for goods and services		(330 615)	(303 419)
Grants and subsidies paid			
Current		(31 750)	(17 784)
Capital		(1 901)	(1 323)
Interest paid		(188)	(189)
Total Operating Payments		**(856 175)**	**(746 278)**
Net Cash From/(Used in) Operating Activities	16	**(38 165)**	**23 651**
CASH FLOWS FROM INVESTING ACTIVITIES			
Investing Receipts			
Proceeds from asset sales	4	4	0
Total Investing Receipts		**4**	**0**
Investing Payments			
Purchases of assets		(5 125)	(4 767)
Total Investing Payments		**(5 125)**	**(4 767)**
Net Cash From/(Used in) Investing Activities		**(5 120)**	**(4 767)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Financing Receipts			
Deposits received		340	257
Equity injections			
Other equity injections		20 000	2 637
Total Financing Receipts		**20 340**	**2 894**
Financing Payments			
Finance lease payments		(49)	(39)
Equity withdrawals		(810)	(10 040)
Total Financing Payments		**(859)**	**(10 079)**
Net Cash From/(Used in) Financing Activities		**19 481**	**(7 185)**
Net increase/(decrease) in cash held		(23 804)	11 699
Cash at beginning of financial year		29 470	17 771
CASH AT END OF FINANCIAL YEAR	6	**5 666**	**29 470**

The Cash Flow Statement is to be read in conjunction with the notes to the financial statements.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

INDEX OF NOTES TO THE FINANCIAL STATEMENTS

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

1. OBJECTIVES AND FUNDING

The Top End Health Service's mission is to improve the health status and wellbeing of all people in the Top End of the Northern Territory. Top End Health Service was established under the *Health Services Regulations* effective 1 July 2014.

The entity is predominantly funded by, and is dependent on, the receipt of the National Health Reform (NHR) payments paid through the Department of Health. The financial statements encompass all funds through which the entity controls resources to carry on its functions and deliver outputs. For reporting purposes, outputs delivered by the entity are summarised into several output groups. Note 3 provide summary financial information in the form of a Comprehensive Operating Statement by output group.

2. STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

a) Statement of Compliance

The financial statements have been prepared in accordance with the requirements of the *Financial Management Act* and related Treasurer's Directions. The *Financial Management Act* requires the Top End Health Service to prepare financial statements for the year ended 30 June based on the form determined by the Treasurer. The form of agency financial statements is to include:

(i) a Certification of the Financial Statements;

(ii) a Comprehensive Operating Statement;

(iii) a Balance Sheet;

(iv) a Statement of Changes in Equity;

(v) a Cash Flow Statement; and

(vi) applicable explanatory notes to the financial statements.

b) Basis of Accounting

The financial statements have been prepared using the accrual basis of accounting, which recognises the effect of financial transactions and events when they occur, rather than when cash is paid out or received. As part of the preparation of the financial statements, all intra-agency transactions and balances have been eliminated.

Except where stated, the financial statements have also been prepared in accordance with the historical cost convention.

The form of the agency financial statements is also consistent with the requirements of Australian Accounting Standards. The effects of all relevant new and revised Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that are effective for the current annual reporting period have been evaluated.

The following new and revised Accounting Standards and Interpretations were effective for the first time in 2015-16:

AASB 1048 Interpretation of Standards This reflects amended versions of Interpretations arising in relation to amendments to AASB 9 Financial Instruments and consequential amendments arising from the issuance of AASB 15 Revenue from Contracts with Customers. The Standard does not impact the financial statements.

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AASB 2013-9 Amendments to Australian Accounting Standards [Part C Financial Instruments] Part C of this Standard amends AASB 9 Financial Instruments to add Chapter 6 Hedge Accounting and makes consequential amendments to AASB 9 and numerous other Standards. The Standard does not impact the financial statements.

AASB 2014-8 Amendments to Australian Accounting Standards arising from AASB 9 This Standard makes amendments to AASB 9 Financial Instruments (December 2009) and AASB 9 Financial Instruments (December 2010). These amendments arise from the issuance of AASB 9 Financial Instruments in December 2014. The Standard does not impact the financial statements.

AASB 2015-3 Amendments to Australian Accounting Standards arising from the withdrawal of AASB 1031 Materiality The Standard completes the withdrawal of references to AASB 1031 in all Australian Accounting Standards and Interpretations, allowing the Standard to effectively be withdrawn. The Standard does not impact the financial statements.

AASB 2015-4 Amendments to Australian Accounting Standards – Financial Reporting Requirements for Australian Groups with a Foreign Parent Amendments are made to AASB 128 Investments in Associates and Joint Ventures to require the ultimate Australian entity to apply the equity method in accounting for interests in associates and joint ventures, if either the entity or the group is a reporting entity, or both the entity and group are reporting entities. The Standard does not impact the financial statements.

AASB 2014-1 Amendments to Australian Accounting Standards (Part E - Financial Instruments) Part E of this Standard defers the application date of AASB 9 Financial Instruments to annual reporting periods beginning on or after 1 January 2018. The Standard does not impact the financial statements.

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NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

The following Standards and interpretations are likely to have an insignificant impact on the financial statements for future reporting periods, but the exact impact is yet to be determined:

Standard/Interpretation	Effective for annual reporting periods beginning on or after
AASB 9 Financial Instruments (December 2014), AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)	1 January 2018
AASB 15 Revenue from Contracts with Customers, AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	1 January 2018
AASB 1056 Superannuation Entities	1 July 2016
AASB 14 Regulatory Deferral Accounts	1 January 2016
AASB 1057 Application of Accounting Standards	1 January 2016
AASB 2014-1 Amendments to Australian Accounting Standards [Part D Consequential arising from AASB 14 Regulatory Deferral Accounts]	1 January 2016
AASB 2014-3 Amendments to Australian Accounting Standards - Accounting for Acquisitions of Interests in Joint Operations [AASB 1 and AASB 11]	1 January 2016
AASB 2014-16 Amendments to Australian Accounting Standards - Agriculture: Bearer Plants [AASB 101,116, 117, 123, 136, 140 and 141]	1 January 2016
AASB 2015-5 Amendments to Australian Accounting Standards - Investment Entities: Applying the Consolidation Exception [AASB 10, 12 and 128]	1 January 2016
AASB 2015-9 Amendments to Australian Accounting Standards - Scope and Application Paragraphs [AASB 8, 133 and 1057]	1 January 2016
AASB 2015-10 Amendments to Australian Accounting Standards - Effective Date of Amendments to AASB 10 and AASB 128	1 January 2016
AASB 2016-1 Amendments to Australian Accounting Standards- Recognition of Deferred Tax Assets for Unrealised Losses [AASB 112]	1 January 2017

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NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

The following Standards and interpretations are expected to have a potential impact on the financial statements for future reporting periods:

Standard/Interpretation	Effective for annual reporting periods beginning on or after	Impact
AASB 2015-6 Amendments to Australian Accounting Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities [AASB 10, 124 and 1049]	1 July 2016	New note disclosure to include remuneration of Key Management Personnel (KMP) and related party transactions.
2016-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107	1 January 2017	New disclosure on the reconciliation of the changes in liabilities arising from financing activities
AASB 16 Leases	1 January 2019	Reclassification of operating leases greater than 12 months to finance lease reporting requirements
AASB 9 Financial Instruments	1 January 2018	Simplified requirements for classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier as opposed to only when incurred
AASB 15 Revenue from Contracts with Customers	1 January 2018	Requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.
AASB 2014-1 Amendments to Australian Accounting Standards [Part E Financial Instruments]	1 January 2018	Amends various AAS's to reflect the deferral of the mandatory application date of AASB 9
AASB 2014-4 Amendments to Australian Accounting Standards - Clarification of Acceptable Methods of Depreciation and Amortisation [AASB 116 and AASB 138]	1 January 2016	Provides additional guidance on how the depreciation or amortisation of property, plant and equipment and intangible assets should be calculated and clarifies that the use of revenue-based methods to calculate the depreciation of an asset is not appropriate.
AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	1 January 2017	Amends the measurement of trade receivables and the recognition of dividends.
AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9	1 January 2018	Amends various AAS's to reflect the changes as a result of AASB 9

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Standard/Interpretation	Effective for annual reporting periods beginning on or after	Impact
AASB 2014-9 Amendments to Australian Accounting Standards - Equity Method in Separate Financial Statements [AASB 1, 127 and 128]	1 January 2016	Allows an entity to account for investments in subsidiaries, joint ventures and associates in its separate financial statement at cost or using the equity method.
AASB 2015-1 Amendments to Australian Accounting Standards - Annual Improvements to Australian Accounting Standards 2012-14 Cycle [AASB 1, 2, 3,5, 7, 11, 110, 119, 121, 133, 134,137 and 140]	1 January 2016	The amendments include AASB 5 change in methods of disposal; AASB 7 Servicing contracts and applicability of the amendments to AASB 7 to condensed interim financial statements; AASB 119 Discount rate: regional market issue and AASB 134 Disclosure of information elsewhere in the interim financial.

c) Reporting Entity

The financial statements cover the Top End Health Service ("the Health Service") as an individual reporting entity. The Health Service is a statutory body which is established under Section 17 of the *Health Services Act* and Section 3 of the *Health Services Regulations*.

The principal place of business of the Health Service is: Royal Darwin Hospital, Rocklands Drive, Casuarina NT 0811

d) Comparatives

Where necessary, comparative information for the 2014-15 financial year has been reclassified to provide consistency with current year disclosures.

e) Presentation and Rounding of Amounts

Amounts in the financial statements and notes to the financial statements are presented in Australian dollars and have been rounded to the nearest thousand dollars, with amounts of $500 or less being rounded down to zero. Figures in the financial statements and notes may not equate due to rounding.

f) Changes in Accounting Policies

There have been no changes to accounting policies adopted in 2015-16 as a result of management decisions.

g) Accounting Judgments and Estimates

The preparation of the financial report requires the making of judgments and estimates that affect the recognised amounts of assets, liabilities, revenues and expenses and the disclosure of contingent liabilities. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

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The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Judgments and estimates that have significant effects on the financial statements are disclosed in the relevant notes to the financial statements. Notes that include significant judgments and estimates are:

- Employee Benefits – Note 2(v) and Note 13: Non-current liabilities in respect of employee benefits are measured as the present value of estimated future cash outflows based on the appropriate Government bond rate, estimates of future salary and wage levels and employee periods of service.
- Property, Plant and Equipment – Note 2(q): The fair value of land, building, infrastructure and property, plant and equipment are determined on significant assumptions of the exit price and risks in the perspective market participant, using the best information available.
- Contingent Liabilities – Note 19: The present value of material quantifiable contingent liabilities are calculated using a discount rate based on the published 10-year Government bond rate.
- Allowance for Impairment Losses – Note 2(r), Note 7: Receivables and Note 17: Financial Instruments. The allowance represents debts that are likely to be uncollectible and are considered doubtful. Debtors are grouped according to their ageing profile and history of previous financial difficulties.
- Depreciation and Amortisation – Note 2(k), Note 9: Property, Plant and Equipment.
- Cross border patient charges accruals – Note 7 Receivables and Note 11 Payables: The accruals are based on the latest exchanged data between jurisdictions with indexation applied.

h) Taxation

Goods and Services Tax

Income, expenses and assets are recognised net of the amount of Goods and Services Tax (GST), except where the amount of GST incurred on a purchase of goods and services is not recoverable from the Australian Tax Office (ATO). In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables are stated with the amount of GST included. The net amount of GST recoverable from, or payable to, the ATO is included as part of receivables or payables in the Balance Sheet.

Cash flows are included in the Cash Flow Statement on a gross basis. The GST components of cash flows arising from investing and financing activities, which are recoverable from, or payable to, the ATO are classified as operating cash flows. Commitments and contingencies are disclosed net of the amount of GST recoverable or payable unless otherwise specified.

Northern Territory Tax Equivalent Regimes

The Northern Territory Tax Equivalents Regimes (TER) improve competitive neutrality between public and private sector entities. The TER levies the equivalent of Commonwealth

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NOTES TO THE FINANCIAL STATEMENTS
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Income Tax and local government rates on certain government owned business units so that such units have the same tax and local government rates positions as comparable private sector entities. TER is not applicable for the Top End Health Service.

i) Income Recognition

Income encompasses both revenue and gains.

Income is recognised at the fair value of the consideration received, exclusive of the amount of GST. Exchanges of goods or services of the same nature and value without any cash consideration being exchanged are not recognised as income.

Grants and Other Contributions

Grants, donations, gifts and other non-reciprocal contributions are recognised as revenue when the agency obtains control over the assets comprising the contributions. Control is normally obtained upon receipt.

Contributions are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

National Health Reform Payments (NHR)

NHR payments support the NHR agreement. NHR payments are based on hospital activity (or block funding where more appropriate) and include funding for Teacher Training and Research.

Territory NHR payments are paid from the Central Holding Authority to the Department of Health and then on-passed to the relevant Health Service. Commonwealth NHR payments are made by the Commonwealth Treasury directly to the State Pool Account within the Department of Health and then on-passed to the relevant Health Service.

Sale of Goods

Revenue from the sale of goods is recognised (net of returns, discounts and allowances) when:

- the significant risks and rewards of ownership of the goods have transferred to the buyer;
- the agency retains neither continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold;
- the amount of revenue can be reliably measured;
- it is probable that the economic benefits associated with the transaction will flow to the agency; and
- the costs incurred or to be incurred in respect of the transaction can be measured reliably.

Rendering of Services

Revenue from rendering services is recognised by reference to the stage of completion of the contract. The revenue is recognised when:

- the amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and
- it is probable that the economic benefits associated with the transaction will flow to the entity.

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NOTES TO THE FINANCIAL STATEMENTS
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Disposal of Assets
A gain or loss on disposal of assets is included as a gain or loss on the date control of the asset passes to the buyer, usually when an unconditional contract of sale is signed. The gain or loss on disposal is calculated as the difference between the carrying amount of the asset at the time of disposal and the net proceeds on disposal. Refer also to Note 4.

Contributions of Assets
Contributions of assets and contributions to assist in the acquisition of assets, being non-reciprocal transfers, are recognised, unless otherwise determined by Government, as gains when the agency obtains control of the asset or contribution. Contributions are recognised at the fair value received or receivable.

j) Repairs and Maintenance Expense

Funding is received for repairs and maintenance works associated with agency assets as part of output appropriation. Costs associated with repairs and maintenance works on agency assets are expensed as incurred.

k) Depreciation and Amortisation Expense

Items of property, plant and equipment, including buildings but excluding land, have limited useful lives and are depreciated or amortised using the straight-line method over their estimated useful lives.

Amortisation applies in relation to intangible non-current assets with limited useful lives and is calculated and accounted for in a similar manner to depreciation.

The estimated useful lives for each class of asset are in accordance with the Treasurer's Directions and are determined as follows:

	2015 and 2016
Buildings	50 years
Sheds/ Demountables	10 - 20 years
Plant and Equipment (refer below)	
Computer hardware	3 - 6 years
Office equipment	5 - 10 years
Medical equipment	5 - 15 years
Furniture and fittings	10 years
Catering equipment	5 - 15 years
Laundry equipment	5 - 15 years

Assets are depreciated or amortised from the date of acquisition or from the time an asset is completed and held ready for use.

l) Interest Expense

Interest expenses include interest and finance lease charges. Interest expenses are expensed in the period in which they are incurred.

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NOTES TO THE FINANCIAL STATEMENTS
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m) Cash and Deposits

For the purposes of the Balance Sheet and the Cash Flow Statement, cash includes cash on hand, cash at bank and cash equivalents. Cash equivalents are highly liquid short-term investments that are readily convertible to cash. Cash at bank includes monies held in the Accountable Officer's Trust Account (AOTA) that are ultimately payable to the beneficial owner – refer also to Note 21.

n) Inventories

Inventories include assets held either for sale (general inventories) or for distribution at no or nominal consideration in the ordinary course of business operations.

General inventories are valued at the lower of cost and net realisable value, while those held for distribution are carried at the lower of cost and current replacement cost. Cost of inventories includes all costs associated with bringing the inventories to their present location and condition. When inventories are acquired at no or nominal consideration, the cost will be the current replacement cost at date of acquisition.

The cost of inventories are assigned using a mixture of first-in, first out or weighted average cost formula or using specific identification of their individual costs.

Inventory held for distribution is regularly assessed for obsolescence and loss.

o) Receivables

Receivables include accounts receivable and other receivables and are recognised at fair value less any allowance for impairment losses.

The allowance for impairment losses represents the amount of receivables the agency estimates are likely to be uncollectible and are considered doubtful. Analyses of the age of the receivables that are past due as at the reporting date are disclosed in an ageing schedule under credit risk in Note 17 Financial Instruments. Reconciliation of changes in the allowance accounts is also presented.

Accounts receivable are generally settled within 30 days and other receivables within 30 days.

p) Prepayments

Prepayments represent payments in advance of receipt of goods and services or that part of expenditure made in one accounting period covering a term extending beyond that period.

q) Property, Plant and Equipment

Acquisitions

All items of property, plant and equipment with a cost, or other value, equal to or greater than $10 000 are recognised in the year of acquisition and depreciated as outlined below. Items of property, plant and equipment below the $10 000 threshold are expensed in the year of acquisition.

The construction cost of property, plant and equipment includes the cost of materials and direct labour, and an appropriate proportion of fixed and variable overheads.

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Complex Assets
Major items of plant and equipment comprising a number of components that have different useful lives, are accounted for as separate assets. The components may be replaced during the useful life of the complex asset.

Subsequent Additional Costs
Costs incurred on property, plant and equipment subsequent to initial acquisition are capitalised when it is probable that future economic benefits in excess of the originally assessed performance of the asset will flow to the agency in future years. Where these costs represent separate components of a complex asset, they are accounted for as separate assets and are separately depreciated over their expected useful lives.

Construction (Work in Progress)
As part of the financial management framework, the Department of Infrastructure is responsible for managing general government capital works projects on a whole of Government basis. Therefore appropriation for all agency capital works is provided directly to the Department of Infrastructure and the cost of construction work in progress is recognised as an asset of that Department. Once completed, capital works assets are transferred to the agency.

r) Revaluations and Impairment

Revaluation of Assets
Subsequent to initial recognition, assets belonging to the following classes of non-current assets are revalued with sufficient regularity to ensure that the carrying amount of these assets does not differ materially from their fair value at reporting date:

- land; and
- buildings.

Plant and equipment are stated at historical cost less depreciation, which is deemed to equate to fair value.

Impairment of Assets
An asset is said to be impaired when the asset's carrying amount exceeds its recoverable amount.

Non-current physical and intangible agency assets are assessed for indicators of impairment on an annual basis or whenever there is indication of impairment. If an indicator of impairment exists, the agency determines the asset's recoverable amount. The asset's recoverable amount is determined as the higher of the asset's depreciated replacement cost and fair value less costs to sell. Any amount by which the asset's carrying amount exceeds the recoverable amount is recorded as an impairment loss.

Impairment losses are recognised in the Comprehensive Operating Statement. They are disclosed as an expense unless the asset is carried at a revalued amount. Where the asset is measured at a revalued amount, the impairment loss is offset against the asset revaluation surplus for that class of asset to the extent that an available balance exists in the asset revaluation surplus.

In certain situations, an impairment loss may subsequently be reversed. Where an impairment loss is subsequently reversed, the carrying amount of the asset is increased to

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the revised estimate of its recoverable amount. A reversal of an impairment loss is recognised in the Comprehensive Operating Statement as income, unless the asset is carried at a revalued amount, in which case the impairment reversal results in an increase in the asset revaluation surplus. Note 15 provide additional information in relation to the asset revaluation surplus.

s) Assets Held for Sale

Assets and disposal groups are classified as held for sale if their carrying amount will be recovered through a sale transaction or a grant agreement rather than continuing use. Assets held for sale consist of those assets that management has determined are available for immediate sale or granting in their present condition and their sale is highly probable within one year from the date of classification.

These assets are measured at the lower of the asset's carrying amount and fair value less costs to sell. These assets are not depreciated. Non-current assets held for sale have been recognised on the face of the financial statements as current assets.

t) Leased Assets

Leases under which the agency assumes substantially all the risks and rewards of ownership of an asset are classified as finance leases. Other leases are classified as operating leases.

Finance Leases

Finance leases are capitalised. A lease asset and lease liability equal to the lower of the fair value of the leased property and present value of the minimum lease payments, each determined at the inception of the lease, are recognised.

Lease payments are allocated between the principal component of the lease liability and the interest expense.

Long-term land lease assets on Aboriginal land are recognized on the balance sheet of the Top End Health Service and amortised accordingly over the term of the lease arrangements. A corresponding liability is recognised under Borrowings.

Operating Leases

Operating lease payments made at regular intervals throughout the term are expensed when the payments are due, except where an alternative basis is more representative of the pattern of benefits to be derived from the leased property. Lease incentives under an operating lease of a building or office space is recognised as an integral part of the consideration for the use of the leased asset. Lease incentives are to be recognised as a deduction of the lease expenses over the term of the lease.

u) Payables

Liabilities for accounts payable and other amounts payable are carried at cost, which is the fair value of the consideration to be paid in the future for goods and services received, whether or not billed to the agency. Accounts payable are normally settled within 30 days.

v) Employee Benefits

Provision is made for employee benefits accumulated as a result of employees rendering services up to the reporting date. These benefits include wages and salaries and recreation leave. Liabilities arising in respect of wages and salaries, recreation leave and other employee benefit liabilities that fall due within twelve months of reporting date are classified

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NOTES TO THE FINANCIAL STATEMENTS
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as current liabilities and are measured at amounts expected to be paid. Non-current employee benefit liabilities that fall due after twelve months of the reporting date are measured at present value, calculated using the Government long-term bond rate.

No provision is made for sick leave, which is non-vesting, as the anticipated pattern of future sick leave to be taken is less than the entitlement accruing in each reporting period.

Employee benefit expenses are recognised on a net basis in respect of the following categories:

- wages and salaries, non-monetary benefits, recreation leave, sick leave and other leave entitlements; and
- other types of employee benefits.

As part of the financial management framework, the Central Holding Authority assumes the long service leave liabilities of Government agencies, including Top End Health Service and as such no long service leave liability is recognised in agency financial statements.

w) Superannuation

Employees' superannuation entitlements are provided through the:

- Northern Territory Government and Public Authorities Superannuation Scheme (NTGPASS);
- Commonwealth Superannuation Scheme (CSS); or
- non-government employee-nominated schemes for those employees commencing on or after 10 August 1999.

The agency makes superannuation contributions on behalf of its employees to the Central Holding Authority or non-government employee-nominated schemes. Superannuation liabilities related to government superannuation schemes are held by the Central Holding Authority and as such are not recognised in agency financial statements.

x) Contributions by and Distributions to Government

The agency may receive contributions from Government where the Government is acting as owner of the agency. Conversely, the agency may make distributions to Government. In accordance with the *Financial Management Act* and Treasurer's Directions, certain types of contributions and distributions, including those relating to administrative restructures, have been designated as contributions by, and distributions to, Government. These designated contributions and distributions are treated by the agency as adjustments to equity.

The Statement of Changes in Equity provides additional information in relation to contributions by, and distributions to, Government.

y) Commitments

Disclosures in relation to capital and other commitments, including lease commitments are shown at Note 18.

Commitments are those contracted as at 30 June where the amount of the future commitment can be reliably measured.

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NOTES TO THE FINANCIAL STATEMENTS
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z) Financial Instruments

A financial instrument is a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

Financial assets and liabilities are recognised on the Balance Sheet when the agency becomes a party to the contractual provisions of the financial instrument. The agency's financial instruments include cash and deposits; receivables; advances; investments loan and placements; payables; advances received; borrowings and derivatives.

Due to the nature of operating activities, certain financial assets and financial liabilities arise under statutory obligations rather than a contract. Such financial assets and liabilities do not meet the definition of financial instruments as per AASB 132 Financial Instruments Presentation. These include statutory receivables arising from taxes including GST and penalties.

Exposure to interest rate risk, foreign exchange risk, credit risk, price risk and liquidity risk arise in the normal course of activities. The agency's investments, loans and placements, and borrowings are predominantly managed through the Northern Territory Treasury Corporation (NTTC) adopting strategies to minimise the risk. Derivative financial arrangements are also utilised to manage financial risks inherent in the management of these financial instruments. These arrangements include swaps, forward interest rate agreements and other hedging instruments to manage fluctuations in interest or exchange rates.

Classification of Financial Instruments

AASB 7 Financial Instruments: Disclosures requires financial instruments to be classified and disclosed within specific categories depending on their nature and purpose.

Financial assets are classified into the following categories:

- financial assets at fair value through profit or loss; and
- loans and receivables.

Financial liabilities are classified into the following categories:

- financial liabilities at fair value through profit or loss (FVTPL); and
- financial liabilities at amortised cost.

Financial Assets or Financial Liabilities at Fair Value through Profit or Loss

Financial instruments are classified as at FVTPL when the instrument is either held for trading or is designated as at FVTPL.

An instrument is classified as held for trading if it is:

- acquired or incurred principally for the purpose of selling or repurchasing it in the near term with an intention of making a profit; or
- part of a portfolio of identified financial instruments that are managed together and for which there is evidence of a recent actual pattern of short-term profit-taking; or
- a derivative that is not a financial guarantee contract or a designated and effective hedging instrument.

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A financial instrument may be designated as at FVTPL upon initial recognition if:

- such designation eliminates or significantly reduces a measurement or recognition inconsistency that would otherwise arise; or
- the instrument forms part of a group of financial instruments, which is managed and its performance is evaluated on a fair value basis, in accordance with a documented risk management or investment strategy, and information about the grouping is provided internally on that basis; or
- it forms part of a contract containing one or more embedded derivatives, and AASB 139 Financial Instruments: Recognition and Measurement permits the contract to be designated as at FVTPL.

Financial liabilities at fair value through profit or loss include deposits held excluding statutory deposits, accounts payable and accrued expenses. Financial assets at fair value through profit or loss include short-term securities and bonds.

Loans and Receivables

For details refer to Note 2(o), but exclude statutory receivables.

Financial Liabilities at Amortised Cost

Financial instrument liabilities measured at amortised cost include all advances received, finance lease liabilities and borrowings. Amortised cost is calculated using the effective interest method.

Fair Value Measurement

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

Fair value measurement of a non-financial asset takes into account a market participant's ability to generate economic benefits by using the asset in its highest and best use or by selling it to another market participant that would use the asset in its highest and best use. The highest and best use takes into account the use of the asset that is physically possible, legally permissible and financially feasible.

When measuring fair value, the valuation techniques used maximise the use of relevant observable inputs and minimise the use of unobservable inputs. Unobservable inputs are used to the extent that sufficient relevant and reliable observable inputs are not available for similar assets/liabilities.

Observable inputs are publicly available data that are relevant to the characteristics of the assets/liabilities being valued. Observable inputs used by the agency include, but are not limited to, published sales data for land and general office buildings.

Unobservable inputs are data, assumptions and judgments that are not available publicly, but are relevant to the characteristics of the assets/liabilities being valued. Such inputs include internal agency adjustments to observable data to take account of particular and potentially unique characteristics/functionality of assets/liabilities and assessments of physical condition and remaining useful life.

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All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the following fair value hierarchy based on the inputs used:

Level 1 – inputs are quoted prices in active markets for identical assets or liabilities;

Level 2 – inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly; and

Level 3 – inputs are unobservable.

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NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

3. COMPREHENSIVE OPERATING STATEMENT BY OUTPUT GROUP

	Note	Top End Hospitals		Community Treatment and Extended Care		Primary Health Care		Top End Wide Support Services		Total	
		2016	2015	2016	2015	2016	2015	2016	2015	2016	2015
		$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
INCOME											
Grants and subsidies revenue											
Current		23 066	13 444	9 878	2 434	28 446	26 514	384 115	356 719	445 505	399 111
Sales of goods and services		38 672	33 572	256	1 931	6 597	5 373	294 544	294 295	340 069	335 171
Gain on disposal of assets	4	117	0	0	0	0	0	8 384	0	8 501	0
Other income		(40)	407	821	16	127	1	0	19 827	908	20 250
TOTAL INCOME		**61 815**	**47 423**	**10 955**	**4 381**	**35 170**	**31 888**	**687 043**	**670 841**	**794 984**	**754 532**
EXPENSES											
Employee expenses		351 695	330 764	40 131	26 218	75 147	68 990	16 184	3 423	483 157	429 395
Administrative expenses											
Purchases of goods and services	5	175 289	138 847	7 754	5 370	21 716	21 784	90 915	86 726	295 674	252 727
Repairs and maintenance		9 970	9 298	0	0	2	0	9 400	15 860	19 372	25 158
Depreciation and amortisation	9	2 787	2 727	38	16	366	367	22 480	18 557	25 671	21 667
Other administrative expenses		1 788	540	3	11	92	55	7	2 772	1 890	3 378
Grants and subsidies expenses											
Current		21	12	3 106	1 405	12 180	225	16 493	16 142	31 800	17 784
Capital		0	0	0	0	0	0	1 901	1 323	1 901	1 323
Interest expenses		15	15	0	0	173	174	0	0	188	189
TOTAL EXPENSES		**541 564**	**482 203**	**51 032**	**33 020**	**109 676**	**91 595**	**157 380**	**144 803**	**859 652**	**751 621**
NET SURPLUS/(DEFICIT)		**(479 749)**	**(434 780)**	**(40 077)**	**(28 639)**	**(74 506)**	**(59 707)**	**529 663**	**526 038**	**(64 669)**	**2 911**
OTHER COMPREHENSIVE INCOME											
Items that will not be reclassified to net surplus/deficit											
Transfers from reserves		0	0	0	0	0	0	0	(45)	0	(45)
Changes in asset revaluation surplus		0	0	0	0	0	0	22 581	(48 395)	22 581	(48 395)
TOTAL OTHER COMPREHENSIVE INCOME		**0**	**0**	**0**	**0**	**0**	**0**	**22 581**	**(48 440)**	**22 581**	**(48 440)**
COMPREHENSIVE RESULT		**(479 749)**	**(434 780)**	**(40 077)**	**(28 639)**	**(74 506)**	**(59 707)**	**552 244**	**477 598**	**(42 088)**	**(45 529)**

This Comprehensive Operating Statement by output group is to be read in conjunction with the notes to the financial statements.

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

4. GAIN ON DISPOSAL OF ASSETS

	2016 $000	2015 $000
Net proceeds from the disposal of non-current assets	4	0
Less: Carrying value of non-current assets disposed	(0)	(0)
Gain on the disposal of non-current assets	**4**	**0**
Proceeds from sale of minor assets	0	0
Total Gain on Disposal of Assets	**4**	**0**

5. PURCHASES OF GOODS AND SERVICES

The net surplus/(deficit) has been arrived at after charging the following expenses:

Goods and services expenses:		
Property maintenance	10 148	7 963
General property maintenance	4 616	4 911
Power	10 748	11 521
Water and sewerage	1 801	1 955
Land rent expense	1	2
Accommodation	707	736
Consultants [1]	1 220	1 412
Advertising [2]	16	7
Agent service agreements	44 768	39 226
Audit fees	73	145
Bank charges	24	25
Client travel	57 530	56 051
Clothing	621	432
Communications	2 431	2 622
Consumables/ general expenses	4 979	4 162
Cross border patient charges	19 957	9 554
Marketing and promotion [3]	407	108
Document production	309	217
Entertainment/ hospitality	39	36
Food	3 940	3 852
Freight	1 499	1 154
Information technology charges	12 880	10 735
IT consultants	535	319
IT hardware and software expenses	1 023	881
Insurance premiums	3	1
Laboratory expenses	9 052	6 306
Legal expenses [4]	579	98
Library services	131	136
Medical/ dental supply and services	78 881	66 555
Membership and subscriptions	413	232
Motor vehicle expenses	4 936	4 353
Office requisites and stationery	1 618	1 783
Other equipment expenses	4 478	3 908
Recruitment [5]	3 583	3 108
Regulatory/ advisory boards/ committees	35	31
Relocation expenses	452	276
Training and study	2 334	1 713

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

	2016	2015
	$000	$000
Transport equipment expenses	41	41
Official duty fares	8 214	5 569
Travelling allowance	654	619
Unallocated corporate credit card expenses	(2)	(28)
	295 674	**252 727**

(1) Includes marketing, promotion and IT consultants.
(2) Does not include recruitment, advertising or marketing and promotion advertising.
(3) Includes advertising for marketing and promotion but excludes marketing and promotion consultants' expenses, which are incorporated in the consultants' category.
(4) Includes legal fees, claim and settlement costs.
(5) Includes recruitment-related advertising costs.

6. CASH AND DEPOSITS

Cash on hand	12	12
Cash at bank	5 655	29 458
Total Cash and Deposits	**5 666**	**29 470**

7. RECEIVABLES

Current		
Accounts receivable	10 573	9 112
Less: Allowance for impairment losses	(3 157)	(1 694)
	7 416	7 418
GST receivables	3 341	2 857
Other receivables(1)	24 531	29 765
	27 872	32 622
Total Receivables	**35 288**	**40 040**

(1) Other receivables include accrued revenue for cross border patient charges.

8. INVENTORIES

Inventories Held for Distribution		
At current replacement cost	7 794	6 129
Total Inventories	**7 794**	**6 129**

During the year the Top End Health Service was required to write-off $0.21m ($0.12m 2014-15) of inventories, the majority being pharmaceuticals due to their short shelf life and the necessity to keep certain lifesaving items on hand.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

	2016	2015
	$000	$000
9. PROPERTY, PLANT AND EQUIPMENT		
Land		
At fair value	34 493	29 187
Buildings		
At fair value	940 520	847 663
Less: Accumulated depreciation	(448 213)	(417 232)
Less: Accumulated impairment loss	(231)	(0)
	492 076	430 431
Plant and Equipment		
At capitalised cost	54 293	50 988
Less: Accumulated depreciation	(36 733)	(35 592)
Less: Accumulated impairment loss	(1 293)	(1 272)
	16 267	14 124
Leased Land		
At fair value	4 083	3 917
Less: Accumulated amortisation	(396)	(291)
	3 687	3 626
Total Property, Plant and Equipment	**546 523**	**477 368**

Property, Plant and Equipment Valuations

The latest revaluations as at 30 June 2016 were independently conducted for the Remote Health Clinics. The valuer was Territory Property Consultants Pty Ltd. Refer to Note 10: Fair Value Measurement of Non-Financial Assets for additional disclosures.

Impairment of Property, Plant and Equipment

Agency property assets were assessed for impairment as at 30 June 2016 as part of the revaluation of the Remote Health Clinics. The impairment losses were charged to the asset revaluation surplus.

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

9. PROPERTY, PLANT AND EQUIPMENT (continued)

2016 Property, Plant and Equipment Reconciliations

A reconciliation of the carrying amount of property, plant and equipment at the beginning and end of 2015-16 is set out below:

	Land	Buildings	Plant and Equipment	Leased Land	Total
	$000	$000	$000	$000	$000
Carrying Amount as at 1 July 2015	29 187	430 431	14 124	3 626	477 368
Additions	0	0	5 124	167	5 291
Disposals	0	0	0	0	0
Depreciation	0	(22 234)	(3 331)	(105)	(25 671)
Additions/(Disposals) from administrative restructuring	0	0	0	0	0
Additions/(Disposals) from asset transfers	(1 540)	67 894	371	0	66 725
Revaluation increments/(decrements)	6 846	16 216	0	0	23 062
Impairment losses	0	(231)	(21)	0	(252)
Impairment losses reversed	0	0	0	0	0
Other movements	0	0	0	0	0
Carrying Amount as at 30 June 2016	**34 493**	**492 076**	**16 267**	**3 687**	**546 523**

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

9. PROPERTY, PLANT AND EQUIPMENT (continued)

2015 Property, Plant and Equipment Reconciliations

A reconciliation of the carrying amount of property, plant and equipment at the beginning and end of 2014-15 is set out below:

	Land	Buildings	Plant and Equipment	Leased Land	Total
	$000	$000	$000	$000	$000
Carrying Amount as at 1 July 2014	24 534	471 527	12 086	3 727	511 874
Additions	0	0	4 766	0	4 766
Disposals	0	0	0	0	0
Depreciation	0	(18 216)	(3 350)	(101)	(21 667)
Additions/(Disposals) from administrative restructuring	0	0	345	0	345
Additions/(Disposals) from asset transfers	0	30 213	286	0	30 499
Revaluation increments/(decrements)	4 653	(53 093)	0	0	(48 440)
Impairment losses	0	0	(9)	0	(9)
Impairment losses reversed	0	0	0	0	0
Other movements	0	0	0	0	0
Carrying Amount as at 30 June 2015	**29 187**	**430 431**	**14 124**	**3 626**	**477 368**

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

10. FAIR VALUE MEASUREMENT OF NON-FINANCIAL ASSETS

a) Fair Value Hierarchy

Fair values of non-financial assets categorised by levels of inputs used to compute fair value are:

	Level 1	Level 2	Level 3	Total Fair Value
	$000	$000	$000	$000
2015-16				
Asset Classes				
Land (Note 9)	0	0	34 493	34 493
Buildings (Note 9)	0	0	492 076	492 076
Plant and equipment (Note 9)	0	0	16 267	16 267
Total	**0**	**0**	**542 836**	**542 836**
2014-15				
Asset Classes				
Land (Note 9)	0	0	29 187	29 187
Buildings (Note 9)	0	0	430 431	430 431
Plant and equipment (Note 9)	0	0	14 124	14 124
Total	**0**	**0**	**473 742**	**473 742**

There were no transfers between Level 1 and Levels 2 or 3 during 2015-16.

b) Valuation Techniques and Inputs

Valuation techniques used to measure fair value in 2015-16 are:

	Level 3 Techniques
Asset Classes	
Land	Cost approach
Buildings	Cost approach
Plant and equipment	Cost approach

There were no changes in valuation techniques from 2014-15 to 2015-16.

The Territory Property Consultants Pty Ltd has provided valuations for the land and building assets.

Level 2 fair values of land and buildings were based on market evidence of sales price per square metre of comparable land and buildings.

Level 3 fair values of specialised buildings and infrastructure were determined by computing their depreciated replacement costs because an active market does not exist for such facilities. The depreciated replacement cost was based on a combination of internal records of the historical cost of the facilities, adjusted for contemporary technology and construction approaches. Significant judgement was also used in assessing the remaining service potential of the facilities, given local environmental conditions, projected usage, and records of the current condition of the facilities.

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

c) Additional Information for Level 3 Fair Value Measurements

(i) Reconciliation of Recurring Level 3 Fair Value Measurements

	Land	Buildings	Plant and equipment
	$000	$000	$000
2015-16			
Fair value as at 1 July 2015	29 187	430 431	14 124
Additions	1 210	67 894	5 522
Disposals	(2 750)	0	(27)
Transfers from Level 2	0	0	0
Transfers to Level 2	0	0	0
Depreciation	0	(22 234)	(3 331)
Gains/losses recognised in net surplus/deficit	0	0	(21)
Gains/losses recognised in other comprehensive income	6 846	15 985	0
Fair value as at 30 June 2016	**34 493**	**492 076**	**16 267**
2014-15			
Fair value as at 1 July 2014	24 534	471 527	12 086
Additions	0	30 213	5 397
Disposals	0	0	0
Transfers from Level 2	0	0	0
Transfers to Level 2	0	0	0
Depreciation	0	(18 216)	(3 350)
Gains/losses recognised in net surplus/deficit	0	0	(9)
Gains/losses recognised in other comprehensive income	4 653	(53 093)	0
Fair value as at 30 June 2015	**29 187**	**430 431**	**14 124**

(ii) Sensitivity analysis

Unobservable inputs used in computing the fair value of land, buildings and plant and equipment include the historical cost and the consumed economic benefit for each asset. Given the large number of agency buildings, plant and equipment, it is not practical to compute a relevant summary measure for the unobservable inputs. In respect of sensitivity of fair value to changes in input value, a higher historical cost results in a higher fair value and greater consumption of economic benefit lowers fair value.

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

	2016	2015
	$000	$000

11. PAYABLES

Accounts payable	4 903	4 756
Accrued expenses[1]	66 368	61 104
Grants and subsidies payable	50	0
Total Payables	**71 321**	**65 860**

[1] Includes liability for cross border patient expenses and other accrued operational expenses

12. BORROWINGS AND ADVANCES

Current		
Finance lease liabilities[1]	45	41
	45	41
Non-Current		
Finance lease liabilities[1]	3 749	3 635
	3 749	3 635
Total Borrowings and Advances	**3 794**	**3 676**

[1] Finance leases relate to long term land leases on Aboriginal land.

13. PROVISIONS

Current		
Employee benefits		
Recreation leave	27 467	25 404
Leave loading	6 715	5 994
Recreation leave fares	231	266
Other current provisions		
Superannuation and fringe benefits tax payable	4 734	4 455
	39 148	36 119
Non-Current		
Employee benefits		
Recreation leave	15 436	15 095
	15 436	15 095
Total Provisions	**54 584**	**51 214**

The Agency employed 3 861 employees as at 30 June 2016 (3 514 employees as at 30 June 2015).

14. OTHER LIABILITIES

Current		
Deposit held[1]	2 076	1 736
Unearned revenue	0	2 520
	2 076	4 256
Total Other Liabilities	**2 076**	**4 256**

[1]Accountable Officer's Trust Account (see Note 21) Governing Council bank account and Hospital Gift Funds.

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

	2016	2015
	$000	$000

15. RESERVES

Asset Revaluation Surplus

(i) Nature and purpose of the asset revaluation surplus

The asset revaluation surplus includes the net revaluation increments and decrements arising from the revaluation of non-current assets. Impairment adjustments may also be recognised in the asset revaluation surplus.

(ii) Movements in the asset revaluation surplus

Balance as at 1 July	151 880	200 275
Increment/(Decrement) – land	6 846	4 653
Additions/(Disposals) from asset transfers – land	(250)	0
Increment/(Decrement) – buildings	16 216	(53 048)
Impairment (losses)/reversals – buildings	(231)	0
Balance as at 30 June	**174 460**	**151 880**

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

	2016	2015
	$000	$000

16. NOTES TO THE CASH FLOW STATEMENT

Reconciliation of Cash

The total of agency 'Cash and deposits' of $5 666 recorded in the Balance Sheet is consistent with that recorded as 'Cash' in the Cash Flow Statement.

Reconciliation of Net Surplus/(Deficit) to Net Cash from Operating Activities

Net Surplus/(Deficit)	(64 669)	2 911
Non-cash items:		
Depreciation and amortisation	25 671	21 667
Asset write-offs/write-downs	232	125
(Gain)/Loss on disposal of assets	(8 501)	(19 925)
Minor new works – non-cash	86	7 198
Changes in assets and liabilities:		
Decrease/(Increase) in receivables	4 752	7 882
Decrease/(Increase) in inventories	(1 876)	(403)
Decrease/(Increase) in prepayments	(170)	(491)
(Decrease)/Increase in payables	5 461	348
(Decrease)/Increase in provision for employee benefits	3 091	1 822
(Decrease)/Increase in other provisions	279	(3)
(Decrease)/Increase in other liabilities	(2 520)	2 520
Net Cash from Operating Activities	**(38 165)**	**23 651**

Non-Cash Financing and Investing Activities

Non-cash Transactions

During the financial year the agency acquired buildings with an aggregate fair value of $56.1m (2015: $17.8m) by non-cash asset transfers from the Department of Infrastructure.

17. FINANCIAL INSTRUMENTS

A financial instrument is a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Financial instruments held by the Top End Health Service include cash and deposits, receivables, payables and finance leases. The Top End Health Service has limited exposure to financial risks as discussed below.

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

a) Categorisation of Financial Instruments

The carrying amounts of the agency's financial assets and liabilities by category are disclosed in the table below.

2015-16 Categorisation of Financial Instruments

	Fair value through profit or loss						
	Held for trading	Designated at fair value	Held to maturity investments	Financial assets - Loans and receivables	Financial assets - available for sale	Financial Liabilities - amortised cost	**Total**
	$000	$000	$000	$000	$000	$000	$000
Cash and deposits	0	5 666	0	0	0	0	5 666
Receivables[1]	0	0	0	31 947	0	0	31 947
Total Financial Assets	**0**	**5 666**	**0**	**31 947**	**0**	**0**	**37 613**
Deposits held[1]	0	0	2 076	0	0	0	2 076
Payables[1]	0	71 321	0	0	0	0	71 321
Finance lease liabilities	0	0	0	0	0	3 794	3 794
Total Financial Liabilities	**0**	**71 321**	**2 076**	**0**	**0**	**3 794**	**77 191**

1. Total amounts disclosed exclude statutory amounts

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

2014-15 Categorisation of Financial Instruments

	Fair value through profit or loss						
	Held for trading	Designated at fair value	Held to maturity investments	Financial assets - Loans and receivables	Financial assets - available for sale	Financial Liabilities - amortised cost	**Total**
	$000	$000	$000	$000	$000	$000	$000
Cash and deposits	0	29 470	0	0	0	0	29 470
Receivables	0	0	0	40 040	0	0	40 040
Total Financial Assets	**0**	**29 470**	**0**	**40 040**	**0**	**0**	**69 510**
Deposits held[1]	0	0	1 736	0	0	0	1 736
Payables[1]	0	65 860	0	0	0	0	65 860
Finance lease liabilities	0	0	0	0	0	3 676	3 676
Total Financial Liabilities	**0**	**65 860**	**1 736**	**0**	**0**	**3 676**	**71 272**

1.Total amounts disclosed exclude statutory amounts

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

b) Credit Risk

The agency has limited credit risk exposure (risk of default). In respect of any dealings with organisations external to Government, the agency has adopted a policy of only dealing with credit worthy organisations and obtaining sufficient collateral or other security where appropriate, as a means of mitigating the risk of financial loss from defaults.

The carrying amount of financial assets recorded in the financial statements, net of any allowances for losses, represents the agency's maximum exposure to credit risk without taking account of the value of any collateral or other security obtained.

Receivables

Receivable balances are monitored on an ongoing basis to ensure that exposure to bad debts is not significant. A reconciliation and ageing analysis of receivables is presented below.

Internal Receivables	Ageing of Receivables	Ageing of Impaired Receivables	Net Receivables
	$000	$000	$000
2015-16			
Not overdue	11	0	11
Overdue for less than 30 days	0	0	0
Overdue for 30 to 60 days	5	0	5
Overdue for more than 60 days	67	0	67
Total	**83**	**0**	**83**

Reconciliation of the Allowance for Impairment Losses	
Opening	0
Written off during the year	0
Recovered during the year	0
Increase/(Decrease) in allowance recognised in profit or loss	0
Total	**0**

2014-15			
Not overdue	6	0	6
Overdue for less than 30 days	0	0	0
Overdue for 30 to 60 days	3	0	3
Overdue for more than 60 days	37	0	37
Total	**46**	**0**	**46**

Reconciliation of the Allowance for Impairment Losses	
Opening	0
Written off during the year	0
Recovered during the year	0
Increase/(Decrease) in allowance recognised in profit or loss	0
Total	**0**

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

External Receivables	Ageing of Receivables	Ageing of Impaired Receivables	Net Receivables
	$000	$000	$000
2015-16			
Not overdue	28 457	0	28 457
Overdue for less than 30 days	1 091	0	1 091
Overdue for 30 to 60 days	546	0	546
Overdue for more than 60 days	4 927	3 157	1 770
Total	**35 021**	**3 157**	**31 864**

Reconciliation of the Allowance for Impairment Losses	
Opening	1 694
Written off during the year	(149)
Recovered during the year	0
Increase/(Decrease) in allowance recognised in profit or loss	1 612
Total	**3 157**

2014-15			
Not overdue	35 798	0	35 798
Overdue for less than 30 days	1 888	0	1 888
Overdue for 30 to 60 days	487	0	487
Overdue for more than 60 days	3 514	1 694	1 820
Total	**41 687**	**1 694**	**39 993**

Reconciliation of the Allowance for Impairment Losses	
Opening	1 098
Written off during the year	(52)
Recovered during the year	0
Increase/(Decrease) in allowance recognised in profit or loss	648
Total	**1 694**

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

c) Liquidity Risk

Liquidity risk is the risk that the agency will not be able to meet its financial obligations as they fall due. The agency's approach to managing liquidity is to ensure that it will always have sufficient liquidity to meet its liabilities when they fall due.

The following tables detail the agency's remaining contractual maturity for its financial assets and liabilities.

2016 Maturity analysis for financial assets and liabilities

	Variable Interest Rate			Fixed Interest Rate					
	Less than a Year	1 to 5 Years	More than 5 Years	Less than a Year	1 to 5 Years	More than 5 Years	Non Interest Bearing	Total	Weighted Average
	$000	$000	$000	$000	$000	$000	$000	$000	%
Assets									
Cash and deposits	0	0	0	0	0	0	5 666	5 666	0
Receivables	0	0	0	0	0	0	31 947	31 947	0
Total Financial Assets	**0**	**0**	**0**	**0**	**0**	**0**	**37 613**	**37 613**	
Liabilities									
Deposits held	0	0	0	0	0	0	2 076	2 076	0
Payables	0	0	0	0	0	0	71 321	71 321	0
Finance lease liabilities	0	0	0	45	258	3 491	0	3 794	4.72
Total Financial Liabilities	**0**	**0**	**0**	**45**	**258**	**3 491**	**73 397**	**77 191**	

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

2015 Maturity analysis for financial assets and liabilities

	Variable Interest Rate			Fixed Interest Rate					
	Less than a Year	1 to 5 Years	More than 5 Years	Less than a Year	1 to 5 Years	More than 5 Years	Non Interest Bearing	Total	Weighted Average
	$000	$000	$000	$000	$000	$000	$000	$000	%
Assets									
Cash and deposits	0	0	0	0	0	0	29 470	29 470	0
Receivables	0	0	0	0	0	0	40 040	40 040	0
Total Financial Assets	**0**	**0**	**0**	**0**	**0**	**0**	**69 510**	**69 510**	
Liabilities									
Deposits held	0	0	0	0	0	0	1 736	1 736	0
Payables	0	0	0	0	0	0	65 860	65 860	0
Finance lease liabilities	0	0	0	41	185	3 450	0	3 676	4.72
Total Financial Liabilities	**0**	**0**	**0**	**41**	**185**	**3 450**	**67 596**	**71 272**	

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. It comprises interest rate risk, price risk and currency risk.

(i) Interest Rate Risk

The Top End Health Service is not exposed to interest rate risk as agency financial assets and financial liabilities, with the exception of finance leases are non-interest bearing. Finance lease arrangements are established on a fixed interest rate and as such do not expose the Top End Health Service to interest rate risk.

(ii) Price Risk

The Top End Health Service is not exposed to price risk as Top End Health Service does not hold units in unit trusts.

(iii) Currency Risk

The Top End Health Service is not exposed to currency risk as Top End Health Service does not hold borrowings denominated in foreign currencies or transactional currency exposures arising from purchases in a foreign currency.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

e) Net Fair Value

The fair value of financial instruments is determined on the following basis:

- the fair value of cash, deposits, advances, receivables and payables approximates their carrying amount, which is also their amortised cost;
- the fair value of derivative financial instruments are derived using current market yields and exchange rates appropriate to the instrument; and
- the fair value of other monetary financial assets and liabilities is based on discounting to present value the expected future cash flows by applying current market interest rates for assets and liabilities with similar risk profiles.

For financial instruments measured and disclosed at fair value, the following table groups the instruments based on the level of inputs used.

2016	Total Carrying Amount	Net Fair Value Level 1	Net Fair Value Level 2	Net Fair Value Level 3	Net Fair Value Total
	$000	$000	$000	$000	$000
Financial Assets					
Cash and deposits	5 666	5 666	0	0	5 666
Receivables	31 947	31 947	0	0	31 947
Total Financial Assets	**37 613**	**37 613**	**0**	**0**	**37 613**
Financial Liabilities					
Deposits held	2 076	2 076	0	0	2 076
Payables	71 321	71 321	0	0	71 321
Total Financial Liabilities	**73 397**	**73 397**	**0**	**0**	**73 397**

2015	Total Carrying Amount	Net Fair Value Level 1	Net Fair Value Level 2	Net Fair Value Level 3	Net Fair Value Total
	$000	$000	$000	$000	$000
Financial Assets					
Cash and deposits	29 470	29 470	0	0	29 470
Receivables	40 040	40 040	0	0	40 040
Total Financial Assets	**69 510**	**69 510**	**0**	**0**	**69 510**
Financial Liabilities					
Deposits held	1 736	1 736	0	0	1 736
Payables	65 860	65 860	0	0	65 860
Total Financial Liabilities	**67 596**	**67 596**	**0**	**0**	**67 596**

There were no changes in valuation techniques during the period.

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

	2016		2015	
	Internal	External	Internal	External
	$000	$000	$000	$000

18. COMMITMENTS

(i) Capital Expenditure Commitments

Capital expenditure commitments primarily related to the purchase of plant and equipment. Capital expenditure commitments contracted for at balance date but not recognised as liabilities are payable as follows:

Within one year	0	0	0	0
Later than one year and not later than five years	0	0	0	0
Later than five years	0	0	0	0
	0	**0**	**0**	**0**

(ii) Operating Lease Commitments

The agency leases property under non-cancellable operating leases expiring from 3 to 5 years. Leases generally provide the agency with a right of renewal at which time all lease terms are renegotiated. The agency also leases items of plant and equipment under non-cancellable operating leases. Future operating lease commitments not recognised as liabilities are payable as follows:

Within one year	0	146	0	199
Later than one year and not later than five years	0	151	0	297
Later than five years	0	0	0	0
	0	**297**	**0**	**496**

(iii) Other Expenditure Commitments

Other non-cancellable expenditure commitments not recognised as liabilities are payable as follows:

Within one year	0	26 363	0	24 860
Later than one year and not later than five years	0	5 706	0	0
Later than five years	0	0	0	0
	0	**32 069**	**0**	**24 860**

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

19. CONTINGENT LIABILITIES AND CONTINGENT ASSETS

a) Contingent Liabilities

The Top End Health Service had no contingent liabilities as at 30 June 2016 or 30 June 2015.

b) Contingent Assets

The Top End Health Service had no contingent assets as at 30 June 2016 or 30 June 2015.

20. EVENTS SUBSEQUENT TO BALANCE DATE

No material events have arisen between the end of the financial year and the date of this report that require adjustment to, or disclosure in these financial statements.

21. ACCOUNTABLE OFFICER'S TRUST ACCOUNT

In accordance with section 7 of the *Financial Management Act*, an Accountable Officer's Trust Account has been established for the receipt of money to be held in trust. A summary of activity is shown below:

Nature of Trust Money	Opening Balance 1 July 2015	Receipts	Payments	Closing Balance 30 June 2016
Private practice revenue	391 618	1 829 241	1 692 833	528 026
Bond money	87 999	84 426	67 311	105 114
Unclaimed money	56 025	570	0	56 595
	535 642	**1 914 237**	**1 760 144**	**689 735**

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

22. WRITE-OFFS, POSTPONEMENTS, WAIVERS, GIFTS AND EX GRATIA PAYMENTS

	Agency		Agency		Territory Items		Territory Items	
	2016	No. of Trans.	2015	No. of Trans.	2016	No. of Trans.	2015	No. of Trans.
	$000		$000		$000		$000	
Write-offs, Postponements and Waivers Under the *Financial Management Act*								
Represented by:								
Amounts written off, postponed and waived by Delegates								
Irrecoverable amounts payable to the Territory or an agency written off	128	352	37	109				
Losses or deficiencies of money written off	0	0	0	1				
Public property written off	21	4	9	84				
Waiver or postponement of right to receive or recover money or property	0	0	0	0				
Total Written Off, Postponed and Waived by Delegates	**149**	**356**	**46**	**194**				
Amounts written off, postponed and waived by the Treasurer								
Irrecoverable amounts payable to the Territory or an agency written off	0	0	0	0				
Losses or deficiencies of money written off	0	0	0	0				
Public property written off	0	0	0	0				
Waiver or postponement of right to receive or recover money or property	0	0	0	0				
Total Written Off, Postponed and Waived by the Treasurer	**0**	**0**	**0**	**0**				
Write-offs, Postponements and Waivers Authorised Under Other Legislation [(a)]	**21**	**2**	**15**	**4**				
Gifts Under the *Financial Management Act*	**0**	**0**	**0**	**0**				
Gifts Authorised Under Other Legislation	**0**	**0**	**0**	**0**				
Ex Gratia Payments Under the *Financial Management Act*	**0**	**0**	**0**	**0**				

[(a)] *Medical Services Act*.

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

23. BUDGETARY INFORMATION

Comprehensive Operating Statement	2015-16 Actual	2015-16 Original Budget	Variance	Note
	$000	$000	$000	
INCOME				
Grants and subsidies revenue				
Current	445 505	370 283	75 222	1
Sales of goods and services	340 069	344 977	(4 908)	
Gain on disposal of assets	4	0	4	2
Other income	9 405	191	9 214	3
TOTAL INCOME	**794 984**	**715 451**	**79 533**	
EXPENSES				
Employee expenses	483 157	391 795	91 362	4
Administrative expenses				
Purchases of goods and services	295 674	281 912	13 762	
Repairs and maintenance	19 372	19 830	(458)	
Depreciation and amortisation	25 671	22 831	2 840	1
Other administrative expenses	1 890	0	1 890	5
Grants and subsidies expenses				
Current	31 800	18 683	13 117	1
Capital	1 901	0	1 901	6
Interest expenses	188	0	188	7
TOTAL EXPENSES	**859 652**	**735 051**	**124 601**	
NET SURPLUS/(DEFICIT)	**(64 669)**	**(19 600)**	**(45 069)**	
OTHER COMPREHENSIVE INCOME				
Items that will not be reclassified to net surplus/deficit				
Changes in asset revaluation surplus	22 581	0	22 581	8
TOTAL OTHER COMPREHENSIVE INCOME	**22 581**	**0**	**22 581**	
COMPREHENSIVE RESULT	**(42 088)**	**(19 600)**	**(22 488)**	

Notes:
The following note descriptions relate to variances greater than 10 per cent or where multiple significant variances have occurred.

1. Original budget is subject to significant variation during the year due to restructures and timing of Commonwealth funding.
2. Sale of fully depreciated plant and equipment.
3. Building transferred for nil consideration.
4. Mainly attributed to the timing of Commonwealth Grant provisions, transition of services from DoH and general Service Delivery Agreement variations.
5. Provision for doubtful debts rose for ageing accounts receivable.
6. Capital grants provided for Ambulance Services.
7. Interest paid for long term finance leases on Aboriginal land.
8. Revaluation of remote health clinics.

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

Balance Sheet	2015-16 Actual	2015-16 Original Budget	Variance	Note
	$000	$000	$000	
ASSETS				
Current assets				
Cash and deposits	5 666	8 509	(2 843)	1
Receivables	35 288	47 924	(12 636)	2
Inventories	7 794	5 843	1 951	3
Prepayments	5 792	5 131	661	4
Total current assets	**54 540**	**67 407**	**(12 867)**	
Non-current assets				
Property, plant and equipment	546 523	510 576	35 947	
Total non-current assets	**546 523**	**510 576**	**35 947**	
TOTAL ASSETS	**601 063**	**577 983**	**23 080**	
LIABILITIES				
Current liabilities				
Deposits held	2 076	1 479	597	5
Payables	71 321	65 515	5 806	
Borrowings and advances	45	39	6	6
Provisions	39 148	34 581	4 567	7
Total current liabilities	**112 590**	**101 614**	**10 976**	
Non-current liabilities				
Borrowings and advances	3 749	3 676	73	
Provisions	15 436	14 816	620	
Total non-current liabilities	**19 186**	**18 492**	**693**	
TOTAL LIABILITIES	**131 775**	**120 106**	**11 669**	
NET ASSETS	**469 288**	**457 877**	**11 411**	
EQUITY				
Capital	382 436	339 628	42 808	8
Reserves	174 460	200 275	(25 815)	9
Accumulated funds	(87 608)	(82 026)	(5 582)	
TOTAL EQUITY	**469 288**	**457 877**	**11 411**	

Notes:

The following note descriptions relate to variances greater than 10 per cent or where multiple significant variances have occurred.

1. Due to budget deficit.
2. Relates to reduction in National Health Reform payments receivable offset by increase in cross border receivables.
3. Increase in pharmaceutical inventories held.
4. Increase in operating prepayments.
5. Accountable Officers Trust Account transactions.
6. Increase in long term finance leases on Aboriginal land.
7. Mainly attributed to the timing of Commonwealth Grant provisions, transition of services from DoH and general Service Delivery Agreement variations
8. Equity injection and increase in completed works transferred in from Department of Infrastructure.
9. Timing variance for decrement in hospital buildings.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Cash Flow Statement	2015-16 Actual	2015-16 Original Budget	Variance	Note
	$000	$000	$000	
CASH FLOWS FROM OPERATING ACTIVITIES				
Operating receipts				
Grants and subsidies received				
Current	445 505	370 283	75 222	1
Receipts from sales of goods and services	372 505	345 168	27 337	
Total operating receipts	**818 010**	**715 451**	**102 559**	
Operating payments				
Payments to employees	(491 721)	(391 795)	(99 926)	2
Payments for goods and services	(330 615)	(301 742)	(28 873)	
Grants and subsidies paid				
Current	(31 750)	(18 683)	(13 067)	1
Capital	(1 901)	0	(1 901)	3
Interest paid	(188)	0	(188)	4
Total operating payments	**(856 175)**	**(712 220)**	**(143 955)**	
Net cash from/(used in) operating activities	**(38 165)**	**3 231**	**(41 396)**	
CASH FLOWS FROM INVESTING ACTIVITIES				
Investing receipts				
Proceeds from asset sales	4	0	4	5
Total investing receipts	**4**	**0**	**4**	
Investing payments				
Purchases of assets	(5 125)	(3 231)	(1 894)	6
Total investing payments	**(5 125)**	**(3 231)**	**(1 894)**	
Net cash from/(used in) investing activities	**(5 120)**	**(3 231)**	**(1 889)**	
CASH FLOWS FROM FINANCING ACTIVITIES				
Financing receipts				
Proceeds of borrowings				
Deposits received	340	0	340	7
Equity injections				
Other equity injections	20 000	0	20 000	8
Total financing receipts	**20 340**	**0**	**20 340**	
Financing payments				
Finance lease payments	(49)	0	(49)	4
Equity withdrawals	(810)	0	(810)	1
Total financing payments	**(859)**	**0**	**(859)**	
Net cash from/(used in) financing activities	**19 481**	**0**	**19 481**	
Net increase/(decrease) in cash held	(23 804)	0	(23 804)	
Cash at beginning of financial year	29 470	8 509	20 961	
CASH AT END OF FINANCIAL YEAR	**5 666**	**8 509**	**(2 843)**	

TOP END HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

Notes:
The following note descriptions relate to variances greater than 10 per cent or where multiple significant variances have occurred.

1. Original budget is subject to significant variation during the year due to restructures and timing of Commonwealth funding.
2. Mainly attributed to the timing of Commonwealth Grant provisions, transition of services from DoH and general Service Delivery Agreement variations.
3. Capital grants provided for Ambulance Services.
4. Payments for long term finance leases on Aboriginal land.
5. Sale of fully depreciated plant and equipment.
6. Timing issue.
7. Accountable Officers Trust Account transactions.
8. Equity injection from Department of Treasury and Finance.

Central Australia Health Service

The Year in review - Board Chair and Chief Operating Officer

Damian Ryan

Board Chair

Sue Korner

Chief Operating Officer

The Central Australia Health Service (CAHS) is governed by an independent skills based board which has worked tirelessly over the year to ensure that the people residing in Central Australia can access a range of quality and responsive services that have been customised to better meet the needs of the community as defined in the formal Service Delivery Agreement (SDA) negotiated with the Department of Health (System Manager).

The 2015-16 year has been a very eventful and successful year for CAHS, building on the preparatory work that marked the previous year. We also successfully transitioned the Alcohol and Other Drugs (AOD) Program into the Service and continued the expansion in the use of Telehealth (an increase of 70%) to provide many patients with the opportunity to attend their appointments with specialists without having to travel vast distances for their follow-up consultations.

CAHS also made significant improvements in reducing the number of patients waiting longer than the clinically recommended time for their elective surgery. This long wait reduction of 54% since July 2015 meant that we reduced the number from 160 to 73. This is an indication of the successful implementation of initiatives for improving elective surgery performance in Central Australia.

Clinical redesign at Alice Springs Hospital, which commenced in the previous year, has also continued to reap improvements with a steady decrease in the number of Take Own Leave or Discharge Against Medical Advice episodes decreasing from 9.21% in 2013-14; 8.2 % in 2014-15 to 7.7% in 2015-16.

Capital expenditure in 2015-16 resulted in the construction of two new health centres at Elliott and Canteen Creek, and extensive refurbishment of the Docker River, Papunya and Titjikala Health Centres. This, with the introduction of the Healthy School Aged Kids program for 5 to 14-year-olds, extended health centre hours at Flynn Drive Community Health Centre, and a dedicated spinal nurse has meant a significant enhancement to primary health care services in Central Australia.

Mental Health Services also introduced two new initiatives during 2015-16 including a housing tenancy support officer, whose role it is to identify and assist individual mental health clients who are experiencing housing strain or are at risk of homelessness, and a court liaison role to assist in the provision of clinical information regarding treatment and management of individuals whilst involved with the justice system.

A new model of care for renal services was introduced in Central Australia, with a group of enrolled nurses commencing at the Flynn Drive Renal Centre. The new model provides enrolled nurses with an opportunity to become dialysis competent, while concurrently building capacity in the renal workforce. Demand for renal services is predicted to continue to grow by at least 4.5% per annum in Central Australia.

Aboriginal employment across CAHS grew from 6.1% in 2014-15 to 7.6% in 2015-16. In January 2015, a Special Measures Plan was implemented across NT Health, including the Health Services. In the first 12 months, CAHS employed 30 Special Measures applicants, an average of 12.5% of advertised vacancies.

It is important to highlight also that we have delivered a net operating surplus in 2015-16 (including unfunded depreciation) and met and in some cases exceeded, most of the Service Delivery Agreement Key Performance Indicators (KPI) targets, with only six out of 22 KPIs slightly off target. Financial management and budgetary controls continue to strengthen across CAHS ensuring ownership of budgets and optimising resources to serve our community.

There are many other achievements that have occurred across CAHS that are highlighted in this report. Recognition must be given to the many recipients of awards throughout the year for their personal achievements, and CAHS also acknowledges the efforts of the Board and staff in Central Australia who have demonstrated a very high level of commitment, dedication and professionalism in all of the activities that have been undertaken.

Role and function

CAHS has a key role in health service delivery in the region, with the aim to achieve better health outcomes for all Central Australians. A significant proportion of the population in Central Australia is Aboriginal people. In addition, a high percentage of the region's population live outside the main towns of Alice Springs and Tennant Creek in remote communities and outstations. The greatest challenges faced by CAHS are to improve the health status of Aboriginal people, to overcome disadvantage, and close the gap between the most and least advantaged in the NT by:

- delivering accessible, appropriate and high quality acute, emergency and outpatient services, primary health care, mental health, population health and other community services to individuals, families and communities
- addressing the areas of greatest need by working with other health providers and local communities in planning, development, delivery and evaluation of health services
- seamlessly integrating acute care, community health and public health services, particularly for those with chronic and prolonged conditions
- supporting people to make positive changes to attitudes and behaviours to promote better health
- maximising independence and self-management of health issues through the ways health services are delivered, to achieve optimal outcomes.

Our Vision

Better health outcomes for all Central Australians

Our Mission

To promote, protect and improve the health and wellbeing of all people in the region in partnership with individuals, families and the community to ensure the delivery of best and most appropriate evidence based care

Our Values

We care about our community and providing patient-centred care, based on community priorities whilst embracing the community's perspectives and experiences

Community at the centre

We are accountable

We are accountable to the community

We ensure the best use of public resources to achieve goals

We are relevant today and ready for tomorrow

We are committed to responding to health needs today and planning for tomorrow

We are committed to high quality care

Our services are underpinned by evidence-based, appropriate and effective practice

We will monitor and evaluate what we do to ensure quality

We value our partnerships

We recognise and value the importance of strong mutually dependent links with our partners

We can only achieve better health outcomes with a collaborative and coordinated approach.

We work together with a shared purpose in delivering care and services to individuals, family and the community

Equity and integrity

We respond to areas of greatest need

We uphold honesty, respect and professionalism in all that we do

We pursue quality outcomes through ethical behaviour

Patient Conrad Wiseman is assisted by prosthetics technician Inosi Matea

Highlights 2015-16

Central Australia Health Service receives accreditation

CAHS was awarded three years' accreditation by the Australian Council of Healthcare Standards (ACHS). Within CAHS, the Alice Springs Hospital, Tennant Creek Hospital and Central Australia Mental Health Service underwent the ACHS accreditation survey against the ten national standards in March 2015. A total of 209 core actions were required to be met to renew accreditation and the staff and management were dedicated to achieving the ten *National Safety and Quality in Healthcare Standards* across the two hospitals and mental health service. ACHS accreditation will remain current until August 2018.

New $5.185 million teaching and training facility

Located at the Alice Springs Hospital site, the soon to be completed facility enables staff to be trained using state-of-the art technology to replicate real emergency situations. Staff and visitors will reap the benefits of the new building which will include a 100 seat theatre as well as a clinical skills training room and two 25 seat tutorial training rooms. Two video conferencing rooms, a student work area, offices and reception area will complete the centre. The new facility, which is expected to be completed by August 2016, will mean that local people undertaking post-graduate studies can work and learn in Central Australia without having to travel interstate.

New model of care for renal services

In February 2016, the first cohort of enrolled nurses commenced a pilot program as part of a new model of care for renal services in Central Australia. With the NT experiencing the highest incidence renal disease in Australia and renal services provided by CAHS growing exponentially over the last seven years, this innovative program has been introduced to help drive efficient service delivery.

A review of the nursing model at the Flynn Drive Renal Dialysis Unit has created the opportunity to employ enrolled nurses under a pioneering training scheme to become competent in the delivery of dialysis. This program will have significant impact in terms of the opportunities for enrolled nurses to expand their skills and scope of practice as well as becoming a model of care for the CAHS renal services. This initiative will go a long way towards meeting the increase in renal service activity with improved staffing and reduction in overtime costs. The demand for renal services is predicted to continue to grow by at least 4.5 per cent per annum in Central Australia so the enterprise will allow for greater mobility of the renal registered nurse workforce across the health service.

Midwifery Group Practice in Tennant Creek leads to improved uptake of antenatal and postnatal care

The Tennant Creek Midwifery Group Practice (MGP), established in 2014, works in collaboration with the Alice Springs Hospital Maternity Services and has partnerships with the Alice Springs Hospital Maternity Unit, Anyinginyi Health Aboriginal Corporation and Tennant Creek Hospital. The MGP models of midwifery care are culturally responsive, aligned with regional consumer need and have proven to be cost-effective. During 2015-16 the service expanded and currently includes three midwives and an Aboriginal health practitioner, supporting women in Tennant Creek and the surrounding Barkly region. Flexible, culturally responsive service delivery and transport options have reduced the barriers of access to mainstream services that can be experienced by Aboriginal women and has resulted in improved health outcomes for both mothers and babies.

Increase in Indigenous Workforce

CAHS has increased the average number of Aboriginal people employed in the service to 7.6% of the total full-time equivalents, compared with 6.1% in the previous financial year. In January 2015, a Special Measures Plan was implemented across NT Health and in the 12 months since then, CAHS has employed 30 Special Measures applicants, at an average of 12.5% of advertised vacancies. It is anticipated that numbers will continue to increase, resulting in increased workforce diversity and employment opportunities for Aboriginal people. A range of Aboriginal workforce strategies are in place to encourage and enable young Aboriginal people to participate in programs that support health career pathways, including Indigenous cadetships, school-based and full-time traineeships, career information tours, work experience opportunities and participation in career expos and school visits.


Alice Springs Hospital
Heartbeat
2015-16
Year at a Glance
The Alice Springs Hospital is dedicated to providing high quality, timely and compassionate healthcare to our community. Heartbeat provides you with a quick snapshot of our achievements and activity for 2015-16.
Activity
111,047 bed days
44,429 presentations - Emergency Department
794 births
3,288 Elective Surgery procedures
5 Clinical Redesign projects
75,617 Outpatient appointments
30,732 dialysis treatments
540 Meals on Wheels prepared
Pharmacy
613,435 prescriptions dispensed
Switchboard
1,300 daily incoming calls Monday-Friday
Kitchen
219,000 meals
55% reduction of long stay patients
Alice Springs staff wins 4 of 13 2016 Nursing & Midwifery Excellence Awards
NT Nursing/ Midwife of Year awarded to Diana Baseley
Anerle-aneme Apmere Meeting Place opened
Introduction of Electronic Patient Journey Board
4.48% of employees identify as Indigenous
NORTHERN TERRITORY GOVERNMENT

Healthy School Age Kids - A new model for providing health checks to 5 to 14 year olds

The *Healthy School Age Kids (HSAK) Care Plan* commenced in February 2016 and is being trialled in 27 remote communities in the Central Australia and Barkly regions, with 1700 children aged 5 to 14 years involved in the program. The HSAK program aims to improve the quality of health services provided to school age children, improve their health and wellbeing, facilitate early identification and treatment of risk factors for preventable chronic conditions, increase the number of school age children having a health assessment and improve the quality and effectiveness of health status information shared with schools. The HSAK program is person-centred and involves parents and carers, medical practitioners, remote area nurses and Aboriginal health practitioners. Health checks are scheduled into the child's electronic health record to ensure that children have a health assessment whether they spend time away from community, don't attend school or attend boarding school.

Valiant effort following severe storm damage in Alice Springs

CAHS experienced an eventful end to the 2015-16 financial year. June 2016 saw the finalisation of the SDA, the Legislative Assembly Estimates Committee hearings, setting the 2016-17 Operational Budget and ongoing fire rectification works. In addition, CAHS had to contend with challenges resulting from a very severe hail and rain storm in Alice Springs on 17 June 2016. Alice Springs Hospital suffered minor flooding in the main ward – a relief, given the extent of fire rectification works being undertaken. There was water ingress to the surgical, paediatric and renal units, however no patients were impacted. The following day saw full functioning restored to these areas due to the magnificent efforts of hospital staff. The rehabilitation and allied health building was damaged by significant water coming through the ceiling. The leadership team of the Alice Springs Hospital, General Manager and Executive deserve recognition for the professional, effective and efficient approach to this emergency. Equally, the effort of CAHS staff is acknowledged in quickly and effectively activating their emergency response plans to ensure business continuity was maintained.

Reduction in elective surgery wait times

CAHS has seen a significant reduction in patients waiting longer than the clinically recommended time for elective surgery in 2015-16. Figures from May 2016 indicate a decrease in the number of long wait patients by 40% since July 2015. Of particular note is ophthalmology where there has been a 69% improvement, from 114 in July 2015 to 35 people in May 2016. These reductions have been achieved through the implementation of business improvement initiatives.

Central Australia shines in Nursing and Midwifery Excellence Awards

The annual Nursing and Midwifery Excellence Awards recognise the outstanding contribution nurses and midwives provide in the delivery of health care across the Northern Territory. This year an unprecedented eight out of 13 awards were presented to CAHS nurses and midwives, including the overall honour of Nurse/Midwife of the Year, which was awarded to Alice Springs midwife and community advocate, Diana Baseley. CAHS congratulates all its award recipients.

Financial sustainability

CAHS has achieved a net operating surplus (excluding revenue/unfunded depreciation) while delivering agreed SDA performance targets and servicing the community. This is the result of the successful implementation of operational controls and efficiencies, budgetary controls and a continued focus on process improvement initiatives. In addition, the 'bottom up /top down' budget development process ensures well-researched, transparent budgets owned by all. This is supported by a comprehensive reporting framework which is strengthening collaboration, awareness and unity in financial sustainability.

Strategic priorities 2016-17

In accordance with the *CAHS Strategic Plan 2014-17*, the following activities and initiatives have been identified as priorities for 2016-17.

Strengthening our workforce culture through educating and retaining a suitably skilled and culturally sensitive workforce by:

- reducing staff turnover
- reviewing work-life balance strategies and developing flexible retention packages
- developing strategies designed to promote 'growing our own'
- enhancing pre-employment and workplace induction processes
- increasing the number of Aboriginal staff employed and level of support provided
- increasing the number of staff receiving cultural safety education.

Improve integration within the Central Australia Health Service by:

- designing, implementing and evaluating a range of specific projects underpinned by evidence-based principles of effectiveness
- improving gastroenterology clinical pathways between specialists and primary health care referrers
- co-locating primary health care and hospital services at Tennant Creek Hospital, with the aim of improving and integrating primary health care service delivery and health outcomes for people in the Barkly region
- establishing an integrated governance mechanism for CAHS AOD services to set the strategic direction for the scope of AOD services delivered by CAHS, improve communication between internal and external AOD providers and strengthen pathways between acute, non-acute and community-based AOD services
- addressing the transition from paediatric team to adult medicine team for respiratory patients in Alice Springs Hospital through the utilisation of a respiratory register and development of a clear transition pathway for horizontal integration between paediatricians and physicians.

Improving early childhood health by developing health care services for children 0-3 years, preventing chronic disease later in life and reducing financial burden on the health service by:

- providing strategic advice and recommendations in the planning and development of CAHS' health care programs and services
- reviewing CAHS' direction and strategies for early years (0-3) health care
- identifying, evaluating and recommending strategies to achieve consistent, evidence-based approaches to early years (0-3) health care.

Reducing the burden of renal disease in Central Australia by:

- establishing governance-level oversight of all renal activity within CAHS through establishment of the CAHS Renal Strategy Group
- ensuring that a strategic perspective on renal service delivery is maintained under the direction of the CAHS Renal Strategy Group
- development of the 2017-18 business case to increase the coordination of renal resources, reduce duplication of services and activities, and increase CAHS' capacity to strategically divert resources towards the prevention and early intervention stages of renal disease.

Achieving better health outcomes for our community through meaningful engagement with and better understanding of our stakeholders by:

- ensuring compliance with the NSQHS Standard 2 – Partnering with Consumers
- developing, implementing and managing the *CAHS Stakeholder Engagement Framework*, *Communications Plan* and Communications matrix
- increase participation of Aboriginal people and organisations in consumer feedback
- increase participation of non-government organisations (NGOs) and other stakeholders in forums.

Continued focus on financial sustainability by:

- furthering exploration and implementation of strategies to maximise revenue generation
- designing services that minimise cost and maximise value for money through effective preventative approaches and maximising continuity of care
- continuing to support and develop business planning, management and reporting capabilities within the health service.

Our leaders

Central Australia Health Service Board

The Central Australia Health Service Board (left to right) Damien Ryan (Chair), Kerry Delahunty, Prof John Wakerman (Deputy Chair), Graham Symons, Dr Christine Lesnikowski, Nardine Collier, Edward Fraser

Damien Ryan,

Central Australia Health Service
Board Chair since 1 July 2014

Damien was born in Alice Springs and has extensive business experience in Central Australia. Before his appointment as Chair of the CAHS Board, he was appointed a member of the Central Australian Hospital Network Governing Council on 29 June 2012. He is currently Mayor of Alice Springs, President of the Local Government Association NT and a member of the Australian Local Government Association. He is a NT Grants Commissioner, a board member of Regional Development Australia NT, co-chair of the Outback Way Development Council, member of the Alice Springs Alcohol Reference Panel, and Vice-President of the Finke Desert Race Committee.

Damien is a member of the CAHS Board's Governance Committee, Finance Risk and Audit Committee, Health Outcomes Committee and Strategic Workforce Committee. He is the Board Champion for the Consumer Participation Project Group.

Professor John Wakerman,

Central Australia Health Service
Board Deputy Chair since 1 July 2014

John is the Associate Dean of Flinders University, Northern Territory. He is a public health medicine specialist and general practitioner. He has specific academic interests in remote health services research and remote health workforce education and training. He also has a strong interest in using evidence based advocacy related to rural and remote health issues. He was appointed to the Central Australian Hospital Network Governing Council on 30 June 2012 and remained a member until the introduction of the CAHS Board on 1 July 2014.

John is currently Chair of the CAHS Board Health Outcomes Committee. He is also a member of the Strategic Workforce Committee and Board Champion for the CAHS Renal Strategy Group.

Dr Christine Lesnikowski,

Central Australia Health Service
Board Member since 1 July 2014

Christine is a general practitioner (GP) and a medical educator. She first moved to the Northern Territory in 1992 and has lived, worked and trained in remote Central Australia, Alice Springs, Katherine and Darwin in a variety of settings from public hospitals and remote community health clinics to private GP clinics. She is a Fellow of the Royal Australian College of General Practice and has a strong interest in primary health care for all across the rural and remote settings. Christine holds a Bachelor of Medicine, Bachelor of Surgery, Bachelor of Science (Biochemistry) and a Graduate Certificate GP Psychiatry. She was appointed to the Central Australian Hospital Network Governing Council on 19 August 2013, a position she held until being appointed to the CAHS Board on 1 July 2014.

Christine is currently the Chair of the CAHS Board's Governance Committee and Private Practice Fund Administration Committee, and Board Champion for the Integrated Care Project Group.

Graham Symons,

Central Australia Health Service
Board Member since 1 July 2014

Graham joined the Northern Territory Public Service in 1984 and has held a number of chief executive and deputy chief executive positions. He worked in the Department of Health for eleven years in various roles; Deputy Chief Executive, Executive Director Top End Health and Community Services, and Head of Policy and Operations for all non-hospital health and community services. He has extensive experience as a director on public sector and not-for-profit boards. Graham holds tertiary qualifications in science, social administration and business.

Graham currently chairs the CAHS Board Strategic Workforce Committee, is a member of the Board's Finance, Risk and Audit Committee and the Department of Health Risk and Audit Committee. He is Board Champion for the Educate and Retain a Skilled and Culturally Sensitive Workforce Project Group.

Edward Fraser,

Central Australia Health Service
Board Member since 1 July 2014

With a strong background in health administration, Edward has worked as a health executive in acute services in three different countries. He has worked as a health executive in primary health care and in government health funder and system design roles. He has also provided research and customer service strategy for non-profit agencies and the private sector in Australia and Qatar and has executive experience in local and state government. Edward was the Chief Administrator of the Qatar National Primary Care Service System for six years which provided services including the National School Health Program and the National Maternal Child Health Program. He also led Qatar's health system reform by strengthening the national primary health care system and establishing the National Primary Health Corporation. He was appointed to the Central Australian Hospital Network Governing Council on 19 August 2013 until his appointment to the CAHS Board.

Edward currently chairs the CAHS Board's Finance, Risk and Audit Committee and is Board Champion for the Early Years (0-3) Business Initiative Project Group.

Kerry Delahunty,

Central Australia Health Service
Board Member since 1 July 2014

Kerry moved to Alice Springs from Adelaide in 1985 and took up employment at the Bindi Pre-Vocational Centre teaching office skills to adults with intellectual disabilities. When she left the centre to set up her own business she continued her association as a member of the Bindi Board of Management. When some time later the organisation separated the employment arm of the business from the residential services division which then became Casa Central Australia, she took up the position of chairperson on the Casa Board of Management, a position she held until she resigned in 2006. Over the years, Kerry and her husband have owned and operated five businesses and she has always been heavily involved in advocacy for people with disabilities.

Kerry is a member of the CAHS Board's Governance and Strategic Workforce Committees and is Board Champion for the Early Years (0-3) Business Initiative Project Group.

Nardine Collier,

Central Australia Health Service
Board Member since 3 March 2015

Nardine is an Alice Springs lawyer with 26 years' experience in law. She has run her own legal practice for the past five years; prior to this, she was a partner of a law firm. She has extensive experience in many areas of law, primarily work health, civil litigation and family law. She obtained her specialist accreditation in family law in 1999 and has a Masters in Applied Law (Family Law) through the College of Law, Sydney. Nardine has appeared extensively in the Family Court, Work Health Court, Local Court and the Supreme Court as both a barrister and solicitor. She is also a trained mediator and arbitrator. Nardine is the Deputy President of the Racing Appeals Tribunal, a sessional member of the NT Courts and Tribunal, and the Legal Practitioners Disciplinary Tribunal.

Nardine is a member of the CAHS Board's Governance Committee and Strategic Workforce Committee and is Board Champion for the Educate and Retain a Skilled and Culturally Sensitive Workforce Project Group.

CAHS Board meeting attendance is outlined in the table below.

Board meeting attendance 2015-16

Board Member	Meetings Attended*
Damien Ryan	9
John Wakerman	10
Christine Lesnikowski	10
Graham Symons	9
Edward Fraser	9
Kerry Delahunty	9
Nardine Collier	9

*A total of 10 meetings were held in the 2015-16 financial year

Board Activities 2015-16

In 2015-16, the CAHS Board focussed on the identification of service gaps, capability assessment and the need and demand for health services in the region. Activities included reviewing current health service capabilities, identifying emerging areas of need and ensuring resources are being directed to those priority areas of need.

The Board has continued with five sub-committees. These include the Finance, Risk and Audit Committee, Governance Committee, Health Outcomes Committee, Strategic Workforce Committee, and the Private Practice Funds Administration Committee. These committees met regularly throughout the year and are pivotal in providing strategic direction to CAHS. In addition to these committees, five strategic project groups were established in September 2015 in order to focus on specific business priority areas. Board Champions have been allocated to each of the five project groups: Educate and Retain a Skilled and Culturally Sensitive Workforce, Integrated Care, Early Years (0-3), Renal Strategy and Consumer Participation.

The CAHS Board continued to meet regularly with the TEHS Board and jointly with the Minister for Health in order to fulfil its statutory requirements.

The Board also met regularly with the Barkly Regional Consumer Advisory Group and conducted four consumer forums, with two held in Alice Springs and two in Tennant Creek. In addition, the Chair and Executive Officer have attended meetings with local authority groups, and health related non-government organisations within the Central Australian region.

Board Committee meeting attendances 2015-16

(expressed as meetings attended/meetings held)

Board Member	Finance Risk and Audit Committee	Governance Committee	Health Outcomes Committee	Strategic Workforce Committee
Damien Ryan	3/8	7/9 Chair	3/6	8/9
John Wakerman	-	-	6/6 Chair	6/9
Christine Lesnikowski	-	9/9	-	-
Graham Symons	7/8	-	-	7/9 Chair
Edward Fraser	7/8 Chair	-	-	-
Kerry Delahunty	-	8/9	-	5/9
Nardine Collier	-	1/3 (appointed in March 2016)	-	2/9

Executive team

Sue Korner,

Chief Operating Officer

Sue Korner is a long term Alice Springs local with a wealth of experience having worked in leadership roles in the health sector – including acute, public health and primary health care – in Central Australia for more than 29 years. Sue brings to the role of Chief Operating Officer (COO), a strong understanding of the health care needs and expectations of Central Australians. Appointed to the role in September 2014, Sue has responsibility for ensuring successful health service delivery in Central Australia. Prior to moving into the role of COO, Sue was Acting CEO of the Northern Territory Medicare Local (now Northern Territory PHN). She has held a number of senior positions within the Department of Health including Central Australia Health Services Regional Director, and served as CEO for the Central Australia Division of Primary Health Care and also as CEO of General Practice Network Northern Territory. Sue was a member of the Central Australia Hospital Network Governing Council and the CAHS Board until her appointment as COO. She is a graduate of the Northern Territory University NT Public Sector Executive Management Program and is a member of the Australian Institute of Company Directors.

The Chief Operating Officer position reports to the Central Australia Health Service Board and the Department of Health Chief Executive

Anubis Pacifico,

Chief Finance Officer

Anubis brings extensive expertise in financial and commercial management, strategic planning, governance and in leading performance improvement in complex environments. Anubis has held a number of senior executive roles including five years as Executive Director Corporate and Chief Finance Officer at Latrobe Community Health Service in Victoria and a significant period as a senior executive with Telstra. In recent years she served as a Director and Chair of Lifeline Gippsland Board.

Anubis holds a Masters of Business Administration, Bachelor of Business (Accountancy), Graduate Diploma in Applied Finance and a Graduate Diploma in Applied Corporate Governance. She is a Fellow of the Certified Practising Accountants of Australia, Fellow of the Institute of Chartered Secretaries and Administrators, Graduate of the Australian Institute of Company Directors, and an Associate Fellow of the Australasian College of Health Service Management.

The Chief Finance Officer is responsible for the financial management, strategic business planning and related corporate governance of CAHS, reporting directly to the COO.

Naomi Heinrich,

General Manager, Alice Springs Hospital

Naomi comes to the role of General Manager of the Alice Springs Hospital with more than 20 years' experience in the health care sector, primarily in acute public health. She has also had extensive corporate experience in the health sector and was the Principal Project Nurse with the South Australian Department of Health. She has held the roles of Nursing Director Corporate Nursing and Nursing Director Emergency and Perioperative Medicine Division at Flinders Medical Centre. Her most recent role was Associate Director with KPMG providing health consultancy within the Australian Government advisory team. She is a Registered Nurse with a Masters in Nursing Science and Bachelor of Nursing.

The General Manager of the Alice Springs Hospital is responsible for providing operational oversight of the hospital and reports to the COO.

Dr Samuel Goodwin,

Acting Executive Director – Medical and Clinical Services

Samuel took on the role of acting Executive Director of Medical and Clinical Services in November 2014. Prior to taking on his current role, he was Acting General Manager of the Barkly Region and Tennant Creek Hospital. He was Deputy Director of Medical and Clinical Services at Alice Springs Hospital. Samuel holds a Bachelor of Medicine, Bachelor of Surgery and a Master of Public Health and Tropical Medicine. He is a Fellow of the Australian College of Rural and Remote Medicine and a Graduate of the Australian Institute of Company Directors. Samuel maintains his clinical practice through his role as a rural generalist at Tennant Creek Hospital, a GP anaesthetist in Alice Springs Hospital and a mainstream general practitioner.

The Executive Director Medical and Clinical Services has professional responsibility for all medical practitioner positions operating under CAHS and has line management responsibility for those at Alice Springs Hospital.

Carol Farmer,

General Manager Primary Health Care

Carol came to the role of General Manager Primary Health Care, following over 30 years' experience in the health care sector, primarily in acute public health in New South Wales. Prior to her appointment in Central Australia, Carol worked in a number of executive and senior management positions including General Manager, A/Executive Director and Director of Nursing and Midwifery Services.

Carol is a Registered Nurse with a Master of Health Service Management, Executive Master of Public Administration, Coronary Care Certificate and a Bachelor of Nursing. In 2014, Carol was appointed as an Honorary Clinical Associate Professor with the Australian Catholic University in recognition of her extensive commitment to nursing education and professional development. In January 2016, Carol assumed the role of Chief Nursing and Midwifery Officer for three months with whole of NT responsibility. Carol is an Australian Council on Healthcare Standards (ACHS) accreditation surveyor and has surveyed extensively across Australia and overseas.

The General Manager, Primary Health Care is responsible for planning, coordinating and overseeing the delivery of multi-disciplinary primary health care services and integrated public health programs across rural, remote and culturally diverse regions and reports to the COO.

Ruth Heather,

General Manager, Barkly Region

Ruth is the General Manager, Barkly and is responsible for Acute, Primary, Mental Health and other community health services in the Barkly Region. She is a trained Nurse and Midwife and holds a Masters of Development Studies, Post Graduate Diploma of Health Management, Certificate in Program Management and is a Prince2 Project Management Practitioner. She has held senior management positions for more than 10 years and has worked extensively within the health and social justice sectors for District Health Boards, Government agencies and non-profit organisations.

Peter Thornton,

General Manager, Mental Health

Peter has over 40 years' experience in the mental health field. He commenced his training in intellectual disabilities in 1976 and was registered as a Mental Nurse in 1979. In the early '80s he completed his Psychiatric Nurse training at Larundel Psychiatric Hospital in Melbourne. During this time he also completed a Diploma of Applied Science in Community Health Nursing. In more recent times Peter successfully completed the Executive Leadership Program. Peter is currently registered as a Psychiatric Nurse and is a member of the Australian Congress of Mental Health Nurses.

Ross Carter,

A/General Manager, Alcohol and Other Drugs Services

Ross has been a Registered Nurse for over 30 years and has held both Clinical and Executive Management positions throughout Australia and overseas. He has worked in the public and private sectors and with non-government organisations, including the International Committee of the Red Cross based in Afghanistan.

The General Manager of Alcohol and Other Drugs Services provides a high level of operational management and coordination to the delivery of both a voluntary alcohol, tobacco and other drugs clinical and education service and a secure assessment and treatment facility. The position ensures services operate within the Northern Territory Alcohol Mandatory Treatment Program, the Alcohol Mandatory Treatment Act 2013 and the Volatile Substance Abuse Prevention Act 2006.

Melissa Brown,

A/Executive Director of Nursing and Midwifery

Melissa assumed the role of acting Executive Director of Nursing and Midwifery in November 2015. She has held a number of key roles within Alice Spring Hospital over the past 24 years, including Clinical Nurse Manager, Nurse Resource Coordinator, Safety and Quality Manager and Nursing Director. Mel is a Registered Nurse and holds a Graduate Diploma in Health Service Administration. She is currently completing a Master of Health Service Management.

The Executive Director Nursing and Midwifery Services manages Nursing and Midwifery Services within the Alice Springs Hospital and provides professional Nursing and Midwifery leadership direction across the Central Australia Health Service.

Larissa Ellis,

Director of Allied Services and Aged Care

Growing up in Alice Springs, Larissa returned to Alice upon completion of her Bachelor of Social Work and has been working as a social worker in the Central Australia region since 1996. During that time she held senior positions with Department of Children and Families and the Alice Springs Correctional Centre. Larissa was Manager of the Alice Springs Hospital Social Work Department from 2010 to 2014 and was appointed to the position of Director Allied Health and Aged Care at Alice Springs Hospital in December 2014.

The Director of Allied Health and Aged Care is responsible for ensuring the effective and efficient delivery of these services to the Central Australian community.

Louise Dennis,

A/Director of Aboriginal Health Practitioners

Louise has been employed as an Aboriginal Health Practitioner in Central Australia for 17 years. She has worked in the non-government acute and primary health care sectors and is a senior member of the Primary Health Care Multidisciplinary Management Team. Louise has Aboriginal Health Practitioner qualifications and holds a Bachelor of Arts. In 2011-12 Louise was a board member of the NT Aboriginal Health Worker Registration Board prior to the transition to national registration in 2012.

The Director of Aboriginal Health Practitioners is responsible for providing professional leadership, support and direction to the Aboriginal and Torres Strait Islander Health Practitioner workforce and other relevant stakeholders across the Central Australia Health Service

Carol Cartwright,

Director Workforce Services

Carol has worked in the Northern Territory Public Service since 1977 and whilst she has worked in various areas and departments, the majority of her time has been spent with the Department of Health. Most positions held have been predominantly in the field of human resources including payroll, education and training, employee relations, case management and early intervention, recruitment and work health and safety together with workers compensation claim management. Carol has also worked in corporate and business service management, regional coordination and remote health operational management.

The Director Workforce Services is responsible for providing comprehensive Human Resource programs, services, strategic advice and support to managers and staff of the Central Australia Health Service.

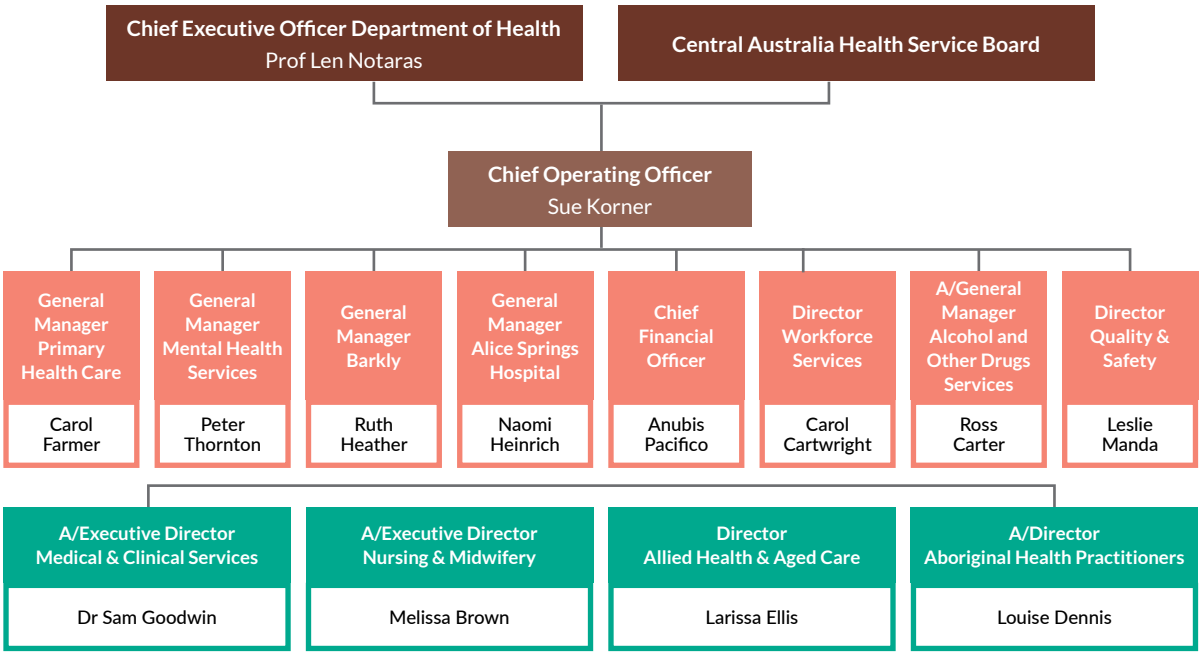
Leslie Manda,

Director of Quality and Safety

Leslie has extensive audit, risk and leadership experience, complimented by change management expertise. Leslie holds a Bachelor of Commerce in Accounting (Honours), Executive Certificate in Voluntary Sector Leadership and is concurrently studying towards a Master of Public Administration and a Certified Practising Accountant certificate. Leslie has the following professional designations: a Professional Member of the Institute of Internal Auditors (PMIIA), a Certified Management System Practitioner (CMSP), a Certified Lean Sigma Six Green Belt and a Certified Lead Auditor.

The Director Quality and Safety is responsible for leading and guiding the Central Australia Health Service to meet the Australian Commission on Health Care National Standards for Health Care together with the provision of accreditation, risk management and governance advice and reporting.

CAHS Executive Leadership Team



Health Service structure

CAHS Board is a statutory body under the Northern Territory *Health Services Act 2014*. Its role is to ensure the provision of health services in Central Australia as outlined in the Service Delivery Agreement with the Department of Health.

The legislated roles and responsibilities of the Board include:

- governance of the service
- provision of strategic direction for the service
- monitoring the performance of the service against the Service Delivery Agreement
- engaging and working collaboratively with key stakeholders
- community leadership functions including promoting ethical behaviour, promoting appropriate culture and values of the service
- leading community engagement by the service
- understanding the health needs of its region
- leading systemic improvements in communication between the service and its community.

CAHS Service encompasses Alice Springs Hospital, Tennant Creek Hospital, Primary Health Care, Mental Health and Alcohol and Other Drugs services.

The Central Australia region covers 64.7% (872 861 km2) of the total NT geographical area and includes Alice Springs, Tennant Creek, and major communities including Elliott, Yuendumu, Kaltukatjara (Docker River), Alpurrurulam (Lake Nash), Ali Curung and many more discrete Aboriginal communities.

As at June 2015, Central Australia had an estimated resident population of 49 270 people, representing 20.1% of the total NT population. Around 60% of the Central Australia population lived in Alice Springs and a further 7.5% lived in Tennant Creek. The remainder of the population live in discrete remote communities and outstations. The Aboriginal population is 43.8% (21 570) of the total Central Australia population.

Major hospitals and services

Alice Springs Hospital

Alice Springs Hospital (ASH) has emergency and outpatient departments and a 183 bed capacity. Services offered at ASH include general medicine, rehabilitation medicine, palliative care, nephrology, emergency medicine, anaesthesia, intensive care, surgery (including ophthalmology, orthopaedics and ear, nose and throat), psychiatry, paediatrics, obstetrics and gynaecology. It is responsible for renal dialysis with 26 chairs in operation at the Flynn Drive Community Health Centre and 20 chairs outsourced to NephroCare. It also has a medical imaging and pathology facility as well as hosting visiting specialists. ASH is a teaching hospital with a strong focus on Aboriginal health and infectious diseases.

Tennant Creek Hospital

Tennant Creek Hospital is a 20 bed hospital with emergency and outpatient departments. It offers a range of clinical, diagnostic and support services, including visiting general medicine, cardiology, renal, surgical and paediatrics specialists, general practice clinic, minor operations, medical, paediatric and minor surgical inpatient services, and allied health outreach services. The hospital has a 12 chair renal dialysis capacity. The Tennant Creek Midwifery Group Practice, established in 2014, works alongside and in collaboration with Alice Springs Hospital Maternity Services. It has partnerships with the local Aboriginal medical service, Anyinginyi Health Aboriginal Corporation, the Tennant Creek Hospital and the Alice Springs Maternity Unit.

Aboriginal Liaison Officer Anthony David with patient Gregory Ladd

Primary Health Care

Primary health care provides health services in both urban and rural settings throughout Central Australia and the Barkly region. Services include the provision of general medical practitioners, oral and hearing health, food and nutrition services, adult and child health checks, breast and other cancer screening services, palliative care, school health, home birthing services, health education and promotion, and health services at the Alice Springs Correctional Centre.

Primary health care services are provided in the remote communities listed below. These services include accident and emergency response, primary health care, ante natal care, healthy school aged kids program, healthy under 5 kids program, childhood and adult immunisation, well women's and men's health screening, preventable chronic conditions program, and infectious diseases prevention and control.

Remote health centre locations:

- Ali Curung
- Haasts Bluff (Ikuntji)
- Hermannsburg
- Finke (Aputula)
- Nyrripi
- Willowra
- Yuendumu
- Titjikala
- Ti Tree (6 Mile)
- Alcoota (Engawala)
- Canteen Creek
- Lake Nash (Alpurrurulam)
- Docker River (Kaltukatjara)
- Harts Range (Atitjere)
- Kings Canyon (Watarrka)
- Imanpa
- Papunya
- Yuelamu
- Yulara
- Tara
- Elliott
- Epenarra
- Laramba
- Mt Liebig (Amunturrngu)

Visiting primary health care services and accident and emergency response is provided to the following remote communities:

- Wilora (visiting services from Tara)
- Bonya (visiting services from Harts Range)
- Wallace Rockhole (visiting services from Hermannsburg)

Mental Health

Central Australia Mental Health Services is a specialist mental health clinic and provides a multi-disciplinary approach to treatment and therapeutic intervention for people in Central Australia who are experiencing a mental illness or mental health problem. This includes assessment, treatment and clinical interventions to clients of all ages in urban and remote communities. Central Australia Mental Health Services also develops prevention, promotion and early intervention strategies in collaboration with other agencies, using a recovery model. The Mental Health Program works across a range of local and national priority areas. It works in partnership with other health services, clinicians, consumers and their carers in order to tailor mental health services that provide the best outcomes for Central Australians.

Specialist integrated mental health services are delivered involving community based adult, child, youth, sub-acute and forensic services as well as inpatient services. These include:

- inpatient assessment, management and treatment of psychiatric presentations, in facilities co-located with the Alice Springs Hospital
- consultation liaison service to the wards of Alice Springs Hospital
- consultation, assessment, referral and treatment services, in the community
- short-term and on-going case management, including sub-acute
- specialist child and adolescent and forensic services
- life promotion services
- consultation liaison service to rural and remote primary health care providers
- a sub-acute facility providing short term residential treatment services with a rehabilitation and recovery focus.

Clinical Nurse Tim Jacobs with Gary Reilly

Alcohol and Other Drugs Services

Alcohol and Other Drugs Services provide confidential treatment and intervention services for individuals and families experiencing substance misuse problems. The service operates within a multidisciplinary team process using a case management model.

Clinical staff and client treatment options are guided by the Clinical Management Team process. The specialist clinical services treatment pathways include: triage and brief intervention, assessment, case management, withdrawal, opioid pharmacotherapy program, volatile substance abuse management and treatment, clinical liaison team, and Alcohol Mandatory Treatment assessment services located at Kywimpere House in Alice Springs.

The Australian Government-funded remote Alcohol and Other Drugs workforce program has the primary role of developing a workforce dedicated to delivering primary health care Alcohol and Other Drugs services to remote Aboriginal communities in the Northern Territory.

Strategic planning framework and directions

The *CAHS Strategic Plan 2014-17* has been developed to guide the activities and priorities of the Health Service at all levels during its first three years of operation. The strategies translate and integrate with the priorities and strategic directions of the Department of Health, aligning the focus of CAHS with Territory wide health system planning, and building a platform for a cohesive and integrated approach to delivery of health services across the NT.

CAHS' strategic goals for 2014-17 address challenges and opportunities faced in the delivery of health services in Central Australia. They are also a framework to drive a realignment of service models and performance which will reshape the way health services are delivered within CAHS and across the NT.

The *CAHS Strategic Plan 2014-17* is built on the foundation of six strategic directions that will drive the efforts and priorities of CAHS:

1. **Promote equitable access to high quality care for our community**
2. **Build a sustainable, well-coordinated and integrated health care system that enhances health outcomes**
3. **Educate and retain a suitably skilled and culturally sensitive workforce**
4. **Continue to improve through evidence-based practice**
5. **Engage and partner with our community to improve health outcomes**
6. **Build a financially sustainable service**

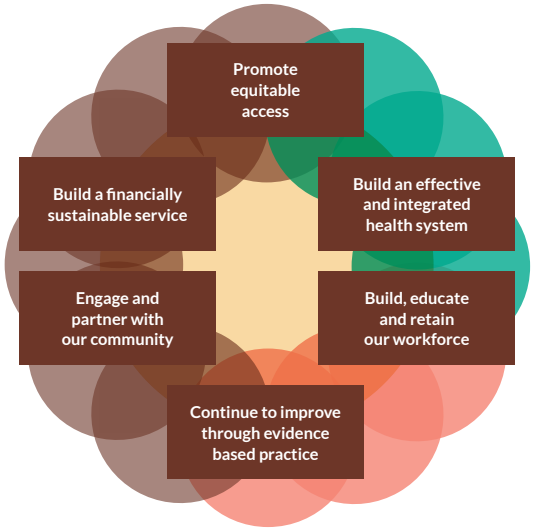
Service Delivery Agreement

The Service Delivery Agreement (SDA) outlines the responsibilities and accountabilities of the Minister for Health, the Department of Health as System Manager and CAHS in the delivery of the services to be purchased under the agreement.

Key elements of the agreement are the:

- specification of services to be delivered by CAHS
- funding to be provided for the delivery of these services
- measures against which the performance of the terms of the agreement will be assessed
- processes for the management of the agreement.

The success of this agreement depends on a strong commitment by CAHS, the CAHS Board and the System Manager to work together to achieve the best health outcomes from available resources.



Clinical governance

Safety and quality

CAHS is committed to the continued improvement of patient safety and quality health care services through the deployment of a comprehensive clinical governance process, providing a systematic approach towards the attainment of targets set out in the CAHS Service Delivery Agreement (SDA). CAHS clinical governance structures provide advice and report on:

- serious incidents, coronial investigations, trend analysis of events and implementation of recommendations
- health service performance monitoring against SDA safety and quality indicators and action towards recommendations necessary to improve patient safety
- workforce credentialing.

Perioperative nurse Hazel Walton (left) with Dennis Bielby and nurse Jolly Varghese

Hand hygiene

Hand hygiene is one of the most important measures in reducing the transmission of health care associated infections. CAHS continues its implementation of the National Hand Hygiene Initiative with the aim to:

- consistently measure and improve hand hygiene compliance statistics
- reduce the rates of healthcare associated infections
- embed hand hygiene and infection control as part of the day to day practice within the health service.

Safety and quality

Safety and quality key performance indicators are outlined in the CAHS SDA.

	Actual				2015-16		2016-17 Target
	2011-12	2012-13	2013-14	2014-15	Target	Actual	
Safety and Quality							
Staphylococcus Aureus Bacteraemia (SAB) Infections[1]	0.79	0.54	0.97	0.50	0.92	0.25	0.92
Hand hygiene compliance	n/a	73.4%	69.6%	69.5%	70.0%	79.1%	75.0%
Potentially preventable hospitalisations[2]	n/a	6.8%	6.9%	7.4%	9.6%	5.7%	9.1%
Discharge summaries dispatched within 48 hours[3]	n/a	n/a	n/a	n/a	n/a	n/a	95%
Inpatients who discharged from hospital or left hospital against medical advice[3]	n/a	n/a	n/a	n/a	n/a	n/a	9.4%

[1] Revised data for 2014-15, previously only reported until May 2015.

[2] Historical data reprocessed due to new definition of PPH.

[3] New measure in SDA.

Access

The following access indicator is outlined in the CAHS SDA.

	Actual				2015-16		2016-17 Target
	2011-12	2012-13	2013-14	2014-15	Target	Actual	
Access							
Telehealth occasions of service[1]	n/a	n/a	n/a	n/a	n/a	n/a	1 150

[1] New measure in SDA.

Incident management

CAHS Board and Executive continue to be ambassadors for the ongoing development and championing of a non-punitive attitude towards incident reporting with a strong focus on learning from adverse events to ensure that all incidents, near misses and shortfalls are reported.

CAHS has an established incident reporting framework with review committees across its divisions to ensure the timely review of incidents and their close reporting and monitoring. This further ensures high risk areas are identified and given the necessary support required to reduce reoccurrence. After an adverse event or incident, CAHS provides support to those affected with the aim to restore confidence in the health service by enabling all parties to participate in an Open Disclosure process. Incidents reported in 2016-16 are listed in the table below according to Incident Severity rating (ISR).

Incident Severity Rating (ISR)

ISR Incidents 2015-16

ISR1 incident is where there is death or permanent loss or reduction of functioning where the person is unlikely to recover from the reduction or loss of function, and it is not as a direct result of their natural disease progression or co-morbidities.	8
ISR2 incident is where there is significant harm or impact on the person/s involved, though any loss or reduction in functioning is temporary and a full recovery to pre incident level is expected, and it is not as a direct result of their natural disease progression or co-morbidities.	47
ISR3 incident is where harm has occurred which may require a higher level of care or observation, but did not have a loss or reduction of function as a result of the incident.	889
ISR4 incident is where harm is minimal and not requiring additional level of care.	1272
ISR5 is an incident that did not cause harm and includes near misses.	1075
Total	3291

Consumer feedback

Complaints

One of the major achievements in the area of complaints management for the period has been an extensive 12 month audit of RiskMan. This audit followed the identification of a compliance issue which showed inconsistencies in the use of RiskMan across CAHS.

Following the audit, a comprehensive follow-up project was implemented to bring all outstanding complaints up to date.

A training package was developed in late 2015 by the Senior Investigation Officer (Office of the COO). Key staff members were provided with intensive training in the use of RiskMan and the correct procedures for ensuring compliance in the recording and resolution of complaints, in keeping with legislative requirements.

Since that training, there has been a significant improvement in compliance throughout CAHS in the recording of both complaints and compliments. The appointment of a dedicated patient advocate at Alice Springs Hospital has also led to vast improvements in both the entering of complaints on Riskman and the timeframes in which they are resolved. Complainants are now receiving acknowledgement of their complaint in the very early stages, and close monitoring has resulted in vastly improved resolution times.

There is still a significant challenge in the area of training for remote staff and, to that end, planning is currently underway to provide a RiskMan training schedule to Primary Health Care staff to ensure there is consistency across the Health Service.

Compliments

There is now a robust system across CAHS for dealing with all consumer feedback, especially in the area of consumer communication. This has also led to a significant improvement in capturing compliments and positive feedback. This was deemed to be especially important to provide a balanced overview of all feedback. Statistics now show a significant increase in the number of compliments provided, giving a more accurate reflection of consumer feedback. Complaints and compliments received in 2015-16 are indicated in the figure below.

CAHS Compliments and Complaints 2015-16

Accreditation

CAHS divisions Alice Springs Hospital, Mental Health and Tennant Creek Hospital attained accreditation to the National Safety and Quality Health Service Standards (NSQHS) in July 2015 and successfully completed their Progress 1 Report in March 2016 as part of the divisions' NSQHS accreditation cycle. The accreditation cycle is for three years with a second progress report due in March 2017 and a re-certification survey in March 2018. All divisions maintained a continued focus on the 10 NSQHS Standards. The benefits of accreditation against the NSQHS Standards include:

- improves the quality of health services provided
- assesses systems in place to ensure that minimum standards of safety and quality are met
- assists in the application of a risk management approach to safety and quality
- provides a means for continuous quality improvement and encourages the health service to achieve and maintain best practice.

Nurse Annette Weacers with Mereana Birkholz

Our people

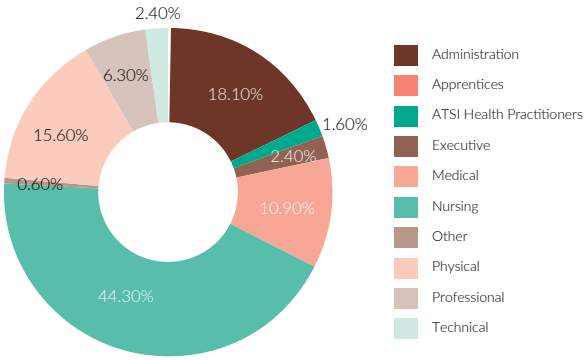
Challenged by growing health service demand and health workforce shortages, CAHS continues to focus on building local capacity and attracting and retaining suitable, experienced staff as paving the way forward to delivering a quality, efficient and effective Health Service.

Workforce profile

At the end of the financial year there were 1699 fulltime equivalent (FTE) staff employed in CAHS. Of these, 44 % (752.86) were classified as nursing staff, 18% (307.69) were administration staff and 1.6% (26.49) were Aboriginal Health Practitioners.

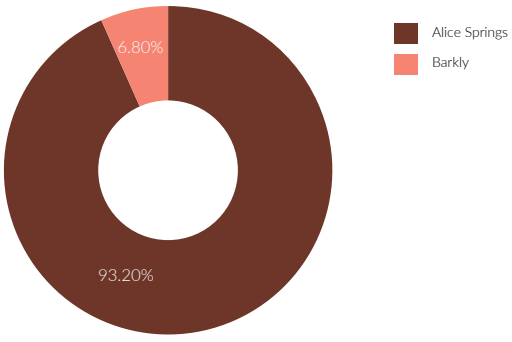
Compared to 2014-15, the increase in staff in 2015-16 is mostly due to the transfer of services from the Department of Health to CAHS, which includes 44.43 FTE staff related to Alcohol and Other Drugs Services. Staff have also been recruited to deliver new community programs made possible by additional Australian Government funding and to fill budgeted positions as part of the progressive recruitment strategy.

CAHS FTE



Note: Figures in the above chart are based on FTE as at final pay period 2015-16 (pay 27).

CAHS FTE by region



Note: Figures in the above chart are based on FTE as at final pay period 2015-16 (pay 27).

CAHS full-time equivalent staff by classification variance from 2014-15 to 2015-16

Classification Stream	2014-15	2015-16	Variation
Administration	266.03	307.69	15.66%
ATSI Health Practitioners	29.2	26.49	-9.28%
Executive	7.6	6	-21.05%
Medical	187.7	184.55	-1.68%
Nursing	710.86	752.86	5.91%
Other	14.86	10.69	-28.06%
Physical	256.41	264.55	3.17%
Professional	106.21	106.77	0.53%
Technical	47.12	40.08	-14.94%
Total	1625.99	1,699.68	4.53%

Outputs and performance

CAHS' financial and activity reporting is based on an output structure as presented in the NT Government's Budget Paper 3 and CAHS SDA.

The defined output groups for 2015-16 are:

- Central Australia Hospitals
- Community Treatment and Extended Care
- Primary Health Care
- Central Australia-Wide Support Services

Central Australia Health Service - Key Performance Indicators

Central Australia Hospitals

Outcome: Improvement and maintenance of the health and wellbeing of those in the community who require acute or specialist care.

Central Australia Hospitals

Provide admitted, non admitted and emergency services.

	Actual				2015-16		2016-17 Target
	2011-12	2012-13	2013-14	2014-15	Target	Actual	
Central Australia Hospitals							
Central Australia Health Service weighted activity units (WAU)[1,2]	n/a	n/a	42 624	45290	49 026	51 090	52 623
Average length of stay[3]	5.0	5.2	4.9	5.1	4.8	4.7	5.2
Elective surgery wait times:[4,5]							
category 1: percentage of patients waiting longer than the clinically recommended time	26.2%	10.7%	26.0%	34.9%	0.0%	24.0%	0.0%
category 2: percentage of patients waiting longer than the clinically recommended time	39.3%	21.4%	22.2%	30.8%	2.4%	29.1%	2.4%
category 3: percentage of patients waiting longer than the clinically recommended time	1.7%	19.3%	18.4%	22.2%	2.4%	15.2%	2.4%
Emergency department presentations departing within 4 hours[5,6]	68.5%	66.7%	66.6%	64.1%	78.0%	63.6%	78.0%

[1] The 2015-16 Budget figure (as at June SDA variation) and Actual figures have been (re)calculated using version 15 of the activity-based funding (ABF) model to enable comparison. The 2016-17 Budget figure has been recalculated in version 15 to reflect projected growth against actual 2015-16 ABF activity.

[2] Activity detail by service stream is available in the relevant service delivery agreement at the Department of Health website: http://health.nt.gov.au/Publications/Corporate_Publications/index.aspx

[3] The average number of days in a hospital for patients who stay at least one night.

[4] Definition reworded.

[5] At the time of publication, the 2016-17 figure mirrored the target for the key performance indicator in the 2015-16 Service Delivery Agreement and was subject to negotiations. Health Services use funding provided to improve the performance to achieve targets.

[6] The variation in 2015-16 reflects the delayed implementation of the short stay Emergency Department at Alice Springs Hospital.

Community Treatment and Extended Care

Outcome: Strengthened capacity of individuals, families and communities to improve and protect their health through strategies and appropriate interventions that minimise harm.

Mental Health

Provide specialist mental health services including assessment, case management and treatment.

Aged Care

Provide services supporting senior Territorians to live in the community, along with hospital care and assessment for residential care.

Alcohol and Other Drugs

Deliver community development, education and training, intervention, treatment and care options to reduce harm attributable to the use and misuse of alcohol, tobacco and other drugs.

	Actual				2015-16		2016-17 Target
	2011-12	2012-13	2013-14	2014-15	Target	Actual	
Community Treatment and Extended Care							
Mental Health							
Individuals receiving community-based public mental health services[1]	1 795	2 073	2 236	2 342	2 400	2 354	2 538
Individuals under 18 receiving community-based public mental health services[1]	271	361	395	447	500	500	518
Post-discharge community mental health care[2,3]	38.2%	53.8%	63.4%	64.7%	70.0%	69.8%	70.0%
28-day mental health re-admissions[3,4]	11.7%	8.9%	10.5%	15.5%	10.0%	11.5%	10.0%
Aged Care							
Aged care occasions of service	1 953	1 363	2 778	3 648	3 700	3 796	3 700
Aged Care Assessment Program clients receiving timely intervention in accordance with priority at referral[3]	89.5%	89.9%	92.4%	81.3%	85.0%	87.4%	85.0%
Alcohol and other Drugs							
Closed episodes in government treatment services[5,6]	307	331	260	270	240	241	257
Completed closed episodes in government treatment services[5,6]	76	221	176	161	119	134	130
Number of referrals to assessment for mandatory treatment[6,7]	n/a	n/a	139	139	204	221	232
Number of Treatment Orders commenced[6,8]	n/a	n/a	109	99	144	109	110

[1] Community-based public mental health services include all mental health services provided by government (excluding government funded non-government organisations) dedicated to the assessment, treatment, rehabilitation or care of non-admitted patients.

[2] The measure indicates the proportion of separations from mental health service organisations' acute care units for which a community service contact was recorded in the seven days immediately following that separation.

[3] 2015-16 data until March only available at time of report.

[4] The measure indicates the percentage of separations from the mental health services' acute mental health inpatient units that results in unplanned re-admission to the same or another public acute mental health inpatient unit within 28 days of discharge.

[5] An episode of alcohol and other drugs treatment is a 'period of contact, with defined dates of commencement and cessation' (National Health data Dictionary). A closed episode of treatment is one where there is a valid date of cessation. A completed closed episode is one where there is a valid date of cessation. A completed closed episode is one where there is a valid date of cessation and the reason for cessation is 'treatment completed'.

[6] Data has been recalculated to reflect transition of the function to the Health Services. Historical variations to previously reported data may have occurred in this process.

[7] The increase is influenced by targeted police operations.

[8] The decrease is influenced by external factors relating to tribunal processes.

Primary Health Care

Outcome: Strengthened capability of Territorians to maintain and improve health through education, prevention, early intervention and access to culturally appropriate assessment, treatment and support services.

Remote Primary Health Care

Provide primary health care services delivered by government health centres located in remote communities.

Urban Primary Health Care

Provide primary health care services delivered by government health services located in urban centres.

Central Australia Wide Community Services

Deliver community care services through hearing, oral and cancer-screening specialists across Central Australia.

	Actual				2015-16		2016-17 Target
	2011-12	2012-13	2013-14	2014-15	Target	Actual	
Primary Health Care							
Remote Primary Health Care							
Episodes of health care services in government-managed remote health centres[1]	117 058	119 968	119 584	120 696	122 800	118 927	119 500
Aboriginal adult health check coverage[2]	22%	49%	64%	69%	70%	68%	70%
Proportion of screened Aboriginal children under 5 years with anaemia[3]	25%	28%	28%	20%	n/a	19%	n/a
Proportion of screened Aboriginal children between 6 months and 5 years of age who have been checked for anaemia[3,4]	72%	75%	80%	85%	n/a	85%	n/a
Proportion of remote Aboriginal women who attended their first antenatal visit in the first trimester of their pregnancy[2,4]	38%	48%	47%	59%	50%	54%	60%
Proportion of remote Aboriginal clients aged 15 years and over with type II diabetes and or coronary heart disease with a chronic disease management plan[2,4]	59%	69%	77%	84%	68%	83%	85%
Proportion of remote Aboriginal clients aged 15 years and over with type II diabetes who have had an HbA1c test[3,4]	73%	80%	84%	90%	n/a	93%	n/a
Proportion of remote Aboriginal clients aged 15 years and over with type II diabetes whose latest HbA1c measurements are lower than or equal to 7 per cent[3,4]	26%	25%	27%	25%	n/a	31%	n/a
Urban Primary Health Care							
Community health occasions of service – urban[5,6]	16 123	15 092	14 929	15 569	15 000	18 339	17 620
Prison health episodes of care	n/a	n/a	29 955	26 240	27 402	27 858	27 609

[1] Health care services are defined as client-related occasions of health surveillance, primary treatment, chronic disease management, palliative care and maternal and child health.

[2] Budget figures realigned with SDA targets.

[3] Definition refers to twelve month reporting period. SDA targets not aligned with twelve month definition.

[4] New measure in BP3. Backcast data provided.

[5] Community health occasions of service in child and family health, general community health, palliative care, school screening service (school-entry age), nutrition services and women's health services as provided by government managed urban-based community health care centres.

[6] The variation is due to increased recruitment and immunisation activity as well as improved reporting.

Central Australia Wide Support Services

Outcome: Strengthen the capacity of Central Australia Health Service to support patients and clients.

Central Australia Wide Support Services

Support patient-centred accountable health service delivery, including aeromedical retrievals and ambulance services, and the Health Service Board.

	Actual				2015-16		2016-17 Target
	2011-12	2012-13	2013-14	2014-15	Target	Actual	
Central Australia-Wide Support Services							
Complaints to the Health and Community Services Complaints Commissioner responded to within timeframes set	n/a	n/a	n/a	n/a	100%	100%	100%
Incident recommendations followed up within timeframes set	n/a	n/a	n/a	n/a	100%	100%	100%

L-R: Lance Armstrong, clinical nurse Tim Jacobs, Amanda Donoghue, Annette Hoberg, Genevieve White

Central Australia Health Service - snapshot of costs

Financial results for 2015-16 against agreed targets based on output groups in Budget Paper 3 are presented in the table below. CAHS financial performance is provided in greater detail in the CAHS Financial Reports section.

	2015-16		2016-17	
	(a)	(b)	(c)	(c) – (a)
Business Line	Budget	Actual	Budget	Note
	$000	$000	$000	
Central Australia Hospitals	**229 446**	**227 461**	**239 177**	1
Central Australia Hospitals	229 446	227 461	239 177	
Community Treatment and Extended Care	**17 925**	**26 118**	**28 691**	2
Mental Health	17 269	16 406	17 589	
Aged Care	656	781	258	
Alcohol and Other Drugs		8 931	10 844	
Primary Health Care	**44 042**	**50 744**	**50 739**	3
Remote Primary Health Care	38 441	44 092	36 702	
Urban Primary Health Care	5 601	6 652	6 714	
Central Australia-Wide Community Services			7 323	
Central Australia-Wide Support Services	**54 797**	**58 429**	**67 630**	4
Central Australia-Wide Support Services	54 797	58 429	67 630	
Total Expenses	**346 210**	**362 752**	**386 237**	
Income	**339 042**	**358 136**	**377 905**	
SURPLUS (+)/DEFICIT (-) BEFORE INCOME TAX	**-7 168**	**-4 616**	**-8 332**	

Notes

[1] The variation in 2015-16 mainly relates to lower than budgeted own source revenue and the associated reduction in expenses. The increase in 2016-17 mostly reflects additional Commonwealth and repairs and maintenance funding.

[2] The variation in 2015-16 is due to the transfer of the Alcohol and Other Drugs program from the Department of Health. The increase in 2016-17 mainly relates to additional Commonwealth funding.

[3] The variation in 2015-16 mainly relates to additional Commonwealth funding and the transfer of remote primary health care grants from the Department of Health. The decrease in 2016-17 is mainly due to the alignment of Commonwealth funding partially offset by the transfer of oral, hearing and cancer screening service delivery functions from the Department of Health.

[4] The variation in 2015-16 is mostly due to additional cross-border revenue, ambulance services funding and depreciation. The increase in 2016-17 mainly relates to additional funding for repairs and maintenance and increased depreciation.

Performance, achievements and outcomes

This section reports on the performance, achievements and outcomes for CAHS against the strategic directions identified in the *CAHS Strategic Plan 2014-17*.

Strategic Direction 1:

Promote equitable access to high quality care for our community

Tennant Creek Hospital making inroads with cognitively impaired patients

The Continual Improvement team at Tennant Creek Hospital has been focussing on the hospital journey for patients with cognitive impairment. Patients with a cognitive impairment are more likely to experience a fall resulting in harm, develop complications like pressure injuries and pneumonia, and have an increased length of stay in hospital. An activity lounge with comfortable chairs, a television and a wall mural painted by local artists has been developed as well as a dementia kit with games and activities.

$10 million support for Central Australia renal patients

The Australian Government will provide $10 million over the next three years to the NT Government to develop accommodation in Tennant Creek and Alice Springs for end-stage renal patients who need to relocate to access treatment. Renal infrastructure, including accommodation for patients and members of their family, is important to ensure patients have access to much needed dialysis and renal support services. During the 2015-16 reporting year, project planning has commenced for the build of renal clinics at Docker River and Papunya, with the design phase nearing completion; design work at Mt Liebig has commenced and continues into the next reporting year. As part of the funding, community housing will be provided in Alice Springs and Tennant Creek for Indigenous renal patients and their families or carers, who are required to relocate from remote communities of Central Australia, to access treatment for end-stage kidney disease. The accommodation project is being overseen by the Northern Territory Department of Housing.

24/7 medical on-call service

The Primary Health Care Medical team undertook a restructure of the on-call roster in July 2015. The length of shifts was reduced to improve safety and reduce overtime. Additional shifts were added to cover peak demand and a retrieval forum has been funded to promote quality. The on-call workforce has proved stable since that time.

CAHS kicks off health message campaign with CAAMA

CAHS has commenced a health message campaign with Aboriginal broadcaster CAAMA Radio to produce a series of health advertisements relevant to the Central Australian Aboriginal population. Four advertisements with key health messages have been developed: 'Don't be a Binge Drinker', 'It's Okay to Ask for Help', 'Never too Young to have a Heart Attack' and 'Drink Water'. The advertisements have been recorded in English, Warlpiri, Arrernte, Warramunga, Pitjantjatjara and Luritja and will be ready for broadcast early in the 2016-17 financial year.

CAHS community events

CAHS has engaged in several community-related promotional activities over the reporting period, including display stands supported by staff members at the International Women's Day Carnival in March and Sexual Assault Awareness Month community event in April.

Mental health tenancy and judicial support

Mental Health Services introduced two new initiatives during 2015-16: a Housing Tenancy Support Officer, whose role is to identify and assist individual mental health clients who are experiencing housing strain or are risk of homelessness; and a Court Liaison role to assist in the provision of clinical information regarding treatment and management of individuals involved with the justice system.

Tennant Creek Hospital after-hours service

Through partnership with the NT PHN, Tennant Creek Hospital has implemented a best practice, culturally appropriate and responsive after hours Social Worker service for victims of domestic and family violence that is affordable, accessible and sustainable. This is the only family violence/social work response service in the NT.

Strategic Direction 2:

Build a sustainable, well-coordinated and integrated health care system that enhances health outcomes

Integrated approach to addiction services

In the 2015-16 reporting year, the Alcohol and Other Drugs service was integrated into CAHS, incorporating addiction services into Central Australia. This further complements the integration of the Sexual Assault Referral Centre under Alice Springs Hospital in the previous period, which provides forensic, counselling and education services for the region.

CAHS receives accreditation

CAHS has been awarded accreditation for three years by the Australian Council of Healthcare Standards (ACHS). Within CAHS, the Alice Springs Hospital, the Tennant Creek Hospital and the Central Australia Mental Health Service underwent the ACHS accreditation survey against the 10 national standards in March 2015. A total of 209 core actions had to be met to renew accreditation and the staff and management were dedicated to achieving the 10 National Safety and Quality in Healthcare Standards across the two hospitals and the mental health service. The ACHS accreditation will remain current until August 2018.

Integrated Care Business Initiative Projects

The Integrated Care Business Initiative Projects, commencing September 2015, aims to identify measures to improve integration within the Central Australia Health Service at the macro, meso and micro levels. This will be achieved through designing, implementing and evaluating a range of specific projects through which approaches to integration may be pressure tested utilising the four stages of clinical redesign: diagnostic phase, solution design phase, implementation phase, and evaluation and sustainability phase. Projects initiated in this reporting period include: improved gastroenterology clinical pathways; respiratory transition from paediatric to adult medicine teams, Alice Springs Hospital; integrated governance for CAHS AOD services; and integration of Primary Health Care and Hospital Services, Tennant Creek. These projects will continue into the 2016-17 financial year.

Clinical Redesign project

The Clinical Redesign project continues at the Alice Springs Hospital, with an ongoing commitment to clinical redesign. The project has seen improvements in patient flow, outpatient waiting list management, timeliness of post-discharge bed cleans and the implementation of an e-journey board. Improvements have also been made in the number of clients taking their own leave or leaving against medical advice, with a decrease from 9.21% in 2013-14, 8.2% in 2014-15 to 7.7% in 2015-16.

Lean thinking for large problems

Alice Springs Hospital held a two-day Process Redesign and Lean Thinking Program in early 2016, facilitated by Flinders Medical Centre, with 23 hospital staff taking part. Participants brought along a 'problem' that had a clinical effect with the intention of working through the principles of 'lean thinking' in order to improve the patient journey. The workshop was an opportunity to consolidate knowledge, reinvigorate redesign and lean thinking, learn new tools for problem solving and continue to extend and develop new ways of thinking to improve patient outcomes.

Healthy School Age Kids Program

The Healthy School Age Kids Care Plan (HSAK) commenced in February 2016 and is being trialled in 27 remote communities in the Central Australia and Barkly regions, with 1700 children aged five to 14 years involved in the program. The HSAK program aims to improve the quality of health services provided to school age children by: improving their health and wellbeing; allowing for early identification and treatment of risk factors for preventable chronic conditions; increasing the coverage of health assessments and improving the quality of health status information shared with schools. The program is person-centred and involves parents and carers, medical practitioners, remote area nurses and Aboriginal health practitioners.

Strategic Direction 3:

Educate and retain a suitably skilled and culturally sensitive workforce

Central Australia Health Service staff recognised with scholarships

Thirteen hospital-based staff from the Central Australia Health Service shared close to $10 000 worth of scholarship funds. The scholarships of up to $750, funded by the Central Australian Hospital Private Practice Funds Administration Committee, were available to staff who have been at the hospital for 12 months or more and who are applying to undertake study that will contribute to improved health outcomes in the region. Two staff utilised their $750 scholarship funds towards the cost of attending the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) annual conference in Wellington. An interest-free loan of $2000 was also offered to a nurse completing a Masters of Health Sciences – Alcohol and Other Drugs.

Aboriginal Cultural Safety Framework

CAHS has established an Aboriginal Cultural Security Framework and matrix to provide direction for CAHS to deliver culturally secure services to Aboriginal people. It is intended to be used as a tool to further strengthen the capacity of the Health Service. The Framework comprises six domains against which activity will be monitored: workforce, communication, whole-of-organisation approach, leadership, consumer participation, and quality, planning, evaluation and research.

Cultural awareness for CAHS staff

Central Australia Health Service continues to partner with the Centre for Remote Health to deliver the Aboriginal Cultural Awareness Program to Health Service staff, with 246 staff members taking part in the 2015-16 reporting year. Through the training, it is hoped that participants gain awareness of Aboriginal cultural beliefs and customs, recognise cultural diversity within and between Aboriginal communities, and increase awareness of the impact of social determinants on the health of Aboriginal people. A Barkly region specific Aboriginal Cultural Awareness Program was under development during the 2015-16 reporting year, with delivery to commence in 2016-17.

Increase in Indigenous Workforce

CAHS has increased the average number of Aboriginal and Torres Strait Islander people employed in the service to 7.6% of the total full-time equivalents, compared with 6.1% in the previous financial year. In January 2015, a *Special Measures Plan* was implemented across the Department of Health and in the 12 months since then, CAHS has employed 30 Special Measures applicants, at an average of 12.5% of advertised vacancies. It is anticipated that numbers will continue to increase, resulting in increased workforce diversity and employment opportunities for Aboriginal people. A range of Aboriginal workforce strategies are in place to encourage and enable young Aboriginal people to participate in programs that support health career pathways, including Indigenous cadetships, school-based and full-time traineeships, career information tours, work experience opportunities and participation in career expos and school visits.

Aboriginal Health Practitioner workforce

The CAHS Aboriginal Health Practitioner (AHP) workforce has remained stable throughout this reporting period, supported by the CAHS AHP Management Team. The team has also facilitated previously registered AHPs to re-enter the workforce. Through the *Back on Track Program*, the AHP Management Team has also had a strong focus on recruitment and ongoing support for AHP trainees to locally grow the workforce, with AHP training being undertaken through Tennant Creek Hospital. The AHP Management Team has also been developing specialist roles for better career opportunities for AHPs in CAHS.

The AHP Management Team provides ongoing support to Aboriginal staff working in remote health centres, facilitates cultural engagement and contributes to the development of remote community advisory committees.

Alice Springs Hospital Cultural Advisor

Alice Springs Hospital has appointed an Aboriginal Cultural Advisor to provide advice on strategic and operational issues regarding Aboriginal health and employment. The role also maintains effective community and stakeholder engagement in support of the advancement of Aboriginal health and wellbeing. As a member of the ASH Executive Committee, the Aboriginal Cultural Advisor works with management to ensure the delivery of culturally appropriate health care, through the provision of advice on specific cultural issues. In addition, the role provides a central point of support and coordination for Aboriginal workforce development at ASH, including monitoring Aboriginal workforce employment and establishing a support network for Aboriginal employees.

Frontline leadership group

Seven CAHS staff were selected to take part in the Department of Health 2016 Leadership and Management Development Program, under two streams: *'Building Our Leaders: First Line Manager Program'* and *'Leading the Way: Middle Managers Program'*. A series of workshops will take place for participants over the course of two years. Successful participants were required to submit a project concept that will form the basis of their participation in the program. Projects will provide tangible benefits to the Health Service, in alignment with the strategic and operational plans of the relevant business units.

1Plus3 methamphetamine information program

Alcohol and Other Drugs Services Central Australia implemented the 1Plus3 Program series to provide factual and current information to assist professionals, families and friends to increase their knowledge about methamphetamine. The series comprises an initial session on 'fast facts', with the option to participate for a further three sessions under separate streams for professionals and families/friends. The additional sessions look at challenges and complexities of methamphetamine use, strengthening supports and safety, treatment options and referral pathways.

Central Australia shines in Nursing and Midwifery Excellence Awards

CAHS congratulates overall winner, Diana Basely and all other CAHS awards recipients at this year's Nursing and Midwifery Excellence Awards: NT Administrator's Medal for Lifetime Achievement in Nursing/Midwifery awarded to Sandra McElligott; 1st Year Graduate Nurse/Midwife awarded to Ingrid Potgieter; Excellence in Nursing/Midwifery Hospital Care awarded to Léa Davidson; Excellence in Nursing/Midwifery Leadership awarded to Diana Baseley; Excellence in Midwifery awarded to Katie Michell; Excellence in Nursing/Midwifery Community Health awarded to Emma Louise Corcoran; and Excellence in Remote Health Nursing/Midwifery awarded to E. Ann Sanotti.

CAHS staff recognised in national awards

CAHS staff have been recognised on the national stage during 2015-16. ASHs' Head of Surgery, Dr Jacob Jacob was awarded the inaugural Aboriginal and Torres Strait Islander Health Medal of the Royal Australasian College of Surgeons, in recognition of his significant contribution to Aboriginal and Torres Strait Islander health. Dr Stephen Brady, Head of the Department of Medicine at ASH was awarded the 2016 Medal for Clinical Services in Rural and Remote Areas from the Royal Australasian College of Physicians. This medal recognises the significant contribution made in providing outstanding clinical service in rural and remote areas of Australia. Jenny Kenna from the Maternity Unit of ASH was named Australia's Midwife of the Year by the Australian College of Midwives, an honour awarded to a midwife who provides extraordinary care and support. Jenny was nominated by the Le Page family from Kulgera near the border of Northern Territory and South Australia. CAHS staff were outstanding in the CRANAplus awards, with Sandra McElligott, a remote nurse and midwife, awarded the Remote Health Professional of the Year and Pauline (Polly) Rubin, a senior mental health clinician, receiving the Excellence in Mentoring award for her contribution to mentoring early career remote health professionals.

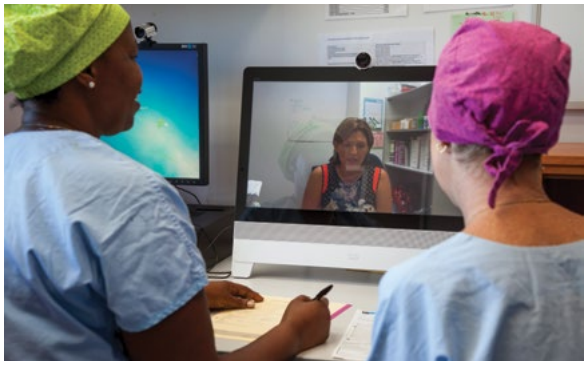
Nurses Grace Mwangi and Annette Weacers with patient Mereana Birkholz and her father Arapeti Birkholz.

Strategic Direction 4:

Continue to improve through evidence-based practice

Telehealth delivers patients services and savings for government

Telehealth technology, championed by the Department of Health has resulted in more remote and regional Territorians getting the medical advice they need without always having to travel to major centres. Figures released after a review of the Patient Assistance Travel Scheme (PATS) – Telehealth Project reveal patient consultations with doctors using Telehealth technology have soared from approximately 200 a year to more than 1000 under a trial project. The program received support from both patients and health professionals, and delivered savings to Government of more than $1.1 million. At the end of the trial, more patients were accessing Telehealth, rather than PATS. The trial project has expanded the availability of the Telehealth system, which connects patients and doctors via video enabled technology, at sites based in Alice Springs and Tennant Creek. In the Barkly, there have been significant increases in Telehealth appointments of more than 700%.



Telehealth in action

Emergency access and Elective surgery waiting time improvements

ASH has seen improvements in both hospital emergency access and elective surgery waiting times. Emergency department presentations departing within four hours have improved from 60% in June 2015 to 65% in June 2016. Wait times for elective surgery performance has also improved this financial year, with a reduction from 160 patients waiting longer than the clinically recommended time for elective surgery in July 2015 to 73 in June 2016.

Strategic Direction 5:

Engage and partner with our community to improve health outcomes

Educational resources provide tools for remote communities

The Central Australia Health Service's Remote Alcohol and Other Drugs Workforce Program has introduced a new educational tool to help deal with growing number of infants born with Foetal Alcohol Spectrum Disorder (FASD) in the Northern Territory. *Yarning about Alcohol and Pregnancy* and Advice Card is a pictorial resource that assesses the level of risk to a woman who is pregnant and who is using alcohol. *Yarning about Alcohol and Pregnancy* and Advice Card has been identified as a valuable resource in the Alice Springs Hospital and remote communities for women being treated during pregnancy.

Health services at Ntaria

Central Australia Health Service, Central Australian Aboriginal Congress Aboriginal Corporation (Congress) and Western Aranda Health Aboriginal Corporation have continued throughout 2015-16 to maintain a Joint Services Agreement which outlines the delivery of health services at Ntaria and Wallace Rockhole. Under the agreement, Congress and CAHS Primary Health Care deliver health services under a single management structure at Ntaria, a significant achievement during this period. The Joint Services Agreement is currently under review.

Strategic Direction 6:

Build a financially sustainable service

Alice Springs Hospital in good health

In the 2015-16 financial year, ASH has established a business case register to support transparent planning for business cases in 2016-17. During this period, ASH has focused on stabilisation, building a strong executive team and establishing clear and transparent business processes. An increase in revenue and a near-balanced budget are testament to these improvements.

Strong financial management practices and budgetary controls across CAHS

CAHS' 'bottom up/top down' budget development process has now been applied across all of CAHS divisions and includes controlled revenue as well as expenditure, ensuring establishment of well researched and transparent budgets owned by all. This is supported by a comprehensive reporting framework and ongoing consultation between finance and clinicians, resulting in managers being empowered to better understand and manage their financial performance.

Improved planning processes for infrastructure and capital equipment across CAHS

Establishment of timelines and consultation processes to improve content and turnaround of submissions for capital and maintenance related activity, along with stronger and more coordinated input in development and monitoring of programs, budgets and monthly performance.

Strengthening financial controls

Highlights include initiatives regarding processing of own source revenue, in particular workers compensation, ineligible patients and rights to private practice, which have reduced revenue leakage. Another area of focus has been recovery of aged debts which has started to deliver results.

Financial statements

Central Australia Health Service

Central Australia Health Service

Financial Performance

For the year ended 30 June 2016

Overview

Central Australia Health Services financial performance is reported in three financial statements: the Operating Statement, the Balance Sheet, and the Cash Flow Statement. These statements and the accompanying notes have been prepared in accordance with the Northern Territory Government's financial management framework and relevant Australian accounting standards. The financial statements include financial data from the 2015-16 financial year and comparative data from 2014-15.

The 2015-16 financial performance for the Agency was within the service delivery agreement parameters for both expenses and revenue.

Main results at a glance

- Central Australia Health Service reported an operating deficit of $4.6 million.
- The equity position increased by $37 million from $161 million in 2014-15 to $198 million in 2015-16.
- Expenses were contained within 0.14% of budget targets.
- Revenue earned was within 0.25% of budget targets.

Operating Statement

Operating Statement Summary	2015-16 $000	2014-15 $000	Variation $000	Variation %
Operating Revenue	358,136	296,056	62,080	20.97%
Operating Expenditure	-362,752	-324,138	38,614	12.91%
Deficit / Surplus	-4,616	-28,082	23,466	

In 2015-16 the Central Australia Health Service returned a $4.6 million deficit. Excluding $10.5 million of depreciation expenditure which is not revenue funded, the full year operating surplus was $5.9 million. The final CAHS result represents a significant financial turnaround from the 2014/15 financial year and is evident of tight cost control.

Operating Revenue

The Central Australia Health Service is predominantly funded by, and is dependent on, the receipt of Territory funded National Health Reform (NHR) payments paid through the Department of Health. The majority of the remaining revenue came from the Australian Government in the form of Activity Based Funding (ABF), National Partnership Payments (NPP) and grant funding.

Operating Expenditure

In 2015-16 the Health Service incurred expenses of $362.7 million, an increase of 12.91% on the previous financial year. Whilst this represents a increase to targets, it is indicative of the increase in activity, as well as the increased cost of service delivery in the health and welfare sector.

Balance Sheet

Balance Sheet Summary	2015-16 $000	2014-15 $000	Variation $000	Variation %
Assets	271,849	227,150	44,699	19.67%
Liabilities	-73,884	-66,269	7,615	11.49%
Equity	197,965	160,881	37,084	

In 2015-16 CAHS's equity position increased by $37 million. The increase is primarily due to equity transfers in of $10 million as a result of Alcohol & Other Drugs(AOD) restructure, and transfer of completed buildings from the Department of Infrastructure to the value of $21 million. In addition, there was a net increase of $11.1 million in the asset revaluation reserve as a result of the latest independent revaluation of building and land assets of remote health clinics.

Statement of Cash Flows

Cash Flow Statement Summary	2015-16 $000	2014-15 $000	Variation $000	Variation %
Cash at Beginning of reporting period	6,968	9,473	-2,505	-26.44%
Receipts	360,369	320,825	39,544	12.32%
Payments	-355,978	-328,328	-27,650	-8.42%
Equity Injections	0	15,027	-15,027	-100.00%
Equity withdrawals	-315	-10,028	9,713	96.86%
Cash at end of reporting period	11,044	6,968	4,076	

The Cash Flow Statement shows the CAHS cash receipts and payments for the financial year. The statement incorporates expenses and revenues from the Operating Statement, after the elimination of all non-cash transactions, with cash movements from the Balance Sheet. The net result is a increase in the agency's cash balances of $4 million over the financial year.

Summary

Budget Target Summary	2016 Final Budget Summary $000	2016 Actual $000	Variation $000	Variation %
Operating Revenue	357,215	358,136	921	0.25%
Operating Expenses	-363,269	-362,752	517	0.14%
Deficit / Surplus	-6,054	-4,616	1,438	

The CAHS performance in expenditure shows a result with a minor variation from planned targets coming within 0.14% of the budget. The CAHS performance in revenue shows a similar minor variation from planned targets coming within 0.25% of the budget.

Auditor-General

Independent Auditor's Report to the Minister for Health

Central Australia Health Service

I have audited the accompanying financial report of Central Australia Health Service which comprises the balance sheet as at 30 June 2016, the comprehensive operating statement, the statement of changes in equity and the cash flow statement for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and the certification of the financial statements by the Accountable Officer.

The Accountable Officer's Responsibility for the Financial Report

The Accountable Officer of the Department of Health is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and for such internal control as the Accountable Officer determines is necessary to enable the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error.

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. Those 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 control relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Accountable Officer, 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

In my opinion the financial report gives a true and fair view of the financial position of Central Australia Health Service as at 30 June 2016, and of its financial performance and its cash flows for the year then ended in accordance with Australian Accounting Standards.

Julie Crisp
Auditor-General for the Northern Territory
Darwin, Northern Territory

27 September 2016

CENTRAL AUSTRALIA HEALTH SERVICE
FINANCIAL REPORT

CERTIFICATION OF THE FINANCIAL STATEMENTS

We certify that the attached financial statements for the Central Australia Health Service have been prepared from proper accounts and records in accordance with the prescribed format, the *Financial Management Act* and Treasurer's Directions.

We further state that the information set out in the Comprehensive Operating Statement, Balance Sheet, Statement of Changes in Equity, Cash Flow Statement, and notes to and forming part of the financial statements, presents fairly the financial performance and cash flows for the year ended 30 June 2016 and the financial position on that date.

At the time of signing, we are not aware of any circumstances that would render the particulars included in the financial statements misleading or inaccurate.

Janet Anderson

Accountable Officer

11/9/2016

Sue Korner

Chief Operating Officer

9. 2016

Anubis Pacifico

Chief Finance Officer

02/09/2016

CENTRAL AUSTRALIA HEALTH SERVICE
COMPREHENSIVE OPERATING STATEMENT
For the year ended 30 June 2016

	Note	2016	2015
		$000	$000
INCOME			
Grants and subsidies revenue			
Current		142 652	133 197
Sales of goods and services		212 165	162 793
Other income		3 319	66
TOTAL INCOME	3	**358 136**	**296 056**
EXPENSES			
Employee expenses		216 825	202 399
Administrative expenses			
Purchases of goods and services	5	115 574	95 046
Repairs and maintenance		4 384	5 577
Depreciation and amortisation	9	10 480	8 757
Other administrative expenses		372	875
Loss on disposal of assets	4	0	1
Grants and subsidies expenses			
Current		14 230	10 851
Capital		849	591
Interest expenses		38	41
TOTAL EXPENSES	3	**362 752**	**324 138**
NET SURPLUS/(DEFICIT)		**(4 616)**	**(28 082)**
OTHER COMPREHENSIVE INCOME			
Items that will not be reclassified to net surplus/deficit			
Transfers from reserves		0	(23)
Changes in asset revaluation surplus	15	11 132	(44 106)
TOTAL OTHER COMPREHENSIVE INCOME		**11 132**	**(44 129)**
COMPREHENSIVE RESULT		**6 516**	**(72 211)**

The Comprehensive Operating Statement is to be read in conjunction with the notes to the financial statements.

CENTRAL AUSTRALIA HEALTH SERVICE
BALANCE SHEET
As at 30 June 2016

	Note	2016	2015
		$000	$000
ASSETS			
Current Assets			
Cash and deposits	6	11 044	6 968
Receivables	7	47 926	39 561
Inventories	8	1 600	1 956
Prepayments		120	274
Total Current Assets		**60 690**	**48 759**
Non-Current Assets			
Property, plant and equipment	9, 10	211 159	178 391
Total Non-Current Assets		**211 159**	**178 391**
TOTAL ASSETS		**271 849**	**227 150**
LIABILITIES			
Current Liabilities			
Deposits held	14	993	1 001
Payables	11	49 453	43 881
Borrowings and advances	12	9	9
Provisions	13	16 087	14 729
Total Current Liabilities		**66 542**	**59 620**
Non-Current Liabilities			
Borrowings and advances	12	772	781
Provisions	13	6 570	5 868
Total Non-Current Liabilities		**7 342**	**6 649**
TOTAL LIABILITIES		**73 884**	**66 269**
NET ASSETS		**197 965**	**160 881**
EQUITY			
Capital		245 147	214 579
Asset revaluation surplus	15	13 321	2 189
Accumulated funds		(60 503)	(55 887)
TOTAL EQUITY		**197 965**	**160 881**

The Balance Sheet is to be read in conjunction with the notes to the financial statements.

CENTRAL AUSTRALIA HEALTH SERVICE
STATEMENT OF CHANGES IN EQUITY
For the year ended 30 June 2016

	Note	Equity at 1 July	Comprehensive result	Transactions with owners in their capacity as owners	Equity at 30 June
		$000	$000	$000	$000
2015-16					
Accumulated Funds		(55 864)	(4 616)	0	(60 480)
Changes in accounting policy		0	0	0	0
Correction of prior period errors		0	0	0	0
Transfers from reserves		(23)	0	0	(23)
Other movements directly to equity		0	0	0	0
		(55 887)	(4 616)	0	(60 503)
Asset Revaluation Surplus	15	2 189	11 132	0	13 321
Capital – Transactions with Owners					
Equity injections					
Equity transfers in		196 432	0	30 884	227 317
Other equity injections		49 779	0	0	49 779
Equity withdrawals					
Capital withdrawal		(31 624)	0	(315)	(31 939)
Equity transfers out		(8)	0	0	(8)
		214 579	0	30 569	245 148
Total Equity at End of Financial Year		**160 881**	**6 516**	**30 569**	**197 965**
2014-15					
Accumulated Funds		(27 782)	(28 082)	0	(55 864)
Transfers from reserves		0	(23)	0	(23)
		(27 782)	(28 105)	0	(55 887)
Asset Revaluation Surplus	15	46 295	(44 106)	0	2 189
Capital – Transactions with Owners					
Equity injections					
Equity transfers in		188 161	0	8 271	196 432
Other equity injections		34 752	0	15 027	49 779
Equity withdrawals					
Capital withdrawal		(21 596)	0	(10 028)	(31 624)
Equity transfers out		(8)	0	0	(8)
		201 309	0	13 270	214 579
Total Equity at End of Financial Year		**219 822**	**(72 211)**	**13 270**	**160 881**

The Statement of Changes in Equity is to be read in conjunction with the notes to the financial statements.

CENTRAL AUSTRALIA HEALTH SERVICE
CASH FLOW STATEMENT
For the year ended 30 June 2016

	Note	2016	2015
		$000	$000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Receipts			
Grants and subsidies received			
Current		142 652	133 197
Receipts from sales of goods and services		217 725	187 471
Total Operating Receipts		**360 377**	**320 668**
Operating Payments			
Payments to employees		(220 085)	(199 724)
Payments for goods and services		(119 546)	(115 895)
Grants and subsidies paid			
Current		(14 218)	(11 441)
Capital		(849)	0
Interest paid		(38)	(41)
Total Operating Payments		**(354 736)**	**(327 101)**
Net Cash From/(Used in) Operating Activities	16	**5 642**	**(6 433)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Investing Receipts			
Proceeds from asset sales	4	0	8
Total Investing Receipts		**0**	**8**
Investing Payments			
Purchases of assets		(1 234)	(1 218)
Total Investing Payments		**(1 234)**	**(1 218)**
Net Cash From/(Used in) Investing Activities		**(1 234)**	**(1 210)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Financing Receipts			
Deposits received		(8)	149
Equity injections			
Other equity injections		0	15 026
Total Financing Receipts		**(8)**	**15 175**
Financing Payments			
Finance lease payments		(9)	(9)
Equity withdrawals		(315)	(10 028)
Total Financing Payments		**(324)**	**(10 037)**
Net Cash From/(Used in) Financing Activities		**(332)**	**5 138**
Net increase/(decrease) in cash held		4 076	(2 505)
Cash at beginning of financial year		6 968	9 473
CASH AT END OF FINANCIAL YEAR	6	**11 044**	**6 968**

The Cash Flow Statement is to be read in conjunction with the notes to the financial statements.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

INDEX OF NOTES TO THE FINANCIAL STATEMENTS

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

1. OBJECTIVES AND FUNDING

The Central Australia Health Service's mission is to improve the health status and wellbeing of all people in the Central Australian region of the Northern Territory. Central Australia Health Service was established under the *Health Services Regulations* effective 1 July 2014.

The entity is predominantly funded by, and is dependent on, the receipt of National Health Reform (NHR) payments paid through the Department of Health. The financial statements encompass all funds through which the entity controls resources to carry on its functions and deliver outputs. For reporting purposes, outputs delivered by the entity are summarised into several output groups. Note 3 provides summary financial information in the form of a Comprehensive Operating Statement by output group.

2. STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

a) Statement of Compliance

The financial statements have been prepared in accordance with the requirements of the *Financial Management Act* and related Treasurer's Directions. The *Financial Management Act* requires Central Australia Health Service to prepare financial statements for the year ended 30 June based on the form determined by the Treasurer. The form of agency financial statements is to include:

(i) a Certification of the Financial Statements;

(ii) a Comprehensive Operating Statement;

(iii) a Balance Sheet;

(iv) a Statement of Changes in Equity;

(v) a Cash Flow Statement; and

(vi) applicable explanatory notes to the financial statements.

b) Basis of Accounting

The financial statements have been prepared using the accrual basis of accounting, which recognises the effect of financial transactions and events when they occur, rather than when cash is paid out or received. As part of the preparation of the financial statements, all intra-agency transactions and balances have been eliminated.

Except where stated, the financial statements have also been prepared in accordance with the historical cost convention.

The form of the agency financial statements is also consistent with the requirements of Australian Accounting Standards. The effects of all relevant new and revised Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that are effective for the current annual reporting period have been evaluated.

The following new and revised Accounting Standards and Interpretations were effective for the first time in 2015-16:

AASB 1048 Interpretation of Standards This reflects amended versions of Interpretations arising in relation to amendments to AASB 9 Financial Instruments and consequential amendments arising from the issuance of AASB 15 Revenue from Contracts with Customers. The Standard does not impact the financial statements.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

AASB 2013-9 Amendments to Australian Accounting Standards [Part C Financial Instruments] Part C of this standard amends AASB 9 Financial Instruments to add Chapter 6 Hedge Accounting and makes consequential amendments to AASB 9 and numerous other standards. The standard does not impact the financial statements.

AASB 2014-8 Amendments to Australian Accounting Standards arising from AASB 9 This Standard makes amendments to AASB 9 Financial Instruments (December 2009) and AASB 9 Financial Instruments (December 2010). These amendments arise from the issuance of AASB 9 Financial Instruments in December 2014. The standard does not impact the financial statements.

AASB 2015-3 Amendments to Australian Accounting Standards arising from the withdrawal of AASB 1031 Materiality The standard completes the withdrawal of references to AASB 1031 in all Australian Accounting Standards and Interpretations, allowing the standard to effectively be withdrawn. The standard does not impact the financial statements.

AASB 2015-4 Amendments to Australian Accounting Standards – Financial Reporting Requirements for Australian Groups with a Foreign Parent Amendments are made to AASB 128 Investments in Associates and Joint Ventures to require the ultimate Australian entity to apply the equity method in accounting for interests in associates and joint ventures, if either the entity or the group is a reporting entity, or both the entity and group are reporting entities. The standard does not impact the financial statements.

AASB 2014-1 Amendments to Australian Accounting Standards (Part E - Financial Instruments) Part E of this standard defers the application date of AASB 9 Financial Instruments to annual reporting periods beginning on or after 1 January 2018. The standard does not impact the financial statements.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

The following Standards and Interpretations are likely to have an insignificant impact on the financial statements for future reporting periods, but the exact impact is yet to be determined:

Standard/Interpretation	Effective for annual reporting periods beginning on or after
AASB 9 Financial Instruments (December 2014), AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)	1 January 2018
AASB 15 Revenue from Contracts with Customers, AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	1 January 2018
AASB 1056 Superannuation Entities	1 July 2016
AASB 14 Regulatory Deferral Accounts	1 January 2016
AASB 1057 Application of Accounting Standards	1 January 2016
AASB 2014-1 Amendments to Australian Accounting Standards [Part D Consequential arising from AASB 14 Regulatory Deferral Accounts]	1 January 2016
AASB 2014-3 Amendments to Australian Accounting Standards - Accounting for Acquisitions of Interests in Joint Operations [AASB 1 and AASB 11]	1 January 2016
AASB 2014-16 Amendments to Australian Accounting Standards - Agriculture: Bearer Plants [AASB 101,116, 117, 123, 136, 140 and 141]	1 January 2016
AASB 2015-5 Amendments to Australian Accounting Standards - Investment Entities: Applying the Consolidation Exception [AASB 10, 12 and 128]	1 January 2016
AASB 2015-9 Amendments to Australian Accounting Standards - Scope and Application Paragraphs [AASB 8, 133 and 1057]	1 January 2016
AASB 2015-10 Amendments to Australian Accounting Standards - Effective Date of Amendments to AASB 10 and AASB 128	1 January 2016
AASB 2016-1 Amendments to Australian Accounting Standards- Recognition of Deferred Tax Assets for Unrealised Losses [AASB 112]	1 January 2017

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

The following Standards and Interpretations are expected to have a potential impact on the financial statements for future reporting periods:

Standard/Interpretation	Effective for annual reporting periods beginning on or after	Impact
AASB 2015-6 Amendments to Australian Accounting Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities [AASB 10, 124 and 1049]	1 July 2016	New note disclosure to include remuneration of Key Management Personnel (KMP) and related party transactions.
2016-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107	1 January 2017	New disclosure on the reconciliation of the changes in liabilities arising from financing activities.
AASB 16 Leases	1 January 2019	Reclassification of operating leases greater than 12 months to finance lease reporting requirements.
AASB 9 Financial Instruments	1 January 2018	Simplified requirements for classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier as opposed to only when incurred.
AASB 15 Revenue from Contracts with Customers	1 January 2018	Requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.
AASB 2014-1 Amendments to Australian Accounting Standards [Part E Financial Instruments]	1 January 2018	Amends various AAS's to reflect the deferral of the mandatory application date of AASB 9.
AASB 2014-4 Amendments to Australian Accounting Standards - Clarification of Acceptable Methods of Depreciation and Amortisation [AASB 116 and AASB 138]	1 January 2016	Provides additional guidance on how the depreciation or amortisation of property, plant and equipment and intangible assets should be calculated and clarifies that the use of revenue-based methods to calculate the depreciation of an asset is not appropriate.
AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	1 January 2017	Amends the measurement of trade receivables and the recognition of dividends.
AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9	1 January 2018	Amends various AAS's to reflect the changes as a result of AASB 9.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Standard/Interpretation	Effective for annual reporting periods beginning on or after	Impact
AASB 2014-9 Amendments to Australian Accounting Standards - Equity Method in Separate Financial Statements [AASB 1, 127 and 128]	1 January 2016	Allows an entity to account for investments in subsidiaries, joint ventures and associates in its separate financial statement at cost or using the equity method.
AASB 2015-1 Amendments to Australian Accounting Standards - Annual Improvements to Australian Accounting Standards 2012-14 Cycle [AASB 1, 2, 3,5, 7, 11, 110, 119, 121, 133, 134,137 and 140]	1 January 2016	The amendments include AASB 5 change in methods of disposal; AASB 7 Servicing contracts and applicability of the amendments to AASB 7 to condensed interim financial statements; AASB 119 Discount rate: regional market issue and AASB 134 Disclosure of information elsewhere in the interim financial.

c) Reporting Entity

The financial statements cover the Central Australia Health Service ("the Health Service") as an individual reporting entity. The Health Service is a statutory body which is established under Section 17 of the *Health Services Act* and Section 4 of the *Health Services Regulations.*

The principal place of business of the Health Service is: Alice Springs Hospital, Gap Road, Alice Springs NT 0870

d) Comparatives

Where necessary, comparative information for the 2014-15 financial year has been reclassified to provide consistency with current year disclosures.

e) Presentation and Rounding of Amounts

Amounts in the financial statements and notes to the financial statements are presented in Australian dollars and have been rounded to the nearest thousand dollars, with amounts of $500 or less being rounded down to zero. Figures in the financial statements and notes may not equate due to rounding.

f) Changes in Accounting Policies

There have been no changes to accounting policies adopted in 2015-16 as a result of management decisions.

g) Accounting Judgments and Estimates

The preparation of the financial report requires the making of judgments and estimates that affect the recognised amounts of assets, liabilities, revenues and expenses and the disclosure of contingent liabilities. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Judgments and estimates that have significant effects on the financial statements are disclosed in the relevant notes to the financial statements. Notes that include significant judgments and estimates are:

- Employee Benefits – Note 2(v) and Note 13: Non-current liabilities in respect of employee benefits are measured as the present value of estimated future cash outflows based on the appropriate Government bond rate, estimates of future salary and wage levels and employee periods of service.
- Property, Plant and Equipment – Note 2(q): The fair value of land, building, infrastructure and property, plant and equipment are determined on significant assumptions of the exit price and risks in the perspective market participant, using the best information available.
- Contingent Liabilities – Note 19: The present value of material quantifiable contingent liabilities are calculated using a discount rate based on the published 10-year Government bond rate.
- Allowance for Impairment Losses – Note 2(r), Note 7: Receivables and Note 17: Financial Instruments. The allowance represents debts that are likely to be uncollectible and are considered doubtful. Debtors are grouped according to their ageing profile and history of previous financial difficulties.
- Depreciation and Amortisation – Note 2(k), Note 9: Property, Plant and Equipment.
- Cross border patient charges accruals – Note 7 Receivables and Note 11 Payables: The accruals are based on the latest exchanged data between jurisdictions with indexation applied.

h) Taxation

Goods and Services Tax

Income, expenses and assets are recognised net of the amount of Goods and Services Tax (GST), except where the amount of GST incurred on a purchase of goods and services is not recoverable from the Australian Tax Office (ATO). In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables are stated with the amount of GST included. The net amount of GST recoverable from, or payable to, the ATO is included as part of receivables or payables in the Balance Sheet.

Cash flows are included in the Cash Flow Statement on a gross basis. The GST components of cash flows arising from investing and financing activities, which are recoverable from, or payable to, the ATO are classified as operating cash flows. Commitments and contingencies are disclosed net of the amount of GST recoverable or payable unless otherwise specified.

Northern Territory Tax Equivalents Regimes (TER)

The Northern Territory Tax Equivalents Regimes improve competitive neutrality between public and private sector entities. The TER levies the equivalent of Commonwealth income

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

tax and local government rates on certain government owned business units so that such units have the same tax and local government rates positions as comparable private sector entities. TER is not applicable to the Central Australia Health Service.

i) Income Recognition

Income encompasses both revenue and gains.

Income is recognised at the fair value of the consideration received, exclusive of the amount of GST. Exchanges of goods or services of the same nature and value without any cash consideration being exchanged are not recognised as income.

Grants and Other Contributions

Grants, donations, gifts and other non-reciprocal contributions are recognised as revenue when the agency obtains control over the assets comprising the contributions. Control is normally obtained upon receipt.

Contributions are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

National Health Reform (NHR) Payments

NHR payments support the NHR agreement. NHR payments are based on hospital activity (or block funding where more appropriate) and include funding for Teacher Training and Research.

Territory NHR payments are paid from the Central Holding Authority to the Department of Health and then on-passed to the relevant Health Service. Commonwealth NHR payments are made by the Commonwealth Treasury directly to the State Pool Account within the Department of Health and then on-passed to the relevant Health Service.

Sale of Goods

Revenue from the sale of goods is recognised (net of returns, discounts and allowances) when:

- the significant risks and rewards of ownership of the goods have transferred to the buyer;
- the agency retains neither continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold;
- the amount of revenue can be reliably measured;
- it is probable that the economic benefits associated with the transaction will flow to the agency; and
- the costs incurred or to be incurred in respect of the transaction can be measured reliably.

Rendering of Services

Revenue from rendering services is recognised by reference to the stage of completion of the contract. The revenue is recognised when:

- the amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and
- it is probable that the economic benefits associated with the transaction will flow to the entity.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Disposal of Assets

A gain or loss on disposal of assets is included as a gain or loss on the date control of the asset passes to the buyer, usually when an unconditional contract of sale is signed. The gain or loss on disposal is calculated as the difference between the carrying amount of the asset at the time of disposal and the net proceeds on disposal. Refer also to Note 4.

Contributions of Assets

Contributions of assets and contributions to assist in the acquisition of assets, being non-reciprocal transfers, are recognised, unless otherwise determined by Government, as gains when the agency obtains control of the asset or contribution. Contributions are recognised at the fair value received or receivable.

j) Repairs and Maintenance Expense

Funding is received for repairs and maintenance works associated with agency assets as part of output appropriation. Costs associated with repairs and maintenance works on agency assets are expensed as incurred.

k) Depreciation and Amortisation Expense

Items of property, plant and equipment, including buildings but excluding land, have limited useful lives and are depreciated or amortised using the straight-line method over their estimated useful lives.

Amortisation applies in relation to intangible non-current assets with limited useful lives and is calculated and accounted for in a similar manner to depreciation.

The estimated useful lives for each class of asset are in accordance with the Treasurer's Directions and are determined as follows:

	2016
Buildings	50 years
Sheds/Demountable	10-20 years
Plant and Equipment (Refer below)	
Computer Hardware	3-6 years
Office Equipment	5-10 years
Medical Equipment	5-15 years
Furniture & Fittings	10 years
Catering Equipment	5-15 years
Laundry Equipment	5-15 years

Assets are depreciated or amortised from the date of acquisition or from the time an asset is completed and held ready for use.

l) Interest Expense

Interest expenses include interest and finance lease charges. Interest expenses are expensed in the period in which they are incurred.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

m) Cash and Deposits

For the purposes of the Balance Sheet and the Cash Flow Statement, cash includes cash on hand, cash at bank and cash equivalents. Cash equivalents are highly liquid short-term investments that are readily convertible to cash. Cash at bank includes monies held in the Accountable Officer's Trust Account (AOTA) that are ultimately payable to the beneficial owner – refer also to Note 21.

n) Inventories

Inventories include assets held either for sale (general inventories) or for distribution at no or nominal consideration in the ordinary course of business operations.

General inventories are valued at the lower of cost and net realisable value, while those held for distribution are carried at the lower of cost and current replacement cost. Cost of inventories includes all costs associated with bringing the inventories to their present location and condition. When inventories are acquired at no or nominal consideration, the cost will be the current replacement cost at date of acquisition.

The cost of inventories are assigned using a mixture of first-in, first out or weighted average cost formula or using specific identification of their individual costs.

Inventory held for distribution is regularly assessed for obsolescence and loss.

o) Receivables

Receivables include accounts receivable and other receivables and are recognised at fair value less any allowance for impairment losses.

The allowance for impairment losses represents the amount of receivables the agency estimates are likely to be uncollectible and are considered doubtful. Analyses of the age of the receivables that are past due as at the reporting date are disclosed in an ageing schedule under credit risk in Note 17 Financial Instruments. Reconciliation of changes in the allowance accounts is also presented.

Accounts receivable are generally settled within 30 days and other receivables within 30 days.

p) Prepayments

Prepayments represent payments in advance of receipt of goods and services or that part of expenditure made in one accounting period covering a term extending beyond that period.

q) Property, Plant and Equipment

Acquisitions

All items of property, plant and equipment with a cost, or other value, equal to or greater than $10 000 are recognised in the year of acquisition and depreciated as outlined below. Items of property, plant and equipment below the $10 000 threshold are expensed in the year of acquisition.

The construction cost of property, plant and equipment includes the cost of materials and direct labour, and an appropriate proportion of fixed and variable overheads.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Complex Assets
Major items of plant and equipment comprising a number of components that have different useful lives, are accounted for as separate assets. The components may be replaced during the useful life of the complex asset.

Subsequent Additional Costs
Costs incurred on property, plant and equipment subsequent to initial acquisition are capitalised when it is probable that future economic benefits in excess of the originally assessed performance of the asset will flow to the agency in future years. Where these costs represent separate components of a complex asset, they are accounted for as separate assets and are separately depreciated over their expected useful lives.

Construction (Work in Progress)
As part of the financial management framework, the Department of Infrastructure is responsible for managing general government capital works projects on a whole of government basis. Therefore appropriation for all agency capital works is provided directly to the Department of Infrastructure and the cost of construction work in progress is recognised as an asset of that Department. Once completed, capital works assets are transferred to the agency.

r) Revaluations and Impairment

Revaluation of Assets
Subsequent to initial recognition, assets belonging to the following classes of non-current assets are revalued with sufficient regularity to ensure that the carrying amount of these assets does not differ materially from their fair value at reporting date:

- land;
- buildings.

Plant and equipment are stated at historical cost less depreciation, which is deemed to equate to fair value.

Impairment of Assets
An asset is said to be impaired when the asset's carrying amount exceeds its recoverable amount.

Non-current physical and intangible agency assets are assessed for indicators of impairment on an annual basis or whenever there is indication of impairment. If an indicator of impairment exists, the agency determines the asset's recoverable amount. The asset's recoverable amount is determined as the higher of the asset's depreciated replacement cost and fair value less costs to sell. Any amount by which the asset's carrying amount exceeds the recoverable amount is recorded as an impairment loss.

Impairment losses are recognised in the Comprehensive Operating Statement. They are disclosed as an expense unless the asset is carried at a revalued amount. Where the asset is measured at a revalued amount, the impairment loss is offset against the asset revaluation surplus for that class of asset to the extent that an available balance exists in the asset revaluation surplus.

In certain situations, an impairment loss may subsequently be reversed. Where an impairment loss is subsequently reversed, the carrying amount of the asset is increased to

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the revised estimate of its recoverable amount. A reversal of an impairment loss is recognised in the Comprehensive Operating Statement as income, unless the asset is carried at a revalued amount, in which case the impairment reversal results in an increase in the asset revaluation surplus. Note 15 provides additional information in relation to the asset revaluation surplus.

s) Assets Held for Sale

Assets and disposal groups are classified as held for sale if their carrying amount will be recovered through a sale transaction or a grant agreement rather than continuing use. Assets held for sale consist of those assets that management has determined are available for immediate sale or granting in their present condition and their sale is highly probable within one year from the date of classification.

These assets are measured at the lower of the asset's carrying amount and fair value less costs to sell. These assets are not depreciated. Non-current assets held for sale have been recognised on the face of the financial statements as current assets.

t) Leased Assets

Leases under which the agency assumes substantially all the risks and rewards of ownership of an asset are classified as finance leases. Other leases are classified as operating leases.

Finance Leases

Finance leases are capitalised. A lease asset and lease liability equal to the lower of the fair value of the leased property and present value of the minimum lease payments, each determined at the inception of the lease, are recognised.

Lease payments are allocated between the principal component of the lease liability and the interest expense.

Long-term land lease assets on Aboriginal land are recognised on the balance sheet of the Central Australia Health Service and amortised accordingly over the term of the lease arrangements. A corresponding liability is recognised under Borrowings.

Operating Leases

Operating lease payments made at regular intervals throughout the term are expensed when the payments are due, except where an alternative basis is more representative of the pattern of benefits to be derived from the leased property. Lease incentives under an operating lease of a building or office space is recognised as an integral part of the consideration for the use of the leased asset. Lease incentives are to be recognised as a deduction of the lease expenses over the term of the lease.

u) Payables

Liabilities for accounts payable and other amounts payable are carried at cost, which is the fair value of the consideration to be paid in the future for goods and services received, whether or not billed to the agency. Accounts payable are normally settled within 30 days.

v) Employee Benefits

Provision is made for employee benefits accumulated as a result of employees rendering services up to the reporting date. These benefits include wages and salaries and recreation leave. Liabilities arising in respect of wages and salaries, recreation leave and other employee benefit liabilities that fall due within twelve months of reporting date are classified

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as current liabilities and are measured at amounts expected to be paid. Non-current employee benefit liabilities that fall due after twelve months of the reporting date are measured at present value, calculated using the Government long-term bond rate.

No provision is made for sick leave, which is non-vesting, as the anticipated pattern of future sick leave to be taken is less than the entitlement accruing in each reporting period.

Employee benefit expenses are recognised on a net basis in respect of the following categories:

- wages and salaries, non-monetary benefits, recreation leave, sick leave and other leave entitlements; and
- other types of employee benefits.

As part of the financial management framework, the Central Holding Authority assumes the long service leave liabilities of Government agencies, including Central Australia Health Service and as such no long service leave liability is recognised in agency financial statements.

w) Superannuation

Employees' superannuation entitlements are provided through the:

- Northern Territory Government and Public Authorities Superannuation Scheme (NTGPASS);
- Commonwealth Superannuation Scheme (CSS); or
- non-government employee-nominated schemes for those employees commencing on or after 10 August 1999.

The agency makes superannuation contributions on behalf of its employees to the Central Holding Authority or non-government employee-nominated schemes. Superannuation liabilities related to government superannuation schemes are held by the Central Holding Authority and as such are not recognised in agency financial statements.

x) Contributions by and Distributions to Government

The agency may receive contributions from Government where the Government is acting as owner of the agency. Conversely, the agency may make distributions to Government. In accordance with the *Financial Management Act* and Treasurer's Directions, certain types of contributions and distributions, including those relating to administrative restructures, have been designated as contributions by, and distributions to, Government. These designated contributions and distributions are treated by the agency as adjustments to equity.

The Statement of Changes in Equity provides additional information in relation to contributions by, and distributions to, Government.

y) Commitments

Disclosures in relation to capital and other commitments, including lease commitments are shown at Note 18.

Commitments are those contracted as at 30 June where the amount of the future commitment can be reliably measured.

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z) Financial Instruments

A financial instrument is a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

Financial assets and liabilities are recognised on the Balance Sheet when the agency becomes a party to the contractual provisions of the financial instrument. The agency's financial instruments include cash and deposits; receivables; advances; investments loan and placements; payables; advances received; borrowings and derivatives.

Due to the nature of operating activities, certain financial assets and financial liabilities arise under statutory obligations rather than a contract. Such financial assets and liabilities do not meet the definition of financial instruments as per AASB 132 Financial Instruments Presentation. These include statutory receivables arising from taxes including GST and penalties.

Exposure to interest rate risk, foreign exchange risk, credit risk, price risk and liquidity risk arise in the normal course of activities. The agency's investments, loans and placements, and borrowings are predominantly managed through the NTTC adopting strategies to minimise the risk. Derivative financial arrangements are also utilised to manage financial risks inherent in the management of these financial instruments. These arrangements include swaps, forward interest rate agreements and other hedging instruments to manage fluctuations in interest or exchange rates.

Classification of Financial Instruments

AASB 7 Financial Instruments: Disclosures requires financial instruments to be classified and disclosed within specific categories depending on their nature and purpose.

Financial assets are classified into the following categories:

- financial assets at fair value through profit or loss;
- loans and receivables; and

Financial liabilities are classified into the following categories:

- financial liabilities at fair value through profit or loss (FVTPL); and
- financial liabilities at amortised cost.

Financial Assets or Financial Liabilities at Fair Value through Profit or Loss

Financial instruments are classified as at FVTPL when the instrument is either held for trading or is designated as at FVTPL.

An instrument is classified as held for trading if it is:

- acquired or incurred principally for the purpose of selling or repurchasing it in the near term with an intention of making a profit; or
- part of a portfolio of identified financial instruments that are managed together and for which there is evidence of a recent actual pattern of short-term profit-taking; or
- a derivative that is not a financial guarantee contract or a designated and effective hedging instrument.

A financial instrument may be designated as at FVTPL upon initial recognition if:

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- such designation eliminates or significantly reduces a measurement or recognition inconsistency that would otherwise arise; or
- the instrument forms part of a group of financial instruments, which is managed and its performance is evaluated on a fair value basis, in accordance with a documented risk management or investment strategy, and information about the grouping is provided internally on that basis; or
- it forms part of a contract containing one or more embedded derivatives, and AASB 139 Financial Instruments: Recognition and Measurement permits the contract to be designated as at FVTPL.

Financial liabilities at fair value through profit or loss include deposits held excluding statutory deposits, accounts payable and accrued expenses. Financial assets at fair value through profit or loss include short-term securities and bonds.

Loans and Receivables

For details refer to Note 2 (o).

Financial Liabilities at Amortised Cost

Financial instrument liabilities measured at amortised cost include all advances received, finance lease liabilities and borrowings. Amortised cost is calculated using the effective interest method.

Fair Value Measurement

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

Fair value measurement of a non-financial asset takes into account a market participant's ability to generate economic benefits by using the asset in its highest and best use or by selling it to another market participant that would use the asset in its highest and best use. The highest and best use takes into account the use of the asset that is physically possible, legally permissible and financially feasible.

When measuring fair value, the valuation techniques used maximise the use of relevant observable inputs and minimise the use of unobservable inputs. Unobservable inputs are used to the extent that sufficient relevant and reliable observable inputs are not available for similar assets/liabilities.

Observable inputs are publicly available data that are relevant to the characteristics of the assets/liabilities being valued. Observable inputs used by the agency include, but are not limited to, published sales data for land and general office buildings.

Unobservable inputs are data, assumptions and judgments that are not available publicly, but are relevant to the characteristics of the assets/liabilities being valued. Such inputs include internal agency adjustments to observable data to take account of particular and potentially unique characteristics/functionality of assets/liabilities and assessments of physical condition and remaining useful life.

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the following fair value hierarchy based on the inputs used:

CENTRAL AUSTRALIA HEALTH SERVICE
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Level 1 – inputs are quoted prices in active markets for identical assets or liabilities;

Level 2 – inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly; and

Level 3 – inputs are unobservable.

CENTRAL AUSTRALIA HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

3. COMPREHENSIVE OPERATING STATEMENT BY OUTPUT GROUP

	Note	Central Australia Hospitals		Community Treatment and Extended Care		Primary Health Care		Central Australian – Wide Support Services		Total	
		2016	2015	2016	2015	2016	2015	2016	2015	2016	2015
		$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
INCOME											
Grants and subsidies revenue											
Current		7 561	4 766	1 527	1 529	14 146	12 373	119 417	114 528	142 652	133 197
Sales of goods and services		9 248	8 149	492	493	2 260	2 004	200 165	152 147	212 165	162 793
Other income		281	66	3 013	0	25	1	0	0	3 319	66
TOTAL INCOME		**17 090**	**12 981**	**5 032**	**2 022**	**16 431**	**14 378**	**319 582**	**266 675**	**358 136**	**296 056**
EXPENSES											
Employee expenses		156 699	152 402	21 350	13 737	36 393	34 352	2 382	1 908	216 825	202 399
Administrative expenses											
Purchases of goods and services	5	64 719	58 295	3 627	2 347	12 291	11 055	34 937	23 350	115 574	95 046
Repairs and maintenance		3 746	4 263	0	0	638	0	0	1 314	4 384	5 577
Depreciation and amortisation	9	1 426	1 472	18	13	166	137	8 870	7 135	10 480	8 757
Other administrative expenses		334	321	9	6	28	43	0	504	372	875
Loss on disposal of assets	4	0	1	0	0	0	0	0	0	0	1
Grants and subsidies expenses											
Current		535	492	1 113	0	1 189	0	11 392	10 359	14 230	10 851
Capital		0	0	0	0	0	0	849	591	849	591
Interest expenses		0	0	0	0	38	41	0	0	38	41
TOTAL EXPENSES		**227 460**	**217 246**	**26 117**	**16 103**	**50 744**	**45 628**	**58 430**	**45 161**	**362 752**	**324 138**
NET SURPLUS/(DEFICIT)		**(210 370)**	**(204 265)**	**(21 085)**	**(14 081)**	**(34 313)**	**(31 250)**	**261 152**	**221 514**	**(4 616)**	**(28 082)**
OTHER COMPREHENSIVE INCOME											
Items that will not be reclassified to net surplus/deficit											
Transfers from reserves		0	0	0	0	0	0	0	(23)	0	(23)
Changes in asset revaluation surplus		0	0	0	0	0	0	11 132	(44 106)	11 132	(44 106)
TOTAL OTHER COMPREHENSIVE INCOME		**0**	**0**	**0**	**0**	**0**	**0**	**11 132**	**(44 129)**	**11 132**	**(44 129)**
COMPREHENSIVE RESULT		**(210 370)**	**(204 265)**	**(21 085)**	**(14 081)**	**(34 313)**	**(31 250)**	**272 284**	**177 385**	**6 516**	**(72 211)**

This Comprehensive Operating Statement by output group is to be read in conjunction with the notes to the financial statements.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

	2016	2015
	$000	$000

4. LOSS ON DISPOSAL OF ASSETS

Net proceeds from the disposal of non-current assets	0	8
Less: Carrying value of non-current assets disposed	0	(9)
Loss on the disposal of non-current assets	**0**	**(1)**
Total Loss on Disposal of Assets	**0**	**(1)**

5. PURCHASES OF GOODS AND SERVICES

The net surplus/(deficit) has been arrived at after charging the following expenses:

Goods and services expenses:		
Property Maintenance	3 683	3 093
General Property Maintenance	3 910	3 701
Power	4 262	4 334
Water and Sewerage	796	604
Land Rent	56	27
Accommodation	210	308
Advertising[1]	12	3
Agent Service Agreements	23 596	17 441
Audit Fees	30	34
Bank Charges	15	15
Client Travel	6 431	6 286
Clothing	75	55
Communications	1 227	1 321
Consultant Fees[2]	96	355
Consumables/General Expenses	2 054	1 504
Cross Border Patient Charges	14 684	4 549
Document Production	511	379
Entertainment/Hospitality	16	10
Food	2 190	1 910
Freight	380	747
Information Technology Charges	5 777	4 662
IT Consultants	24	28
IT Hardware and Software Expenses	445	302
Insurance Premiums	14	13
Laboratory Expense	55	2 366
Legal Expenses[4]	8	43
Library Services	18	45
Marketing and Promotion[3]	85	21
Medical/Dental Supply and Services	32 167	28 569
Membership and Subscriptions	71	121
Motor Vehicle Expenses	2 951	2 576
Office Requisites and Stationery	717	631
Official Duty Fares	1 542	2 073
Other Equipment Expenses	2 175	2 018
Recruitment Expenses[5]	4 129	3 996

CENTRAL AUSTRALIA HEALTH SERVICE
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For the year ended 30 June 2016

	2016 $000	2015 $000
Reg/Advisory Boards/Committees	48	46
Relocation Expenses	38	21
Training and Study Expenses	648	458
Transport Equipment Expenses	3	0
Travelling Allowance	428	377
Unallocated Corporate Credit Card Expenses	(4)	4
Total Purchases of Goods and Services	**115 574**	**95 046**

(1) Includes marketing and promotion.
(2) Does not include recruitment, advertising or marketing and promotion advertising.
(3) Includes advertising for marketing and promotion but excludes marketing and promotion consultants' expenses, which are incorporated in the consultants category.
(4) Includes legal fees, claim and settlement costs.
(5) Includes recruitment-related advertising costs.

6. CASH AND DEPOSITS

Cash on hand	7	5
Cash at bank	11 037	6 963
Total Cash and Deposits	**11 044**	**6 968**

7. RECEIVABLES

Current		
Accounts receivable	1 988	1 648
Less: Allowance for impairment losses	(729)	(509)
	1 259	1 139
GST receivables	961	1 045
Other receivables(1)	45 706	37 377
	46 667	38 422
Total Receivables	**47 926**	**39 561**

(1)Other receivables include accrued revenue for cross border patient charges.

8. INVENTORIES

Inventories Held for Distribution		
At current replacement cost	1 600	1 956
Total Inventories	**1 600**	**1 956**

During the year the Central Australia Health Service was required to write-off $0.09m ($0.06m 2014-15) of pharmaceutical inventories. This was due to their short shelf life and the necessity to keep certain lifesaving items on hand.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

	2016	2015
	$000	$000
9. PROPERTY, PLANT AND EQUIPMENT		
Land		
At fair value	4 545	4 225
Buildings		
At fair value	377 756	334 975
Less: Accumulated depreciation	(178 697)	(168 758)
Less: Accumulated impairment loss	(13)	0
	199 046	166 217
Plant and Equipment		
At capitalised cost	25 737	24 396
Less: Accumulated depreciation	(18 354)	(16 654)
Less: Accumulated impairment loss	(580)	(579)
	6 803	7 163
Leased Land		
At fair value	852	851
Less: Accumulated depreciation	(87)	(65)
	765	786
Total Property, Plant and Equipment	**211 159**	**178 391**

Property, Plant and Equipment Valuations

The latest revaluations as at 30 June 2016 were independently conducted for the Remote Health Clinics. The valuer was Territory Property Consultants Pty Ltd. Refer to Note 10: Fair Value Measurement of Non-Financial Assets for additional disclosures.

Impairment of Property, Plant and Equipment

Agency property assets were assessed for impairment as at 30 June 2016 as part of the revaluation of the Remote Health Clinics. The impairment losses were charged to the asset revaluation surplus.

CENTRAL AUSTRALIA HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

9. PROPERTY, PLANT AND EQUIPMENT (continued)

2016 Property, Plant and Equipment Reconciliations

A reconciliation of the carrying amount of property, plant and equipment at the beginning and end of 2015-16 is set out below:

	Land	Buildings	Plant and Equipment	Leased Property, Plant and Equipment	Total
	$000	$000	$000	$000	$000
Carrying Amount as at 1 July 2015	4 225	166 217	7 162	786	178 391
Additions	0	0	1 234	0	1 234
Disposals	0	0	0	0	0
Depreciation	0	(8 796)	(1 663)	(22)	(10 480)
Additions/(Disposals) from administrative restructuring	0	0	0	0	0
Additions/(Disposals) from asset transfers	787	30 027	71	0	30 885
Revaluation increments/(decrements)	(466)	11 611	0	0	11 145
Impairment losses	0	(13)	(1)	0	(14)
Impairment losses reversed	0	0	0	0	0
Other movements	0	0	0	0	0
Carrying Amount as at 30 June 2016	**4 545**	**199 046**	**6 803**	**765**	**211 159**

9. PROPERTY, PLANT AND EQUIPMENT (continued)

2015 Property, Plant and Equipment Reconciliations

A reconciliation of the carrying amount of property, plant and equipment at the beginning and end of 2014-15 is set out below:

	Land	Buildings	Plant and Equipment	Leased Property, Plant and Equipment	Total
	$000	$000	$000	$000	$000
Carrying Amount as at 1 July 2014	3 770	210 176	7 513	808	222 267
Additions	0	0	1 219	0	1 219
Disposals	0	0	(9)	0	(9)
Depreciation	0	(7 070)	(1 665)	(22)	(8 757)
Additions/(Disposals) from administrative restructuring	0	0	75	0	75
Additions/(Disposals) from asset transfers	0	8 196	31	0	8 227
Revaluation increments/(decrements)	455	(45 085)	0	0	(44 630)
Other movements	0	0	(1)	0	(1)
Carrying Amount as at 30 June 2015	**4 225**	**166 217**	**7 163**	**786**	**178 391**

CENTRAL AUSTRALIA HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

10. FAIR VALUE MEASUREMENT OF NON-FINANCIAL ASSETS

a) Fair Value Hierarchy

Fair values of non-financial assets categorised by levels of inputs used to compute fair value are:

	Level 1	Level 2	Level 3	Total Fair Value
	$000	$000	$000	$000
2015-16				
Asset Classes				
Land (Note 10)	0	0	4 545	4 545
Buildings (Note 10)	0	0	199 046	199 046
Plant & Equipment (Note 10)	0	0	6 803	6 803
Total	**0**	**0**	**210 394**	**210 394**
2014-15				
Asset Classes				
Land (Note 10)	0	0	4 225	4 225
Buildings (Note 10)	0	0	166 217	166 217
Plant & Equipment (Note 10)	0	0	7 163	7 163
Total	**0**	**0**	**177 605**	**177 605**

There were no transfers between Level 1 and Levels 2 or 3 during 2015-16.

b) Valuation Techniques and Inputs

Valuation techniques used to measure fair value in 2015-16 are:

	Level 3 Techniques
Asset Classes	
Land	Cost approach
Buildings	Cost approach

There were no changes in valuation techniques from 2014-15 to 2015-16.

The latest revaluations as at 30 June 2016 were independently conducted for the Remote Health Clinics. The valuer was Territory Property Consultants Pty Ltd. Refer to Note 10: Fair Value Measurement of Non-Financial Assets for additional disclosures.

Level 3 fair values of specialised buildings and infrastructure were determined by computing their depreciated replacement costs because an active market does not exist for such facilities. The depreciated replacement cost was based on a combination of internal records of the historical cost of the facilities, adjusted for contemporary technology and construction approaches. Significant judgement was also used in assessing the remaining service

CENTRAL AUSTRALIA HEALTH SERVICE
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potential of the facilities, given local environmental conditions, projected usage, and records of the current condition of the facilities.

c) Additional Information for Level 3 Fair Value Measurements

(i) Reconciliation of Recurring Level 3 Fair Value Measurements

	Land	Buildings	Plant & Equipment
	$000	$000	$000
2015-16			
Fair value as at 1 July 2015	4 225	166 217	7 162
Additions	787	30 027	1 305
Disposals	0	0	0
Depreciation	0	(8 796)	(1 663)
Gains/losses recognised in net surplus/(deficit)	0	0	0
Gains/losses recognised in other comprehensive income	(466)	11 598	(1)
Fair value as at 30 June 2016	**4 545**	**199 046**	**6 803**
2014-15			
Fair value as at 1 July 2014	3 770	210 176	7 513
Additions	0	8 196	1 324
Disposals	0	0	(9)
Depreciation	0	(7 070)	(1 665)
Gains/losses recognised in net surplus/(deficit)	0	(501)	(1)
Gains/losses recognised in other comprehensive income	455	(44 584)	0
Fair value as at 30 June 2015	**4 225**	**166 217**	**7 163**

(ii) Sensitivity analysis

Unobservable inputs used in computing the fair value of buildings include the historical cost and the consumed economic benefit for each building. Given the large number of agency buildings, it is not practical to compute a relevant summary measure for the unobservable inputs. In respect of sensitivity of fair value to changes in input value, a higher historical cost results in a higher fair value and greater consumption of economic benefit lowers fair value.

CENTRAL AUSTRALIA HEALTH SERVICE
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	2016	2015
	$000	$000
11. PAYABLES		
Accounts payable	1 140	2 498
Accrued expenses[1]	48 302	41 383
Other payables	12	0
Total Payables	**49 453**	**43 881**

[1]Includes liability for cross border patient expenses and other accrued operational expenses.

12. BORROWINGS AND ADVANCES		
Current		
Finance lease liabilities[1]	9	9
	9	9
Non-Current		
Finance lease liabilities[1]	772	781
	772	781
Total Borrowings and Advances	**781**	**790**

[1]Finance leases relate to long term land leases on Aboriginal land.

13. PROVISIONS		
Current		
Employee benefits		
Recreation leave	11 375	10 493
Leave loading	2 823	2 496
Recreation leave fares and other benefits	28	60
Other current provisions		
Other provisions – includes provisions for superannuation and Fringe Benefits Tax payable	1 861	1 680
	16 087	**14 729**
Non-Current		
Employee benefits		
Recreation leave	6 570	5 868
Total Provisions	**22 657**	**20 597**

The Agency employed 1 699 employees as at 30 June 2016 (1 626 employees as at 30 June 2015).

14. OTHER LIABILITIES		
Current		
Deposit held[1]	993	1 001
Total Other Liabilities	**993**	**1 001**

[1]Accountable Officers Trust Account (see note 21)
Governing Council bank account and Hospital Gift Funds.

CENTRAL AUSTRALIA HEALTH SERVICE
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	2016	2015
	$000	$000

15. RESERVES

Asset Revaluation Surplus

(i) Nature and purpose of the asset revaluation surplus

The asset revaluation surplus includes the net revaluation increments and decrements arising from the revaluation of non-current assets. Impairment adjustments may also be recognised in the asset revaluation surplus.

(ii) Movements in the asset revaluation surplus

Balance as at 1 July	2 189	46 295
Increment/(Decrement) – land	(466)	455
Increment/(Decrement) – buildings	11 598	(44 561)
Increment/(Decrement) – plant and equipment	1	0
Balance as at 30 June	**13 321**	**2 189**

16. NOTES TO THE CASH FLOW STATEMENT

Reconciliation of Cash

The total of 'Cash and deposits' of $11 044 recorded in the Balance Sheet is consistent with that recorded as 'Cash' in the Cash Flow Statement.

Reconciliation of Net Surplus/(Deficit) to Net Cash from Operating Activities

Net Surplus/(Deficit)	(4 616)	(28 082)
Non-cash items:		
Depreciation and amortisation	10 480	8 757
Asset write-offs/write-downs	88	566
(Gain)/Loss on disposal of assets	0	(30)
Changes in assets and liabilities:		
Decrease/(Increase) in receivables	(8 365)	15 107
Decrease/(Increase) in inventories	269	(45)
Decrease/(Increase) in prepayments	154	(187)
(Decrease)/Increase in payables	5 571	(3 640)
(Decrease)/Increase in provision for employee benefits	1 880	1 063
(Decrease)/Increase in other provisions	180	58
Net Cash from Operating Activities	**5 642**	**(6 433)**

CENTRAL AUSTRALIA HEALTH SERVICE
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Non-Cash Financing and Investing Activities

Non cash transfers
During the financial year the entity acquired buildings with an aggregate fair value of $20.9 million by non-cash asset transfers from the Department of Infrastructure.

17. FINANCIAL INSTRUMENTS

A financial instrument is a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Financial instruments held by the Central Australia Health Service include cash and deposits, receivables, payables and finance leases. The Central Australia Health Service has limited exposure to financial risks as discussed below.

CENTRAL AUSTRALIA HEALTH SERVICE

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

a) Categorisation of Financial Instruments

The carrying amounts of the agency's financial assets and liabilities by category are disclosed in the table below.

2015-16 Categorisation of Financial Instruments

	Fair value through profit or loss						
	Held for trading	Designated at fair value	Held to maturity investments	Financial assets - Loans and receivables	Financial assets - available for sale	Financial Liabilities - amortised cost	**Total**
	$000	$000	$000	$000	$000	$000	$000
Cash and deposits	0	11 044	0	0	0	0	11 044
Receivables[(1)]	0	0	0	46 965	0	0	46 965
Total Financial Assets	**0**	**11 044**	**0**	**46 965**	**0**	**0**	**58 009**
Deposits held[(1)]	0	0	993	0	0	0	993
Payables[(1)]	0	49 453	0	0	0	0	49 453
Finance lease liabilities	0	0	0	0	0	781	781
Total Financial Liabilities	**0**	**49 453**	**993**	**0**	**0**	**781**	**51 227**

[(1)]Total amounts disclosed exclude statutory amounts.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

2014-15 Categorisation of Financial Instruments

	Fair value through profit or loss						
	Held for trading	Designated at fair value	Held to maturity investments	Financial assets - Loans and receivables	Financial assets - available for sale	Financial Liabilities - amortised cost	**Total**
	$000	$000	$000	$000	$000	$000	$000
Cash and deposits	0	6 968	0	0	0	0	6 968
Receivables	0	0	0	39 561	0	0	39561
Total Financial Assets	**0**	**6 968**	**0**	**39 561**	**0**	**0**	**46 529**
Deposits held[1]	0	0	1 001	0	0	0	1 001
Payables[1]	0	43 881	0	0	0	0	43 881
Finance lease liabilities	0	0	0	0	0	790	790
Total Financial Liabilities	**0**	**43 881**	**1 001**	**0**	**0**	**790**	**45 672**

[1]Total amounts disclosed exclude statutory amounts.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

b) Credit Risk

The agency has limited credit risk exposure (risk of default). In respect of any dealings with organisations external to government, the agency has adopted a policy of only dealing with credit worthy organisations and obtaining sufficient collateral or other security where appropriate, as a means of mitigating the risk of financial loss from defaults.

The carrying amount of financial assets recorded in the financial statements, net of any allowances for losses, represents the agency's maximum exposure to credit risk without taking account of the value of any collateral or other security obtained.

Receivables

Receivable balances are monitored on an ongoing basis to ensure that exposure to bad debts is not significant. A reconciliation and ageing analysis of receivables is presented below.

Internal Receivables	Ageing of Receivables	Ageing of Impaired Receivables	Net Receivables
	$000	$000	$000
2015-16			
Not overdue	4	0	4
Overdue for less than 30 days	24	0	24
Overdue for 30 to 60 days	0	0	0
Overdue for more than 60 days	16	0	16
Total	**44**	**0**	**44**

Reconciliation of the Allowance for Impairment Losses	
Opening balance	0
Written off during the year	0
Recovered during the year	0
Increase/(Decrease) in allowance recognised in profit or loss	0
Total	**0**

2014-15			
Not overdue	1	0	1
Overdue for less than 30 days	6	0	6
Overdue for 30 to 60 days	0	0	0
Overdue for more than 60 days	4	0	4
Total	**11**	**0**	**11**

Reconciliation of the Allowance for Impairment Losses	
Opening balance	0
Written off during the year	0
Recovered during the year	0
Increase/(Decrease) in allowance recognised in profit or loss	0
Total	**0**

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

External Receivables	Ageing of Receivables	Ageing of Impaired Receivables	Net Receivables
	$000	$000	$000
2015-16			
Not overdue	46 231	0	46 231
Overdue for less than 30 days	199	0	199
Overdue for 30 to 60 days	139	0	139
Overdue for more than 60 days	1 080	729	351
Total	**47 649**	**729**	**46 921**

Reconciliation of the Allowance for Impairment Losses	
Opening balance	509
Written off during the year	(9)
Recovered during the year	0
Increase/(Decrease) in allowance recognised in profit or loss	229
Total	**729**

2014-15			
Not overdue	37 273	0	37 273
Overdue for less than 30 days	1 911	0	1 911
Overdue for 30 to 60 days	128	0	128
Overdue for more than 60 days	746	509	237
Total	**40 058**	**509**	**39 549**

Reconciliation of the Allowance for Impairment Losses	
Opening balance	269
Written off during the year	(69)
Recovered during the year	0
Increase/(Decrease) in allowance recognised in profit or loss	309
Total	**509**

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

c) Liquidity Risk

Liquidity risk is the risk that the agency will not be able to meet its financial obligations as they fall due. The agency's approach to managing liquidity is to ensure that it will always have sufficient liquidity to meet its liabilities when they fall due.

The following tables detail the agency's remaining contractual maturity for its financial assets and liabilities.

2016 Maturity analysis for financial assets and liabilities

	Variable Interest Rate			Fixed Interest Rate					
	Less than a Year	1 to 5 Years	More than 5 Years	Less than a Year	1 to 5 Years	More than 5 Years	Non Interest Bearing	Total	Weighted Average
	$000	$000	$000	$000	$000	$000	$000	$000	%
Assets									
Cash and deposits	0	0	0	0	0	0	11 044	11 044	0
Receivables	0	0	0	0	0	0	46 965	46 965	0
Advances	0	0	0	0	0	0	0	0	0
Total Financial Assets	**0**	**0**	**0**	**0**	**0**	**0**	**58 009**	**58 009**	
Liabilities									
Deposits held	0	0	0	0	0	0	993	993	0
Payables	0	0	0	0	0	0	49 453	49 453	0
Finance lease liabilities	0	0	0	9	41	731	0	781	4.72
Total Financial Liabilities	**0**	**0**	**0**	**9**	**41**	**731**	**50 446**	**51 227**	

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
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2015 Maturity analysis for financial assets and liabilities

	Variable Interest Rate			Fixed Interest Rate					
	Less than a Year	1 to 5 Years	More than 5 Years	Less than a Year	1 to 5 Years	More than 5 Years	Non Interest Bearing	Total	Weighted Average
	$000	$000	$000	$000	$000	$000	$000	$000	%
Assets									
Cash and deposits	0	0	0	0	0	0	6 968	6 968	0
Receivables	0	0	0	0	0	0	39 561	39 561	0
Advances	0	0	0	0	0	0	0	0	0
Total Financial Assets	**0**	**0**	**0**	**0**	**0**	**0**	**46 529**	**46 529**	
Liabilities									
Deposits held	0	0	0	0	0	0	1 001	1 001	0
Payables	0	0	0	0	0	0	43 881	43 881	0
Finance lease liabilities	0	0	0	9	39	742	0	790	4.72
Total Financial Liabilities	**0**	**0**	**0**	**9**	**39**	**742**	**44 882**	**45 672**	

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. It comprises interest rate risk, price risk and currency risk.

(i) Interest Rate Risk

The Central Australia Health Service is not exposed to interest rate risk as agency financial assets and financial liabilities, with the exception of finance leases are non interest bearing. Finance lease arrangements are established on a fixed interest rate and as such do not expose the Central Australia Health Service to interest rate risk.

(ii) Price Risk

The Central Australia Health Service is not exposed to price risk as Central Australia Health Service does not hold units in unit trusts.

(iii) Currency Risk

The Central Australia Health Service is not exposed to currency risk as Central Australia Health Service does not hold borrowings denominated in foreign currencies or transactional currency exposures arising from purchases in a foreign currency.

e) Net Fair Value

The fair value of financial instruments is determined on the following basis:

- the fair value of cash, deposits, advances, receivables and payables approximates their carrying amount, which is also their amortised cost;
- the fair value of derivative financial instruments are derived using current market yields and exchange rates appropriate to the instrument; and

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

- the fair value of other monetary financial assets and liabilities is based on discounting to present value the expected future cash flows by applying current market interest rates for assets and liabilities with similar risk profiles.

For financial instruments measured and disclosed at fair value, the following table groups the instruments based on the level of inputs used.

2016	Total Carrying Amount	Net Fair Value Level 1	Net Fair Value Level 2	Net Fair Value Level 3	Net Fair Value Total
	$000	$000	$000	$000	$000
Financial Assets					
Cash and deposits	11 044	11 044	0	0	11 044
Receivables	46 965	46 965	0	0	46 965
Total Financial Assets	**58 009**	**58 009**	**0**	**0**	**58 009**
Financial Liabilities					
Deposits held	993	993	0	0	993
Payables	49 453	49 453	0	0	49 453
Finance lease liabilities	781	781	0	0	781
Total Financial Liabilities	**51 227**	**51 227**	**0**	**0**	**51 227**

2015	Total Carrying Amount	Net Fair Value Level 1	Net Fair Value Level 2	Net Fair Value Level 3	Net Fair Value Total
	$000	$000	$000	$000	$000
Financial Assets					
Cash and deposits	6 968	6 968	0	0	6 968
Receivables	39 561	39 561	0	0	39 561
Total Financial Assets	**46 529**	**46 529**	**0**	**0**	**46 529**
Financial Liabilities					
Deposits held	1 001	1 001	0	0	1 001
Payables	43 881	43 881	0	0	43 881
Finance lease liabilities	790	790	0	0	790
Total Financial Liabilities	**45 672**	**45 672**	**0**	**0**	**45 672**

There were no changes in valuation techniques during the period.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

	2016		2015	
	Internal	External	Internal	External
	$000	$000	$000	$000

18. COMMITMENTS

(i) Capital Expenditure Commitments

Capital expenditure commitments primarily related to the purchase of plant and equipment. Capital expenditure commitments contracted for at balance date but not recognised as liabilities are payable as follows:

Within one year	0	0	0	0
Later than one year and not later than five years	0	0	0	0
Later than five years	0	0	0	0
	0	**0**	**0**	**0**

(ii) Operating Lease Commitments

The agency leases property under non-cancellable operating leases expiring from 3 to 5 years. Leases generally provide the agency with a right of renewal at which time all lease terms are renegotiated. The agency also leases items of plant and equipment under non-cancellable operating leases. Future operating lease commitments not recognised as liabilities are payable as follows:

Within one year	0	213	0	223
Later than one year and not later than five years	0	297	0	511
Later than five years	0	0	0	0
	0	**510**	**0**	**734**

(iii) Other Expenditure Commitments

Other non-cancellable expenditure commitments not recognised as liabilities are payable as follows:

Within one year	0	8 932	0	7 467
Later than one year and not later than five years	0	5 644	0	0
Later than five years	0	0	0	0
	0	**14 576**	**0**	**7 467**

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

19. CONTINGENT LIABILITIES AND CONTINGENT ASSETS

a) Contingent Liabilities

The Central Australia Health Service had no contingent liabilities as at 30 June 2016 or 30 June 2015.

b) Contingent Assets

The Central Australia Health Service had no contingent assets as at 30 June 2016 or 30 June 2015.

20. EVENTS SUBSEQUENT TO BALANCE DATE

No events have arisen between the end of the financial year and the date of this report that require adjustment to, or disclosure in these financial statements.

21. ACCOUNTABLE OFFICER'S TRUST ACCOUNT

In accordance with Section 7 of the *Financial Management Act*, an Accountable Officer's Trust Account has been established for the receipt of money to be held in trust. A summary of activity is shown below:

Nature of Trust Money	Opening Balance 1 July 2015	Receipts	Payments	Closing Balance 30 June 2016
Private Practice Revenue	160 489	80 352	35 371	**205 470**
Bond Money	413 993	100 905	184 120	**330 778**
Unclaimed Money	124 641	417	0	**125 058**
	699 123	**181 674**	**219 491**	**661 306**

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NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

22. WRITE-OFFS, POSTPONEMENTS, WAIVERS, GIFTS AND EX GRATIA PAYMENTS

	Agency		Agency		Territory Items		Territory Items	
	2016	No. of Trans.	2015	No. of Trans.	2016	No. of Trans.	2015	No. of Trans.
	$000		$000		$000		$000	
Write-offs, Postponements and Waivers Under the *Financial Management Act*								
Represented by:								
Amounts written off, postponed and waived by Delegates								
Irrecoverable amounts payable to the Territory or an agency written off	9	11	14	32				
Losses or deficiencies of money written off	0	0	0	0				
Public property written off	1	2	1	29				
Waiver or postponement of right to receive or recover money or property	0	0	0	0				
Total Written Off, Postponed and Waived by Delegates	**10**	**13**	**15**	**61**				
Amounts written off, postponed and waived by the Treasurer								
Irrecoverable amounts payable to the Territory or an agency written off	0	0	55	4				
Losses or deficiencies of money written off	0	0	0	0				
Public property written off	0	0	0	0				
Waiver or postponement of right to receive or recover money or property	0	0	0	0				
Total Written Off, Postponed and Waived by the Treasurer	**0**	**0**	**55**	**4**				
Write-offs, Postponements and Waivers Authorised Under Other Legislation	**0**	**0**	**0**	**0**				
Gifts Under the *Financial Management Act*	**0**	**0**	**0**	**0**				
Gifts Authorised Under Other Legislation	**0**	**0**	**0**	**0**				
Ex Gratia Payments Under the *Financial Management Act*	**0**	**0**	**0**	**0**				

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

23. BUDGETARY INFORMATION

Comprehensive Operating Statement	2015-16 Actual	2015-16 Original Budget	Variance	Note
	$000	$000	$000	
INCOME				
Grants and subsidies revenue				
Current	142 652	133 451	9 201	
Sales of goods and services	212 165	205 561	6 604	
Other income	3 319	30	3 289	1
TOTAL INCOME	**358 136**	**339 042**	**19 094**	
EXPENSES				
Employee expenses	216 825	210 318	6 507	
Administrative expenses				
Purchases of goods and services	115 574	109 717	5 857	
Repairs and maintenance	4 384	3 350	1 034	2
Depreciation and amortisation	10 480	8 875	1 605	
Other administrative expenses	372	0	372	3
Grants and subsidies expenses				
Current	14 230	13 950	280	
Capital	849	0	849	4
Interest expenses	38	0	38	5
TOTAL EXPENSES	**362 752**	**346 210**	**16 542**	
NET SURPLUS/(DEFICIT)	**(4 616)**	**(7 168)**	**2 552**	
OTHER COMPREHENSIVE INCOME				
Items that will not be reclassified to net surplus/deficit				
Changes in asset revaluation surplus	11 132	0	11 132	6
TOTAL OTHER COMPREHENSIVE INCOME	**11 132**	**0**	**11 132**	
COMPREHENSIVE RESULT	**6 516**	**(7 168)**	**13 684**	

Notes:
The following note descriptions relate to variances greater than 10 per cent or where multiple significant variances have occurred.

1. Original budget is subject to significant variation during the year due to restructures and timing of Commonwealth funding.
2. Additional repairs and maintenance budget transferred from Minor New Works program.
3. Write offs and doubtful debts expenses.
4. Capital grant for ambulance services.
5. Finance lease interest relating to long term leases on Aboriginal land.
6. Revaluation of remote health clinics.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Balance Sheet	2015-16 Actual	2015-16 Original Budget	Variance	Note
	$000	$000	$000	
ASSETS				
Current assets				
Cash and deposits	11 044	9 491	1 553	1
Receivables	47 926	54 667	(6 741)	2
Inventories	1 600	1 974	(374)	3
Prepayments	120	88	32	4
Total current assets	**60 690**	**66 220**	**(5 530)**	
Non-current assets				
Property, plant and equipment	211 159	214 409	(3 250)	
Total non-current assets	**211 159**	**214 409**	**(3 250)**	
TOTAL ASSETS	**271 849**	**280 629**	**(8 780)**	
LIABILITIES				
Current liabilities				
Deposits held	993	853	140	5
Payables	49 453	47 522	1 931	
Borrowings and advances	9	8	1	
Provisions	16 087	14 038	2 049	6
Total current liabilities	**66 542**	**62 421**	**4 121**	
Non-current liabilities				
Borrowings and advances	772	790	(18)	
Provisions	6 570	5 437	1 133	6
Total non-current liabilities	**7 342**	**6 227**	**1 115**	
TOTAL LIABILITIES	**73 884**	**68 648**	**5 236**	
NET ASSETS	**197 965**	**211 981**	**(14 016)**	
EQUITY				
Capital	245 147	208 630	36 517	6
Reserves	13 321	46 295	(32 974)	7
Accumulated funds	(60 503)	(42 944)	(17 559)	8
TOTAL EQUITY	**197 965**	**211 981**	**(14 016)**	

Notes:
The following note descriptions relate to variances greater than 10 per cent or where multiple significant variances have occurred.

1. Relates to budget surplus.
2. Relates to reduction in National Health Reform Funding receivable, offset by increase in cross border receivables.
3. Reduction in pharmaceuticals held.
4. Increase in operating prepayments.
5. Increase in cash balances of Hospital Gift Funds & Governing Council accounts.
6. Original budget is subject to significant variation during the year due to restructures and timing of Commonwealth funding.
7. Timing variance due to hospital building decrement in prior years.
8. Prior year budget deficit carried forward.

CENTRAL AUSTRALIA HEALTH SERVICE
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Cash Flow Statement	2015-16 Actual	2015-16 Original Budget	Variance	Note
	$000	$000	$000	
CASH FLOWS FROM OPERATING ACTIVITIES				
Operating receipts				
Grants and subsidies received				
Current	142 652	133 451	9 201	
Receipts from sales of goods and services	217 725	205 591	12 134	
Total operating receipts	**360 377**	**339 042**	**21 335**	
Operating payments				
Payments to employees	(220 085)	(210 318)	(9 767)	
Payments for goods and services	(119 546)	(113 067)	(6 479)	
Grants and subsidies paid				
Current	(14 218)	(13 950)	(268)	
Capital	(849)	0	(849)	1
Interest paid	(38)	0	(38)	2
Total operating payments	**(354 736)**	**(337 335)**	**(17 401)**	
Net cash from/(used in) operating activities	**5 642**	**1 707**	**3 935**	
CASH FLOWS FROM INVESTING ACTIVITIES				
Investing receipts				
Proceeds from asset sales	0	0	0	
Total investing receipts	**0**	**0**	**0**	
Investing payments				
Purchases of assets	(1 234)	(1 735)	501	3
Total investing payments	(1 234)	(1 735)	501	
Net cash from/(used in) investing activities	**(1 234)**	**(1 735)**	**501**	
CASH FLOWS FROM FINANCING ACTIVITIES				
Financing receipts				
Deposits received	(8)	0	(8)	4
Total financing receipts	**(8)**	**0**	**(8)**	
Financing payments				
Finance lease payments	(9)	(0)	(9)	5
Equity withdrawals	(315)	(0)	(315)	3
Total financing payments	**(324)**	**(0)**	**(324)**	
Net cash from/(used in) financing activities	**(332)**	**(0)**	**(332)**	
Net increase/(decrease) in cash held	4 076	(28)	4 104	
Cash at beginning of financial year	6 968	9 519	(2 551)	
CASH AT END OF FINANCIAL YEAR	**11 044**	**9 491**	**1 553**	

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Notes:
The following note descriptions relate to variances greater than 10 per cent or where multiple significant variances have occurred.

1. Capital grant for ambulance services.
2. Finance lease interest relating to long term leases on Aboriginal land.
3. Original budget is subject to significant variation during the year due to restructures and timing of Commonwealth funding.
4. Accountable Officer's Trust Account transactions.
5. Finance lease payments for long term leases on Aboriginal land.

Appendices

Appendix A - Legislation

Legislative responsibilities

Under the current Administrative Arrangements the Department of Health has responsibility for administering 32 pieces of legislation, 23 Acts and nine Regulations.

Acts administered by the Department of Health on behalf of the Minister for Health, the Minister for Disability Services and the Minister for Mental Health Services include:

Guardianship of Adults Act
Alcohol Mandatory Treatment Act (excluding Part 6)
Cancer (Registration) Act
Carers Recognition Act
Disability Services Act
Emergency Medical Operations Act
Food Act
Health Practitioner Regulation (National Uniform Legislation) Act
Health Practitioners Act (except Part 3)
Health Services Act 2014
Medical Services Act
Medicines, Poisons and Therapeutic Goods Act
Mental Health and Related Services Act (except Part 15)
National Health Funding Pool and Administration (National Uniform Legislation) Act
Notifiable Diseases Act
Private Hospitals Act
Public and Environmental Health Act
Radiation Protection Act
Tobacco Control Act (except provisions about smoking in liquor licensed premises, licensing and enforcement)
Transplantation and Anatomy Act
Volatile Substance Abuse Prevention Act
Water Supply and Sewerage Services Act (provisions about water quality standards)

Regulations administered by the Department of Health

Alcohol Mandatory Treatment Regulations
Cancer (Registration) Regulations
Food Regulations
Health Services Regulations
Medicines, Poisons and Therapeutic Goods Regulations
Mental Health and Related Services Regulations
Public and Environmental Health Regulations
Radiation Protection Regulations
Tobacco Control Regulations
Volatile Substance Abuse Prevention Regulations

Appendix B - Grant recipients

2015/16 FY Grant & Subsidy Disbursement Data

Exhibited data represents grant and subsidy payments managed by the Grants Administration Unit for the Department of Health during the 2015/16 financial year, where total payments during the financial year have exceeded $10,000.

Recipient Organisation	Total Payments
ABORIGINAL HOSTELS LTD	$505,137.00
ALICE SPRINGS TOWN COUNCIL	$30,000.00
AMITY COMMUNITY SERVICES	$365,491.00
AMSANT ABORIGINAL MEDICAL SERVICES ALLIANCE OF THE NT INC	$956,284.00
ANGLICARE N.T. LTD.	$1,429,106.00
ANIMAL MANAGEMENT IN RURAL & REMOTE INDIGENOUS COMMUNITIES INC	$55,809.00
ANTI-CANCER FOUNDATION OF SOUTH AUSTRALIA	$65,144.00
ANYINGINYI HEALTH ABORIGINAL CORPORATION	$233,007.00
ARTHRITIS FOUNDATION OF THE NORTHERN TERRITORY INC	$85,118.00
ASSOCIATION OF ALCOHOL AND OTHER DRUG AGENCIES NT INC	$273,240.00
ASTHMA FOUNDATION OF THE NT INC	$294,138.00
AUSTRALIAN BREASTFEEDING ASSOCIATION - NT REGIONAL BRANCH	$20,027.00
AUSTRALIAN REGIONAL AND REMOTE COMMUNITY SERVICES LTD	$103,321.00
AUTISM NORTHERN TERRITORY INC	$15,912.00
BAGOT COMMUNITY INCORPORATED	$462,251.00
BARKLY REGION ALCOHOL AND DRUG ABUSE ADVISORY GROUP INCORPORATED	$3,444,651.58
BARKLY REGIONAL COUNCIL	$77,424.00
BEYOND BLUE LIMITED	$241,139.00
BUSHMOB INCORPORATED	$1,549,725.00
CALVARY COMMUNITY CARE	$141,222.00
CANCER COUNCIL OF THE NT INC	$375,704.00
CARERS NT INCORPORATED	$407,823.00
CARPENTARIA DISABILITY SERVICES INC	$15,653,706.00
CASA CENTRAL AUSTRALIA INCORPORATED	$4,278,700.00
CATHOLICCARE NT	$908,326.00
CENTRAL AUSTRALIAN ABORIGINAL ALCOHOL PROGRAM UNIT	$2,408,743.00
CENTRAL AUSTRALIAN ABORIGINAL CONGRESS ABORIGINAL CORPORATION	$1,983,744.00
CENTRAL AUSTRALIAN REMOTE HEALTH DEVELOPMENT SERVICES LTD	$308,640.00
CENTRAL DESERT REGIONAL COUNCIL	$28,872.00
CENTRE FOR REMOTE HEALTH	$33,154.00
CHILDBIRTH EDUCATION ASSOCIATION DARWIN INC	$40,573.00
CHILDBIRTH EDUCATION ASSOCIATION INCORPORATED (CA)	$58,678.00

Recipient Organisation	Total Payments
COUNCIL FOR ABORIGINAL ALCOHOL PROGRAM SERVICES INC.	$713,945.00
CRISIS LINE INC. (T/A LIFELINE TOP END)	$200,000.00
D & R COMMUNITY SERVICES PTY LTD	$328,353.00
DANILA DILBA BILURU BUTJI BINNILUTLUM HEALTH SERVICE ABORIGINAL CORPORATION	$551,446.00
DARWIN COMMUNITY LEGAL SERVICES INC	$85,324.00
DEAF CHILDREN AUSTRALIA	$32,776.00
DIABETES ASSOCIATION OF THE NT INC	$827,527.00
DISABILITY ADVOCACY SERVICE	$75,318.00
DOWN SYNDROME ASSOCIATION OF THE NT INC	$129,558.00
DRAKE AUSTRALIA PTY LTD	$566,651.00
DRUG AND ALCOHOL SERVICES ASSOCIATION ALICE SPRINGS INCORPORATED	$1,676,159.00
DUNDEE PROGRESS ASSOCIATION INCORPORATED	$38,104.00
EAST ARNHEM REGIONAL COUNCIL	$861,196.00
EASTERN HEALTH	$63,845.00
EMPLOYEE ASSISTANCE SERVICE NT INC	$205,223.00
F.O.R.W.A.A.R.D.	$913,197.00
FAMILY PLANNING WELFARE ASSOCIATION OF NT INC.	$790,754.00
FCD HEALTH LTD	$1,566,476.00
FORSTER FOUNDATION - BANYAN HOUSE	$919,043.00
GOLDEN GLOW CORPORATION (NT) PTY LTD	$3,809,825.00
GROW	$199,291.00
GUIDE DOGS ASSOCIATION OF SA & NT INC.	$79,759.00
HEALTH NETWORK NORTHERN TERRITORY LTD T/A NORTHERN TERRITORY PHN	$220,694.00
HEALTHSCOPE OPERATIONS PTY LTD	$2,168,223.00
HOLYOAKE	$544,747.00
HPA INCORPORATED	$851,824.00
INDUSTRY EDUCATION NETWORKING PTY LTD	$2,450,646.00
INTEGRATED DISABILITY ACTION INC	$30,397.00
JILAMARA ARTS AND CRAFTS ASSOCIATION	$62,546.00
KALANO COMMUNITY ASSOCIATION INC.	$698,104.00
KAREN SHELDON CATERING PTY LTD	$6,330,669.00
KATHERINE TOWN COUNCIL	$20,000.00
KATHERINE WEST HEALTH BOARD	$4,329,471.00
KIDSAFE NT INCORPORATED	$124,308.00
LARRAKIA NATION ABORIGINAL CORPORATION	$276,413.00
LAYNHAPUY HOMELANDS ABORIGINAL CORPORATION	$125,240.00

Recipient Organisation	Total Payments
LIFE WITHOUT BARRIERS	$13,232,121.00
LIFELINE CENTRAL AUSTRALIA INC	$411,520.00
LIFESTYLE SOLUTIONS (AUST) LTD	$8,640,497.00
LOCAL GOVERNMENT ASSOCIATION OF THE NORTHERN TERRITORY	$151,501.00
MABUNJI ABORIGINAL RESOURCE ASSOC INC	$15,000.00
MACDONNELL REGIONAL COUNCIL	$162,466.00
MALABAM HEALTH BOARD ABORIGINAL CORPORATION	$89,510.00
McDONNELL SHIRE	$67,786.00
MENTAL HEALTH ASSOCIATION OF CENTRAL AUSTRALIA	$1,318,250.00
MENTAL HEALTH AUSTRALIA LTD	$20,249.00
MENTAL ILLNESS FELLOWSHIP OF AUSTRALIA (NT) INC	$459,969.00
MENZIES SCHOOL OF HEALTH RESEARCH	$4,456,845.00
MISSION AUSTRALIA	$1,198,792.00
MIWATJ HEALTH ABORIGINAL CORPORATION	$2,931,603.00
NATIONAL DISABILITY SERVICES LTD	$418,847.00
NATIONAL HEART FOUNDATION	$246,000.00
NATURAL FAMILY PLANNING COUNCIL NT INC	$12,291.00
NORTH AUSTRALIA GLOBAL SERVICES PTY LTD (T/A TERRITORY CARE & SUPPORT SERVICE)	$2,574,519.25
NORTHERN TERRITORY AIDS AND HEPATITIS COUNCIL INC	$1,262,315.00
NORTHERN TERRITORY MENTAL HEALTH COALITION	$154,390.00
NT FRIENDSHIP & SUPPORT INC (K)	$237,497.00
OZ HELP FOUNDATION LTD	$25,000.00
PEPPIMENARTI ASSOCIATION INC	$897,603.00
ROPER GULF REGIONAL COUNCIL	$95,987.00
ROYAL FLYING DOCTOR SERVICE OF AUSTRALIA CENTRAL OPERATIONS	$4,053,428.00
RUBY GAEA DARWIN CENTRE AGAINST SEXUAL VIOLENCE INCORPORATED	$391,740.00
SOMERVILLE COMMUNITY SERVICES INC	$9,327,467.00
SOMERVILLE FOUNDATION INC	$470,000.00
ST. JOHN AMBULANCE AUST. NT INC.	$24,845,134.00
STEP OUT COMMUNITY ACCESS SERVICE INC	$1,287,257.00
SUDDEN INFANT DEATH ASSOCIATION OF THE NORTHERN TERRITORY	$25,000.00
SUNRISE HEALTH SERVICE ABORIGINAL CORPORATION	$4,620,499.00
TANGENTYERE COUNCIL ABORIGINAL CORPORATION	$54,032.00
THE FLINDERS UNIVERSITY OF SOUTH AUSTRALIA T/A FLINDERS UNIVERSITY	$332,073.00
THE TRUSTEE FOR THE JACKSON FAMILY TRUST T/A CENTRE LABOUR FORCE	$172,495.00
THE TRUSTEE FOR THE SALVATION ARMY (NT) PROPERTY TRUST	$1,079,395.00

Recipient Organisation	Total Payments
TOP END ASSOCIATION FOR MENTAL HEALTH INC	$2,437,552.00
TOP END MENTAL HEALTH CONSUMER ORGANISATION INC	$142,098.00
TOTAL RECREATION	$311,995.00
VICTORIA DALY REGIONAL COUNCIL	$120,552.00
WALTJA TJUTANGKU PALYAPAYI ABORIGINAL CORPORATION	$123,064.00
WARLPIRI YOUTH DEVELOPMENT ABORIGINAL CORPORATION	$59,360.00
WEST ARNHEM REGIONAL COUNCIL	$120,114.00
WEST DALY REGIONAL COUNCIL	$98,691.00
WESTERN DESERT NGANAMPA WALYTJA PALYANTJAKU TJUTAKU ABORIGINAL CORPORATION	$263,359.00
WURLI WURLINJANG ABORIGINAL CORPORATION	$970,662.00
Grand Total	**$160,088,386.83**

Appendix C - Reporting against the PSEMA

Reporting against the PSEMA Legislation and Employment Instructions

Human Resource Actions in accordance with the PSEMA

	Initiated	Progressed	Not Progressed	Withdrawn	Carried fwd to 16/17
S49 Discipline	12	8			4
S44 Inability or unsatisfactory performance	3	1			2
S48 Retirement on grounds of invalidity	0				
S50 Summary dismissal	0				
S54 Abandonment of employment	4	3			1
S41 Declaration of potentially surplus employee	0				
S43 Redeployment	0				
S43 Redundancy voluntary	1	1			
S43 redundancy non-voluntary	0				
S32(3)(b) Probation - termination of employment	0				
S33 Termination of fixed period or casual contract	1	1			
S59B Promotion Appeals	6	5		1	
S59 Grievances	27	See Below			
S59A Discipline and Inability Appeals	4		2	2	
S59(1)(a) Grievances about Termination on Probation	1			1	

Outcomes of Grievances 2015-16	
Resolved through PSA&GR involvement:	15
Agency action confirmed:	1
Agency action confirmed with comments:	1
Resolved within the Agency:	1
Withdrawn	2
Being handled by agency	1
Pending:	6

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NORTHERN TERRITORY GOVERNMENT