DEPARTMENT OF
HEALTH

2016-17 ANNUAL REPORT

NORTHERN TERRITORY GOVERNMENT

This report would not have been possible without the valuable support and contributions of the many people who have assisted by providing content, images and their time.

NORTHERN TERRITORY GOVERNMENT

DEPARTMENT OF
HEALTH

Chief Executive
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The Hon Natasha Fyles MLA
Minister for Health
Parliament House
DARWIN NT 0800

Dear Minister

I am pleased to present you with the 2016-17 Annual Report for the Department of Health and the Health Services. 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 on the performance and achievements of 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

Professor Catherine Stoddart
3 October 2017

Purpose of the report

The Department of Health Annual Report 2016-17 provides information about the Northern Territory (NT) health system and its financial and non-financial performance for 2016-17.

It is prepared for the Minister for Health to submit to the NT Legislative Assembly to meet reporting requirements under the *Public Sector Employment and Management Act*, the *Financial Management Act*, the *Information Act* and subordinate legislation.

It includes information about the:

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

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 and Top End and Central Australia Health Services.

All three agencies report against their priorities and budget program outputs with their associated key performance indicators.

Under the current Administrative Arrangements, the Department of Health has responsibility for administering 35 pieces of legislation, 23 acts and 12 regulations.

This legislation is listed in section 8.

Acknowledgement to traditional owners

We respectfully acknowledge 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.

Aboriginal and Torres Strait Islander people are advised that this resource may contain images of deceased community members.

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For more information, including an electronic version of the annual report, visit the Department of Health website: **www.health.nt.gov.au**

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1. OVERVIEW AND HIGHLIGHTS

Chief Executive Officer's Report

Since I commenced in the position of Chief Executive Officer in March 2017, I have confirmed and deepened my appreciation of the breadth and complexity of the work undertaken by the Northern Territory (NT) public health system.

The public health system in the NT is made up of the Department and the two Health Services – Top End Health Service and Central Australia Health Service. Together, with our non-government health service providers, we strive to improve the health and wellbeing of all Territorians.

Our achievements are largely due to the passionate and dedicated staff, our greatest asset, who work across a significant geographic region and in unique and sometimes challenging conditions. I have managed to visit some parts of the Territory and plan to get out and about to see firsthand the impressive work that is happening across the Territory.

I have been amazed by, and immensely proud of, our achievements, both individually and as a team. Collectively, these achievements have made significant improvements to the health and wellbeing of our community as well as to the systems and processes that ensure safe and quality services. These achievements are mentioned throughout this annual report.

Our staff are high achievers and have been recognised locally and nationally for their contributions to health and wellbeing. Congratulations and thank you to all of you. Some of the award highlights are set out later in this section.

To guide us going forward, we are finalising our new NT Health Strategic Plan. My vision for the new strategic plan is that it will enable us to strive for the best health outcomes for Territorians. It will provide us with a shared purpose and build on the significant achievements and work that has already been done.

The development of the plan will look at our unique opportunities for changing the health and wellbeing of Territorians by reviewing our models of care and the way we undertake our roles. The plan will draw on our critical mass of expertise and skill, ensure we use technology to its full advantage and develop and grow our workforce with a culture that values learning and knowledge sharing. I am really excited about the development of this plan and the journey we will take in the years ahead.

We have a significant number of key priorities for 2017-18, including:

- Delivering on Government commitments particularly those relating to early childhood, mental health and suicide prevention.
- Implementing Government's alcohol harm reduction and reform measures.
- Preparing to open the Palmerston Regional Hospital.
- Planning for the delivery of the PET Scanner at Royal Darwin Hospital.
- Establishing the new Territory wide Clinical Senate and Health Advisory Committees in the Health Services.

Of course another key priority, which is also a significant challenge for 2017-18 is to ensure that we maximise our financial allocation in this climate of financial pressure. This will require us to make some tough choices to ensure financial sustainability. Difficult financial times can also provide opportunities for innovative thinking and innovation is another of my passions. I am keen to work with staff and my colleagues within and external to government to try new and innovative ways of delivering our services that maximise our human and financial resources in providing safe and quality care.

This year saw the dissolution of the NT Health Boards to make way for a new governance model for the Health Services. I would like to take this opportunity to thank the Board Chairs, Mrs Annette Burke, Top End Health Service and Mr Damien Ryan, Central Australia Health Service and all of the Board members for their commitment and contribution to the health and wellbeing of Territorians and for the achievements gained by the Health Services during their tenure.

Finally, I am honoured to be part of NT Health and look forward to the year ahead and facing head on the challenges and opportunities awaiting me in my role as Chief Executive.

Top End Health Service year in review

Michael Kalimnios
Chief Operating Officer

In 2016-17 we continued to improve the quality, effectiveness and efficiency of the Top End Health Service (TEHS). Our aim is to ensure all our services and staff focus on a patient-centred approach by putting the needs of our patients at the centre of everything we do. Some of the highlights for the year included:

Palmerston Regional Hospital

The Palmerston Regional Hospital Operational Commissioning Project is on time and on track. Achievements for 2016-17 included:

- Finalising service design, documentation and approval of all Individual Services Delivery Models and an overall Campus Service Model.
- The final development stage for all clinical and non-clinical commissioning plans.
- Developing the comprehensive Change Stakeholder Engagement and Communications Master Plan.

Royal Darwin Hospital Redevelopment

The Royal Darwin Hospital (RDH) Redevelopment Program was expanded to provide $72 million in capital funding for upgrades and refurbishments of the main ward block. Achievements for 2016-17 included:

- A new paediatrics ward.
- Complete upgrade of Ward 4B including the outpatients clinics and development of a new emergency department waiting room.

Gove District Hospital and New Primary Health Care Centre Facilities

Construction commenced to redevelop the emergency department at Gove District Hospital. The redevelopment is due for completion by the end of 2017.

Building works have been completed on the new Umbakumba and Numbulwar Primary Health Care Centres in East Arnhem South. The Numbulwar Primary Health Care Centre will include a new mortuary facility.

Elective Surgery

Over the past 12 months, the Division of Surgery and Critical Care RDH, Katherine Surgical Services and Gove Surgical Services achieved outstanding results in reducing the patient wait times for elective surgery. Achievements included:

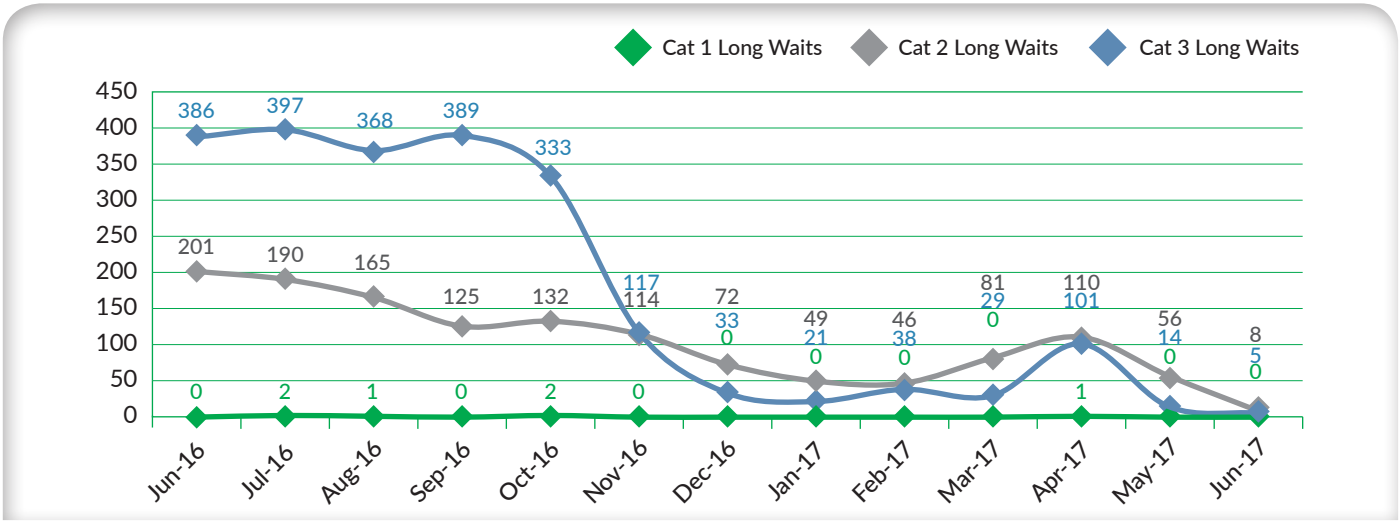
- RDH successfully reached zero per cent of patients waiting longer than 30 days for surgery (referred to as Category 1).
- The number of patients waiting longer than 90 days for surgery (referred to as Category 2) dropped from 201 to just 8.
- The number of patients waiting longer than 12 months for surgery (referred to as Category 3) reduced from 386 to just 5.

Renal Services Integration

In 2016-17, the Renal Services Integration project achievements included:

- Establishment of a Home Therapies Unit.
- Co-locating the chronic kidney disease nurses and home therapies. This will improve patient flow, planning and coordination through the integration of care from chronic kidney disease to renal replacement therapy stages.
- Expanding the Renal Allied Health Care team to include an occupational therapist and psychologist which will improve transition to care and assist patients to be independent.
- Strengthening consumer participation through consumer workshops and partnerships with non-government organisations to provide treatment in remote communities.

TEHS Elective Surgery Long Waits June 2016 to June 2017



Maternity Services Integration

Strong leadership from the clinical leaders in the maternity units of Gove, Katherine and Darwin has fostered a collaborative approach to Integrated Maternity Care, including homebirth. A commitment to service improvement and a patient centred model is providing the most relevant and appropriate care to all maternity patients. Achievements for 2016-17 included:

- Collaboration with NT Primary Health Network to develop a smooth patient journey from general practice to TEHS shared care.
- Development of a triage process that ensures women are offered and referred to services that best meet their needs.
- Development of a central clinical register of women referred to TEHS to help clinicians co-ordinate appropriate care, patient referrals and staff resourcing.
- The Community Midwifery Practice, Darwin Homebirth Service and Midwifery Group Practice have made the necessary preparations to merge into an all-risk collaborative model, offering caseload midwifery to women who choose home or hospital birthing.
- Gove District Hospital and Katherine Hospital commenced shared care case management of women who have high risk pregnancies with their primary providers in remote communities. This enables women to access their initial care closer to home and reduces unnecessary patient travel.

Mum Jocelyn Uibo and baby Keanu born at the Royal Darwin Hospital in 2017.

Midwives now work closely with a link midwife in Darwin to ensure a smooth transition if a woman's care needs are transferred or specialist input is required.

Our Staff

The TEHS staff have worked throughout the year to sharpen our focus on patient-centred care and strengthen our workforce culture and capability. Successes were acknowledged and celebrated at the Service Excellence and Innovation Awards.

Held on 9 June as part of TEHS Quality Week, the awards recognise and celebrate the integral role that all TEHS staff play in delivering on our vision of *Building Better Care*, *Better Health*, *Better Communities*, *Together*.

This year's awards were presented across six categories: Governance; Risk Management; Stakeholder Participation; Workforce Development; Leadership and Culture; and Continuous Improvement.

Our Board

I would like to thank the Top End Health Service Board Chair and Members for their significant contribution to our Health Service over the past three years. On 30 June 2017 the Board was dissolved and a Service Administrator was appointed as an interim arrangement while new administrative arrangements are developed in 2017-18.

Central Australia Health Service year in review

Sue Korner
Chief Operating Officer

The 2016-17 year saw continued success in the implementation of our Strategic Plan and achievement against the activities and priorities outlined in our Service Delivery Agreement.

The Central Australia Health Service (CAHS) continued to evolve with the successful integration of Central Australia hearing and oral health services, building on the previous year's integration of the Central Australia primary health care and alcohol and other drugs services' programs.

Alice Springs Hospital

The Alice Springs Hospital (ASH) provides essential services to the people of Central Australia.

Highlights for ASH in 2016-17 included:

- The new Intensive Care Unit and High Dependency Unit, a state-of-the-art 10-bed unit funded as part of the Northern Territory Government's $21 million refurbishment of Alice Springs Hospital. This project was completed in November 2016.
- Continuing to meet significant increases in activity, from 51,090 National Weighted Activity Units (NWAUs*) in 2015-16 to 52,609 NWAUs in 2016-17 or a three per cent increase, together with an 8.65 per cent decrease in the average length of stay through improved efficiencies in inpatient service delivery.

  *NWAUs are the unit of measurement for the number and complexity of patients receiving public hospital and specialist outreach services.
- Responding to an increase in inpatient activity, with a 3.91 per cent increase in overnight inpatient separations and periods of activity greater than 100 per cent occupancy. The per cent of patients discharged from the emergency department within four hours remains above 87 per cent with 33 per cent of all patients presenting to the emergency department requiring admission.

Improved Services

The Central Australia Health Service continues to improve services by focussing on health outcomes including:

- An increase in renal services capacity in Tennant Creek with four additional dialysis chairs so more patients can dialyse closer to home.
- Targeted childhood programs to deliver a substantial reduction in childhood anaemia.
- Introducing the Safewards Program to reduce mental health seclusion rates from approximately 20 per month to five per month.
- Improved use of technology. For example, an increase in Telehealth consultations from less than 1000 in 2015-16 to over 1700 in 2016-17. This results in more efficient use of clinicians' time and more timely and convenient access to services for patients.

Doctor and patients using Telehealth.

The Research, Education and Development Centre

In December 2016 construction of the new Research, Education, Development (RED) Centre, was completed. The Centre replaces the Teaching and Training Facility and is a significant improvement to the education and training facilities available on the Alice Springs Hospital campus. The RED Centre complements Alice Springs Hospital's growing role as an education hub for nursing and medical trainees. The Federal Government contributed $5.185 million to construction costs of the RED Centre.

Our Staff

The skilled and committed staff of CAHS are key to our capacity to drive improvement in the health services we provide. I want to thank all staff for their dedication throughout the year to improve our services.

One way in which we can acknowledge the contributions of staff is through the implementation of our Recognition of Staff Milestones Program. These awards recognise career milestones at five, ten, 15, 20 and 25 years of service. The inaugural awards were presented in November 2016. In the first year of the awards 572 staff received a certificate of appreciation and a specially designed service pin reflecting the number of years served. The awards will now be an annual event.

Our focus on supporting and developing staff was reflected in a decrease in staff turnover from 7.4 per cent in 2015-16 to 5.7 per cent in 2016-17 and an increase in Aboriginal staffing levels from 8.5 per cent in the previous year to 9 per cent of the workforce in 2016-17.

Our Board

I want to thank the Central Australia Health Service Board for their contribution to our Health Service over the past three years. On 30 June 2017 the Board was dissolved and a Service Administrator was appointed as an interim arrangement while new administrative arrangements are developed in 2017-18.

NEW ANUAL EVENT

Recognition of Staff Milestones Program. These awards recognise career milestones at five, ten, 15, 20 and 25 years of service.

CAHS staff celebrated their length of service awards at the inaugural Recognition of Staff Milestones function in Alice Springs in November 2016.

Recognition of Awards

Chronic Disease Network Recognition Awards

Award	Winner
Chronic Disease Health Promotion/Program Delivery	Diabetes Antenatal Care and Education (DANCE) team - (Alice Springs Hospital, Menzies School of Health Research and Baker IDI)
Aboriginal and Torres Strait Islander Health and Leadership (Female)	Julie Hill – Strong Women Program Coordinator, Central Australia Health Service
Aboriginal and Torres Strait Islander Health and Leadership (Male)	Charlie Gunabarra – Senior Aboriginal Health Practitioner, Top End Health Service

Chief Minister's Awards for Excellence in the Public Sector

Award	Winner
Strengthening Government and Public Administration award	The development and implementation of the Policy Guideline Centre (PGC). Special mentions to Lisa Collard, Leah Magee, Margaret Purnell, Jacquene Cranna and Mary Byrne for their involvement with this project
Innovation in the Public Sector Award	Katherine Hospital's Patient Assistance Travel Scheme (PATS) Telehealth Project. Special mentions to Michelle McGuirk, Alarna Delmenico, and Stuart Arbon for involvement with this project
Chief Minister's Medal	Janice Diamond for her contribution to the public service in aged care

2016 Aboriginal and Torres Strait Islander Health Practitioner Excellence Awards

Award	Winner
2016 Legend Award (ATSIHP of the year) and winner ATSIHP Remote Category	Mr Jason King, Santa Teresa Health Centre, Central Australian Aboriginal Congress
Highly commended, ATSIHP Remote category	Ms Jillian Katawarra, Ikuntji Health Centre, Central Australia Health Service
Winner, ATSIHP Specialist	Miss Pilar Cubillo, Batchelor Institute, Darwin
Highly Commended, ATSIHP Specialist	Miss Sumaria Corpus, Danila Dilba Health Service, Darwin
Winner, ATSIHP Urban Category	Mr Robert Charles, Central Australia Health Service, Alice Springs
Highly Commended, ATSIHP Urban category	Miss Chiquita Bin-Saris, Danila Dilba Health Service, Darwin
Winner, ATSIHP New Practitioner	Mr Kevin Ungwanaka, Ntaria (Hermannsburg) Health Centre, Central Australia Health Service
Highly commended, ATSIHP New Practitioner	Miss Jayclyn (Jess) Pascoe, Elliott Health Centre, Central Australia Health Service

2016 Nursing and Midwifery Awards

Award	Winner
2017 Nurse/Midwife of the Year	Cherie Whitbread
Northern Territory Administrator's Medal for Lifetime Achievement in Nursing/Midwifery	Denys Spencer
1st Year Graduate Nurse/ Midwife of the Year	David Szyc
Excellence in Aged, Disability and Residential Nursing	Rosalina De Guzman
Excellence in Alcohol and Other Drugs Nursing	Pauline Reynolds
Client Appreciation Award for Excellence in Nursing/ Midwifery	Methinee Intarapanya
Excellence in Nursing/ Midwifery Education and/or Research	Cherie Whitbread
Excellence in Enrolled Nursing	Charmaine Mack
Excellence in Nursing/ Midwifery Hospital Care	Dana Bailey
Excellence in Nursing/ Midwifery Leadership	Jeanette Berthelsen
Excellence in Mental Health Nursing	Ingrid Herbert
Excellence in Midwifery	Bettina Dunkley
Excellence in Nursing/ Midwifery Primary and Community Health	Eleanor Crighton
Excellence in Remote Health Nursing/Midwifery	Stuart Mobsby
Team Award for Excellence in Nursing/Midwifery Intensive Care Unit	Alice Springs Hospital

Other Awards

Award	Winner
Australian Catholic University's (ACU) Aboriginal and Torres Strait Islander Community Award	Cherisse Buzzacott winner for 2016 and Alumni of the Year
Menzies Medallion	Dr Christine Connors for her significant contribution to primary health care, Indigenous health and Top End health services delivery in the Northern Territory
Honorary Fellow of the Australian College of Nurse Practitioners.	Professor Sandra Dunn, Senior Nursing Advisor in the Office of the Chief Nursing and Midwifery Officer
Asia Pacific Emergency Medical Teams Strategic Advisory Group	Ms Bronte Martin, Director of Nursing at the NCCTRC, "double medalled" by first being selected to represent Australia on the WHO Asia Pacific Emergency Medical Teams Strategic Advisory Group, and then being chosen to chair the Group
ABC Heywire National competition winner	Crystella Campbell AOD CAHS
Remote Area Health Corps (RAHC) Annette Walker Award	Dr Margaret Niemann
Johnson and Johnson's Midwife of the Year Award	Prue Tierney
Royal Australasian College of Physicians Medal for clinical service in rural and remote areas	Dr Simon Quilty
Chamber of Commerce Northern Territory award for Best Government Department.	Alice Springs Hospital's Medical East Ward

NT Health Fast Facts

In 2016-17, taxpayer funding was used to provide a range of health services, including:

152,232 presentations to the emergency department

12,048 admissions for injuries or poisonings

604 admissions for heart attack

77,534 admissions for dialysis (haemodialysis)

1,297 admissions for Chronic Obstructive Pulmonary Disease

3,442 admissions for mental health

49,840 residents enrolled in the My Health Record national health system

81,260 overall admissions to NT public hospitals (excluding dialysis)

53,198 emergency cases resulting in ambulance attendance

3,429 babies born with assistance from a health professional

13,473 overall admissions requiring a surgical procedure

6,424 people assisted by aeromedical services

Chief Health Officer's Report

Dr Hugh Heggie

The Chief Health Officer (CHO) provides high level public health advice to the Chief Executive Officer of the Department of Health and the Minister for Health as well as other government agencies on health related issues.

In 2016-17 the Office of the Chief Health Officer (the Office) was restructured to include the Environmental Health Branch, the Centre for Disease Control and the Medical Education and Training Centre.

The CHO represents the Northern Territory on the National Health and Medical Research Council and the Australian Health Protection Principal Committee (AHPPC). The AHPPC is a sub-committee of the Australian Health Ministers' Advisory Council and the functions include overseeing disease control and health aspects of disaster and emergency preparation and response.

The CHO has extensive statutory functions under NT legislation ranging from the *Public and Environmental Health Act* and the *Notifiable Diseases Act* to the *Food Act*. The Office also has a legislative role in other acts such as the *Volatile Substance Abuse Prevention Act* and the *Mental Health and Related Services Act*.

Our population

The Northern Territory (NT) has distinctive population characteristics compared with other Australian jurisdictions. Geographically, the NT is the third largest of the states and territories, covering approximately 18 per cent of the Australian land mass, yet it has only 1 per cent of the national population, giving the NT the lowest population density of any state or territory.

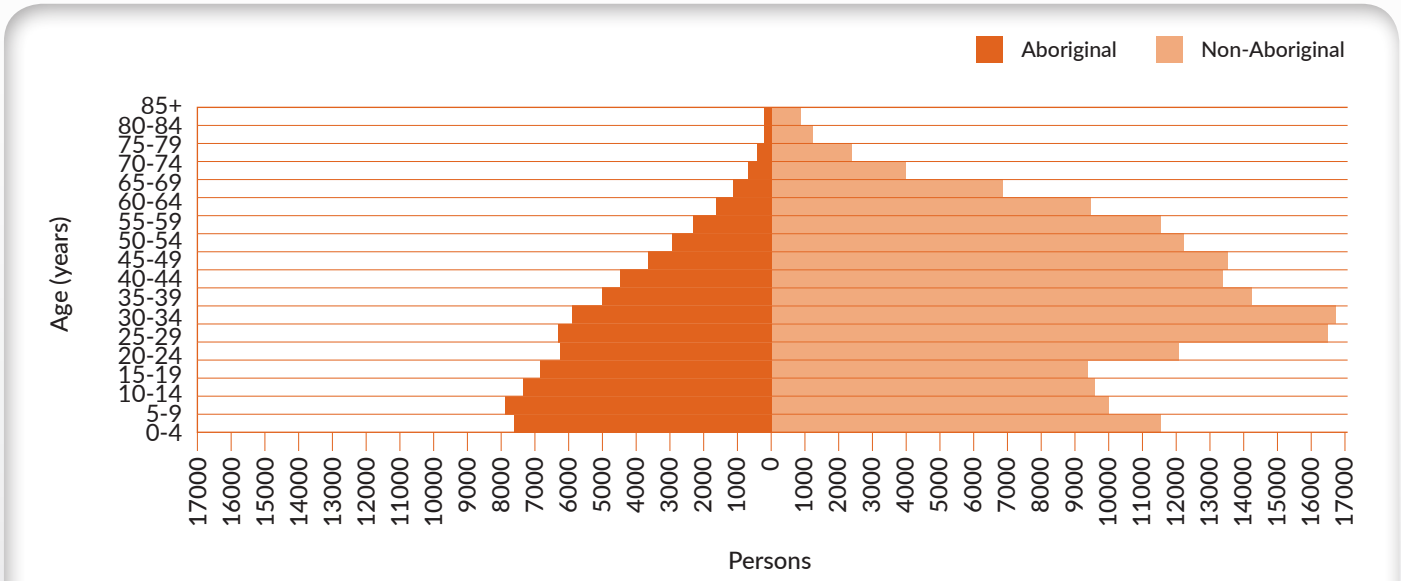
Latest available figures provide an estimated resident population of 244,880 reflecting a growth of 530 people (0.2 per cent) over the previous year. This is the lowest rate of growth of all jurisdictions. The NT also has a relatively young population, with a median age of 33 years compared with the national median age of 37 years. Males continue to outnumber females with 112 males for every 100 females.

Two further unique characteristics of the NT population are the high proportion of Aboriginal people and the geographic distribution of the population. As at June 2016 there was estimated to be 71,760 Aboriginal residents, which is 29.3 per cent of the total NT population and 10 per cent of the total Australian Aboriginal population.

The geographic distribution of the Aboriginal population varies from the non-Aboriginal population. The majority of Aboriginal residents live in remote areas and represents 78.7 per cent of the total NT Aboriginal population. In contrast the majority of the non-Aboriginal population (73.3 per cent) live in the greater Darwin area including Darwin city, Palmerston city and Litchfield Shire.

The NT Aboriginal population has a different population profile compared with the non-Aboriginal population (Figure 1).

Figure 1: Population distribution by age group and Aboriginal status, Northern Territory, 2016



Source: Department of Health, 2017, 'Northern Territory Resident Population Estimates by Age, Sex, Indigenous Status and Health Districts (1971-2016)', prepared by Health Gains Planning, file updated on 6 March 2017, using ABS Estimated Resident Population

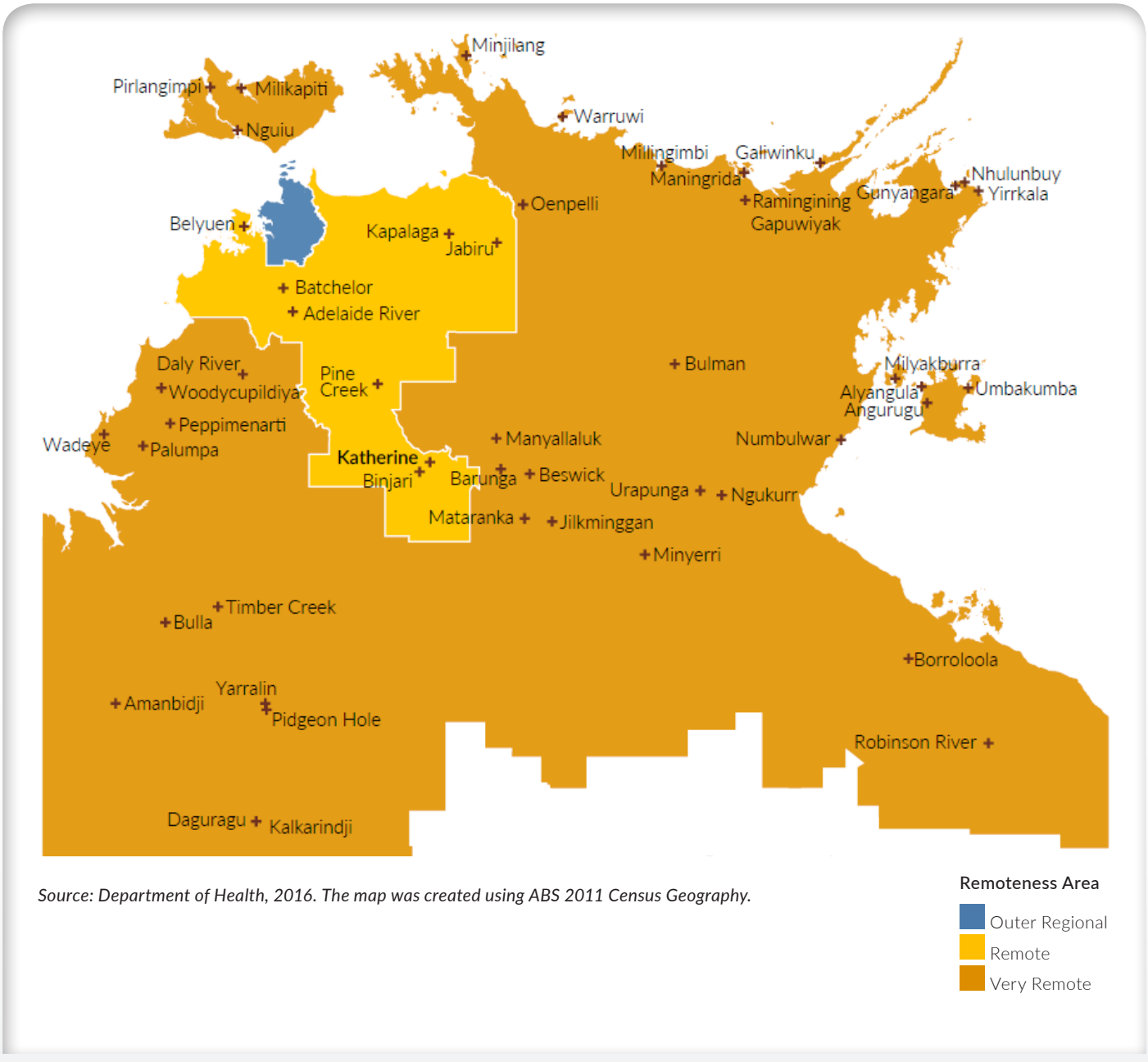
Top End Health Service

The TEHS region covers 35.3 per cent or 475,338 km² of the total area of the Northern Territory as it covers the Darwin, East Arnhem and Katherine districts.

As at June 2016 the TEHS region had an estimated resident population of 195,550 people representing 80 per cent of the total NT population. Almost three quarters of residents (142,120) live within the Darwin urban area and 89.3 per cent of these people are non-Aboriginal.

The distribution of the TEHS population among the health districts varies between Aboriginal and non-Aboriginal residents. The Top End Aboriginal population is fairly evenly spread among the health districts, with the highest proportion living in the Darwin Urban district (30.4 per cent) and the lowest proportion living in the Katherine health district (21.9 per cent). In contrast, 87.3 per cent of the Top End non-Aboriginal population live in the Darwin Urban health district with small numbers in the other districts.

Map 1: Top End Health Service Region



Source: Department of Health, 2016. The map was created using ABS 2011 Census Geography.

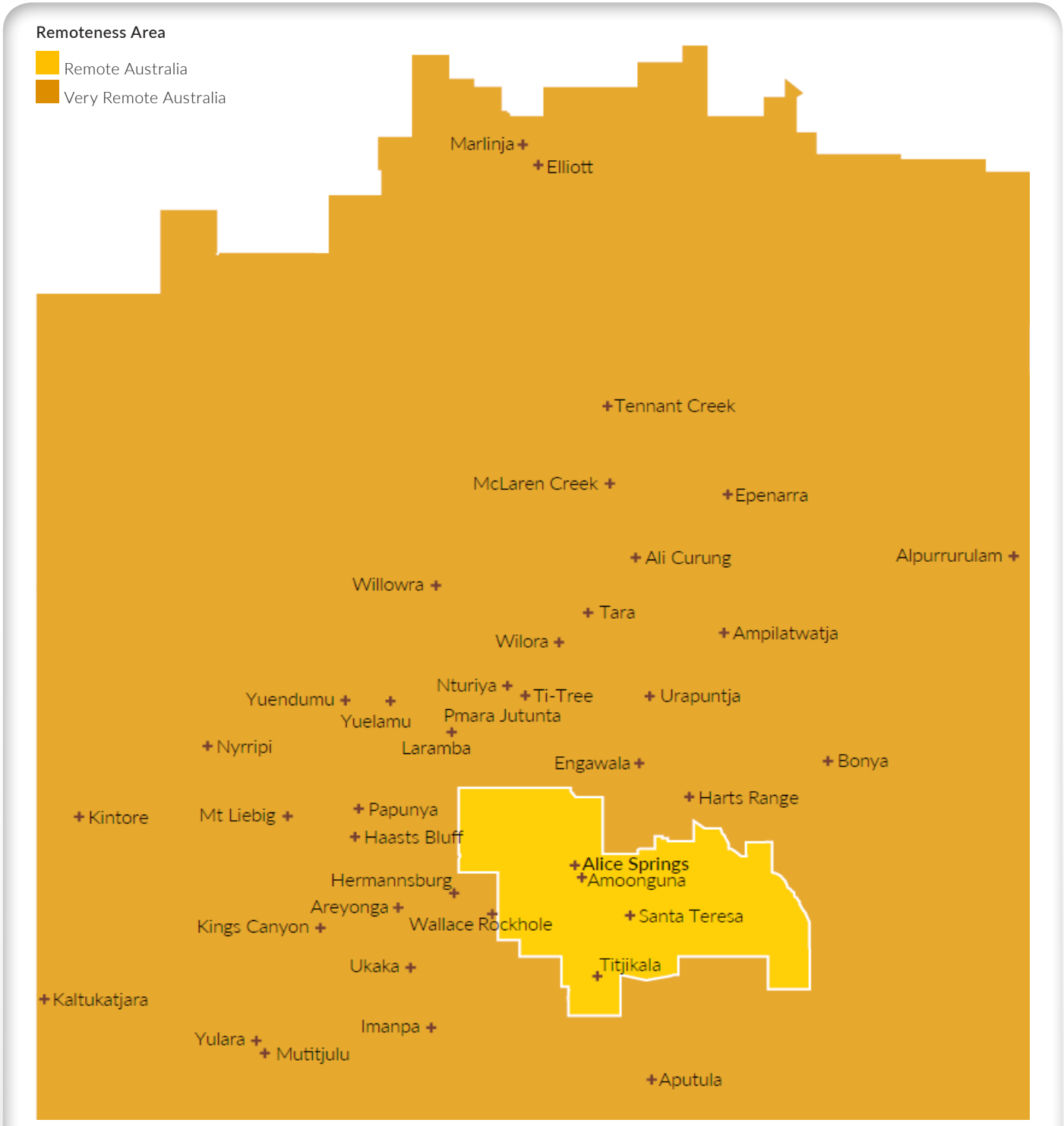
Central Australia Health Service

The CAHS region covers two-thirds (64.7 per cent) of the total area of the Northern Territory taking in the Alice Springs and Barkly districts.

As at June 2016 the CAHS region had an estimated resident population of 49,330 people representing 20 per cent of the total NT population of which 43.7 per cent were Aboriginal.

Some 83.3 per cent of the non-Aboriginal Central Australian population reside in Alice Springs. Almost half (48 per cent) of Aboriginal residents live in small communities within the Alice Springs Rural district, 30.3 per cent reside in the Alice Springs Urban district and the remaining 21.7 per cent live in the Barkly health district.

Map 2: Central Australia Health Service Region



Source: Department of Health, 2016. The map was created using ABS 2011 Census Geography.

Our health

The health needs of a population are driven by the cumulative burden of many different conditions that cause ill health and injury and that result in death. Historically the causes of death have been useful in assessing the relative importance of different conditions.

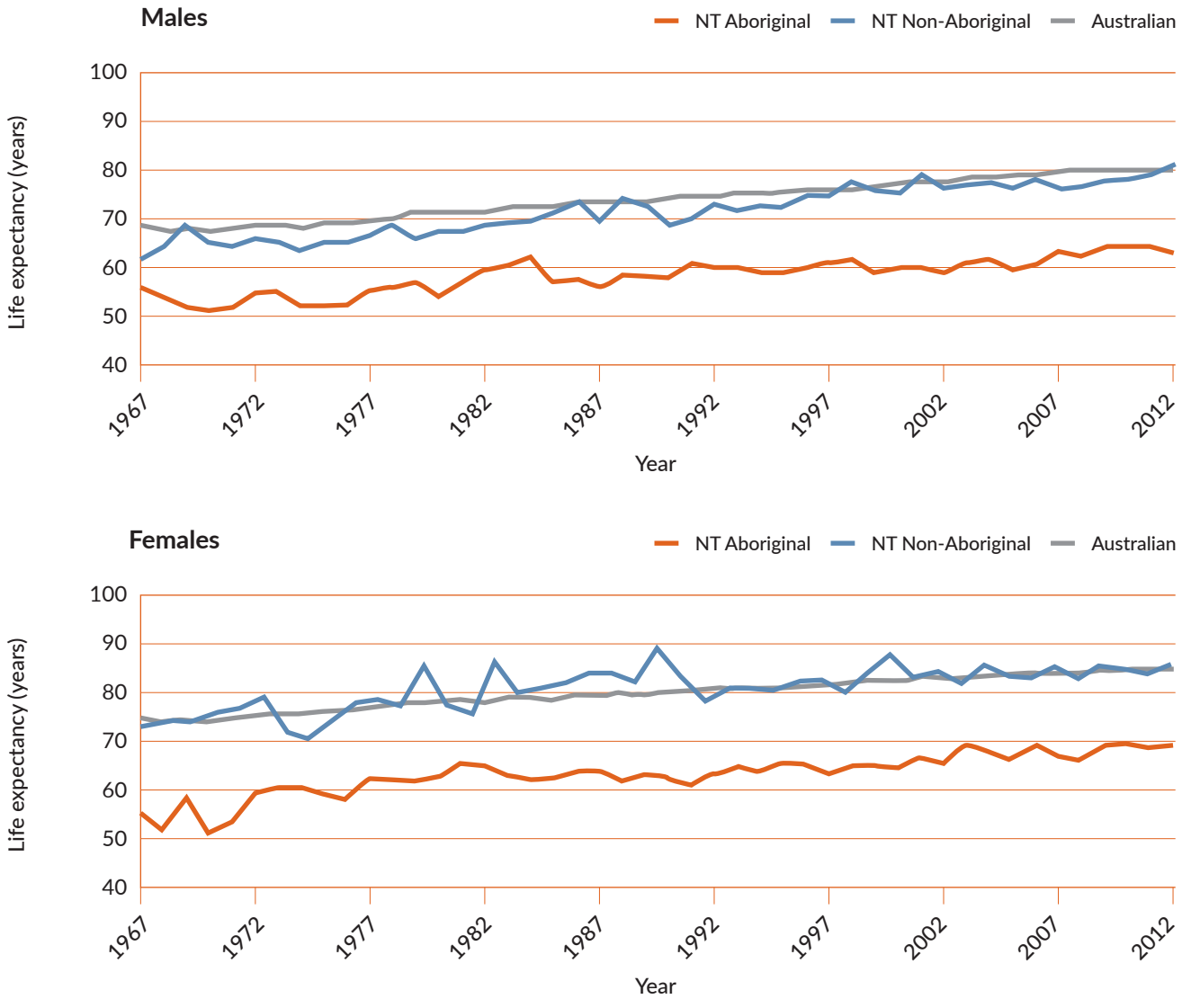
Information on age at death is also used, and provides the leading indicator of the health of a population – life expectancy at birth. Information on cause of death and age at death has been combined to deliver a more refined indicator of health need, the years of potential life lost. The death of individual at a younger age is assessed as contributing a much greater health burden than a death at an older age.

For example if the life expectancy in a population is 80 years, the group of people who died at 20 years of age will each contribute 60 years of potential years of life lost. The indicator is measured as "years of life lost".

The NT is the only jurisdiction for which life expectancy at birth for both Aboriginal and non-Aboriginal residents can be reported across a long time-period (currently 46 years from 1967 to 2012.) The results highlight that there has been substantial improvements for all Territorians.

For Aboriginal male and female Territorians life expectancy has improved by 7.5 years and 14 years respectively. For non-Aboriginal Territorians the improvements in life expectancy have been similar to the whole Australian population, which improved to 12.8 years for males and 10.2 years for females. The long term trends are presented in Figure 2.

Figure 2: Life expectancy at birth for all Australians and for Northern Territory Aboriginal and non-Aboriginal residents, 1967–2012, by sex



Source: Georges N, Guthridge S, Li SQ et al. Progress in closing the gap in life expectancy at birth for Aboriginal people in the Northern Territory, 1967-2012. Med J Aust 2017;207(1):25-30. © Copyright 2017 The Medical Journal of Australia – reproduced with permission.

While these improvements are impressive, a continuing challenge has been to close the gap in life expectancy between Aboriginal and non-Aboriginal populations. While both populations have had substantial improvement there has been little change in the gap. An analysis of the changes in age at death reflects the conditions that have underpinned these changes.

For the non-Aboriginal population, the improvement in life expectancy has largely been from a fall in death rates for adults, particularly those aged between 55 and 74 years. This factor alone contributed 46 per cent of overall improvement for males and 39 per cent of the gains for females. Improvements have occurred across many conditions, but fall in deaths rates for cardiovascular disease are particularly important and are associated with reduced smoking prevalence and improvements in health care, including active management of coronary artery disease.

For the Aboriginal population, the last 50 years have been a period of major transition. For the period from 1967 to 1984, life expectancy improved by 5.8 years for males and 9.5 years for females, of which the greatest contribution was from falls in infant mortality (73 per cent for males, and 43 per cent for females).

More generally there was improvement across different age groups through initiatives including the better management of infectious diseases, the use of antibiotics and vaccination programs, and improved maternal and early childhood services. This has been somewhat offset by the increasing impact of chronic diseases, including diabetes, cardiovascular disease and renal disease.

Further improvement and a closing of the gap in life expectancy will require continued efforts to reduce the impact of chronic diseases. The gap in life expectancy between NT Aboriginal and total Australians is now 16.3 years, and the greatest contribution to that gap is the high mortality for Aboriginal adults, with those aged 35-54 years contributing 35 per cent and those aged 55 to 74 contributing 38 per cent of the life expectancy gap.

In 2016, the third Australian Burden of Disease study was published, and included summary information for the Northern Territory.

National results highlight the relative contribution of both fatal and non-fatal conditions to the total burden of disease for all Australians. Cancer, cardiovascular disease, mental health and substance abuse, and musculoskeletal conditions are the leading causes of the total burden of disease across the Australian population.

The NT results (Figure 3) demonstrate a different order of priority for the NT Aboriginal population than for all Australians, with injury as a leading cause of burden, a reflection of the high rates of fatal and non-fatal injuries for younger Aboriginal Territorians. Cardiovascular disease, mental health and substance abuse and cancer complete the top four conditions.

Figure 3: Leading causes of total burden (proportion of DALY %), Indigenous Australians, Northern Territory, 2011

Mental/substance use	13
Cardiovascular	16
Injuries	19
Cancer	9
Respiratory	5
Musculoskeletal	4
Infant/congenital	6
Neurological	2
Endocrine	5
Gastrointestinal	4
Infectious diseases	5
Kidney/urinary	5
All other disease groups	7

Source: Australian Institute of Health and Welfare 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Australian Burden of Disease Study series no.6.BOD 7.Canberra: AIHW (modified from Table 12.1.4, page 263)

Key Issues and Interventions

Key issues and interventions for 2016-17 included:

Immunisation

NT Health worked in partnership with health clinics, schools, general practice and Aboriginal Community Controlled Health Organisations to maintain high immunisation coverage rates in infants, children and older people in the NT.

A particular successful outcome for the year has been the high coverage of influenza vaccine in Aboriginal children. In 2016-17 for Aboriginal children aged six months to less than five years the NT total coverage was 53.7 per cent compared with 11.4 per cent Australia wide.

More work is underway to increase immunisation rates in infants, children, and school aged children for the National Immunisation Program vaccines. This includes: revising current policy and education delivery; improving data quality in the NT Immunisation Register and Australian Immunisation Register; providing recall lists to immunisation providers and reminders for overdue children; and developing joint immunisation strategies with the Department of Education.

Enhanced guidelines for the National Immunisation Program vaccine eligibility and strategies to improve service delivery and the role of the new whole of life Australian Immunisation Register have been promoted with immunisation providers in regional areas. This has been achieved in collaboration with the NT Primary Health Network.

NT pharmacist led immunisations commenced in March 2017 enabling trained pharmacists across the Territory to administer influenza, measles-mumps-rubella, and diphtheria-pertussis-tetanus (DTP) vaccines to eligible residents 16 years or older.

In consultation with key pharmacy and health care organisations, a set of education and practice requirements was developed including an online upskilling course to enable pharmacists to provide a safe and effective immunisation service in the NT. This will enable more accessible training, particularly for vaccine providers in more remote areas.

The AusVax Safety Project was introduced in September 2016, in partnership with Palmerston and Casuarina Community Care Centre, to monitor, detect and provide real time feedback on possible adverse events following vaccination of children who received DTP and influenza vaccines under five years of age.

This improved vaccine safety surveillance assists to increase public confidence in vaccines. It also reassures parents who may have experienced a minor adverse event following vaccination and provides information about the risk of a future similar event and what to do if this occurs.

The herpes zoster program provided support and education for the implementation of the National Immunisation Herpes Zoster Program for people aged 70 years with a catch up program for people aged 71-79 years of age. Around 3000 doses of Zostavax have been distributed since the beginning of the program on 1 November 2016.

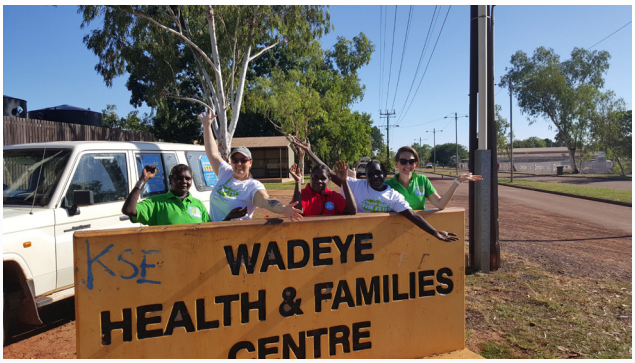
Renal disease can be better managed with increased vaccination coverage of renal dialysis clients. In November 2016 the Department worked in partnership with Darwin region renal units to increase vaccine coverage among renal dialysis clients, particularly for pneumococcal, influenza and hepatitis B vaccines.

Increased vaccination rates were achieved through staff education sessions, engaging vaccination champions, providing special vaccination clinics and working with unit managers to improve processes around assessing new clients, timeliness of vaccination, and data transmission.

This project has been extended to include regional dialysis units including Katherine and Alice Springs.

No jab, no pay legislation resulted in a significant increase in calls to the NT Immunisation Register phone line to around 3000 calls per month. To ensure calls could be answered promptly, a triaging system was introduced and additional nurses rostered to manage the large volume of calls.

In addition, secure online access to the NT Immunisation Register was promoted to approved vaccine providers allowing 24 hour read only access to immunisation records so that families could be advised of their vaccination status.



Wadeye Children's Influenza Vaccination Program – the local clinic staff and child health nurses are justifiably proud of another year of high influenza vaccination coverage at 75 per cent in children aged 6 months to 5 years.

Volatile Substance Abuse

Volatile Substance Abuse (VSA) is a complex community issue requiring coordinated responses. In 2016-17 the Centre for Disease Control (CDC) effectively led the NT Health response in partnership with Miwatj Health Aboriginal Corporation and the VSA team as part of a whole of government response, to an outbreak of lead toxicity due to avgas sniffing in East Arnhem. The CDC compiled and reported on the blood lead level data collected by Miwatj and TEHS. As part of the response, a management guide was collectively developed by government and non-government primary care services, the VSA teams and specialist paediatricians led by the Community Physician to identify, test and manage people who might have been sniffing avgas.

This outbreak added to the rationale for the mandatory notification of elevated blood levels being advocated by the CDC and as a result, changes have been made to legislation that will make elevated blood lead levels notifiable in the NT from August 2017.

Infectious Diseases

Measles, mumps and rubella (MMR). Ongoing effort continued in 2016-17 to maximise vaccination, maintain surveillance and prevent outbreaks.

The CDC issued four NT wide mumps health alerts and continued to assist communities where clusters are recognised to identify residents not up-to-date with MMR vaccinations to be offered the MMR vaccinations.

Crusted scabies was made notifiable in March 2016 and 47 cases of crusted scabies were notified to CDC in 2016-17. Education was provided to patients and families, supported by coordinated public health responses. The majority of NT cases were identified from East Arnhem and urban Darwin.

Pertussis is a contagious respiratory tract infection that is preventable by vaccine. The CDC prioritises the identification and treatment of contacts to minimise transmission to high risk patients. Four high risk infants aged new born to six months were admitted to hospital for treatment and review.

Acute rheumatic fever (ARF) prevention is targeted by the Rheumatic Heart Disease (RHD) control program to reduce first episodes and recurrences of ARF and to reduce the burden of RHD by providing education to patients, their families and health staff. There are currently 1679 patients receiving monthly prophylactic penicillin injections, most of whom will require treatment for ten years.

Trachoma elimination continues to be an NT priority. The trachoma control program promotes trachoma awareness, facilitates screening and provides treatment to all at risk communities. Trachoma rates remain low overall but have plateaued in the NT and there remain some communities with a high prevalence. This reinforces the need to address the issues of facial cleanliness and environmental hygiene as we work toward the global goal of elimination of blinding trachoma by 2020.

Tuberculosis (TB) notification rates are slowly declining among Aboriginal people through curative treatment, contact tracing and preventative treatment of high risk contacts, especially young children under five years. The CDC notified 18 new cases of TB disease.

Latent TB infection (LTBI) which represents a group of people at risk of progressing to TB disease was diagnosed in 561 people and 196 (35 per cent) were commenced on preventative TB treatment. Screening tests for 299 LTBIs were undertaken on overseas-born school children in the Darwin region.

TB outreach visits were conducted to Nhulunbuy, Katherine, Maningrida and Tennant Creek and TB clinics ran monthly at the Darwin Correctional Centre.

Influenza is characterised by seasonal occurrence. The CDC observed two influenza spikes in 2016-17. In addition to the normal seasonal increase there was a secondary spike largely contained within East Arnhem.

Rotavirus and Shigellosis require attention to good hygiene measures. Two NT-wide alerts were issued by the CDC to raise the awareness of clinicians and assist in their diagnosis and management of rotavirus. Environmental Health and CDC continue to focus on strategies to improve health hardware and hygiene messages.

Syphilis has required a focussed response from the CDC since the present outbreak was first identified in the Alice Springs region in 2014. Measures undertaken to address the outbreak include:

- Working with primary health care (PHC) services to ensure all cases are followed up and traced if possible.
- Public health alerts to health services targeting primary care doctors and nurses in remote communities to promote testing.
- Producing and promoting guidelines for use by PHC staff in remote communities.
- Community screening events in remote "hot spot" communities.
- Ongoing education sessions to remote communities to promote the need for:
  - Repeat testing.
  - Correct dosage of antibiotics.
  - Meticulous follow-up of pregnant women to prevent congenital syphilis.

Mosquito Borne Infectious Diseases

In 2016-17, salt marsh mosquito numbers remained relatively low in the Darwin urban region for most of the year, except for seasonally high numbers recorded in October, November and December.

To reduce pest and potential disease problems caused by this mosquito, a total of 26 aerial survey and control operations were carried out and a total of 2055 hectares of mosquito breeding habitat was aerially treated.

Eleven media warnings to advise the public on high biting midge and mosquito numbers and mosquito borne disease risks were issued.

The exotic dengue, chikungunya and Zika virus vectors (*Aedes aegypti* and *Aedes albopictus*) are not present in the NT, however the Asian tiger mosquito (*Aedes Albopictus*) was detected at East Arm Wharf in June 2017. The enhanced surveillance and control activities used in the response to this exotic mosquito incursion were successful. The NT remains free of exotic vector mosquitoes.

Ross River virus cases remained below the five year mean during all months of the year, despite periodically high salt marsh mosquito numbers between October and December.

Dengue is not transmitted in the NT and disease notifications were confined to 56 overseas acquired cases recorded in the NT in 2016-17 (including confirmed and probable diagnosis), along with one overseas acquired chikungunya case.

Malaria cases, all acquired overseas yielded 19 notifications in the NT, including seven cases, with patients positive for gametocytes that were investigated by the Medical Entomology unit.

Murray Valley Encephalitis was addressed through the annual public risk awareness campaign in January 2017. Messages were delivered in local languages on radio and on Facebook in remote communities across the NT.

Glen Helen Gorge Alice Springs.

Environment

The Environmental Health Branch administers the ***Food Act*** and performs a range of legislative requirements including registration of food businesses, food recalls and outbreak investigations.

A graduated and proportionate response is taken by the Environmental Health Branch in administering the Act with an emphasis on continual improvement in compliance through education.

However if there is a serious risk to public health a number of enforcement tools are used including seizure of food, improvement notices and prohibition orders or penalty infringement notices.

The Branch also has a role in investigating and advising on poisons and chemicals in our community.

Food safety activities in 2016-17 included:

- A major multi-jurisdictional food borne illness was investigated in conjunction with OzFoodNet which resulted in expanded food safety controls.
- 31 improvement notices, three prohibition orders and seven penalty infringement notices were issued.
- 26 outbreaks of gastroenteritis, including a large outbreak of *Staphylococcal* gastroenteritis affecting market stall patrons were investigated.
- An outbreak of salmonellosis which resulted in 20 people becoming ill after eating turtle in a remote community was also investigated.

Per- and poly-fluoroalkyl substances (PFAS) are a class of manufactured chemicals that have been used since the 1950s to make products that resist heat, stains, grease and water, non-stick cookware products and fire-fighting foams. These chemicals have been identified worldwide as emerging contaminants.

A PFAS interagency working group (PFASIWG) was established in the NT in April 2016 to implement a co-ordinated approach to the investigation and response to potential environmental and health issues related to PFAS. The Environmental Health Branch and the NT Environment Protection Authority co-chair the PFASIWG leading the NT PFAS investigation.

The Branch has provided input to a detailed site investigation being undertaken by the Australian Government's Department of Defence and the two reports commissioned examining the levels of PFAs in aquatic seafood taken from waterways around Darwin.

Chemicals and poisons information is essential to community safety by assisting the general public to obtain pest management services from trained and qualified persons thus reducing risks from pesticide use. Information on pest management technician licensing is now available on the nt.gov.au website. The information includes what to expect from a licensed technician and a register of persons holding a NT pest management technician licence (updated every month). This initiative is supported by a Facebook campaign.

Medical education and training

The Medical Education and Training Centre (METC) gained accreditation from the Australian Medical Council and was approved as the accrediting authority for intern programs for the next five years. In 2016-17 the METC developed and implemented a new governance structure.

In 2016-17 METC successfully introduced the processing of intern applications as bulk recruitment using eRecruit. METC staff participated in a Prevocational Education forum in Tasmania.

2016 Medical Education and Training Centre NT Junior Doctor and Clinical Educator of the Year Awards

NT Junior Doctor of the Year

Dr Tessa Finney-Browne

NT Clinical Educator of the Year

Dr Simon Quilty FRACP
Katherine Hospital

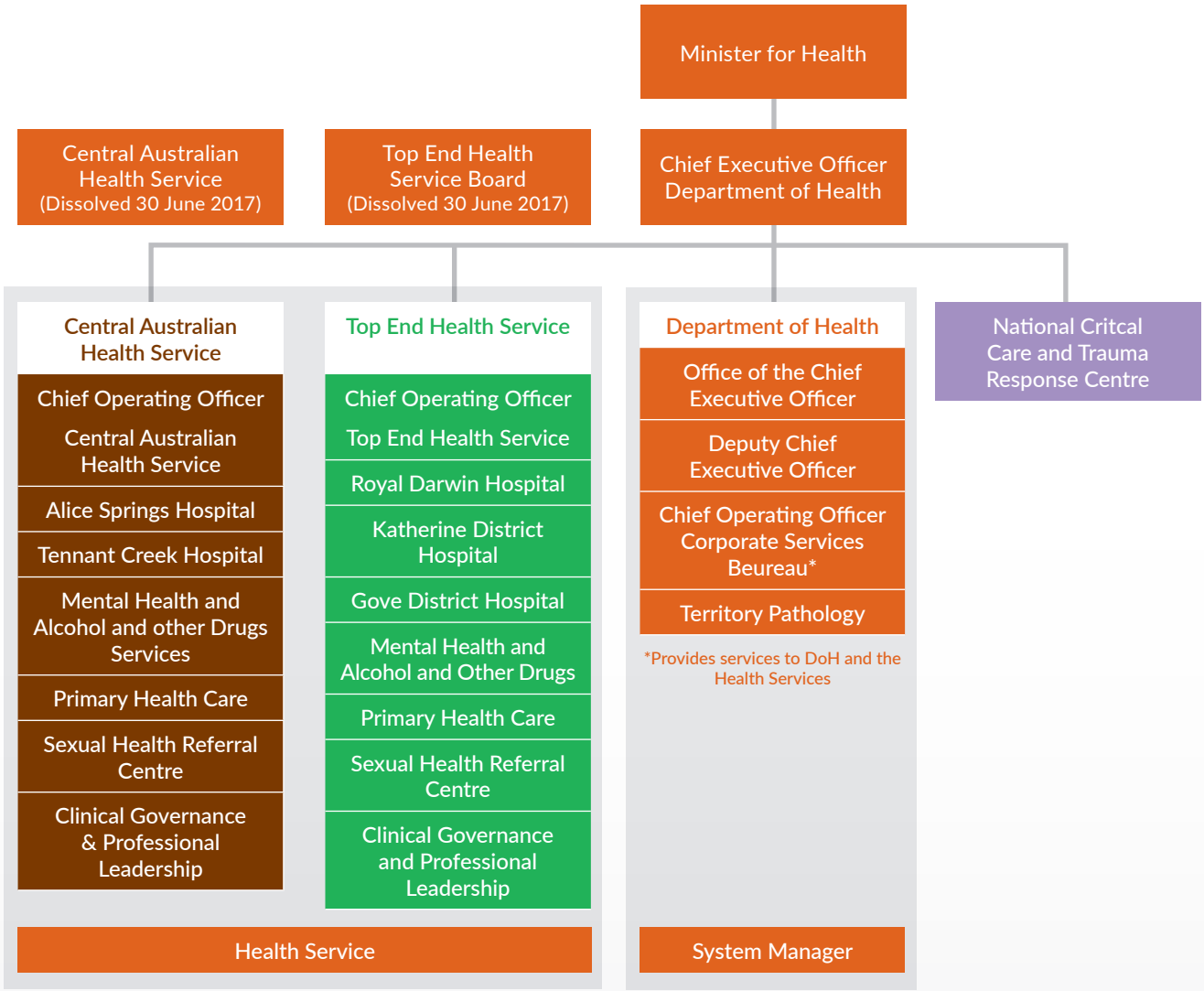
2. THE NT HEALTH SYSTEM

NT Health System Functional Structure

The public health system in the Northern Territory comprises three entities: the Department of Health as System Manager and two health service providers, being Top End Health Service and Central Australia Health Service.

Each health service operates in accordance with its legislative and regulatory framework and is responsible for the provision of health services as set out in their Service Delivery Agreements with the Department of Health.

The Health Services and the Department of Health work collaboratively to build a cohesive and integrated health system to achieve better health outcomes for Territorians.



Our Leaders

Department of Health

Professor Catherine Stoddart
Chief Executive Officer

Commenced as the Northern Territory's Chief Executive Officer of the Department of Health in March 2017.

Catherine was previously the Deputy Chief Executive and Chief Nurse at the Oxford University Hospitals NHS Foundation Trust in the UK from March 2014. Catherine has held positions across a number of health services including Chief Nurse and Midwifery Officer of Western Australia, Regional Director for the Kimberly region, Executive Director Nursing and Midwifery for the WA Country Health Service, and Director Clinical Reform WA Health.

As a Nuffield Fellow (2000) and Churchill Fellow (2006) she reviewed models for isolated clinical practice in Alaska and Canada, focusing on Indigenous communities. She is a Visiting Professor of Nursing at Oxford Brookes University and Associate Professor at Edith Cowan and Notre Dame Universities.

Catherine has a Bachelor of Science (Nursing), Master of Project Management and Master of Business Administration. She was awarded the 2011 Telstra Western Australia Business Woman of the Year for leadership and development of aboriginal employment programs across Health. In September 2013, Catherine received the Public Service Medal in recognition of her contribution to health and innovative global community health volunteering programs.

Department of Health

Janet Anderson
Deputy Chief Executive Officer

Commenced as the Northern Territory's Deputy Chief Executive Officer of the Department of Health in November 2015. Janet was the acting Chief Executive Officer from September 2016 - March 2017.

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.

Department of Health

Lisa Watson
Chief Operating Officer

Commenced as the Northern Territory's Chief Operating Officer of the Department of Health in August 2015.

With a career spanning over 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.

Department of Health

Jan Currie
Senior Director, Office of the Chief Executive

Commenced as the Senior Director, Office of the Chief Executive in March 2011.

Jan has been in the public sector in senior management roles since 1989. She was with the Department of Justice until taking up a position in the Department of Health in 1998. Since joining the Department of Health Jan has held senior executive positions with responsibility for Executive Services, ministerial liaison, risk, audit and assurance, counter disaster and emergency response, legal services, freedom of information and privacy, media marketing and communications, corporate services, human resources, industrial relations and workforce.

Jan lead the restructure of the Department of Health following the Bansemer Review of the Department in 2001. From 2007 to 2010 Jan held the position of Deputy General Manager, Royal Darwin Hospital and in mid-2010 held the position of Deputy Chief Executive Acute Care leading up to the national health reform which saw a restructure of the Department.

Top End Health Service

Michael Kalimnios
Chief Operating Officer

Commenced as Chief Operating Officer of the Top End Health Service in January 2015.

Prior to this role, Michael was the Chief Finance Officer and Acting Executive Director of Funding, Performance and Corporate within the Department of Health for three years.

Michael is also a Chartered Accountant and has worked in senior roles within the public health sector for more than 20 years.

Central Australia Health Service

Sue Korner
Chief Operating Officer

Commenced as the Chief Operating Officer of the Central Australia Health Service in September 2014.

Prior to this role, Sue was Acting Chief Executive Officer 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 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 30 years.

Overview of the Department of Health

Vision	Healthy Territorians engaged and living in Healthy Communities.
Mission	We promote, protect and improve the health and wellbeing of all Territorians in partnership with individuals, families and the community.
Values	We are driven by public sector 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 and to drive greater efficiency and effectiveness in our public hospitals and primary health care.

The Department is the system manager for the Northern Territory Health system. The Department is therefore 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 and the Northern Territory Aboriginal Health Forum.

Our Strategic Plan 2014-2017

Our strategic plan will drive the efforts and priorities of NT Health at all levels, and is built on the foundation of seven strategic objectives:

- Promote and protect health and wellbeing.
- Deliver appropriate care to vulnerable people and populations.
- Improve Aboriginal health outcomes.
- Better coordinate and integrate care.
- Strive for clinical and corporate excellence.
- Build a highly skilled and culturally responsive workforce.
- Drive financial sustainability.

The Strategic Plan can be found online at health.nt.gov.au

Our Structure

At the end of 2016-17 the Department's functional units included:

- The Office of the Chief Executive.
- The Office of the Deputy Chief Executive.
- Corporate Services Bureau.

The Department also hosts the National Critical Care and Trauma Response Centre and Territory Pathology.

In accordance with the *Health Services Act 2014*, the Chief Executive Officer (CEO) of the Department of Health has system-wide responsibilities and the Chief Operating Officers of the two Health Services have a reporting relationship to the CEO.

The Office of the Chief Executive

The Office of the Chief Executive provides executive support and coordinates information and activities across the agency, the Minister's Office and other key external stakeholders. The Office includes the following functions:

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

The Office of the Deputy Chief Executive

The Office of the Deputy Chief Executive works closely with the Health Services to plan improvements to patient care and to drive greater efficiency and effectiveness. The Office includes the following functions:

- Public Health and Medical Services.
- Nursing and Midwifery.
- System Performance and Innovation.
- System Strategic Policy and Planning.
- Alcohol and Other Drugs and Mental Health Services.
- Office of Disability.

Corporate Services Bureau

Corporate Services Bureau provides strategic leadership and service delivery of centralised corporate support functions, with an emphasis on efficiency, innovation and service excellence. The Bureau includes the following functions:

- Data Management and System Reporting.
- Financial Services.
- Grants Management System.
- Human Resources Management.
- Information Systems and Services.
- Infrastructure Services.
- Strategic Procurement and Contracting.
- Program Management Office.

Innovation in the Public Sector winners – Health Policy Guidelines Program.

National Critical Care and Trauma Response Centre (NCCTRC)

The NCCTRC is part of the Australian Government's disaster and emergency medical response to incidents of national and international significance. It supports an enhanced surge capacity for hospitals to provide a rapid response in the event of a mass casualty incident in the region. It consists of the following functions:

- Royal Darwin Hospital trauma service.
- Management of surgeon accreditation.
- Education and training of clinical and academic leadership in disaster and trauma care.

Australian paramedic Jon Moores training colleagues at the Timor-Leste Ambulance Service Centre in April 2017.

Territory Pathology

Territory Pathology provides pathology services for the NT public health system.

Overview of the Top End Health Service

Our Vision	Building Better Care, Better Health, Better Communities Together.
Our Mission	We promote, protect and improve the health and wellbeing of all Territorians in partnership with individuals, families and the community to ensure the delivery of best and most appropriate evidence based care.
Values	Our values are an essential and enduring part of our organisation and are reflective of who we are: **T** Teamwork and Trust **E** Excellence and Equity **H** Honesty and Accountability **S** Service and Innovation

Our Role and Responsibilities

Top End Health Service is a statutory body under the Northern Territory *Health Services Act 2014*. The role of the Top End Health Service is to ensure the provision of health services in the Top End as outlined in the Service Delivery Agreement (SDA) with the Department of Health.

Top End Health Service delivers the following public health services across the Top End region:

- Hospital care.
- Primary Health Care.
- Aged Care.
- Mental Health.
- Alcohol and Other Drugs.
- Oral Health.
- Hearing Health.
- Cancer Screening.

Responsibilities include:

- Compliance with the terms of the SDA and its schedules.
- Ensuring the Health Service meets Northern Territory and Australian Government legislation policy, plans, frameworks, and quality and safety standards, professional registration and clinical credentialing standards and practice.
- Achievement and maintenance of service and facility accreditation.
- Operational and business continuity planning.
- Community engagement and working collaboratively with key stakeholders to better understand the needs of the community.
- Promoting appropriate culture and values.
- Leading systemic improvements in communication between the service and the community.

Our Strategic Plan 2014-17

Our Strategic Plan has six strategic directions:

1. Foster a culture that promotes ownership of performance.
2. Promote a culture of innovation.
3. Provide safe and quality healthcare services.
4. Provide affordable and efficient healthcare services.
5. Ensure equitable access to healthcare services.
6. Build a sustainable and quality workforce.

Our Charter

Our Organisational Culture Charter is focused around patient-centred care. All aspects of our culture lead back to, and ground the organisation in ensuring the best outcome for our patients.

More information about Top End Health Service can be found online at health.nt.gov.au

Our Structure

At the end of 2016-17, TEHS's functional structure included:

- The Office of the Chief Operating Officer.
- The Strategic Executive Team.
- The Operational Executive Team.

The Office of the Chief Operating Officer

The Office of the Chief Operating Officer provides executive support, governance and co-ordination of information and activities across the Top End Health Service.

Strategic Executive Team

The Strategic Executive team's role is to build on operational effectiveness, formulate budget policy and promote financial integrity, oversee use of resources, implement management controls, manage administrative support functions and develop and oversight projects.

Operational Executive Team

The role of the Operational Executive is to provide operational leadership and performance management of the Top End Health Service to ensure effectiveness and efficiency of health services.

Functional Chart

Overview of the Central Australia Health Service

Vision	Better Health Outcomes for All Central Australians.
Mission	To promote, protect and improve the health and wellbeing of all people in the region in partnership with individuals, families and the community and to ensure the delivery of the best and most appropriate evidence based care.
Values	1. Equity and integrity. 2. Community at the centre. 3. We value our partnerships. 4. We are committed to high quality care. 5. We are relevant today and ready for tomorrow. 6. We are accountable.

Our Role and Responsibilities

Central Australia Health Service is a statutory body under the Northern Territory *Health Services Act 2014*. The role of the Central Australia Health Service is to ensure the provision of health services in Central Australia as outlined in the Service Delivery Agreement (SDA) with the Department of Health.

Central Australia Health Service includes:

- Alice Springs Hospital (including Hearing Health, Aged Care and Sexual Assault Referral Services).
- Barkly Region (including Tennant Creek Hospital and Barkly Primary Health Care).
- Primary Health Care Central (including Prison Health, Remote and Urban Primary Health Care, Oral Health and Remote Alcohol and Other Drugs Program).
- Mental Health.
- Alcohol and Other Drugs Services.
- Finance, Infrastructure and Business.
- Office of the Chief Operating Officer.
- Safety and Quality.

Responsibilities include:

- Compliance with the terms of the SDA and its schedules.
- Ensuring the Health Service meets Northern Territory and Australian Government legislation policy, plans, frameworks, and quality and safety standards, professional registration and clinical credentialing standards and practice.
- Achievement and maintenance of service and facility accreditation.
- Operational and business continuity planning.
- Community engagement and working collaboratively with key stakeholders to better understand the needs of the community.
- Promoting appropriate culture and values of the service.

Our Strategic Plan 2014-17

Our strategic plan is built on the foundation of six strategic directions which 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.

More information about Central Australia Health Service can be found at health.nt.gov.au

Our Structure

At the end of the 2016-17 year the CAHS functional structure included:

- The Office of the Chief Operating Officer.
- The Strategic Executive Team.
- Operational Support Services.
- Operational Executive Team.

The Office of the Chief Operating Officer

The Office of the Chief Operating Officer provides executive support, governance and coordination of information and activities across the Central Australia Health Service.

Strategic Executive Team

The role of the Strategic Executive Team is to ensure the development of the CAHS operational business plans, provide operational leadership and direction including the identification of priorities, risks (corporate and clinical), opportunities and strategies to facilitate the delivery of health services in Central Australia in accordance with the Service Delivery Agreement and Central Australia Health Service Strategic Plan.

Operational Support Services

Operational Support Services provides executive support and coordinates information and activities across the Central Australia Health Service.

Operational Executive Leadership Group

The role of the Operational Executive Leadership Group is to provide operational oversight of the performance of CAHS, resource management (financials, infrastructure and workforce), risk and audit compliance and monitoring of the National Safety and Quality Health Standards.

Functional Chart

NT Health System Shared Priorities for 2017-18

Priorities for NT Health in 2017-18 are focussed on implementing the Northern Territory Government's agenda and working with the Australian Government on reforms in health and disability services.

Early Childhood Strategy and the Royal Commission into the Protection and Detention of Children

The Department and Health Services will work with other Government agencies to implement Government approved recommendations for child protection and youth justice reforms arising from the Royal Commission into the Protection and Detention of Children.

A Child and Adolescent Strategic Health Plan for Young People aged 0 to 24 years will be developed to provide a holistic whole-of-government approach to improving the health and wellbeing of young people in the Territory and support the early childhood strategy.

Alcohol Reform

The Department and the Health Services will play a key role in responding to the Government's review of alcohol policies and legislation. This will include working with key stakeholders to develop appropriate responses to prevent harm from alcohol and to provide appropriate models of care for people who are affected by alcohol.

Domestic and Family Violence Reduction Strategy

The Department and Health Services will continue to work to develop service responses and operational protocols to support the implementation of the Northern Territory Government Domestic and Family Violence Reduction Strategy.

National Disability Insurance Scheme (NDIS)

During 2017-18, the National Disability Insurance Scheme will continue to transition in the Northern Territory. From 1 July 2017, the Top End Remote and supported accommodation services in Katherine and Alice Springs will commence transition.

This phase of the transition will see approximately 1,000 people transition to the NDIS.

Work will progress on participant and provider readiness as part of planning for the next stage to commence in 2018-19 with the rest of the Darwin region and Central Australia to transition from 1 July 2018.

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 Addendum to the National Health Reform Agreement: Revised Public Hospital Arrangements. 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 as part of bilateral agreements on coordinated care.
- Incorporating safety and quality into hospital pricing and funding, to avoid funding unnecessary or unsafe care by shadow pricing hospital acquired complications.

Mental Health and Suicide Prevention

The Department and Health Services will continue to implement changes and reforms to the public mental health system in accordance with the Fifth National Mental Health and Suicide Prevention Plan 2017-2022. In 2017-18 key activities include:

- Release of the Northern Territory Suicide Prevention Plan.
- Finalise the review of the Northern Territory Mental Health Strategy to reflect the directions of the Fifth National Mental Health and Suicide Prevention Plan 2017-2022.

Department of Health Priorities for 2017-18

In the first half of 2017-2018 the Department of Health will be focussed on developing a new strategic plan for the period 2018 to 2021. The plan will be informed by current projects including the Core Clinical Systems Renewal Program, the corporate services review, governance reforms that continue to flow from national health reform and the Northern Territory Government's agenda for improving the health of the people of the Northern Territory.

Governance Reform

The Department will continue to work with the Health Services to develop and implement the Government's governance reform of the public health system. Priorities for 2017-18 will be the introduction of a Clinical Senate and the Health Advisory Committees.

A Sustainable Health System

The Department will continue to work with the Health Services to ensure that the Northern Territory has a sustainable public health system. This will include focussing initiatives on health expenditures to deliver measureable health outcomes as well as ensuring the Territory has the health infrastructure and workforce required to improve the health of the population.

Collaboration and Partnership

The Department and Health Services will continue to work with Northern Territory Primary Health Network (NT PHN) to implement initiatives to improve service integration and roll out funding for health services including mental health and alcohol and other drugs services. The Department, Health Services and the NT PHN will work together to implement the coordinated care bilateral agreement and the Health Care Homes.

To improve mental health services a new partnership between the Territory government and non-government organisations will be trialled to provide support services to people with mental illness who live in public housing in Darwin and Palmerston.

Infrastructure Plan Capital Commitments

The Department and Health Services will work together in the development of a Total Asset Management Plan. Key infrastructure projects in 2017-18 include:

- Commissioning of the Palmerston Regional Hospital which is scheduled to open mid-2018.
- Progress the project to provide a PET scanner and cyclotron at the Royal Darwin Hospital.
- Upgrades to Gove District Hospital.
- Investing to increase the capacity of renal dialysis services including a purpose-built Darwin Renal Centre and improving access to dialysis in remote communities.
- Building a multistorey carpark at the Royal Darwin Hospital.
- Installing 12 new specialist chemotherapy chairs at the Royal Darwin Hospital.

Core Clinical Systems Renewal Program

The Core Clinical Systems Renewal Program is a five year $259 million project funded in the 2017-18 Budget that will create a Territory wide single integrated client-centric health electronic record system. Priorities for 2017-18 include:

- Completion of the implementation planning study and transition to configuration of a new core clinical system.
- Implementation of a new master person index.
- Completion of wireless internet access across the NT.
- The deployment of a single, centralised IT helpdesk.

Corporate Services Review

A review of the corporate services in the Department and the two Health Services will occur in 2017-18. The purpose of the review is to gain a better understanding of our current corporate service operating model in order to ensure that we have an optimal model that utilises our resources in the most effective and efficient manner and aligns to our current organisational structure.

The outcome of the review is to assist with analysis of our current operating model and provide recommendations for changes to ensure best practice corporate service delivery that meets our current and future business needs.

Top End Health Service Priorities for 2017-18

Improving Patient Flow

TEHS will continue to improve patient flow and access to elective surgery. In 2017-18 the focus will be on improved discharge procedures and protocols. This will include work to further implement home based wards, enhanced models of care and procedures to addressing frequent users and unnecessary admissions.

Strengthening Workforce Culture and Capacity

It is intended that the Organisational Culture Learning and Development Program will continue with a range of activities to embed the Organisational Culture Charter across all levels of the organisation.

Palmerston Regional Hospital

The Palmerston Regional Hospital commissioning project will continue in 2017-18 to complete the work for the commencement of hospital operations in mid-2018.

Integrated Services

The focus of integrated approaches to improve the patient experience will continue. In 2017-18 there will be a continued emphasis on integrated care in maternity services. This will include completing transition to a new structure to support improved case management of vulnerable women, establishment of a care coordination team and improved collaborative care arrangements. This will result in a fully integrated maternity service with single point of referral and GP shared care arrangements.

Ambulatory Care

Ambulatory care will be improved through centralised intake and improved waitlist management for patient access to specialist services. Pilot sites will be established in selected remote communities that will utilise Telehealth and improved coordination of outreach services and patient travel to provide timely access to services.

Sustainable health services

TEHS will continue to identify opportunities to provide financially sustainable health services. In 2017-18 a service wide supply chain management strategy will be implemented.

Central Australia Health Service Priorities for 2017-18

Strengthening our workforce culture

To strengthen our workforce we will continue to implement strategies articulated in the NT Aboriginal Cultural Security Framework and increase the intake of trainees, apprentices and cadets.

To reduce high turn-over in the primary health care workforce flexible working arrangements will be promoted including job sharing, nursing pools and timely permanent appointment. A post-employment survey will be implemented to determine the effectiveness of workplace pre-employment and induction processes.

Integrated services

To improve the patient experience and achieve better health outcomes it is important that services are well integrated.

To prevent unnecessary readmission to hospital we will develop a medical retrieval and consultation centre to achieve timely retrieval of patients from remote communities and enhanced handover back to referring local health services.

Integrating Alcohol and Other Drug Services under Acute Services management will improve the clinical safety of patients withdrawing from the effects of alcohol and other substances.

The expanded use of Telehealth consultations will minimise the inconvenience of travel for patients and provide for a more timely assessment of patient treatment options.

Better health outcomes through community engagement

To better match health service development to the needs of stakeholders, CAHS will establish a Health Advisory Committee, expand local health advisory groups to eight remote communities, hold biannual community forums in Alice Springs and Tennant Creek and meet regularly with the Barkly Region Consumer Advisory Group.

Reducing the burden of renal disease

Slowing the progression of renal disease to defer the requirement for renal replacement therapy will continue to be a priority. This will be achieved through prevention, improved management of chronic kidney disease and engaging with the Menzies School of Health Research to develop strategies to slow the progression of end stage renal disease.

CAHS will expand access to renal dialysis facilities in Alice Springs to meet growing demand and promote the use of self-care models of renal dialysis to provide flexible and efficient treatment options.

A Heads of Agreement with Western Desert Dialysis signed in May 2017 will provide remote renal dialysis services at Docker River, Papunya and Mt Liebig. These services are expected to commence in 2017-18.

Tennant Creek Renal Unit.

Improving early childhood health care

CAHS will continue to focus on improving the health of young children through the Healthy Under 5 Kids (HU5K) Program by decreasing the number of children who are underweight or anaemic.

Sustainable health services

CAHS will continue to improve its systems and approaches to achieve financial sustainability and maximise effective service delivery.


Royal Darwin Hospital

3. PERFORMANCE REPORTING

Department of Health Performance in 2016-17: Priorities

The following progress was achieved to meet the priorities for 2016-17.

1. Palmerston Regional Hospital

In 2016-17 the Palmerston Regional Hospital project commenced operational commissioning with the project team working alongside Top End Health Service to develop:

- Service delivery models.
- Workforce strategies to ensure appropriate staffing.
- Input from clinical staff into facility infrastructure and technology to enable optimal patient care.
- Financial modelling for the hospital.
- Communication and change management strategies for 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, with the first patients to be treated in mid-2018.

2. Strategic Information Management Initiatives

Infrastructure Upgrades

During 2016-17 Wi-Fi and critical infrastructure upgrades occurred in all NT Health service sites including hospitals and 56 remote and urban health centres.

The Core Clinical Systems Renewal Program (CCSRP)

In June 2017, the CCSRP completed a highly complex procurement process within 12 months, which was a major program milestone. InterSystems Australia Pty Ltd will supply the new core clinical system for NT Health. The procurement process was driven by significant clinical input to ensure the new system aligns with the real life clinical context.

National Telehealth Connection Service

The National Telehealth Connection Service was implemented, allowing expanded access to the NT Health Telehealth services network for Aboriginal controlled medical services, interstate service providers and other key stakeholders.

New eCredentialling System

Key achievements included the procurement of the Cgov eCredentialing System and the completion of the detailed implementation planning study. The eCredentialling system will improve employee screening, practitioner credentialing and assignment of appropriate scopes of clinical practice. Implementation is now underway and will be delivered in 2017-18.

eProcurement Project's Supply Chain Management software

Implementation of the Health Procurement System is well underway with the first roll out at Central Australia Health Service sites. This system will provide NT Health with greater visibility of purchases and allow for more detailed reporting and spend analysis of consumables.

Electronic Document Records Management system

Adoption and uptake of the electronic management system was rolled out to the Corporate Services Bureau in 2016-17 with implementation to continue across the Department's work units in 2017-18.

Enterprise Master Person Index Project

The passive registry was implemented in 2016-17 as part of the Enterprise Master Person Index project and will be used by health information managers as a tool to assist in merging medical records. In 2017-18 the project will implement an active registry with demographic data synchronisation in preparation for the core clinical system.

Information Security and Access Framework

The Information Security and Access Framework was developed in 2016-17 with stakeholder collaboration and is designed to protect the confidentiality and integrity of patient information. Implementation of the Framework across NT Health will occur in 2017-18.

New Hospital Billing System (eBilling)

The new hospital billing system was deployed in November 2016. This system interfaces with both the hospital patient administration system and the Government Accounting System. In combination, these systems serve to contribute to the financial sustainability of Northern Territory public health services.

3. Disability Services

The Bilateral Agreement between the Commonwealth and the Northern Territory: Transition to a National Disability Insurance Scheme (the Bilateral Agreement) was signed in May 2016. The Bilateral Agreement sets out the National Disability Insurance Scheme (NDIS) transition schedule in the NT. The transition commenced on 1 July 2016 with the continued rollout in the Barkly region, following a two year NDIS trial.

The next stage of transition commenced on 1 January 2017 with the East Arnhem region and Darwin based supported accommodation services. From 1 July 2017, the Top End Remote and supported accommodation services in Katherine and Alice Springs will transition, with the rest of the Darwin region and Central Australia from 1 July 2018. The full scheme will commence from 1 July 2019.

4. Purchasing health services for better health outcomes

In 2016-17 the Department continued to work in partnership with the Health Services towards more accessible and sustainable health service delivery.

Performance was monitored against the key performance indicators outlined in the Service Delivery Agreements which incorporated new measures such as mental health seclusion rate and Telehealth occasions of service.

Achievements in 2016-17 included:

- The transition of oral health, hearing health and cancer screening services from the Department to the Health Services.
- Successful implementation of strategies resulting in markedly improved performance for measures such as mental health inpatient community follow-up; mental health seclusion rates; and TEHS elective surgery wait times.

The increasing demands of providing cost effective and sustainable health services will continue to present challenges for the Department and Health Services in 2017-18.

Aligned with national health care reform, priorities for 2017-18 will include a focus on safety, quality and coordinated care.

5. Adult Guardianship

The independent statutory Office of the Public Guardian (OPG) was established on 28 July 2016 under the *Guardianship of Adults Act 2016*.

The Office of the Public Guardian operates independently and reports directly to the Minister for Health.

The Department of Health provides financial assistance and administrative support, in dealing with and managing staff, assets and financial resources. For 2016-17, the Department of Health allocated $4,608,000 for the Office of the Public Guardian to perform legislated functions and employment of 27 full time staff.

6. Neurosurgical and cardiothoracic services

Specialist neurosurgical services commenced at Royal Darwin Hospital in March 2017 and work continues to grow capacity and capability.

Planning for the requirements to commence cardiothoracic surgery is well underway, with planning being undertaken across the spectrum of cardiology to support establishment of the service.

The introduction of increased surgical services at Royal Darwin Hospital represents a significant increase in services at the hospital for Territorians.

7. National Health Reform

The Australian Government and states and territories developed the *Addendum to the National Health Reform Agreement: Revised Public Hospitals Arrangements* based on the heads of agreement that was signed in April 2016.

The Addendum includes details about the operation of a Commonwealth funding cap (6.5 per cent) for public hospital activity, coordinated care bilateral agreements and pricing and funding changes for sentinel events and hospital acquired complications.

8. Corporate Services Bureau Strategy

Following its launch in January 2016, implementation of the Corporate Services Bureau (CSB) Strategy has progressed positively in 2016-17. The achievements during the year included:

- Launch of the Our Culture Statement.
- Enhanced service standards.
- New education and training programs and workshops.

Department of Health Performance in 2016-17: Strategic Objectives

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.

The Chronic Diseases Network conference themed 'Protection, Prevention, Promotion: Healthy future: Chronic conditions and public health' was held in September 2016, providing valuable professional development opportunities and networking for 311 health practitioners and other delegates from the Northern Territory and interstate.

The Chronic Diseases Network produced a quarterly newsletter (the Chronicle) and a monthly email update aimed at sharing information to support chronic conditions prevention.

NT Health's Women's Health Strategy Unit made a significant contribution to the review of the Government's domestic and family violence strategy 'Safety is Everyone's Right' as well as development of the new Domestic and Family Violence and Sexual Violence Reduction Strategy. Subsequent initiatives included: publication of the NT Health Domestic and Family Violence policy and drafting the clinical guidelines for identifying and responding to domestic and family violence.

Critical groundwork to develop the Healthy Under 5 Kids Partnering with Families Program (HU5KPF) was finalised. The HU5KPF is a universal standardised child and family health program for all families with children 0-5 years of age. Work to date has focussed on child growth milestones and prevention of anaemia.

The evaluation of a six month pilot of the HU5KPF undertaken in seven remote primary health care services managed by Top End and Central Australia Health Services, will be used to direct the implementation of the program throughout the remainder of NT Health's primary health care centres.

The Department of Health in collaboration with the Department of Education's Early Childhood Education and Care Division implemented an innovative partnership to deliver hearing and language health promotion activities within an early years' service facility.

Community Hearing Workers co-located in Families as First Teachers facilities strengthened opportunity for families and communities to participate in the prevention of hearing loss and promotion of language development in children with hearing loss.

The Newborn Hearing Screening program at all NT public birthing facilities screened 98 per cent of neonates in 2016-17.

Essential preparatory work towards implementing the NT Government's commitments in relation to child health includes:

- Developing a NT Child and Adolescent Strategic Health Plan for young people aged 0 to 24 years with a focus on 9-18 years.
- Expanding intensive home nurse visiting services for new mothers in vulnerable families.
- Updating the current NT Child Health Record (Yellow Book) content.

Primary Health Care Nurse Stacey de Grave conducting home visits in Alice Springs, August 2016.

The Darwin Men's Health Week Expo held in June 2017 managed to encourage 100 men to participate in the "Pit Stop Health Check", a program engaging men in discussion on managing their health and wellbeing. Compared with the 2016 Men's Health Week Expo, there was an eighty per cent increase in men participating in the "Pit Stop".

An 18 month review of the implementation of Healthy Choices Made Easy policy was completed this year. The policy ensures healthy food and drink options are available to staff, volunteers and visitors to NT Health facilities and is based on a traffic-light system of food categorisation, where GREEN foods and drinks are the healthiest and RED ones are energy-dense nutrient-poor foods or drinks.

Key achievements since the implementation of Healthy Choices Made Easy included:

- Alice Springs Hospital kiosk showed a significant improvement, with only 34 per cent of food and drinks sold classified as RED compared with 70 per cent of foods before the introduction.
- Vending machines in Royal Darwin Hospital do not sell RED foods and drinks.

The 2015 Market Basket Survey was published. This annual survey monitors the cost, availability and variety of core foods in 81 remote stores and compares them with regional major supermarkets and district corner stores.

An NT Healthy Workplace Toolkit was developed and circulated for consultation. The toolkit is designed to assist workplaces to create supportive workplace environments that promote healthy behaviours. It contains the tools, resources and 'how to' to assist workplaces identify, develop and deliver health promotion activities to address smoking rates, harmful consumption of alcohol, obesity and mental health and wellbeing.

A four-year agreement with Australian Football League NT was established for the delivery of oral health promotion to Michael Long Centre students and use of Thunder professionals to promote healthy lifestyle messages.

The Office of Aboriginal Health Policy and Engagement contributed to improving the health literacy of consumers via the NT Health Consumer Participation Facebook page (currently listing 180 likes and up to 500 consumer posts) and ongoing administration of the Aboriginal Health Innovation Sponsorship Fund that allocated $73,186 for 12 projects across NT 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.

The Women's Health Strategy Unit successfully managed the NT Termination of Pregnancy Law Reform Project.

Key project milestones were:

- Reviewing, developing and implementing the *NT Termination of Pregnancy Law Reform Act* (commenced on 1 July 2017) via public consultations, preparation and passage of the Bill.
- Development of the NT Termination of Pregnancy Regulations, including establishing credentialing procedures for medical practitioners and a new database and data collection and reporting procedures for termination of pregnancy.
- Development and publication of the NT Health Clinical Guidelines for Termination of Pregnancy.
- Development and facilitation of education and training for medical and health professionals.
- Development of new service delivery models for termination of pregnancy and dissemination of media and communication strategies for medical and health practitioners and consumers.

The first NT Health Transgender and Intersex health policy in conjunction with a Steering Committee made up of key government and non-government stakeholders was developed symbolising a significant achievement.

The successful 'Young Mothers are Strong Mothers' program had 11 young Aboriginal mothers participating in the program, graduating from the Batchelor Institute of Indigenous Studies with a Certificate II in Community Services. The 'Young Mothers are Strong Mothers' program has been transferred to the Department of Education upon pilot completion and continues to be delivered through the Palmerston Children and Family Centre.

In 2016-17, 984 of the 1945 (51 per cent) ear, nose and throat (ENT) consultations to Indigenous children and youth under 21 years were delivered to children in their own communities using Teleotology (an innovative telehealth system).

In 2016-17 4380 audiology (hearing) assessments were provided through urban and outreach facilities. Hearing has improved for a large proportion of children and young people who received two or more services from hearing health specialists. Almost half (48 per cent) of the children who had hearing loss at their first service showed improvement at their last service. More than half (59 per cent) of children and young people had a reduction in the degree of their hearing impairment.

Development and implementation of the NT Aboriginal Cultural Security Framework 2016-2026 has fostered the development of policies in support of improved outcomes for vulnerable people and populations across NT Health by the application of the Framework's priority action areas.

$73,186

Aboriginal Health Innovation Sponsorship Fund allocated $73,186 for 12 projects across NT Health.

3. Improve Aboriginal health outcomes

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

The Chronic Conditions Strategy Unit, in collaboration with Top End and Central Australia Health Services, Healthy Living NT, NT Primary Health Network and Aboriginal Medical Services Alliance NT, has developed a model of care for Cardiac Secondary Prevention in remote communities. This new service commencing implementation in Top End remote communities will see cardiac clients following discharge from hospital receive multidisciplinary and coordinated care in the primary health care setting.

A hundred health professionals from acute and primary health care services completed new online modules in diabetes care for Aboriginal clients in remote Top End Health Services.

A domestic and family violence screening tool and clinical guidelines for identifying and responding to domestic and family violence were revised with the involvement of Aboriginal organisations and consumers.

In July 2016 the remote primary health care service in Millingimbi transitioned to Aboriginal community control through the Miwatj Health Aboriginal Corporation, under the auspices of the Pathways to Community Control Policy. This is a joint policy of partners in the NT Aboriginal Health Forum (NTAHF).

The Department of Health worked with the NTAHF to further develop the suite of tools available to assist regions to progress Aboriginal community control of health services. Examples of the tools include a clear set of criteria against which business cases will be assessed and a template for such business cases.

The Office of Aboriginal Health Policy provided an annual grant to the Aboriginal Medical Services Alliance Northern Territory in support of that organisation's strategic leadership in the advancement of Aboriginal health and wellbeing, advice on eHealth and ICT initiatives, and alcohol and other drugs workforce development across the NT Aboriginal community controlled health services sector. There was also continued support for a number of organisations including Malabam Health Board (Maningrida), the National Heart Foundation, Menzies School of Health Research and Royal Darwin Hospital to research, develop and evaluate programs and services to improve health outcomes for Aboriginal Territorians.

The Back on Track Project was expanded to encompass all types of clinical and non-clinical employment categories. This included implementation of the Special Measures Program targeting Aboriginal people that resulted in a one per cent increase per annum between 2014-15 and 2016-17 in Aboriginal employment across NT Health.

Both Top End Health Service and Central Australia Health Service demonstrated improved performance across a number of Aboriginal specific key performance indicators, particularly in primary health care. Details are included the Health Service performance sections.

Nurse Colleen Court with Mum Charlotte Sumskas and her baby at the Ali Curung Health Centre.

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.

In 2016-17, the Department developed a bilateral agreement with the Commonwealth to implement coordinated care reforms. This work will be progressed in 2017-18 and will focus on improving data quality and linkages, coordination of outreach services and access to aged care for remote residents.

Advisory groups were established to oversee the development of: termination of pregnancy law reform project; a domestic and family violence policy and clinical guidelines; and a transgender and intersex policy and associated resources.

The major Hearing Health Information Management System (HHIMS) software solution was developed to enable real time data collection and coordination functions that support complex multi-provider hearing health care. An enhancement of the HHIMS solution, referred to as the iHearing portal, has been scoped through funding received under the Australian Government Indigenous Advancement Strategy. The iHearing portal for early childhood personnel, teachers, special education teachers and principals provides decision support and resources for quality teaching and acoustic enhancements appropriate for children with hearing loss.

The Department oversaw the Telehealth NT Project, which facilitated the first Tele-Specialist services via the National Telehealth Connection Service.

The Territory Pathology Clinical Reference Group provided a forum for clinicians to work with Territory Pathology to improve pathways of care for patients. In 2016-17 on-site molecular testing was introduced into Alice Springs.

A number of new and revised business cases were approved for strategic ICT projects, including the Electronic Document Record Management Project, Oral Health Service NT Titanium Information System Upgrade, the Office of the Public Guardian Information Management System, and the National Critical Care and Trauma Response Centre Data Warehouse Inventory System.

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.

The Strategic Information Management Steering Committee (SIMSC) is NT Health's information and communication technology (ICT) governance group. The primary role of SIMSC is to provide strategic direction, effective governance and oversight of ICT activity, including information management, data management and ICT investment.

Key outcomes in 2016-17 included:

- Implementing a Project Assurance Program, including independent reviews on seven strategic ICT projects.
- Monitored the successful deployment and implementation of the Enterprise Hospital Billing System project, delivering a proven software solution enabling billing transactions to downstream parties.
- In collaboration with the Australian Digital Health Agency, provided oversight to the next phase of the National My Health Record Project which saw the Northern Territory become the second jurisdiction to begin uploading pathology reports from its public health facilities to the national My Health Record.
- Drafted the Information Access and Security Framework, policy and guidelines.

The Domestic and Family Violence Advisory Group agreed to pilot clinical guidelines and training enabling testing and evaluation prior to being implemented more broadly.

The NT Health Termination of Pregnancy Reform Governance Advisory Group was established to reform the termination of pregnancy legislation to ensure it was appropriate and acceptable to the community, and enacted promptly and smoothly.

The Health Promotion Strategy Unit developed and maintained effective relationships with Charles Darwin University (CDU), Menzies School of Health Research (MSHR) and the Bachelor Institute of Indigenous Tertiary Education (BIITE) to promote continued excellence in clinical care and teaching by:

- Participating in course reviews and Course Advisory Committees to ensure quality and currency of the Bachelor of Health Sciences (at CDU), the Health Promotion elective in the Masters of Public Health and the Health Promotion units in the Aboriginal Health Practitioner Certificate IV.
- Establishing a Deed of Agreement with BIITE – formalising the training role of Department of Health staff in delivery of the Apply Fluoride Varnish and Recognise and Respond to Oral Health Issues courses.

- Workshops on 'Effective Communication: improving health literacy and cultural safety in health care', delivered in two pilots sites, were developed by the Office of Aboriginal Health Policy and Engagement in partnership with Charles Darwin University and Flinders University.

The Office of Aboriginal Health Policy and Engagement lead the development and implementation of a trial of a culturally appropriate patient experience survey tool across NT Health to provide a mechanism for direct consumer feedback, particularly for people from non-English speaking backgrounds, for the continuous improvement of health service delivery.

In 2016-17 the Department managed a Territory-wide infrastructure program of capital works ($271.6 million) and minor new works ($6.7 million). A total of $28.3 million repairs and maintenance projects were also funded.

New remote health centres were completed at Galiwinku ($6.7 million funded by Australian Government), Numbulwar ($7.14 million funded by Australian Government) and Umbakumba ($6 million jointly funded by Northern Territory Government, Australian Government and Groote Island Bickerton Island Enterprises).

Major infrastructure refurbishment and redevelopment works continue to be undertaken at Royal Darwin, Gove and Alice Springs Hospitals as outlined in the respective Health Services' section.

The Addendum to the National Health Reform Agreement includes provisions to incorporate quality and safety into hospital pricing and funding, with the aim of delivering better health outcomes, improve patient safety and support greater efficiency in the health system.

New intensive care unit at the Alice Springs Hospital.

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.

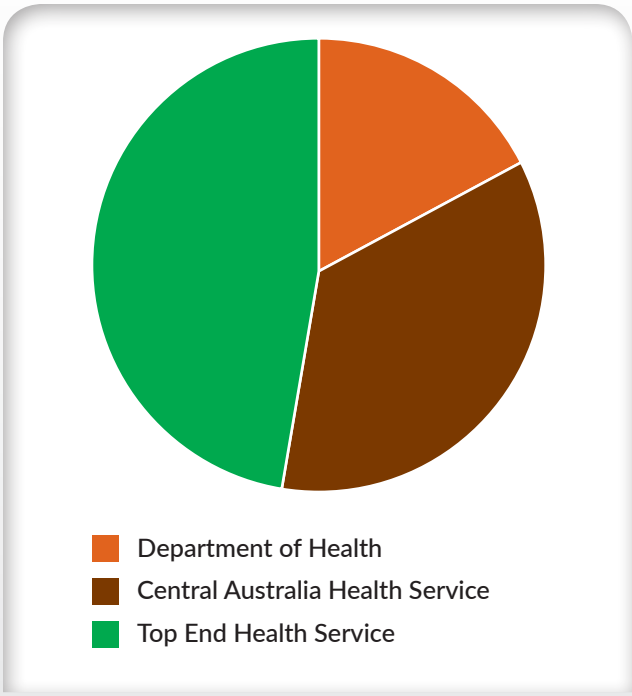
Enhancing the skills and cultural responsiveness of the workforce was achieved by a range of activities and programs including:

- Delivering the Health Promotion Short Course and the Social Marketing in Health Workshop in Darwin, attended by 36 participants from NT Health and Health and Community Services NGOs.
- Delivering the Introduction to Quality Improvement Program Planning System training to 68 NT Health staff and the Health Promotion Continuous Quality Improvement training to 20 NT Health staff.
- Development of resources to support staff in responding to domestic and family violence.
- Delivering workshops in conjunction with other key stakeholders on the implementation of the new NT Termination of Pregnancy Law Reform Act.

Aboriginal cultural awareness continues to be a key learning and development priority for NT Health. During 2016-17, 625 staff attended the Aboriginal Cultural Awareness Program which builds knowledge and capability to enable NT Health employees to provide a culturally appropriate service and improve health outcomes.

In 2016-17, a 'Walking in Two Worlds' reverse cross cultural training was piloted in Central Australia Health Service to support the department's commitment to the Cross Cultural Training Framework 2016-2017.

Aboriginal Cultural Awareness Program Course Attendance by Agency 2016-17



In partnership with Charles Darwin University and Flinders University, the Office of Aboriginal Health Policy and Engagement delivered the 'Effective Communication: improving health literacy and cultural safety in health care' pilot workshop in Alice Springs and Katherine. The final pilot workshop to be held in Gove in July 2017 will be followed by an evaluation and recommendations on future rollout.

NT Health invests in a number of programs and initiatives to increase Aboriginal workforce participation, reflective of the community it serves. Major programs and initiatives include: Special Measures; early careers development; Aboriginal and Torres Strait Islander Health Practitioner scholarships; traineeships; Indigenous cadetship support (see Chapter 6 for details of these initiatives).

The Office of Aboriginal Health Policy and Engagement developed and implemented the following initiatives in support of NT Health strengthening and retaining its Aboriginal workforce:

- The Back on Track: Strengthening Aboriginal Workforce Strategy.
- A health focussed remote training pilot in Wadeye to deliver a Certificate 1 qualification in foundation literacy and numeracy skills to help grow the pipeline into Aboriginal Health Practitioner employment.

The Department worked with external stakeholders to develop and implement an NT Health Indigenous Health Academy providing year 12 students with a stepping stone into the allied health professions.

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 Department of Health prioritised financial sustainability in the NT Health Strategic Plan 2014-17 to ensure the NT Health system is well positioned to deliver an integrated service and to improve the efficiency and effectiveness of primary care and to make the best use of hospital resources.

In 2016-17, NT Health undertook a range of activities to improve financial management within the Department of Health and the broader health system, including:

- Implementation of a new integrated billing system to better manage patient billing and improve revenue reporting.
- Improved debt recovery practices, reducing amount of unrecoverable debts.

The Department commenced a Strategic Asset Management Planning project which will deliver Total Asset Management Plans, hospital master plans and an NT Health Strategic Infrastructure Plan. The project is being undertaken in three stages. Stage 1 commenced in 2017 and will see condition audits undertaken of Territory-wide health assets and the production of initial Total Asset Management Plans and an initial NT Health Strategic Infrastructure Plan.

Territory Pathology worked with the Health Services to:

- Maximise potential revenue collections.
- Improve the efficiency and cost effectiveness of pathology services.

The Department continues to promote financial sustainability and transparency through the implementation of improvements for the management of grants to external service providers.

From 1 July 2017, all Departmental grants will continue to be managed through the existing legacy system which has recently undergone a number of enhancements to ensure that it effectively support grants management until the launch of Grants NT.

In 2016-17 focus continued on ensuring an appropriate level of governance and contract management for high value, high risk contracts to ensure contract conformance and performance and benefits realisation. Efforts continued with the customisation and implementation of the Supply Chain Management System and with the establishment of major health consumable contract arrangements bringing sustainable efficiencies. Additionally the Department actively participated in the development of the whole of Government contract management system due to be rolled out in 2017-18.

Department of Health Performance in 2016-17: Budget Paper Outputs

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

Output groups:

- Territory-Wide Services
- Disease Prevention and Health Protection
- Community Treatment and Extended Care
- National Critical Care and Trauma Response
- Office of the Public Guardian
- Health Services
- Corporate and Governance

Output Group: Territory-Wide Services

Outcome:	Strengthened capability of Territorians to maintain and improve health.
Output:	Territory-Wide Services Provide support for an integrated Territory-wide primary health care service including reporting, policy, planning, grant management and legislative support.

Key achievements for this output

- Transfer of oral health, hearing health and cancer screening services from the Department to the Top End and Central Australia Health Services.
- Reform of the termination of pregnancy law, including enactment of the *NT Termination of Pregnancy Act*.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Percentage of non-government organisation grant recipients' satisfaction with grant	n/a	n/a	n/a	80%	81%	●	82%

Performance against key performance indicators

This is a new indicator commencing in 2016-17. All 19 non-government organisations receiving grants from the Territory-Wide Services function were surveyed, with 16 responding to the survey and providing an 81 per cent satisfaction rating.

Output Group: Disease Prevention and Health Protection

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

Key achievements for this output

- A per- and poly-fluoroalkyl substances (PFAS) interagency working group established to implement a co-ordinated approach to the investigation and response to potential environmental and health issues related to PFAS.
- A major multi-jurisdictional food borne illness was investigated in conjunction with OzFoodNet which resulted in increased food safety controls.
- Trained pharmacists may now administer influenza, measles-mumps-rubella, and diphtheria-pertussis-tetanus vaccines to eligible adults 16 years or older.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Authorities issued[1,2]	4 318	4 211	4 032	4 050	4 038	-	4 050
Environmental health complaints investigations initiated within one working day of notification	98%	98%	98%	98%	98%	●	98%

[1] Authorities, including registrations and licences, issued under *the Public and Environmental Health Act*, *Food Act*, *Medicines, Poisons and Therapeutic Goods Act*, *Private Hospitals Act;* and *Radiation Protection Act*, as well as regulations subordinate to each Act.

[2] The number of authorities issued is determined by the number of individual applications for registrations and licenses made by individuals and businesses and authorities processed and issued by the Department of Health.

Performance against key performance indicators

No significant variance in these indicators. The vast majority of authorities issued are based on the number of businesses registered, which is usually based on business confidence and market forces, over which the Department of Health has no direct control.

Output: Disease Control

Output:

Deliver disease prevention and early intervention services, rheumatic heart disease services and register, promote immunisation coverage and education, disease surveillance and management, screening services, trachoma elimination, contact tracing for mycobacterial diseases, HIV/AIDS and sexually transmitted infections, environmental management of mosquito-borne diseases, and management of disease outbreaks.

Key achievements for this output

- The NT was kept free of exotic mosquitos and the incidence of endemic mosquito cases was low.
- Screening and treatment was provided to communities at risk of endemic trachoma.
- Rapid response to trace over 700 potential contacts (primarily through SMS) and carry out the necessary public health interventions to reduce the spread of two separate measles cases.
- In the Rheumatic Heart Disease Program, patients receiving more than 80 per cent of their scheduled secondary injections continued to increase steadily from 32 per cent in 2013 to 51 per cent in 2017.
- The Community Physician together with Miwatj and other community based organisations responded to the outbreak of lead toxicity due to Avgas sniffing in East Arnhem. The Community Physician chaired the Volatile Substance Abuse (VSA), Health and Territory Families working group as a subgroup of the Department of the Chief Minister's VSA Stakeholder Working group. Elevated blood lead levels was made notifiable in the NT and the changes to the legislation will be gazetted on 1 August 2017.
- The Sexual Health and Blood Borne Virus Unit worked with Danila Dilba to engage the homeless and transient Aboriginal community and conducted community screening events for sexually transmitted infections in remote "hot spot" communities in collaboration with Primary Health Care staff.
- The Tuberculosis (TB) Unit continued to expand preventative latent TB infection treatment and education to those at risk.
- The Surveillance Unit conducted a trial whereby SMS was used to contact campylobacteriosis (common cause of gastroenteritis) cases in Darwin; the trial had a 50 per cent response rate and found that at least a quarter of people acquired their infection overseas.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Notification of HIV[1]	22	12	28	20	24	-	28
Occasions of service at Clinic 34 in Darwin and Alice Springs	9 292	7 741	12 201	10 500	12 326	●	10 815
Proportion of notified cases of exotic mosquito-borne diseases for which the place of infection was ascertained within two days	99%	99%	97%	100%	95%	●	100%
Children fully immunised: -at age 12 months[2]	91%	91%	93%	93%	93%	●	95%
-at age 2 years[2]	93%	87%	89%	88%	88%	●	90%
People completing treatment for tuberculosis[3]	100%	100%	100%	100%	100%	●	100%
Units of sterile injecting equipment distributed through the Needle and Syringe Program	n/a	n/a	n/a	480 000	578 978	●	530 000
People living with HIV who receive Anti-Retroviral Therapy	n/a	n/a	97.9%	90%	95%	●	90%

[1] Due to data lag issues, the number of actual notifications of HIV may increase as May/June notifications are added.

[2] A new immunisation agreement is being negotiated for 2017-18 – 2020-21 and targets are under review.

[3] Proportion of tuberculosis cases completing treatment by Directly Observed Therapy that is due to be completed within that year.

Performance against key performance indicators

The increase in occasions of service at Clinic 34 in Darwin and Alice Springs is a consequence of campaigns to promote testing for sexually transmitted infections and blood borne viruses, as well as sexual health education and promotion in response to high endemic rates of sexually transmitted infections, and in particular the current epidemic of infectious syphilis in the NT.

The rise in units of sterile injecting equipment distributed through the NT Needle and Syringe Program was expected, as in 2016 the Government approved the broadening of authorisation to dispense equipment to injecting drug users as a public health prevention measure. In addition, the installation of vending machines in Darwin, Palmerston and Alice Springs was authorised.

We successfully met the World Health Organisation's target of having 90 per cent of HIV patients attending Clinic 34 to be on antiretroviral treatment. This is in spite of the transient HIV population moving through the Territory.

Output Group: Community Treatment and Extended Care

Outcome:	**Strengthened capacity of individuals, families and communities to improve and protect their health and wellbeing.**
Output:	**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, service funding and program management and legislative support.

Key achievements for this output

- Comprehensive public review of alcohol policy and legislation frameworks across the Northern Territory in order to develop an evidence-based overarching alcohol harm reduction framework.
- The Banned Drinker Register (BDR) model has been approved with additional pathways and a new role of the BDR Registrar to replace the previous tribunal system and SMART court of the previous BDR. Another feature of this model is the incentivised therapeutic support options that encourage and support people with an alcohol issue to seek help and potentially reduce their ban for participating in and completing therapeutic support.
- The Alcohol Mandatory Treatment (AMT) framework and legislation will be repealed on 31 August 2017. The Alcohol and Other Drugs Directorate has worked with service delivery providers to manage the transition of service delivery.
- The former AMT facility in Darwin is being re-purposed to the new centrally located Sobering Up Shelter, assessment and withdrawal service and a 40 bed rehabilitation service.
- Participation in national medicinal cannabis committees and the development of medicinal cannabis guidelines for the NT is an ongoing piece of work.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Number of assessments undertaken in non-government treatment services	n/a	n/a	n/a	n/a	2 933	-	3 329
Number of treatment episodes commenced in NGO services	n/a	n/a	n/a	n/a	2 537	-	2 832
Number of episodes of treatment completed in NGO services	n/a	n/a	n/a	n/a	1 392	-	1 111

Performance against key performance indicators

These are new indicators commencing in 2016-17. Due to data lag, the 2016-17 actuals are projected estimates based on data available at February 2017.

Output: Disability Services

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

Key achievements for this output

- The *Bilateral Agreement between the Commonwealth and the Northern Territory: Transition to a National Disability Insurance Scheme* (the Bilateral Agreement) was signed in May 2016. The Bilateral Agreement sets out the transition schedule in the NT for the NDIS. The transition commenced on 1 July 2016 with the continued rollout in the Barkly region, following a two year NDIS trial. The next stage of transition commenced on 1 January 2017 with the East Arnhem region and Darwin based supported accommodation services.
- The transition to the NDIS represents a significant shift for the existing disability service sector that operates within a unique and complex service delivery context.
- To support the service sector transition the NT Government applied for funding through the Australian Government, Department of Social Services, Sector Development Fund. The NT Government was successful in obtaining $6.8 million in 2017 to deliver sector development projects, which included:
  - Community planning to better understand and meet participant needs by engaging with local communities to identify and respond to the opportunities that the NDIS presents for social and economic participation for individuals and the community.
  - Stimulating the market and enhancing service models to deliver a greater range of services and supports, especially in remote communities.
  - Building participant, family and carer readiness to maximise their engagement with and participation in the NDIS.
  - Growing workforce capacity to provide more services in remote areas.
  - The Office of Disability has developed the NT Quality and Safeguarding Framework (the Framework), which has the key focus of building the capability and capacity of the NT disability service sector to meet full Scheme national registration in June 2019 and support the sector during this period. The Framework was launched in November 2016.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Clients accessing full-time accommodation services	195	195	198	198	198	●	90
Clients accessing community support services [1]	2 626	2 669	2476	2 800	n/a	-	2 400
Clients accessing professional support services	6 410	6 065	6 513	6 000	6 410	●	5 600
Occasions clients access professional support services	57 800	59 127	65 150	55 000	62 109	●	50 900

[1] The actual for community support services is not available as data becomes available January 2018.

Performance against key performance indicators

Per the *Bilateral Agreement between the Commonwealth and the Northern Territory Government: Transition to a National Disability Insurance Scheme* (NDIS), the Northern Territory commenced transition to the full scheme of the NDIS from 1 July 2016. A as consequence, budgets for 2017-18 will decrease.

The transition of clients and services will see a gradual reduction in all key deliverables.

Output:	Mental Health Provide support for an integrated Territory-wide mental health service including reporting, policy, planning, service funding, program management and legislative support.

Key achievements for this output

- Appointment of full time Chief Psychiatrist Dr Denise Riordan in February 2017.
- The review of the Suicide Prevention Strategy for the Northern Territory is well underway. Community consultations have been completed and will inform a revised plan. This project has a whole-of-government steering committee to provide input into the Strategy. This initiative contains a range of activities aimed at reducing and minimising the incidence of suicide in the NT and developing a culturally appropriate response to suicide and suicide prevention.
- Commencement of the review of the NT Mental Health Strategic Plan to ensure the current plan remains contemporary in light of national mental health sector reforms.
- A steering committee was established to oversight the needs assessment of the Darwin Trial Housing Accommodation Support for people experiencing severe mental illness in public housing.
- Work was done to establish nationally recognised indicators to monitor and measure improvements in mental health service delivery, including safety and quality, patient health and systems health (trends and sustainability).
- The Chief Psychiatrist provided advice to the Royal Commission into Protection and Detention of Children in the Northern Territory. Advice relating to supports and services to children before the justice system in the Territory has been considered, and a review is underway to respond to the target cohort of children between NT Health, Territory Families and court services.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Discharges from residential support services planned	n/a	n/a	n/a	n/a	60	-	60
Average daily bed usage in community supported accommodation facilities	n/a	n/a	n/a	n/a	85%	-	85%
Suicide Prevention training attendance	n/a	n/a	n/a	n/a	1 700	-	1 700
Clients accessing community support service	n/a	n/a	n/a	n/a	2 500	-	2 500

Performance against key performance indicators

These are new indicators commencing in 2016-17. Due to data lag, the 2016-17 actuals are projected estimates based on data available February 2017.

Output Group: National Critical Care and Trauma Response

Outcome:	**High quality and efficient emergency medical response services to the north Australian and South East Asian regions, building disaster capability and resistance across the regions.**
Output:	**National Critical Care and Trauma Response** Operation and development of the National Critical Care and Trauma Response Centre that provides evidence-based emergency care, research, education and maintenance, enabling health responses to incidents of national significance, including deployable capability.

Key achievements for this output

- In collaboration with the World Health Organisation, achieved global verification for the AUSMAT capability in October 2016.
- The Nursing Director, NCCTRC was endorsed as the first Emergency Medical Teams (EMT) regional chair for the Asia-Pacific region.
- Appointed a Medical Director to provide medical leadership and support to the Disaster, Education and Research Teams.
- Continued to develop relationships in the Asia-Pacific region with ongoing training opportunities to strengthen disaster resilience with capacity building.
- The Royal Darwin Hospital Trauma Service, managed by the NCCTRC, maintains Level 2 accreditation from the Royal Australian College of Surgeons while contributing to locally and nationally relevant research projects.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Training participants	1 030	991	895	695	692		750
Response to local, national and international deployment requests	n/a	n/a	100%	100%	100%		100%

Performance against key performance indicators

The number of training participants in 2016-17 was less than projected in Budget Paper 3 (i.e. 760 participants). This was due to courses having to be rescheduled to suit availability of participants and instructors, and obtaining the appropriate approvals in a timely fashion in international locations.

Output Group: Office of the Public Guardian

Outcome:	The interests of adults with impaired decision-making capacity across the Territory are promoted and protected.
Output:	Office of the Public Guardian Provide contemporary, best practice guardianship services consistent with the Guardianship Principles. Promote the rights of Territorians with impaired capacity through strong and effective individual and systems advocacy. Provide a range of information to the community and stakeholders about guardianship and related issues. Develop effective and efficient systems to meet legislative and organisational objectives.

Key achievements for this output

- The independent statutory Office of the Public Guardian (OPG) was established on 28 July 2016 under the *Guardianship of Adults Act 2016*. The Office operates independently and reports directly to the Minister for Health; OPG is providing a separate annual report to the Minister.
- The Department of Health provides financial assistance and administrative support to OPG. In 2016-17 $4,608,000 was allocated for the Public Guardian to perform its functions and employ 27 full time staff.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Number of individuals under adult guardianship	n/a	n/a	n/a	n/a	890	-	868
Number of Aboriginal people under guardianship	n/a	n/a	n/a	n/a	543	-	493
Number of people under community guardianship	n/a	n/a	n/a	n/a	315	-	305
Number of people under sole guardianship	n/a	n/a	n/a	n/a	332	-	315
Number of people under joint guardianship	n/a	n/a	n/a	n/a	243	-	240
Number of financial management orders only	n/a	n/a	n/a	n/a	10	-	8
Number of financial management orders - Public Guardian	n/a	n/a	n/a	n/a	397	-	437
Number of new orders - Public Guardian[1]	n/a	n/a	n/a	n/a	91	-	99
Number of new orders – community	n/a	n/a	n/a	n/a	83	-	95
Number of new applications received - guardianship investigations	n/a	n/a	n/a	n/a	189	-	251

[1] Includes sole and joint guardianship orders to the Public Guardian.

Performance against key performance indicators

These are new indicators commencing in 2016-17. Please refer to the Public Guardian's annual report for further details.

Output Group: Health Services

Outcome:	Ensure the best possible health of Territorians and visitors in the Top End and Central Australia is achieved and maintained through high quality, safe and efficient services.
Output:	Top End and Central Australia Health Services Provide acute to primary health care services in hospitals, health centres and in the home.

Key achievements for this output

- Processes to improve the accuracy of data capturing and coding were implemented.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Total Weighted Activity Units[1]	124 673	129 557	149 656	149 950	162 107	●	155 563

[1] Budget figures realigned with CAHS and TEHS Service Delivery Agreement targets. Data across years are not directly comparable as the activity based funding model is updated each year resulting in minor volume changes.

Performance against key performance indicators

The total activity based funding activity exceeded the estimate as a result of increased activity and improved activity counting and coding.

Department of Health - Snapshot of Costs

Financial results for 2016-17 against agreed targets based on output groups in the 2017-18 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.

Output Group / Output	End of Year Budget	Actuals	Budget vs Actuals	Note
	$000	$000	$000	
Territory-Wide Services	**12 650**	**16 591**	**3 941**	
Territory-Wide Services	12 650	16 591	3 941	1
Disease Prevention and Health Protection	**19 063**	**26 010**	**6 947**	
Environmental Health	3 592	5 473	1 881	2
Disease Control	15 471	20 537	5 066	
Community Treatment and Extended Care	**142 363**	**160 961**	**18 598**	
Alcohol and Other Drugs	38 340	33 115	- 5 225	3
Disability Services	95 193	119 426	24 233	4
Mental Health	8 830	8 421	- 409	
Corporate and Governance	**108 051**	**111 285**	**3 234**	
Corporate and Governance	62 401	65 635	3 234	5
Shared Corporate Services	45 650	45 650		
National Critical Care and Trauma Response	**10 957**	**11 036**	**79**	
National Critical Care and Trauma Response	10 957	11 036	79	
Office of the Public Guardian	**4 608**	**4 117**	**- 491**	
Office of the Public Guardian	4 608	4 117	- 491	
Health Services	**1 160 352**	**1 160 648**	**296**	
Top End and Central Australia Health Services	1 160 352	1 160 648	296	
Total Expenses	**1 458 044**	**1 490 648**	**32 604**	

Notes

1. Numerous complex restructures have impacted on the budget, contributing to variances.
2. Strategies to manage service demand were not able to be achieved.
3. Delays in Commonwealth funded programs.
4. Service demand and the cost of transitioning to National Disability Insurance Scheme (NDIS).
5. Predominantly due to legal and ICT cost pressures.

Top End Health Service Performance in 2016-17: Priorities

The following progress was achieved to meet the priorities for 2016-17.

1. Improving patient flow and elective surgery access

Through the Improving Patient Flow and Elective Surgery Access project in 2016-17, TEHS achieved significant improvements in elective surgery access. Notably, in June 2017 elective surgery performance was in line with national benchmarks across all categories for the first time.

As part of the elective surgery access improvement agenda, TEHS developed and implemented:

- A TEHS Elective Surgery Procedure Framework.
- A TEHS wide surgical services roster which included improved theatre scheduling and wait list management.
- A review and redesign of the same day procedure unit model.

2. Strengthening workforce culture and capacity

In 2016-17, TEHS commenced implementation of the Strengthening Workforce Culture Action Plan. A major activity for this project was development and delivery of a TEHS Organisational Culture Learning and Development Program. Over 400 staff at the executive, senior and middle manager level attended the training in 2016-17.

3. Maternity Services Integration

In 2016-17, TEHS started its integrated maternity services reform, which included transitioning existing teams to a new structure to support improved case management of vulnerable women, establishment of a care coordination team and improved collaborative care arrangements.

4. Renal services integration

The TEHS Service Integration Framework was used to integrate renal services across primary and hospital care settings. This work included development of new governance structures, new models of care, strengthening of home therapies and recruitment of additional staff to support provision of comprehensive care.

5. Ambulatory care

In 2016-17, the focus of the ambulatory care project was to develop an integrated model of ambulatory care for TEHS and undertake diagnostics across our outpatient, outreach and Telehealth services to inform both the model and its implementation.

In 2017-18 the focus will shift to implementation including establishment of remote pilot sites and significant redesign of outpatient services.

Physiotherapist Clee Tonkin and patient David Crawford.

6. Palmerston Regional Hospital

With the Palmerston Regional Hospital (PRH) set to open in mid-2018, the focus for TEHS was to develop and validate service delivery models including planning how services will operate across Royal Darwin Hospital and the PRH and ensuring comprehensive planning for the integration of services.

TEHS commenced the implementation phase of the project and is working to ensure that operational commissioning activities continue to align with milestones for infrastructure development and practical completion of construction works.

7. Discharge summaries

Providing discharge summaries for patients leaving hospital is a significant factor in a patient's on-going well-being, providing crucial information for primary health care practitioners about treatment and medications.

Comprehensive diagnostics of TEHS discharge planning processes were undertaken in 2016-17, the outcomes of which were used to establish an implementation plan for improved discharge procedures.

8. Financial sustainability

TEHS continued to work towards long term financial sustainability goals in 2016-17, with measures put in place at every level of the organisation to improve efficient and effective service provision. This work will continue in 2017-18.

9. Royal Darwin Hospital redevelopment

Significant redevelopment works were undertaken at the Royal Darwin Hospital in 2016-17, including:

- New outpatients department.
- New pathology collection area.
- New patient transit lounge.
- New paediatric wards.
- New isolation room capacity.

The redevelopment will be finalised in 2017-18 with the completion of the main entrance foyer and an external emergency department waiting area.

10. Gove District Hospital

The redevelopment of the Gove District Hospital emergency department is expected to be completed in August 2017. The redevelopment is the culmination of two years of planning and construction as part of the Australian Government Health and Hospital Fund program of works.

11. Cardiothoracic and neurosurgical services

Specialist neurosurgical services commenced at Royal Darwin Hospital in March 2017 and work continues to grow capacity and capability. To year end there was a notable increase in the number of patients having their surgery in Darwin.

Planning for the commencement of cardiothoracic surgery is well underway, with comprehensive planning being undertaken across the cardiology care continuum.

The introduction of complex surgical services at RDH such as neurosurgery and cardiothoracic surgery represent a significant increase in capability of the hospital and in our ability to provide care closer to home for Territorians.

11. PET scanner and cyclotron at the Royal Darwin Hospital

Designs are currently being finalised for the PET facility and the tender for cyclotron design closed on 19 April 2017. It is intended that the cyclotron and chemotherapy works will be publicly tendered together to obtain a single construction contractor to minimise disruption around the Alan Walker Cancer Care Centre. The PET service is expected to be operational in September 2018 and the cyclotron facility will be operational in the first half of 2019.

Aerial view of the Royal Darwin Hospital.

Top End Health Service Performance in 2016-17: Strategic Objectives

1. Foster a culture that promotes ownership of performance

- Established corporate and clinical governance frameworks.
- Developed and implemented a performance framework.
- The service integration framework was implemented in renal and maternity services.
- Significant improvement in the timely access to elective surgery, improvements in mental health readmissions, mental health community seven day follow up, seclusion rates and primary health care indicators.
- Significant improvement in counting and coding of patient activity.
- All service areas are now using RiskMan (electronic incident reporting system) and a corporate risk register was established.

2. Promote a culture of innovation

- Established the TEHS Service Excellence and Innovation Awards.
- Developed an improved model for ambulatory care which is to be implemented in 2017-18.
- Reform to surgical services with a single service, multiple campus approach.
- Improving Patient Flow initiatives include new models for the Lorraine Brennan Centre, acute surgical unit, home based wards and capacity management.
- The successful pilot of the Katherine Patient Assistance Transport Scheme Telehealth project with sustained outcomes.
- Transition to community control is an ongoing priority and TEHS has successfully transitioned Millingimbi to Miwatj.

Winner of the 2017 Service Excellence and Innovation Award Rachel Buckly receiving her award from Dr Giles.

3. Provide safe and quality healthcare services

- Regional Community Advisory Groups and Friends of TEHS established for community engagement.
- Annual patient surveys.
- Priority projects support clinical practice and patient-centred evidence-based care, including extensive engagement with clinical areas across TEHS as well as consultation with the community on TEHS needs assessment.
- Structured approach to actively engaging clinicians in planning, review and implementation of services e.g. needs assessment, new surgical services, cancer services review, allied health service development.

4. Provide affordable and efficient healthcare services

- TEHS governance and organisational structures support business improvement for more efficient and effective health services.
- A performance framework was developed and implemented across regions and services.
- The Revenue Optimisation Priority Project resulted in significant revenue increases through Medicare and private patients.
- Significant improvement in counting and coding of activity optimised Activity Based Funding revenue.
- The Financial Sustainability Priority Project focused on improving efficiency of services and implementing a range of measures to achieve financial sustainability.

5. Ensure equitable access to healthcare services

- The Improving Patient Flow and Elective Surgery Access Priority Projects improved access and patient flow.
- The renal and maternity services integration projects support primary and acute care collaboration.
- Service development in renal, cancer and surgical services include a focus on flexible service provision according to need, maximising capacity and capability.
- The informatics team is working to improve the real time availability of clinical information.
- Significant work on the development of health literacy resources has occurred.

6. Build a sustainable and quality workforce

- Aboriginal Workforce Recruitment and Retention Strategy was established and is being implemented at all levels across the organisation.
- TEHS achieved an increase in the number of Aboriginal employees.
- The Strengthening Workforce Culture and Capacity Priority Project focussed on defining desired cultures and behaviours to support workforce adaptability, flexibility, professional development and ownership. In 2016-17 this included:
  - Development of the Culture Charter and the workforce culture development program.
  - Aligning systems, processes and capabilities to foster high quality leadership and management.
  - Investing in leadership capability and capacity at all levels of the organisation.
- Measures are in place to increase the uptake of graduate nursing study opportunities.

From left to right, Collen Kantilla, Senior Aboriginal Health Practitioner, Anthea Kerinaiua Senior Aboriginal Community Worker, Iris Raye A/Principal Aboriginal Health Practitioner Advisor and Monica Pilakui, Strong Women Worker conducting an early morning meeting at Julanimawu Health Clinic on the Tiwi Islands.

Top End Health Service Performance in 2016-17: Budget Paper Outputs

Top End Health Service's financial and activity reporting is based on an output structure as presented in the NT Government's Budget Paper 3 and TEHS SDA.

Output groups:

- Top End Hospitals
- Community Treatment and Extended Care
- Primary Health Care
- Top End-Wide Support Services

Output Group: Top End Hospitals

Outcome:	Improvement and maintenance of the health and wellbeing of those in the community who require acute or specialist care.
Output:	Top End Hospitals Provide admitted, non-admitted and emergency services.

Key achievements for this output

- Continued implementation of priority projects such as the Improving Patient Flow and Elective Surgery Access has seen performance improve.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Top End Health Service Weighted Activity Units (WAU)[1]	82 049	84 267	98 566	98 076	109 498	●	104 143
Average length of stay (days)[2]	6	6	5.3	5.4	5.2	●	5.1
Elective surgery long waits[3]:						●	
- category 1: percentage of patients waiting longer than clinically recommended time	5.5%	2.4%	1.7%	0%	0%	●	0%
- category 2: percentage of patients waiting longer than clinically recommended time	41%	43%	32.5%	2.4%	1.9%	●	2.4%
- category 3: percentage of patients waiting longer than clinically recommended time	19.8%	23.5%	26.6%	2.4%	0.5%	●	2.4%
Emergency department presentations departing within 4 hours	58.5%	60.8%	65%	78%	64%	●	78%

[1] Budget figures realigned with TEHS Service Delivery Agreement targets. Data across years are not directly comparable as the activity based funding model is updated each year resulting in minor volume changes.

[2] The average number of days in a hospital for patients who stay at least one night.

[3] The 2015-16 actual figures were adjusted to align with elective surgery definitions.

Performance against key performance indicators

Activity (WAU) increases are a result of increased activity (e.g. elective surgery, emergency department presentations) and improved activity counting and coding.

In 2016-17, the sustained improvement for the average length of stay was supported by accessing the Lorraine Brennan Centre to increase bed capacity for Hospital in the Home, ambulatory care and escort accommodation from 58 to 75 beds.

Top End Health Service invested significantly in reducing elective surgery long waits to achieve this remarkable result (refer Performance in 2016-17: Priorities).

Work continues to increase the proportion of emergency department presentations departing within four hours. The key challenge is access to a hospital bed for those emergency department patients requiring admission. The improving patient flow initiatives and enhanced inpatient bed capacity strategies are designed to improve this admission process.

Top End Health Service continued strategies in 2016-17 to improve patient flow. These strategies include process changes and commissioning new or improved infrastructure such as: 11.00 am discharge; expanded transit lounge capacity; and standardised multi-disciplinary team ward round protocols.

Royal Darwin Hospital operating theatre.

Output Group: 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.**
Output:	**Mental Health** Provide specialist mental health services including assessment, case management and treatment.

Key achievements for this output

- The Mental Health Access Team responded to 13,000 calls from the community.
- The Darwin Court Liaison Service commenced in February 2016 and over 2016-17 it became established and is now a valuable and well utilised service.
- Ongoing refurbishment of parts of the inpatient facilities continued in 2016-17.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Individuals receiving community-based public mental health services[1]	5 306	5 306	5 152	5 500	5 223	●	5 300
Individuals under 18 receiving community-based public mental health services[1]	1 022	978	921	1 200	854	●	900
Post-discharge community mental health care[2]	43.5%	49.3%	60.2%	70%	84%	●	70%
28-day mental health re-admissions[3]	10.9%	7.9%	11.3%	10%	11.4%	●	10%
Mental health rate of acute seclusion episodes (per 1000 bed days)[4]	n/a	n/a	n/a	≤20	18.3	●	≤10

[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] 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] 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.

[4] New measure reported in the TEHS 2016-17 Service Delivery Agreement.

Performance against key performance indicators

For individuals under 18 receiving community based public mental health services, the variation is due to improved coordination and partnership with Headspace Top End. Top End Health Service Mental Health and Headspace continue to closely collaborate.

As Headspace established their Top End presence, some young people who would previously have entered our Child and Adolescent services now have a choice and some of them will select Headspace as their preferred provider.

The proportion of people who separate from an acute care facility and are provided with a community service contact within seven days of separation has improved markedly in 2016-17. This result was achieved by the establishment of a Mental Health Practitioner position to follow-up patients within seven days.

To reduce 28 day readmissions, the mental health inpatient and ambulatory care teams worked together to improve planning coordination policies and procedures that influence discharge processes.

Output: Aged Care

Provide services to support senior Territorians to live in the community, along with hospital care and assessment for residential care.

Key achievements for this output

In line with the ageing population:

- The number of incoming referrals to the Memory Service has increased, with approximately 46 new clients referred per month.
- The Short Term Restorative Care program has continued to be provided following a successful tender process.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Aged care occasions of service [1]	8 338	9 049	11 541	11 300	12 068	●	12 000
Aged Care Assessment Program clients receiving timely intervention in accordance with priority at referral	92.6%	92.8%	94.4%	85%	93.7%	●	85%

[1] 2017-18 Budget figures realigned with SDA targets.

Performance against key performance indicators

There has been a sustained increase in the number of aged care occasions of service.

Output: 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.

Key achievements for this output

- TEHS reviewed and re-designed the Opioid Use Disorder in General Practice training and Shared Care program, improving diagnosis and management in general practice and enabling maintenance treatment of opioid use disorder.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Number of assessments undertaken in Northern Territory Government treatment services	n/a	n/a	n/a	n/a	627	-	1 300
Number of episodes of treatment commenced in Northern Territory Government services	n/a	n/a	n/a	n/a	309	-	618
Number of episodes of treatment completed in Northern Territory Government services	n/a	n/a	n/a	n/a	186	-	372

Performance against key performance indicators

These are new indicators commencing in 2016-17. Due to data lag, the 2016-17 actuals are projected estimates based on data available at February 2017.

Output Group: 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.
Output:	Remote Primary Health Care Provide primary health care services delivered by government health centres located in remote communities.

Key achievements for this output

- Building works were completed on the new Galiwinku Primary Health Care Centre which included a new mortuary facility.
- Building works were completed on the new Umbakumba Primary Health Care Centre.
- All three Tiwi Islands communities achieved three years' accreditation against the Australian General Practice Accreditation Limited Standards.
- TEHS continued to invest in the use of Telehealth to enhance the delivery of services in the remote primary health care setting. A total of 1,693 occasions of service using Telehealth were delivered.
- Implementation of a fully integrated maternity service across TEHS, provides cohesive and seamless maternity services across the full continuum of care.
- Millingimbi Primary Health Care Centre successfully transitioned to Miwatj Health Aboriginal Corporation on 1 July 2016.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Episodes of health care services in government-managed remote health centres[1]	233 256	240 077	289 818	232 864	240 108	●	259 397
Aboriginal adult health check coverage	52%	61%	66%	70%	69%	●	70%
Proportion of screened Aboriginal children under 5 years with anaemia[2]	19%	16%	17%	15%	10%	●	12%
Proportion of screened Aboriginal children between 6 months and 5 years of age who have been checked for anaemia[2]	76%	75%	73%	87%	77%	●	87%
Proportion of remote Aboriginal women who attended their first antenatal visit in the first trimester of their pregnancy[3]	50%	54%	56%	60%	66%	●	70%
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[3]	77%	85%	82%	85%	89%	●	90%
Proportion of remote Aboriginal clients aged 15 years and over with type II diabetes who have had an HbA1c test[2]	65%	70%	81%	80%	82%	●	80%
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%[2]	41%	38%	44%	42%	42%	●	42%

[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 aligned with SDA targets. Indicator now reported using six month definition as per SDA. Backcast data included.

[3] Budget figures aligned with SDA targets.

Performance against key performance indicators

In general, there was steady performance across the remote primary health care key performance indicators.

One area of marked improvement is the proportion of remote Aboriginal women who attended their first antenatal visit in the first trimester of their pregnancy. This improvement is a result of:

- An increased number of remote midwives who have focussed on maternal and women's health.
- The Continuous Quality Improvement program which actively monitors a range of indicators including maternal health.
- A diabetes and pregnancy partnership promoting the importance of diagnosing diabetes early in pregnancy and improving maternity education.

An area of focus in 2016-17 was the screening and management of children with anaemia. TEHS identified issues that were impacting on results and in response implemented:

- Improved staff training.
- Children follow-up lists.
- A staff progress feedback reporting system.

The notable improvement in the proportion of clients with a chronic disease management plan is a result of additional efforts for two districts, East Arnhem North and Top End West Arnhem, which were below target. Action plans were put in place and results have steadily improved over the last six months. All other regions maintained good performance, contributing to the overall improvement.

Output:

Urban Primary Health Care

Provide primary health care services delivered by government health services located in urban centres.

Key achievements for this output

- NT Cardiac commenced visiting services performing echocardiograms at the prison reducing the amount of transfers to hospital to access cardiac services.
- Upgrade of client service area at Casuarina Community Care Centre.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Community health occasions of service – urban[1]	112 067	107 332	109 721	110 000	106 245	🔴	110 000
Prison health episodes of care	42 889	46 535	48 025	46 000	50 889	🟢	53 410

[1] 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.

Performance against key performance indicators

The Primary Health Care Urban area includes the Nhulunbuy and Katherine regions for the indicator. The lower than target result for community health occasions of service is due to the significant population decrease at Nhulunbuy since the mine closure.

Output:

Top End-Wide Community Services

Provide community care services through hearing, oral health and cancer screening specialists across the Top End.

Key achievements for this output

- Hearing health, oral health and cancer screening services transitioned from the Department to TEHS on 1 December 2016.
- BreastScreenNT screened 4 438 women across TEHS in 2016-17.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Oral health occasions of service[1]	n/a	n/a	n/a	35 500	36 334	●	36 500
Percentage of remote Aboriginal children (from total assessed) diagnosed with moderate/ severe/ profound hearing impairment	n/a	n/a	n/a	9.5%	9.7%	-	9.5%
Early detection of conductive hearing loss in remote Aboriginal communities[2]	n/a	n/a	n/a	n/a	n/a	-	45.0%

[1] 2017-18 Budget figures realigned with SDA targets.

[2] New measure included in 2017-18 SDA; it replaces the percentage of remote Aboriginal children diagnosed with moderate/severe/ profound hearing impairment.

Performance against key performance indicators

There were no significant variances to targets in 2016-17.

Output Group: Top End-Wide Support Services

Outcome:	Safe, efficient, effective and accessible public health services for Top End residents
Output:	Top End-Wide Support Services Support patient-centred accountable health service, including aeromedical retrievals and ambulance services

Key achievements for this output

- Corporate and Clinical Governance Frameworks developed, with final versions approved 21 July 2017.
- Organisational Culture Charter developed.
- Organisational Culture Learning and Development Program developed and implemented.
- Aboriginal and Torres Strait Islander Recruitment and Retention Strategy 2016-17 – 2018-19 launched.
- Developed and implemented governance, management plans and reporting structures for grants management.
- Established Transition to Community Control Governance Committee to oversee future health service transitions to non-government organisations.
- Established and advanced contract governance and management of key service areas.
- Completed a needs assessment and development of primary health care service matrix.
- Commenced specialist neurosurgical services at Royal Darwin Hospital.
- Significant planning towards commissioning of cardiothoracic surgery and PET scanner and cyclotron capability.
- Completed a cancer services review.
- Transitioned Infrastructure and Engineering Services to a TEHS wide focus to improve alignment and delivery of these services.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Complaints to the Health and Community Services Complaints Commissioner responded to within timeframes set	n/a	n/a	100%	100%	100%	●	100%
Incident recommendations followed up within timeframes set	n/a	n/a	100%	100%	100%	●	100%

Performance against key performance indicators

Target achieved for these indicators.

Top End Health Service - snapshot of costs

Financial results for 2016-17 against agreed targets based on output groups in the 2017-18 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.

Output Group / Output	End of Year Budget	Actuals	Budget vs Actuals	Note
	$000	$000	$000	
Territory-Wide Praimary Health Care	**582,898**	**589,247**	**6,349**	1
Top End Hospitals	582 898	589,247	6,349	
Community Treatment and Extended Care	**48,332**	**55,100**	**6,768**	2
Mental Health	30 217	38,062	7,845	
Aged Care	5 237	4,274	-963	
Alcohol and Other Drugs	12 878	12,764	-114	
Primary Health Care	**125,079**	**135,250**	**10,171**	3
Remote Primary Health Care	88 634	97,458	8,824	
Urban Primary Health Care	14 395	17,412	3,017	
Top-End Wide Community Services	22 050	20,380	-1,670	
Top End-Wide Support Services	**166,226**	**171,751**	**5,525**	4
Top End-Wide Support Services	166,226	171,751	5,525	
Total Expenses	**922,535**	**951,348**	**28,813**	

Notes

1. Mainly patient travel, agency labour and overtime costs. There is also a requirement to realign output resources to reflect service delivery requirements and business priorities.
2. Largely due to high cost mental health clients with supported accommodation requirements. There is also a requirement to realign output resources to reflect service delivery requirements and business priorities.
3. There is a requirement to realign output resources to reflect service delivery requirements and business priorities.
4. Due to Cross Border charges and extraordinary redevelopment costs due to temporary ward closures, particularly at the Royal Darwin Hospital, and the reliance of external acquisitions to lease hospital beds.

Central Australia Health Service Performance in 2016-17: Priorities

The following progress was achieved to meet the priorities for 2016-17.

1. Strengthen our workforce culture through educating and retaining a suitably skilled and culturally sensitive workforce

CAHS made solid progress for this priority. Achievements include: a reduction in staff turnover from 7.4 per cent in the previous year to 5.7 per cent; commencement of nine school-based apprentices, 17 work experience placements and 170 school based visits; and increasing the number of Aboriginal staff employed up from 8.3 per cent to 9 per cent.

CAHS commenced Aboriginal Cultural Awareness Programs in Tennant Creek Barkly to complement a similar program in Alice Springs and initiated a clinician based cultural safety education program at Alice Springs Hospital.

CAHS continued to implement strategies to improve work-life balance and staff retention. Employment arrangements were changed in primary health care to recruit permanent rather than fixed term contract nursing staff. This work will continue in 2017-18 where opportunities for job share will be explored.

2. Improve integration within the Central Australia Health Service

Co-location of primary health care and hospital services in Tennant Creek was completed. Management responsibility for Alcohol and Other Drugs was transferred to Acute Care, complete with specialist clinician oversight of the clinical services as at 30 June 2017.

The integration pathway for the management of respiratory services was progressed with further refinement to occur in 2017-18 using the evidence based principle of effectiveness; this work is jointly developed with the Top End Health Service.

3. Improve early childhood health by developing health care services for children 0-3 years

The Healthy Under 5 Kids Program was formally reviewed with encouraging emerging trends, particularly around a decrease in the number of children who have been assessed as underweight, stunted, growing poorly; however there is still more to be achieved with respect to children who are anaemic.

4. Reduce the burden of renal disease

The CAHS Renal Strategy Group was established. Planning for the redevelopment of Flynn Drive, Tennant Creek and Gap Road services was undertaken with the latter service locations being developed. A business case for the expansion/ redevelopment of Flynn Drive was developed to meet projected future growth in demand for renal dialysis services.

5. Achieve better health outcomes for our community through meaningful engagement with our stakeholders

The Stakeholder Engagement Framework and Communications Plan was established to underpin engagement.

There were bi-annual community forums in Alice Springs and Tennant Creek and quarterly engagement with the Barkly Region Consumer Advisory Group.

Remote local Health Advisory Groups throughout Central Australia were formed, with one operating consistently.

A heads of agreement with Western Desert Dialysis to undertake remote renal dialysis services at Papunya, Docker River and Mt Liebig in 2017-18 was signed.

6. Continued focus on financial sustainability

There was consistent improvement in the generation of controllable revenue from $12.3 million in 2015-16 to $13.8 million in 2016-17, just below the target of $14 million. Overall, CAHS increased its controllable revenue generation by almost 30 per cent in the past three years. CAHS achieved a net surplus to budget for the second consecutive year.

Central Australia Health Service Performance in 2016-17: Strategic Objectives

1. Promote equitable access to high quality care for our community

- Developed a business case to improve the coordination of renal resources, reduce duplication of services and activities, and increase CAHS' capacity to divert resources towards the prevention and early intervention stages of renal disease.
- Increased use of eHealth and Telehealth to improve health outcomes for remote communities.
- Continued proactive recruitment of Aboriginal employees to provide a culturally appropriate health service.
- Delivered the Healthy Under 5 Kids Program to remote communities to educate, identify and mitigate health issues.

2. Build a sustainable, well-coordinated and integrated health care system that enhances health outcomes

- Opening of the new Research, Education and Development (RED) Centre, together with the new Intensive Care Unit at Alice Springs Hospital.
- Establishment of governance-level oversight of all renal activities within CAHS through the establishment of CAHS Renal Strategy Group.
- Increased renal capacity in Tennant Creek with an additional four dialysis chairs.
- The final Healthy Under 5 Kids Program Report was released in March 2017. The report utilised data from all NT health service providers, including non-government organisations; it showed a decrease in the number of children who have been assessed as underweight, stunted and growing poorly.
- Telehealth consultation services continued to grow from less than 1000 in the previous year to more than 1733 in 2016-17 with over 55 different Telehealth clinics now available.

3. Educate and retain a suitably skilled and culturally sensitive workforce

- A continued focus on the employment and retention of Aboriginal Health Workers in remote communities.
- CAHS established a social media platform which features recruitment videos targeting potential employees from interstate and elsewhere. The videos provide an overview of Central Australia described by staff working in remote communities. This assists with recruitment and retention of staff as they are better prepared for the challenges of remote health work.
- Reviewed the "People Matters" survey results and reviewed staff exit surveys upon staff leaving the health service to further identify strategies to enhance staff retention.
- Reviewed the mandatory Aboriginal Cultural Awareness program.
- Developed a peer support program for new employees.
- CAHS introduced a Staff Recognition of Service Program recognising five, 10, 15, 20 and 25 plus years of service.

Nurse Ann Sanotti with Derek Major at the Nyirripi Health Care Centre.

4. Continuous improvement through evidence-based practice

- An expansion of the CAHS Quality and Safety Unit to ensure all RiskMan and other relevant reporting systems are actively monitored.
- Implemented the recommendations of the Patient Care Assistant Review to better reflect the roles and responsibilities of this workforce.
- Alice Springs Hospital continues to meet significant increases in demand (5.58 per cent increase in separations) together with an 8.65 per cent decrease in the average length of stay through improved efficiencies in service delivery.
- Mental health seclusion rates improved from approximately 20 per month to less than five per month. This was largely due to implementation of the Safewards and the Non-Violent Crisis Intervention Programs.

5. Engage with our community to improve health outcomes

- Consumer feedback has been a particular focus in the year with the establishment of the Stakeholder Engagement Framework and Communications Plan.
- Member of a coalition of stakeholders being granted the Centre for Innovation in Rural Health status by the National Health and Medical Research Council.
- Developed a CAHS social network platform to provide further opportunities for engagement with the community and feedback.
- Piloted an in-language patient experience survey.

6. Build a financially sustainable service

- CAHS has delivered a net surplus to budget for the second consecutive year.
- There has been improved generation of controllable revenue from $10.7 million in 2015-2016 to $12.5 million this year.
- The roll-out of the Telehealth program provided significant savings in transport costs and Patient Assistance Travel Scheme funding.
- Improved financial management across the whole service, accountability and a real direction on financial stability has ensured CAHS remains in a strong financial position in 2017-18, particularly with a tighter fiscal environment, increased activity and health service demand.

Central Australia Health Service Performance in 2016-17: Budget Paper Outputs

Central Australia Health Service's financial and activity reporting is based on an output structure as presented in the NT Government's Budget Paper 3 and CAHS SDA.

Output groups:

- Central Australia Hospitals
- Community Treatment and Extended Care
- Primary Health Care
- Central Australia-Wide Support Services

Output Group: Central Australia Hospitals

Outcome:	**Improvement and maintenance of the health and wellbeing of those in the community who require acute or specialist care.**
Output:	**Central Australia Hospitals** Provide admitted, non-admitted and emergency services.

Key achievements for this output

- Ongoing implementation of patient flow initiatives to improve timely access to hospital beds.
- Continued reduction to length of stay.
- Exceeded emergency department access targets for patients discharged from the emergency department (87 per cent).

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Central Australia Health Service Weighted Activity Units (WAU)[1]	42 624	45290	51 090	51 874	52 609	●	51 510
Average length of stay (days)[2]	4.9	5.1	4.7	5.2	4.7	●	4.8
Elective surgery long waits[3]:							
- category 1: percentage of patients waiting longer than clinically recommended time	26%	34.9%	25.8%	0%	34.8%	●	0%
- category 2: percentage of patients waiting longer than clinically recommended time	22.2%	30.8%	21%	2.4%	51.9%	●	2.4%
- category 3: percentage of patients waiting longer than clinically recommended time	18.4%	22.2%	9.8%	2.4%	11.5%	●	2.4%
Emergency department presentations departing within 4 hours	66.6%	64.1%	63.6%	78%	65%	●	78%

[1] 2017-18 Budget figure realigned with CAHS Service Delivery Agreement target. Data across years are not directly comparable as the activity based funding model is updated each year resulting in minor volume changes.

[2] The average number of days in a hospital for patients who stay at least one night.

[3] The 2015-16 actual figures were adjusted to align with elective surgery definitions.

Performance against key performance indicators

In 2016-17 there was a 3.5 per cent increase in patient separations compared with the previous year. Processes were implemented to improve the accuracy of activity capturing and coding and therefore optimising activity revenue.

The average length of stay has improved due to efficiencies in inpatient service delivery including the commencement of an additional medical team to meet patient demand and improved bed management processes to support patient flow.

The elective surgery 2016-17 actuals are off target. Ongoing challenges in achieving targets are a result of specialist recruitment difficulties, staff leave, patients not attending theatre appointments and difficulties in acquiring Visiting Medical Officer (VMO) services. Patients are managed in terms of clinical priority and those patients requiring immediate intervention are actively managed through reprioritisation or are transferred to Adelaide. CAHS recently recruited to some specialist areas and has achieved more stability for VMO clinics. This should consequently reduce waiting times. CAHS also maintains some patients on waiting lists for clinical reasons even though they did not attend multiple appointments.

In terms of emergency department presentations departing within four hours, activity pressures resulting in regular bed block have impacted performance. The 2016-17 result is a marginal improvement on 2015-16 even though there was a five per cent increase in emergency department attendances, with a five per cent increase in patients requiring inpatient admission from the emergency department.

Alice Springs Hospital.

Output Group: Community Treatment and Extended Care

Outcome:	Strengthened capacity of individuals, families and communities to improve and protect their health and wellbeing.
Output:	Output: Mental Health Provide specialist mental health services including assessment, case management and treatment.

Key achievements for this output

- Introduction of staff training programs significantly reducing mental health seclusion rates.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Individuals receiving community-based public mental health services[1]	2 236	2 342	2 354	2538	2 377		2 900
Individuals under 18 receiving community-based public mental health services[1]	395	447	500	518	586		800
Post-discharge community mental health care[2]	63.4%	64.7%	69.8%	70%	89.1%		70%
28-day mental health readmissions	10.5%	15.5%	11.5%	10%	13.5%		10%
Mental health rate of acute seclusion episodes (per 1000 bed days)[3]	n/a	n/a	n/a	≤20	13		≤10

[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] Measure indicates the percentage of separations from the mental health services' acute mental health inpatient units that results in unplanned readmission to the same or another public acute mental health inpatient unit within 28 days of discharge.

[3] New indicator in 2016-17 SDA with budget targets aligned.

Performance against key performance indicators:

There has been a steady increase in the number of adults and youth receiving community mental health services in recent years. The increased number is a result of higher rates of screening and detection in CAHS.

Significant improvements were achieved for the post-discharge community mental health care due to an ongoing focus and review of the service's processes.

The 28-day mental health readmission indicator is affected by the relatively small number of admissions which impact the readmission per centage. There are a number of reasons for readmissions to the mental health unit. Besides chronic schizophrenia and lack of medication compliance, many of the readmissions relate to alcohol and substance abuse, along with associated threats of self-harm, or harm to others. The Mental Health Risk Management Team reviews all 28 day readmissions through the Risk Management system.

The Mental Health Unit has worked assiduously to put in place successful strategies to decrease our rate of seclusion events. This strategy has involved additional staff training by way of Safewards and Nonviolent Crisis Intervention.

Output: Aged Care

Provide services supporting senior Territorians to live in the community, along with hospital care and assessment for residential care.

Key achievements for this output

In line with the ageing population:

- The number of incoming referrals to the Memory Service has increased, with approximately 46 new clients referred per month.
- The Short Term Restorative Care program has continued to be provided following a successful tender process.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Aged care occasions of service[1]	2 778	3 648	3 796	3 700	3 088	●	3 800
Aged Care Assessment Program clients receiving timely intervention in accordance with priority at referral	92.4%	81.3%	87.4%	85%	71.7%	●	85%

[1] 2017-18 Budget figures realigned with SDA targets.

Performance against key performance indicators

The fluctuations in service delivery within this small team were impacted by planned and unplanned leave and delays in recruitment to vacancies.

Output: 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.

Key achievements for this output

- The Alcohol Mandatory Treatment Program was maintained despite recruitment and retention challenges, particularly in the context of the pending cessation of the service.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Number of assessments undertaken in Northern Territory Government treatment services	n/a	n/a	n/a	-	195	-	585
Number of episodes of treatment commenced in Northern Territory Government services	n/a	n/a	n/a	-	74	-	183
Number of episodes of treatment completed in Northern Territory Government services	n/a	n/a	n/a	-	27	-	111

Performance against key performance indicators

These are new measures commencing in 2016-17. Due to data lag, the 2016-17 actuals are projected estimates based on data available at February 2017.

Increased activity is expected with implementation of the Banned Drinkers Register.

Output Group: 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.
Output:	Remote Primary Health Care Provide primary health care services delivered by government health centres located in remote communities.

Key achievements for this output

- Over 90 per cent continuity of medical service provision to remote communities.
- Increase in Aboriginal workers recruited through Back on Track.
- Australian General Practice Accreditation Limited accreditation for three remote health centres commenced with registration completed.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Episodes of health care services in government-managed remote health centres[1]	119 584	120 696	118 927	119 500	112 241	🔴	120 000
Aboriginal adult health check coverage	64%	69%	68%	70%	67%	🟡	70%
Proportion of screened Aboriginal children under 5 years with anaemia[2]	27%	20%	22%	18%	8%	🟢	15%
Proportion of screened Aboriginal children between 6 months and 5 years of age who have been checked for anaemia[2]	69%	65%	72%	87%	75%	🔴	87%
Proportion of remote Aboriginal women who attended their first antenatal visit in the first trimester of their pregnancy[3]	47%	59%	54%	60%	58%	🟡	70%
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[3]	77%	84%	83%	85%	85%	🟢	90%
Proportion of remote Aboriginal clients aged 15 years and over with type II diabetes who have had an HbA1c test[2]	64%	69%	78%	80%	78%	🟡	80%
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%[2]	27%	27%	32%	35%	29%	🔴	35%

[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 excluding Barkly.

[2] Budget figures aligned with SDA targets. Indicator now reported using six month definition as per SDA. Backcast data included.

[3] Budget figures aligned with SDA targets.

Performance against key performance indicators

A decrease in the number of consultations reflects significant difficulties in recruiting nursing staff for a period of four months between November 2016 and March 2017. This, coinciding with the implementation of the remote nursing review recommendation of two nurses at all times in remote communities, meant that services to a number of communities were limited to emergency services only.

Primary health care continues to improve the management of children with anaemia as a result of the introduction of an anaemia care plan and the filling of vacant childhood nurse positions.

For the proportion of screened children with anaemia, significant gains were made in 2016-17. In part, this is due to all child health nurse positions being filled during the reporting period and an improved identification and reporting system.

An increased focus on education in remote communities has seen a positive result in the number of mothers attending their first antenatal visit in their first trimester. The number of antenatal women ranges from eight to ten each month across the CAHS four districts, with an average of two per district. Additional education is provided in those communities where there are higher presentations to the health centre after 13 weeks.

Primary health care is just below its target of 70 per cent coverage overall for adult health checks (67 per cent). Although many health centres are above target there are several health centres which are underperforming; these centres will be targeted in 2017-18 for intense coordinated attention. Specifically these centres will be visited by men's health officers and an accompanying medical officer.

The result for remote Aboriginal clients with type II diabetes and/or coronary heart disease with a chronic disease management plan has held a positive trend and was on target.

The proportion of remote Aboriginal clients with type II diabetes who have had a recent HbA1c test has not reached the target. Primary health is currently reviewing the need to purchase additional diabetes control analysers and increase testing within individual clinics.

Staff turnover negatively impacts on the continuity of care and this is a key contributing factor in improving the proportion of clients with an HbA1c result equal to or less than seven per cent. Improved results are expected as CAHS has recruited a second diabetic educator.

Output: Urban Primary Health Care

Provide primary health care services delivered by government health services located in urban centres.

Key achievements for this output

- Enhanced vigilance of juvenile detainee health care, due to:
  - A mumps outbreak at Alice Springs Correctional Centre (ASCC) which resulted in additional immunisations and follow-up.
  - The introduction of Telehealth which resulted in additional consultations at the ASCC clinic, such that a nurse will sit with the patient during the Telehealth consultations and perform any additional observations the Alice Springs Hospital (ASH) Consultant may require. Previously these consultations would only be recorded as out-patient appointments at ASH.
- Increased service delivery meeting unmet need in prison health.
- Provision of a new service in spinal injury and stomal therapy for patients in the urban setting.
- Increased nutritional services to the urban community.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Community health occasions of service – urban[1]	14 929	15 569	18 339	17 620	15 487		17 000
Prison health episodes of care	29 955	26 240	27 858	27 609	35 893		28 000

[1] 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.

Performance against key performance indicators

The number of prison health episodes of care notably increased as a result of the allocation of additional staff during 2016-17, in particular, one visiting medical officer, one registered nurse, one chronic disease co-ordinator and one medicines nurse.

The lower than budget outcome for urban community health services is due to challenges in recruiting and retaining staff.

Output:	**Central Australia-Wide Community Services** Deliver community care services through hearing and oral health specialists across Central Australia.

Key achievements for this output

- Successful integration of hearing health, oral health and cancer screening services into CAHS.
- Recommenced hearing health and ear, nose and throat surgical remote community visits.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Oral health occasions of service[1]	n/a	n/a	n/a	13 400	14 426	●	13 500
Per centage of remote Aboriginal children (from total assessed) diagnosed with moderate/ severe/ profound hearing impairment	n/a	n/a	n/a	10%	5.6%	-	10%
Early detection of conductive hearing loss in remote Aboriginal children[2]	n/a	n/a	n/a	n/a	n/a	-	45%

[1] 2017-18 Budget figures realigned with SDA targets

[2] New measure introduced in 2017-18 to identify services provided to manage hearing loss in Aboriginal children, aged five years or less.

Performance against key performance indicators

Occasions of service has increased in 2016-17 due to improved staff retention and attraction.

Output Group: Central Australia-Wide Support Services

Outcome:	**Strengthen the capacity of Central Australia Health Service to support patients and clients.**
Output:	**Central Australia-Wide Support Services** Support patient-centred accountable health service delivery, including aeromedical retrievals and ambulance services.

Key achievements for this output

- Ongoing development of effective, professional support services workforce in Central Australia.

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Complaints to the Health and Community Services Complaints Commissioner responded to within timeframes set	n/a	n/a	100%	100%	100%	●	100%
Incident recommendations followed up within timeframes set	n/a	n/a	100%	100%	100%	●	100%

Performance against key performance indicators

Complaints from the Health and Community Services Complaints Commission continue to be finalised within the required period. This is largely due to CAHS dedicating complaints investigation staff whose role it is to coordinate and monitor the progress for the finalisation of complaints.

Central Australia Health Service - snapshot of costs

Financial results for 2016-17 against agreed targets based on output groups in 2017-18 Budget Paper 3 are presented in the table below. Central Australia Health Service's financial performance is provided in greater detail in the CAHs Financial Reports section.

Output Group / Output	End of Year Budget	Actuals	Budget vs Actuals	Note
	$000	$000	$000	
Central Australia Hospitals	242 538	242 213	- 325	1
Central Australia Hospitals	242 538	242 213	- 325	
Community Treatment and Extended Care	28 132	25 696	-2 436	2
Mental Health	17 586	17 191	- 395	
Aged Care	920	753	- 167	
Alcohol and Other Drugs	9 626	7 752	-1 874	
Primary Health Care	59 836	59 705	- 131	3
Remote Primary Health Care	46 096	46 907	811	
Urban Primary Health Care	6 850	6 783	- 67	
Central Australia-Wide Community Services	6 890	6 015	- 875	
Central Australia-Wide Support Services	63 981	67 159	3 178	4
Central Australia-Wide Support Services	63 981	67 159	3 178	
Total Expenses	**394 487**	**394 773**	**286**	

Notes

1. Delays in the finalisation of contracts for renal services.
2. Underspend due to delays in the delivery of alcohol and other drugs programs.
3. There is a requirement to realign output resources to reflect service delivery requirements and business priorities.
4. Additional depreciation, which is a non-cash expense.

Alice Springs Hospital

4. GOVERNANCE

Department of Health Corporate Governance

The Northern Territory Health System Governance and Accountability Framework (the framework) provides a high level overview of NT Health, its organisation of functions, structure and roles. The framework details the governance and accountability arrangements that enable NT Health to fulfil its responsibility for the overall leadership and direction for development, delivery management and performance of the public health system in the Northern Territory. The framework is available on the Department's intranet site.

Since the commencement of the *Health Services Act* 2014 (the Act) on 1 July 2014, NT Health comprises three entities:

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

Each Health Service is governed by a Health Service Board, which is accountable to the Department for the Health Service's performance.

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. As part of the review process, the Government announced changes to the health system's governance in May 2017:

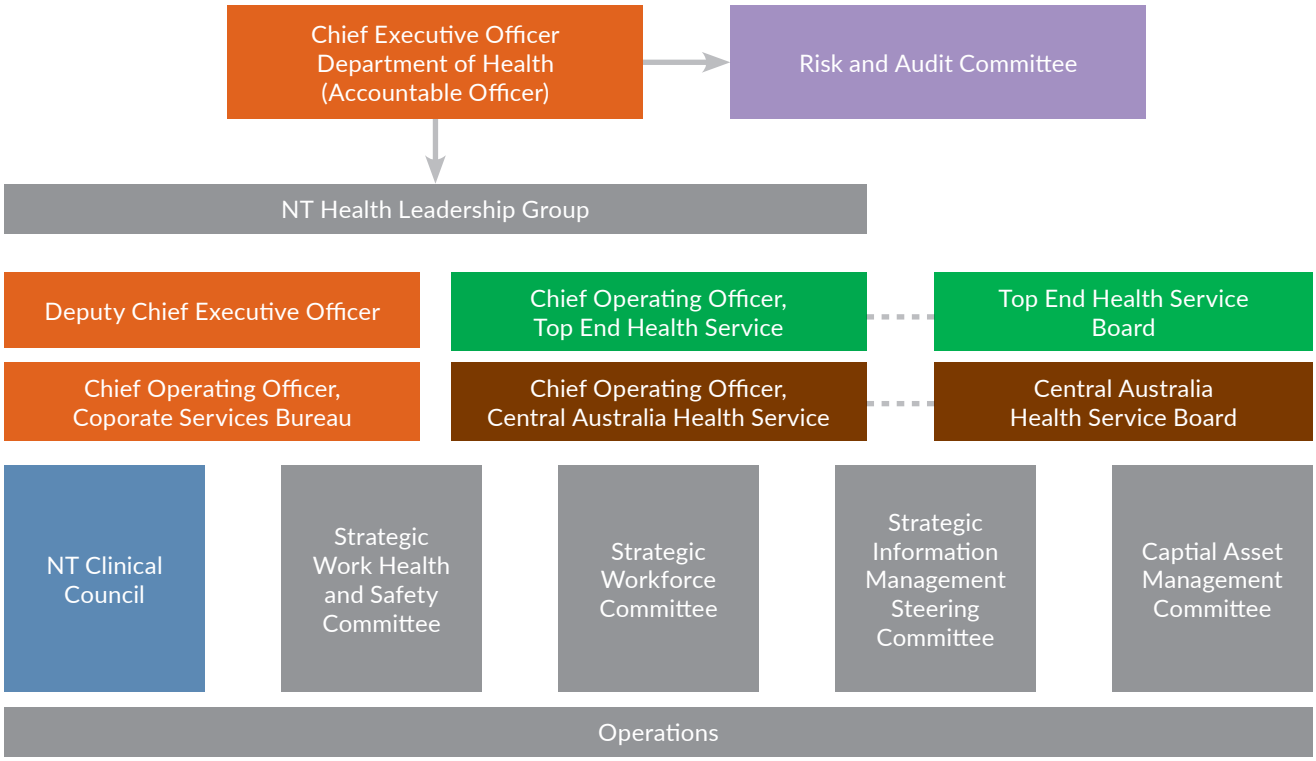
- Health Service Boards would be dissolved from 30 June 2017.
- A Service Administrator would be appointed in each Health Service, to perform the Board's functions, as an interim arrangement while longer term changes to the governance were finalised.
- A Health Advisory Committee would be established in each Health Service.
- The NT Clinical Council would be reinvigorated as the Clinical Senate.

Governance Framework

To ensure appropriate accountability and oversight of the NT Health system, a number of committees have been established.

The key governance mechanism is the NT Health Leadership Group, supported by several standing committees which provide specific focus on key areas of organisational and clinical governance. Each committee is governed by an agreed terms of reference that sets out the committee's role, responsibilities, membership and meeting arrangements.

NT Health Governance Framework



Key Committees and Councils

NT Health Leadership Group

The NT Health Leadership Group provides strategic leadership, stewardship, direction, clinical and corporate governance to the public health system in the NT.

The NT Health Leadership Group members are:

- Prof Catherine Stoddart (Chair),
  Chief Executive Officer, DoH
- Ms Janet Anderson
  Deputy Chief Executive, DoH
- Ms Lisa Watson
  Chief Operating Officer, Corporate Services Bureau, DoH
- Mr Michael Kalimnios
  Chief Operating Officer, TEHS
- Ms Sue Korner
  Chief Operating Officer, CAHS
- Ms Jan Currie (Secretariat)
  Senior Director, Office of the CE, DoH

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.
- Set the agenda for strategic direction.
- Addresses work health and safety performance and risk management issues.

No formal meetings were held in 2016-17 however work health and safety matters were managed at the Departmental and Health Services level and escalated to NT Health Leadership Group as required. The Committee is to be re-formed in 2017-18.

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 Department to meet responsibilities outlined in the Health Services Act and other relevant legislation.

The Committee meets on a quarterly basis to review the performance, allocation of resources, or program issues.

Members include the Chief Operating Officers of Corporate Services Bureau, Top End Health Service and Central Australia Health Service and the Senior Director of Infrastructure and Services. The Committee met five times in 2016-17.

Strategic Information Management Steering Committee

The aim of the Strategic Information Management Committee (SIMSC) is to provide strategic direction regarding information management, knowledge management and information and communications technology for the Department and the Health Services.

SIMSC plans, prioritises, approves and monitors delivery of major information management, knowledge management and information and communications technology infrastructure initiatives.

The Committee also provides direction in relation to the Department's involvement in national information committees, alignment with national strategies and standards and development of information policies and procedures.

In 2016-17 SIMSC participated in the Northern Territory Government Information Governance Board. The Chief Information Officer also participated in the Northern Territory Government ICT Leadership Group, as a Board member of the Australian Digital Health Agency (the Agency) Board, the Agency's Jurisdictional Advisory Committee and co-chaired the National Health Chief Information Officers' Forum. The Committee met five times in 2016-17.

Risk and Audit Committee

The Risk and Audit Committee is an independent advisory committee with the primary purpose of providing assurance and assistance to the Chief Executive Officer in relation to the effectiveness of Department of Health's, Top End Health Service's and Central Australia Health Service's (referred to as NT Health) systems, processes and internal controls in the management of governance, risk and compliance.

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

In understanding the importance placed on internal audit, the 2016-17 program resulted in 200 days of internal audit projects by an external audit firm. In addition, ad-hoc audits, external audits and internal compliance verifications were completed during the year.

The Risk and Audit Committee membership and composition changed during 2016-17.

The Risk and Audit Committee Membership July 2016 to January 2017	
Prof Villis Marshall	Chair, External Member
Major General Michael Krause	External Member
Antoni Murphy	External Member
Janet Anderson	Voting Member, Deputy Chief Executive, DoH
Ex- officio non-voting members	
Lisa Watson	Chief Operating Officer CSB (DoH)
Jan Currie	Senior Director, Office of the CEO
Michael Martin	Board Member TEHS
Graham Symons	Board Member CAHS
Yvonne Sundmark	Director Risk Management and Audit

The Risk and Audit Committee Membership February 2017 to June 2017	
Antoni Murphy	Chair, External Member
Hieu Nguyen	Deputy Chair, External Member
David Keirs	External Member
Janet Anderson	Voting Member, Deputy Chief Executive (DoH)
Dr Hugh Heggie	Voting Member, Chief Health Officer, DoH
Ex- officio non-voting members	
Lisa Watson	Chief Operating Officer (CSB, DOH)
Jan Currie	Senior Director, Office of the CEO (DOH)
Michael Martin	Board Member TEHS
Graham Symons	Board Member CAHS
Yvonne Sundmark	Director Risk Management and Audit

The Department's risk management framework complies with the Financial Management Act and aligns with Risk Management Standard ISO 31000. The risk framework, policy and standards form part of internal control arrangements that enable management to control risk exposure consistent with the level of risk management maturity of the Department.

The Risk and Audit Committee oversaw an internal and external audit program in 2016-17. The internal audit program examines internal controls, effectiveness of policies and procedures and processes in areas not covered by any other audit engagements. Significant audits conducted in 2016-17 included:

Work Health and Safety (WHS) maturity

The objective of this audit was to assess the maturity of NT Health's WHS Management System (WHSMS) using a WHS Maturity Assessment Tool, with a view to establishing the current versus desired level of maturity for NT Health's WHSMS.

The output of the maturity assessment was a strategic roadmap outlining recommendations to achieve a desired level of maturity.

Fraud Review

The objective of the audit was to assess NT Health's ability to prevent, detect and respond to fraud risks and incidents, identifying opportunities to strengthen fraud management approach and implementation.

Business Resilience Status

The objective of this audit was to assess NT Health's maturity using a framework with a focus on four key elements: business continuity risk assessment; business impact analysis; business continuity plan development; and training, testing and maintenance of the business continuity plan.

Child Safety Audit

The objective of this audit was to obtain an understanding of child safety practices across NT Health, giving consideration to the five key organisational elements: child protection governance and policies; child protection culture; child protection risk management framework; regular child protection learnings; and robust recruitment and employee screening processes.

Compliance with Information Privacy Principles (IPPs)

The objective of this audit was to review the Department of Health's and Top End Health Service's compliance with the IPPs for medical records to determine whether NT Health is appropriately protecting the privacy of the personally identifiable information it collects, uses and discloses.

External audits conducted in 2016-17

(Audits conducted by the Auditor-General)

Department of Health end-of-year review 30 June 2016

The objective of this review was to assess the adequacy of selected aspects of end of financial year controls over reporting, accounting and material financial transactions and balances of Department of Health.

Pool funding acquittal 2016

The objective of the audit was to provide an audit opinion on the special purpose financial statement prepared in the accordance with the *National Health Funding Pool and Administration (National Uniform Legislation) Act 2012*.

Central Australia Health Service financial statement audit for the year ended 30 June 2016

The objective of the audit was to conduct sufficient audit work to form an opinion on the financial statements of Central Australia Health Service for the year ended 30 June 2016.

Top End Health Service financial statement audit for the year ended 30 June 2016

The objective of the audit was to conduct sufficient audit work to form an opinion on the financial statements of Top End Health Service for the year ended 30 June 2016.

Performance management system audit, contract management: St John Ambulance Australia (NT) Incorporated and Care Flight NT Limited

The objective of the audit was to assess the performance management system in place at the Department of Health that enables the Department to manage its contracts and agreements.

Survey of fraud control arrangements within selected Northern Territory Government (NTG) agencies

The purpose of this survey was to assess key aspects of fraud control arrangements in place across the NTG public service.

Department of Health annual compliance audit

The objective of the audit was to assess that internal control systems are operating in accordance with the *Financial Management Act* and the Treasurer's Directions.

Department of Health review of the Electronic Medication Management Application (eMMa) IT Controls

The objective of the audit was to assess the internal controls of the eMMa system.

Excessive leave entitlements – Department of Health, Top End Health Service and Central Australia Health Service

The objective of the audit was to examine leave accruals for employees of the Department of Health, Top End Health Service and Central Australia Health Service.

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	2015-16	2016-17
Applications lodged during the year	168	229
Applications granted in full	121	128
Applications granted in part	10	28
Applications refused in full	13	56
Applications transferred	4	1
Applications withdrawn	10	7
Applications outstanding at end of year	10	9

The increase in applications in 2016-17 can be attributed to an increased awareness by the public of their rights in regard to accessing personal information and an increased awareness of the legislative requirements of Freedom of Information applications within the Department.

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 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 2016-17 one privacy complaint was made. The matter was investigated thoroughly and it was determined that the allegations were unsubstantiated.

Correction of personal information

In 2016-17, the unit received 10 applications to correct personal information held by the Department. All applications were investigated and corrective action applied, where applicable, pursuant to the provisions of the Act.

Third party consultations

In 2016-17, the unit received four third party consultation requests from external parties seeking support for the release of government information. The unit consulted with the relevant program areas and supported the release of information, either in full or in part.

Communication

Timely and effective communication is a key feature of NT Health's commitment to good governance at all levels. A number of internal communication mechanisms are used by the Chief Executive Officer:

- NT Health Leadership Group communique (messages released by the NT Health Leadership Group following meetings of the Group).
- Chief Executive Officer broadcast messages (ad-hoc emails from the Office of the Chief Executive).
- Health Heartbeat (a fortnightly email from the Office of the Chief Executive and which is available on the Intranet).

All areas of NT Health are encouraged to develop and use communication methods appropriate to their area.

Health Services Boards

Top End Health Service Board

The Top End Health Service (TEHS) Board had eight members during 2016-17, with no changes in Board membership during the year. The TEHS Board was dissolved with effect from 30 June 2017.

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.

TEHS Board meeting attendance 2016-17

Board Member	Number of Meetings
Annette Burke	8
Diane Walsh	10
Trish Angus	10
Michael Martin	6
Connie Jape	7
Sarah Giles	8
Alan Cass	9
Amin Islam	9
Meetings held	10

Board activities 2016-17

The 2016-17 Service Delivery Agreement (SDA) between the Board and the Department of Health was signed on 28 June 2016. TEHS Board committee structures and processes support operations and assist the Board discharge its accountabilities under the SDA.

Committees

Four Board committees advised and assisted the Board to manage its obligations:

- Finance, Risk and Audit
- Community and Consumer Engagement
- Safety and Quality
- Governance

Committee meeting attendance 2016-17

Board Member	Finance, Risk and Audit	Community and Consumer Engagement	Safety and Quality	Governance
Annette Burke			1	
Diane Walsh		6	4	4
Trish Angus	8			4
Michael Martin	7	4		
Connie Jape		5	6	
Sarah Giles			5	
Alan Cass	6			3
Amin Islam	7			
Meetings held	8	6	6	4

Governance

During its life, the Board has undertaken an annual review of its governance arrangements, including comparison to standards of accepted practice. During the year, the Board engaged Australian Institute of Company Directors to undertake a governance review using its Governance Assessment Tool. Results of the survey in May 2017 showed a significant improvement in maturity and governance, with all areas rated as “sound” or “mature”.

Central Australia Health Service Board

The Central Australia Health Service (CAHS) Board had seven members during 2016-17, with Professor John Wakerman taking approved leave from January to June 2017. No other Board membership changes occurred in this year. The CAHS Board was dissolved with effect from 30 June 2017.

CAHS Board (Left to Right): Damien Ryan (Chair), Kerry Delahunty, Prof. John Wakerman (Deputy Chair), Graham Symons, Dr Christine Lesnikowski, Nardine Collier, Edward Fraser.

CAHS Board meeting attendance 2016-17

Board Member	Number of Meetings
Damien Ryan	10
Prof John Wakerman	6/6*
Nardine Collier	9
Dr Christine Lesnikowski	10
Edward Fraser	9
Kerry Delahunty	8
Graham Symons	10
Meetings held	11

* Meetings available to board members.

Board activities 2016-17

The 2016-17 Service Delivery Agreement (SDA) between the Board and the Department of Health was signed on 29 June 2016. CAHS committee structures and processes support operations and assist the Board monitor its accountabilities under the SDA.

Committees

Four Board committees worked to advise and assist the Board manage its obligations:

- Finance, Risk and Audit.
- Health Outcomes (joint Committee with TEHS).
- Strategic Workforce.
- Governance.

Committee meeting attendance 2016-17

Board Member	Finance, Risk and Audit	Health Outcomes	Strategic Workforce	Governance
Damien Ryan	9	4	5	8
Prof John Wakerman		6 Chair	4	
Nardine Collier			8 Chair	6
Dr Christine Lesnikowski				9 Chair
Edward Fraser	9			
Kerry Delahunty			5	8
Graham Symons	10 Chair		4	
Meetings held	11	6	8	10

Department of Health 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.

NT Clinical Council

The NT Clinical Council did not meet due to the restructure of the Department of Health however it will be reconstituted as the Clinical Senate in 2017-2018.

Clinical networks

Clinical networks draw together stakeholders including NT Health clinicians, private sector providers, community representatives and other experts in a variety of fields. The networks achieve a high level of clinician engagement and collaboration in the planning and development of services across the NT and the coordination of service delivery in a culturally safe manner. In 2016-17, key achievements of the clinical networks were:

- The NT Cancer Care Network focussed efforts on developing a new NT Cancer Care Plan 2017-2021.
- The NT Cancer Care Network progressed nationally endorsed Optimal Cancer Care Pathways for head and neck cancers.
- The NT Rehabilitation Health Network developed and published the NT Rehabilitation Strategy 2017-2021 which outlines the key priorities, strategies and outcomes that will be the focus for delivery of rehabilitation services in the NT over the next five years.

Sentinel events

Sentinel events are unexpected 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.

Sentinel Event	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
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		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 [1]				1		
Infant discharge to wrong family or infant abduction						
Total	0	1	2	2	0	1

Notes

1. Change to Maternal sentinel event definition and adoption of the World Health Organisation 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 the Australian Health Ministers Advisory Council in November 2014.

Coronial recommendations

The coroner's office investigates deaths and suspected deaths in the Northern Territory on behalf of the community. The types of deaths the coroner investigates are called reportable deaths.

A reportable death includes:

- 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.

During 2016-17, seven inquests related to NT Health occurred of which six had recommendations.

As a result of the coronial recommendations:

- NT Health implemented a Falls Prevention Package for the emergency department; provided education during orientation and additional one-to-one training; and conducted regular clinical audits.
- NT Health implemented the use of a Patient Inter-hospital Transfer Summary to guide clinicians in the conduct of a thorough handover of patients to another health and facility; and undertaken audits.
- A second forensic pathologist was recruited to Territory Pathology.
- NT Health commenced a review of the volatile substance misuse legislation. Guidelines and prevention measures form part of the commitment to ensure the NT provides efficient and effective care and treatment in the management of clients.

Health service accreditation

The Department of Health requires 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 Health Services have maintained accreditation.

Enhancing clinical governance

The NT Health Clinical Governance Policy Framework has been extended for one year to allow further review to incorporate the second edition of the national standards.

Clinical risk management

In 2016-17 a range of tools were developed to support the management of complaints and adverse incidents. New eLearning modules were developed to support staff in the use of the incident information management system (RiskMan). The eLearning modules are self-enrolling and completed online. The new modules are due for release in September 2017.

NT Health's incident management system (RiskMan) is currently upgrading its database. The upgraded system is a complete redesign to enable a more progressive user experience and has some added functions and features. The new version is expected to be released in August 2017.

MyHospitals Website

The MyHospitals website has been set up to ensure the Australian community has easy access to nationally consistent and comparable performance information for public and private hospitals. The website includes a range of performance reports including:

- Staphylococcus aureus bloodstream infections.
- Time spent in emergency departments.
- Wait time for elective surgery.
- Costs of acute admitted patients.
- Hand hygiene.
- Cancer surgery wait time.
- Length of stay in public hospitals.

More information can be located at www.myhospitals.gov.au

Australian Atlas of Healthcare Variation

The Second Australian Atlas of Healthcare Variation (the Atlas) was released on 5 June 2017. The Atlas is published by the Australian Commission on Safety and Quality in Health Care in collaboration with the Australian Institute of Health and Welfare.

The aim of the Atlas is to identify variation in hospital admission rates across Australia for key conditions, and the number of potentially preventable hospitalisations.

The Atlas examines four clinical themes: chronic disease and infection - potentially preventable hospitalisations; cardiovascular conditions; women's health; and maternity and surgical intervention.

It provides detailed context and interpretation to explain the variations, recommended actions to potentially reduce unwarranted variation and highlights issues that require further analysis.

The information in relation to Aboriginal patients will be valuable for the Northern Territory in assessing and reducing unwarranted variations in health care. To read key findings and recommendations please visit the Atlas of Healthcare Variation at www.safetyandquality.gov.au

Top End Health Service Clinical Governance

TEHS is committed to the continued improvement of patient safety and quality health care services through a comprehensive clinical governance process.

TEHS' clinical governance structures provide advice and reports 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.

Safety and Quality

The TEHS Service Delivery Agreement includes safety and quality indicators which are monitored and discussed at performance meetings with the Department. The performance for these indicators is shown in the table below.

Mental health safety and quality indicators are reported in the mental health output under TEHS Community Treatment and Extended Care output group performance section (Chapter 3).

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Staphylococcus Aureus Bacteraemia (SAB) Infections[1]	1.09	0.76	0.75	1.07	1.02	●	1.07
Hand hygiene compliance	70.6%	76.4%	81.8%	75.0%	80.6%	●	80%
Potentially preventable hospitalisations	7.9%	8.1%	6.8%	9.1%	6.9%	●	9.1%
Discharge summaries dispatched within 48 hours[2]	n/a	n/a	n/a	95%	n/a	-	95%
Inpatients who discharged from hospital or left hospital against medical advice	n/a	n/a	n/a	9.1%	9.5%	●	8.0%

[1] Refers to the number of SAB infections per 10,000 patient bed days.
[2] Indicator not measured due to data reporting issues.

Incident management

Incidents or near misses that potentially harm consumers or carers and staff are reported via an online 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.

The reported incidents in 2016-17 are shown in the table below.

Incident Severity Rating (ISR)	2015-16	2016-17
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	9
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	100
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	2 573
ISR4 incident is where harm is minimal and not requiring additional level of care	2 492	3 953
ISR5 is an incident that did not cause harm and includes near misses	2 173	3 737
Total	7 055*	10 372**

* The 2015-16 Annual Report figure inaccurately represented as 7065.
** The 2015-16 and 2016-17 figures are not comparable as the 2016-17 data include the addition of the transitioning services of oral health, hearing health and cancer screening. The 2016-17 data also reflect increased reporting by mental health and alcohol and other drug units.

Client and Patient Experience

Top End Health Service (TEHS) is committed to improving patient experience and has dedicated a number of initiatives for this purpose, including the new TEHS Organisational Culture Charter which focuses on patient centred care. Patient experience in TEHS is measured through patient experience surveys, complaints/compliments and by consumer participation.

Patient surveys

TEHS runs a number of patient surveys with the main one being the hospital inpatient survey conducted in October every year. Our last survey indicated the satisfaction rate across the three Top End hospitals is 90.42 per cent.

TEHS is working on a new online survey tool which would improve our ability to obtain feedback from patients.

The Friends of TEHS program was officially launched in November 2016 to facilitate consumer participation in decisions made about the health service. This program offers a framework for staff to engage with consumers in a structured approach, ensuring consistency across the service.

TEHS has actively recruited consumers to join the program in the last six months and 20 Friends of TEHS are now registered and have attended the induction.

Complaints

TEHS received 614 complaints in 2016-17, which is an increase of 15 per cent from the previous year (532 complaints). A summary of the complaints received is shown in the table below.

The data show the largest increases in complaints are in treatment and medication. A portion of this increase may be attributed to the three new services transitioned to TEHS during 2016-17 (i.e. oral health services, hearing health services and cancer screening services). TEHS also actively sought feedback from consumers to improve services which appears to have increased the number of complaints made. Many quality improvement activities are the direct result of consumer feedback and TEHS is committed to provide services that are responsive to the needs of consumers and the community.

A communication skills and complaint management training package was delivered to TEHS staff to improve workforce skills around communication and capacity to manage complaints appropriately at the point of service.

Compliments

TEHS received 269 compliments in the 2016-17, which is an increase of 40 per cent from last year (192 compliments). This increase is likely due to the reason outlined above in relation to complaints.

Complaints	2015-16	2016-17
Access To facility, to subsidies, refusal to admit or treat, service availability, waiting list delays.	97	99
Treatment Co-ordination, diagnosis, delay, unexpected outcome, wrong/inappropriate, inadequate consultation, no/inappropriate referral, withdrawal of, excessive rough/painful, infection control, private/public election.	132	171
Communication / Information Attitude/ manner, inadequate information provided, incorrect/misleading information provided, special needs not considered.	145	146
Environment / Management Administrative process, cleanliness and hygiene of facility, physical environment of facility, staffing and rostering, statutory obligations / accreditation.	58	58
Consent / Decision Making Consent not obtained or inadequate, involuntary admission or treatment, uninformed consent.	13	25
Medical Records Access to/ transfer of records, record keeping.	9	11
Fees / Cost Billing practices cost of treatment, financial consent.	7	7
Medication Administering, dispensing, prescribing and supply/storage/security of medications.	29	56
Reports Access to/transfer of records, record keeping.	6	8
Discharge / Transfers Inadequate discharge, information on follow up care not provided.	26	16
Professional Conduct Unsatisfactory professional conduct.	8	12
Grievances Inadequate or no response to complaint lodged	2	5
Total	532	614

Central Australia Health Service Clinical Governance

CAHS is committed to the continued improvement of patient safety and quality health care services through a comprehensive clinical governance process.

CAHS has a Clinical Governance Framework based on an integrated approach to clinical risk management, clinical effectiveness, an effective workforce and continuous quality improvement.

Performance across these facets is monitored by the CAHS Clinical Governance Committee and reported through each divisional Clinical Governance Committee. CAHS clinical governance structures provide advice and reports 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.

Safety and Quality

The CAHS Service Delivery Agreement includes safety and quality indicators which are monitored and discussed at performance meetings with the Department. The performance for these indicators is shown in the table below.

Mental health safety and quality indicators are reported in the mental health output under CAHS Community Treatment and Extended Care output group performance section (Chapter 3).

Key Performance Indicators	Previous Years			Current Year			Future Target
	2013-14	2014-15	2015-16	2016-17			2017-18
	Actual	Actual	Actual	Budget	Actual	Status	Budget
Staphylococcus Aureus Bacteraemia (SAB) Infections[1]	0.97	0.50	0.25	0.92	1.01	🔴	0.92
Hand hygiene compliance	69.6%	69.5%	79.1%	75%	77%	🟢	80%
Potentially preventable hospitalisations	6.9%	7.4%	5.7%	9.1%	5.2%	🟢	9.1%
Discharge summaries dispatched within 48 hours[2]	n/a	n/a	n/a	95%	n/a	-	95%
Inpatients who discharged from hospital or left hospital against medical advice	n/a	n/a	n/a	9.4%	10.2%	🟡	8.5%

[1] Refers to the number of SAB infections per 10,000 patient bed days.
[2] Indicator not measured due to data reporting issues.

Incident Management

Executive leads and senior management proactively manage patient incidents, clinical issues, hazards, risks and near misses.

Incidents or near misses that potentially harm consumers, carers and staff are reported via an online based integrated risk management system.

The information is reported through Clinical Governance where events such as aggression, clinical handover, falls, medication errors and pressure injuries are reviewed and where possible trends identified and managed appropriately and in a timely manner.

Incidents that are rated at a lower level are trended and targeted action plans are developed and implemented.

Serious events and incidents are escalated to Executive Management so that there is visibility and they can be managed quickly and effectively to prevent possible reoccurrence. Open disclosure is actively promoted when things do not go to plan and CAHS continues to foster a strong reporting culture and all staff are encouraged to report incidents or near misses no matter how big or small.

The incidents reported in 2016-17 are shown in the table below.

Incident Severity Rating (ISR)	2015-16	2016-17
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	3
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	59
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	854
ISR4 incident is where harm is minimal and not requiring additional level of care	1272	1119
ISR5 is an incident that did not cause harm and includes near misses	1075	1099
Total	3291	3134

Client and Patient Experience

Understanding and improving our clients' and patients' experience is a key component to the successful delivery of high quality care. This experience shapes and informs our service delivery strategies and improves our services.

As outlined in the CAHS priorities performance section (Chapter 3), CAHS engages several community forums to improve engagement and facilitate feedback .

Feedback forms are given to clients and patients to encourage them to provide comments. Completed forms are uploaded to RiskMan (feedback reporting system) to ensure feedback is managed effectively.

Complaints

In 2016-17 there was a marked increase in the use of RiskMan with a visible improvement in the categorisation, management and resolution of complaints.

CAHS reported a 12 per cent increase in the number of complaints. This rise is largely due to management and staff encouraging clients and patients to provide feedback. A summary of the complaints received in 2016-17 is shown in the table below.

Compliments

Central Australia Health Service has received 256 compliments in the 2016-17, which is an increase of three per cent from last year (248 compliments). This increase in compliments is likely due management and staff encouraging clients and patients to provide feedback.

Complaints	2015-16	2016-17
Access To facility, to subsidies, refusal to admit or treat, service availability, waiting list delays.	38	41
Treatment Co-ordination, diagnosis, delay, unexpected outcome, wrong/inappropriate, inadequate consultation, no/inappropriate referral, withdrawal of, excessive rough/painful, infection control, private/public election.	40	39
Communication / Information Attitude/ manner, inadequate information provided, incorrect/misleading information provided, special needs not considered.	39	48
Environment / Management Administrative process, cleanliness and hygiene of facility, physical environment of facility, staffing and rostering, statutory obligations / accreditation.	37	38
Consent / Decision Making Consent not obtained or inadequate, involuntary admission or treatment, uninformed consent.	2	4
Medical Records Access to/ transfer of records, record keeping.	3	10
Fees / Cost Billing practices, cost of treatment, financial consent.	4	0
Medication Administering, dispensing, prescribing and supply/storage/security of medications.	2	3
Reports Access to/transfer of records, record keeping.	0	0
Discharge / Transfers Inadequate discharge, information on follow up care not provided.	4	9
Professional Conduct Unsatisfactory professional conduct.	20	19
Grievances Inadequate or no response to complaint lodged	0	1
Total	189	212

5. SUSTAINABILITY AND ENVIRONMENT

Energy and Environmental Management

NT Health is the largest energy using and greenhouse gas emitting Northern Territory Government agency. As such, it is important that NT Health lead by example and tune and optimise its built infrastructure to be as efficient and greenhouse-friendly as possible within existing budgets.

In 2016-17:

- New health buildings built by the NT Government met the Section J minimum energy efficiency requirements in the Building Code of Australia (not mandatory in the NT).
- The Department of Health tender for a new head office included best practice environmental sustainability requirements.
- New remote health centres were built to meet the sustainable design requirements included in the "Department of Health Generic Guidelines for Remote Health Centre Infrastructure".

The Territory's largest hospital, Royal Darwin Hospital (RDH), is responsible for more energy use and greenhouse gas emissions than all NT Government schools put together.

The continuous improvement of Royal Darwin Hospital's carbon footprint since 2008 offers a case study regarding what is cost effective and possible when funding is available for energy management. Figure 1 illustrates that, since the commencement of a Department of Health energy management program in 2008-09, RDH's carbon footprint reduced by eight per cent even though the campus building footprint grew by eight per cent. Figure 2 highlights that the greenhouse gas emissions per square metre of floor area at RDH reduced by 19 per cent from 2009-2017.

Figure 1 - RDH Total Greenhouse Gas Emissions (Tonnes $CO_{2(e)}$) and floor area trends

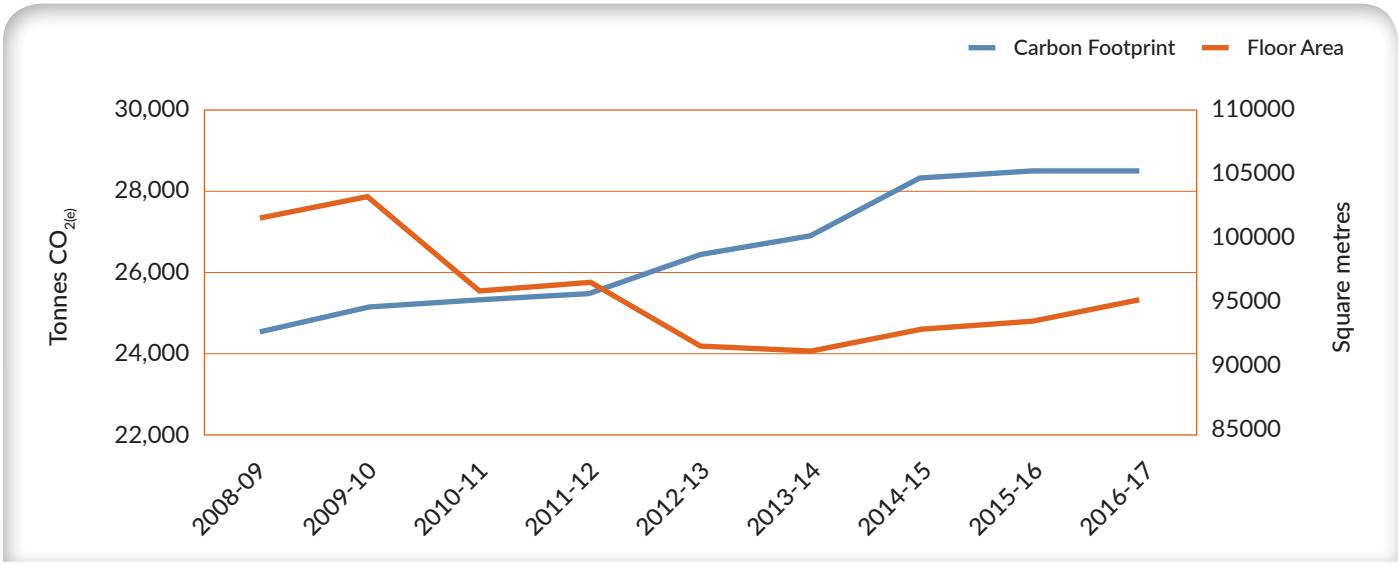
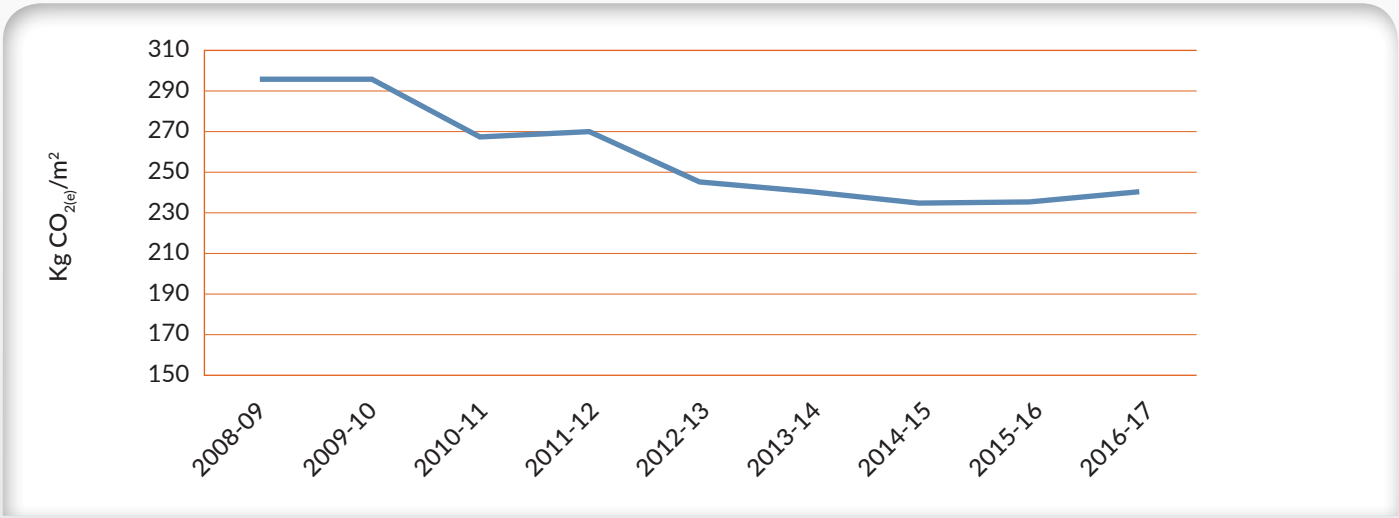


Figure 2 - RDH Total Greenhouse Intensity (Kg $CO_{2(e)}$/Square metre of floor area)



The long term savings at RDH can largely be attributed to:

- A lighting upgrade that saved up to 60 per cent of light fitting energy use, while preserving the embodied energy in 3,500 light fittings.
- The installation and continuous tuning of ultra-high efficiency air conditioning chillers.
- Replacement of steam boiler burners with new high efficiency burners.
- New water and energy efficient laundry equipment.
- Best practice energy efficient design of new buildings on campus.

Without these initiatives, the floor area growth at RDH since 2008-09 would be contributing approximately an additonal 3,700 tonnes of greenhouse gas to the atmosphere each year. To look at these savings another way, RDH energy management initiatives are saving greenhouse gas emissions equivalent to that which would be saved by the installation of a three megawatt photovoltaic solar farm.

Alice Springs Hospital's (ASH) cogeneration plant was completed in June 2014 and cost effectively recycles exhaust gas waste heat from on-site power generation.

The heat recovery process can generate up to 40 per cent of the steam used by ASH (for sterilisation, hot water heating, heating and the laundry) as cost and carbon free steam. So far this system has been reducing ASH's carbon footprint by 9-14 per cent per year and it has the potential to further reduce the campus environmental impact in future years.

Other NT Health sustainability outcomes in 2016-17 included:

- ASH obtained funding to improve the environmental quality of its kitchen waste water.
- Gove District Hospital continued its program to replace old inefficient lights with LED lights, tuned the operation of its boilers to save 4-10 per cent of energy use and installed variable speed drives to improve the efficiency of the air conditioning chilled water system.
- Tennant Creek Hospital installed new efficient air conditioning chillers, continued its program to replace old lights with LED lights and installed equipment to use clean renal dialysis process waste water for garden irrigation.
- Katherine Hospital continued its LED light replacement program.

Figure 3 - ASH Total Greenhouse Gas Emmissions (Tonnes $CO_{2(e)}$) and floor area trends

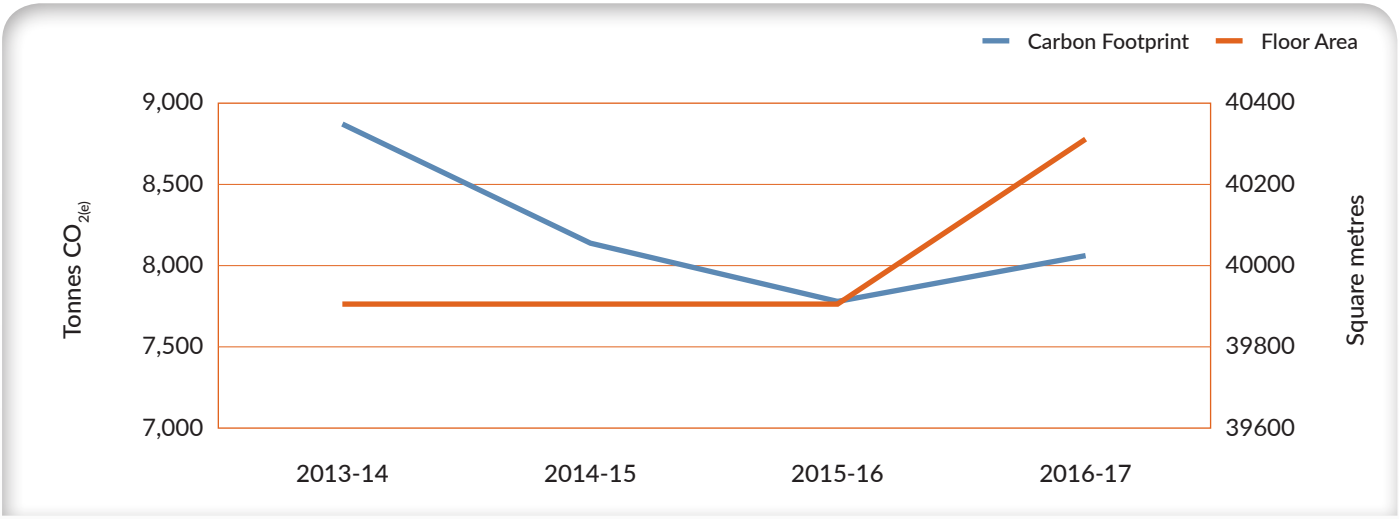
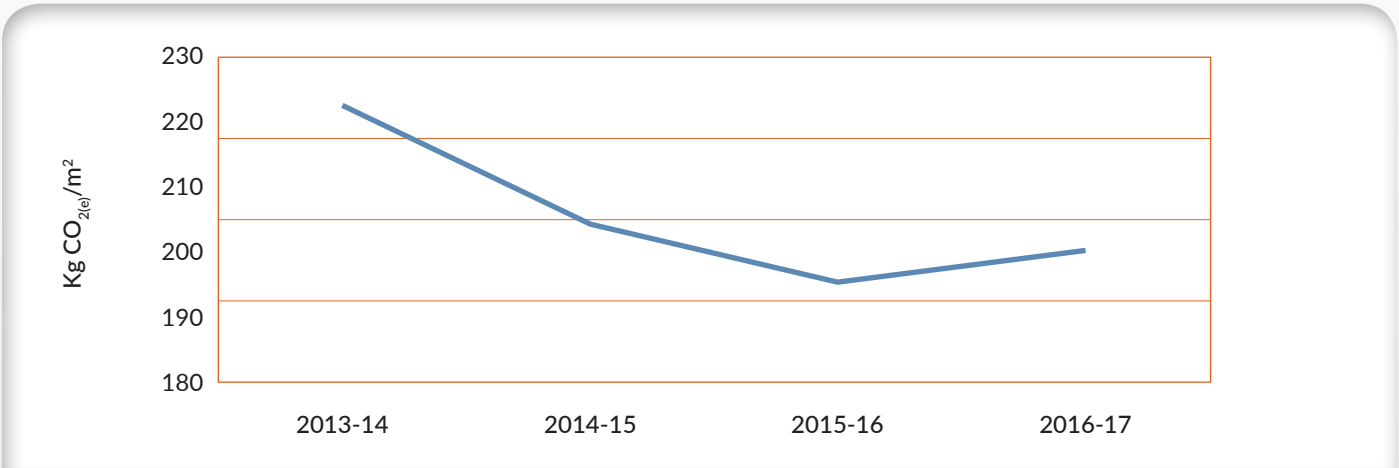


Figure 4 - ASH Greenhouse Intensity (Kg $CO_{2(e)}$/Square metre of floor area)



Red Sands

6. OUR PEOPLE

NT Health Workforce

NT Health Workforce

73 per cent of our workforce were female

73% Female

8 per cent identified as Aboriginal or Torres Strait Islander people

8% Aboriginal/ Torres Strait Islander

22 per cent identified English as a second language

English 22% Second language

1 per cent identified as having a disability

Disability 1%

83 per cent of our workforce were full-time

83% Full-time

17 per cent of our workforce were part-time or casual

17% Part-time or Casual

80 per cent of our workforce worked on the frontline

80% Frontline

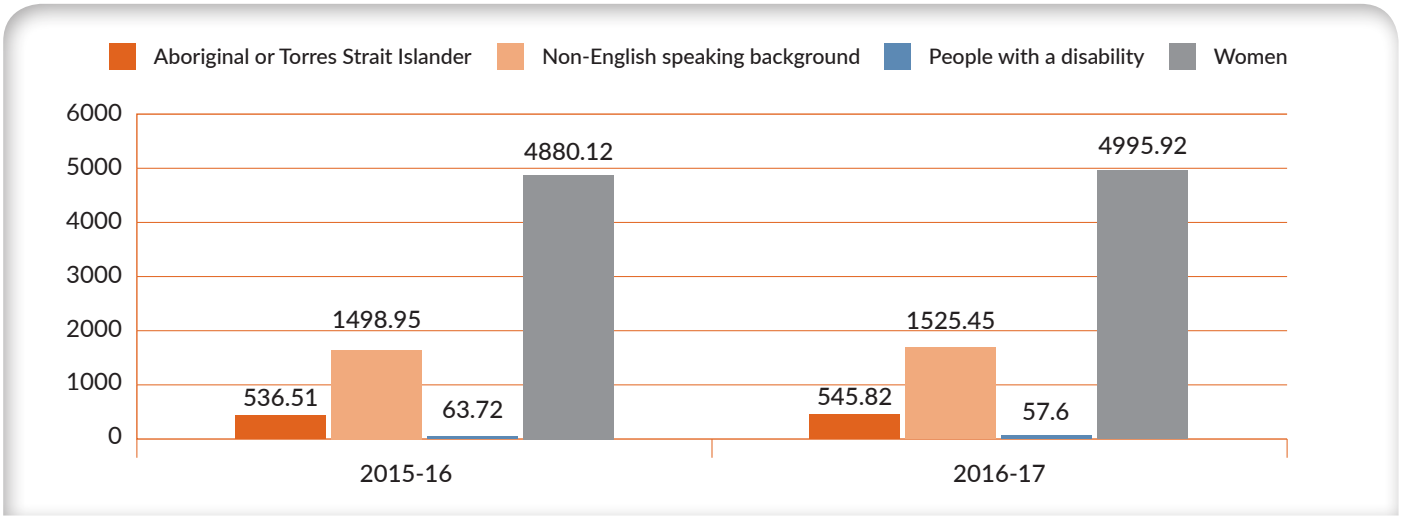
Workforce Profile

- The NT Health workforce grew by 185 Full Time Equivalent (FTE) in 2016-17 with most of this increase attributed to physical, professional, medical and nursing staff in-line with increased health service activity.
- NT Health experienced a reduction in resignations by approximately 150 FTE compared with the 2015-16 financial year.
- Classifications experiencing the lowest turnover include Aboriginal Health Practitioners, nursing and medical staff. NT Health actively supports a diverse workforce through participation in sector wide employment strategies.
- Currently the NT Health workforce comprises 73 per cent female, 22 per cent from a non–English speaking background, 8 per cent identified as Aboriginal and less than 1 per cent identified as having a disability.
- Additional work is required to build a workforce that is reflective of the community it serves and will continue to lead in the implementation of sector-wide strategies such as Special Measures.

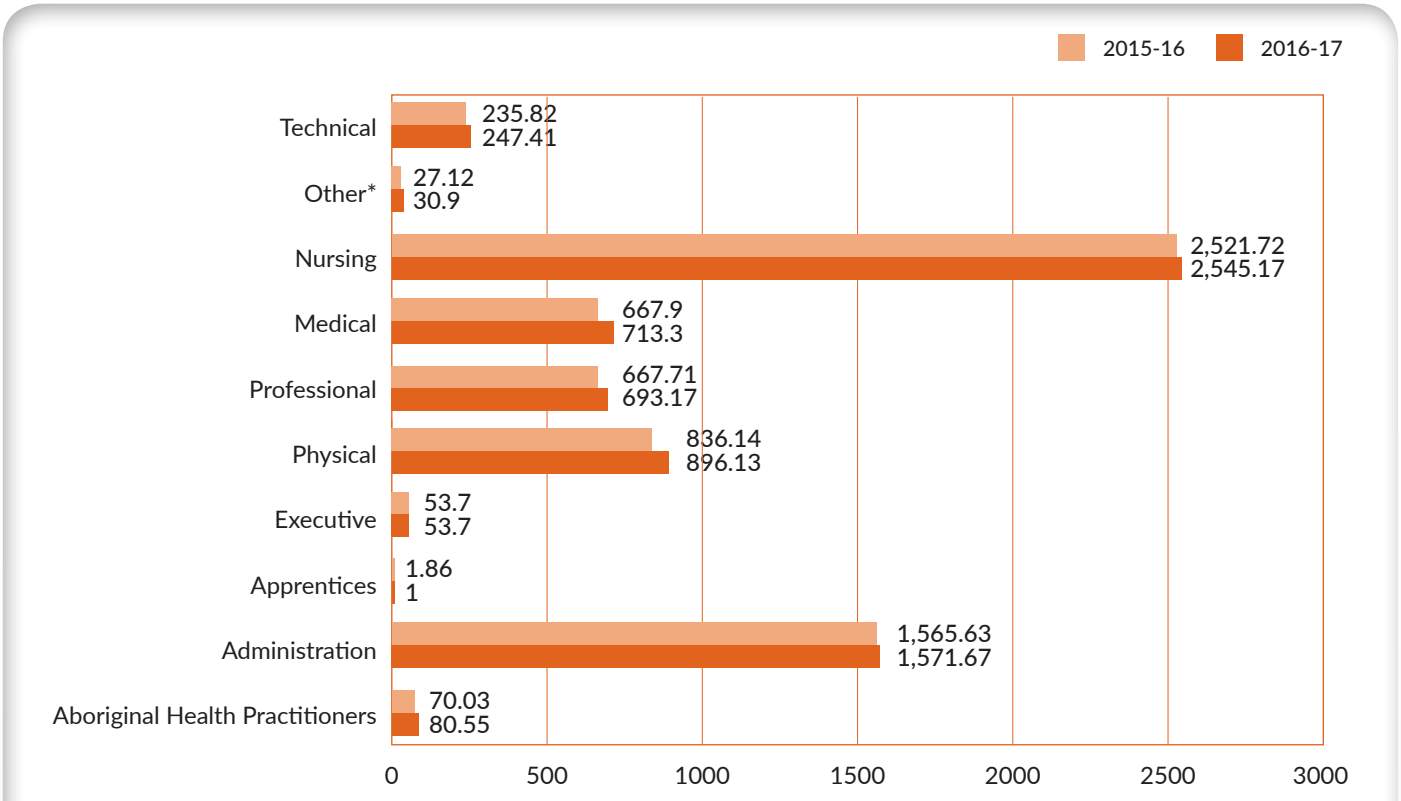
From left to rignt, Daryl Little Men's Health Coordinator (MHC), Dy Kelaart Primary Health Care Manager, David Hanley (MHC) and Brian Castine (MHC).a the 2016 Men's Health forum in Central Australia.

Total paid FTE last pay periods 2016 and 2017	2016	2017
Department of Health	1,086.47	912.84
Top End Health Service	3,861.48	4,129.29
Central Australia Health Service	1,699.68	1,790.87
Total	**6,647.63**	**6,833.0**

NT Health number of employees by diversity group, 2015-16 and 2016-17



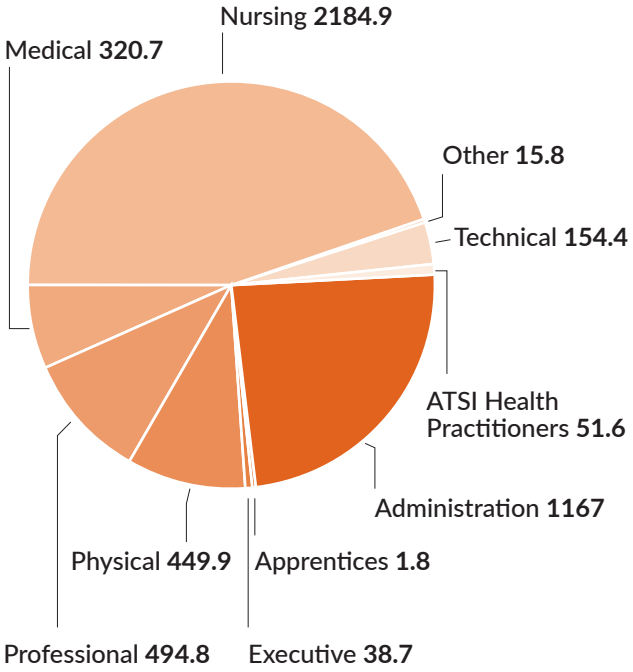
NT Health workforce (paid FTE) profile by classification, 2015-16 and 2016-17



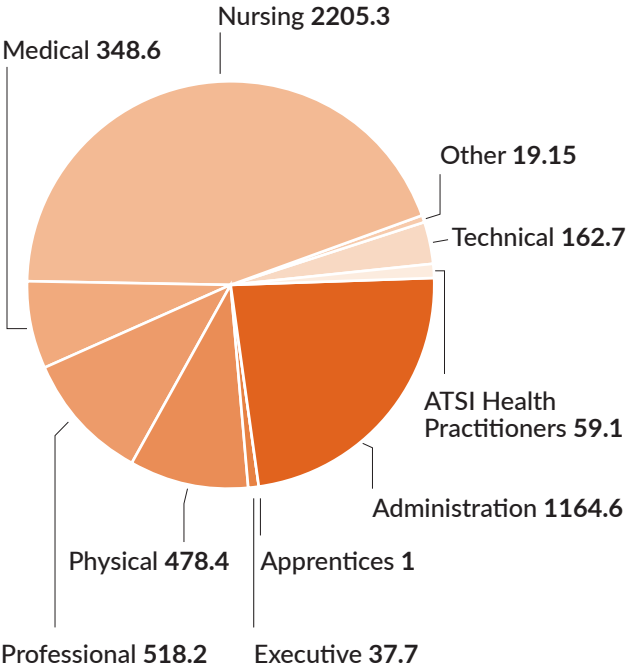
*Other refers to Board Members, Compensation - Former Employees, Adult Guardianship Board Members, Graduate Trainees, School Based Trainees, Admin and Corp Services Graduate, Trainee Non-Classified and Trainee Non-Classified – RDO.

NT Health employee classification by gender, June 2016 and June 2017

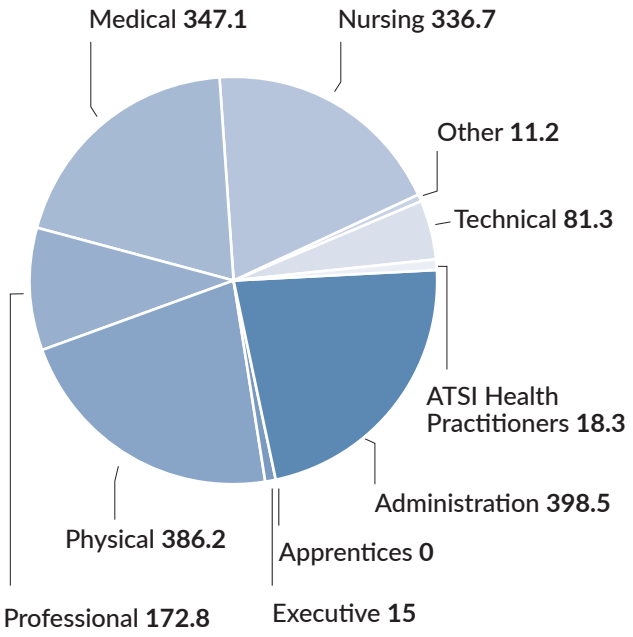
NT Health Female Workforce at 30 June 2016



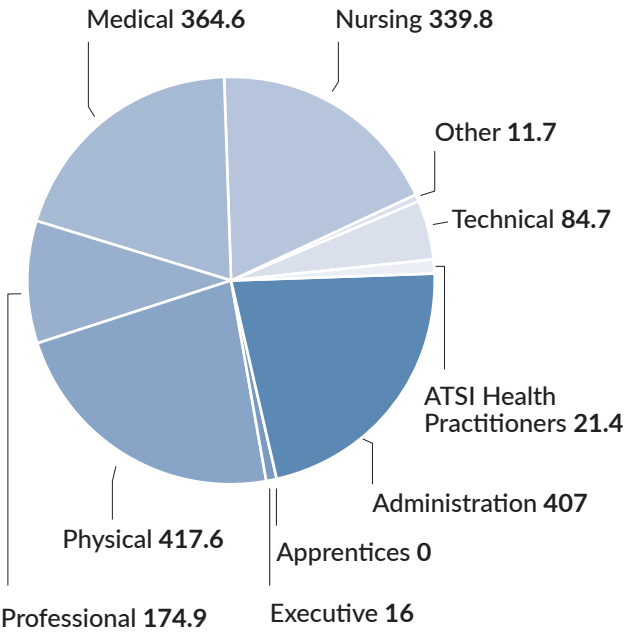
NT Health Female Workforce at 30 June 2017



NT Health Male Workforce at 30 June 2016



NT Health Male Workforce at 30 June 2017



*Other refers to Board Members, Compensation - Former Employees, Graduate Trainees, School Based Trainees, Admin and Corp Services Graduates, Trainee Non-Classified and Trainee Non-Classified – RDO.

Department of Health Workforce

Department of Health Workforce

69 per cent of our workforce were female

69% Female

7 per cent identified as Aboriginal or Torres Strait Islander people

7% Aboriginal/ Torres Strait Islander

16 per cent identified English as a second language

English **16%** Second language

1 per cent identified as having a disability

Disability **1%**

94 per cent of our workforce were full-time

94% Full-time

6 per cent of our workforce were part-time or casual

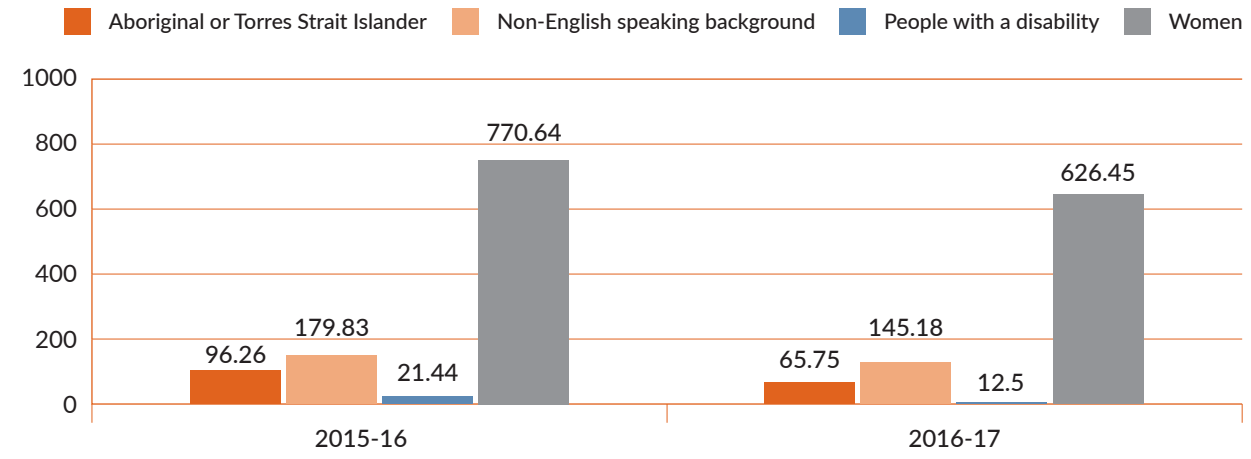
6% Part-time or Casual

Workforce Profile

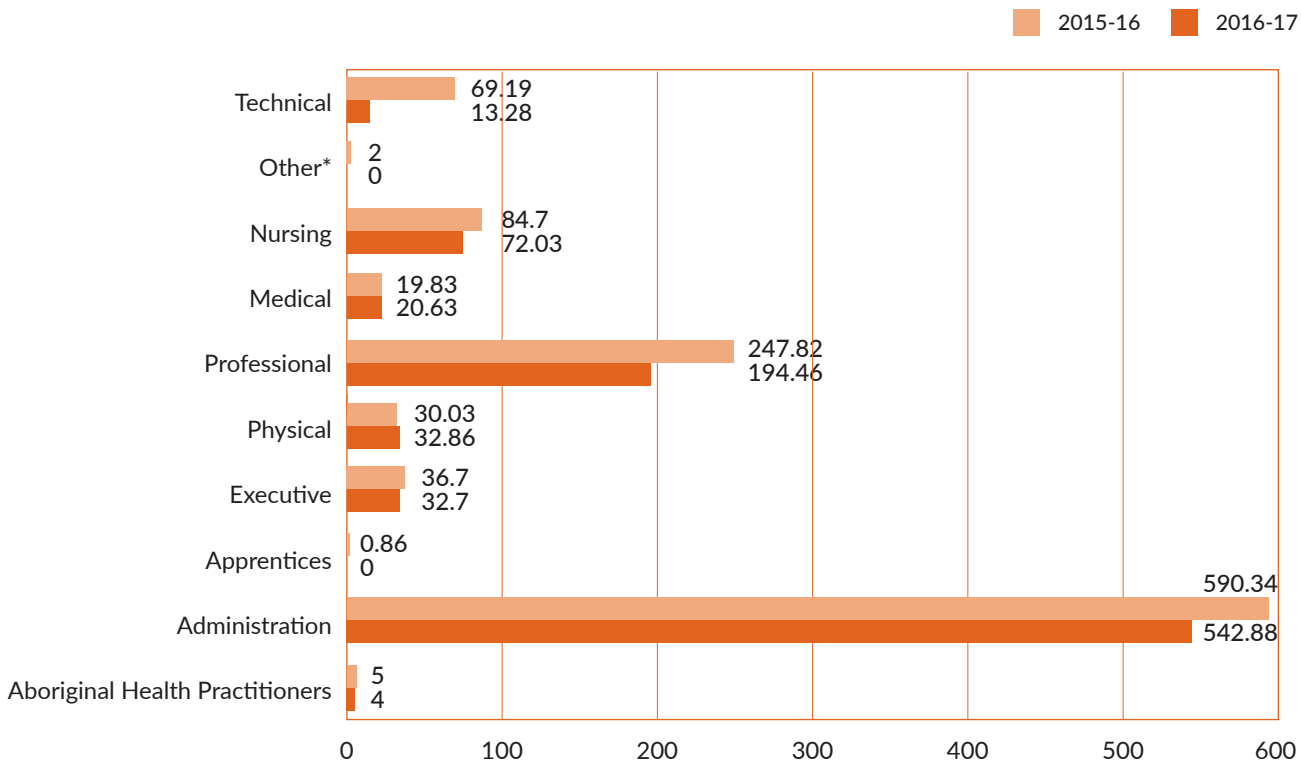
- The DoH workforce reduced by 174 FTE in 2016-2017 which was mostly in the administrative, professional and technical streams. This was predominantly due to the transition of oral health, hearing health and cancer screening services to the Top End and Central Australia Health Services.
- NT Health invests in the development of a highly skilled and culturally responsive workforce with staff retention being an important priority to support continuity of care as well as continuous improvement.
- DoH strives to have a workforce representative of the community it serves. Currently the workforce comprises 69 per cent female, 16 per cent from a non-English speaking background, 7 per cent identified as Aboriginal and over 1 per cent identified as having a disability.

Optimal Cancer Care Pathways in Practice Project Team.

DoH number of employees by diversity group, 2015-16 and 2016-17



DoH workforce (paid FTE) profile by classification, 2015-16 and 2016-17



*Other refers to Board Members, Compensation - Former Employees, Adult Guardianship Board Members, Graduate Trainees, School Based Trainees, Admin and Corp Services Graduate, Trainee Non-Classified and Trainee Non-Classified – RDO.

The Top End Health Service Workforce

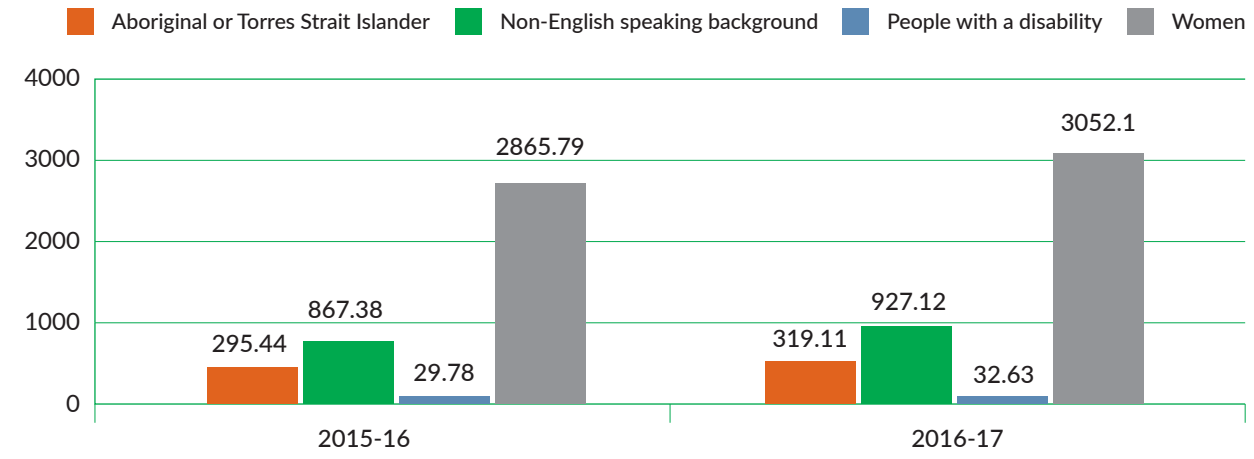
	Top End Health Service Workforce
74 per cent of our workforce were female	74% Female
8 per cent identified as Aboriginal or Torres Strait Islander people	8% Aboriginal/ Torres Strait Islander
22 per cent identified English as a second language	English 22% Second language
1 per cent identified as having a disability	Disability 1%
80 per cent of our workforce were full-time	80% Full-time
20 per cent of our workforce were part-time or casual	20% Part-time or Casual
68 per cent of our workforce worked on the frontline	68% Frontline

Workforce Profile

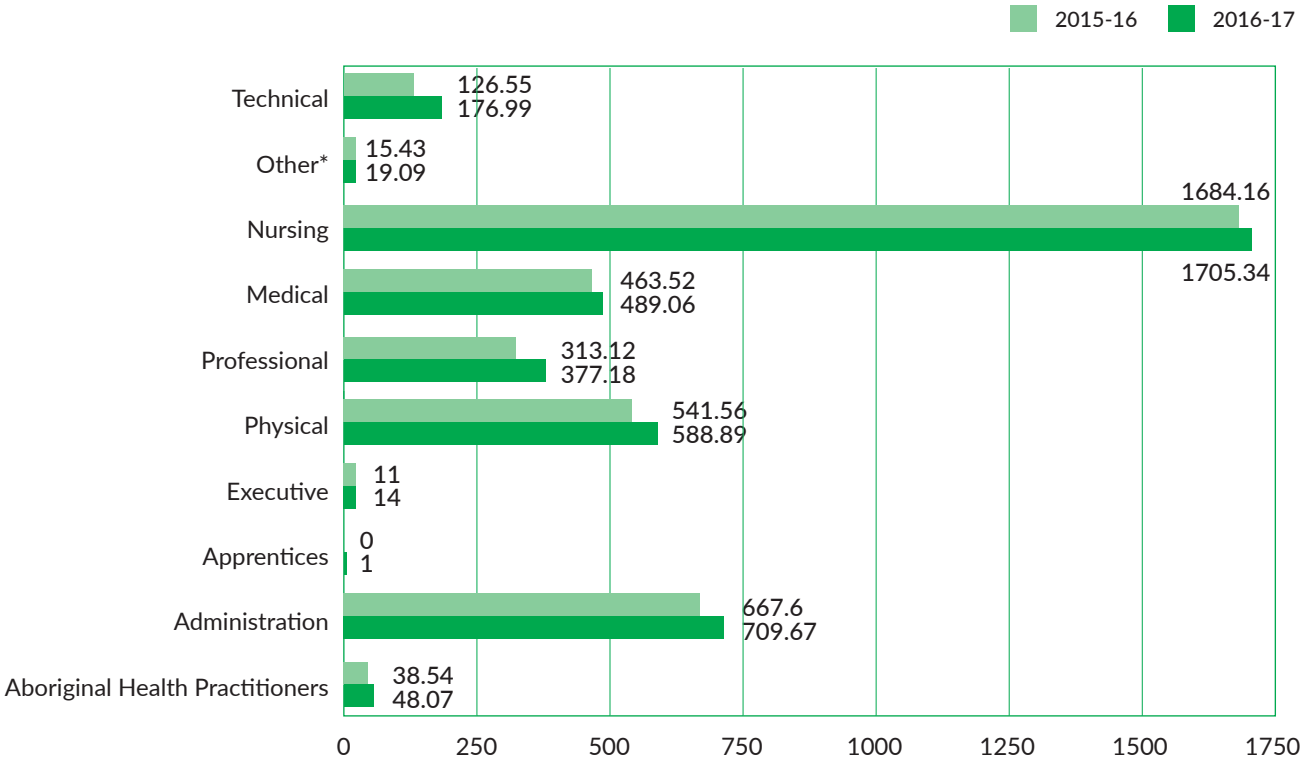
- TEHS overall FTE has risen by 6.94 per cent which can be attributed to the additions of the oral health, hearing services and aged care teams during 2016-17. Given the nature of the positions in these teams, this would also explain the variances in TEHS Professional and Technical streams.
- There was a increase in the number of Aboriginal Health Practitioners in 2016-17 which is in line with both TEHS commitment to increasing Aboriginal participation in the workforce, and our commitment to providing appropriate career pathways for Aboriginal employees.
- The promotion of flexible work arrangements across the service has seen significant growth in part time employment across Physical, Medical and Technical streams as well as a modest increase in nursing staff classified as part-time.

Royal Darwin Hospital Emergency Department.

TEHS – number of employees by diversity group, 2015-16 and 2016-17



TEHS workforce (paid FTE) profile by classification, 2015-16 and 2016-17



*Other refers to all trainees both full time and school based (inclusive of Aboriginal Health Practitioner Trainees)

Central Australia Health Service Workforce

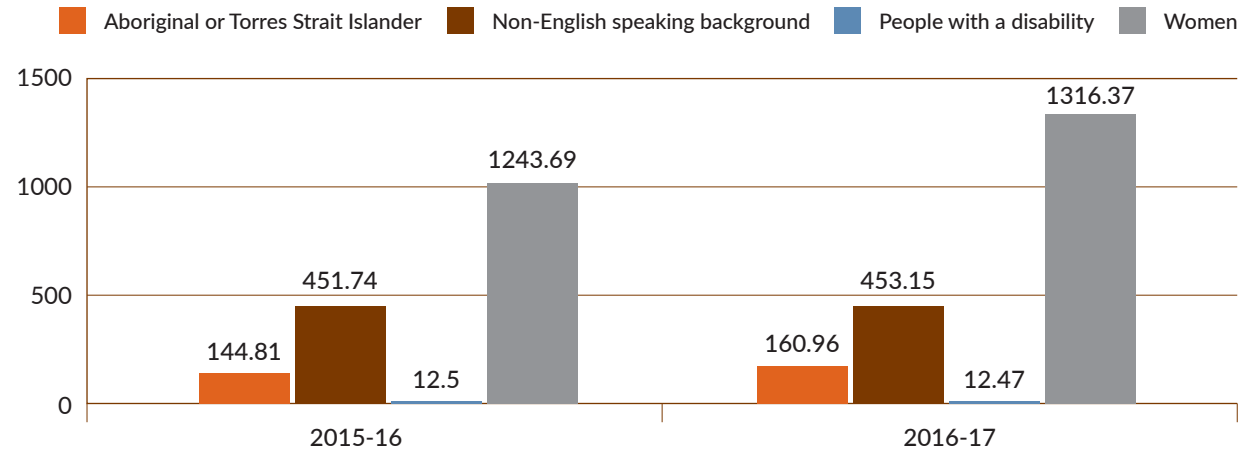
	Central Australia Health Service Workforce
74 per cent of our workforce were female	74% Female
9 per cent identified as Aboriginal or Torres Strait Islander people	9% Aboriginal/ Torres Strait Islander
25 per cent identified English as a second language	English 25% Second language
1 per cent identified as having a disability	Disability 1%
84 per cent of our workforce were full-time	84% Full-time
16 per cent of our workforce were part-time or casual	16% Part-time or Casual
86 per cent of our workforce worked on the frontline	86% Frontline

Workforce Profile

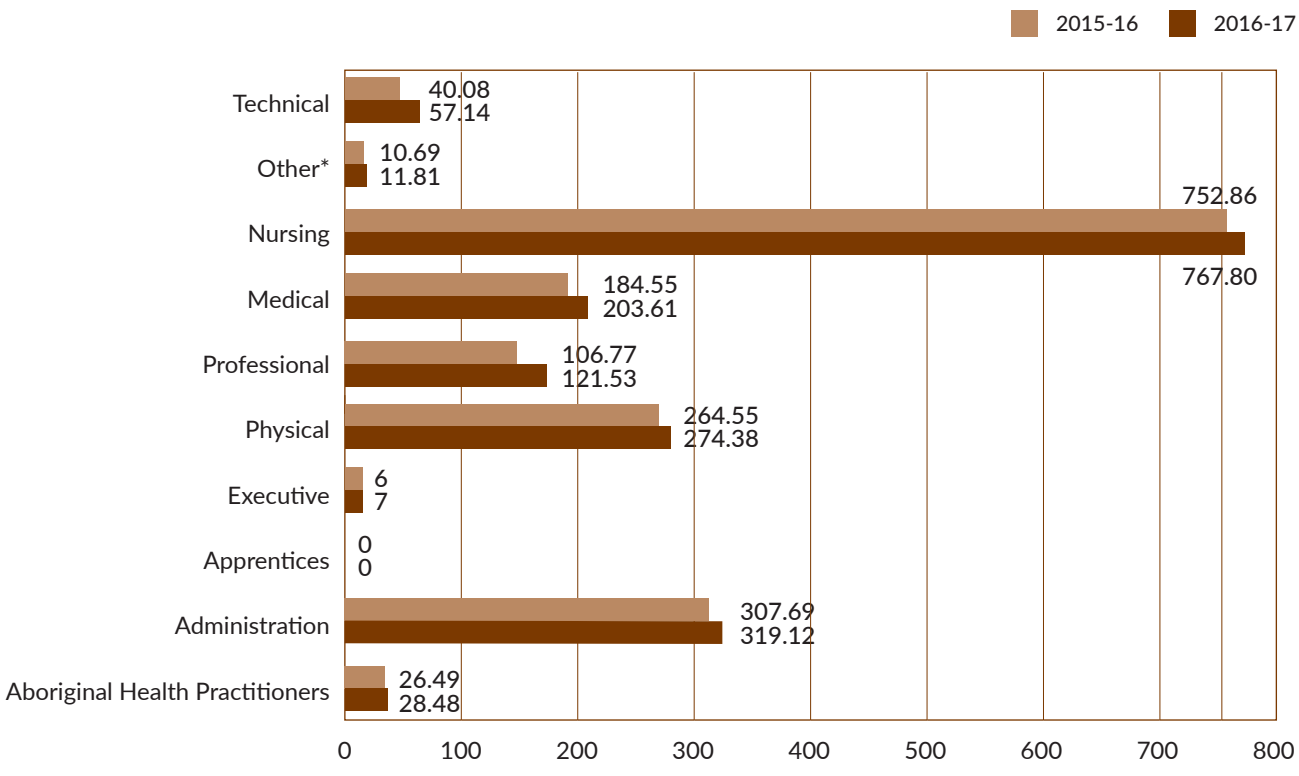
- CAHS has focussed on their strategic priority to educate and retain a suitably skilled and culturally sensitive workforce. This work included initiatives to reduce staff turnover, improve pre-employment and workplace induction processes and increase the number of Aboriginal employees.
- At the end of the financial year there were 1790.87 FTE. Of these, 42.87 per cent were Nurses, 17.81 per cent were Administrative Officers, 15.32 per cent were Physicals, 11.37 per cent were Medical Officers and 1.59 per cent were Aboriginal Health Practitioners.
- Aside from efforts made to fill budgeted positions, the increase in staffing numbers (5.36 per cent) compared with 2015-16 is attributed in part to the transfer of services from the Department of Health, specifically oral and hearing health services.

Alice Springs Hospital Emergency Department.

CAHS – number of employees by diversity group, 2015-16 and 2016-17



CAHS workforce (paid FTE) profile by classification, 2015-16 and 2016-17



*Other refers to all trainees both full time and school based (inclusive of Aboriginal Health Practitioner Trainees)

Developing a Sustainable Workforce

Department of Health Supporting and Developing our Workforce

The Chief Executive Officer of the Department retains overall responsibility for all staff employed. This section contains human resources-related information on all staff employed in the public health system.

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

Staffing and Recruitment

Early Careers

The Department employed strategies to engage and support new employees through the early stages of their career, with the intent to retain those participants into the future.

These programs include:

- Group Training Northern Territory (GTNT) 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.

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

- Cadetships.
- NTG traineeships and Indigenous traineeships programs (including school based traineeships).
- Entry level recruitment for administrative and professional roles.
- Indigenous employment program.
- Vacation students.
- Graduates.

Traineeships

During 2016-17, NT Health employed 19 trainees enrolled in Certificate II, III or IV Business, Certificate II Kitchen Operations, Certificate II or III Community Services, Certificate II or III Dental Assisting. Of these:

- 68 per cent identified as Aboriginal.
- 68 per cent remain active.
- Three students were in Darwin, 10 in Alice Springs, four in Tennant Creek and two in Katherine.
- 16 were undertaking school based traineeships.
- NT Heath hosted five Aboriginal trainees under third party hosting arrangements with GTNT in the fields of community services and dental assisting.
- In 2017, two trainees won awards through GTNT which were for Aboriginal apprentice of the year and trainee of the year.

In addition across TEHS there were 33 trainees completing a certificate I-IV in Aboriginal and Torres Strait Islander primary health care. Seventeen of these trainees were undertaking the certificate IV for registration as an Aboriginal Health Practitioner, with seven of these graduating in 2016-17.

Across CAHS there were 13 trainees completing a certificate I- IV in Aboriginal and Torres Strait Islander primary health care. Four of these trainees were undertaking the certificate IV for registration as an Aboriginal Health Practitioner, with one of these graduating in May 2017 and three scheduled to apply for registration in October 2017.

Xavier Catholic College at Wurrumiyanga on the Tiwi Islands is delivering a combined certificate II in Community Services, Health Services and Aboriginal and Torres Strait Islander Primary Health Care.

Special Measures

NT Health has led the way in implementing Special Measures to increase Aboriginal workforce participation in the Northern Territory public sector to reflect the community it serves. The Special Measures initiative commenced in January 2015 to enable priority consideration of Aboriginal applicants for all NT Health advertised vacancies. There is continued improvement in this area with Aboriginal employees currently representing 8.1 per cent of the NT Health workforce including 3.8 per cent in senior management/executive levels. The recently completed biennial review of the initiative highlighted overall positive results with a 13.2 per cent increase in the proportion of Aboriginal applicants being selected and 67 per cent retention of Special Measures applicants selected between 1 January 2015 and 31 December 2016. Special Measures will continue, subject to a biennial review in 2019.

Indigenous Cadetship Support

The Indigenous Cadetship Support Program, jointly funded by the Australian Government, supports Aboriginal people studying undergraduate degrees full time at a recognised tertiary institution. Students undertake work placements every year as part of the program. In 2016-17, NT Health cadets accounted for the majority (81 per cent) of the cadets across the NT public service, and as at 30 June 2017, NT Health supported 34 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 24 per cent had completed their degrees and 62 per cent remained active. Of the eight cadets that completed study in 2016, five are ongoing employees in the allied health field, two continued with further education and one is doing the graduate nurse program in Perth, Western Australia.

Aboriginal and Torres Strait Islander Health Practitioner Scholarships

Four scholarships each year are offered to students studying the certificate IV in Aboriginal and Torres Strait Islander Primary Health Care Practice. Each scholarship provides payment of $5,000 per year in two half payments of $2,500 for up to two years of study.

Jayclyn Pascoe, registered Aboriginal and Torres Strait Islander Health Practitioner working at the Elliot clinic.

Learning and Development

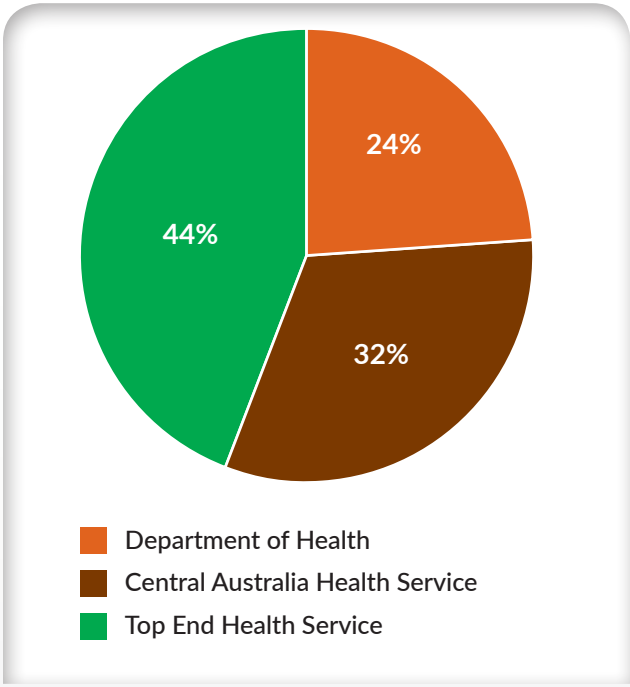
NT Health focussed on workforce planning to meet current requirements and prepare for future demands. The Department recognises the importance of building a sustainable and capable workforce and is committed to continuous development. A coordinated approach is used to enhance knowledge and skills and develop staff leadership and management capability. Training opportunities are available through face to face, online and blended modes.

Short Courses

In 2016-17, 1263 staff completed a comprehensive suite of tailored short courses which were offered across the Territory as follows:

- Appropriate Workplace Behaviours – Staff and 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.
- Aboriginal Cultural Awareness.

Number of attendances



Leadership and Management Programs

NT Health committed to improving the leadership and management capability of staff. Two key programs, Building Our Leaders First Line Managers and Leading the Way Middle Managers delivered over 30 Department-determined competencies and are specifically tailored to NT Health requirements.

In total, 314 managers and leaders participated in the tailored programs including 55 NT Health employees who attended the 2016-2017 programs.

Departmental Orientation Program

NT Health offered a face-to-face and online departmental orientation program which provides a comprehensive introduction for new employees. This information enables employees to integrate quickly into NT Health to gain an understanding of government frameworks, relevant legislation, mandatory reporting and key policies and guidelines. A total of 1229 new employees completed the NT Health orientation program in 2016-2017.

eLearning

NT Health is committed to the continuous development of eLearning and utilises the eLearning platform, 'MyLearning' to provide access to corporate and clinical online courses from a central portal. MyLearning is accessible 24/7 via the internet, enabling remote and regional staff to access learning and development opportunities. During 2016-2017, 109 online self-paced corporate and clinical courses were available through the MyLearning System and 2722 participants completed online training.

Employee Recognition and Achievements

Service Milestones

NT Health proudly participated in the Ministerially hosted 'Recognition of Service Milestones' function to formally recognise and reward employees for the years of service they have provided to the Northern Territory Government.

In 2016-2017 more than 25 NT Health employees were recognised for their NT public service tenure with five of those attending ministerially hosted functions for the completion of 30, 35 and 40 plus years of service.

NT Health also acknowledges employees for various service milestones through a range of work unit specific events communicated through internal channels.

Employee Satisfaction

People Matter Survey 2016 and People Plan

In May 2016, NT Health employees took part in the NT public service biennial People Matter Survey (the Survey). The Survey feedback provides valuable insights into employee perceptions of the workplace environment and opportunities for strengthening engagement and satisfaction levels. A total of 1910 employees completed the survey representing a 32 per cent response rate; an improved result in comparison with previous years (e.g. 25 per cent in 2014 and 30 per cent in 2011). NT Health achieved positive results such as: 81 per cent employees indicated their commitment to service and 82 per cent employees indicated they have a clear understanding of how their work contributes to the organisation.

In 2016-17, a dedicated response plan was developed to address the survey feedback. NT Health also launched its inaugural People Plan 2017-18. The People Plan is an overarching document informed by survey feedback and demonstrates the organisation's commitment to its most valuable resource, its people.

Department of Health Our People Plan.

Performance Management

NT Health utilised the Work Partnership Plan (WPP) to promote and improve employee effectiveness, build high performing teams and establish a shared understanding of the connection between individual and organisational goals. During 2016-2017, 309 employees attended the NT Health WPP information sessions which were delivered across the Territory.

NT Health also provides capability development in WPP, particularly for managers through the training program "Performance Management and the Art of Giving and Receiving Feedback". In 2016-17, 219 employees completed this program.

Human Resource Actions

The following table is a record of human resource actions in accordance with the *Public Sector Employment Management Act (PSEMA)*.

DoH Reporting against the PSEMA	2015-16			2016-17		
Human Resource Action	Total	Carried	Withdrawn	Total	Carried	Withdrawn
S32 (3)(b) Probation – termination of employment						
S33 Termination of fixed period or casual contract				1		
S41 Declaration of potentially surplus employee						
S43 Redeployment						
S43 Redundancy voluntary						
S43 Redundancy non-voluntary						
S44 Inability or unsatisfactory performance						
S48 Retirement on the grounds of invalidity						
S49 Discipline	1			2	1	
S50 Summary dismissal						
S54 Abandonment of employment				1		
*S59 Grievances	9		1	1		
S59(1)(a) Grievances about termination on probation						
S59A Discipline and inability appeals	3		2			
S59B Promotion appeals	4		1			
Total	**17**	**0**	**4**	**5**	**1**	**0**

*Section 59 Grievances

Outcomes	2015-16	2016-17
Resolved	8	1
Withdrawn	1	
Unresolved		
Total	**9**	**1**

Section 59 Grievances relate to bullying, recruitment process, inappropriate behaviour, outcome of anti-discrimination settlement, performance issue, termination inability.

Developing a Top End Health Service Supporting and Developing our Workforce

In 2016-17, TEHS's Strengthen Workforce Culture and Capacity Project saw the completion of four key pieces of work including:

- A report on the findings of the organisational culture of TEHS. This was based on a comprehensive process of consultation with staff at all levels, assessment of a cultural survey tool and research on the importance of culture.
- An Action Plan completed with 72 recommended actions.
- Development of a TEHS Organisational Culture Charter which sets out our culture and describes how it manifests in the way our staff, managers and leaders work, operate and interact with patients, carers and families. At the centre of the Charter is 'Patient Centred Care' which outlines how we do our work and unites us as an organisation.
- Development of a Cultural Learning and Development Program which recognises the vital role managers and leaders have as organisational change agents. The program was formally launched in early 2017 with the intent to provide practical training to our managers and leaders to build the essential knowledge, leadership and skills to engage in conversations with staff about the TEHS Organisational Culture Charter.

Staffing and Recruitment

TEHS continued to follow the simplified recruitment process, in line with Northern Territory public sector requirements and applied processes for the quality assurance of all recruitment selection reports. In addition, all staff attended regular and ongoing recruitment refresher training.

TEHS also committed to the Special Measures initiative and workforce development programs outlined in the Department of Health's Staffing and Recruitment section.

Learning and Development

As part of TEHS Strengthening Workforce Culture and Capacity Project, a number of key learning initiatives such as the Customer Service Ethos Charter were implemented. This training program focusses on delivering service excellence with an emphasis on patient centred care. A pilot training session was delivered in June 2017 to key support services staff and will be progressively rolled out to all professions across TEHS in 2017-18.

Clinical Learning, Education and Research (CLEaRS)

CLEaRS plays a major role in the TEHS and NT-wide nursing and midwifery activities via the Department's Office of the Chief Nurse. CLEaRS has significant input into the graduate program, career pathway development, and the Remote Area Nurse Safety review.

During 2016-17, CLEaRS expanded from the largely RDH based programs to deliver TEHS wide. Of particular note is involvement in the roll out of the Cognitive Care Program, the Chemotherapy and Cancer Care Education Program and the Anaesthetic and Recovery Education initiative for nurses.

A range of P3 Aggression Management Programs have also been delivered for remote primary health care staff on site across the Tiwi Islands as well as a Train-the-Trainer Program to sustain local delivery. The delivery of a tracheostomy workshop has been extended to Alice Springs via video conference to accompany local practical skills sessions.

Employee Satisfaction

TEHS's work in strengthening the workforce culture and the implementation of the TEHS Organisational Culture Charter, with statements of expected behaviour of staff and managers, is directly aligned to the People Plan. TEHS also implemented a three year Aboriginal and Torres Strait Islander Retention and Recruitment Strategy and supported the implementation of the strategy by establishing an Aboriginal and Torres Strait Islander Workforce and Engagement team. Our work partnership plans have been adapted to reflect the key themes of the Culture Charter.

Employee Recognition and Achievements

In 2016-17, the TEHS Service Excellence and Innovation Awards refocussed the inaugural Quality Awards Program which occurred in the previous year. The Awards now recognise the integral role that all TEHS staff play to deliver our vision of Building Better Care, Better Health, Better Communities, Together.

TEHS also recognised the significant milestones of 38 long serving and dedicated employees at an awards ceremony. Certificates were jointly presented by the TEHS Board Chair and the Chief Operating Officer to staff recognised for 30, 35, 40 and 50 years of service.

Performance Management

In 2017, TEHS introduced its newly developed Organisational Culture Charter into the WPP Framework as a means to strengthen and enhance workforce culture and promote the organisation's values. WPPs are referred to in the Department of Health's Performance Management Section.

TEHS Reporting against the PSEMA	2015-16			2016-17		
Human Resource Action	Total	Carried	Withdrawn	Total	Carried	Withdrawn
S32 (3)(b) Probation – termination of employment						
S33 Termination of fixed period or casual contract	1			1		
S41 Declaration of potentially surplus employee						
S43 Redeployment						
S43 Redundancy voluntary						
S43 Redundancy non-voluntary						
S44 Inability or unsatisfactory performance	1			5	2	1
S48 Retirement on the grounds of invalidity						
S49 Discipline	9			20	6	3
S50 Summary dismissal						
S54 Abandonment of employment	2			11	1	2
*S59 Grievances	13	6	1	33	4	2
S59(1)(a) Grievances about termination on probation	1		1			
S59A Discipline and inability appeals						
S59B Promotion appeals	2			4		3
Total	**29**	**6**	**2**	**74**	**13**	**11**

*Section 59 Grievances

Outcomes	2015-16	2016-17
Resolved	6	27
Withdrawn	1	2
Unresolved	6	4
Total	**13**	**33**

Section 59 Grievances relate to bullying, recruitment process, inappropriate behaviour, outcome of anti-discrimination settlement, performance issue, termination inability.

Central Australia Health Service Supporting and Developing our Workforce

In 2016-17, CAHS Educate and Retain a Suitably Skilled and Culturally Sensitive Workforce Team worked to enhance pre-employment and workplace induction processes, and increase the number of Aboriginal staff employed and the level of support provided to them.

Achievements in 2016-17 included:

- Production of an Employee Handbook (hard copy and electronic versions).
- Development of a workplace 'Buddy Program' with implementation expected in the coming months.
- Development of a 'Post Employment Survey' was completed and is currently being trialled.
- Development of a response plan to the NT public service People Matter Survey.
- Creation and recruitment to an Aboriginal Workforce Development Manager position.

Staffing and Recruitment

An estimated 1.7 per cent reduction in turnover was achieved in the 2016-17 compared with the previous year. The reduction occurred across all classifications and is attributed in part to an initiative to increase opportunities for ongoing recruitment to vacant positions, particularly when long term funding has been identified. One significant example of this initiative is the changes made to primary health care nursing recruitment practices. Previously nurses were only recruited on a fixed term basis of four to five years, whereas current practices focus on ongoing employment wherever possible.

A review of the current recruitment and retention entitlements was undertaken in early 2016-2017. As the current entitlements were considered to be extensive and used regularly across all classifications, it was determined that any future requirements would be considered and addressed on an individual, case by case basis.

Learning and Development

In 2016-17, CAHS staff attended 402 short courses. Examples of short courses are listed in the Department's Learning and Development section.

Employee Satisfaction

CAHS developed a response plan to address the lowest scoring overall results in the 2016 People Matter Survey. Strategies include:

- Provide staff with the survey results and initiatives developed to address identified concerns.
- Implement a planned approach to developing a positive workplace culture through the Organisational Development Framework.
- Provide a safe working environment through modelling positive behaviours in line with our values and supporting attendance at workshops.
- Adopt a positive approach to complaint and conflict resolution in addition to endorsing the provision of complaints management training for all supervisors.
- Ensure operational business plans are in place and work partnership plans are completed for all staff inclusive of discussions and development planning to support attainment of the NT public service Competency Leadership Framework expectations.
- Support staff attendance to selection and Special Measure procedure training.
- Ensure all change management practices are aligned to NT public service agreements and requirements.
- Continue to support staff recognition ceremonies.
- Incorporating a code of conduct into the CAHS orientation 'meet and greet' sessions.
- Continue to increase the proportion of permanent employment rather than fixed term contracts (casual or short term).

Employee Recognition and Achievements

CAHS recognises and values staff contributions through the job well done celebrations.

In 2016-17, 572 staff members were recognised for exceptional performance. As part of this recognition, the following milestones were also acknowledged:

- Five years of service – 297 staff.
- 10 years of service – 145 staff.
- 15 years of service – 61 staff.
- 20 years of service – 42 staff.
- 25 years of service – 25 staff.
- 30 years of service – two staff.
- 35 years of service – two staff.

CAHS Reporting against the PSEMA	2015-16			2016-17		
Human Resource Action	Total	Carried	Withdrawn	Total	Carried	Withdrawn
S32 (3)(b) Probation – termination of employment						
S33 Termination of fixed period or casual contract						
S41 Declaration of potentially surplus employee						
S43 Redeployment						
S43 Redundancy voluntary	1					
S43 Redundancy non-voluntary						
S44 Inability or unsatisfactory performance	2	1		2		
S48 Retirement on the grounds of invalidity						
S49 Discipline	2			1		
S50 Summary dismissal						
S54 Abandonment of employment	3		1	3		1
*S59 Grievances	5	3		3		
S59(1)(a) Grievances about termination on probation						
S59A Discipline and inability appeals				1		
S59B Promotion appeals				1	1	
Total	13	4	1	11	1	1

*Section 59 Grievances

Outcomes	2015-16	2016-17
Resolved	2	3
Withdrawn		
Unresolved	3	
Total	5	3

Section 59 Grievances relate to bullying, recruitment process, inappropriate behaviour, outcome of Anti-Discrimination settlement, performance issue, termination inability.

Work Health and Safety

Territory Government organisations operate under the legislative framework of the *Northern Territory Work Health and Safety Act* and the *Northern Territory Work Health and Safety Regulations*. The *Northern Territory Work Health and Safety Act* imposes mutual responsibilities for employers and employees to jointly manage the health, safety and wellbeing of all persons in the workplace.

The Department of Health has taken the lead role in creating the following strategic objectives that each agency works towards to make continual improvements to workplace health and safety across the NT Health system.

Objective 1 - Strengthen Leadership, Employee Involvement and Consultation

Improving Work Health and Safety (WHS) performance requires a supportive organisational structure and culture, as well as the participation of all employees.

Department of Health

A Work Health and Safety leadership framework is being developed to better define leadership roles and responsibilities, and in doing so improve WHS performance and governance. Further work is underway to define the WHS values and a potential culture program for the participation of all employees. WHS committees exist in all health sites, providing opportunities for workforce participation. These committees meet regularly and report up through the Leadership Group WHS Committee to the Chief Executive.

Top End Health Services

TEHS delivered a variety of drivers to increase WHS presence within all aspects of operations and planning in 2016-17. All communications to and for staff include WHS elements encouraging and promoting uptake into service delivery.

These actions include:

- Increased frequency and range of WHS related training and education sessions on offer for all staff.
- Consistent and increased staff consultation by way of working groups, steering groups and risk workshops aimed to engage staff participation and awareness of direct impacts to staff or services with improvements and design of practices and planning for operational activities.
- Executive and senior management recognising staff for safety and wellbeing initiatives implemented by way of the Top End Health Service Safety and Quality Awards.

This culture change focus will be continued with the 2017 – 2020 Work, Health and Safety Business Plan activities.

Central Australia Health Service

CAHS has a well-established WHS Steering Committee and divisional sub-committees.

In 2016-17 there were 42 active Health and Safety representatives who continually provide feedback regarding all staff and patient WHS issues.

Objective 2 - Build Skills and Capacity with Our Employees to Identify Hazards and Manage Risks Effectively

Identifying and managing hazards and risks are critical to reducing the number of injuries in our workplaces. Central to this is employee capability to identify, assess, control and communicate hazards, and manage workplace risks.

Department of Health

Developing employee risk management skills through facilitated training for fire wardens, WHS committee members, workplace inspections, risk assessment, hazardous manual handling and office ergonomics was a continued focus during the year. WHS training is also offered via e-learning modules and through information sessions on the WHS Management System in the “Leading the way” and “Building our leaders” leadership programs.

Top End Health Service

In 2016-17, there was a 9.7 per cent increase in reported workplace incidents and hazards demonstrating staff improvement in reporting, increased confidence with risk recognition and the understanding and implementation of distributed WHS related information.

Central Australia Health Service

CAHS conducted workplace inspections through staff consultation. The inspections conducted in 2016-17 were above the set targets. This method has proved to be an effective means to identifying hazards and manage risks.

Achievements in reducing hazards and risks within CAHS has been obtained through education and established by quarterly reporting processes, with a strong emphasis on eliminating or controlling hazards and risks as far as reasonably practicable utilising a risk management approach.

Objective 3 - Improve our Work Health and Safety Management System

The NT Health System is committed to preventing work-related illness and injuries. Prevention is underpinned by an efficient, effective and contemporary WHS Management System.

Department of Health

A review of the Work Health Safety Management System commenced with an aim to improve and provide an accessible, contemporary management system which incorporates health and safety requirements for all NT Health workplace environments. A WHS maturity audit was undertaken in late 2016 to identify areas to target for improvement. A WHS Strategic Roadmap (three year outlook) was developed and approved. Actions implemented against the recommendations will continue to progress in 2017-18 and are to be regularly reported to the Audit and Risk Committee.

Top End Health Service

A 2017 system review identified where improvements could be made and these have been incorporated in the Work Health and Safety Business Plan activities for 2017-2020. Of particular noting is that the Top End Health Service achieved a 90 per cent compliance rate with internal workplace audit activities planned and conducted.

Central Australia Health Service

A WHS Management System has been implemented and training provided for all CAHS employees. Divisions implement the WHS Management System through the WHS committees and risk management processes.

CAHS has a clear goal to improve WHS inspections and risk assessments through proactive and consultative involvement from all employees. Achieving this will goal will support a stronger implementation of the WHS management system which will reduce or eliminate hazards and risks within CAHS workplaces.

Objective 4 - Reduce the Incidence and Severity of Occupational Injury and Illness

The NT Health System is committed to providing a healthy and safe work environment for all employees. Should incidents or injuries occur, the NTHS will work to reduce the impact on the affected employees and others in the workplace.

Department of Health

In accordance with the *Return to Work Act 2015*, 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.

A high level of support is also provided to injured workers to assist them in remaining at, or returning to work. In 2016-17, the Department of Health (excluding the Health Services) received 10 new workers compensation claims.

Incidents are monitored in order to identify appropriate intervention strategies, including training to reduce the likelihood of incidents or injuries, and to contribute to ensuring a healthy and safe work environment for all employees. In 2016-17, the Department of Health (excluding the Health Services) received 51 incident reports. Manual handling training is provided to assist with ensuring a safe workplace, contributing to an overall reduction of workplace acquired musculoskeletal injuries and disorders. Reported incidents of workplace acquired musculoskeletal injuries and disorders have continued to decline over the past three reporting periods as a result.

Aggression minimisation awareness sessions occur as part of the Department of Health's orientation program. A comprehensive aggression management training program: P3 Aggression Management Program (Prevent, Plan, Protect), occurs monthly in the Top End and Central Australia Health Services and a train-the-trainer program helps ensure a continuous and sustainable training program for all work units where the training is mandatory. In 2016-17, 1165 employees attended an aggression minimisation awareness session, facilitated through Department of Health's orientation program.

Top End Health Services

Next year will see further focus on injury reduction in two main areas: manual handling related injury (Body Stressing) and aggression management incident and injury (Mental Factors and Being Hit by Objects) with the introduction of reduction strategies implemented.

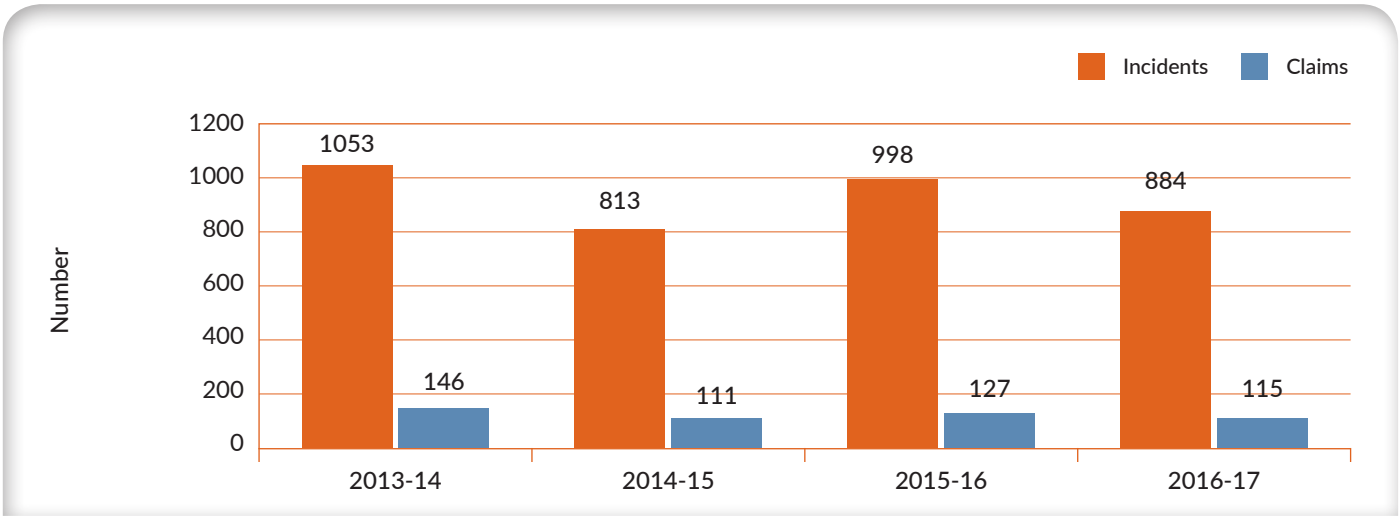
Central Australia Health Service

Early intervention initiatives have been implemented when an employee sustains a minor injury that is likely to be resolved within three months with limited treatment and no time lost other than the day of the injury.

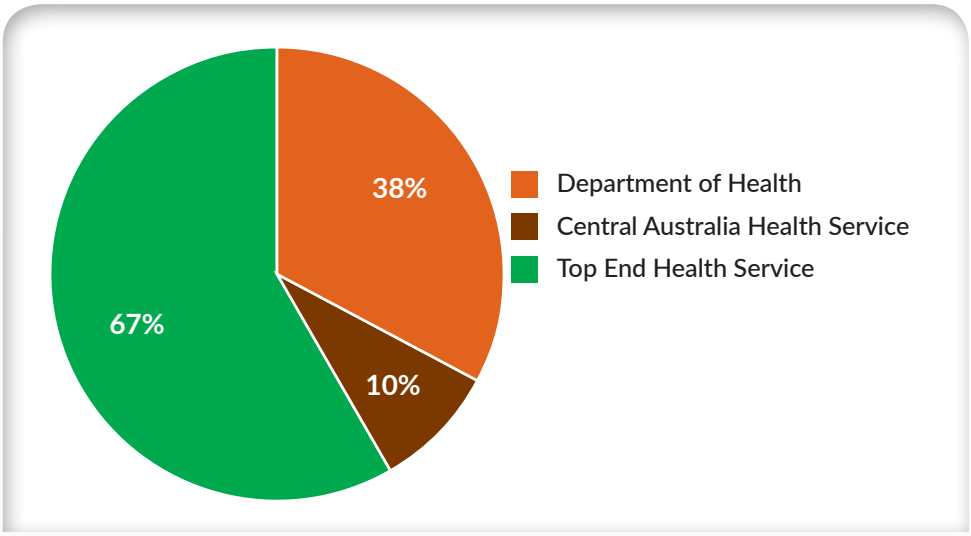
Workers Compensation

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

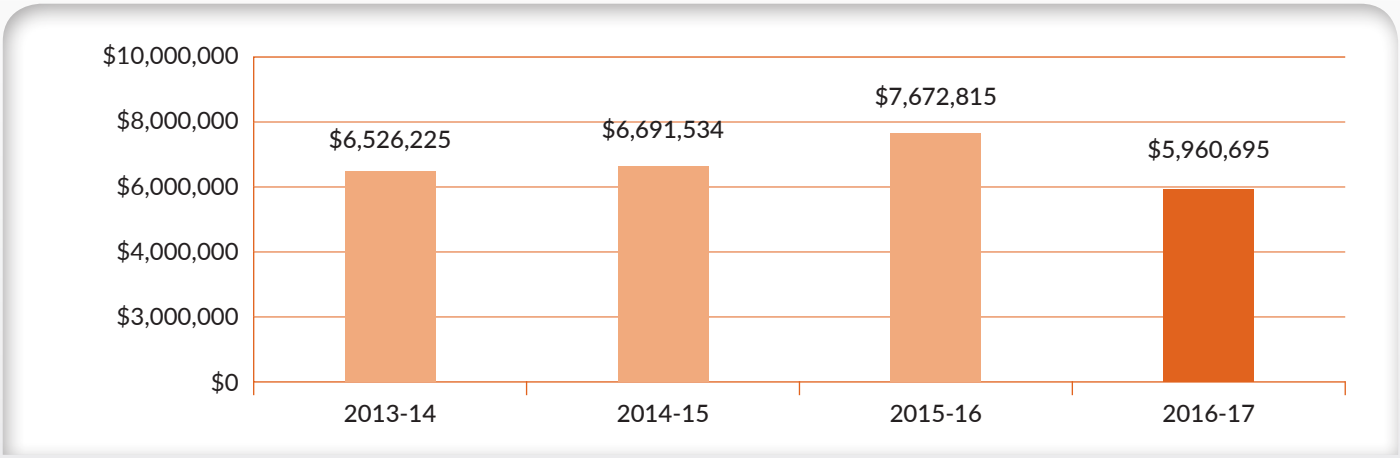
NT Health workers compensation incidents and claims (DoH, TEHS and CAHS)



Claims lodged in 2016-7



NT Health total compensation costs (DoH, TEHS and CAHS)



Royal Darwin Hospital.

7. FINANCIALS

Department of Health Financial Statement Overview

The 2016-17 financial statements and the accompanying notes for the Department of Health (the Department) have been prepared on an accrual basis in accordance with the Australian Accounting Standards. The Department's financial performance for the financial year and its financial position as at 30 June 2017 are reported in four financial statements: Comprehensive Operating Statement, Balance Sheet, Statement of Changes in Equity and Cash Flow Statement.

Main results at a glance

- The Department reported an operating deficit of $39.9 million.
- Revenue earned was $1.45 billion and within 0.03 per cent of the budget target.
- Expenses were $1.49 billion and about 2.24 per cent higher than the budget target.
- The equity position decreased by $6.0 million in 2016-17 to $17.8 million.

Comprehensive Operating Statement

Summary	2016-17 $000	2015-16 $000	Variation $000	Variation %
Operating income	1 450 699	1 397 246	53 453	3.83
Operating expenses	(1 490 646)	(1 390 702)	(99 944)	7.19
Net Surplus/(Deficit)	(39 947)	6 544	(46 491)	
Other Comprehensive Income	1 234	943	291	30.86
Comprehensive Result	(38 713)	7 487	(46 200)	

In 2016-17 the Department's Comprehensive Operating Statement showed a net operating deficit of $39.9 million and a total comprehensive result of $38.7 million. The full year operating deficit exclusive of depreciation, which is not revenue funded, was $35.6 million predominantly due to disability service demands.

Operating Income

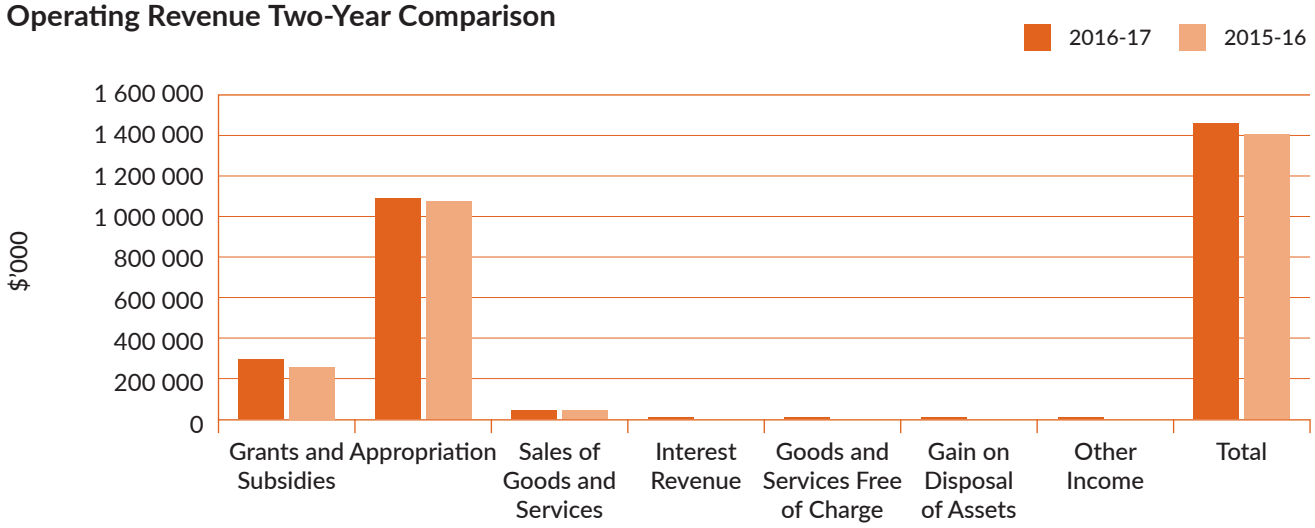
The Department's income includes operating revenue in the form of grants and subsidies, output appropriation and goods and services income. The total revenue for 2016-17 was $1.45 billion, an increase of $53 million from 2015-16.

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

Included in the Department's total revenue is $10.7 million of notional income for services received free of charge from the Department of Corporate and Information Services (DCIS). This relates to centralised corporate services which is fully negated by an offsetting expense classified under Other Administrative expenses.

The Department's income and expenditure include funding on-passed to Top End Health Service and Central Australia Health Service.

Operating Revenue Two-Year Comparison



The increase in revenue earned in 2016-17 when compared to 2015-16 includes the following:

- Grants and Subsidies – the increase of $43 million relates primarily to increases in NT Block funding, which is on-passed to Top End Health Service and Central Australia Health Service (the Health Services); and
- Output Revenue – the increase of about $11 million is mainly due to a Treasurer's Advance of $7.2 million to partly fund legal settlements and assist with costs associated to secure care services, and increased Commonwealth funding relating to Remote Aboriginal Investment.

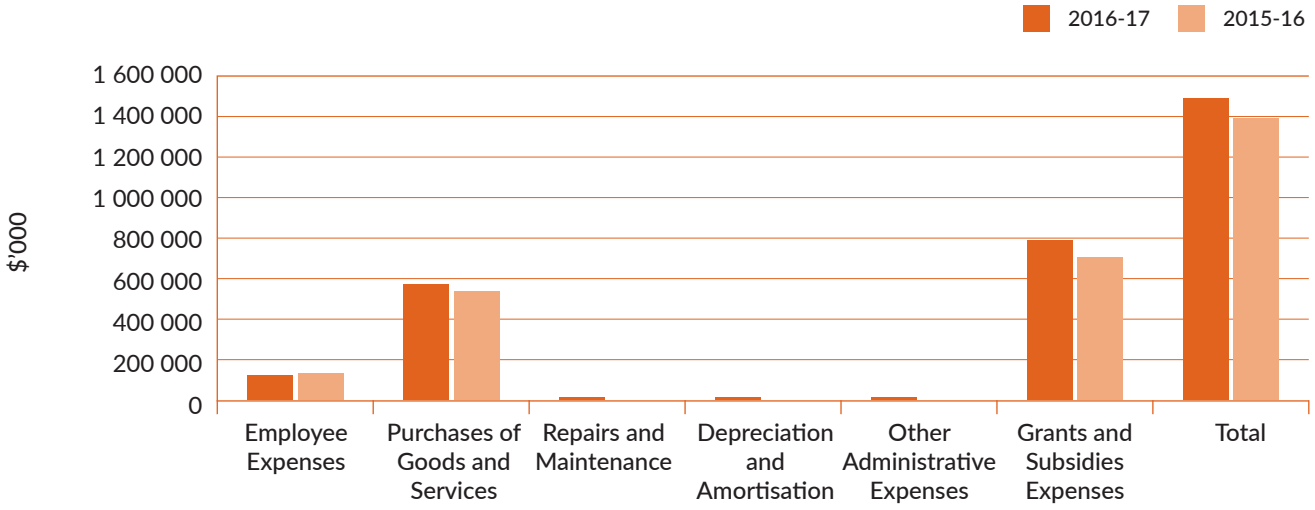
Refer to Note 3 for the Comprehensive Operating Statement by output group.

Operating Expense

The Department's operating expenditure comprise mainly of purchases of goods and services and grants and subsidies, majority of which are on-passed to the Health Services. The remaining expenses relate to cost of employees, repairs and maintenance, other administrative expenses and depreciation.

In 2016-17 the Department incurred expenses of about $1.5 billion, an increase of 7.19 per cent from the previous financial year. The increase is reflective of the funding on-passed to the Health Services, disability service demands and cost of service delivery in the health sector.

Operating Expenditure Two-Year Comparison



The major movement in expenses relates to the following:

- *Grants and Subsidies* – the increase of $81 million is mainly due to the additional funding for 2016-17 on passed to the Health Services and higher grant payments in disability;
- *Employee Expenses* – the decrease of $15 million or 11.7 per cent reflects the decrease in employees in 2016-17, mainly due to the transfer of Hearing, Oral, Cancer Screening services from the Department to the Health Services, offset by the 3 per cent Enterprise Bargaining Agreement (EBA) increase during the year; and
- *Purchases of Goods and Services* – the increase of $34.4 million is predominantly due to the additional funding in 2016-17 for the provision of health services. Further details are provided in Note 6.

Refer to Note 3 for the Comprehensive Operating Statement by output group.

Summary	2016-17 Final Budget $000	2016-17 Actual $000	Variation $000	Variation %
Operating income	1 450 311	1 450 699	388	0.03
Operating expenses	(1 458 044)	(1 490 646)	(32 602)	2.24
Net deficit	(7 733)	(39 947)	(32 214)	

The Department's performance in both revenue generation and expenditure control resulted in minor variations from planned targets. Whilst revenue came within 0.03 per cent of the budget target, expenditure was higher by 2.24 per cent primarily due to disability service demands.

Balance Sheet

Summary	2016-17 $000	2015-16 $000	Variation $000	Variation %
Assets	36 447	44 344	(7 897)	(17.81)
Liabilities	(18 607)	(20 544)	1 937	(9.43)
Net Assets	17 840	23 800	(5 960)	

The Department's net financial position at 30 June 2017 is $17.8 million.

Of the Department's total assets at 30 June 2017, 68 per cent or $24.7 million relates to property, plant and equipment (PPE) while the remaining assets comprise mainly of current assets including cash and deposits, receivables and prepayments.

The decrease of $7.9 million in total assets in 2016-17 compared to 2015-16 primarily relates to the net impact of the Department's operating deficit for the financial year and the transfer of assets to and from the Department as a result of the restructures, mostly with the Health Services.

Majority of the Department's liabilities at 30 June 2017 relate to employee provisions, accounting for 71 per cent of total liabilities or about $13.2 million. The remaining liabilities comprise of accounts payable and accrued expenses.

The decrease in liabilities is predominantly due to the $1.92 million decrease in provisions in 2016-17 compared to 2015-16. This is in line with the decrease in employees in 2016-17 primarily due to the transfer of Hearing, Oral and Cancer Screening services to the Health Services. Further details on provisions can be found in Note 14 of the Financial Statements

Statement of Changes in Equity

Summary	2016-17 $000	2015-16 $000	Variation $000	Variation %
Equity, at 1 July	23 800	27 638	(3 838)	(13.89)
Accumulated Funds	(39 947)	6 544	(46 491)	(710.44)
Asset Revaluation Reserves	1 234	943	291	30.86
Net Equity Injections/Withdrawals	32 753	(11 325)	44 078	(389.21)
Equity, at 30 June	17 840	23 800	(5 960)	

The Statement of Changes in Equity reflects movements in equity balances during the financial year.

The decrease of $5.9 million in the Department's equity position is the net result of the following:

- $39.9 million deficit for the financial year;
- $7 million of equity transferred out, including the transfer of assets to the Health Services in relation to Hearing, Oral and Cancer Screening services; offset by
- $27.6 million of net equity injection from the Central Holding Authority during the financial year;
- $10.2 million of equity transferred in, mainly representing the value of completed capital works from the Department of Infrastructure, Planning and Logistics and assets transferred in from the Department of Trade, Business and Innovation in regards to Alcohol Policy;
- $0.4 million Commonwealth NPP capital payments;
- capital appropriation of about $1.7 million; and
- $1.2 million net revaluation increments on land and buildings.

Cash Flow Statement

Summary	2016-17 $000	2015-16 $000	Variation $000	Variation %
Cash, at 1 July	16 312	18 301	(1 989)	(10.87)
Receipts	1 462 522	1 407 144	55 378	3.94
Payments	(1 501 833)	(1 410 767)	(91 066)	6.46
Equity injections	37 785	1 634	36 151	2212.42
Equity withdrawals	(8 232)	-	(8 232)	(100.00)
Cash, at 30 June	6 554	16 312	(9 758)	

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.

Department of Health Financial Statements

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.

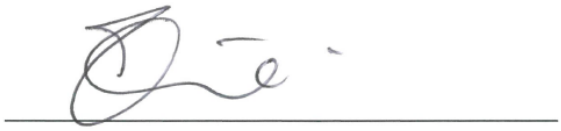
We further state that the information set out in the Comprehensive Operating Statement, Balance Sheet, Statement of Changes in Equity, Cash Flow Statement, and notes to and forming part of the financial statements, presents fairly the financial performance and cash flows for the year ended 30 June 2017 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.

Professor Catherine Stoddart

Accountable Officer

28/08/2017



Tamara Biro

A/Chief Finance Officer

28/08/2017

DEPARTMENT OF HEALTH
COMPREHENSIVE OPERATING STATEMENT
For the year ended 30 June 2017

	Note	2017	2016
		$000	$000
INCOME			
Grants and subsidies revenue			
Current		300 842	257 799
Capital		0	410
Appropriation			
Output		1 025 849	1 020 500
Commonwealth		62 372	57 064
Sales of goods and services		45 906	46 678
Interest revenue		12	16
Goods and services received free of charge	4	10 738	11 233
Gain on disposal of assets	5	2	4
Other income		4 978	3 542
TOTAL INCOME	3	**1 450 699**	**1 397 246**
EXPENSES			
Employee expenses		113 670	128 809
Administrative expenses			
Purchases of goods and services	6	571 932	537 563
Repairs and maintenance		696	583
Depreciation and amortisation	11, 12	4 292	4 679
Other administrative expenses[1]		10 885	11 401
Grants and subsidies expenses			
Current		789 162	678 346
Capital		9	10 825
Community service obligations		0	18 496
TOTAL EXPENSES	3	**1 490 646**	**1 390 702**
NET SURPLUS/(DEFICIT)		**(39 947)**	**6 544**
OTHER COMPREHENSIVE INCOME			
Items that will not be reclassified to net surplus/deficit			
Changes in asset revaluation surplus		1 234	943
TOTAL OTHER COMPREHENSIVE INCOME		**1 234**	**943**
COMPREHENSIVE RESULT		**(38 713)**	**7 487**

[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 2017

	Note	2017	2016
		$000	$000
ASSETS			
Current Assets			
Cash and deposits	8	6 554	16 312
Receivables	9	2 391	3 790
Inventories	10	0	434
Prepayments		2 460	1 364
Total Current Assets		**11 405**	**21 900**
Non-Current Assets			
Advances and investments		300	300
Property, plant and equipment	11, 12	24 742	22 144
Total Non-Current Assets		**25 042**	**22 444**
TOTAL ASSETS		**36 447**	**44 344**
LIABILITIES			
Current Liabilities			
Payables	13	5 377	5 393
Provisions	14	13 230	15 151
Total Current Liabilities		**18 607**	**20 544**
TOTAL LIABILITIES		**18 607**	**20 544**
NET ASSETS		**17 840**	**23 800**
EQUITY			
Capital		285 728	252 975
Asset revaluation surplus	16	3 784	2 550
Accumulated funds		(271 672)	(231 725)
TOTAL EQUITY		**17 840**	**23 800**

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 2017

	Note	Equity at 1 July	Comprehensive result	Transactions with owners in their capacity as owners	Equity at 30 June
		$000	$000	$000	$000
2016-17					
Accumulated Funds		(231 928)	(39 947)		(271 875)
Transfers from reserves		203			203
		(231 725)	(39 947)		(271 672)
Asset Revaluation Surplus	16	2 550	1 234		3 784
Capital – Transactions with Owners					
Equity injections					
Capital appropriation		76 774		1 679	78 453
Equity transfers in		618 150		10 215	628 365
Other equity injections		183 645		35 652	219 297
Specific purpose payments					
National partnership payments		3 504		454	3 958
Commonwealth – capital					
Equity withdrawals					
Capital withdrawal		(118 895)		(8 232)	(127 127)
Equity transfers out		(510 203)		(7 015)	(517 218)
		252 974		32 753	285 728
Total Equity at End of Financial Year		**23 800**	**(38 713)**	**32 753**	**17 840**
2015-16					
Accumulated Funds		(238 471)	6 544		(231 928)
Transfers from reserves		203			203
		(238 269)	6 544		(231 725)
Asset Revaluation Surplus	16	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)	252 975
Total Equity at End of Financial Year		**27 638**	**7 486**	**(11 324)**	**23 800**

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 2017

	Note	2017 $000	2016 $000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Receipts			
Grants and subsidies received			
Current		300 842	257 799
Capital		0	410
Appropriation			
Output		1 025 849	1 020 500
Commonwealth		62 372	57 064
Receipts from sales of goods and services		73 448	71 351
Interest received		12	16
Total Operating Receipts		**1 462 523**	**1 407 140**
Operating Payments			
Payments to employees		(115 247)	(134 231)
Payments for goods and services		(595 296)	(560 986)
Grants and subsidies paid			
Current		(789 162)	(678 346)
Capital		(9)	(10 825)
Community service obligations		0	(22 884)
Total Operating Payments		**(1 499 714)**	**(1 407 271)**
Net Cash From/(Used in) Operating Activities	17	**(37 191)**	**(132)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Investing Receipts			
Proceeds from asset sales	5	0	4
Total Investing Receipts		**0**	**4**
Investing Payments			
Purchases of assets		(2 120)	(3 496)
Total Investing Payments		**(2 120)**	**(3 496)**
Net Cash From/(Used in) Investing Activities		**(2 120)**	**(3 492)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Financing Receipts			
Equity injections			
Capital appropriation		1 679	509
Commonwealth appropriation		454	0
Other equity injections		35 652	1 125
Total Financing Receipts		**37 785**	**1 634**
Financing Payments			
Equity withdrawals		(8 232)	0
Total Financing Payments		**(8 232)**	**0**
Net Cash From/(Used in) Financing Activities		**29 553**	**1 634**
Net increase/(decrease) in cash held		(9 758)	(1 989)
Cash at beginning of financial year		16 312	18 301
CASH AT END OF FINANCIAL YEAR	8	**6 554**	**16 312**

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 2017

INDEX OF NOTES TO THE FINANCIAL STATEMENTS

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

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.

a) Machinery of Government Changes

Transfers In

Details of Transfer: Alcohol Policy unit transferred from the Department of Trade, Business and Innovation

Basis of Transfer: Administrative Arrangements Order 12 September 2016

Date of Transfer: Effective from 1 July 2016

The assets and liabilities transferred as a result of this change were as follows:

Assets	***$000***
Cash	4 314
	4 314
Liabilities	
Payables	7
Provisions	164
	171
Net Assets	**4 143**

Transfers Out

Details of Transfer: Pensioner Concessions unit transferred to Territory Families

Basis of Transfer: Administrative Arrangements Order 12 September 2016

Date of Transfer: Effective from 1 July 2016

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

The assets and liabilities transferred as a result of this change were as follows:

Assets	***$000***
Property, Plant and Equipment	4
	4
Liabilities	
Payables	2
Provisions	95
	97
Net Assets	**(93)**

Details of Transfer: Hearing, Oral and Cancer Screening services transferred to the Top End and Central Australia Health Services

Basis of Transfer: Health Services Act 12 April 2017

Date of Transfer: Effective from 1 July 2016

The assets and liabilities transferred as a result of this change were as follows:

Assets	***$000***
Inventory	434
Receivables	59
Prepayments	35
Property, Plant and Equipment	5 526
	6 054
Liabilities	
Payables	50
Provisions	1 929
	1 979
Net Assets	**4 075**

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

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 2016-17:

AASB 124 Related Party Disclosures

This standard applies to not-for-profit sector for the first time in 2016-17. The accounting standard requires disclosures about the remuneration of key management personnel, transactions with related parties, and relationships between parent and controlled entities. For any such transactions, disclosures will include the nature of the related party relationship, as well as information about those transactions' terms/conditions and amounts, any guarantees given/received, outstanding receivables/payables, commitments, and any receivables where collection has been assessed as being doubtful.

Several other amending standards and AASB interpretations have been issued that apply to the current reporting periods, but are considered to have no impact on public sector reporting.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

Standards and Interpretations Issued but Not Yet Effective

At the date of authorisation of the financial statements, the following standards and interpretations were in issue but are not yet effective and are expected to have a potential impact on future reporting periods:

AASB 16 Leases

AASB 16 Leases is effective for annual reporting periods beginning on or after 1 January 2019 and will be reported in these financial statements for the first time in 2019-20. When the standard is effective it will supersede AASB 117 Leases and requires the majority of leases to be recognised on the balance sheet.

For lessees with operating leases, a right-of-use asset will now come onto the balance sheet together with a lease liability for all leases with a term of more than 12 months, unless the underlying assets are of low value. The Comprehensive Operating Statement will no longer report operating lease rental payments, instead a depreciation expense will be recognised relating to the right-to-use asset and interest expense relating to the lease liability.

While for lessors, the finance and operating lease distinction remains largely unchanged. For finance leases, the lessor recognises a receivable equal to the net investment in the lease. Lease receipts from operating leases are recognised as income either on a straight-line basis or another systematic basis where appropriate.

Consequently, it is expected that approximately $1 million in operating lease commitments will be required to be recognised in the balance sheet through a lease liability and corresponding right to use asset from 2019-20 in accordance with AASB 16 Leases. In the comprehensive income statement the operating lease expense will be replaced with a depreciation expense relating to the right to use asset and interest expense relating to the lease liability. These cannot be quantified at this time.

AASB 1058 Income for not-for-profit entities and AASB 15 Revenue from contracts with customers

AASB 1058 Income for Not-for-Profit Entities and AASB 15 Revenue with Contracts with Customers are effective for annual reporting periods beginning on or after 1 January 2019 and will be reported in these financial statements for the first time in 2019-20.

Under the new AASB 1058 Income for Not-for-Profit Entities, revenue from grants and donations will be recognised when any associated performance obligation to provide goods or services is satisfied, and not immediately upon receipt as currently occurs. Consequently, more liabilities will be recognised in the balance sheet after adoption of this standard.

AASB 1058 clarifies and simplifies income-recognition requirements that apply to not-for-profit entities in conjunction with AASB 15 Revenue from Contracts with Customers.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

While the full impacts are yet to be determined, potential impacts identified include:

- Grants received to construct or acquire a non-financial asset will be recognised as a liability, and subsequently recognised as revenue as the performance obligations under the grant are satisfied. At present, such grants are recognised as revenue on receipt.
- Grants with an enforceable agreement and sufficiently specific performance obligations will be recognised as revenue progressively as the associated performance obligations are satisfied. At present, such grants are recognised as revenue on receipt.
- Grants that have an enforceable agreement but no specific performance obligations but have restrictions on the timing of expenditure will also continue to be recognised on receipt as time restriction on the use of funds is not sufficiently specific to create a performance obligation.
- Grants that are not enforceable and/or not sufficiently specific will not qualify for deferral, and continue to be recognised as revenue as soon as they are controlled.

Several other amending standards and AASB interpretations have been issued that apply to future reporting periods, but are considered to have limited impact on future financial reporting.

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 Department of Health include income, expenses, assets, liabilities and equity over which the Department of Health 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 accountable for certain Territory items managed on behalf of Government, these items have been separately disclosed in Note 22 – Schedule of Administered Territory Items.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

e) Comparatives

Where necessary, comparative information for the 2015-16 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 2016-17 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.

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) 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.

3. COMPREHENSIVE OPERATING STATEMENT BY OUTPUT GROUP

	Note	Territory-Wide Services		Pensioner Concessions		Disease Prevention and Health Protection		Community Treatment and Extended Care		Corporate and Governance		National Critical Care and Trauma Response		Health Services		Office of the Public Guardian		Total	
		2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000
INCOME																			
Grants and subsidies revenue																			
Current		402	2 118	0	0	4 519	4 592	4 437	907	1 809	5 923	235	601	289 440	243 658	0	0	300 842	257 799
Capital		0	410	0	0	0	0	0	0	0	0	0	0		0	0	0	0	410
Appropriation																			
Output		0	0	0	0	0	0	0	0	1 025 849	1 020 500	0	0	0	0	0	0	1 025 849	1 020 500
Commonwealth		850	9 107	0	0	4 422	6 427	30 691	16 711	0	950	10 041	10 216	16 368	13 653	0	0	62 372	57 064
Sales of goods and services		13	468	0	0	125	265	5	14	1 555	2 790	140	350	44 068	42 791	0	0	45 906	46 678
Interest revenue		0	0	0	0	0	0	0	0	12	16	0	0	0	0	0	0	12	16
Goods and services received free of charge	4	0	894	0	0	0	0	0	0	10 738	10 339	0	0	0	0	0	0	10 738	11 233
Gain on disposal of assets	5	0	0	0	0	0	4	2	0	0	0	0	0	0	0	0	0	2	4
Other income		3 143	16	0	2 354	65	152	1 026	835	744	184	0	0	0	0	0	0	4 978	3 542
TOTAL INCOME		**4 408**	**13 014**	**0**	**2 354**	**9 131**	**11 440**	**36 161**	**18 467**	**1 040 707**	**1 040 702**	**10 416**	**11 168**	**349 876**	**300 101**	**0**	**0**	**1 450 699**	**1 397 246**
EXPENSES																			
Employee expenses		5 115	25 920	0	596	18 072	17 890	30 632	26 724	50 674	51 418	6 322	6 177	0	85	2 855	0	113 670	128 809
Administrative expenses				0															
Purchases of goods and services	6	1 384	8 922	0	882	5 253	5 724	5 997	5 733	33 609	33 479	4 132	3 104	520 295	479 718	1 262	0	571 932	537 563
Repairs and maintenance		53	0	0	0	0	0	0	0	643	583	0	0	0	0	0	0	696	583
Depreciation and amortisation	11, 12	1 929	2 123	0	1	29	28	75	47	1 978	2 257	281	222	0	0	0	0	4 292	4 679
Other administrative expenses[1]		60	16	0	2	1	14	16	27	10 790	11 259	1	60	17	24	0	0	10 885	11 401
Grants and subsidies expenses																			
Current		8 049	7 760	0	7 110	2 655	2 686	124 241	97 758	13 590	7 836	291	186	640 336	555 009	0	0	789 162	678 346
Capital		0	0	0	0	0	0	0	10 826	0	0	9	0	0	0	0	0	9	10 825
Community service obligations		0	0	0	18 496	0	0	0	0	0	0	0	0	0	0	0	0	0	18 496
TOTAL EXPENSES		**16 590**	**44 741**	**0**	**27 087**	**26 010**	**26 342**	**160 961**	**141 115**	**111 284**	**106 832**	**11 036**	**9 749**	**1 160 648**	**1 034 836**	**4 117**	**0**	**1 490 646**	**1 390 702**
NET SURPLUS/(DEFICIT)		**(12 182)**	**(31 727)**	**0**	**(24 733)**	**(16 879)**	**(14 902)**	**(124 800)**	**(122 648)**	**929 423**	**933 870**	**(620)**	**1 419**	**(810 772)**	**(734 735)**	**(4 117)**	**0**	**(39 947)**	**6 544**
OTHER COMPREHENSIVE INCOME																			
Items that will not be reclassified to net surplus/deficit																			
Changes in asset revaluation surplus		0	0	0	0	0	0	0	0	1 234	943	0	0	0	0	0	0	1 234	943
TOTAL OTHER COMPREHENSIVE INCOME		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1 234**	**943**	**0**	**0**	**0**	**0**	**0**	**0**	**1 234**	**943**
COMPREHENSIVE RESULT		**(12 182)**	**(31 727)**	**0**	**(24 733)**	**(16 879)**	**(14 902)**	**(124 800)**	**(122 648)**	**930 657**	**934 813**	**(620)**	**1 419**	**(810 772)**	**(734 735)**	**(4 117)**	**0**	**(38 713)**	**7 487**

[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 2017

Income

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.

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;
- it is probable that the economic benefits associated with the transaction will flow to the agency;
- the amount of revenue can be reliably measured; 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.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

4. GOODS AND SERVICES RECEIVED FREE OF CHARGE

	2017 $000	2016 $000
Corporate and information services	10 738	11 233
Total Goods and Services Received Free of Charge	**10 738**	**11 233**

5. GAIN ON DISPOSAL OF ASSETS

Net proceeds from the disposal of non-current assets	0	4
Less: Carrying value of non-current assets disposed	0	(0)
Gain on the disposal of non-current assets	**0**	**4**
Proceeds from sale of minor assets	2	0
Total Gain on Disposal of Assets	**2**	**4**

6. PURCHASES OF GOODS AND SERVICES

The net surplus/(deficit) has been arrived at after charging the following expenses:

Goods and services expenses:		
Property maintenance	1 050	5 515
General property maintenance	662	949
Power	848	1 035
Water and sewerage	100	123
Accommodation	580	1 145
Advertising [1]	14	27
Agent service agreements	520 395	475 943
Audit fees	660	406
Bank charges	13	14
Client travel	211	336
Clothing	85	75
Communications	1 220	1 372
Consultant fees [2]	2 153	1 062
Consumables/general expenses	1 762	1 894
Cross border patient charges	21	51
Document production	331	411
Entertainment/hospitality	143	65
Food	165	163
Freight	102	147
IT charges	6 532	7 876
IT consultants	6 150	10 678
IT hardware and software expenses	7 119	6 482
Insurance premium	3	1
Laboratory expenses	79	160
Legal expenses [3]	6 631	2 671
Library services	1 302	1 435
Marketing and promotion [4]	869	702

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

	2017 $000	2016 $000
Medical/dental supply and services	4 123	5 124
Membership and subscriptions	513	476
Motor vehicle expenses	1 923	2 364
Office requisites and stationery	364	459
Official duty fares	1 326	2 202
Other equipment expenses	1 543	1 548
Recruitment expenses [5]	177	223
Regulatory/advisory boards/committees	172	519
Relocation expenses	115	75
Training and study expenses	1 952	2 872
Transport equipment expenses	128	135
Travelling allowance	439	938
Unallocated corporate credit card expenses	(79)	(111)
Goods and services costs allocation	38	0
Total Purchases of Goods and Services	**571 932**	**537 563**

[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.

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.

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NOTES TO THE FINANCIAL STATEMENTS
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7. WRITE-OFFS, POSTPONEMENTS, WAIVERS, GIFTS AND EX GRATIA PAYMENTS

	Agency 2017 $000	Agency No. of Trans.	Agency 2016 $000	Agency No. of Trans.	Territory Items 2017 $000	Territory Items No. of Trans.	Territory Items 2016 $000	Territory Items No. of Trans.
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	0	0	4	3	0	0	0	0
Losses or deficiencies of money written off	0	0	0	0	0	0	0	0
Public property written off	123	18	2	3	0	0	0	0
Waiver or postponement of right to receive or recover money or property	0	0	0	0	0	0	0	0
Total Written Off, Postponed and Waived by Delegates	**123**	**18**	**6**	**6**	**0**	**0**	**0**	**0**
Amounts written off, postponed and waived by the Treasurer								
Irrecoverable amounts payable to the Territory or an agency written off	0	0	0	0	0	0	0	0
Losses or deficiencies of money written off	0	0	0	0	0	0	0	0
Public property written off	0	0	0	0	0	0	0	0
Waiver or postponement of right to receive or recover money or property	0	0	0	0	0	0	0	0
Total Written Off, Postponed and Waived by the Treasurer	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Write-offs, Postponements and Waivers Authorised Under Other Legislation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Gifts Under the *Financial Management Act*	0	0	0	0	0	0	0	0
Gifts Authorised Under Other Legislation	0	0	0	0	0	0	0	0
Ex Gratia Payments Under the *Financial Management Act*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

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NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

8. CASH AND DEPOSITS

	2017 $000	2016 $000
Cash on hand	11	6
Cash at bank	6 544	16 307
	6 554	**16 312**

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.

9. RECEIVABLES

Current		
Accounts receivable	684	993
Less: Allowance for impairment losses	(189)	(170)
	495	823
GST receivables	1 688	2 928
Other receivables	208	39
	1 896	2 967
Total Receivables	**2 391**	**3 790**

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 18 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.

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.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

10. INVENTORIES

	2017 $000	2016 $000
Inventories Held for Distribution		
At current replacement cost	0	434
Total Inventories	**0**	**434**

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.
During the year dental inventories were transferred from the Department of Health to Top End Health Service.

11. PROPERTY, PLANT AND EQUIPMENT

Land		
At fair value	1 982	1 310
Buildings		
At fair value	22 689	16 528
Less: Accumulated depreciation	(9 186)	(9 782)
	13 502	6 746
Plant and Equipment		
At fair value	31 616	40 848
Less: Accumulated depreciation	(20 776)	(25 301)
Less: Accumulated impairment loss	(1 583)	(1 459)
	9 258	14 088
Total Property, Plant and Equipment	**24 742**	**22 144**

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

11. PROPERTY, PLANT AND EQUIPMENT (continued)

2017 Property, Plant and Equipment Reconciliations

A reconciliation of the carrying amount of property, plant and equipment at the beginning and end of 2016-17 is set out below:

	Land	Buildings	Plant and Equipment	Total
	$000	$000	$000	$000
Carrying Amount as at 1 July 2016	1 310	6 746	14 088	22 144
Additions		31	2 089	2 120
Disposals				
Depreciation		(959)	(3 334)	(4 292)
Additions/(Disposals) from asset transfers	220	6 903	(3 461)	3 662
Revaluation increments/(decrements)	453	781		1 234
Impairment losses			(124)	(124)
Other movements				
Carrying Amount as at 30 June 2017	**1 982**	**13 502**	**9 258**	**24 742**

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 asset transfers	(1 377)	(11 438)	(143)	(12 958)
Revaluation increments/(decrements)				
Impairment losses			(2)	(2)
Other movements			943	943
Carrying Amount as at 30 June 2016	**1 310**	**6 746**	**14 088**	**22 144**

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
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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, Planning & Logistics is responsible for managing general government capital works projects on a whole of Government basis. Therefore appropriation for capital works is provided directly to the Department of Infrastructure, Planning & Logistics 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.

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.
The latest revaluations as at 30 June 2017 were independently conducted by Territory Property Consultants Pty Ltd. Refer to Note 12: Fair Value Measurement of Non-Financial Assets for additional disclosures

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.

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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 16 provides additional information in relation to the asset revaluation surplus.
Agency property, plant and equipment assets were assessed for impairment as at 30 June 2017. As a result of this review $123,591 of impairment losses were recognised against plant and equipment. Impairment losses were charged to expenses.

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:

	2017
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

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

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. 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.

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.

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12. 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
2016-17				
Asset Classes				
Land (Note 11)			1 982	1 982
Buildings (Note 11)			13 502	13 502
Plant & Equipment (Note 11)			9 258	9 258
Total			**24 742**	**24 742**
2015-16				
Asset Classes				
Land (Note 11)			1 310	1 310
Buildings (Note 11)			6 746	6 746
Plant & Equipment (Note 11)			14 088	14 088
Total			**22 144**	**22 144**

There were no transfers between Level 1 and Levels 2 or 3 during 2016-17.

b) Valuation Techniques and Inputs

Valuation techniques used to measure fair value in 2016-17 are:

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

There were no changes in valuation techniques from 2015-16 to 2016-17.

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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
2016-17			
Fair value as at 1 July 2016	1 310	6 746	14 088
Additions	220	6 934	2 089
Disposals			(3 461)
Transfers from Level 2			
Transfers to Level 2			
Depreciation		(959)	(3 334)
Gains/losses recognised in net surplus/deficit			(124)
Gains/losses recognised in other comprehensive income	453	781	
Fair value as at 30 June 2017	**1 982**	**13 502**	**9 258**
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**

(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.

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	2017	2016
	$000	$000

13. PAYABLES

Accounts payable	1 927	3 464
Accrued expenses	3 450	1 929
Total Payables	**5 377**	**5 393**

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.

14. PROVISIONS

Current

Employee benefits		
Recreation leave	10 059	11 637
Leave loading	1 661	1 837
Other employee benefits	71	56
Other current provisions		
Other provisions – includes provisions for Superannuation, Fringe Benefits Tax and Payroll Tax payable	1 439	1 621
Total Provisions	**13 230**	**15 151**

The Agency employed 913 employees as at 30 June 2017 (1,086 employees as at 30 June 2016).

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.

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.

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15. COMMITMENTS

Disclosures in relation to capital and other commitments, including lease commitments. Commitments are those contracted as at 30 June where the amount of the future commitment can be reliably measured.

	2017		2016	
	Internal	External	Internal	External
	$000	$000	$000	$000
(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	226	0	342
Later than one year and not later than five years	0	18	0	244
Later than five years	0	0	0	0
	0	**244**	**0**	**586**
(iii) Other Expenditure Commitments				
Other non-cancellable expenditure commitments not recognised as liabilities are payable as follows:				
Within one year	0	37 283	0	82 372
Later than one year and not later than five years	0	62 520	0	16 314
Later than five years	0	0	0	0
	0	**99 803**	**0**	**98 686**

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	2017	2016
	$000	$000

16. 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	2 550	1 607
Increment/(Decrement) – land	453	0
Increment/(Decrement) – buildings	781	0
Increment/(Decrement) – administrative restructuring	0	943
Balance as at 30 June	**3 784**	**2 550**

17. NOTES TO THE CASH FLOW STATEMENT

Reconciliation of Cash

The total of agency 'Cash and deposits' of $6,554 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)	**(39 947)**	**6 544**
Non-cash items:		
Depreciation and amortisation	4 292	4 679
Asset write-offs/write-downs	124	2
R&M – minor new works non cash	56	0
(Gain)/Loss on disposal of assets	0	(4)
Changes in assets and liabilities:		
Decrease/(Increase) in receivables	1 399	(1 380)
Decrease/(Increase) in inventories	(83)	(307)
Decrease/(Increase) in prepayments	(1 096)	2 494
(Decrease)/Increase in payables	(16)	(10 526)
(Decrease)/Increase in provision for employee benefits	(1 738)	(1 320)
(Decrease)/Increase in other provisions	(182)	(313)
Net Cash from Operating Activities	**(37 191)**	**(132)**

Non-Cash Transfers

During the financial year the Agency acquired buildings with an aggregate fair value of $9 million by non-cash asset transfers from the Department of Infrastructure, Planning and Logistics.

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NOTES TO THE FINANCIAL STATEMENTS
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18. 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 and payables.

Financial assets and liabilities are recognised on the Balance Sheet when the agency becomes a party to the contractual provisions of the financial instrument. 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.

a) Categorisation of Financial Instruments

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

2016-17 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		6 554					6 554
Receivables[1]				703			703
Advances				300			300
Total Financial Assets		**6 554**		**1 003**			**7 557**
Payables[1]		5 377					5 377
Total Financial Liabilities		**5 377**					**5 377**

1.Total amounts disclosed here exclude statutory amounts

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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
Total Financial Assets		**16 312**		**1 162**			**17 474**
Payables[1]		5 393					5 393
Total Financial Liabilities		**5 393**					**5 393**

1.Total amounts disclosed here exclude statutory amounts

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.
- 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.

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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
Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market other than those held for trading and available for sale. Loans and receivables 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.

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.

Derivatives
The agency enters into a variety of derivative financial instruments to manage its exposure to interest rate risk. The agency does not speculate on trading of derivatives.
Derivatives are initially recognised at fair value on the date a derivative contract is entered in to and are subsequently remeasured at their fair value at each reporting date. The resulting gain or loss is recognised in the Comprehensive Operating Statement immediately unless the derivative is designated and qualifies as an effective hedging instrument, in which event, the timing of the recognition in the Comprehensive Operating Statement depends on the nature of the hedge relationship. Application of hedge accounting will only be available where specific designation and effectiveness criteria are satisfied.

Netting of Swap Transactions
The agency, from time to time, may facilitate certain structured finance arrangements, where a legally recognised right to set-off financial assets and liabilities exists, and the Territory intends to settle on a net basis. Where these arrangements occur, the revenues and expenses are offset and the net amount is recognised in the Comprehensive Operating Statement.

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.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

Internal Receivables	Aging of Receivables	Aging of Impaired Receivables	Net Receivables
	$000	$000	$000
2016-17			
Not overdue	257	0	257
Overdue for less than 30 days	0	0	0
Overdue for 30 to 60 days	0	0	0
Overdue for more than 60 days	0	0	0
Total	**257**	**0**	**257**

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**

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**

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

External Receivables	Aging of Receivables	Aging of Impaired Receivables	Net Receivables
	$000	$000	$000
2016-17			
Not overdue	385		385
Overdue for less than 30 days	52		52
Overdue for 30 to 60 days	0		0
Overdue for more than 60 days	198	189	9
Total	**635**	**189**	**446**
Reconciliation of the Allowance for Impairment Losses			
Opening		170	
Written off during the year		0	
Recovered during the year		0	
Increase/(Decrease) in allowance recognised in profit or loss		19	
Total		**189**	
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		0	
Increase/(Decrease) in allowance recognised in profit or loss		108	
Total		**170**	

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

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.

2017 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	63						6 491	6 554	1.69
Receivables							703	703	
Advances							300	300	
Total Financial Assets	**63**						**7 494**	**7 557**	
Liabilities									
Payables							5 377	5 377	
Total Financial Liabilities							**5 377**	**5 377**	

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	
Total Financial Assets	**52**						**17 422**	**17 474**	
Liabilities									
Payables							5 393	5 393	
Total Financial Liabilities							**5 393**	**5 393**	

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

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 Department of Health has very limited exposure to interest rate risk as agency financial assets and financial liabilities, with the exception of 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 2017		
Financial assets – cash at bank	7	(7)
Net Sensitivity	**7**	**(7)**
30 June 2016		
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 agency does not hold units in unit trusts.

(iii) Currency Risk

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

e) Net Fair Value

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
For the year ended 30 June 2017

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.
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.

2017	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	6 554	6 554			6 554
Receivables	703	703			703
Advances and Investments	300	300			300
Total Financial Assets	**7 557**	**7 557**			**7 557**
Financial Liabilities					
Payables	5 377	5 377			5 377
Total Financial Liabilities	**5 377**	**5 377**			**5 377**

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
Receivables	862	862			862
Advances and Investments	300	300			300
Total Financial Assets	**17 474**	**17 474**			**17 474**
Financial Liabilities					
Payables	5 393	5 393			5 393
Total Financial Liabilities	**5 393**	**5 393**			**5 393**

There were no changes in valuation techniques during the period.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

19. RELATED PARTIES

i) Related Parties

The Department of Health is a government administrative entity and is wholly owned and controlled by the Territory Government. Related parties of the department include:

- the Portfolio Minister and key management personnel (KMP) because they have authority and responsibility for planning, directing and controlling the activities of the department directly; and
- spouses, children and dependents who are close family members of the Portfolio Minister or KMP; and
- all public sector entities that are controlled and consolidated into the whole of government financial statements; and
- any entities controlled or jointly controlled by KMP's or the Portfolio Minister or controlled or jointly controlled by their close family members.

ii) Key Management Personnel (KMP)

Key management personnel of the Department of Health are those persons having authority and responsibility for planning, directing and controlling the activities of the department. These include the Minister of Health, the Chief Executive Officer and the other members of the NT Health Oversite Committee.

iii) Remuneration of Key Management Personnel

The details below exclude the salaries and other benefits of the Minister of Health as the Minister's remunerations and allowances are payable by the Department of the Legislative Assembly and consequently disclosed within the Treasurer's Annual Financial Statements.
The aggregate compensation of key management personnel of Department Health is set out below:

	2017
	$000
Short-term benefits	926
Post-employment benefits	98
Long-term benefits	-
Termination benefits	-
Total	**1 024**

iv) Related party transactions:

Transactions with Northern Territory Government controlled entities

The department's primary ongoing source of funding is received from the Central Holding Authority in the form of output and capital appropriation and on-passed Commonwealth national partnership and specific purpose payments.
The following table provides quantitative information about related party transactions entered into during the year with all other Northern Territory Government controlled entities.

Related Party	Revenue from related parties for year ended 30 June 2017	Payments to related parties for year ended 30 June 2017	Amounts owed by related parties for year ended 30 June 2017	Amounts owed to related parties for year ended 30 June 2017
	$000	$000	$000	$000
All NTG agencies	56 389	1 161 895	257	1 445
Associates	-	-	-	-
Subsidiaries	-	-	-	-

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

Revenue from related parties include corporate services charges and goods and services received free of charge. Significant payments to related parties include the funding transactions relating to the purchaser provider relationship between the department and the Top End and Central Australia Health Services and notional corporate charges. The department's transactions with other government entities were not individually significant.

Other related party transactions

Given the breadth and depth of Territory Government activities, related parties will transact with the Territory Public sector in a manner consistent with other members of the public including paying stamp duty and other government fees and charges and therefore these transactions have not been disclosed. There were no other related party transactions during the financial year.
Related party transactions of the former minister have not been assessed as the period served during the 2016-17 financial year is considered minor.

20. CONTINGENT LIABILITIES AND CONTINGENT ASSETS

a) Contingent Liabilities
The Department of Health had no contingent liabilities as at 30 June 2017 or 30 June 2016.
b) Contingent Assets
The Department of Health had no contingent assets as at 30 June 2017 or 30 June 2016.

21. 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.

22. 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)).

	2017	2016
	$000	$000
TERRITORY INCOME AND EXPENSES		
Income		
Fees from regulatory services	408	402
Other income	124	0
Total Income	**531**	**402**
Expenses		
Central Holding Authority income transferred	531	402
Total Expenses	**531**	**402**
Territory Income less Expenses	**0**	**0**
TERRITORY ASSETS AND LIABILITIES		
Assets		
Other receivables	0	0
Total Assets	**0**	**0**
Liabilities		
Central Holding Authority income payable	0	0
Total Liabilities	**0**	**0**
Net Assets	**0**	**0**

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

23. BUDGETARY INFORMATION

Comprehensive Operating Statement	2016-17 Actual	2016-17 Original Budget	Variance	Note
INCOME	$000	$000	$000	
Grants and subsidies revenue				
Current	300 842	250 470	50 372	1
Capital	0	0	0	
Appropriation				
Output	1 025 849	1 054 350	(28 501)	
Commonwealth	62 372	54 266	8 106	1
Sales of goods and services	45 906	46 263	(357)	
Interest revenue	12	0	12	2
Goods and services received free of charge	10 738	14 690	(3 952)	3
Gain on disposal of assets	2	0	2	4
Other income	4 978	226	4 752	5
TOTAL INCOME	**1 450 699**	**1 420 265**	**30 434**	
EXPENSES				
Employee expenses	113 670	119 676	(6 006)	
Administrative expenses				
Purchases of goods and services*	571 932	547 446	24 486	
Repairs and maintenance	696	684	13	
Depreciation and amortisation	4 292	4 623	(330)	
Other administrative expenses	10 885	14 690	(3 805)	3
Grants and subsidies expenses				
Current*	789 162	714 285	74 877	6
Capital	9	336	(327)	7
Community service obligations	0	24 178	(24 178)	8
TOTAL EXPENSES	**1 490 646**	**1 425 918**	**64 728**	
NET SURPLUS/(DEFICIT)	**(39 947)**	**(5 653)**	**(34 294)**	
OTHER COMPREHENSIVE INCOME				
Items that will not be reclassified to net surplus/deficit				
Changes in asset revaluation surplus	1 234	0	1 234	9
TOTAL OTHER COMPREHENSIVE INCOME	**1 234**	**0**	**1 234**	
COMPREHENSIVE RESULT	**(38 713)**	**(5 653)**	**(33 060)**	

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

1. Budget subject to variation due to timing of Commonwealth funding.
2. State Pool account interest.
3. Notional billing.
4. Sale of minor assets.
5. Prior year refund.

* Includes funding on-passed to Top End Health Service and Central Australia Health Service.

6. The variance does not capture additional funding on-passed to Top End Health Service and Central Australia Health Service as well as additional funding for the Department and includes the end of year deficit.
7. Budget misalignment.
8. Function transferred to Territory Families.
9. Land and building revaluation increment.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

Balance Sheet	2016-17 Actual	2016-17 Original Budget	Variance	Note
	$000	$000	$000	
ASSETS				
Current assets				
Cash and deposits	6 554	24 592	(18 038)	1
Receivables	2 391	2 410	(19)	
Inventories	0	127	(127)	2
Prepayments	2 460	3 858	(1 398)	3
Total current assets	**11 405**	**30 987**	**(19 582)**	
Non-current assets				
Advances and investments	300	300	0	
Property, plant and equipment	24 742	59 611	(34 869)	4
Total non-current assets	**25 042**	59 911	(34 869)	
TOTAL ASSETS	**36 447**	**90 898**	**(54 451)**	
LIABILITIES				
Current liabilities				
Payables	5 377	15 917	(10 540)	4
Provisions	13 230	16 788	(3 558)	4
Total current liabilities	**18 607**	**32 705**	**(14 098)**	
TOTAL LIABILITIES	**18 607**	**32 705**	**(14 098)**	
NET ASSETS	**17 840**	**58 193**	**(40 353)**	
EQUITY				
Capital	285 728	298 890	(13 162)	
Reserves	3 784	1 607	2 177	5
Accumulated funds	(271 672)	(242 304)	(29 368)	1
TOTAL EQUITY	**17 840**	**58 193**	**(40 353)**	

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

1. Consistent with end of year deficit.
2. Oral health inventories transferred to Top End Health Service.
3. Predominantly NT block funding to Top End Health Service and Central Australia Health Service.
4. Transfer of functions to Top End Health Service and Central Australia Health Service.
5. Land and building revaluation increment.

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

Cash Flow Statement	2016-17 Actual	2016-17 Original Budget	Variance	Note
CASH FLOWS FROM OPERATING ACTIVITIES	$000	$000	$000	
Operating receipts				
Grants and subsidies received				
Current	300 842	250 470	50 372	1
Appropriation				
Output	1 025 849	1 054 350	(28 501)	
Commonwealth	62 372	54 266	8 106	1
Receipts from sales of goods and services	73 448	46 489	26 959	2
Interest received	12	0	12	3
Total operating receipts	**1 462 523**	**1 405 575**	**56 947**	
Operating payments				
Payments to employees	(115 247)	(119 676)	4 429	
Payments for goods and services	(595 296)	(548 130)	(47 166)	
Grants and subsidies paid				
Current	(789 162)	(714 285)	(74 877)	
Capital	(9)	(336)	327	4
Community service obligations	0	(24 178)	24 178	5
Total operating payments	**(1 499 714)**	**(1 406 605)**	**(93 109)**	
Net cash from/(used in) operating activities	**(37 191)**	**(1 030)**	**(36 162)**	
CASH FLOWS FROM INVESTING ACTIVITIES				
Investing receipts				
Proceeds from asset sales	0	23	(23)	6
Total investing receipts	0	**23**	**(23)**	
Investing payments				
Purchases of assets	(2 120)	(32 156)	30 036	7
Total investing payments	(2 120)	**(32 156)**	30 036	
Net cash from/(used in) investing activities	**(2 120)**	**(32 133)**	**30 013**	
CASH FLOWS FROM FINANCING ACTIVITIES				
Financing receipts				
Equity injections				
Capital appropriation	1 679	31 679	(30 000)	7
Commonwealth appropriation	454	454	0	
Other equity injections	35 652	0	35 652	8
Total financing receipts	**37 785**	**32 133**	**5 652**	
Financing payments				
Equity withdrawals	(8 232)	0	(8 232)	8
Total financing payments	**(8 232)**	**0**	**(8 232)**	
Net cash from/(used in) financing activities	**29 553**	**32 133**	**(2 581)**	
Net increase/(decrease) in cash held	(9 758)	(1 030)	(8 728)	
Cash at beginning of financial year	16 312	25 622	(9 310)	
CASH AT END OF FINANCIAL YEAR	**6 554**	**24 592**	**18 038**	

DEPARTMENT OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

Notes:
The following note descriptions relate to variances greater than 10 per cent or where multiple significant variances have occurred.
1. Budget subject to variation due to timing of Commonwealth funding.
2. GST receipts not budgeted.
3. State Pool account interest.
4. Budget misalignment.
5. Function transferred to Territory Families.
6. Nil non-current assets were sold.
7. Capital budget carried forward.
8. End of year equity injection and impact of restructures.

24. BUDGETARY INFORMATION: 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 fees from regulatory services. The Department does not gain control over assets arising from these collections, consequently no income is recognised in the Departments financial statements. The transactions relating to these activities are reported as administered items in this note.

Administered Territory Items	2016-17 Actual	2016-17 Original Budget	Variance	Note
	$000	$000	$000	
TERRITORY INCOME AND EXPENSES				
Income				
Fees from regulatory services	408	126	282	1
Other income	124	0	124	2
Total income	**531**	**126**	**405**	
Expenses				
Central Holding Authority income transferred	531	126	405	
Other administrative expenses	0	0		
Total expenses	**531**	**126**	**405**	
Territory income less expenses	**0**	**0**	**0**	
TERRITORY ASSETS AND LIABILITIES				
Assets				
Other receivables	0	0	0	
Total assets	**0**	**0**	**0**	
Liabilities				
Central Holding Authority income payable	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. Licence fees.
2. Unclaimed monies.

Top End Health Service Financial Statement Overview

The 2016-17 financial statements and the accompanying notes for Top End Health Service (the Health Service) have been prepared on an accrual basis in accordance with the Australian Accounting Standards. The Health Service's financial performance for the financial year and its financial position as at 30 June 2017 are reported in four financial statements: Comprehensive Operating Statement, Balance Sheet, Statement of Changes in Equity and Cash Flow Statement.

Main Results at a glance

- Top End Health Service reported an operating deficit of $43.2 million, a $28.4 million improvement from last year's restated[1] deficit of $71.6 million.
- Revenue earned was $120.1 million higher compared to last year and was within 0.17 per cent of budget targets.
- Expenses incurred were $91.7 million higher than last year and were within 3.12 per cent of budget targets.
- The equity position decreased by $22.9 million.

Comprehensive Operating Statement

	2016-17	2015-16 *Restated*[1]	Variation	
Summary	$000	$000	$000	%
Operating income	908 125	788 013	120 112	15.24
Operating expenses	(951 348)	(859 653)	(91 695)	10.67
Net deficit	(43 223)	(71 640)	28 417	
Other Comprehensive items	(7 197)	22 581	(29 778)	(131.87)
Comprehensive Result	**(50 420)**	**(49 059)**	**(1 361)**	

In 2016-17 the Health Service's Comprehensive Operating Statement showed a net operating deficit of $43.2 million, lower than last year's deficit of $71.6 million. The operating deficit exclusive of depreciation expense, which is not revenue funded, is $14.7 million.

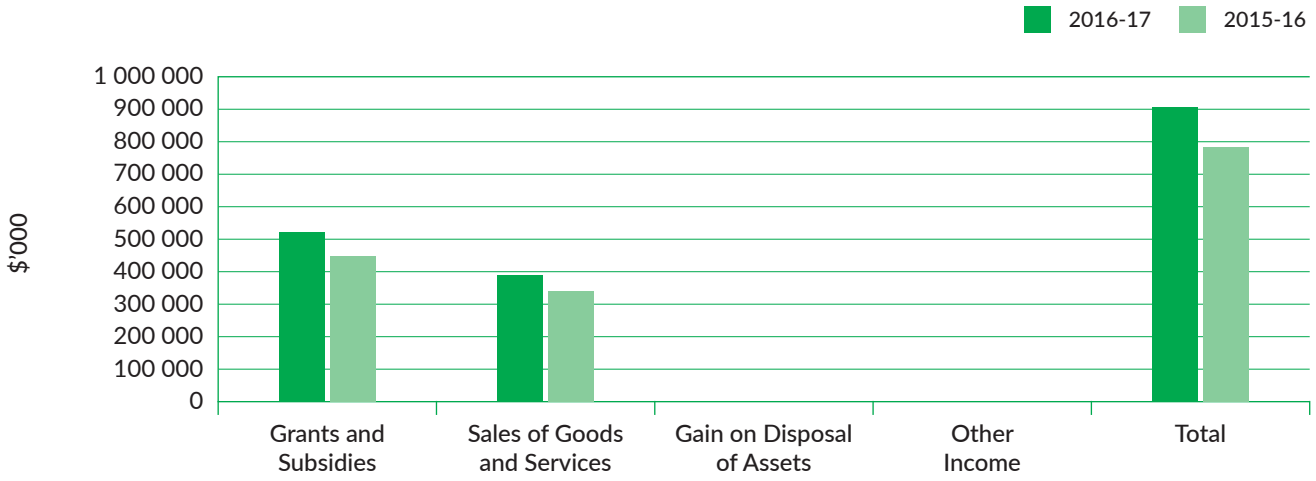
Operating Income

The Health Service's revenue includes operating revenue in the form of grants and subsidies as well as goods and services income. The total revenue for 2016-17 was $908.1 million, an increase of about $120.1 million from 2015-16.

The Health Service is largely funded by, and is dependent on, the receipt of Northern Territory (NT) Block Funding payments paid through the Department of Health (the Department). The remaining revenue mainly relates to Activity Based Funding, National Partnership Payments and Commonwealth Own-Purpose Expense funding.

[1] Refer to Note 2(g) of the financial statements.

Operating Revenue Two-Year Comparison



The major movement in revenue includes the following:

- Grants and Subsidies – the increase of $73.1 million relates primarily to $51.6 million NT Block funding, which includes the transfer of Hearing, Oral, Cancer Screening services from the Department to the Health Service and increased funding of $21.1 million in Commonwealth funded programs, predominantly in Highly Specialised Drugs, Transition Care and Remote Aboriginal Investment; and
- Sales of Goods and Services – the increase of about $47.2 million was largely due to increases in funding received under the National Health Reform Agreement through Activity Based Funding in line with the increase in activities delivered by the Health Service.

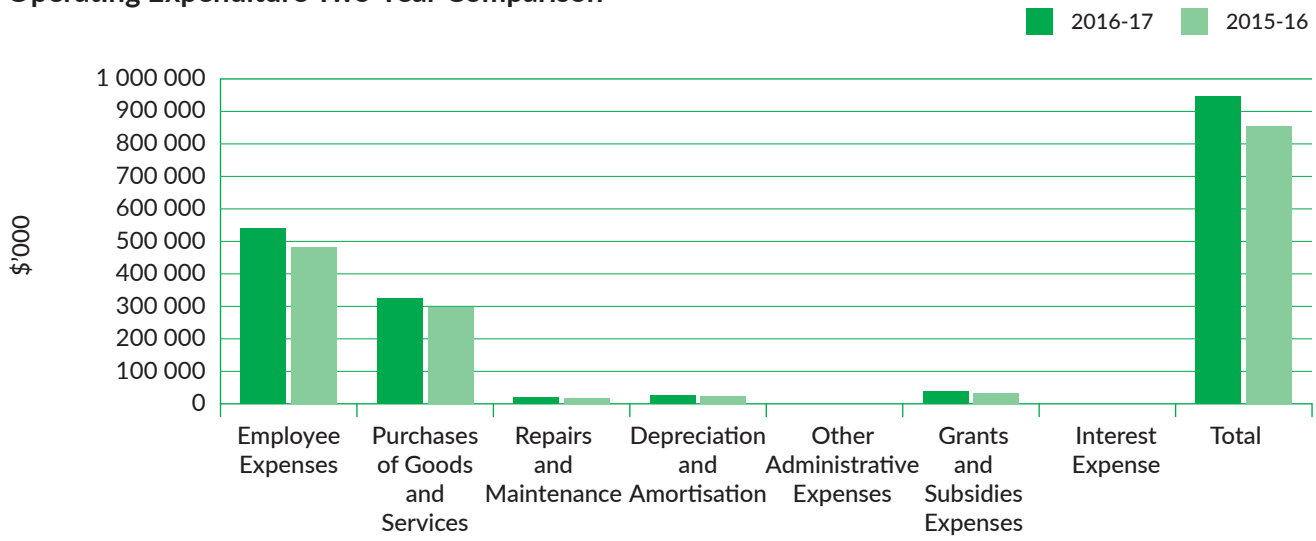
Note 3 of the financial statements present the Comprehensive Operating Statement by output group.

Operating Expense

The Health Service's operating expenditure comprise mainly of employee expenses and purchases of goods and services in order to deliver the required public health services within Top End Australia. The remainder relates to repairs and maintenance, grants and subsidies, other administrative expenses and depreciation.

In 2016-17 the Health Service incurred expenses of $951.3 million, an increase of 10.67 per cent from 2015-16. This is reflective of the increased funding in 2016-17 and increased activity and cost of service delivery in the health sector. The increase is also due to the impact of the transfer of Hearing, Oral and Cancer Screening services from the Department to the Health Service.

Operating Expenditure Two-Year Comparison



The major movement in expenses incurred relates to the following:

- Employee Expenses – the increase of $55.7 million or 11.5 per cent reflects the 7 per cent increase in employees in 2016-17, which was partly due to the transfer of Hearing, Oral, Cancer Screening services from the Department to the Health Service, and the impact of the 3 per cent Enterprise Bargaining Agreement (EBA) increase during the financial year; and
- Purchases of Goods and Services – the increase of $29.9 million is predominantly due to increased funding in 2016-17 for the provision of health services and the transfer of Hearing, Oral and Cancer Screening services from the Department to the Health Service. Further details on purchases of goods and services can be found in Note 5.

Note 3 of the financial statements present the Comprehensive Operating Statement by output group.

Summary	2016-17 Final Budget $000	2016-17 Actual $000	Variation $000	%
Operating income	909 713	908 125	(1 588)	(0.17)
Operating expenses	(922 535)	(951 348)	(28 813)	3.12
Net deficit	**(12 822)**	**(43 223)**	**(30 401)**	

The Health Service's performance in revenue generation control showed a result that had minor variation from planned targets. Revenue across the Health Service came within 0.17 per cent of the annual budget target.

Expenses were however higher by 3.12 per cent from the budget target mainly due to the unforeseen impact of redevelopment at Royal Darwin Hospital resulting in temporary ward closures and reliance of external acquisitions to lease hospital beds, higher cross border charges, patient travel, agency labour and overtime costs.

Balance Sheet

Summary	2016-17 $000	2015-16 *Restated*[1] $000	Variation $000	%
Assets	588 242	601 063	(12 821)	(2.13)
Liabilities	(168 336)	(158 158)	(10 178)	6.44
Net Assets	**419 906**	**442 905**	**(22 999)**	

Of the $588.2 million total assets, 92 per cent or $538.3 million relates to property, plant and equipment (PPE) held at 30 June 2017 while the remaining assets comprise of current assets in the form of cash and deposits, receivables, inventories and prepayments.

The decrease of $12.8 million in total assets is reflective of the operating deficit in 2016-17 combined with the depreciation and revaluation decrements on PPE, but partially offset by the transfer of completed capital works from the Department of Infrastructure, Planning and Logistics (DIPL) during the financial year, and the transfer of assets to the Health Service from the Department as a result of the restructure.

Majority of the Health Service's liabilities at 30 June 2017 relate to payables, employee provisions, and other liabilities relating to rental revenue received in advance. The remaining liabilities comprise of deposits held, borrowings and advances.

The increase in liabilities of $10.2 million is predominantly due to the increase in accrued expenses, including liability for cross border patient expenses and the increase in employee provisions as a result of the transfer of Hearing, Oral and Cancer Screening services to the Health Service. Further details on payable and provisions can be found in Notes 12 and 14 of the financial statements respectively.

Statement of Changes in Equity

Summary	2016-17 $000	2015-16 *Restated*[1] $000	Variation $000	Variation %
Equity, at 1 July	**442 905**	**414 210**	**28 695**	**6.93**
Accumulated Funds	(43 223)	(71 640)	28 417	(39.67)
Asset Revaluation Reserves	(7 197)	22 581	(29 778)	(131.87)
Net Equity Injections/Withdrawals	27 421	77 754	(50 333)	(64.73)
Equity, at 30 June	**419 906**	**442 905**	**(22 999)**	

The Statement of Changes in Equity reflects movements in equity balances during the financial year.

The decrease in equity of $22.9 million was predominantly the result of the following:

- $43.2 million deficit for the financial year;
- $7.2 million revaluation decrement on land and buildings;
- capital withdrawals of $1.5 million relating to liabilities assumed by the Health Service as a result of the restructure;
- $23.6 million of equity transferred in, mainly representing the value of completed capital works from DIPL and the value of assets transferred from the Department in regards to Hearing, Oral and Cancer Screening services; and
- $5.5 million of equity injection from the Central Holding Authority.

Cash Flow Statement

Summary	2016-17 $000	2015-16 $000	Variation $000	Variation %
Cash Balance, 1 July	**5 666**	**29 470**	**(23 804)**	**(80.77)**
Receipts	962 386	818 354	144 032	17.60
Payments	(969 631)	(861 348)	(108 283)	12.57
Equity injections	5 562	20 000	(14 438)	(72.19)
Equity withdrawals	(1 477)	(810)	(667)	82.35
Cash Balance, 30 June	**2 506**	**5 666**	**(3 160)**	

The Cash Flow Statement shows the Health Service's cash receipts and payments for the financial year. The statement incorporates expenses and revenues from the Comprehensive Operating Statement, after the elimination of all non-cash transactions, with cash movements from the Balance Sheet. The net result is a decrease in the Health Service's cash balances of $3.2 million compared to 2015-16.

Auditor-General

Independent Auditor's Report to the Minister for Health

Top End Health Service

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Opinion

I have audited the accompanying financial report of Top End Health Service, which comprises the balance sheet as at 30 June 2017, and the comprehensive operating statement, statement of changes in equity and cash flow statement for the year then ended, a summary of significant accounting policies and other explanatory notes, and the certification of the financial statements by the Accountable Officer.

In my opinion, the financial report gives a true and fair view, in all material respects, of the financial position of Top End Health Service as at 30 June 2017, and of its financial performance and its cash flows for the year then ended in accordance with Australian Accounting Standards.

Basis for Opinion

I conducted my audit in accordance with Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. I am independent of Top End Health Service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. I have also fulfilled my other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Other Information

The Accountable Officer of the Department of Health is responsible for the other information. The other information comprises the information included in Top End Health Service's financial statement overview for the year ended 30 June 2017, but does not include the financial report and my auditor's report thereon.

My opinion on the financial report does not cover the other information and accordingly I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial report, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial report or my knowledge obtained in the audit or otherwise appears to be materially misstated.

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Responsibilities of the Accountable Officer for the Financial Report

The Accountable Officer 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.

In preparing the financial report, management is responsible for assessing Top End Health Service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate Top End Health Service or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing Top End Health Service's financial reporting process.

Auditor-General

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Auditor's Responsibilities for the Audit of the Financial Report

My objectives are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial report.

As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 Top End Health Service's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on Top End Health Service's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause Top End Health Service to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Julie Crisp
Auditor-General for the Northern Territory

Darwin, Northern Territory

2 October 2017

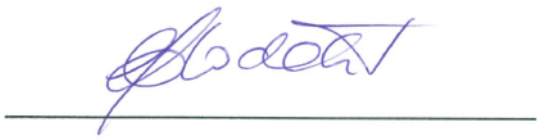
Top End Health Service Financial Statements

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 2017 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.



Professor Catherine Stoddart

Accountable Officer

5 September 2017

Michael Kalimnios

Chief Operating Officer

5th September 2017

Brigid Bourke

Chief Finance Officer

5 September 2017

TOP END HEALTH SERVICE
COMPREHENSIVE OPERATING STATEMENT
For the year ended 30 June 2017

	Note	2017	Restated 2016[(1)]
		$000	$000
INCOME			
Grants and subsidies revenue			
Current		518 704	445 506
Sales of goods and services		387 281	340 069
Gain on disposal of assets	4	6	4
Other income		2 134	2 434
TOTAL INCOME	3	**908 125**	**788 013**
EXPENSES			
Employee expenses		538 838	483 157
Administrative expenses			
Purchases of goods and services	5	325 559	295 674
Repairs and maintenance		20 061	19 372
Depreciation and amortisation	10	28 540	25 671
Other administrative expenses		743	1 890
Grants and subsidies expenses			
Current		35 938	31 800
Capital		1 477	1 901
Interest expenses		192	188
TOTAL EXPENSES	3	**951 348**	**859 653**
NET DEFICIT		**(43 223)**	**(71 640)**
OTHER COMPREHENSIVE INCOME			
Items that will not be reclassified to net deficit			
Changes in asset revaluation reserve		(7 197)	22 581
TOTAL OTHER COMPREHENSIVE INCOME		**(7 197)**	**22 581**
COMPREHENSIVE RESULT		**(50 420)**	**(49 059)**

[(1)]Refer to Note 2(g) for further details.

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 2017

	Note	2017	Restated 2016[(1)]	Restated 2015[(1)]
		$000	$000	$000
ASSETS				
Current Assets				
Cash and deposits	7	2 506	5 666	29 470
Receivables	8	37 772	35 288	40 040
Inventories	9	8 267	7 794	6 129
Prepayments		1 414	5 792	5 621
Total Current Assets		**49 959**	**54 540**	**81 260**
Non-Current Assets				
Property, plant and equipment	10,11	538 283	546 523	485 752
Total Non-Current Assets		**538 283**	**546 523**	**485 752**
TOTAL ASSETS		**588 242**	**601 063**	**567 012**
LIABILITIES				
Current Liabilities				
Deposits held	15	2 136	2 076	1 736
Payables	12	77 060	71 321	65 860
Borrowings and advances	13	51	45	41
Provisions	14	60 038	54 584	51 214
Other liabilities	15	1 483	1 413	3 933
Total Current Liabilities		**140 768**	**129 439**	**122 784**
Non-Current Liabilities				
Borrowings and advances	13	4 012	3 749	3 635
Other liabilities	15	23 556	24 970	26 383
Total Non-Current Liabilities		**27 568**	**28 719**	**30 018**
TOTAL LIABILITIES		**168 336**	**158 158**	**152 802**
NET ASSETS		**419 906**	**442 905**	**414 210**
EQUITY				
Capital		409 857	382 436	304 682
Asset revaluation reserve	17	167 263	174 460	151 880
Accumulated funds		(157 214)	(113 991)	(42 352)
TOTAL EQUITY		**419 906**	**442 905**	**414 210**

[(1)]Refer to Note 2(g) for further details.

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 2017

	Note	Equity at 1 July	Comprehensive result	Transactions with owners in their capacity as owners	Equity at 30 June
		$000	$000	$000	$000
2016-17					
Accumulated Funds		(113 964)	(43 223)	0	(157 187)
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
		(113 991)	(43 223)	0	(157 214)
Asset revaluation reserve	17	174 460	(7 197)	0	167 263
Capital – Transactions with Owners					
Equity injections					
Capital appropriation		0	0	0	0
Equity transfers in		430 205	0	23 606	453 811
Other equity injections		47 123	0	5 562	52 685
Specific purpose payments		0	0	0	0
National partnership payments		0	0	0	0
Commonwealth – capital		0	0	0	0
Equity withdrawals					
Capital withdrawal		(90 998)	0	(1 477)	(92 475)
Equity transfers out		(3 895)	0	(270)	(4 164)
		382 436	0	27 421	409 857
Total Equity at End of Financial Year		**442 905**	**(50 420)**	**27 421**	**419 906**
Restated 2015-16[(1)]					
Accumulated Funds		(22 913)	(64 669)	0	(87 581)
Changes in accounting policy		0	0	0	0
Correction of prior period errors[(1)]		(19 412)	(6 971)	0	(26 383)
Transfers from reserves		(27)	0	0	(27)
Other movements directly to equity		0	0	0	0
		(42 352)	(71 640)	0	(113 991)
Asset revaluation reserve	17	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		**414 210**	**(49 059)**	**77 754**	**442 905**

[(1)]Refer to Note 2(g) for further details.

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 2017

	Note	2017 $000	2016 $000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Receipts			
Grants and subsidies received			
Current		518 704	445 505
Receipts from sales of goods and services		443 591	372 505
Total Operating Receipts		**962 295**	**818 010**
Operating Payments			
Payments to employees		(531 203)	(491 721)
Payments for goods and services		(396 415)	(330 615)
Grants and subsidies paid			
Current		(35 988)	(31 750)
Capital		(1 477)	(1 901)
Interest paid		(192)	(188)
Total Operating Payments		**(965 275)**	**(856 175)**
Net Cash From/(Used in) Operating Activities	18	**(2 980)**	**(38 165)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Investing Receipts			
Proceeds from asset sales	4	32	4
Total Investing Receipts		**32**	**4**
Investing Payments			
Purchases of assets		(4 296)	(5 124)
Total Investing Payments		**(4 296)**	**(5 124)**
Net Cash From/(Used in) Investing Activities		**(4 264)**	**(5 120)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Financing Receipts			
Deposits received		59	340
Equity injections			
Other equity injections		5 562	20 000
Total Financing Receipts		**5 621**	**20 340**
Financing Payments			
Finance lease payments		(60)	(49)
Equity withdrawals		(1 477)	(810)
Total Financing Payments		**(1 537)**	**(859)**
Net Cash From/(Used in) Financing Activities		**4 084**	**19 481**
Net increase/(decrease) in cash held		(3 160)	(23 804)
Cash at beginning of financial year		5 666	29 470
CASH AT END OF FINANCIAL YEAR	7	**2 506**	**5 666**

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 2017

INDEX OF NOTES TO THE FINANCIAL STATEMENTS

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

1. OBJECTIVES AND FUNDING

The Top End Health Service's ("the Health Service") 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 Top End Health Service 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 Top End Health Service controls resources to carry on its functions and deliver outputs. For reporting purposes, outputs delivered by the Top End Health Service are summarised into several output groups. Note 3 provides summary financial information in the form of a Comprehensive Operating Statement by output group.

d) Machinery of Government Changes

Transfers In

Details of Transfer: Hearing, Oral and Cancer Screening units transferred from the Department of Health

Basis of Transfer: Health Services Act 12 April 2017

Date of Transfer: Effective from 1 July 2016

The assets and liabilities transferred as a result of this change were as follows:

Assets	**$000**
Receivables	59
Inventory	434
Prepayments	35
Property, Plant and Equipment	4 742
	5 270
Liabilities	
Payables	38
Provisions	1 576
	1 614
Net Assets	**3 656**

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

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 Health Service financial statements is to include:

(iii) a Certification of the Financial Statements;

(iv) a Comprehensive Operating Statement;

(v) a Balance Sheet;

(vi) a Statement of Changes in Equity;

(vii) a Cash Flow Statement; and

(viii) 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 Health Service 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 2016-17:

AASB 124 Related Party Disclosures
This standard applies to the not-for-profit sector for the first time in 2016-17. The accounting standard requires disclosures about the remuneration of key management personnel, transactions with related parties, and relationships between parent and controlled entities. For any such transactions, disclosures will include the nature of the related party relationship, as well as information about those transactions' terms/conditions and amounts, any guarantees given/received, outstanding receivables/payables, commitments, and any receivables where collection has been assessed as being doubtful.

Several other amending standards and AASB interpretations have been issued that apply to the current reporting periods, but are considered to have no impact on public sector reporting.

Standards and Interpretations Issued but Not Yet Effective

At the date of authorisation of the financial statements, the following standards and interpretations were in issue but are not yet effective and are expected to have a potential impact on future reporting periods:

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

AASB 16 Leases

AASB 16 Leases is effective for annual reporting periods beginning on or after 1 January 2019 and will be reported in these financial statements for the first time in 2019-20. When the standard is effective it will supersede AASB 117 Leases and requires the majority of leases to be recognised on the balance sheet.

For lessees with operating leases, a right-of-use asset will now come onto the balance sheet together with a lease liability for all leases with a term of more than 12 months, unless the underlying assets are of low value. The Comprehensive Operating Statement will no longer report operating lease rental payments, instead a depreciation expense will be recognised relating to the right-to-use asset and interest expense relating to the lease liability.

For lessors, the finance and operating lease distinction remains largely unchanged. For finance leases, the lessor recognises a receivable equal to the net investment in the lease. Lease receipts from operating leases are recognised as income either on a straight-line basis or another systematic basis where appropriate.

Consequently, it is expected that approximately $1.89 million in operating lease commitments will be required to be recognised in the balance sheet through a lease liability and corresponding right to use asset from 2019-20 in accordance with AASB 16 Leases. In the comprehensive income statement the operating lease expense will be replaced with a depreciation expense relating to the right to use asset and interest expense relating to the lease liability. These cannot be quantified at this time.

AASB 1058 Income for not-for-profit entities and AASB 15 Revenue from contracts with customers

AASB 1058 Income for Not-for-Profit Entities and AASB 15 Revenue with Contracts with Customers are effective for annual reporting periods beginning on or after 1 January 2019 and will be reported in these financial statements for the first time in 2019-20.

Under the new AASB 1058 Income for Not-for-Profit Entities, revenue from grants and donations will be recognised when any associated performance obligation to provide goods or services is satisfied, and not immediately upon receipt as currently occurs. Consequently, more liabilities will be recognised in the balance sheet after adoption of this standard.

AASB 1058 clarifies and simplifies income-recognition requirements that apply to not-for-profit entities in conjunction with AASB 15 Revenue from Contracts with Customers.

While the full impacts are yet to be determined, potential impacts identified include:

- Grants received to construct or acquire a non-financial asset will be recognised as a liability, and subsequently recognised as revenue as the performance obligations under the grant are satisfied. At present, such grants are recognised as revenue on receipt.
- Grants with an enforceable agreement and sufficiently specific performance obligations will be recognised as revenue progressively as the associated performance obligations are satisfied. At present, such grants are recognised as revenue on receipt.
- Grants that have an enforceable agreement but no specific performance obligations but have restrictions on the timing of expenditure will also continue to be recognised on receipt as time restriction on the use of funds is not sufficiently specific to create a performance obligation.
- Grants that are not enforceable and/or not sufficiently specific will not qualify for deferral, and continue to be recognised as revenue as soon as they are controlled.

Several other amending standards and AASB interpretations have been issued that apply to future reporting periods, but are considered to have limited impact on future financial reporting.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

c) Reporting Entity

The financial statements cover the Top End 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*. For financial reporting purposes, the Health Service is a not-for-profit entity.

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 2015-16 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 2016-17 as a result of management decisions.

g) Correction of Prior Period Errors

In November 2012, the Health Service and Menzies School of Health Research (Menzies) entered into an agreement to lease where the Health Service provided Menzies with a licence to construct a building at their cost in its land. In March 2015, the building was gifted to the Health Service in exchange for Menzies acquiring a right of use of the building at $1.00 peppercorn rental per annum over a lease term of 20 years.

The fair value of the building taken up was equivalent to the total construction costs of $28.267 million. This was fully recognised as revenue which occurred in two transactions over the years ended 30 June 2015 and 30 June 2016. However, as this revenue was essentially rent received in advance, the transactions should have been recognised in the Health Service's balance sheet as a liability and revenue to be drawn down annually over the life of the lease term.

As the error was made in a reporting period prior to the comparative period (ie. 30 June 2016), the Balance Sheet opening balances as at 1 July 2015 were restated, in accordance with AASB 101 Presentation of Financial Statements, as follows:

- Buildings were increased by $8.440 million and accumulated depreciation by $0.056 million to record the additional costs of the gifted building that were not previously recorded.
- Other current liabilities were increased by $1.413 million and other non-current liabilities by $26.383 million to recognise the rental revenue received in advance as at 30 June 2015.
- Accumulated funds were decreased by $19.412 million to recognise the change from current year net surplus of $2.911 million to a net deficit of $16.501 million.

With the exception of the buildings and the accumulated depreciation, the financial statements were further misstated for the year ended 30 June 2016 and therefore, resulted in the restatement of the following line items in the 2016 comparatives column:

- Other current liabilities was increased by $1.413 million and other non-current liabilities by $24.970 million to recognise the liability balances of the rental revenue received in advance as at 30 June 2016.
- Accumulated funds were decreased by $26.383 million ($19.412 million in 2015 and $6.971 million in 2016).
- Other income was decreased by $6.971 million.
- Net deficit was increased by $6.971 million.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

The following tables show the restatement of each line item affected by the error.

RESTATEMENT OF FINANCIAL STATEMENTS AS A RESULT OF A CORRECTION OF A PRIOR PERIOD ERROR
For the comparative year ended 30 June 2016

Financial Statements Line Item/ Balance Affected	Note	2016	Correction of Error Adjustment	Restated 2016
		$000	$000	$000
OPERATING STATEMENT (EXTRACT)				
INCOME				
Other income		9 405	(6 971)	2 434
TOTAL INCOME	3	**794 984**	**(6 971)**	**788 013**
NET DEFICIT		**(64 669)**	**(6 971)**	**(71 640)**
COMPREHENSIVE RESULT		**(42 088)**	**(6 971)**	**(49 059)**
BALANCE SHEET (EXTRACT)				
LIABILITIES				
Current Liabilities				
Other liabilities	15	0	1 413	1 413
Total Current Liabilities		**128 026**	**1 413**	**129 439**
Non-Current Liabilities				
Other liabilities	15	0	24 970	24 970
Total Non-Current Liabilities		**3 749**	**24 970**	**28 719**
TOTAL LIABILITIES		**131 775**	**26 383**	**158 158**
NET ASSETS		**469 288**	**(26 383)**	**442 905**
EQUITY				
Accumulated funds		(87 608)	(26 383)	(113 991)
TOTAL EQUITY		**469 288**	**(26 383)**	**442 905**
STATEMENT OF CHANGES IN EQUITY (EXTRACT)				
Correction of prior period errors		0	(6 971)	(6 971)

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

RESTATEMENT OF FINANCIAL STATEMENTS AS A RESULT OF A CORRECTION OF A PRIOR PERIOD ERROR
For the comparative year opening balances as at 1 July 2015

Financial Statements Line Item/ Balance Affected	Note	2015	Correction of Error Adjustment	Restated 2015
		$000	$000	$000
BALANCE SHEET (EXTRACT)				
Non-Current Assets				
Property, plant and equipment	10,11	477 368	8 384	485 752
Total Non-Current Assets		**477 368**	**8 384**	**485 752**
TOTAL ASSETS		**558 628**	**8 384**	**567 012**
LIABILITIES				
Current Liabilities				
Other liabilities	15	2 520	1 413	3 933
Total Current Liabilities		**121 371**	**1 413**	**122 784**
Non-Current Liabilities				
Other liabilities	15	0	26 383	26 383
Total Non-Current Liabilities		**3 635**	**26 383**	**30 018**
TOTAL LIABILITIES		**125 006**	**27 796**	**152 802**
NET ASSETS		**433 622**	**(19 412)**	**414 210**
EQUITY				
Accumulated funds		(22 940)	(19 412)	(42 352)
TOTAL EQUITY		**433 622**	**(19 412)**	**414 210**

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.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

i) 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 Equivalent Regimes (TER) improve competitive neutrality between public and private sector entities. The TER levies the equivalent of Commonwealth 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 recognised for the Top End Health Service as the Health Service is in a deficit position for the year ended 30 June 2017.

j) Contributions by and Distributions to Government

The Health Service may receive contributions from Government where the Government is acting as owner of the Health Service. Conversely, the Health Service 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 Health Service as adjustments to equity.

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

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	
		2017	2016	2017	2016	2017	2016	2017	Restated 2016[1]	2017	Restated 2016[1]
		$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
INCOME											
Grants and subsidies revenue											
Current		34 976	23 066	11 388	9 878	35 150	28 446	437 190	384 116	518 704	445 506
Sales of goods and services		34 802	38 672	279	256	5 220	6 597	346 980	294 544	387 281	340 069
Gain on disposal of assets	4	1	4	0	0	5	0	0	0	6	4
Other income		139	73	2	821	580	127	1 413	1 413	2 134	2 434
TOTAL INCOME		**69 918**	**61 815**	**11 669**	**10 955**	**40 955**	**35 170**	**785 583**	**680 073**	**908 125**	**788 013**
EXPENSES											
Employee expenses		378 232	351 695	44 616	40 131	93 871	75 147	22 118	16 184	538 838	483 157
Administrative expenses											
Purchases of goods and services	5	197 780	175 289	7 880	7 754	26 272	21 716	93 627	90 916	325 559	295 674
Repairs and maintenance		9 843	9 970	0	0	0	2	10 218	9 400	20 061	19 372
Depreciation and amortisation	10	2 673	2 787	24	38	923	366	24 920	22 480	28 540	25 671
Other administrative expenses		700	1 788	13	3	23	92	7	7	743	1 890
Grants and subsidies expenses											
Current		4	21	2 567	3 106	13 984	12 180	19 384	16 493	35 938	31 800
Capital		0	0	0	0	0	0	1 477	1 901	1 477	1 901
Interest expenses		15	15	0	0	177	173	0	0	192	188
TOTAL EXPENSES		**589 247**	**541 564**	**55 100**	**51 032**	**135 250**	**109 676**	**171 751**	**157 381**	**951 348**	**859 653**
NET SURPLUS/(DEFICIT)		**(519 329)**	**(479 749)**	**(43 431)**	**(40 077)**	**(94 295)**	**(74 506)**	**613 832**	**522 692**	**(43 223)**	**(71 640)**
OTHER COMPREHENSIVE INCOME											
Items that will not be reclassified to net surplus/(deficit)											
Changes in asset revaluation reserve		0	0	0	0	0	0	(7 197)	22 581	(7 197)	22 581
TOTAL OTHER COMPREHENSIVE INCOME		**0**	**0**	**0**	**0**	**0**	**0**	**(7 197)**	**22 581**	**(7 197)**	**22 581**
COMPREHENSIVE RESULT		**(519 329)**	**(479 749)**	**(43 431)**	**(40 077)**	**(94 295)**	**(74 506)**	**606 635**	**545 273**	**(50 420)**	**(49 059)**

[1]Refer to Note 2(g) for further details.

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 2017

Income

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 Health Service 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 Health Service 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 Health Service; 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 Health Service.

	2017	2016
	$000	$000
4. GAIN ON DISPOSAL OF ASSETS		
Net proceeds from the disposal of non-current assets	32	4
Less: Carrying value of non-current assets disposed	(26)	(0)
Gain on the disposal of non-current assets	6	4
Proceeds from sale of minor assets	0	0
Total Gain on Disposal of Assets	**6**	**4**

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

5. PURCHASES OF GOODS AND SERVICES

The net deficit has been arrived at after charging the following expenses:	2017 $000	2016 $000
Goods and services expenses:		
Property maintenance	9 003	10 148
General property maintenance	5 010	4 616
Power	10 555	10 748
Water and sewerage	1 863	1 801
Land rent expense	0	1
Accommodation	1 469	707
Consultants [1]	430	1 220
Advertising [2]	28	16
Agent service agreements	45 159	44 768
Audit fees	77	73
Bank charges	36	24
Client travel	61 011	57 530
Clothing	604	621
Communications	2 719	2 431
Consumables/ general expenses	5 522	4 979
Cross border patient charges	20 862	19 957
Marketing and promotion [3]	362	407
Document production	402	309
Entertainment/ hospitality	50	39
Food	3 813	3 940
Freight	1 610	1 499
Information technology charges	13 334	12 880
IT consultants	728	535
IT hardware and software expenses	1 074	1 023
Insurance premiums	2	3
Laboratory expenses	10 348	9 052
Legal expenses [4]	246	579
Library services	88	131
Medical/ dental supply and services	100 246	78 881
Membership and subscriptions	381	413
Motor vehicle expenses	5 329	4 936
Office requisites and stationery	1 659	1 618
Other equipment expenses	4 870	4 478
Recruitment [5]	3 638	3 583
Regulatory/ advisory boards/ committees	49	35
Relocation expenses	409	452
Training and study	2 606	2 334
Transport equipment expenses	35	41
Official duty fares	8 917	8 214
Travelling allowance	1 053	654
Unallocated corporate credit card expenses	(39)	(2)
Goods and services cost allocation	1	0
	325 559	**295 674**

[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.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

Repairs and Maintenance Expense

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

Interest Expense

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

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

	Health Service		Health Service		Territory Items		Territory Items	
	2017	No. of Trans.	2016	No. of Trans.	2017	No. of Trans.	2016	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	222	337	128	352	0	0	0	0
Losses or deficiencies of money written off	0	0	0	0	0	0	0	0
Public property written off	39	10	21	4	0	0	0	0
Waiver or postponement of right to receive or recover money or property	0	0	0	0	0	0	0	0
Total Written Off, Postponed and Waived by Delegates	**261**	**347**	**149**	**356**	0	0	0	0
Amounts written off, postponed and waived by the Treasurer								
Irrecoverable amounts payable to the Territory or an agency written off	148	12	0	0	0	0	0	0
Losses or deficiencies of money written off	0	0	0	0	0	0	0	0
Public property written off	0	0	0	0	0	0	0	0
Waiver or postponement of right to receive or recover money or property	0	0	0	0	0	0	0	0
Total Written Off, Postponed and Waived by the Treasurer	**148**	**12**	**0**	**0**	0	0	0	0
Write-offs, Postponements and Waivers Authorised Under Other Legislation[(a)]	**0**	**0**	**21**	**2**	0	0	0	0
Gifts Under the *Financial Management Act*	**0**	**0**	**0**	**0**	0	0	0	0
Gifts Authorised Under Other Legislation	**0**	**0**	**0**	**0**	0	0	0	0
Ex Gratia Payments Under the *Financial Management Act*	**60**	**1**	**0**	**0**	0	0	0	0

[(a)] *Medical Services Act.*

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

	2017 $000	2016 $000
7. CASH AND DEPOSITS		
Cash on hand	12	12
Cash at bank	2 494	5 654
	2 506	**5 666**

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 23.

8. RECEIVABLES		
Current		
Accounts receivable	9 308	10 573
Less: Allowance for impairment losses	(3 236)	(3 157)
	6 072	7 416
GST receivables	3 280	3 341
Other receivables[(1)]	28 420	24 531
	31 700	27 872
Total Receivables	**37 772**	**35 288**

[(1)] Other receivables include accrued revenue for cross border patient charges.

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 Health Service 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 19 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.

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.

9. INVENTORIES		
Inventories Held for Distribution		
At current replacement cost	8 267	7 794
Total Inventories	**8 267**	**7 794**

During the year the Top End Health Service was required to write-off $0.24m ($0.21m 2015-16) 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 2017

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.

10. PROPERTY, PLANT AND EQUIPMENT

Land		
At fair value	31 613	34 493
Buildings		
At fair value	959 021	940 520
Less: Accumulated depreciation	(476 178)	(448 213)
Less: Accumulated impairment loss	(231)	(231)
	482 612	492 076
Plant and Equipment		
At capitalised cost	61 838	54 293
Less: Accumulated depreciation	(40 350)	(36 733)
Less: Accumulated impairment loss	(1 332)	(1 293)
	20 156	16 267
Leased Land		
At fair value	4 411	4 083
Less: Accumulated amortisation	(509)	(396)
	3 902	3 687
Total Property, Plant and Equipment	**538 283**	**546 523**

2017 Property, Plant and Equipment Reconciliations

A reconciliation of the carrying amount of property, plant and equipment at the beginning and end of 2016-17 is set out below:

	Land	Buildings	Plant and Equipment	Leased Land	Total
	$000	$000	$000	$000	$000
Carrying Amount as at 1 July 2016	34 493	492 076	16 267	3 687	546 523
Additions	0	0	4 296	328	4 624
Disposals	0	0	(25)	0	(25)
Depreciation/Amortisation	0	(24 718)	(3 709)	(113)	(28 540)
Additions/(Disposals) from administrative restructuring	0	0	0	0	0
Additions/(Disposals) from asset transfers	(220)	19 791	3 366	0	22 937
Revaluation increments/(decrements)	(2 660)	(4 537)	0	0	(7 197)
Impairment losses	0	0	(39)	0	(39)
Impairment losses reversed	0	0	0	0	0
Other movements	0	0	0	0	0
Carrying Amount as at 30 June 2017	**31 613**	**482 612**	**20 156**	**3 902**	**538 283**

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

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	Leased Land	Total
	$000	$000	$000	$000	$000
Carrying Amount as at 1 July 2015[(1)]	29 187	438 815	14 124	3 626	485 752
Additions	0	0	5 124	167	5 291
Disposals	0	0	0	0	0
Depreciation/Amortisation	0	(22 234)	(3 331)	(106)	(25 671)
Additions/(Disposals) from administrative restructuring	0	0	0	0	0
Additions/(Disposals) from asset transfers[(1)]	(1 540)	59 510	371	0	58 341
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**

[(1)]The amounts have been restated for the error set out in Note 2(g) relating to the recognition of buildings.

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 Health Service 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, Planning and Logistics is responsible for managing general government capital works projects on a whole of Government basis. Therefore appropriation for all Health Service capital works is provided directly to the Department of Infrastructure, Planning and Logistics 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 Health Service.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

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.

The latest revaluations as at 30 June 2017 were independently conducted. The valuer was Territory Property Consultants Pty Ltd. Refer to Note 11: Fair Value Measurement of Non-Financial Assets for additional disclosures.

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 Health Service 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 Health Service 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 reserve for that class of asset to the extent that an available balance exists in the asset revaluation reserve.

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 reserve. Note 17 provides additional information in relation to the asset revaluation reserve.

Health Service property, plant and equipment assets were assessed for impairment as at 30 June 2017. As a result of this review $38,520 of impairment losses were recognised against plant and equipment. Impairment losses were charged to expenses.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

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.

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

	2017 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

Leased land are amortised over the life of the lease.

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

Leased Assets

Leases under which the Health Service 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.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

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
2016-17				
Asset Classes				
Land (Note 10)	0	0	31 613	31 613
Buildings (Note 10)	0	0	482 612	482 612
Plant and equipment (Note 10)	0	0	20 156	20 156
Total	**0**	**0**	**534 381**	**534 381**
2015-16				
Asset Classes				
Land (Note 10)	0	0	34 493	34 493
Buildings (Note 10)	0	0	492 076	492 076
Plant and equipment (Note 10)	0	0	16 267	16 267
Total	**0**	**0**	**542 836**	**542 836**

There were no transfers between Level 1 and Levels 2 or 3 during 2016-17.

b) Valuation Techniques and Inputs

Valuation techniques used to measure fair value in 2016-17 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 2015-16 to 2016-17.
The Territory Property Consultants Pty Ltd has provided valuations for the land and buildings assets.

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 2017

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
2016-17			
Fair value as at 1 July 2016	34 493	492 076	16 267
Additions	0	19 791	7 662
Disposals	(220)	0	(25)
Transfers from Level 2	0	0	0
Transfers to Level 2	0	0	0
Depreciation	0	(24 718)	(3 709)
Gains/losses recognised in net deficit	0	0	0
Gains/losses recognised in other comprehensive income	(2 660)	(4 537)	(39)
Fair value as at 30 June 2017	**31 613**	**482 612**	**20 156**
2015-16			
Fair value as at 1 July 2015[(1)]	29 187	438 815	14 124
Additions[(1)]	1 210	59 510	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 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**

[(1)]The amounts have been restated for the error set out in Note 2 (g) relating to the recognition of buildings.

(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 Health Service 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 2017

		2017 $000	2016 $000
12.	**PAYABLES**		
	Accounts payable	4 016	4 903
	Accrued expenses[(1)]	73 044	66 368
	Grants and subsidies payable	0	50
	Total Payables	**77 060**	**71 321**

[(1)]Includes liability for cross border patient expenses and other accrued operational expenses

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 Health Service. Accounts payable are normally settled within 30 days.

13.	**BORROWINGS AND ADVANCES**		
	Current		
	Finance lease liabilities	51	45
		51	45
	Non-Current		
	Finance lease liabilities	4 012	3 749
		4 012	3 749
	Total Borrowings and Advances	**4 063**	**3 794**

14.	**PROVISIONS**		
	Current		
	Employee benefits		
	Recreation leave	47 941	42 904
	Leave loading	6 798	6 715
	Recreation leave fares	181	231
	Other current provisions		
	Superannuation and fringe benefits tax payable	5 118	4 734
		60 038	54 584
	Total Provisions	**60 038**	**54 584**

The Health Service employed 4,130 employees as at 30 June 2017 (3,861 employees as at 30 June 2016).

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

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.

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 the Health Service financial statements.

15. OTHER LIABILITIES

	2017	Restated 2016[1]
	$000	$000
Current		
Deposit held[2]	2 136	2 076
Unearned revenue	1 483	1 413
	3 619	3 489
Non-Current		
Unearned revenue	23 556	24 970
	23 556	24 970
Total Other Liabilities	**27 175**	**28 459**

[1]The amounts have been restated for the error set out in Note 2 (g) relating to the recognition of rental revenue received in advance.
[2]Accountable Officer's Trust Account (see Note 23) Governing Council bank account and Hospital Gift Funds.

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 Health Service 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 the Health Service financial statements.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

16. COMMITMENTS

Disclosures in relation to capital and other commitments, including lease commitments. Commitments are those contracted as at 30 June where the amount of the future commitment can be reliably measured.

	2017		2016	
	Internal	External	Internal	External
	$000	$000	$000	$000
(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 Health Service leases property under non-cancellable operating leases expiring from 3 to 5 years. Leases generally provide the Health Service with a right of renewal at which time all lease terms are renegotiated. The Health Service 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	2 090	0	2 273
Later than one year and not later than five years	0	5 431	0	6 600
Later than five years	0	3	0	925
	0	**7 524**	**0**	**9 798**
(iii) Other Expenditure Commitments				
Other non-cancellable expenditure commitments not recognised as liabilities are payable as follows:				
Within one year	0	33 941	0	26 363
Later than one year and not later than five years	0	61 916	0	5 706
Later than five years	0	0	0	0
	0	**95 857**	**0**	**32 069**

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
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	2017 $000	2016 $000

17. RESERVES

Asset Revaluation Reserve

(i) Nature and purpose of the asset revaluation reserve

The asset revaluation reserve 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 reserve.

(ii) Movements in the asset revaluation reserve

Balance as at 1 July	174 460	151 880
Increment/(Decrement) – land	(2 660)	6 846
Additions/(Disposals) from asset transfers – land	0	(251)
Increment/(Decrement) – buildings	(4 537)	16 216
Impairment (losses)/reversals – building	0	(231)
Balance as at 30 June	**167 263**	**174 460**

18. NOTES TO THE CASH FLOW STATEMENT

Reconciliation of Cash

The total of Health Service 'Cash and deposits' of $2 506 000 recorded in the Balance Sheet is consistent with that recorded as 'Cash' in the Cash Flow Statement.

Reconciliation of Net Deficit to Net Cash from Operating Activities

Net Deficit[1]	(43 223)	(71 640)
Non-cash items:		
Depreciation and amortisation	28 540	25 671
Asset write-offs/write-downs	275	232
(Gain)/Loss on disposal of assets	(6)	(4)
Assets acquired below fair value	(118)	(113)
Minor new works – non-cash	0	86
Changes in assets and liabilities:		
Decrease/(Increase) in receivables	(2 484)	4 752
Decrease/(Increase) in inventories	(192)	(1 876)
Decrease/(Increase) in prepayments	4 378	(171)
(Decrease)/Increase in payables	5 739	5 461
(Decrease)/Increase in provision for employee benefits	5 070	3 091
(Decrease)/Increase in other provisions	384	279
(Decrease)/Increase in other liabilities[1]	(1 343)	(3 933)
Net Cash from Operating Activities	**(2 980)**	**(38 165)**

[1]The amounts have been restated for the error set out in Note 2(g) relating to the net deficit and the relevant non-cash and liability items.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

Non-Cash Financing and Investing Activities

During the financial year the Health Service acquired buildings with an aggregate fair value of $18.2m (2016: $56.1m) by non-cash asset transfers from the Department of Infrastructure, Planning and Logistics.

19. 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.

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 Health Service'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.

a) Categorisation of Financial Instruments

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

2017 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	2 506	0	0	0	0	2 506
Receivables[(1)]	0	0	0	34 492	0	0	34 492
Total Financial Assets	**0**	**2 506**	**0**	**34 492**	**0**	**0**	**36 998**
Deposits held[(1)]	0	0	2 136	0	0	0	2 136
Payables[(1)]	0	77 060	0	0	0	0	77 060
Finance lease liabilities	0	0	0	0	0	4 062	4 062
Total Financial Liabilities	**0**	**77 060**	**2 136**	**0**	**0**	**4 062**	**83 258**

[(1)] Total amounts disclosed here exclude statutory amounts.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

2016 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 here exclude statutory amounts.

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; 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.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

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.

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

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market other than those held for trading and available for sale. Loans and receivables 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.

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TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

b) Credit Risk

The Health Service has limited credit risk exposure (risk of default). In respect of any dealings with organisations external to Government, the Health Service 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 Health Service'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
2016-17			
Not overdue	910	0	910
Overdue for less than 30 days	0	0	0
Overdue for 30 to 60 days	0	0	0
Overdue for more than 60 days	43	0	43
Total	**953**	**0**	**953**

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**

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**

TOP END HEALTH SERVICE
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For the year ended 30 June 2017

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**

External Receivables	Aging of Receivables	Aging of Impaired Receivables	Net Receivables
	$000	$000	$000
2016-17			
Not overdue	1 909	0	1 909
Overdue for less than 30 days	2 355	0	2 355
Overdue for 30 to 60 days	339	0	339
Overdue for more than 60 days	3 752	3 236	516
Total	**8 355**	**3 236**	**5 119**

Reconciliation of the Allowance for Impairment Losses

Opening	3 157
Written off during the year	(369)
Recovered during the year	0
Increase/(Decrease) in allowance recognised in profit or loss	448
Total	**3 236**

2015-16			
Not overdue	3 926	0	3 926
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	**10 490**	**3 157**	**7 333**

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**

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

c) Liquidity Risk

Liquidity risk is the risk that the Health Service will not be able to meet its financial obligations as they fall due. The Health Service'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 Health Service's remaining contractual maturity for its financial assets and liabilities.

2017 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	2 506	2 506	0
Receivables	0	0	0	0	0	0	34 492	34 492	0
Total Financial Assets	**0**	**0**	**0**	**0**	**0**	**0**	**36 998**	**36 998**	
Liabilities									
Deposits held	0	0	0	0	0	0	2 136	2 136	0
Payables	0	0	0	0	0	0	77 060	77 060	0
Finance lease liabilities	0	0	0	51	291	3 720	0	4 062	4.16
Total Financial Liabilities	**0**	**0**	**0**	**51**	**291**	**3 720**	**79 196**	**83 258**	

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 2017

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 Health Service 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.

e) Net Fair Value

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 Health Service 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 Health Service 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:

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.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
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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.

2017	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	2 506	2 506	0	0	2 506
Receivables	34 492	34 492	0	0	34 492
Total Financial Assets	**36 998**	**36 998**	**0**	**0**	**36 998**
Financial Liabilities					
Deposits held	2 136	2 136	0	0	2 136
Payables	77 060	77 060	0	0	77 060
Finance lease liabilities	4 062	4 062	0	0	4 062
Total Financial Liabilities	**83 258**	**83 258**	**0**	**0**	**83 258**

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
Finance lease liabilities	3 794	3 794	0	0	3 794
Total Financial Liabilities	**77 191**	**77 191**	**0**	**0**	**77 191**

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 2017

20. RELATED PARTIES

a) Related Parties

The Top End Health Service is a government business division and is wholly owned and controlled by the Territory Government. Related parties of the Health Service include:

- the Portfolio Minister and key management personnel (KMP) because they have authority and responsibility for planning, directing and controlling the activities of the Health Service directly; and
- spouses, children and dependants who are close family members of the Portfolio Minister or KMP; and
- all public sector entities that are controlled and consolidated into the whole of government financial statements; and
- any entities controlled or jointly controlled by KMP's or the Portfolio Minister or controlled or jointly controlled by their close family members.

b) Key Management Personnel (KMP)

Key management personnel of the Top End Health Service are those persons having authority and responsibility for planning, directing and controlling the activities of Top End Health Service. These include the Minister of Health, the Chief Executive Officer, the members of the Hospital Board, the Chief Operating Officer and other members of the executive leadership team.

c) Remuneration of Key Management Personnel

The details below exclude the salaries and other benefits of the Minister of Health as the Minister's remunerations and allowances are payable by the Department of the Legislative Assembly and consequently disclosed within the Treasurer's Annual Financial Statements. They also exclude the CEO as these details are disclosed in the Department of Health financial statements.

The aggregate compensation of key management personnel of the Top End Health Service is set out below:

	2017
	$000
Short-term benefits	2 262
Post-employment benefits	172
Long-term benefits	-
Termination benefits	-
Total	**2 434**

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NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

d) Related Party Transactions

Transactions with Northern Territory Government controlled entities

The following table provides quantitative information about related party transactions entered into during the year with Northern Territory Government controlled entities.

Related party	Revenue from related parties	Payments to related parties	Amounts owed by related parties	Amounts owed to related parties
	$000	$000	$000	$000
All NTG Government departments	815 027	71 157	1 592	276
Associates	0	0	0	0
Subsidiaries	0	0	0	0

The Health Service's primary ongoing source of funding is received from the Department of Health in the form of Activity Based and Block funding payments, on-passed Commonwealth Own Purpose Expenditure funding and national partnership revenue.

Significant payments to related parties include corporate services charges to Department of Health and Department of Corporate and Information Services.

The Health Service also transacts with other government entities, however these are not individually significant.

Other related party transactions

Given the breadth and depth of Territory Government activities, related parties will transact with the Territory Public sector in a manner consistent with other members of the public including paying stamp duty and other government fees and charges and therefore these transactions have not been disclosed. All other related party transactions in excess of $10,000 have been provided in the table below.

Transaction type	Transaction value for year ended 30 June 2017	Net receivable/ (payable) as at 30 June 2017	Commitments as at 30 June 2017
	$000	$000	$000
Purchases of goods[1]	306	(28)	0

[1]. TEHS purchased office equipment worth $305,832 during the year from an entity controlled by a KMP, of which $28,073 was payable as at year end.

The amounts outstanding are unsecured and will be settled in cash. No guarantees have been given or received. No expense has been recognised in the current year for bad or doubtful debts in respect of the amounts owed by related parties.

Related party transactions of the former minister have not been assessed as the period served during the 2016-17 financial year is considered minor.

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NOTES TO THE FINANCIAL STATEMENTS
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21. CONTINGENT LIABILITIES AND CONTINGENT ASSETS

a) Contingent Liabilities

The Top End Health Service had no contingent liabilities as at 30 June 2017 or 30 June 2016.

b) Contingent Assets

The Top End Health Service had no contingent assets as at 30 June 2017 or 30 June 2016.

22. 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.

23. 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	Receipts	Payments	Closing Balance
	1 July 2016			30 June 2017
Private practice revenue	528 026	404 573	198 164	734 435
Bond money	105 114	70 372	68 381	107 105
Unclaimed money	56 595	770	23 276	34 089
	689 735	**475 715**	**289 821**	**875 629**

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NOTES TO THE FINANCIAL STATEMENTS
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24. BUDGETARY INFORMATION

Comprehensive Operating Statement	2016-17 Actual	2016-17 Original Budget	Variance	Note
	$000	$000	$000	
INCOME				
Grants and subsidies revenue				
Current	518 704	474 906	43 798	
Sales of goods and services	387 281	355 841	31 440	
Gain on disposal of assets	6	0	6	1
Other income	2 134	191	1 943	2
TOTAL INCOME	**908 125**	**830 938**	**77 187**	
EXPENSES				
Employee expenses	538 838	486 247	52 591	3
Administrative expenses				
Purchases of goods and services	325 559	278 858	46 701	4
Repairs and maintenance	20 061	23 000	(2 939)	5
Depreciation and amortisation	28 540	29 128	(588)	
Other administrative expenses	743	0	743	6
Grants and subsidies expenses				
Current	35 938	36 202	(264)	
Capital	1 477	0	1 477	7
Interest expenses	192	0	192	8
TOTAL EXPENSES	**951 348**	**853 435**	**97 913**	
NET DEFICIT	**(43 223)**	**(22 497)**	**(20 726)**	
OTHER COMPREHENSIVE INCOME				
Items that will not be reclassified to net deficit				
Changes in asset revaluation reserve	(7 197)	0	(7 197)	9
TOTAL OTHER COMPREHENSIVE INCOME	**(7 197)**	**0**	**(7 197)**	
COMPREHENSIVE RESULT	**(50 420)**	**(22 497)**	**(27 923)**	

Notes:

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

1. Gain on disposal of plant and equipment.
2. Rental revenue adjustment.
3. Additional activity in line with additional funding along with high agency labour and overtime costs.
4. Additional activity in line with additional funding along with unforeseen impact of redevelopment at Royal Darwin Hospital resulting in temporary ward closures and reliance of external acquisitions to lease hospital beds as well as higher cross border charges and patient travel.
5. R&M works not completed.
6. Increase in provision for doubtful debts resulting from ageing receivables.
7. Budget for the program in Current Grants.
8. Interest paid for long term finance leases on Aboriginal land.
9. Land and building revaluation decrement.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

Balance Sheet	2016-17 Actual	2016-17 Original Budget	Variance	Note
	$000	$000	$000	
ASSETS				
Current assets				
Cash and deposits	2 506	27 645	(25 139)	1
Receivables	37 772	40 044	(2 272)	
Inventories	8 267	6 129	2 138	2
Prepayments	1 414	5 622	(4 208)	3
Total current assets	**49 959**	**79 440**	**(29 481)**	
Non-current assets				
Property, plant and equipment	538 283	548 452	(10 169)	
Total non-current assets	**538 283**	**548 542**	**(10 169)**	
TOTAL ASSETS	**588 242**	**627 892**	**(39 650)**	
LIABILITIES				
Current liabilities				
Deposits held	2 136	1 737	399	4
Payables	77 060	65 866	11 194	5
Borrowings and advances	51	41	10	6
Provisions	60 038	51 213	8 825	7
Other liabilities	1 483	2 520	(1 037)	8
Total current liabilities	**140 768**	**121 377**	**19 391**	
Non-current liabilities				
Borrowings and advances	4 012	3 635	377	6
Other liabilities	23 556	0	23 556	8
Total non-current liabilities	**27 568**	**3 635**	**23 933**	
TOTAL LIABILITIES	**168 336**	**125 012**	**43 324**	
NET ASSETS	**419 906**	**502 880**	**(82 974)**	
EQUITY				
Capital	409 857	411 751	(1 894)	
Reserves	167 263	151 879	15 384	9
Accumulated funds	(157 214)	(60 750)	(96 464)	8
TOTAL EQUITY	**419 906**	**502 880**	**(82 974)**	

Notes:

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

1. Consistent with end of year deficit.
2. Oral health inventories transitioned over from Department of Health.
3. Timing delay in receipt of standard quarterly invoice in advance.
4. Increase in private practice revenue held in the Accountable Officer's Trust Account.
5. Increase in unpaid expenditure.
6. Commencement of new long term finance leases on Aboriginal land.
7. Due to oral health, hearing and cancer screening program employees transitioning from Department of Health and increase in employee resources in line with additional funding.
8. Rental revenue received in advance.
9. Due to timing variance in budget.

TOP END HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

Cash Flow Statement	2016-17 Actual	2016-17 Original Budget	Variance	Note
CASH FLOWS FROM OPERATING ACTIVITIES	$000	$000	$000	
Operating receipts				
Grants and subsidies received				
Current	518 704	474 906	43 798	
Receipts from sales of goods and services	443 591	356 032	87 559	1
Total operating receipts	**962 295**	**830 938**	**131 357**	
Operating payments				
Payments to employees	(531 203)	(486 247)	(44 956)	
Payments for goods and services	(396 415)	(301 858)	(94 557)	1
Grants and subsidies paid				
Current	(35 988)	(36 202)	214	
Capital	(1 477)	0	(1 477)	2
Interest paid	(192)	0	(192)	3
Total operating payments	**(965 275)**	**(824 307)**	**140 968**	
Net cash from/(used in) operating activities	**(2 980)**	**6 631**	**(9 611)**	
CASH FLOWS FROM INVESTING ACTIVITIES				
Investing receipts				
Proceeds from asset sales	32	0	32	4
Total investing receipts	**32**	**0**	**32**	
Investing payments				
Purchases of assets	(4 296)	(6 631)	2 335	5
Total investing payments	**(4 296)**	**(6 631)**	**2 335**	
Net cash from/(used in) investing activities	**(4 264)**	**(6 631)**	**2 367**	
CASH FLOWS FROM FINANCING ACTIVITIES				
Financing receipts				
Deposits received	60	0	60	6
Equity injections				
Other equity injections	5 562	0	5 562	7
Total financing receipts	**5 621**	**0**	**5 621**	
Financing payments				
Finance lease payments	(60)	0	(60)	3
Equity withdrawals	(1 477)	0	(1 477)	8
Total financing payments	**(1 537)**	**0**	**(1 537)**	
Net cash from/(used in) financing activities	**4 084**	**0**	**4 084**	
Net increase/(decrease) in cash held	(3 160)	0	(3 160)	
Cash at beginning of financial year	5 666	27 645	(21 979)	
CASH AT END OF FINANCIAL YEAR	**2 506**	**27 645**	**(25 139)**	

Notes:

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

1. Predominantly rental revenue received in advance.
2. Budget for the program in Current Grants.
3. Interest paid for long term finance leases on Aboriginal land.
4. Gain on disposal of plant and equipment.
5. Decrease on planned capital equipment purchases.
6. Accountable Officer's Trust Account transactions.
7. Equity injection.
8. Predominantly relating to the restructure of oral health, hearing and cancer screening program from Department of Health.

Central Australia Health Services Financial Statement Overview

The 2016-17 financial statements and the accompanying notes for the Central Australia Health Service (the Health Service) have been prepared on an accrual basis in accordance with the Australian Accounting Standards. The Health Service's financial performance for the financial year and its financial position as at 30 June 2017 are reported in four financial statements: Comprehensive Operating Statement, Balance Sheet, Statement of Changes in Equity and Cash Flow Statement.

Main results at a glance

- Central Australia Health Service reported an operating deficit of $0.9 million, an improvement from last year's reported deficit of $4.6 million.
- Revenue was $393.8 million and within 1.74 per cent of budget targets.
- Expenses totalled $394.8 million and were contained within 0.07 per cent of budget targets.
- The equity position increased by $11.1 million in 2016-17 to $209.1 million.

Comprehensive Operating Statement

Summary	2016-17	2015-16	Variation	Variation
	$000	$000	$000	%
Operating Income	393 841	358 136	35 705	9.97
Operating Expenses	(394 773)	(362 752)	(32 021)	8.83
Net Deficit	**(932)**	**(4 616)**	**3 684**	
Other Comprehensive items	(2 547)	11 132	(13 679)	(122.88)
Comprehensive Result	(3 479)	6 516	(9 995)	

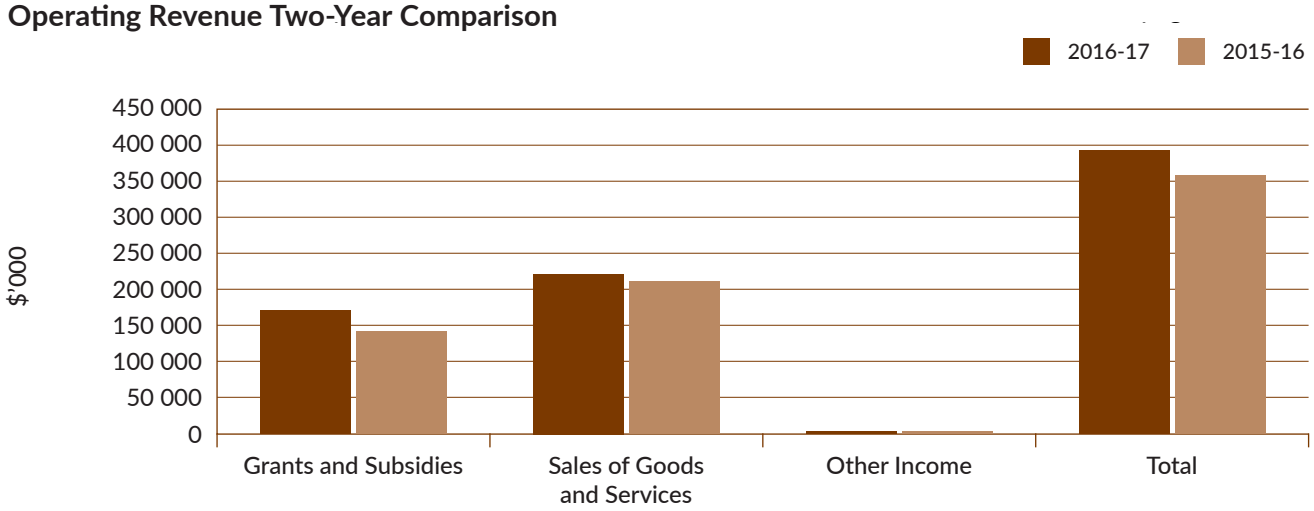
In 2016-17, the Comprehensive Operating Statement shows the Health Service had incurred a $0.9 million operating deficit, lower than last year's reported operating deficit by $3.7 million. Excluding $12.1 million of depreciation expense, which is not revenue funded, the Health Service resulted in an operating surplus of $11.2 million. The operating surplus (exclusive of depreciation) has been driven by sound financial management strategies, tight cost control measures, and the impact of delays in finalisation of contracts for renal services and in the delivery of alcohol and other drugs programs.

Operating Income

The Health Service's revenue includes operating revenue in the form of grants and subsidies as well as goods and services income. The total revenue for 2016-17 were $393.8 million, an increase of about $35.7 million from 2015-16.

The Health Service is largely funded by, and is dependent on, the receipt of Northern Territory (NT) Block Funding payments paid through the Department of Health (the Department). The remaining revenue predominantly relates to Activity Based Funding and National Partnership Payments from the Commonwealth and other funding sources.

Operating Revenue Two-Year Comparison



The major movement in income includes the following:

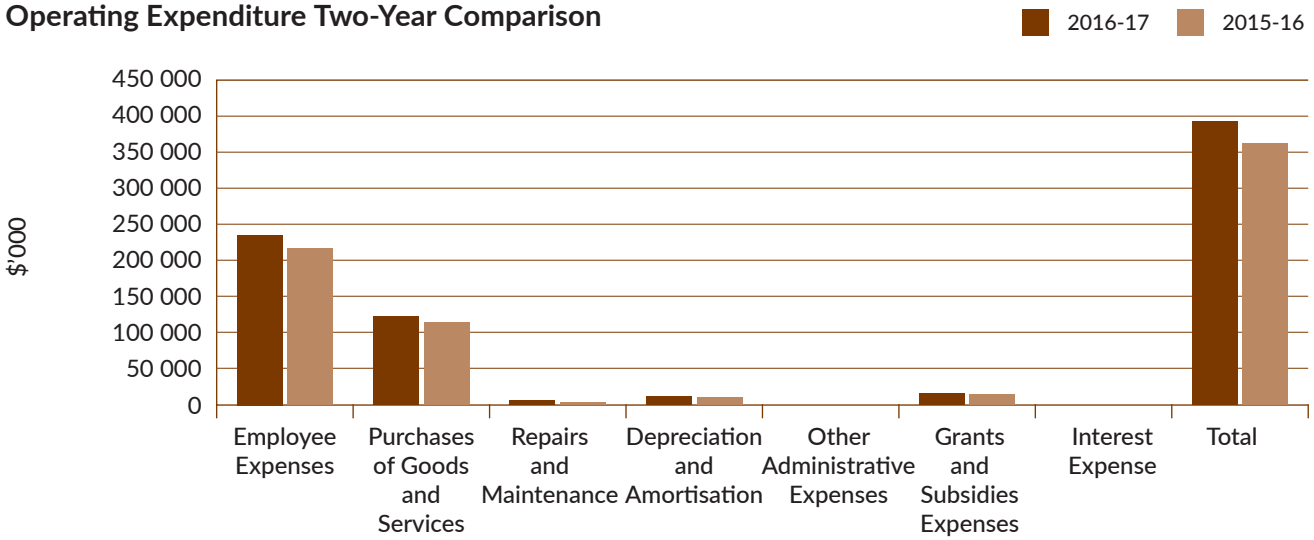
- *Grants and Subsidies* – the increase of $28.4 million relates primarily to increases in NT Block Funding of $18.1 million, including the transfer of Hearing and Oral Health services from the Department to the Health Service, funding of about $7.8 million in Commonwealth funded programs, predominantly in Remote Aboriginal Investment and Highly Specialised Drugs, and funding of $2.6 million from other funding sources; and
- *Sales of Goods and Services* – the increase of about $9.8 million primarily relates to additional funding received under the Commonwealth National Health Reform Agreement through Activity Based Funding and an increase in own-source revenue.

Operating Expenses

The Health Service's operating expenditure comprise mainly of employee expenses and purchases of goods and services in order to deliver the required public health services within Central Australia. The remainder relates to repairs and maintenance, grants and subsidies, other administrative expenses and depreciation.

In 2016-17 the Health Service incurred expenses of $394.8 million, an increase of $32.1 million or 8.83 per cent from the previous financial year which reflects the increased funding and cost of service delivery in the health sector. The increase is also due to the transfer of Hearing and Oral Health services from the Department to the Health Service.

Operating Expenditure Two-Year Comparison



The major movement in expenses incurred relates to the following:

- *Employee Expenses* – the increase of $20.1 million or 9.2 per cent reflects the 5.4 per cent increase in employees in 2016-17, which was partly due to the transfer of Hearing and Oral Health services from the Department to the Health Service, and the 3 per cent Enterprise Bargaining Agreement (EBA) increase during the year; and
- *Purchases of Goods and Services* – the increase of $7.7 million is predominantly due to additional funding in 2016-17 for the provision of health services and the transfer of Hearing and Oral Health services from the Department. Further details on Purchases of Goods and Services are provided in Note 4 of the Financial Statements.

Summary	2016-17 Final Budget $000	2016-17 Actual $000	Variation $000	Variation %
Operating Income	387,097	393,841	6,744	1.74
Operating Expenses	(394,487)	(394,773)	(286)	0.07
Net deficit	(7,390)	(932)	6,458	

The Health Service's performance in both revenue and expenditure shows a result with a minor variation from planned targets coming within 1.74 per cent and 0.07 per cent of the budget respectively.

Balance Sheet

Summary	2016-17 $000	2015-16 $000	Variation $000	Variation %
Assets	289 672	271 849	17 823	6.56
Liabilities	(80 589)	(73 884)	(6,705)	9.08
Net Assets	209 083	197 965	11 118	

Of the $289.7 million total assets, about 74 per cent or $213.6 million relates to property, plant and equipment while the remaining assets consist of current assets including cash and deposits, receivables, inventories and prepayments. The increase in total assets is the net result of the operating surplus (exclusive of depreciation) generated during the financial year and the restructures during the financial year. This is also partly due to increase in cash due to program delays.

The majority of the Health Service's liabilities relates to payables and employee provisions, where the combined balance as at 30 June 2017 accounts for 97 per cent of total liabilities. The remaining liabilities comprise of borrowings and advances, deposits held and other liabilities.

The increase in liabilities of $6.7 million is predominantly due to an increase of $4.3 million in payables and $1.7 million in provisions partly resulting from the transfer of Hearing and Oral Health services where the related employee provisions have been transferred to and assumed by the Health Service. Further details on provisions can be found in Note 13 *Provisions*.

Statement of Changes in Equity

Summary	2016-17 $000	2015-16 $000	Variation $000	Variation %
Equity, at 1 July	197 965	160 881	37 084	23.05
Accumulated Funds	(932)	(4 616)	3 684	(79.81)
Asset Revaluation Reserve	(2 547)	11 132	(13 679)	(122.88)
Net Equity Injections/Withdrawals	14 597	30 569	(15 972)	(52.25)
Equity, at 30 June	209 083	197 965	11 117	

The Statement of Changes in Equity reflects movements in equity balances during the financial year.

The increase in equity of $11.1 million was the net result of the following movements:

- $15.9 million of equity transferred in, mainly representing the value of completed capital works from the Department of Infrastructure, Planning and Logistics (DIPL) and the assets transferred from the Department in regards to Hearing and Oral Health services;
- $0.9 million deficit for the financial year;
- capital withdrawals of $0.3 million largely relating to liabilities assumed by the Health Service as a result of the restructure;
- $1.2 million of net assets transferred out to DIPL; and
- $2.5 million net revaluation decrement on land and buildings.

Cash Flow Statement

Summary	2016-17 $000	2015-16 $000	Variation $000	Variation %
Cash, at 1 July	11 044	6 968	4 076	58.5
Receipts	400 960	360 369	40 591	11.26
Payments	(392 130)	(355 978)	(36 152)	10.16
Equity Injections	0	0	0	0
Equity withdrawals	(288)	(315)	27	(8.57)
Cash, at 30 June	19 586	11 044	8 542	

The Cash Flow Statement shows the Health Service cash receipts and payments for the financial year. The statement incorporates revenues and expenses from the Comprehensive Operating Statement, after the elimination of all non-cash transactions, with cash movements from the Balance Sheet. The net result for 2016-17 is an increase of $8.5 million in cash balances compared to 2015-16, which is consistent with the operating surplus.

Auditor-General

Independent Auditor's Report to the Minister for Health

Central Australia Health Service

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Opinion

I have audited the accompanying financial report of Central Australia Health Service, which comprises the balance sheet as at 30 June 2017, and the comprehensive operating statement, statement of changes in equity and cash flow statement for the year then ended, a summary of significant accounting policies and other explanatory notes, and the certification of the financial statements by the Accountable Officer.

In my opinion, the financial report gives a true and fair view, in all material respects, of the financial position of Central Australia Health Service as at 30 June 2017, and of its financial performance and its cash flows for the year then ended in accordance with Australian Accounting Standards.

Basis for Opinion

I conducted my audit in accordance with Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. I am independent of Central Australia Health Service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. I have also fulfilled my other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Other Information

The Accountable Officer of the Department of Health is responsible for the other information. The other information comprises the information included in Central Australia Health Service's financial statement overview for the year ended 30 June 2017, but does not include the financial report and my auditor's report thereon.

My opinion on the financial report does not cover the other information and accordingly I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial report, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial report or my knowledge obtained in the audit or otherwise appears to be materially misstated.

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Responsibilities of the Accountable Officer for the Financial Report

The Accountable Officer 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.

In preparing the financial report, management is responsible for assessing Central Australia Health Service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate Central Australia Health Service or to cease operations, or has no realistic alternative but to do so.

Auditor-General

Page 2 of 2

Those charged with governance are responsible for overseeing Central Australia Health Service's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Report

My objectives are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial report.

As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 Central Australia Health Service's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on Central Australia Health Service's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause Central Australia Health Service to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Julie Crisp
Auditor-General for the Northern Territory

Darwin, Northern Territory

2 October 2017

Level 12 Northern Territory House 22 Mitchell Street Darwin 0800 Tel: 08 8999 7155

Central Australia Health Service Financial Statements

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 2017 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.

Professor Catherine Stoddart

Accountable Officer

5 September 2017

Sue Korner

Chief Operating Officer

5 September 2017

Murray Brown

A/Chief Finance Officer

5 September 2017

CENTRAL AUSTRALIA HEALTH SERVICE
COMPREHENSIVE OPERATING STATEMENT
For the year ended 30 June 2017

	Note	2017 $000	2016 $000
INCOME			
Grants and subsidies revenue			
Current		171 091	142 652
Sales of goods and services		221 954	212 165
Other income		796	3 319
TOTAL INCOME	3	**393 841**	**358 136**
EXPENSES			
Employee expenses		236 854	216 825
Administrative expenses			
Purchases of goods and services	4	123 298	115 574
Repairs and maintenance		5 794	4 384
Depreciation and amortisation	9	12 186	10 480
Other administrative expenses		223	372
Grants and subsidies expenses			
Current		15 721	14 230
Capital		659	849
Interest expenses		38	38
TOTAL EXPENSES	3	**394 773**	**362 752**
NET DEFICIT		**(932)**	**(4 616)**
OTHER COMPREHENSIVE INCOME			
Items that will not be reclassified to net deficit			
Changes in asset revaluation reserve	16	(2 547)	11 132
TOTAL OTHER COMPREHENSIVE INCOME		**(2 547)**	**11 132**
COMPREHENSIVE RESULT		**(3 479)**	**6 516**

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 2017

	Note	2017 $000	2016 $000
ASSETS			
Current Assets			
Cash and deposits	6	19 586	11 044
Receivables	7	53 068	47 926
Inventories	8	1 480	1 600
Prepayments		1 893	120
Total Current Assets		**76 027**	**60 690**
Non-Current Assets			
Property, plant and equipment	9,10	213 645	211 159
Total Non-Current Assets		**213 645**	**211 159**
TOTAL ASSETS		**289 672**	**271 849**
LIABILITIES			
Current Liabilities			
Deposits held	14	952	993
Payables	11	53 774	49 453
Borrowings and advances	12	9	9
Provisions	13	24 391	22 657
Other Liabilities	14	700	0
Total Current Liabilities		**79 826**	**73 112**
Non-Current Liabilities			
Borrowings and advances	12	763	772
Total Non-Current Liabilities		**763**	**772**
TOTAL LIABILITIES		**80 589**	**73 884**
NET ASSETS		**209 083**	**197 965**
EQUITY			
Capital		259 744	245 147
Asset revaluation reserve	16	10 774	13 321
Accumulated funds		(61 435)	(60 503)
TOTAL EQUITY		**209 083**	**197 965**

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 2017

	Note	Equity at 1 July	Comprehensive result	Transactions with owners in their capacity as owners	Equity at 30 June
		$000	$000	$000	$000
2016-17					
Accumulated Funds		(60 480)	(932)	0	(61 412)
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
		(60 503)	(932)	0	(61 435)
Asset Revaluation Reserve	16	13 321	(2 547)	0	10 774
Capital – Transactions with Owners					
Equity injections					
Equity transfers in		227 316	0	15 879	243 195
Other equity injections		49 778	0	0	49 778
Equity withdrawals					
Capital withdrawal		(31 939)	0	(288)	(32 227)
Equity transfers out		(8)	0	(994)	(1 002)
		245 147	0	14 597	259 744
Total Equity at End of Financial Year		**197 965**	**(3 479)**	**14 597**	**209 083**
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 Reserve	16	2 189	11 132	0	13 321
Capital – Transactions with Owners					
Equity injections					
Equity transfers in		196 432	0	30 884	227 316
Other equity injections		49 778	0	0	49 778
Equity withdrawals					
Capital withdrawal		(31 624)	0	(315)	(31 939)
Equity transfers out		(8)	0	0	(8)
		214 578	0	30 569	245 147
Total Equity at End of Financial Year		**160 880**	**6 516**	**30 569**	**197 965**

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 2017

	Note	2017 $000	2016 $000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Receipts			
Grants and subsidies received			
Current		171 091	142 652
Receipts from sales of goods and services		229 870	217 726
Total Operating Receipts		**400 961**	**360 378**
Operating Payments			
Payments to employees		(234 088)	(220 085)
Payments for goods and services		(139 231)	(119 546)
Grants and subsidies paid			
Current		(15 734)	(14 218)
Capital		(659)	(849)
Interest paid		(38)	(38)
Total Operating Payments		**(389 750)**	**(354 736)**
Net Cash From/(Used in) Operating Activities	17	**11 211**	**5 642**
CASH FLOWS FROM INVESTING ACTIVITIES			
Investing Payments			
Purchases of assets		(2 332)	(1 234)
Total Investing Payments		**(2 332)**	**(1 234)**
Net Cash From/(Used in) Investing Activities		**(2 332)**	**(1 234)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Financing Receipts			
Deposits received		(40)	(8)
Equity injections			
Other equity injections		0	0
Total Financing Receipts		**(40)**	**(8)**
Financing Payments			
Finance lease payments		(9)	(9)
Equity withdrawals		(288)	(315)
Total Financing Payments		**(297)**	**(324)**
Net Cash From/(Used in) Financing Activities		**(337)**	**(332)**
Net increase/(decrease) in cash held		8 542	4 076
Cash at beginning of financial year		11 044	6 968
CASH AT END OF FINANCIAL YEAR	6	**19 586**	**11 044**

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 2017

INDEX OF NOTES TO THE FINANCIAL STATEMENTS

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

1. OBJECTIVES AND FUNDING

The Central Australia Health Service's ("the Health Service") 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.

a) Machinery of Government Changes

Transfers In

Details of Transfer: Hearing and Oral units transferred from the Department of Health

Basis of Transfer: Administrative Arrangements Order 12 September 2016

Date of Transfer: Effective from 1 July 2016

The assets and liabilities transferred as a result of this change were as follows:

Assets	***$000***
Property, Plant and Equipment	*784*
	784
Liabilities	
Payables	*12*
Provisions	*353*
	365
Net Assets	***419***

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

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 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 the Health Service 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 Health Service 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 2016-17:

AASB 124 Related Party Disclosures

This standard applies to the not-for-profit sector for the first time in 2016-17. The accounting standard requires disclosures about the remuneration of key management personnel, transactions with related parties, and relationships between parent and controlled entities. For any such transactions, disclosures will include the nature of the related party relationship, as well as information about those transactions' terms/conditions and amounts, any guarantees given/received, outstanding receivables/payables, commitments, and any receivables where collection has been assessed as being doubtful.

Several other amending standards and AASB interpretations have been issued that apply to the current reporting periods, but are considered to have no impact on public sector reporting.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
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Standards and Interpretations Issued but Not Yet Effective

At the date of authorisation of the financial statements, the following standards and interpretations were in issue but are not yet effective and are expected to have a potential impact on future reporting periods:

AASB 16 Leases

AASB 16 Leases is effective for annual reporting periods beginning on or after 1 January 2019 and will be reported in these financial statements for the first time in 2019-20. When the standard is effective it will supersede AASB 117 Leases and requires the majority of leases to be recognised on the balance sheet.

For lessees with operating leases, a right-of-use asset will now come onto the balance sheet together with a lease liability for all leases with a term of more than 12 months, unless the underlying assets are of low value. The Comprehensive Operating Statement will no longer report operating lease rental payments, instead a depreciation expense will be recognised relating to the right-to-use asset and interest expense relating to the lease liability.

For lessors, the finance and operating lease distinction remains largely unchanged. For finance leases, the lessor recognises a receivable equal to the net investment in the lease. Lease receipts from operating leases are recognised as income either on a straight-line basis or another systematic basis where appropriate.

Consequently, it is expected that approximately $1.2 million in operating lease commitments will be required to be recognised in the balance sheet through a lease liability and corresponding right to use asset from 2019-20 in accordance with AASB 16 Leases. In the comprehensive income statement the operating lease expense will be replaced with a depreciation expense relating to the right to use asset and interest expense relating to the lease liability. These cannot be quantified at this time.

AASB 1058 Income for not-for-profit entities and AASB 15 Revenue from contracts with customers

AASB 1058 Income for Not-for-Profit Entities and AASB 15 Revenue with Contracts with Customers are effective for annual reporting periods beginning on or after 1 January 2019 and will be reported in these financial statements for the first time in 2019-20.

Under the new AASB 1058 Income for Not-for-Profit Entities, revenue from grants and donations will be recognised when any associated performance obligation to provide goods or services is satisfied, and not immediately upon receipt as currently occurs. Consequently, more liabilities will be recognised in the balance sheet after adoption of this standard.

AASB 1058 clarifies and simplifies income-recognition requirements that apply to not-for-profit entities in conjunction with AASB 15 Revenue from Contracts with Customers.

While the full impacts are yet to be determined, potential impacts identified include:

- Grants received to construct or acquire a non-financial asset will be recognised as a liability, and subsequently recognised as revenue as the performance obligations under the grant are satisfied. At present, such grants are recognised as revenue on receipt.
- Grants with an enforceable agreement and sufficiently specific performance obligations will be recognised as revenue progressively as the associated performance obligations are satisfied. At present, such grants are recognised as revenue on receipt.
- Grants that have an enforceable agreement but no specific performance obligations but have restrictions on the timing of expenditure will also continue to be recognised on receipt as time restriction on the use of funds is not sufficiently specific to create a performance obligation.

CENTRAL AUSTRALIA HEALTH SERVICE
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- Grants that are not enforceable and/or not sufficiently specific will not qualify for deferral, and continue to be recognised as revenue as soon as they are controlled.

Several other amending standards and AASB interpretations have been issued that apply to future reporting periods, but are considered to have limited impact on future financial reporting. For financial reporting purposes, the Health Service is a not-for-profit entity.

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. For financial reporting purposes, the Health Services is a not – for – profit entity.

The principal place of business of the Health Service is: 1st Floor Eurilpa House, Alice Springs NT 0870.

d) Comparatives

Where necessary, comparative information for the 2015-16 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 2016-17 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.

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.

CENTRAL AUSTRALIA HEALTH SERVICE
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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 (TER)

The Northern Territory Tax Equivalents Regimes improve competitive neutrality between public and private sector entities. The TER levies the equivalent of Commonwealth 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 recognised for the Central Australia Health Service as the Health Service is in a deficit position for the year ended 30 June 2017.

i) Contributions by and Distributions to Government

The Health Service may receive contributions from Government where the Government is acting as owner of the Health Service. Conversely, the Health Service 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 Health Service as adjustments to equity.

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

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

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	
		2017	2016	2017	2016	2017	2016	2017	2016	2017	2016
		$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
INCOME											
Grants and subsidies revenue											
Current		10 154	7 562	4 641	1 527	15 239	14 146	141 056	119 417	171 090	142 652
Sales of goods and services		9 929	9 248	327	492	2 714	2 260	208 984	200 165	221 954	212 165
Other income		426	281	55	3 013	316	25	0	0	797	3 319
TOTAL INCOME		20 509	17 091	5 023	5 032	18 269	16 431	350 040	319 582	393 841	358 136
EXPENSES											
Employee expenses		167 850	156 699	21 061	21 350	43 289	36 393	4 654	2 383	236 854	216 825
Administrative expenses											
Purchases of goods and services	4	67 508	64 719	3 657	3 627	13 920	12 291	38 213	34 937	123 298	115 574
Repairs and maintenance		4 842	3 746	0	0	952	638	0	0	5 794	4 384
Depreciation and amortisation	9	1 300	1 426	22	18	263	166	10 601	8 870	12 186	10 480
Other administrative expenses		194	334	3	9	26	29	0	0	223	372
Grants and subsidies expenses											
Current		518	535	954	1 113	1 218	1 190	13 031	11 392	15 721	14 230
Capital		0	0	0	0	0	0	659	849	659	849
Interest expenses		0	0	0	0	38	38	0	0	38	38
TOTAL EXPENSES		242 212	227 459	25 697	26 117	59 706	50 745	67 158	58 431	394 773	362 752
NET SURPLUS/DEFICIT		(221 703)	(210 368)	(20 674)	(21 085)	(41 437)	(34 314)	282 882	261 151	(932)	(4 616)
OTHER COMPREHENSIVE INCOME											
Items that will not be reclassified to net surplus/deficit											
Changes in asset revaluation reserve		0	0	0	0	0	0	(2 547)	11 132	(2 547)	11 132
TOTAL OTHER COMPREHENSIVE INCOME		0	0	0	0	0	0	(2 547)	11 132	(2 547)	11 132
COMPREHENSIVE RESULT		(221 703)	(210 368)	(20 674)	(21 085)	(41 437)	(34 314)	280 335	272 283	(3 479)	6 516

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
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Income

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 Health Service 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 Health Service 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 Health Service; 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 2017

4. PURCHASES OF GOODS AND SERVICES

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

	2017 $000	2016 $000
Goods and services expenses:		
Property Maintenance	4 274	3 684
General Property Maintenance	3 418	3 910
Power	3 763	4 262
Water and Sewerage	781	796
Land Rent	63	56
Accommodation	572	210
Advertising[1]	2	12
Agent Service Agreements	24 087	23 596
Audit Fees	56	30
Bank Charges	20	15
Client Travel	6 522	6 431
Clothing	136	75
Communications	1 407	1 227
Consultant Fees[2]	290	96
Consumable/General Expenses	3 710	2 054
Cross Border Patient Charges	15 320	14 684
Document Production	483	511
Entertainment/Hospitality	27	16
Food	2 112	2 190
Freight	448	380
Information Technology Charges	5 849	5 777
IT Consultants	70	24
IT Hardware and Software Expenses	393	445
Insurance Premiums	13	14
Laboratory Expense	151	55
Legal Expenses[3]	96	8
Library Services	32	18
Marketing and Promotion[4]	145	85
Medical/Dental Supply and Services	34 960	32 167
Membership and Subscriptions	88	71
Motor Vehicle Expenses	3 340	2 951
Office Requisites and Stationery	717	717
Office Duty Fares	1 714	1 542
Other Equipment Expenses	2 796	2 175
Recruitment Expenses[5]	4 009	4 129
Reg/Advisory Boards/Committees	45	48
Relocation Expenses	15	38
Training and Study Expenses	837	648
Transport Equipment Expenses	8	3
Travelling Allowance	534	428
Unallocated Corporate Credit Card Expenses	(6)	(4)
Penalty Interest –Late Payments	1	0
Total Purchases of Goods and Services	**123 298**	**115 574**

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

(2) Does not include recruitment, advertising or marketing and promotion advertising.
(3) Includes legal fees, claims and settlement costs.
(4) Includes advertising for marketing and promotion but excludes marketing and promotion consultants' expenses, which are incorporated in the consultants' category.
(5) Includes recruitment-related advertising costs.

Repairs and Maintenance Expense

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

Interest Expense

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

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

	Health Service		Health Service		Territory Items		Territory Items	
	2017	No. of Trans.	2016	No. of Trans.	2017	No. of Trans.	2016	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*	58	85	9	11	0	0	0	0
Losses or deficiencies of money written off	0	0	0	0	0	0	0	0
Public property written off	79	15	1	2	0	0	0	0
Waiver or postponement of right to receive or recover money or property	0	0	0	0	0	0	0	0
Total Written Off, Postponed and Waived by Delegates	**137**	**100**	**10**	**13**	**0**	**0**	**0**	**0**
Amounts written off, postponed and waived by the Treasurer								
Irrecoverable amounts payable to the Territory or an agency written off	88	6	0	0	0	0	0	0
Losses or deficiencies of money written off	0	0	0	0	0	0	0	0
Public property written off	0	0	0	0	0	0	0	0
Waiver or postponement of right to receive or recover money or property	0	0	0	0	0	0	0	0
Total Written Off, Postponed and Waived by the Treasurer	**88**	**6**	**0**	**0**	**0**	**0**	**0**	**0**
Write-offs, Postponements and Waivers Authorised Under Other Legislation	**0**	**0**	**0**	**0**	0	0	0	0
Gifts Under the *Financial Management Act*	**0**	**0**	**0**	**0**	0	0	0	0
Gifts Authorised Under Other Legislation	**0**	**0**	**0**	**0**	0	0	0	0
Ex Gratia Payments Under the *Financial Management Act*	**0**	**0**	**0**	**0**	0	0	0	0

* Increase is due to the implementation of improved processes in debt management. Number of write-offs in 2016/17 goes back several years.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

	2017	2016
	$000	$000

6. CASH AND DEPOSITS

Cash on hand	7	7
Cash at bank	19 579	11 037
Total Cash and Deposits	**19 586**	**11 044**

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 22.

7. RECEIVABLES

Current

Accounts receivable	1 919	1 988
Less: Allowance for impairment losses	(637)	(729)
	1 282	1 259
GST receivables	1 290	961
Other receivables [(1)]	50 496	45 706
	51 786	46 667
Total Receivables	**53 068**	**47 926**

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 Health Service 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 18 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.

[(1)] Includes accrued revenue and cross border receivables.

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.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
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8. INVENTORIES

	2017	2016
Inventories Held for Distribution	$000	$000
At current replacement cost	1 480	1 600
Total Inventories	**1 480**	**1 600**

During the year the Central Australia Health Service was required to write-off $0.07m ($0.09m 2015-16) of inventories, the majority being pharmaceuticals due to their short shelf life and the necessity to keep certain lifesaving items on hand.

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.

9. PROPERTY, PLANT AND EQUIPMENT

Land		
At fair value	4 403	4 545
Buildings		
At fair value	382 936	377 756
Less: Accumulated depreciation	(182 383)	(178 697)
Less: Accumulated impairment loss	(13)	(13)
	200 540	199 046
Plant and Equipment		
At capitalised cost	26 377	25 737
Less: Accumulated depreciation	(17 759)	(18 354)
Less: Accumulated impairment loss	(659)	(580)
	7 959	6 803
Leased Land		
At fair value	852	852
Less: Accumulated depreciation	(109)	(87)
	743	765
Total Property, Plant and Equipment	**213 645**	**211 159**

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
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9. PROPERTY, PLANT AND EQUIPMENT (continued)

2017 Property, Plant and Equipment Reconciliations

A reconciliation of the carrying amount of property, plant and equipment at the beginning and end of 2016-17 is set out below:

	Land	Buildings	Plant and Equipment	Leased Land	Total
	$000	$000	$000	$000	$000
Carrying Amount as at 1 July 2016	4 545	199 046	6 803	765	211 159
Additions	0	0	2 332	0	2 332
Disposals	0	0	0	0	0
Depreciation/Amortisation	0	(10 528)	(1 636)	(22)	(12 186)
Additions/(Disposals) from administrative restructuring	0	0	0	0	0
Additions/(Disposals) from asset transfers	0	14 426	539	0	14 965
Revaluation increments/(decrements)	(143)	(2 404)	0	0	(2 547)
Impairment losses	0	0	(79)	0	(79)
Impairment losses reversed	0	0	0	0	0
Other movements	0	0	0	0	0
Carrying Amount as at 30 June 2017	**4 403**	**200 540**	**7 959**	**743**	**213 645**

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	4 225	166 217	7 162	786	178 390
Additions	0	0	1 234	0	1 234
Disposals	0	0	0	0	0
Depreciation/Amortisation	0	(8 796)	(1 663)	(21)	(10 480)
Additions/(Disposals) from administrative restructuring	0	0	0	0	0
Additions/(Disposals) from asset transfers	786	30 027	71	0	30 884
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**	**6 804**	**765**	**211 159**

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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 Health Service 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, Planning and Logistics is responsible for managing general government capital works projects on a whole of Government basis. Therefore appropriation for all capital works is provided directly to the Department of Infrastructure, Planning and Logistics 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 Health Service.

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.

The latest revaluations as at 30 June 2017 were independently conducted. The valuer was Territory Property Consultants Pty Ltd. Refer to Note 10: Fair Value Measurement of Non-Financial Assets for additional disclosures.

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 Health Service 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 Health Service 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.

CENTRAL AUSTRALIA HEALTH SERVICE
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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 reserve.

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 reserve. Note 16 provides additional information in relation to the asset revaluation reserve.

The Health Service property, plant and equipment assets were assessed for impairment as at 30 June 2017. As a result of this review $79,477 of impairment losses were recognised against plant and equipment. Impairment losses were charged to expenses.

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.

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

	2017 and 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

Leased land are amortised over the life of the lease.

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

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
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Leased Assets

Leases under which the Health Service 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.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
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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
2016-17				
Asset Classes				
Land (Note 9)	0	0	4 403	4 403
Buildings (Note 9)	0	0	200 540	200 540
Plant and Equipment(Note 9)	0	0	7 959	7 959
Total	**0**	**0**	**212 902**	**212 902**
2015-16				
Asset Classes				
Land (Note 9)	0	0	4 545	4 545
Buildings (Note 9)	0	0	199 046	199 046
Plant and Equipment(Note 9)	0	0	6 803	6 803
Total	**0**	**0**	**210 394**	**210 394**

There were no transfers between Level 1 and Levels 2 or 3 during 2016-17.

b) Valuation Techniques and Inputs

Valuation techniques used to measure fair value in 2016-17 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 2015-16 to 2016-17.

The Territory Property Consultants Pty Ltd has provided valuations for the land and buildings assets.

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.

CENTRAL AUSTRALIA HEALTH SERVICE
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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
2016-17			
Fair value as at 1 July 2016	4 545	199 046	6 803
Additions	0	16 839	2 939
Disposals	0	(2 413)	(68)
Depreciation	0	(10 528)	(1 636)
Gains/losses recognised in net surplus/deficit	0	0	(79)
Gains/losses recognised in other comprehensive income	(143)	(2 404)	0
Fair value as at 30 June 2017	**4 402**	**200 540**	**7 959**
2015-16			
Fair value as at 1 July 2015	4 225	166 217	7 162
Additions	786	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	0
Fair value as at 30 June 2016	**4 545**	**199 046**	**6 804**

(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 Health Service 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.

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		2017	2016
		$000	$000
11.	**PAYABLES**		
	Accounts payable	2 529	1 140
	Accrued expenses(1)	51 245	48 301
	Other payables	0	12
	Total Payables	**53 774**	**49 453**

(1) Includes liability for cross border patient expenses and other accrued operational expenses

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 Health Service. Accounts payable are normally settled within 30 days.

12.	**BORROWINGS AND ADVANCES**		
	Current		
	Finance lease liabilities(1)	9	9
		9	9
	Non-Current		
	Finance lease liabilities(1)	763	772
		763	772
	Total Borrowings and Advances	**772**	**781**

(1) Finance leases relate to long term leases on Aboriginal land.

13.	**PROVISIONS**		
	Current		
	Employee benefits		
	Recreation leave	19 615	17 945
	Leave loading	2 726	2 823
	Recreation leave fares and other benefits	33	28
	Other current provisions		
	Other provisions – includes provisions for superannuation and Fringe Benefits Tax payable	2 017	1 861
	Total Provisions	**24 391**	**22 657**

The Health Service employed 1,791 employees as at 30 June 2017 (1,699 employees as at 30 June 2016).

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.

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.

CENTRAL AUSTRALIA HEALTH SERVICE
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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 Health Service financial statements.

	2017	2016
	$000	$000
14. OTHER LIABILITIES		
Current		
Deposit held (1)	952	993
Other liabilities	700	0
	1 652	**993**

Total Other Liabilities

(1) Accountable Officers Trust Account Governing Council bank account and Hospital Gift Funds

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 Health Service 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 Health Service financial statements.

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NOTES TO THE FINANCIAL STATEMENTS
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15. COMMITMENTS

Disclosures in relation to capital and other commitments, including lease commitments. Commitments are those contracted as at 30 June where the amount of the future commitment can be reliably measured.

	2017		2016	
	Internal	External	Internal	External
	$000	$000	$000	$000
(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	2 272	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	**2 272**	**0**	**0**
(ii) Operating Lease Commitments				
The Health Service leases property under non-cancellable operating leases expiring from 3 to 5 years. Leases generally provide the health service with a right of renewal at which time all lease terms are renegotiated. The Health Service 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	1 289	0	1 467
Later than one year and not later than five years	0	2 617	0	3 388
Later than five years	0	453	0	770
	0	**4 359**	**0**	**5 625**
(iii) Other Expenditure Commitments				
Other non-cancellable expenditure commitments not recognised as liabilities are payable as follows:				
Within one year	0	15 925	0	8 932
Later than one year and not later than five years	0	35 627	0	5 644
Later than five years	0	0	0	0
	0	**51 552**	**0**	**14 576**

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16. RESERVES

	2017	2016
Asset Revaluation Reserve	$000	$000

(i) Nature and purpose of the asset revaluation reserve

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 reserve.

(ii) Movements in the asset revaluation reserve

Balance as at 1 July	13 321	2 189
Increment/(Decrement) – land	(143)	(466)
Increment/(Decrement) – buildings	(2 404)	11 598
Increment/(Decrement) – plant and equipment	0	1
Balance as at 30 June	**10 774**	**13 321**

17. NOTES TO THE CASH FLOW STATEMENT

	2017	2016
Reconciliation of Cash	$000	$000

The total of Health Service 'Cash and deposits' of $19 586 000 recorded in the Balance Sheet is consistent with that recorded as 'Cash' in the Cash Flow Statement.

Reconciliation of Net Deficit to Net Cash from Operating Activities

Net Deficit	(932)	(4 616)
Non-cash items:		
Depreciation and amortisation	12 186	10 480
Asset write-offs/write-downs	146	88
Assets acquired below fair value	(80)	0
Changes in assets and liabilities:		
Decrease/(Increase) in receivables	(5 142)	(8 365)
Decrease/(Increase) in inventories	53	269
Decrease/(Increase) in prepayments	(1 773)	154
(Decrease)/Increase in payables	4 320	5 572
(Decrease)/Increase in provision for employee benefits	1 576	1 880
(Decrease)/Increase in other provisions	157	180
(Decrease)/Increase in other liabilities	700	0
Net Cash from Operating Activities	**11 211**	**5 642**

Non-Cash Financing and Investing Activities

During the financial year the Health Service acquired buildings with an aggregate fair value of $14.9 million by non-cash asset transfers from the Department of Infrastructure, Planning and Logistics.

CENTRAL AUSTRALIA HEALTH SERVICE
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For the year ended 30 June 2017

18. 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.

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 Health Service'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.

CENTRAL AUSTRALIA HEALTH SERVICE
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a) Categorisation of Financial Instruments

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

2016-17 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	19 586	0	0	0	0	19 586
Receivables [1]	0	0	0	51 778	0	0	51 778
Total Financial Assets	**0**	**19 586**	**0**	**51 778**	**0**	**0**	**71 364**
Deposits held [1]	0	0	952	0	0	0	952
Payables [1]	0	53 774	0	0	0	0	53 774
Finance Lease Liabilities	0	0	0	0	0	772	772
Total Financial Liabilities	**0**	**53 774**	**952**	**0**	**0**	**772**	**55 498**

[1] Total amounts disclosed here exclude statutory amounts

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 here exclude statutory amounts

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

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; 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.

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.

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

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market other than those held for trading and available for sale. Loans and receivables exclude statutory receivables.

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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.

b) Credit Risk

The Health Service has limited credit risk exposure (risk of default). In respect of any dealings with organisations external to Government, the Health Service 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 Health Service'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 in the following table.

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Internal Receivables	Aging of Receivables	Aging of Impaired Receivables	Net Receivables
	$000	$000	$000
2016-17			
Not overdue	3	0	3
Overdue for less than 30 days	13	0	13
Overdue for 30 to 60 days	0	0	0
Overdue for more than 60 days	60	0	60
Total	**76**	**0**	**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**

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	0
Written off during the year	0
Recovered during the year	0
Increase/(Decrease) in allowance recognised in profit or loss	0
Total	**0**

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External Receivables	Aging of Receivables	Aging of Impaired Receivables	Net Receivables
	$000	$000	$000
2016-17			
Not overdue	560	0	560
Overdue for less than 30 days	264	0	264
Overdue for 30 to 60 days	106	0	106
Overdue for more than 60 days	913	637	276
Total	**1 843**	**637**	**1 206**

Reconciliation of the Allowance for Impairment Losses

Opening	729
Written off during the year	(146)
Recovered during the year	0
Increase/(Decrease) in allowance recognised in profit or loss	54
Total	**637**

2015-16			
Not overdue	526	0	526
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	**1 946**	**729**	**1 215**

Reconciliation of the Allowance for Impairment Losses

Opening	509
Written off during the year	(9)
Recovered during the year	0
Increase/(Decrease) in allowance recognised in profit or loss	229
Total	**729**

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c) Liquidity Risk

Liquidity risk is the risk that the Health Service will not be able to meet its financial obligations as they fall due. The Health Service'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 Health Service's remaining contractual maturity for its financial assets and liabilities.

2017 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	19 586	19 586	0
Receivables	0	0	0	0	0	0	51 778	51 778	0
Total Financial Assets	**0**	**0**	**0**	**0**	**0**	**0**	**71 364**	**71 364**	
Liabilities									
Deposits held	0	0	0	0	0	0	952	952	0
Payables	0	0	0	0	0	0	53 774	53 774	0
Finance lease liabilities	0	0	0	9	54	709	0	772	4.72
Total Financial Liabilities	**0**	**0**	**0**	**9**	**54**	**709**	**54 726**	**55 498**	

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
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
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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 the Health Service 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

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 Health Service 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 Health Service 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:

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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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.

2017	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	19 586	19 586	0	0	19 586
Receivables	51 778	51 778	0	0	51 778
Total Financial Assets	**71 364**	**71 364**	**0**	**0**	**71 364**
Financial Liabilities					
Deposits held	952	952	0	0	952
Payables	53 774	53 774	0	0	53 774
Finance lease liabilities	772	772	0	0	772
Total Financial Liabilities	**55 498**	**55 498**	**0**	**0**	**55 498**

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**

There were no changes in valuation techniques during the period.

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19. RELATED PARTIES

i) Related Parties

The Central Australia Health Service is a government administrative entity and is wholly owned and controlled by the Territory Government. Related parties of the Health Service include:

- the Portfolio Minister and key management personnel (KMP) because they have authority and responsibility for planning, directing and controlling the activities of the Health Service directly; and
- spouses, children and dependants who are close family members of the Portfolio Minister or KMP; and
- all public sector entities that are controlled and consolidated into the whole of government financial statements; and
- any entities controlled or jointly controlled by KMP's or the Portfolio Minister or controlled or jointly controlled by their close family members.

ii) Key Management Personnel (KMP)

Key management personnel of the Central Australia Health Service are those persons having authority and responsibility for planning, directing and controlling the activities of the entity. These include the Minister of Health, the Chief Executive Officer, the members of the Hospital Board, the Chief Operating Officer and other members of the executive leadership team.

iii) Remuneration of Key Management Personnel

The details below exclude the salaries and other benefits of the Minister of Health as the Minister's remunerations and allowances are payable by the Department of the Legislative Assembly and consequently disclosed within the Treasurer's Annual Financial Statements. They also exclude the CEO as these details are disclosed in the Department of Health financial statements.

The aggregate compensation of key management personnel of Central Australia Health Service is set out below:

	2016-17
	$000
Short-term benefits	2 962
Post-employment benefits	278
Total	**3 240**

iv) Related party transactions:

Transactions with Northern Territory Government controlled entities

The following table provides quantitative information about related party transactions entered into during the year with Northern Territory Government controlled entities.

Related party	Revenue from related parties	Payments to related parties	Amounts owed by related parties	Amounts owed to related parties
	$000	$000	$000	$000
All NTG Government departments	351 324	39 196	595	778

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The Health Service's primary ongoing source of funding is received from the Department of Health in the form of Activity Based and Block funding payments, on-passed Commonwealth Own Purpose Expenditure funding and national partnership revenue.

Significant payments to related parties include corporate services charges to Department of Health and Department of Corporate and Information Services.

The Health Service also transacts with other government entities, however these are not individually significant.

Other related party transactions

Given the breadth and depth of Territory Government activities, related parties will transact with the Territory Public sector in a manner consistent with other members of the public including paying stamp duty and other government fees and charges and therefore these transactions have not been disclosed. All other related party transactions in excess of $10,000 have been provided in the table below.

Transaction type	Transaction value for year ended 30 June 2017	Net receivable/ (payable) as at 30 June 2017	Commitments as at 30 June 2017
	$000	$000	$000
Purchases of goods and services [1]	25	(1)	0

[1] CAHS purchased goods and services worth $25,483 during the year from an entity controlled by a close family member of KMP, of which $1,210 was payable as at year end.

The amounts outstanding are unsecured and will be settled in cash. No guarantees have been given or received. No expense has been recognised in the current year for bad or doubtful debts in respect of the amounts owed by related parties.

Related party transactions of the former minister have not been assessed as the period served during the 2016-17 financial year is considered minor.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
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20. CONTINGENT LIABILITIES AND CONTINGENT ASSETS

a) Contingent Liabilities

The Central Australia Health Service had no contingent liabilities as at 30 June 2017 or 30 June 2016.

b) Contingent Assets

The Central Australia Health Service had no contingent assets as at 30 June 2017 or 30 June 2016.

21. 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.

22. 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 2016	Receipts	Payments	Closing Balance 30 June 2017
Private practice revenue	205 470	573 564	490 252	288 782
Bond money	330 778	160 203	138 136	352 845
Unclaimed money	125 058	(99 944)	(558)	25 672
	661 306	**633 823**	**627 830**	**667 300**

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

23. BUDGETARY INFORMATION

Comprehensive	2016-17 Actual	2016-17 Original Budget	Variance	Note
	$000	$000	$000	
INCOME				
Grants and subsidies revenue				
Current	171 091	166 630	4 461	
Sales of goods and services	221 954	211 245	10 709	
Other income	796	30	766	1
TOTAL INCOME	**393 841**	**377 905**	**15 936**	
EXPENSES				
Employee expenses	236 854	213 697	23 157	2
Administrative expenses				
Purchases of goods and services	123 298	140 297	(16 999)	2
Repairs and maintenance	5 794	6 100	(306)	
Depreciation and amortisation	12 186	10 049	2 137	3
Other administrative expenses	223	0	223	4
Grants and subsidies expenses				
Current	15 721	16 094	(373)	
Capital	659	0	659	5
Interest expenses	38	0	38	6
TOTAL EXPENSES	**394 773**	**386 237**	**8 535**	
NET DEFICIT	**(932)**	**(8 332)**	**7 400**	
OTHER COMPREHENSIVE INCOME				
Items that will not be reclassified to net deficit				
Changes in asset revaluation reserve	(2 547)	0	(2 547)	7
TOTAL OTHER COMPREHENSIVE INCOME	**(2 547)**	**0**	**(2 547)**	
COMPREHENSIVE RESULT	**(3 479)**	**(8 332)**	**4 853**	

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

1. Salary recoveries.
2. Additional activity in line with additional funding along with a category of cost misalignment.
3. Higher than expected depreciation.
4. Write-offs and bad debt expenditure not budgeted.
5. Budget for the program in current grants.
6. Interest paid for long term finance leases on Aboriginal land.
7. Land and building revaluation decrement.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

Balance Sheet	2016-17 Actual	2016-17 Original Budget	Variance	Note
	$000	$000	$000	
ASSETS				
Current Assets				
Cash and deposits	19 586	8 960	10 626	1
Receivables	53 068	39 563	13 505	2
Inventories	1 480	1 956	(476)	3
Prepayments	1 893	274	1 619	4
Total Current Assets	76 027	50 753	25 274	
Non-Current Assets				
Property, plant and equipment	213 645	197 357	16 288	
Total Non-Current Assets	213 645	197 357	16 288	
TOTAL ASSETS	**289 672**	**248 110**	**41 562**	
LIABILITIES				
Current Liabilities				
Deposits held	952	1 001	(49)	
Payables	53 774	43 885	9 889	5
Borrowings and advances	9	9	0	
Provisions	24 391	20 597	3 794	6
Other liabilities	700	0	700	7
Total Current Liabilities	**79 826**	**65 492**	**14 334**	
Non-current liabilities				
Borrowings and advances	763	781	(18)	
Total Non-Current Liabilities	**763**	**781**	**(18)**	
TOTAL LIABILITIES	**80 589**	**66 273**	**14 316**	
NET ASSETS	**209 083**	**181 837**	**27 246**	
EQUITY				
Capital	259 774	249 921	9 853	
Asset revaluation reserve	10 744	2 189	8 555	8
Accumulated funds	(61 435)	(70 273)	8 838	1
TOTAL EQUITY	**209 083**	**181 837**	**27 246**	

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

1. Consistent with end of year surplus.
2. Predominantly from cross border receivables.
3. Reduction in medical/oral sundries.
4. Contract prepayment.
5. Increase in unpaid expenditure.
6. Due to oral health and hearing program employees transitioning from Department of Health and increase in employee resources in line with additional funding.
7. Recognition of NT block funding from Department of Health.
8. Revaluation for remote health clinics.

CENTRAL AUSTRALIA HEALTH SERVICE
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

Cash Flow Statement	2016-17 Actual $000	2016-17 Original Budget $000	Variance $000	Note
CASH FLOWS FROM OPERATING ACTIVITIES				
Operating receipts				
Grants and subsidies received				
Current	171 091	166 630	4 461	
Receipts from sales of goods and services	229 870	211 275	18 595	
Total operating receipts	**400 961**	**377 905**	**23 056**	
Operating payments				
Payments to employees	(234 088)	(213 697)	(20 391)	
Payments for goods and services	(139 231)	(146 397)	7 166	
Grants and subsidies paid				
Current	(15 734)	(16 094)	360	
Capital	(659)	0	(659)	1
Interest paid	(38)	0	(38)	2
Total operating payments	**(389 750)**	**(376 188)**	**(13 562)**	
Net cash from/(used in) operating activities	**11 211**	**1 717**	**9 494**	
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	(2 332)	(1 735)	(597)	3
Total investing payments	**(2 332)**	**(1 735)**	**(597)**	
Net cash from/(used in) investing activities	**(2 332)**	**(1 735)**	**(597)**	
CASH FLOWS FROM FINANCING ACTIVITIES				
Financing receipts				
Deposits received	(40)	0	(40)	4
Total financing receipts	**(40)**	**0**	**(40)**	
Financing payments				
Finance lease payments	(9)	0	(9)	2
Equity withdrawals	(288)	0	(288)	5
Total financing payments	**(297)**	**0**	**(297)**	
Net cash from/(used in) financing activities	**(337)**	**0**	**(337)**	
Net increase/(decrease) in cash held	8 542	(18)	8 560	
Cash at beginning of financial year	11 044	8 978	2 066	
CASH AT END OF FINANCIAL YEAR	**19 586**	**8 960**	**10 626**	

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

1. Budget for the program in current grants.
2. Interest paid for long term finance leases on Aboriginal land.
3. Increase on planned capital equipment purchases.
4. Accountable Officer's Trust Account transactions.
5. Predominantly relating to the restructure of oral health and hearing program from Department of Health.

Evacuation at Mt Ives Station RFDS Central Operations

8. APPENDICES

Glossary

AGPAL - Australian General Practice Accreditation Limited

AHMAC – Australian Health Advisory Council

AHPPC – Australian Health Protection Principal Committee

AOD - Alcohol and Other Drugs

ARF – Acute rheumatic fever

ASH – Alice Springs Hospital

ASCC – Alice Springs Correctional Centre

CAHS - Central Australia Health Service

CDC - Centre for Disease Control

CEO – Chief Executive Officer

CHO – Chief Health Officer

CLEaRS – Clinical Learning, Education and Research

DoH - Department of Health

DTP – Diphtheria-pertussis-tetanus

eMMa – Electronic Medication Management Application

EMT – Emergency Medical Terms

FTE - Fulltime Equivalent

GTNT – Group Training Northern Territory

HU5K – Healthy under 5 Kids

ICT – Information and Communications Technology

IPP – Information Privacy Principals

ISR - Incident Severity Rating

IT – Information Technology

LED – Light Emitting Diode

LTBI - Latent Tuberculosis Infection

METC - Medical Education and Training Centre

NATA - National Association of Testing Authorities

NHS – National Health Service

NHCCTRC – National Critical Care and Trauma Response Centre

NT - Northern Territory

NTPS - Northern Territory Public Service

NT PHN – Northern Territory Primary Heath Network

NWAU - National Weighted Activity Units

PET – Position Emission Tomography

PFAS - Per- and poly-fluoro alkyl substances

PFASIWG - PFAS Interagency Working Group

PHC - Primary Health Care

PSEMA – Public Sector Employment Management Act

PTE - Part-time Equivalent

RACGP - Royal Australian College of General Practitioners

RED - Research, Education and Development

RHD - Rheumatic Heart Disease

SAB – Staphylococcus Aureus Bacteraemia

SDA – Service Delivery Agreement

SHBBVU - Sexual Health and Blood Borne Virus Unit

SIMSC – Strategic Information Management Committee

TB – Tuberculosis

TEHS – Top End Health Service

VSA – Volatile Substance Abuse

WHO – World Health Organisation

WHS - Work Health and Safety

WPP - Work Partnership Plan

Grant Recipients

2016-17 FY Grant and Subsidy Disbursement Data	
ABORIGINAL HOSTELS LTD	518,750.00
ALICE SPRINGS TOWN COUNCIL	30,000.00
AMITY COMMUNITY SERVICES INC	443,733.00
AMSANT INCORPORATED	900,000.00
ANGLICARE N.T. LTD.	1,645,862.00
ANIMAL MANAGEMENT IN RURAL & REMOTE INDIGENOUS COMMUNITIES INC	52,000.00
ANYINGINYI HEALTH ABORIGINAL CORPORATION	316,013.00
ARTBACK NT INCORPORATED	54,990.91
ARTHRITIS FOUNDATION OF THE NORTHERN TERRITORY INC	87,144.00
ASSOCIATION OF ALCOHOL AND OTHER DRUG AGENCIES NT INCORPORATED	162,193.00
ASTHMA FOUNDATION OF THE NT INC	305,292.00
AUSTRALIAN BREASTFEEDING ASSOCIATION	20,504.00
AUSTRALIAN INDIGENOUS LEADERSHIP CENTRE LTD	68,181.82
AUSTRALIAN RED CROSS SOCIETY	63,636.36
AUSTRALIAN REGIONAL AND REMOTE COMMUNITY SERVICES LTD	156,814.00
AUTISM NORTHERN TERRITORY INC	15,958.00
BAGOT COMMUNITY INCORPORATED	513,253.00
BALUNU FOUNDATION LIMITED	20,000.00
BARKLY REGION ALCOHOL AND DRUG ABUSE ADVISORY GROUP INCORPORATED	2,492,548.31
BARKLY REGIONAL COUNCIL	240,039.72
BEYOND BLUE LIMITED	42,118.00
BINJARI COMMUNITY ABORIGINAL CORPORATION	31,818.18
BUSHMOB INCORPORATED	1,560,327.72
CALVARY COMMUNITY CARE	144,584.00
CANCER COUNCIL OF THE NT INC	384,646.00
CARERS NT INCORPORATED	407,826.00
CARPENTARIA DISABILITY SERVICES INC	7,895,110.00
CASA CENTRAL AUSTRALIA INCORPORATED	4,212,351.00
CASUARINA SOCCER CLUB INC	15,000.00
CATHOLICCARE NT	1,227,939.37
CENTRAL AUSTRALIAN ABORIGINAL ALCOHOL PROGRAMMES UNIT INC	3,078,699.90
CENTRAL AUSTRALIAN ABORIGINAL CONGRESS ABORIGINAL CORPORATION	2,112,696.00
CENTRAL AUSTRALIAN REMOTE HEALTH DEVELOPMENT SERVICES LTD	363,217.00
CENTRAL DESERT REGIONAL COUNCIL	29,560
CHILDBIRTH EDUCATION ASSOCIATION DARWIN INC	41,539.00
CHILDBIRTH EDUCATION ASSOCIATION INCORPORATED (CA)	60,075.00
CHILDREN'S GROUND LIMITED	50,000.00
COUNCIL FOR ABORIGINAL ALCOHOL PROGRAM SERVICES INCORPORATED	765,165.00
CRISIS LINE INC. (T/A LIFELINE TOP END)	33,333.00
DEADLY TREADLIES	13,636.36
DANILA DILBA BILURU BUTJI BINNILUTLUM HEALTH SERVICE ABORIGINAL CORPORATION	589,181.00
DARWIN COMMUNITY LEGAL SERVICES INC	87,355.00
DEAF CHILDREN AUSTRALIA	54,850.00
DIABETES ASSOCIATION OF THE NT INC	847,222.00
DISABILITY ADVOCACY SERVICE	77,112.00

2016-17 FY Grant and Subsidy Disbursement Data	
DOWN SYNDROME ASSOCIATION OF THE NT INC	132,641.00
DRAKE AUSTRALIA PTY LTD	229,652.00
DRUG AND ALCOHOL SERVICES ASSOCIATION ALICE SPRINGS INCORPORATED	1,835,261.00
DUNDEE PROGRESS ASSOCIATION INCORPORATED	39,011.00
EAST ARNHEM REGIONAL COUNCIL	824,487.27
EASTERN HEALTH	67,576.00
EMPLOYEE ASSISTANCE SERVICE NT INC	205,263.35
FAMILY PLANNING WELFARE ASSOCIATION OF NT INC.	807,544.00
FCD HEALTH LTD	1,603,758.00
FORSTER FOUNDATION FOR DRUG REHABILITATION	970,250.00
FOUNDATION OF REHABILITATION WITH ABORIGINAL ALCOHOL RELATED DIFFICULTIES CORPORATION	1,047,093.00
GOLDEN GLOW CORPORATION (NT) PTY LTD	3,275,870.00
GROW	203,655.00
GUIDE DOGS ASSOCIATION OF SA & NT INC.	81,658.00
GUNDJEIHMI ABORIGINAL CORPORATION	10,000.00
HEALTH NETWORK NORTHERN TERRITORY LTD T/A NORTHERN TERRITORY PHN	225,947.00
HEALTHSCOPE OPERATIONS PTY LTD	1,472,795.00
HOLYOAKE ALICE SPRINGS INC	591,706.00
HPA INCORPORATED	752,716.00
INDUSTRY EDUCATION NETWORKING PTY LTD	2,712,901.00
INTEGRATED DISABILITY ACTION INC	133,500.00
JILAMARA ARTS AND CRAFTS ASSOCIATION	62,546.00
KALANO COMMUNITY ASSOCIATION INC	506,039.00
KAREN SHELDON CATERING PTY. LTD.	5,682,523.68
KATHERINE WEST HEALTH BOARD	4,315,969.00
KIDSAFE NT INCORPORATED	127,267.00
LARRAKIA NATION ABORIGINAL CORPORATION	329,630.00
LAYNHAPUY HOMELANDS ABORIGINAL CORPORATION	128,221.00
LIFE WITHOUT BARRIERS	12,629,992.45
LIFELINE AUSTRALIA LTD	100,000.00
LIFELINE CENTRAL AUSTRALIA INC	375,182.00
LIFESTYLE SOLUTIONS (AUST) LTD	12,239,618.00
LOCAL GOVERNMENT ASSOCIATION OF THE NORTHERN TERRITORY	118,393.00
MABUNJI ABORIGINAL RESOURCE ASSOC INC	15,000.00
MACDONNELL REGIONAL COUNCIL	314,059.00
MALABAM HEALTH BOARD ABORIGINAL CORPORATION	422,988.00
MENTAL HEALTH ASSOCIATION OF CENTRAL AUSTRALIA	1,330,425.00
MENTAL HEALTH AUSTRALIA LTD	20,512.00
MENTAL ILLNESS FELLOWSHIP OF AUSTRALIA (NT) INC	460,625.00
MENZIES SCHOOL OF HEALTH RESEARCH	9,933,325.00
MISSION AUSTRALIA	1,723,380.45
MIWATJ HEALTH ABORIGINAL CORPORATION	4,510,794.00
NATIONAL DISABILITY SERVICES LTD	428,816.00
NATIONAL HEART FOUNDATION	204,760.00
NATURAL FAMILY PLANNING COUNCIL NT INC	12,584.00
NGAANYATJARRA PITJANTATJARRA YANKUNYTJATJARA WOMENS COUNCIL	56,545.46
NORTH AUSTRALIA GLOBAL SERVICES PTY LTD (T/A TERRITORY CARE & SUPPORT SERVICE)	1,672,751.00

2016-17 FY Grant and Subsidy Disbursement Data	
NORTHERN TERRITORY AIDS AND HEPATITIS COUNCIL INC	1,230,930.00
NORTHERN TERRITORY MENTAL HEALTH COALITION	158,064.00
NT FRIENDSHIP & SUPPORT INC	264,140.00
OZ HELP FOUNDATION LTD	25,595.00
PALNGUN WURNANGAT ABORIGINAL CORPORATION	13,636.36
PAPULU APPARR-KARI ABORIGINAL CORPORATION	136,363.63
PEPPIMENARTI ASSOCIATION INC	918,966.00
PIPELINE TALENT PTY LTD	68,181.81
ROPER GULF REGIONAL COUNCIL	155,105.18
ROYAL FLYING DOCTOR SERVICE OF AUSTRALIA CENTRAL OPERATIONS	4,175,031.00
RUBY GAEA DARWIN CENTRE AGAINST SEXUAL VIOLENCE INCORPORATED	406,595.00
SCHOOL GROUP MANAGEMENT COUNCIL BARKLY	18,181.82
SOMERVILLE COMMUNITY SERVICES INC	6,077,397.00
ST VINCENT DE PAUL SOCIETY	900,000.00
ST. JOHN AMBULANCE AUST. NT INC.	28,199,200.00
STEP OUT COMMUNITY ACCESS SERVICE INC	1,317,111.00
SUNRISE HEALTH SERVICE ABORIGINAL CORPORATION	4,845,186.45
TANGENTYERE COUNCIL ABORIGINAL CORPORATION	1,224,938.00
THAMARRURR DEVELOPMENT CORPORATION LIMITED	81,818.18
THE ARNHEM LAND PROGRESS ABORIGINAL CORPORATION	10,000.00
THE FLINDERS UNIVERSITY OF SOUTH AUSTRALIA T/A FLINDERS UNIVERSITY	555,724.64
THE GAP YOUTH AND COMMUNITY CENTRE ABORIGINAL CORPORATION	15,440.00
THE TRUSTEE FOR ANTI-CANCER FOUNDATION OF SOUTH AUSTRALIA	68,950.00
THE TRUSTEE FOR THE SALVATION ARMY (NT) PROPERTY TRUST	1,228,363.00
TOP END ASSOCIATION FOR MENTAL HEALTH INC	2,470,358.00
TOP END MENTAL HEALTH CONSUMER ORGANISATION INC	235,480.00
TOTAL RECREATION	303,359.00
VICTORIA DALY REGIONAL COUNCIL	179,012.00
WALTJA TJUTANGKU PALYAPAYI ABORIGINAL CORPORATION	144,793.00
WARLPIRI YOUTH DEVELOPMENT ABORIGINAL CORPORATION	87,479.00
WEST ARNHEM REGIONAL COUNCIL	49,840.00
WESTERN DESERT NGANAMPA WALYTJA PALYANTJAKU TJUTAKU ABORIGINAL CORPORATION	269,627.00
WURLI WURLINJANG ABORIGINAL CORPORATION	1,021,729.45
YUGUL MANGI DEVELOPMENT ABORIGINAL CORPORATION	90,909.09
Grand Total	**164,125,009.92**

Legislation

Acts administered by the Department of Health

Alcohol Mandatory Treatment Act (excluding Part 6) Repealed by the Alcohol Harm Reduction Act 2017 (ACT NO. 16, 2017) which commenced on 1 September 2017.

Cancer (Registration) Act

Carers Recognition Act

Disability Services Act

Emergency Medical Operations Act

Food Act

Guardianship of Adults 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

Termination of Pregnancy Law Reform 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 – Repealed (see above)

Cancer (Registration) Regulations

Food Regulations

Guardianship of Adults Act

Health Services Regulations

Medicines, Poisons and Therapeutic Goods Regulations

Mental Health and Related Services Regulations

Public and Environmental Health Regulations

Radiation Protection Regulations

Termination of Pregnancy Law Reform Regulations

Tobacco Control Regulations

Volatile Substance Abuse Prevention Regulations