New South Wales Auditor-General's Report

Financial Audit

Volume Ten 2015

Health

The role of the Auditor-General

The roles and responsibilities of the Auditor-General, and hence the Audit Office, are set out in the *Public Finance and Audit Act 1983*.

Our major responsibility is to conduct financial or 'attest' audits of State public sector agencies' financial statements. We also audit the Total State Sector Accounts, a consolidation of all agencies' accounts.

Financial audits are designed to add credibility to financial statements, enhancing their value to end-users. Also, the existence of such audits provides a constant stimulus to agencies to ensure sound financial management.

Following a financial audit the Audit Office issues a variety of reports to agencies and reports periodically to parliament. In combination these reports give opinions on the truth and fairness of financial statements, and comment on agency compliance with certain laws, regulations and government directives. They may comment on financial prudence, probity and waste, and recommend operational improvements.

We also conduct performance audits. These examine whether an agency is carrying out its activities effectively and doing so economically and efficiently and in compliance with relevant laws. Audits may cover all or parts of an agency's operations, or consider particular issues across a number of agencies.

Performance audits are reported separately, with all other audits included in one of the regular volumes of the Auditor-General's Reports to Parliament – Financial Audits.

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Pursuant to the *Public Finance and Audit Act 1983*,
I present Volume Ten of my 2015 report.

A T Whitfield PSM
Acting Auditor-General
8 December 2015

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Section One

Health

Executive Summary

This report analyses the results of the financial statement audits of the Health cluster entities for the year ended 30 June 2015. The table below summarises key observations.

Financial performance and reporting	
Financial reporting	Unqualified audit opinions were issued on the financial statements of all entities in the cluster. The quality and timeliness of financial reporting continues to improve.
Financial performance	The actual 2014-15 financial performance of local health districts/specialty networks varied to the budgets agreed with the Ministry of Health at the beginning of the year.
Financial controls	
Annual leave	Managing annual leave remains a significant challenge as over a third of NSW Health's workforce has excessive annual leave balances. One Staff Specialist had not recorded 20 weeks of annual leave taken dating back to 2009.
Overtime	NSW Ambulance's overtime remains significant and strategies to reduce it are not working.
Backlog maintenance	NSW Health's backlog maintenance was quantified for the first time at $323 million at 30 June 2015.
Asset Management	Health Infrastructure was managing 20 major capital projects at 30 June 2015, each with a cost over $50.0 million.
Governance	
Performance monitoring	Four local health districts were not meeting expectations in the performance agreements with the Secretary of NSW Health.
Service agreements	Many of the service agreements between the Secretary of NSW Health and health entities continue to be signed late.
Conflicts of interest, gifts and benefits	Health entities need to review how they manage conflicts of interest, gifts and benefits.
Service delivery	
Emergency department performance	NSW Health, on average, met emergency department triage response time targets for the second consecutive year.
Ambulance response times	The average ambulance response time for potentially life threatening cases in New South Wales rose to its highest level in five years.
Unplanned re-admissions	No local health district or specialty network achieved the Ministry of Health's unplanned re-admissions target of five per cent in 2014-15.

Financial performance and reporting

The quality of financial reporting continues to improve

The Health cluster has continually improved the quality of financial reporting in recent years. Misstatements identified in 2014-15 and reported to agency management fell from 207 in 2012-13 to 49 in 2014-15. All material misstatements were corrected during the audit of agencies financial statements.

Original budgets excluded $860 million of capital funding

The overall budgeted operating deficit at the beginning of 2014-15 for all local health districts/specialty networks was $459 million. This was revised during the year to an overall surplus of $393 million. Of the difference, $860 million is due to capital funding being excluded from the original budgets. A further $8.0 million in net adjustments were made to budgets following supplementations and other changes.

Three local health districts' costs are consistently above the State price

The average cost of providing health services at Far West, Western NSW and Southern NSW local health districts' has been consistently higher than the efficient State price over the past three years. These three local health districts will receive combined transition grants of $70.8 million in 2015-16 to cover the difference.

Transition grants paid to local health districts/specialty networks continue to fall

In 2015-16, $182 million in transition grants will be paid to thirteen local health districts/specialty networks that are providing services at a cost greater than the efficient State price compared to $248 million paid to ten local health districts/specialty networks in 2014-15.

Financial controls

Most identified IT issues are caused by weak user administration processes

Weak user administration processes accounted for most Information Technology issues identified in 2014-15. Ineffective communication of financial system access changes between health entities and HealthShare NSW was a contributing factor.

Recommendation

> Management and communication of user administration processes between health entities and HealthShare NSW should be strengthened.

Managing leave remains a significant challenge for health entities

Health entities are not effectively managing employee annual leave balances as more than a third of the workforce have excessive leave balances. Despite instructions from the Ministry and expectations set out in the State Budget, health entities are not effectively managing employee annual leave balances.

Recommendation (repeat issue)

> Health entities should continue reviewing the approach to managing excessive annual leave in 2015-16. They should:
>
> - monitor current and projected leave balances to the end of the financial year on a monthly basis
> - agree formal leave plans with employees to reduce leave balances over an acceptable timeframe.

The number of employees taking no annual leave during the financial year is also increasing.

Recommendation (repeat issue)

Health entities should monitor employees who take no or very little leave in a rolling 12 month period.

NSW Ambulance faces significant challenges in managing sick leave. Strategies to address the problem have been delayed.

Recommendation (repeat issue)

NSW Ambulance should implement targeted human resource strategies to address significant challenges it faces managing sick leave.

NSW Ambulance's overtime (including call backs) remains significant

NSW Ambulance's overtime (including call backs) continues to be significantly higher than that incurred by other health entities. Strategies to reduce overtime are not working. In 2014-15, NSW Ambulance's overtime represented 28.1 per cent of its salaries and wages expense.

Recommendation (repeat issue)

NSW Ambulance should review the effectiveness of its strategies and rostering practices to reduce excessive overtime and call back payments.

A Staff Specialist had not recorded 20 weeks of annual leave dating back to 2009

The failure of supervisors to approve employee timesheets continues to be a problem. A local health district identified unrecorded annual leave for Staff Specialists dating back to 2009. The local health district advises shortcomings in internal controls over the approval and recording of time worked by Staff Specialists contributed to the problem.

Recommendation

Health entities should:

- ensure timesheets are approved by supervisors before pay runs are complete
- review Staff Specialists' rostering and leave recording practices by 30 June 2016, and immediately address any internal control weaknesses.

Visiting Medical Officer's continued to submit claims for payment irregularly or late

In 2014-15, Visiting Medical Officer's (VMO's) continued to submit claims for payment irregularly or late, sometimes over 12 months late. Over 12,300 claims were submitted totalling $104 million, for work performed prior to 1 July 2014. In 2014-15, South Western Sydney Local Health District made 41 payments to a doctor totalling $429,800 for work performed over six years ago. The pay of VMO's can now be reduced if they submit claims more than 12 months late however local health districts/specialty networks are yet to discount late claims received.

Many information technology projects are running behind schedule

The revised completion dates for six of the nine major information technology projects being managed by eHealth NSW have been delayed from the dates advised last year.

Recommendation

eHealth NSW should perform a detailed review of the way it manages information technology projects. The review should analyse the reasons for project delays and identify strategies to mitigate the risk on future projects.

Not all health entities are adequately monitoring purchase order usage

Thirteen health entities indicated they are monitoring purchase order usage for each budget holder. Other health entities only monitor usage at an organisation wide level because they do not have reports at a budget holder level.

Recommendation (repeat issue)

Health entities not monitoring purchase order usage for each budget holder should do so by 31 March 2016. These entities should:

- identify which budget holders are not using purchase orders and understand why
- implement targeted strategies to improve compliance with the Ministry of Health's purchase order target.

Dormant special purpose accounts not yet resolved

Almost 60 per cent of special purpose accounts remained idle during 2014-15. Two successive Auditor-General's Reports to Parliament have recommended the Ministry work with each health entity to determine what they should do with dormant special purpose funds or funds whose purpose is unclear. The Ministry advises it is seeking legal guidance to ensure funds are appropriately used without breaching legislation or donor imposed conditions.

Recommendations (repeat issues)

The Ministry should issue guidance and work with each health entity to determine what they should do with dormant special purpose funds or funds whose purpose is unclear.

Health entities should arrange appropriate approvals to move funds from special purpose accounts to the Public Contributions Trust Fund by 31 March 2016.

Governance

Four local health districts are not meeting performance expectations

Four local health districts were considered by the Ministry of Health to be either not performing or underperforming with expectations set out in the service agreements with the Secretary of NSW Health at 30 June 2015. Finance was a common performance concern. In some cases, Emergency Treatment Performance, National Elective Surgery Targets, service access and patient flow were also performance concerns. The Ministry is managing these entities in accordance with its performance review process.

Health entities' service agreements continue to be signed late

Many of the service agreements between the Secretary of NSW Health and health entities continue to be signed late. Northern NSW Local Health District did not sign its 2015-16 service agreement until 12 November 2015.

Recommendation

The Secretary of NSW Health and health entities should finalise their service agreements by 31 July.

Two health entities do not have conflicts of interest registers

Murrumbidgee Local Health District and the Justice Health and Forensic Mental Health Network did not have registers to identify, assess and manage conflicts of interest, as directed by the Ministry.

Recommendation

Murrumbidgee Local Health District and the Justice Health and Forensic Mental Health Network should implement conflicts of interest registers immediately.

Conflicts of interest registers may be incomplete

While most local health districts and specialty networks have conflicts of interest registers, they may be incomplete. Some entities only have a conflicts of interest register for the board, or a sub-committee of the board. These registers will not capture conflicts of interest associated with secondary employment or relationships with suppliers.

Recommendations

Chief Executives should review, by 31 March 2016:

- local procedures and ensure conflicts of interest are being managed effectively
- the conflicts of interest registers maintained by the health entity to ensure all entries are being recorded.

Chief Audit Executives should review conflicts of interest registers to ensure they are complete, all actions have been addressed, trends are analysed, and instances requiring further action are followed up.

The number of entries recorded in gifts and benefits registers varies significantly

The number of entries recorded on health entities' gifts and benefits registers varied significantly in 2014-15. Sydney Children's Hospitals Network recorded 250 entries whereas nine local health districts each recorded less than ten entries.

Recommendations

Chief Executives should review, by 31 March 2016:

- local procedures and ensure gifts and benefits are being managed effectively
- the gifts and benefits registers maintained by the health entity to ensure all entries are being recorded.

Chief Audit Executives should regularly review gifts and benefits registers to ensure all actions have been completed, trends are analysed, and instances requiring further action are followed up.

Service delivery

Average emergency department triage response times were better than target

NSW Health, on average, met the emergency department triage response time targets across all triage categories in 2014-15 for the second consecutive year.

NSW Health's emergency department treatment performance remains below target

NSW Health improved its emergency department treatment performance in 2014-15, but did not achieve its target of 81 per cent of patients being admitted, transferred or discharged within four hours of presenting. In 2014-15, the State average was 74.3 per cent compared to 73.9 per cent in 2013-14.

NSW Ambulance response times remain above the national average

The median (50th percentile) ambulance response time for potentially life threatening cases in New South Wales rose to its highest level in five years. It increased from 10.8 minutes in 2013-14 to 11.2 minutes in 2014-15 and remains above the national average.

Elective surgery performance improves

NSW Health continued improving its elective surgery performance. All three categories of elective surgery have improved over the past four years.

Targets for unplanned and mental health acute re-admissions were not met

No local health district or specialty network achieved the unplanned re-admissions target for 2014-15. In 2014-15, the rate of unplanned re-admissions increased from 6.8 per cent to seven per cent, above the Ministry's target of five per cent.

Only four health entities achieved the mental health acute re-admissions target for 2014-15.

Staphylococcus aureus bloodstream infection rates below the national benchmark

The rate of *Staphylococcus aureus* bloodstream infection in NSW Hospitals was well below the national benchmark of two cases per 10,000 bed days in 2014-15. The New South Wales average was 0.73 cases per 10,000 bed days in 2014-15.

Introduction

Introduction

This report provides Parliament and other users of the Health cluster entities' financial statements with an analysis of the results and key observations in the following areas:

Financial Performance and Reporting

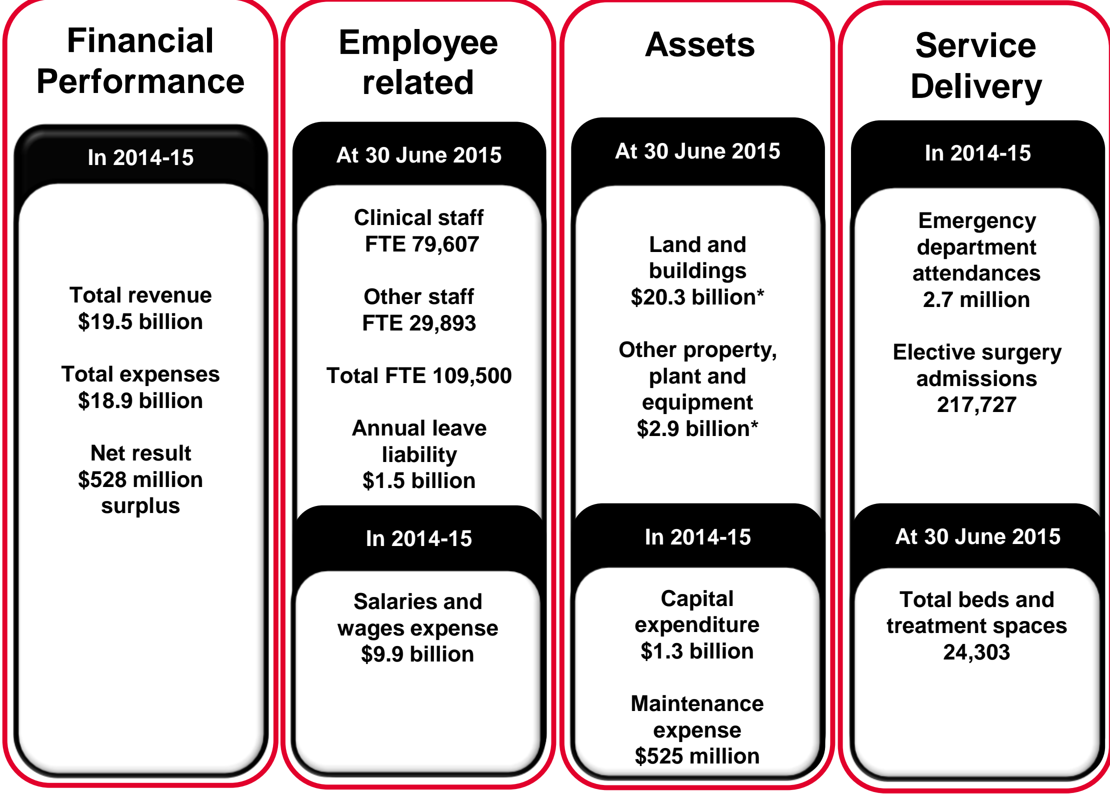
Financial Controls

Governance

Service Delivery.

Snapshot of NSW Health

A snapshot of NSW Health is shown below.



* Gross asset replacement value.

Snapshot of the Cluster

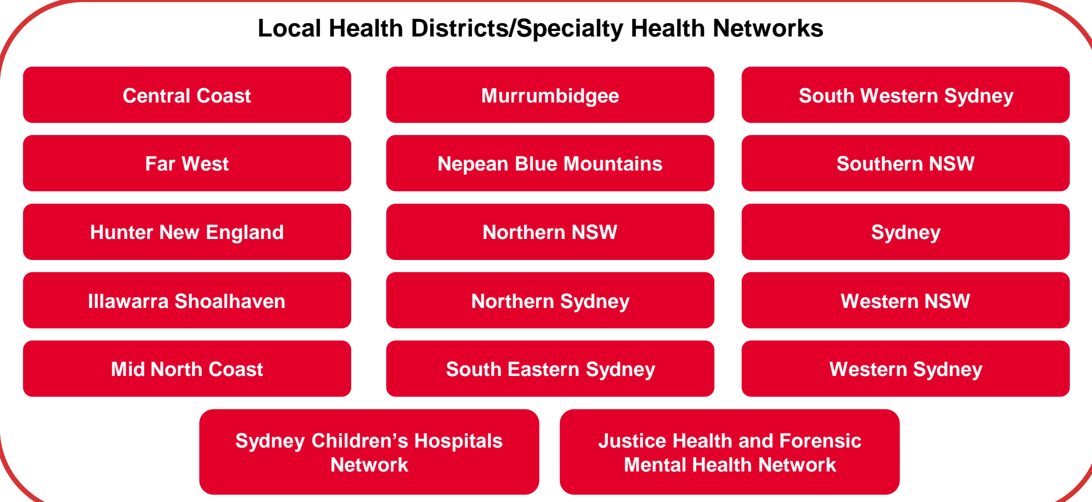
NSW Government agencies are grouped in clusters to enhance the coordination of policy development and the delivery of services. Each cluster is led by a coordinating Minister and may be supported by portfolio Ministers. The Ministry of Health (the Ministry) is the lead agency in the cluster. It is responsible for:

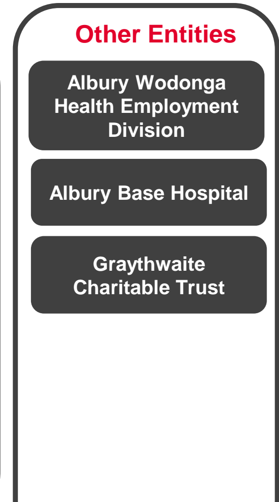
- providing health care services to patients and the community
- promoting wellness and illness prevention
- developing health care policy and planning
- managing, monitoring and reporting on health system performance
- building healthy communities by working with other parts of the NSW Government.

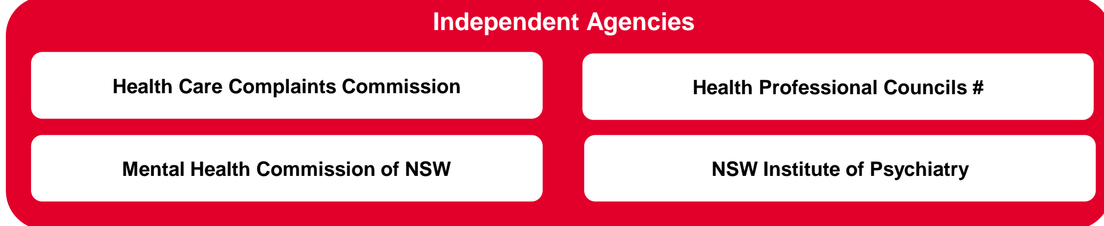
The commentary in this report covers the following cluster entities:

Health Cluster

Ministry of Health (Principal Department/Lead Agency)







\# Health Professional Councils is the aggregate of the Psychology, Podiatry, Physiotherapy, Pharmacy, Osteopathy, Optometry, Occupational Therapy, Nursing and Midwifery, Medical Radiation Practice, Medical, Dental, Chiropractic, Chinese Medicine, and Aboriginal and Torres Strait Islander Health Practice Councils.

Note: The diagram above excludes the 29 special purpose service entities and staff agencies controlled by health entities.

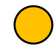
Changes to the Health cluster after 1 July 2015

Since 1 November 2015, NSW Kids and Families is no longer a separate health entity. The entity was abolished and its functions transferred to the newly created Office of Kids and Families within the Ministry of Health. The Office will continue to progress the program of work to support 'Healthy, Safe and Well: A Strategic Health Plan for Children, Young People and Families 2014–24'.

Status of 2014 Recommendations

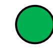
Last year's Auditor-General's Report to Parliament on the Health cluster included 30 recommendations for cluster entities to improve financial management, internal controls, and governance. The current status of each recommendation is shown below.

Status	Recommendation	Current Status
The Ministry should:		
	Issue guidance and work with each health entity to determine what they should do with any dormant special purpose funds or funds whose purpose is unclear (repeat issue).	In 2014-15, the Ministry implemented a new State-wide electronic registry to help manage special purpose and trust accounts. The Ministry advises it is seeking legal guidance to ensure funds are appropriately used without breaching legislation or donor imposed conditions. Details are provided in the chapter on Financial Controls.
	Finalise 2014-15 service agreements immediately and in the future, before the end of the previous financial year.	The Ministry advises that finalising service agreements is constrained by the release of the State budget and board meeting cycles. Many of the service agreements between the Secretary of NSW Health and health entities continue to be signed late. Northern NSW Local Health District did not sign its 2015-16 service agreement until 12 November 2015. Details are provided in the chapter on Governance.
	Communicate its liquidity ratio definition and target to health entities and include it in the service agreement with health entities, extend its monitoring of health entities liquidity to include Pillar agencies and divisions within Health Administration Corporation, and improve cash management across NSW Health to ensure health entities do not have liquidity well in excess of target levels.	The Ministry included a minimum weekly cash reserve in each health entity's service agreement/compact that it will use to monitor cash on hand during the year. Details are provided in the chapter on Financial Performance and Reporting.
	Review whether there are any other types of employment arrangements, in addition to Clinical Academic employees, where leave may not be recorded.	The Ministry advises it is not aware of other employment arrangements where leave may not be recorded. Details are provided in the chapter on Financial Controls.
	Develop a project plan for its asset and facilities maintenance working party, with deliverable dates for its key activities, and report against that plan.	The Ministry advises the asset and facilities maintenance working party has developed a high-level project plan with key deliverable dates for its key activities. The working party reports milestones achieved against the plan. Details are provided in the chapter on Financial Controls.

Status	Recommendation	Current Status
The Ministry should:		
	Document a policy as to which goods and services require a purchase order and ensure this is reflected in the monthly reporting for health entities.	The Ministry advises it has reviewed NSW Health's purchase order policy, and that a monthly purchase order usage report is provided to Chief Executives for monitoring. Details are provided in the chapter on Financial Controls.
	Review the reasons for significant delays in finalising HealthShare NSW and NSW Health Pathology service agreements to ensure these are dealt with in the new model charters and that accountability is clearly defined.	The Ministry advises the new model charters more accurately reflect the governance arrangements in NSW Health and the underpinning statutory framework. Details are provided in the chapter on Governance.
Health agencies should:		
	Arrange approval to move funds from special purpose accounts to the Public Contributions Trust Fund by 31 March 2015.	In 2014-15, the Ministry implemented a new State-wide electronic registry to help manage special purpose and trust accounts. The Ministry advises it is seeking legal guidance to ensure funds are appropriately used without breaching legislation or donor imposed conditions. Details are provided in the chapter on Financial Controls.
	Address information technology issues. Specifically they need to: • review and test their disaster recovery plans to ensure they can restore financial systems in the event of a disaster • improve processes around user administration to prevent unauthorised access to the financial systems.	Disaster recovery planning issues were partially resolved during the year for the shared financial systems supported by eHealth NSW. However, disaster recovery planning issues continue for some health entity financial systems. Details are provided in the chapter on Financial Controls.
	Manage excessive annual leave balances more effectively in 2014-15 (repeat issue). They should: • agree formal leave plans with employees to reduce their leave balances over an acceptable timeframe • monitor current and projected leave balances to the end of the financial year on a monthly basis.	Most health entities advise they are monitoring current and projected leave balances. However, the 2014-15 audits identified that some health entities have not agreed formal leave plans with employees to reduce leave balances. This is an ongoing issue for health entities. Details are provided in the chapter on Financial Controls.
	Monitor employees who take no or very little leave in a rolling 12 month period (repeat issue).	Most health entities advise they are doing this, but Far West Local Health District and Cancer Institute NSW are not. Details are provided in the chapter on Financial Controls.
	Review the annual leave balances of Clinical Academic employees to ensure all leave taken has been recorded and internal controls around the processing of Clinical Academic leave records to ensure leave taken is processed in the payroll system.	Most health entities advise they are doing this. South Eastern Sydney, South Western Sydney and Nepean Blue Mountains local health districts have not done this review. Details are provided in the chapter on Financial Controls.

Status	Recommendation	Current Status
Health agencies should:		
	Manage sick leave more effectively in 2014-15 and implement targeted strategies to reduce sick leave.	Health entities advise they are doing this. Further work is needed as average sick leave hours per full time equivalent employee remains well above the Ministry's target. Details are provided in the chapter on Financial Controls.
	Monitor purchase order usage for each budget holder to improve compliance with the Ministry of Health's purchase order target.	Thirteen health entities advise they are monitoring this. Other health entities advise they only monitor usage at an organisation wide level. Details are provided in the chapter on Financial Controls.
	Ensure relevant information systems support the management of annual leave (HealthShare NSW and health entities).	The Ministry and health entities addressed this recommendation during the year.
	Have their Chief Executives advise supervisors of their obligation to approve timesheets.	Most health entities advise they are doing this. Further, the Ministry advises that implementation of a new rostering system will enable Chief Executives to have better visibility of compliance with this requirement. Details are provided in the chapter on Financial Controls.
	Strengthen their internal control processes to ensure visiting medical officers (VMO) submit claims for payment in a timely manner.	The Ministry advises changes have been made to VMO pay determinations to discourage the late submission of claims. Details are provided in the chapter on Financial Controls.
	Develop their asset maintenance plans and identify and measure maintenance backlog by 30 June 2015 (partial repeat issue).	The Ministry advises health entities prepared asset maintenance plans and quantified backlog maintenance for the first time. Details are provided in the chapter on Financial Controls.
	Review asset useful lives across the sector by no later than 28 February 2015 (repeat issue).	The Ministry advises it conducted the review in January 2015. From 1 July 2015, health entities are required to perform annual useful life assessments on high value plant and equipment assets. Details are provided in the chapter on Financial Controls.
NSW Ambulance should:		
	Implement targeted human resource strategies to respond to significant challenges it faces in managing annual leave, sick leave and overtime (including call back) payments.	NSW Ambulance advises it is implementing strategies to help manage annual leave and unplanned overtime costs. However, implementation of strategies to manage sick leave have been delayed until it has replaced its payroll system, which is expected in 2015-16. Details are provided in the chapter on Financial Controls.
	Review its rostering practices to identify further strategies to reduce excessive overtime and call back payments.	NSW Ambulance advises it continues to review rostering practices throughout the State, in particular in regional areas, to reduce after hour call outs of paramedic. Details are provided in the chapter on Financial Controls.

Status	Recommendation	Current Status
NSW Ambulance should:		
●	Complete the review of the effectiveness of its revenue system and patient billing practices by 31 March 2015.	An external firm completed the review in June 2015 and made eleven recommendations. Seven recommendations have been implemented, with the remaining four in progress. Details are provided in the chapter on Financial Controls.
●	Significantly improve compliance with the Ministry of Health's purchase order target.	NSW Ambulance improved purchase order usage in 2014-15. The Ministry advises since February 2015, NSW Ambulance processed 80 per cent of invoices with a purchase order (49 per cent in 2013-14). Details are provided in the chapter on Financial Controls.
NSW Kids and Families should:		
●	Significantly improve compliance with the Ministry of Health's purchase order target.	NSW Kids and Families improved purchase order usage in 2014-15. The Ministry advises since February 2015, NSW Kids and Families processed 86 per cent of invoices with a purchase order (65 per cent in 2013-14). Details are provided in the chapter on Financial Controls.
Northern Sydney Local Health District should:		
●	Plan its 2014-15 stocktake to ensure it is completed and relevant accounting records updated before 30 June 2015.	Northern Sydney Local Health District addressed this recommendation during the year.
Health Infrastructure should:		
●	Capture key lessons learnt for future projects after one of its contractors went into administration. It should ensure it has appropriate strategies to monitor how suppliers are performing, especially for multi-year contracts.	Health Infrastructure responded by implementing a number of initiatives. Details are provided in the chapter on Financial Controls.
eHealth NSW should:		
●	Conduct post implementation reviews of recently completed information technology projects. The reviews should be performed as soon as possible to: • assess whether the projects achieved their intended outcomes • determine whether management practices were effective in keeping the project on time and budget • capture lessons learnt for application to future projects.	eHealth NSW advises it conducted post implementation reviews for three recently completed projects. Details are provided in the chapter on Financial Controls.

Status	Recommendation	Current Status
eHealth NSW should:		
	Have robust systems and processes to measure the benefits realisation for completed information technology projects. eHealth NSW should by 30 June 2015: • clearly define roles and responsibilities for measuring benefits realisation • establish a timeline for regularly assessing and re-assessing the benefits realisation • formally measure and document the benefit realisation for each completed project.	eHealth NSW advises it has developed a benefits management framework that provides guidance on roles and responsibilities for measuring benefits realisation as well as guidance on establishing schedules for benefits measurement. Details are provided in the chapter on Financial Controls.
	Capture the reasons for delays in information technology projects as well as lessons learnt for application to future projects.	eHealth NSW advises it addressed this recommendation during the year.
Western NSW Local Health District should:		
	Implement appropriate strategies and controls to more accurately capture and record triage data over imminently life threatening (T2) incidents.	Western NSW Local Health District advises it implemented targeted review and monitoring processes to ensure data over T2 incidents is accurately captured and recorded in a timely manner. Details are provided in the chapter on Service Delivery.

2014 recommendation status

Fully addressed Partially addressed Not addressed

Financial Performance and Reporting

Financial performance and reporting are important elements of good governance. Accurate and timely reporting enables the public to receive reliable information about the financial performance of agencies. Additionally, the government requires accurate and timely financial performance information to enable effective decision making.

This chapter outlines audit findings about financial performance and reporting of entities in the Health cluster for 2014-15. The table below summarises our key observations and conclusions or recommendations.

Financial reporting

Observation	Conclusion or recommendation
Unqualified audit opinions were issued for all entities in the cluster and reported misstatements fell from 207 in 2012-13 to 49 in 2014-15. Early close procedures continue to allow issues to be resolved and financial reporting risks to be addressed early in the audit process.	Further improvements to early close procedures will reduce reporting timeframes, improve financial statement quality and increase audit efficiency.

Financial performance

Observation	Conclusion or recommendation
Thirteen local health districts/specialty networks recorded an operating surplus in 2014-15.	This was primarily due to the capital funding received during the year for new facilities, upgrades and redevelopments.
Fifteen local health districts received 85.3 per cent of their revenue from the State Government. The entities have varying levels of reliance on government funding.	Some health entities are less reliant on government funding to support operations because they generate higher levels of revenue from own sources.
The Ministry of Health and its controlled entities' expenses grew by 4.9 per cent in 2014-15 (6.1 per cent in 2013-14).	Expense grew less than the six per cent long-term annual growth rate for NSW Health outlined in the 2014-15 Budget Papers.
The liquidity of local health districts/specialty networks ranged from a quick ratio of 0.2 to 13.3 at 30 June 2015. Ten local health districts/specialty networks had a quick ratio of one or less. These entities did not have sufficient short term assets to cover their short term liabilities.	To strengthen cash management by local health districts/specialty networks, the Ministry has: • set clear expectations around the management of cash flows for those requiring cash assistance • specified in the 2015-16 service agreements the minimum weekly cash reserve they will use to monitor their liquidity levels during the year.
The actual 2014-15 financial performance of local health districts/specialty networks varied to the budgets agreed with the Ministry at the beginning of the financial year. The agreed budgets are continually revised during the financial year.	Significant changes to budgets during the year reduce their impact and relevance. The Ministry continues to manage performance across NSW Health to improve the accuracy of budgeting practices.

Financial performance	
Observation	**Conclusion or recommendation**
The average cost of providing health services at Far West, Western NSW and Southern NSW local health districts has been consistently higher than the efficient State price over the past three years.	These three rural local health districts will receive combined transition grants of $70.8 million in 2015-16 to cover the difference between their projected average costs and the efficient State price.
In 2015-16, $182 million in transition grants will be paid to thirteen local health districts/specialty networks compared to $248 million paid to ten local health districts/specialty networks in 2014-15.	Transition grants paid to local health districts/specialty networks continue to fall. This indicates they are providing services more efficiently.

Quality of Financial Reporting

Unqualified audit opinions issued for all entities' 30 June 2015 financial statements

Unqualified audit opinions were issued on the 30 June 2015 financial statements of entities in the cluster. Two significant matters were reported this year. This is an improvement on the ten significant matters reported last year. This year's matters are detailed below.

- In June 2015, NSW Ambulance wrote off $67.5 million of aged patient debts relating to 2013-14 and earlier financial years.
- The Aboriginal and Torres Strait Islander Health Practice Council of New South Wales' (the Council) financial statements were not prepared on a 'going concern' basis because the Council has been unable to secure sufficient funding to continue operating. The Council's forecast indicated that cash flows will not be sufficient to service operational expenses beyond October 2016.

The number of large misstatements continues to fall

Overall, the Health cluster has continued to improve the quality of financial reporting in recent years. Misstatements identified in 2014-15 and reported to agency management fell from 207 in 2012-13 to 49 in 2014-15. Six misstatements individually greater than $5.0 million were identified in 2014-15, compared to seven in 2013-14, and 16 in 2012-13. Large errors have a greater potential to affect the reliability of the financial statements.

The number and dollar value of misstatements in the cluster over the past three years is detailed in the table below. These were corrected where necessary.

	Number of misstatements					
Year ended 30 June	**2015**		**2014**		**2013**	
	Corrected	**Uncorrected**	**Corrected**	**Uncorrected**	**Corrected**	**Uncorrected**
Less than $50,000	1	8	18	19	7	72
$50,000 - $249,999	3	8	2	12	2	24
$250,000 - $999,999	2	7	1	26	1	36
$1,000,000 - $4,999,999	1	13	1	23	6	35
Greater than $5,000,000	--	6	3	4	6	10
Total number of misstatements	**7**	**42**	**25**	**84**	**30**	**177**

Source: Statutory Audit Reports issued by the Audit Office.

Timeliness of Financial Reporting

Early close procedures have improved the quality and timeliness of financial reporting

Audit opinions on cluster entities' financial statements were issued within statutory deadlines, which were earlier than the prior year. The successful completion of early close procedures contributed to more audit opinions being issued before the end of September.

Health entities were given less time to submit early close procedures and pro forma financial statements for audit. The deadline for audit teams to report findings from the early close process to agency management also reduced. Bringing forward early close procedures helped ensure a smoother year-end process and allowed more time to resolve key issues.

Early close procedures are designed to bring forward traditional year-end activities, such as valuing assets and resolving financial reporting issues, to reduce reporting timeframes, improve quality and increase audit efficiency.

Some health entities can improve early close procedures by:

- resolving all significant accounting issues during the early close process or documenting a clear path towards timely resolution
- ensuring sufficient documentation supports management's proposed accounting treatments, judgements and assumptions
- ensuring management sufficiently engages with its valuer and interrogates the findings
- compiling adequate working papers to support revaluations of property, plant and equipment to allow for an efficient and effective audit before year-end
- stronger communication and collaboration between the entity and its shared service provider to close out issues
- timely review of misstatements identified in the previous year's audits and developing processes to ensure they do not recur.

Key Financial Information

The Ministry recorded an overall net surplus of $529 million in 2014-15, an increase of $72.0 million from the $457 million net surplus recorded in 2013-14. The large net surpluses for the last two years were due to significant capital funding received and recorded as revenue. The funding is spent on procuring hospitals and other assets which are recorded on the balance sheet and depreciated over their useful lives often around 40 years.

The value of assets held by the Ministry totalled $16.6 billion at 30 June 2015, up from $15.5 billion at 30 June 2014. The increase in assets was due to significant capital expenditure on new facilities, upgrades and redevelopments. Eleven local health districts/specialty networks revalued land, buildings and infrastructure assets in 2014-15 adding to the recorded value of the assets. Total liabilities remained steady at $4.3 billion over the last two years.

Appendix One and Two of this report provide a summary of key financial results for entities in the cluster.

Financial and Sustainability Analysis

As with any well run business, health entities must manage their finances so they can meet current and future spending commitments to provide health services, adapt quickly to emerging risks and remain financially sustainable.

The following table summarises the performance of health entities against some key financial indicators as at, and for the year ended, 30 June 2015.

Health entity	Surplus/ (deficit) $'000	Government funding %	Expense growth rate %	Net cost of services favourable/ (unfavourable) variance $m	Liquidity*	Capital replacement ratio
Consolidated entity						
Ministry of Health	528,540	84.2	4.9	(0.4)	--	1.9
Local health districts/specialty health networks						
Central Coast	1,319	86.1	5.2	0.2	0.2	1.0
Far West	(586)	85.3	3.5	0.1	0.3	1.1
Hunter New England	34,101	84.4	3.9	5.7	2.8	1.7
Illawarra Shoalhaven	51,875	86.9	4.4	3.3	0.5	3.1
Justice Health and Forensic Mental Health Network	2,799	93.9	5.4	5.0	13.3	0.4
Mid North Coast	23,695	86.3	7.4	0.9	1.6	2.5
Murrumbidgee	78,983	83.7	0.2	(4.5)	0.3	5.6
Nepean Blue Mountains	(11,235)	87.8	6.0	0.1	0.2	0.3
Northern NSW	45,275	87.3	4.2	(1.6)	0.5	3.2
Northern Sydney	82,046	81.0	8.3	(1.7)	2.6	2.3
South Eastern Sydney	9,696	80.9	3.9	(20.0)	0.7	1.1
South Western Sydney	(14,290)	86.8	6.5	1.2	0.2	0.8
Southern NSW	105,025	89.1	4.2	3.2	3.8	11.6
Sydney	(41,160)	82.2	5.8	0.4	0.2	0.8
Sydney Children's Hospitals Network	4,825	75.0	3.9	0.8	0.2	0.7
Western NSW	63,733	86.7	2.6	1.9	1.3	2.5
Western Sydney	35,753	84.9	5.5	(15.8)	1.3	2.0
Pillar agencies						
Agency for Clinical Innovation	2,606	96.7	8.9	1.3	--	0.9
Bureau of Health Information	550	97.2	5.9	0.5	--	0.3
Cancer Institute of NSW	(10,479)	97.1	20.1	(10.5)	--	2.6
Clinical Excellence Commission	(553)	91.9	5.9	(1.8)	--	4.3
Health Education and Training Institute	4,766	81.4	(3.3)	3.5	--	0.3
NSW Kids and Families	1,030	99.1	30.2	0.5	--	--
Shared State-wide services						
Health Administration Corporation	61,913	35.9	7.0	(2.1)	--	2.2

* Liquidity measure is the quick ratio (see Appendix Two). This is not available for the consolidated entity, Pillar agencies and Health Administration Corporation.

Source: Net cost of service variance – NSW Ministry of Health (unaudited). Other indicators – audited financial statements.

Some entities recorded significant surpluses due to capital funding

Thirteen local health districts/specialty networks recorded an operating surplus in 2014-15. This was primarily due to the capital funding received during the year for new facilities, upgrades and redevelopments. The receipt of capital grants can significantly impact the reported financial results. As noted earlier in the chapter, capital funding received is recorded as revenue. The funding is spent on procuring hospitals and other assets which are recorded on the balance sheet and depreciated over their useful lives often around 40 years.

The Far West, Nepean Blue Mountains, South Western Sydney and Sydney local health districts recorded deficits. Deficits can occur as health entities are not funded for depreciation expenses.

Varied level of reliance on government funding

Fifteen local health districts received 85.3 per cent of their revenue from the State Government. Of the local health districts, South Eastern Sydney had the lowest State Government funding percentage at 80.9 per cent. South Eastern Sydney's other revenue sources were sales of goods and services (15.6 per cent) and other sources (3.5 per cent). In contrast, Southern NSW had the highest State Government funding percentage at 89.1 per cent. Southern NSW's other revenue sources were sales of goods and services (8.4 per cent) and other sources (2.5 per cent).

Sydney Children's Hospitals Network received 75 per cent of its revenue from State Government funding, the lowest percentage. It also had the lowest percentage in 2013-14 at 76.5 per cent. This is because it had a higher percentage of funding from sales of goods and services (11.5 per cent) and grants and contributions (10.4 per cent). The proceeds it, and other health entities, receive from fundraising activities and donations are held in special purpose accounts and trust funds. These can only be spent in accordance with the specified conditions.

Health entities' revenue mostly comes from State and Commonwealth grant funding tied to the delivery of health care. Private patients are a source of revenue as are the provision of other services such as pharmacy sales, diagnostic imaging, private practice fees, car park fees, cafeteria sales, and income from investments.

Lower expense growth rate

The Ministry of Health and its controlled entities' expenses grew by 4.9 per cent in 2014-15 (6.1 per cent in 2013-14). This is less than the six per cent long-term annual expense growth rate for NSW Health outlined in the 2014-15 Budget Papers.

Expenses at thirteen local health districts/specialty networks grew by less than six per cent in 2014-15. Murrumbidgee Local Health District had the lowest expense growth rate of just 0.2 per cent in 2014-15 because, on 1 July 2014, NSW Health transferred a range of mental health and community health services from the District to Albury Wodonga Health, which is administered through the Victorian health system.

Expenses at four local health districts grew by more than six per cent in 2014-15. They were Northern Sydney (8.3 per cent), Mid North Coast (7.4 per cent), South Western Sydney (6.5 per cent) and Nepean Blue Mountains (six per cent) local health districts. Northern Sydney's expense growth rate was higher due to increased activity following completion of the Royal North Shore Hospital Clinical Services Building. Similarly, Mid North Coast's expense growth rate was higher following completion of the Port Macquarie Base Hospital, which provides new and expanded facilities and a greater range of services.

While the expense growth rate can be impacted by significant, one-off expenses it is important health entities control the underlying growth in health care expenditure.

Performance against net cost of services budget improved

The Ministry uses performance against budgeted net cost of services as the key measure of health entities' financial performance. Net cost of services is the difference between total expenses and third party revenue, excluding government contributions.

In 2014-15, five local health districts had an unfavourable net cost of services variances against budget (seven in 2013-14). They were South Eastern Sydney ($20.0 million), Western Sydney ($15.8 million), Murrumbidgee ($4.5 million), Northern Sydney ($1.7 million) and Northern NSW ($1.6 million) local health districts. These local health districts also had the largest net cost of services overruns in 2013-14.

Four of these local health districts (South Eastern Sydney, Western Sydney, Murrumbidgee and Northern Sydney) were assessed by the Ministry as either not performing or underperforming at 30 June 2015 against the performance agreements with the Secretary of NSW Health. Each has a formal recovery plan for 2015-16 which sets clear expectations for financial improvement. Further details are provided in the Governance chapter of this report.

Three of these local health districts (South Eastern Sydney, Western Sydney and Murrumbidgee) have received additional cash assistance from the Ministry over the past three years.

Five local health districts received $64.2 million in cash assistance in 2014-15

In 2014-15, five local health districts received a total of $64.2 million in cash assistance to pay bills on time. The Ministry provides cash assistance needed to pay debts when they become due.

The following table shows cash assistance paid to health entities over the past three years.

Additional Cash Assistance			
Year ended 30 June	2015 $m	2014 $m	2013 $m
South Eastern Sydney Local Health District	39.2	25.0	37.6
Western Sydney Local Health District	13.0	14.8	12.8
Sydney Local Health District	4.8	--	2.6
Northern NSW Local Health District	4.5	5.2	--
Murrumbidgee Local Health District	2.7	5.3	4.4
Other local health districts*	--	13.4	75.2
Total	**64.2**	**63.7**	**132.6**

* In 2013-14, this comprised Northern Sydney ($13.4 million). In 2012-13, this comprised Northern Sydney ($42.0 million), Western NSW ($21.4 million), Nepean Blue Mountains ($10.1 million) and Southern NSW ($1.7 million).

Source: Ministry of Health (unaudited).

South Eastern Sydney, Western Sydney and Murrumbidgee local health districts have consistently received cash assistance over the past three years. At 30 June 2015, the Ministry assessed each of these local health districts as either not performing or underperforming.

Northern Sydney did not receive cash assistance in 2014-15, but did in the previous two years. Northern Sydney was de-escalated from a serious underperformance risk during the year, recognising that its finances had improved. Further details are provided in the Governance chapter of this report.

Liquidity levels vary across NSW Health

The liquidity of local health districts/specialty networks ranged from a quick ratio of 0.2 to 13.3 at 30 June 2015. The quick asset ratio is a liquidity indicator which measures the amount of highly liquid current assets (excluding restricted assets) available to cover current liabilities.

At 30 June 2015, ten local health districts/specialty networks had a quick ratio of one or less. These entities did not have sufficient short term assets to cover their short term liabilities at 30 June 2015. However, health entities receive weekly funding from the Ministry. Health entities also have the capacity to review the timing of subsidy cash flows to ensure debts can be paid when they become due.

At 30 June 2015, seven local health districts/specialty networks had a quick ratio of one or more. This indicates these entities were more financially secure in the short term than health entities with lower quick ratios. It also highlights where cash management across NSW Health can be reviewed to ensure health entities do not have excessive liquidity.

Last year’s Auditor-General’s Report to Parliament recommended the Ministry:

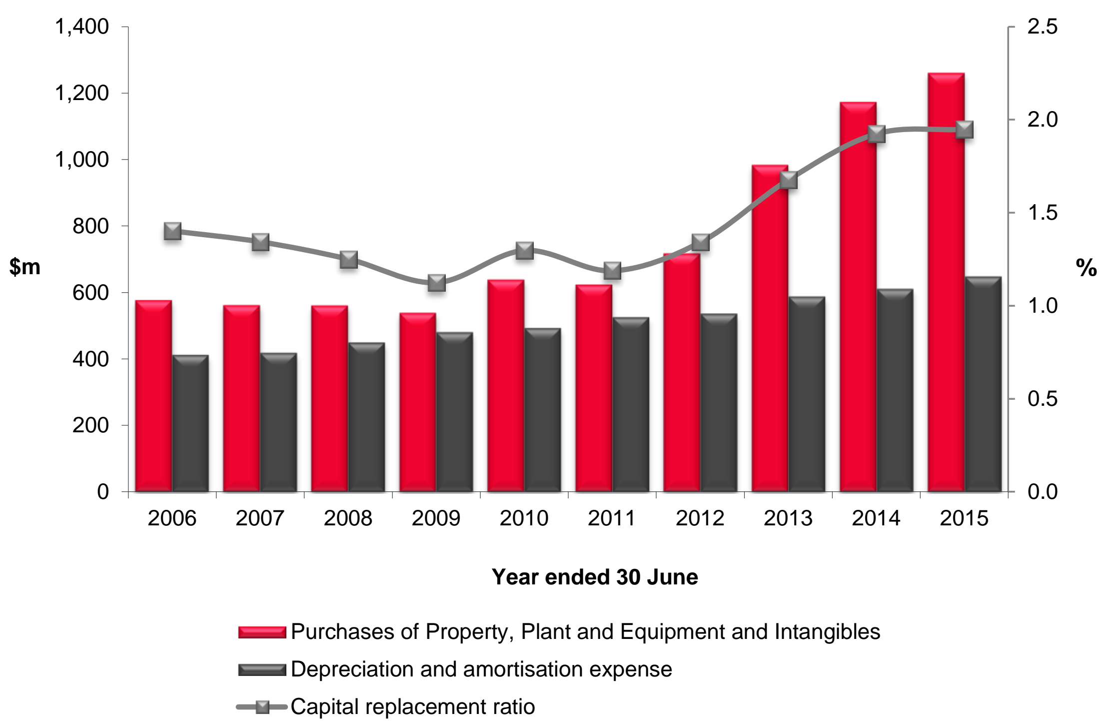
- communicate its liquidity ratio definition and target with health entities and include it in the service agreements with health entities
- extend its monitoring of health entities’ liquidity to include Pillar agencies and divisions within Health Administration Corporation
- improve cash management across NSW Health to ensure health entities do not have liquidity well in excess of the Ministry’s target.

The Ministry has responded by including a minimum weekly cash reserve in the 2015-16 service agreements between the Secretary of NSW Health and local health districts/specialty networks. The Ministry will use this to monitor the level of cash held by its controlled entities during the year.

Significant ongoing investment in hospitals and other assets

The capital replacement, or asset sustainability ratio, approximates the extent to which physical assets managed by health entities are being replaced. It compares the rate of spending on renewing or growing capital assets against related depreciation. A ratio greater than one indicates capital expenditure is greater than the rate of depreciation.

The overall capital replacement ratio for NSW Health was 1.9 in 2014-15 (1.9 in 2013-14). The graph below shows the capital replacement ratio in NSW Health over the past ten years.



Source: Audited financial statements.

Twelve local health districts/specialty networks had high capital replacement ratios

Twelve local health districts/specialty networks had capital replacement ratios greater than one in 2014-15 reflecting significant capital expenditure across NSW Health. Southern NSW Local Health District recorded the highest ratio at 11.6, due to capital expenditure on the South East Regional Hospital in Bega. The South East Regional Hospital in Bega is a $188 million project. Similarly, Murrumbidgee Local health District's ratio was 5.6 due to capital expenditure on the Wagga Wagga Redevelopment, which is a $270 million project.

Five local health districts/specialty networks had low capital replacement ratios

Five local health districts/specialty networks had capital replacement ratios less than one in 2014-15. They were Justice Health and Forensic Mental Health Network, Nepean Blue Mountains, and South Western Sydney, and Sydney local health districts, and Sydney Children's Hospitals Netowrk. Nepean Blue Mountains Local Health District and Sydney Children's Hospitals also had capital replacement ratios less than one in 2013-14.

The capital replacement ratio is a long-term indicator, because capital expenditure can be deferred in the short-term if insufficient funds are available. However, entities not meeting the ratio over the long term may be under-investing in the assets required for service delivery.

Performance against Budget

Original budgets excluded $860 million of capital funding

The overall budgeted operating deficit at the beginning of 2014-15 for all local health districts/specialty networks was $459 million. This was revised during the year to an overall surplus of $393 million. Of the difference, $860 million is due to capital funding being excluded from the original budgets. A further $8.0 million in net adjustments were made to budgets following supplementations and other changes.

The Ministry monitors individual health entities' performance against budget and provides cash assistance to ensure required service levels are met. Health entities' budget figures are updated frequently throughout the year to reflect transfers of functions, employee award changes and supplementations received after the initial budget.

Frequent changes to approved budgets during the year reduce their effectiveness in managing limited resources. Comparing entities' performance against budget assists in understanding how public funds are being used to achieve NSW Government policy objectives.

The table below shows:

- the original budget at the beginning of the financial year (excluding additional capital funding)
- the final budget at the end of the financial year, including additional supplementations
- the actual operating surplus or deficit reported by each local health district/specialty network for the year-ended 30 June 2015
- variances between the actual operating surplus or deficit and the initial and final budgets.

	Budgeted operating surplus/(deficit)		Actual operating surplus/ (deficit)	Favourable/(unfavourable) variance			
	Original	Final		Original vs Actual		Final vs Actual	
Year ended 30 June 2015	**$m**	**$m**	**$m**	**$m**	**% ^**	**$m**	**% ^**
Justice Health and Forensic Mental Health Network	(0.4)	(2.1)	2.8	3.2	1.6	4.9	2.5
Sydney Children's Hospitals Network	(24.1)	(11.8)	4.8	28.9	4.2	16.6	2.4
South Eastern Sydney*	(45.3)	(10.6)	9.7	55.0	3.5	20.3	1.3
Sydney*	(38.7)	(54.3)	(41.2)	(2.5)	0.2	13.1	0.9
Southern NSW	(2.1)	102.2	105.0	107.1	30.8	2.8	0.8
Far West	(3.1)	--	(0.6)	2.5	2.4	(0.6)	0.6
Mid North Coast	(12.2)	20.7	23.7	35.9	6.6	3.0	0.6
Murrumbidgee*	(8.2)	81.5	79.0	87.2	17.2	(2.5)	0.5
Northern NSW*	(24.3)	42.3	45.3	69.6	10.0	3.0	0.4
Illawarra Shoalhaven	(13.6)	49.5	51.9	65.5	8.1	2.4	0.3
South Western Sydney	(50.9)	(19.3)	(14.3)	36.6	2.3	5.0	0.3
Central Coast	(19.9)	(0.3)	1.3	21.2	3.0	1.6	0.2
Hunter New England	(61.7)	29.0	34.1	95.8	4.8	5.1	0.3
Nepean Blue Mountains	(24.0)	(12.4)	(11.2)	12.8	1.9	1.2	0.2
Northern Sydney	(57.1)	79.0	82.0	139.1	9.3	3.0	0.2
Western Sydney*	(30.5)	34.2	35.8	66.3	4.3	1.6	0.1
Western NSW	(42.8)	63.5	63.7	106.5	13.1	0.2	--

* Local health district received cash assistance in 2014-15. Refer to commentary above.

^ Absolute value of favourable/(unfavourable) variance as a percentage of total expenses excluding losses for 2014-15.

Source: Original and final budget operating surplus/(deficit) – Ministry of Health (unaudited). Actual operating surplus/(deficit) – Audited financial statements.

Three local health districts had differences exceeding $100 million between their initial 2014-15 budget and final budget. They were Northern Sydney ($136 million), Western NSW ($106 million) and Southern NSW ($104 million) local health districts.

Better performance against final budgets

In 2014-15, two local health districts had unfavourable budget results, Murrumbidgee ($2.5 million) and Far West ($0.6 million). By comparison, seven local health districts performed unfavourably against their revised budgets in 2013-14.

The Treasurer has continued to communicate with agency chief financial officers, the importance of accurate financial information at various forums. The Treasurer's request for the Auditor-General to review the estimates and forecasts in the 2014-15 'Half Yearly Budget Review' and 2015-16 'Budget Papers' was also aimed at improving the overall quality of budgets and projections.

Health funding

Three rural local health districts costs are consistently above the State price

Far West, Western NSW and Southern NSW local health districts projected average costs have been consistently higher than the State price over the past three years. The Ministry has recognised this, and included a specific transition grant to account for the higher cost of providing health services in rural locations in the 2015-16 service agreements. These local health districts will receive combined transition grants of $70.8 million in 2015-16 ($91.3 million in 2014-15) to cover the difference between their projected average costs and the State price. This includes transition grants for acute and emergency services of $39.9 million ($52.2 million).

Five other local health districts' projected average costs are expected to be higher than the State price by less than five per cent for 2015-16. They are Murrumbidgee, Northern Sydney, Sydney, Hunter New England and Illawarra Shoalhaven local health districts.

Eight local health districts/specialty networks projected average costs are expected to be lower than the State price for 2015-16. Mid North Coast and South Western Sydney local health districts were the only two agencies whose projected average costs have consistently been lower than the State price over the past three years.

In 2015-16, the Ministry is funding activity based services using a State price of $4,569 per weighted activity ($4,583 in 2014-15 and $4,671 in 2013-14).

The following table details the projected average cost of each local health district/specialty networks' services for 2014 to 2016.

Year ended 30 June	Projected average cost 2016 $	2015 $	2014 $
State price	**4,569**	**4,583**	**4,671**
Far West	🔴 5,827	🔴 6,115	🔴 5,741
Western NSW	🔴 5,094	🔴 5,397	🔴 5,240
Southern NSW	🔴 5,007	🔴 5,279	🔴 5,238
Murrumbidgee	🟡 4,779	🟡 4,745	🔴 5,000
Northern Sydney	🟡 4,684	🟢 4,548	🟡 4,860
Sydney	🟡 4,662	🟢 4,477	🟢 4,609
Hunter New England	🟡 4,615	🟢 4,504	🟢 4,535
Illawarra Shoalhaven	🟡 4,574	🟡 4,612	🟡 4,877
South Eastern Sydney	🟢 4,555	🟡 4,665	🔴 4,961
Central Coast	🟢 4,513	🟡 4,628	🟢 4,574
Northern NSW	🟢 4,504	🟡 4,586	🟡 4,857
Western Sydney	🟢 4,494	🔴 4,897	🔴 4,918
Nepean Blue Mountains	🟢 4,432	🟢 4,457	🟡 4,876
Sydney Children's Hospitals Network	🟢 4,381	🟢 4,488	🔴 4,982
South Western Sydney	🟢 4,290	🟢 4,174	🟢 4,355
Mid North Coast	🟢 4,124	🟢 4,243	🟢 4,670

🟢 Projected average cost less than State Price

🟡 Projected average cost higher than State Price (less than 5 per cent)

🔴 Projected average cost higher than State Price (greater than 5 per cent)

Source: NSW Ministry of Health (unaudited).

Local health districts/specialty networks are funded based on a combination of activity based funding (ABF) and block funding. For ABF services, local health districts/specialty networks are funded at the lower of the projected average cost or the 'State price' set by the Ministry. Some health entities also receive transition grants (see below) when the projected average cost is higher than the State price.

The State price and a local health districts/specialty networks projected average costs are influenced by:

- productivity improvements
- changes in input costs
- better capture and reporting of activity
- refinements in standardisation of cost allocation.

Caution should be taken when comparing the State price from one year to the next. The price varies year to year as additional services are funded through ABF and the activity is included in the calculation of the State price.

Transition grants continue to fall

In 2015-16, $182 million in transition grants will be paid to thirteen local health districts/specialty networks. By comparison, $248 million in transition grants was paid to ten local health districts/specialty networks in 2014-15. Transition grants are paid when local health districts/specialty networks provide services at a cost greater than the State price.

Each local health district/specialty network, except South Eastern Sydney, Mid North Coast and Northern NSW local health districts, will receive transition grants in 2015-16. All health entities continuously review the accuracy and completeness of their costing, patient activity data and their clinical practices, to reduce variances from the State price.

The following table shows transition grants paid to health entities in 2014-15 and planned for 2015-16.

Local health district/speciality network	Transition grant (acute and emergency services)	Transition grant (non-admitted)	Transition grant - other services	Total transition grants	Total transition grants
Year ended 30 June	**2016 $m**	**2016 $m**	**2016 $m**	**2016 $m**	**2015 $m**
Western NSW	20.4	1.5	20.8	**42.7**	54.9
Sydney Children's Hospitals Network	--	35.0	--	**35.0**	--
Southern NSW	13.2	--	2.7	**15.9**	23.7
Northern Sydney	--	--	13.7	**13.7**	--
Nepean Blue Mountains	--	13.2	--	**13.2**	18.4
Western Sydney	--	13.0	--	**13.0**	50.1
Far West	6.3	1.7	4.2	**12.2**	12.7
Sydney	9.0	--	--	**9.0**	29.9
Murrumbidgee	8.1	--	--	**8.1**	5.2
Hunter New England	--	--	6.9	**6.9**	38.9
South Western Sydney	--	6.0	--	**6.0**	--
Central Coast	--	4.1	--	**4.1**	6.1
Illawarra Shoalhaven	--	1.9	--	**1.9**	--
South Eastern Sydney	--	--	--	**--**	8.4
Mid North Coast	--	--	--	**--**	--
Northern NSW	--	--	--	**--**	--
Total	**57.0**	**76.4**	**48.3**	**181.7**	**248.3**

Source: NSW Ministry of Health (unaudited).

Transition grants for acute and emergency services continue to fall. In 2015-16, $57.0 million will be paid to five local health districts compared to $105 million paid to six local health districts in 2014-15. However, two local health districts (Sydney and Murrumbidgee) will receive higher transition grants for acute and emergency services in 2015-16.

The transition grant calculations are influenced by the quality of costing and patient activity data and changes in patient classifications. As local health districts and the Sydney Children's Hospitals Network continue to review and improve their data accuracy, transition grants will fluctuate from year to year.

ABF readiness reassessment identifies opportunities for improvement

The 2013 Auditor-General's Report to Parliament recommended the Ministry conduct a formal ABF readiness reassessment of whether NSW Health had effective systems and processes to support ABF. In August 2014, the Ministry engaged an independent consultant to reassess NSW Health's readiness. The review found local health districts/specialty networks had:

- largely implemented the recommendations from the 2012 readiness assessment
- predominantly been effective in putting in place the systems, processes and workforce with the required skills and capabilities to operate within an ABF environment
- embraced ABF as an opportunity to support ongoing efforts to improve both service delivery and service efficiency.

The review found NSW Health had made significant progress implementing the key elements and principles for a successful ABF model. However, the review noted there were still opportunities for improvement with a key priority for further embedding ABF principles into budgeting, improving the quality of ABF data and operationalising the use of activity base management.

Financial Controls

Appropriate financial controls help ensure the efficient and effective use of resources and the implementation and administration of NSW Health policies. They are essential for quality and timely decision making to achieve desired outcomes.

This chapter outlines findings about financial controls of entities in the Health cluster for 2014-15. The table below summarises key findings, conclusions and recommendations.

Financial controls	
Observation	**Conclusion or recommendation**
Most IT issues identified in health entities are caused by weak user administration processes.	**Recommendation:** Management and communication of user administration processes between health entities and HealthShare NSW should be strengthened.
Managing excess annual leave remains a significant challenge for health entities. More than a third of NSW Health's workforce has excessive annual leave balances.	**Recommendation (repeat issue):** Health entities should continue reviewing the approach to managing excessive annual leave in 2015-16. They should: • monitor current and projected leave balances to the end of the financial year on a monthly basis • agree formal leave plans with employees to reduce leave balances over an acceptable timeframe • monitor employees who take no or very little leave in a rolling12 month period.
NSW Ambulance faces significant challenges in managing sick leave. Implementing strategies to manage sick leave have been delayed.	**Recommendation (repeat issue):** NSW Ambulance should implement targeted human resource strategies to address significant challenges it faces managing sick leave.
NSW Ambulance's overtime (including call backs) remains significant. Strategies to reduce overtime are not working.	**Recommendation (repeat issue):** NSW Ambulance should review the effectiveness of its strategies and rostering practices to reduce excessive overtime and call back payments.
A Staff Specialist at Hunter New England Local Health District had not recorded 20 weeks of annual leave dating back to 2009. Shortcomings in internal controls over the approval and recording of time worked by Staff Specialists contributed to the problem.	**Recommendation:** Health entities should: • ensure timesheets are approved by supervisors before pay runs are complete • review Staff Specialists' rostering and leave recording practices by 30 June 2016, and immediately address any internal control weaknesses.
In 2014-15, Visiting Medical Officers (VMO) continued to submit claims for payment irregularly or late, sometimes over 12 months late. The pay of VMOs can now be reduced if they submit late claims.	Local health districts/specialty networks should start discounting late claims submitted by VMOs.
NSW Health quantified its total backlog maintenance for the first time. The backlog was $323 million at 30 June 2015. Health entities identified and measured backlog maintenance in their 2015 Asset Strategic Plans.	Local health districts/specialty networks are now able to ensure maintenance works are well targeted and timely, to meet their future service needs.

Financial controls	
Observation	**Conclusion or recommendation**
NSW Health has implemented a new asset management system.	Despite the new system, NSW Health faces challenges to ensure the quality and completeness of data in the asset management system, as it varies between health entities and hospitals.
The revised completion dates for six of the nine major information technology projects being managed by eHealth NSW have been delayed from the dates advised last year.	**Recommendation:** eHealth NSW should perform a detailed review of the way it manages information technology projects. The review should analyse the reasons for project delays and identify strategies to mitigate the risk on future projects.
Not all health entities are adequately monitoring purchase order usage.	**Recommendation (repeat issue):** Health entities not monitoring purchase order usage for each budget holder should do so by 31 March 2016. These entities should: • identify which budget holders are not using purchase orders and understand why • implement targeted strategies to improve compliance with the Ministry of Health's purchase order target.
Dormant special purpose accounts are not yet resolved. Almost 60 per cent of these accounts, totalling $215 million, remained idle during 2014-15.	**Recommendations (repeat issues):** The Ministry should issue guidance and work with each health entity to determine what they should do with dormant special purpose funds or funds whose purpose is unclear. Health entities should arrange appropriate approvals to move funds from special purpose accounts to the Public Contributions Trust Fund by 31 March 2016.

Internal Controls

Almost a third of internal control issues reported were repeat issues

The 2014-15 financial statement audits identified 164 internal control issues. By comparison, 200 were identified in 2013-14 and 259 in 2012-13. The number of repeat recommendations decreased in 2014-15 compared to the previous year, but the time taken to action recommendations can improve. In 2014-15, there were 49 repeat recommendations (73 in 2013-14).

Repeat recommendations

Issues identified in the 2014-15 audits which were reported in the previous year and had not been addressed or fully resolved included:

- Management of excessive annual leave balances needs continued focus at most health entities. Further details are provided later in this chapter.
- Many timesheets are not being approved by supervisors before pay runs are complete. Further details are provided later in this chapter.
- Some visiting medical officers continue to submit claims for payment irregularly or late. Further details are provided later in this chapter.

No high risk internal control weaknesses were identified in 2014-15

The 2014-15 audits of health entities did not identify any high risk internal control weaknesses. However, areas were identified where internal controls could be improved. These were reported to the relevant agencies' management together with recommendations to address the weaknesses.

Details of the internal control weaknesses and key themes are summarised below.

Governance issues

Governance issues included:

- Some health entities had incomplete gifts and benefits registers. Further details are provided in the Governance chapter of this report.
- Instances were identified where a local health district had limited processes to identify related party transactions. Further details are provided in the Governance chapter of this report.

Other control issues

Other control issues included:

- Instances of unrecorded annual leave for staff specialists were identified in one local health district. Some balances dated back to 2009. Further details are provided later in this chapter.
- Clinical academic salary payments made by a local health district to a university were not supported by a formal or signed agreement substantiating the district's responsibility to pay. Further details are provided later in this chapter.
- Leasing registers were not maintained by a local health district, increasing the risk that leasing arrangements are not effectively managed.

Financial performance and reporting issues

Financial performance and reporting issues included:

- Instances were identified where employee benefits were not recorded as liabilities.
- The need to improve the quality and review of general ledger reconciliations.
- Completed projects need to be capitalised in a timely manner.
- Accounts payable control accounts, old receipt accruals and old invoices on-hold need to be reviewed and cleared.

Breakdowns and weaknesses in internal controls increase the risk of fraud and error. The 2014-15 audits concluded that, generally, internal controls were designed appropriately and operated effectively to produce reliable and timely financial reports.

Information Technology Controls

Most identified IT issues are caused by weak user administration processes

> **Recommendation**
>
> **Management and communication of user administration processes between health entities and HealthShare NSW should be strengthened.**

Information systems audits focus on the information technology (IT) processes and controls that support the integrity of financial data used to prepare agencies' financial statements.

Sixteen IT issues were identified for health entities in 2014-15 (27 in 2013-14). Of these, seven were identified in last year's audits.

Weak user administration processes accounted for most IT issues identified in 2014-15. These weaknesses increase the risk of users having excessive or unauthorised access to critical financial systems, compromising the integrity and security of financial data residing in these systems.

Ineffective communication of financial system access changes between Health entities and HealthShare NSW contributed to the user administration issues.

Disaster Recovery Planning

Last year's Auditor-General's Report to Parliament recommended health entities review and test their disaster recovery plans to ensure they can restore financial systems in the event of a disaster.

Disaster recovery planning issues were partially resolved during the year for the shared financial systems supported by eHealth NSW. However, issues with disaster recovery planning continue for some financial systems supported by health entities.

Human Resources

At 30 June 2015, NSW Health employed around 109,500 full time equivalent employees (107,600 at 30 June 2014), 72.7 per cent of whom (72.9 per cent) were clinical staff. The State-wide percentage of employee related expenses compared to total expenses was 63.4 per cent in 2014-15 (63.6 per cent in 2013-14).

Human Resource challenges at NSW Ambulance

NSW Ambulance faces significant challenges in managing sick leave

Recommendation (repeat issue)

NSW Ambulance should implement targeted human resource strategies to address significant challenges it faces managing sick leave.

Last year's Auditor-General's Report to Parliament recommended NSW Ambulance implement targeted human resource strategies to address significant challenges it faces managing annual leave, sick leave and overtime (including call back) payments.

NSW Ambulance advises:

- it is implementing strategies to help manage annual leave and unplanned overtime costs
- the implementation of strategies to manage sick leave has been delayed until NSW Ambulance replaces its payroll system, which is expected during 2015-16.

Managing excess annual leave

Managing excess annual leave remains a significant challenge for health entities

Recommendation (repeat issue)

Health entities should continue reviewing the approach to managing excessive annual leave in 2015-16. They should:

- **monitor current and projected leave balances to the end of the financial year on a monthly basis**
- **agree formal leave plans with employees to reduce leave balances over an acceptable timeframe.**

More than a third of NSW Health's workforce has excessive annual leave balances

The number of employees in NSW Health with leave balances above target increased from 34,999 at 30 June 2014 to 45,240 at 30 June 2015. Some employees in NSW Health accrue four weeks of annual leave each year. For others, such as those working a seven day roster, the accrual can be as high as seven weeks per year.

At 30 June 2015, South Western Sydney Local Health District had the highest percentage of employees with balances exceeding 30 days (47.8 per cent) while the Health Education and Training Institute had the lowest percentage (12.8 per cent).

The table below shows the number of employees in NSW Health with excessive leave.

Excessive annual leave balances					
At 30 June	2015	2014	2013	2012	Trend
Number of employees with excessive leave*	45,240	34,999	28,707	28,051	INCREASING
Percentage of workforce	36.4	28.7	23.8	22.9	INCREASING

* 2015 figures based on 30 days or more, 2014 figures based on 35 days or more, 2013 and 2012 figures based on 40 days or more.

Source: NSW Ministry of Health (unaudited).

Reducing excessive annual leave remains a significant challenge for many health entities. Despite instructions from the Ministry and expectations set out in the State Budget, health entities are not effectively managing employee annual leave balances.

Last year's Auditor-General's Report to Parliament recommended health entities manage excessive annual leave balances more effectively in 2014-15. This included agreeing formal leave plans with employees to reduce their leave balances over an acceptable timeframe and monitoring current and projected leave balances to the end of the financial year on a monthly basis. Most health entities advise they are monitoring current and projected leave balances. However, the 2014-15 audits identified that some health entities have not agreed formal leave plans with employees to reduce their leave balances.

Treasury Circular TC14/11 'Reduction of Accrued Recreation Leave Balances' required agencies to make all reasonable attempts to reduce accrued employee recreation leave balances to a maximum of 30 days or less by 30 June 2015. This target was reduced from 40 days or less at 30 June 2013 and from 35 days or less at 30 June 2014.

Health entities should continue to review the approach to managing excessive annual leave. Excess leave entitlements can adversely affect an organisation because the liability generally increases over time as salary rates increase, impacting cash flow requirements. The health and welfare of staff can also be adversely affected if staff do not take sufficient leave. Further, fraud is more likely to be detected when people are on leave, as staff performing key control functions are replaced.

The Ministry advises:

- a requirement for health entities to manage and monitor employee leave has been included in their 2015-16 Service Agreements
- it has provided health entities with leave management strategies and reports to help manage excess leave
- from April 2015, health entities have access to the State Management Reporting Service to monitor and report on staff leave balances.

The number of employees taking no annual leave during the financial year is increasing

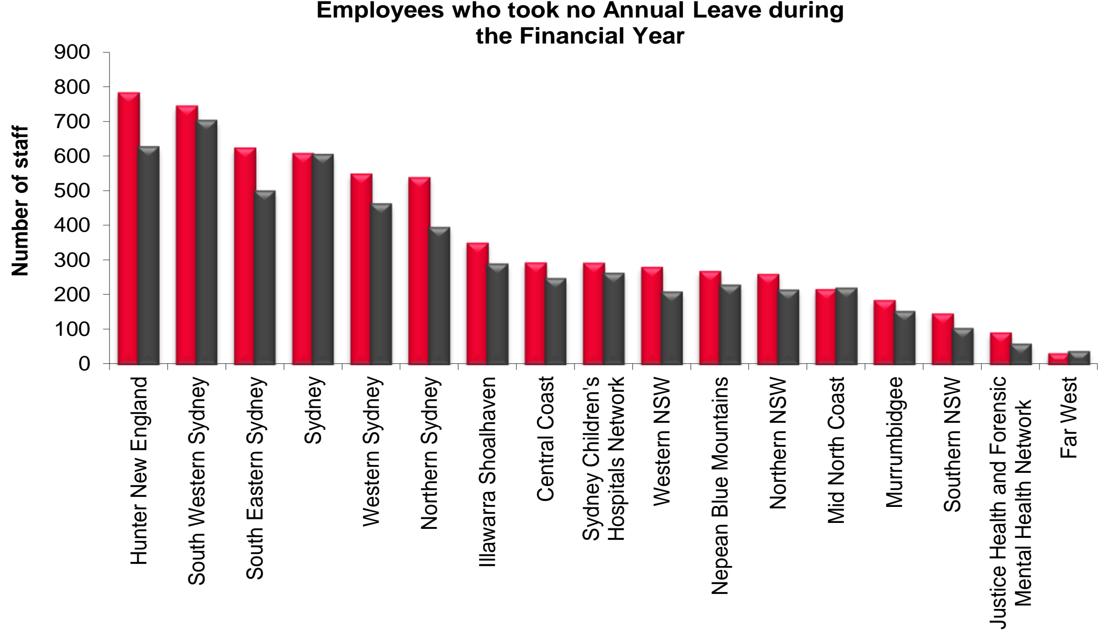
Recommendation (repeat issue)

Health entities should monitor employees who take no or very little leave in a rolling 12 month period.

The number of employees at local health districts/specialty networks who did not take annual leave during the year increased from 5,270 in 2013-14 to 6,209 in 2014-15. Last year's Auditor-General's Report to Parliament recommended all health entities monitor employees who take no or very little annual leave in a rolling 12 month period. Only Mid North Coast and Far West local health districts reduced the number of employees who took no annual leave in 2014-15. The other local health districts/specialty networks had a higher number of employees who took no annual leave in 2014-15.

Entities need exception reporting to identify employees who are taking leave but not recording it in the system, and employees who should be, but are not taking leave, to mitigate fraud and health risks.

The graph below shows the number of employees at local health districts/specialty networks who took no annual leave during 2014-15. Hunter New England Local Health District had the most number of employees who took no leave in 2014-15 at 780, followed by South Western Sydney Local Health District with 742 and Sydney Local Health District with 605.



Note: 2013-14 information has been updated from data published in last year's Auditor-General's Report to Parliament. The information now excludes employees who commenced employment part way through the financial year.

Source: NSW Ministry of Health (unaudited).

Clinical Academic leave records are not always reviewed

South Eastern Sydney, South Western Sydney and Nepean Blue Mountains local health districts have not reviewed the leave records of Clinical Academic employees to ensure all annual leave taken has been recorded.

Last year's Auditor-General's Report to Parliament recommended health entities review the annual leave balances of Clinical Academic employees to ensure all leave taken has been recorded. It also recommended health entities review the internal controls around the processing of Clinical Academic leave records to ensure leave taken is processed in the payroll system. South Eastern Sydney, South Western Sydney and Nepean Blue Mountains local health districts reported that they have not done this.

There are approximately 224 Clinical Academic staff employed across NSW Health. They provide clinical and associated administrative services for public patients in public hospitals. Their primary employment is within universities' faculties of medicine, but they are on NSW Health's payroll system where their leave entitlements are recorded. Last year's Auditor-General's Report to Parliament also recommended the Ministry review whether there are other employment arrangements where leave may not be recorded. The Ministry advises it is not aware of any such arrangements. However, the 2014-15 audit identified instances of unrecorded annual leave for staff specialists dating back to 2009 in one local health district. Further details are provided later in this chapter.

Managing sick leave

Each NSW Health employee took an average of 62.4 hours of sick leave in 2014-15

In 2014-15, employees working across NSW Health took an average of 62.4 hours of sick leave per full time equivalent employee (FTE), which is higher than the Ministry's target of 50 hours per FTE.

Over the past three years, no local health district or specialty network has met the Ministry's sick leave target. However, eight local health districts and one specialty network had, on average, fewer sick leave hours per FTE in 2014-15 compared to 2013-14.

For the last three years the Justice Health and Forensic Mental Health Network has had the highest sick leave per FTE across all local health districts/specialty networks, with its employees taking an average of 68.3 hours in 2014-15 (69.3 hours in 2013-14). Sydney Local Health District had the lowest average rate per FTE with its employees taking an average of 58.3 hours (Sydney Children's Hospitals Network had the lowest rate in 2013-14 with an average of 56.6 hours).

The following table shows average sick leave hours per FTE in NSW Health compared to the Ministry of Health's target.

Sick leave				
Service measure	Actual	Target	Status	Actual
Year ended 30 June		2015		2014
Average sick leave hours per full time equivalent employee	62.4	50	NOT MET	62.6

Source: NSW Ministry of Health (unaudited).

NSW Ambulance employees are taking the most sick leave

NSW Ambulance had the highest sick leave rate, with its employees taking an average of 81.2 hours sick leave per FTE in 2014-15 (80.8 hours in 2013-14). Health Infrastructure had the lowest average rate per FTE at 33.2 hours (39.1 hours).

In 2014-15, employees working in the Ministry of Health took an average of 60.9 hours (51.7 hours). The Ministry did not meet the target it set for NSW Health.

Only four entities recorded average sick leave hours taken per FTE below the Ministry's target. They were the Agency for Clinical Innovation, Bureau of Health Information, Clinical Excellence Commission and Health Infrastructure.

High levels of sick leave can have adverse operational and financial impacts on health entities, because fewer employees are available to deliver services and overtime is paid to other employees to maintain minimum staffing levels.

The Ministry advises:

- it expects health entities to develop strategies to promote health and safety and attendance at the workplace
- it has distributed specific strategies on managing sick leave to health entities
- since April 2015, health entities have access to the State Management Reporting Service to monitor and report on staff sick leave balances.

Last year's Auditor-General's Report to Parliament recommended health entities manage sick leave more effectively in 2014-15 and implement targeted strategies to reduce sick leave taken. Health entities advise that initiatives they have implemented to reduce sick leave include: coaching managers to better manage sick leave; reviewing staff on long term sick leave and developing return to work plans; sick leave data being reviewed by cost centre managers; trend reports on sick leave being reviewed at Finance and Performance Committees; and medical reviews being conducted for employees taking excessive sick leave.

Employees are eligible for sick leave when ill or injured, or, in certain cases, when looking after ill or injured family members.

Overtime Payments (including call backs)

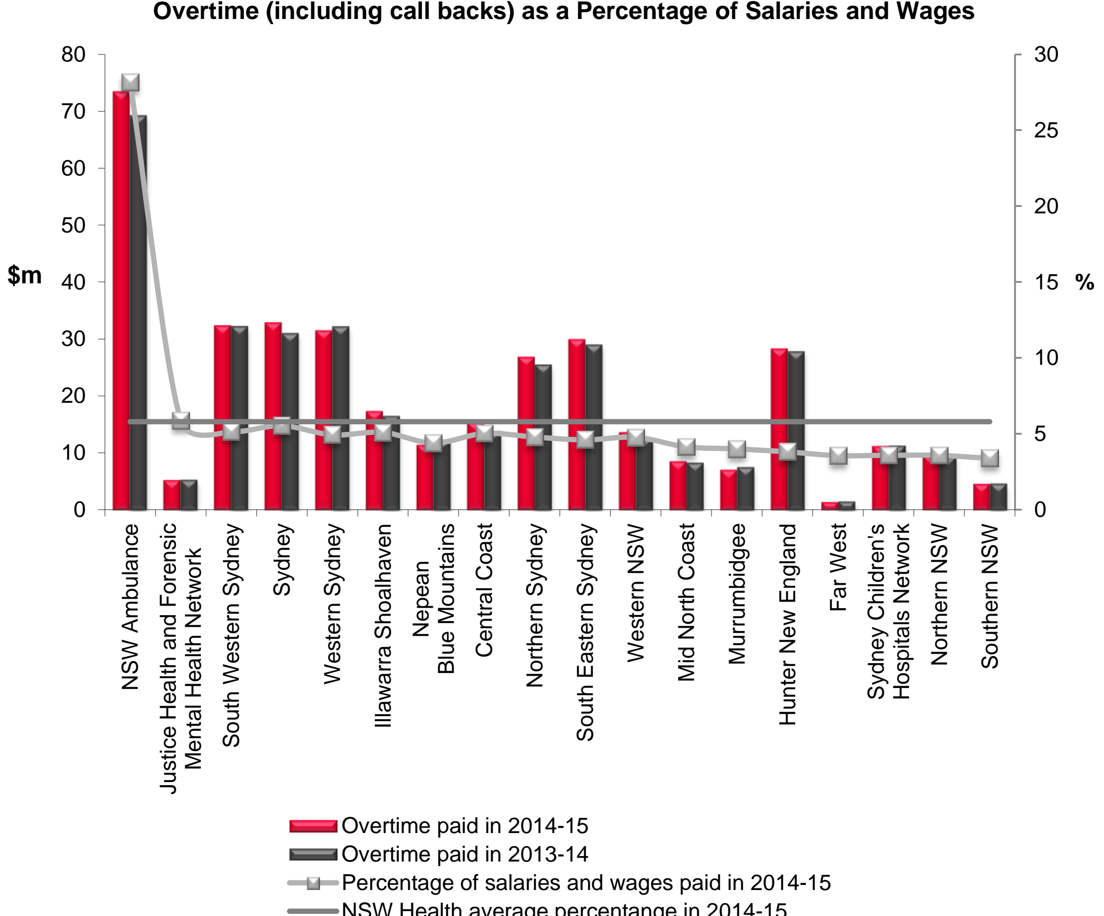
NSW Ambulance's overtime (including call backs) remains significant

Recommendation

NSW Ambulance should review the effectiveness of its strategies and rostering practices to reduce excessive overtime and call back payments.

NSW Ambulance's overtime (including call backs) continues to be significantly higher than that incurred by other health entities. Strategies to reduce overtime are not working. In 2014-15, its overtime represented 28.1 per cent of its salaries and wages expense (27.7 per cent in 2013-14). This is attributed to employee award provisions, the nature of its operations and the number of staff on call, particularly in rural areas where there is not enough staff for a 24 hour roster. NSW Ambulance reviews the highest 20 overtime earners each quarter (in terms of hours worked and overtime paid) to assess if there are fatigue issues.

The graph below shows overtime (including call backs) by health entity.



Source: NSW Ministry of Health (unaudited).

Last year's Auditor-General's Report to Parliament recommended NSW Ambulance review its rostering practices to identify additional strategies to reduce excessive overtime and call back payments. NSW Ambulance advises it continues to review rostering practices throughout the State, in particular in regional areas, to reduce after hour call outs of paramedic crews.

The percentage of salaries and wages spent on overtime fell in 2014-15

The overall management of overtime across NSW Health is improving marginally with overtime payments as a percentage of salaries and wages expense declining slightly over the last three years.

Overtime (including call backs)				
Year ended 30 June	2015	2014	2013	Trend
Total overtime payments (including call backs) ($m)	377	368	370	--
Percentage of salaries and wages expense	4.2	4.3	4.5	DECREASING

Source: NSW Ministry of Health (unaudited).

While total overtime payments (including call backs) increased to $377 million in 2014-15 ($368 million in 2013-14) overtime payments as a percentage of salaries and wages expense fell to 4.2 per cent (4.3 per cent).

Some medical officers earn more in overtime than their base salary

The highest overtime earner in NSW Health in 2014-15 was a medical officer with a base salary of $112,725 who received more than $178,000 in overtime and call backs. The table below shows the five employees paid the most overtime (including call backs) in 2014-15.

Position	Local health district	Annual base salary $	Overtime/ call back paid $
Year ended 30 June		2015	2015
Registrar, Medical Officer	Sydney	112,725	178,871
Registrar, Medical Officer	South Western Sydney	112,725	171,167
Registrar, Medical Officer	South Eastern Sydney/Sydney	112,725	163,250
Career Medical Officer Senior	South Western Sydney	194,097	160,125
Career Medical Officer Senior	Western NSW	194,097	154,838

Source: NSW Ministry of Health (unaudited).

A career medical officer earned over $503,000 in overtime over the past three years

The table below shows four employees consistently claimed, and were paid, more than $120,000 in overtime (including call backs) from 2012-13. The highest overtime earner, a career medical officer, earned more than $503,000 in overtime and call backs over the past three years.

Position	Local health district	Annual base salary	Overtime/ call back paid	Overtime/ call back paid	Overtime/ call back paid	Total Overtime/ call back paid
Year ended 30 June		2015 $	2015 $	2014 $	2013 $	$
Career Medical Officer Senior	Western NSW	194,097	154,838	191,995	156,663	**503,496**
Career Medical Officer Senior	South Western Sydney	194,097	160,125	188,148	149,367	**497,640**
Career Medical Officer Senior	Western Sydney	194,097	122,234	156,713	197,486	**476,433**
Career Medical Officer Senior	Northern NSW	194,097	137,745	145,971	158,818	**442,534**

Source: NSW Ministry of Health (unaudited).

A call back occurs when a staff member is on call and is asked to come to work. Under the Award, the staff member is paid a minimum of four hours regardless of the time worked.

Overtime is paid at a premium rate and, if not effectively managed, can result in higher costs and work, health and safety issues, particularly when fatigued employees perform high-risk tasks.

NSW Health expects that the new state-wide rostering system to provide better visibility of employees between rosters and help minimise back to back shifts inside required rest periods.

Time Recording

A Staff Specialist had not recorded 20 weeks of annual leave dating back to 2009

Recommendation

Health entities should:

- **ensure timesheets are approved by supervisors before pay runs are complete**
- **review Staff Specialists' rostering and leave recording practices by 30 June 2016, and immediately address any internal control weaknesses.**

The failure of supervisors to approve employee timesheets continues to be a problem. Hunter New England Local Health District advises it identified around 20 weeks of annual leave taken by a Staff Specialist, dating as far back as 2009, that had not been recorded. Another Staff Specialist had two weeks of unrecorded annual leave. The District advises shortcomings in internal controls over the approval and recording of time worked by Staff Specialists contributed to the problem.

Stronger controls over the approval of timesheets before submission for payroll processing would reduce the high volume of roster adjustments, manual pays, salary overpayments and staff taking leave but not recording it in the system.

All health entities should conduct a risk-based review of Staff Specialists' rostering and leave recording practices to ensure they do not have similar issues. The absence of timesheet approval controls increases the risk of staff claiming and being paid for hours they have not worked.

Last year's Auditor-General's Report to Parliament recommended Chief Executives of health entities advise supervisors of their obligations to approve timesheets to prevent employees being paid without a supervisor confirming they worked the hours recorded on their timesheets.

State-wide Rostering System

New rostering system to be implemented over the next three years

NSW Health is continuing its long term project to consolidate the multiple rostering systems used across the sector and replace it with a single State-wide rostering system. In 2014-15, the new rostering system was implemented at eHealth NSW and HealthShare NSW. The implementation has commenced at other health entities, but the rollout across the State is not expected to finish until 2018 at the earliest.

The Ministry advises:

- eHealth NSW is working closely with clinical and administrative stakeholders across the State to ensure the rostering system is fit for purpose and reflects State-wide health system policy and local practices
- key challenges remain in delivering the project, such as:
  - differing maturity levels in rostering practices across the State
  - software performance and ongoing scalability issues which are currently being resolved with vendors.

The original budget for the project was $94.6 million (revised budget: $89.6 million). At 30 June 2015, $85.0 million had been spent on the project. The benefits of the new system are expected to include:

- consistent application of Awards resulting in more accurate pays
- visibility of overtime and call-backs which can be used to analyse trends and behaviours
- reduced manual pay adjustments through electronic submissions
- increased visibility of staff moving between rosters to minimise back to back shifts inside required rest periods
- reduced number of payroll queries
- improved management of casual and agency staff by making information available to support better decisions on when to allocate a shift to agency staff.

NSW Ambulance – Death and Disability Scheme

Death and Disability scheme insurance premiums have increased almost fourfold

Insurance premiums for NSW Ambulance's Death and Disability scheme rose from $5.8 million in 2013-14 to $21.7 million in 2014-15. NSW Ambulance advises the increase is due to claims experience and general insurance market conditions. The Ministry of Health continues to consider other viable options to address the unfavourable trend in scheme costs.

Under the scheme, an injured officer receives a lump sum payment if their physical or mental disability prevents them performing the duties they were substantively employed to do. The amount they are entitled to varies depending on their age and whether the injury leading to their disability occurred on or off duty. At present, employees and NSW Ambulance contribute up to 1.8 per cent and 3.6 per cent respectively of the employees' base salary to fund the liability.

Workplace Health and Safety

NSW Health's workers' compensation claims continue to fall

NSW Health paid $162 million in workers' compensation insurance premiums in 2014-15 compared to $194 million in 2013-14, mainly because the number of workers' compensation claims has fallen over the last three years.

Workers' compensation claims				
Service measure – year ended 30 June	**2015**	**2014**	**2013**	**Trend**
Total Number of claims	4,612	4,821	5,389	REDUCING

Source: NSW Ministry of Health (unaudited).

The most common injury to health employees is body stress, which include muscle strains and back conditions due to the high frequency of lifting and handling patients. Nurses continue to be the most likely to be injured with 40 per cent of all claims in 2014-15 (39.7 per cent in 2013-14) made by them.

Mental stress claims continue to be the costliest injury, with the average claim costing $36,280 in 2014-15 ($22,162), more than triple the cost of other injury types. These claims are mainly attributable to work-related harassment or workplace bullying, work pressure and exposure to occupational violence or traumatic events.

Workers' compensation claims by injury type are shown in the table below.

Workers' compensation claims by injury type	Number of claims	Cost of claims	Number of claims	Cost of claims	Number of claims	Cost of claims
Year ended 30 June	**2015**	**$m**	**2014**	**$m**	**2013**	**$m**
Body stress	2,183	24.8	2,303	25.2	2,470	25
Slips and falls	830	9.1	819	7.8	964	9.3
Mental stress	328	11.9	370	8.2	392	8.7
Hit by objects	600	3.6	229	0.9	741	5
Motor vehicle	67	0.4	75	0.3	97	0.9
Other causes	604	5.6	1,025	7.8	725	3.6
Total	**4,612**	**55.4**	**4,821**	**50.3**	**5,389**	**52.5**

Source: NSW Ministry of Health (unaudited).

NSW Health continues to implement strategies to reduce workplace injuries as part of the Work Health and Safety proactive strategic plan 2014-16. Some of these strategies include: conducting a work injury screening and early intervention study; reviewing the management of workers' compensation claims; providing training courses on managing difficult claims; and undertaking a pre-employment screening pilot program.

Visiting Medical Officers

The pay of Visiting Medical Officers can now be reduced if they submit late claims

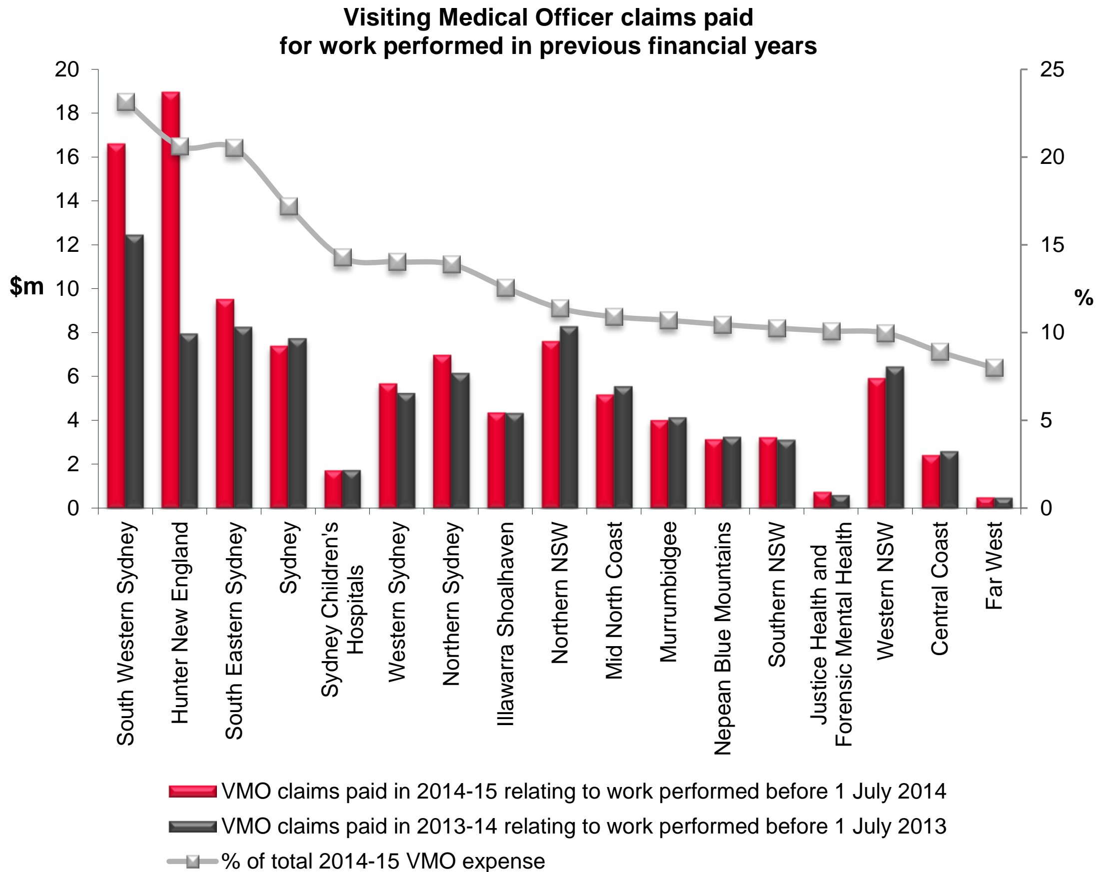
Visiting Medical Officers (VMOs) are doctors engaged as independent contractors in the public health system and they generally also work in private practice. VMO contracts are with individual local health districts and specialty networks. VMOs submit claims to hospitals for work they perform on public patients.

Last year's Auditor-General's Report to Parliament recommended health entities strengthen internal control processes to ensure VMOs submit claims in a timely manner. The Ministry advises that during 2014-15, changes were made to VMO pay determinations to discourage the late submission of claims. Health entities now have an option to pay only 50 per cent of a VMO's claim if it is submitted more than 12 months after the service was provided subject to 28 days notice being provided to the VMO. After 24 months, no payments need be made by health entities subject to 28 days notice to the VMO.

In 2014-15, VMO's continued to submit claims for payment irregularly or late

VMOs submitted over 12,300 claims for payment (10,700 claims in 2013-14), totalling $104 million, for work performed before 1 July 2014 ($88.3 million before 1 July 2013). This included 720 claims (1,600 claims) or $5.5 million ($10.8 million) for services provided more than 12 months prior. In total, health entities paid $705 million to VMO's in 2014-15 ($676 million in 2013-14).

The graph below shows the value of VMO claims paid for services performed in previous financial years.



Source: NSW Ministry of Health (unaudited).

Hunter New England (2,250 claims for $19.0 million) and South Western Sydney (1,400 claims for $16.6 million) local health districts paid the most in VMO claims during 2014-15 for work performed before 1 July 2014.

A doctor was paid over $429,000 for work performed over six years ago

In 2014-15, South Western Sydney Local Health District made 41 payments to a doctor totalling $429,800 for work performed in March 2008 and earlier. The oldest claim was August 2004. Similarly in August 2014, Northern Sydney Local Health District paid a doctor for work performed in July 2007.

As a proportion of total VMO expenses, South Western Sydney Local Health District paid the most in VMO claims in 2014-15 for work performed before 1 July 2014 (South Eastern Sydney Local Health District in 2013-14). These payments represented 23.2 per cent (19.8 per cent) of its VMO expense for the year.

Asset Management

Backlog Maintenance

NSW Health's backlog maintenance was $323 million at 30 June 2015

NSW Health quantified its total backlog maintenance for the first time. Total estimated backlog maintenance was $323 million at 30 June 2015. One health entity assessed its backlog maintenance at $83.9 million; more than a quarter of the total backlog maintenance. Backlog maintenance estimates ranged between health entities from $2.4 million to $83.9 million at 30 June 2015.

Last year's Auditor-General's Report to Parliament recommended the Ministry's asset and facilities maintenance working party develop a project plan with key deliverable dates for its key activities and report against that plan. It also recommended health entities develop asset maintenance plans, and identify and measure maintenance backlog.

The Ministry advises:

- the asset and facilities maintenance working has developed a high-level project plan with key deliverable dates for its key activities. The working party also reports milestones achieved against the plan
- health entities have identified and measured maintenance backlog in 2015 Asset Strategic Plans
- those health entities required to prepare Asset Strategic Plans have also prepared asset maintenance plans.

The role of the Ministry's asset and facilities maintenance working party includes:

- providing guidance on NSW Health's maintenance framework
- ensuring maintenance reform initiatives are strategically coordinated
- advising on appropriate governance models for maintenance across NSW Health
- guiding further development of strategic maintenance plans across the sector
- advising on the implementation of maintenance key performance indicators and benchmarks, including backlog maintenance
- guiding the implementation of State-wide maintenance strategies.

Maintenance expenditure remains above the Ministry's benchmark

The State-wide benchmark set by the Ministry to help it and health entities assess the adequacy of their maintenance spend is 2.15 per cent (2.15 per cent in 2013-14) of the gross asset replacement value. In 2014-15, the total maintenance spend across the sector was $525 million ($466 million) or 2.5 per cent (2.4 per cent) of gross asset replacement value.

Asset Replacement Refurbishment Program

The Asset Refurbishment and Replacement Program is a new program to help health entities address the backlog of critical maintenance projects across NSW public hospitals. The program provides $500 million in funding over the next ten years.

In 2014-15, $9.5 million was spent on the program, with a further $50.0 million expected to be spent in 2015-16. The benefits expected from the program include:

- stopping assets deteriorating to the point that repairing them is not cost effective
- preventing complete asset failure, where an asset can no longer be used and patient care is impacted
- extending the useful life of existing assets and avoiding capital works
- improving the performance of assets and reducing service disruptions
- through centralised funding, allowing State-wide determination of individual project priorities across all health agencies so the most critical projects will progress with clearer transparency of decisions.

State-wide Asset Management System

NSW Health has implemented a new asset management system

The Ministry implemented a new State-wide asset management system. Core asset management functions were made available to health entities in 2014-15. By 30 June 2015, the Ministry had spent $11.1 million on the new system, around $1.0 million more than the revised budget of $10.1 million.

The quality and completeness of data in the system varies between health entities and hospitals. Data completeness and quality is expected to improve over time as the system matures. Some initiatives being implemented by the Ministry to help improve data quality include:

- establishing working parties to review and implement asset management policy and practices including data improvement
- providing health agencies with data cleansing support as they progressively review and validate their data registers
- a State-wide program to verify and/or collect asset data
- projects to align biomedical equipment data standards across health and to verify and amend high-value owned and leased medical equipment data.

A performance audit on 'asset management in Health' is proposed for 2016-17.

Asset Stocktakes

Last year's Auditor-General's Report to Parliament recommended Northern Sydney Local Health District plan its 2014-15 stocktake to ensure it was completed and relevant accounting records were updated before 30 June 2015. The District has addressed this recommendation.

Capital Projects

Major Projects Completed in 2014-15

Major hospital projects were completed ahead of time and within budget

Health Infrastructure completed four major capital works projects with an estimated cost of $50.0 million or more in 2014-15. As shown in the table below, these projects were completed ahead of time and within the approved budget. The total actual cost of the completed projects was $10.4 million higher (2.5 per cent) than original budgeted cost.

Project description	Original budgeted cost $m	Revised budgeted cost $m	Actual cost $m	Original estimated completion year	Year completed
Campbelltown Macarthur Redevelopment Stage 1	139.1	133.1	112.1	2016	2015
Hornsby Hospital Redevelopment Stage 1	120.0	121.0	96.5	2017	2015
Missenden Mental Health Unit	67.0	67.0	65.8	2015	2014
Royal North Shore Hospital Clinical Services Building	91.8	159.9	153.9	2016	2014
Total	**417.9**	**481.0**	**428.3**		

Source: NSW Ministry of Health (unaudited).

The Campbelltown Macarthur Redevelopment delivered a new multi-storey acute services building with new inpatient wards, ambulatory, outpatient, allied health services, pathology and clinical information.

The Hornsby Hospital Redevelopment delivered eight new surgical theatres including one dedicated endoscopy procedure room, perioperative spaces needed to implement the high volume short stay model of care, and three inpatient units of 28 beds.

The Missenden Mental Health Unit delivered a relocated and upgraded Mental Health Unit with the potential for new ambulatory health services accommodation to meet growth in service demand.

The Royal North Shore Hospital Clinical Services Building provides better integration of women's, children's, burns and mental health services with the acute services building. The actual cost of the project was $62.1 million higher than the original budget due to scope changes and delivery of 60 additional beds.

Last year's Auditor-General's Report to Parliament recommended Health Infrastructure capture key lessons learnt for future projects after one of its developers went into administration. It recommended Health Infrastructure implement appropriate strategies to monitor how suppliers are performing in particular for multi-year contracts. Health Infrastructure responded by implementing a number initiatives, including:

- requiring contractors to submit cash flow projections at the start of a project and to update these monthly
- updating its retention trust requirements to compel contractors to hold subcontractor retentions in trust and to provide regular reports on the movement in and out of these funds. This ensures Health Infrastructure is aware of the extent and status of these retentions, and allows subcontractor assets to be carved out from any contractor insolvencies.

Capital Projects Still in Progress

Major capital projects are running on or ahead of time

Health Infrastructure is managing 20 major projects each with an estimated cost of more than $50.0 million. Most projects are running on or ahead of time. Overall, the revised budgeted cost is $16.6 million less than the original approved budget of $4.3 billion. At 30 June 2015, Health Infrastructure had spent $1.6 billion on these projects or 36.3 per cent of the original budgeted cost. The following table summarises these projects.

Project description	Original budgeted cost $m	Revised budgeted cost $m	Costs at 30 June 2015 $m	Original estimated completion year	Revised completion year
Northern Beaches Hospital Redevelopment Stage 1	600.0	600.0	100.1	2019	2018
Asset Refurbishment / Replacement Strategy State-wide	500.0	500.0	6.7	2021	2024
Westmead Hospital Redevelopment Stage 1	430.0	430.0	17.0	2021	2021
Gosford Hospital Redevelopment	368.0	368.0	15.6	2021	2019
St George Hospital Redevelopment Stage 1	282.0	282.0	19.5	2021	2021
Wagga Wagga Redevelopment Stage 1	270.1	270.1	178.6	2017	2017
Blacktown - Mt Druitt Hospital Redevelopment	267.6	259.2	171.1	2016	2016
Tamworth Hospital Stage 2	220.0	210.8	172.5	2017	2016
Council of Australian Governments Initiatives –	189.8	189.8	187.7	2014	2016
South East Regional Hospital	187.7	187.1	149.7	2016	2015
Sydney Ambulance Metro Infrastructure Strategy	150.0	150.0	17.0	2019	2019
Prince of Wales Comprehensive Cancer and Blood Disorder	114.0	114.0	43.4	2017	2016
Parkes and Forbes Hospital	110.7	110.7	64.7	2016	2016
Wollongong Elective Surgical Unit	106.1	106.7	100.0	2015	2015
Dubbo Health Service Stage 1	91.3	91.3	73.8	2016	2015
Byron Central Hospital	88.0	88.0	39.8	2019	2016
Royal North Shore Hospital Phases 1 - 3	84.6	84.6	84.0	2015	2015
Kempsey Hospital	80.9	81.9	58.3	2016	2016
Lismore Hospital Redevelopment Stage 3	80.2	80.2	46.1	2016	2016
Sutherland Hospital Expansion	62.9	62.9	7.4	2017	2017
Total	**4,283.9**	**4,267.3**	**1,553.0**		

Source: NSW Ministry of Health (unaudited).

Public-private partnership - Northern Beaches Hospital

In December 2014, NSW Health contracted with Healthscope to design, build, operate and maintain the new Northern Beaches Hospital. Working in partnership with NSW Health, Healthscope will provide public patient services over the next 20 years. At the completion of the contract, a portion of the hospital will revert to NSW Government ownership, and Healthscope will continue to deliver services from a portion of the facility to private patients for a further 20 years. The new hospital is expected to open in 2018 and cost about $1.0 billion to construct.

A summary of the contract is available on Treasury's Public Private Partnerships website at www.treasury.nsw.gov.au/__data/assets/pdf_file/0010/126694/NBH_-_Contract_Summary_Executive_Summary.pdf .

Fully Depreciated Plant and Equipment

Last year's Auditor-General's Report to Parliament recommended NSW Health review asset useful lives across the sector by no later than 28 February 2015. The Ministry advises:

- it conducted a review in January 2015
- from 1 July 2015, in addition to assessing land and building assets, health entities are required to assess the useful lives of high value plant and equipment assets annually
- the results of its review were communicated to Chief Executives in February 2015.

Information Technology Projects

Information Technology Projects in Progress

Many information technology projects are running behind schedule

Recommendation

eHealth NSW should perform a detailed review of the way it manages information technology projects. The review should analyse the reasons for project delays and identify strategies to mitigate the risk on future projects.

At 30 June 2015, eHealth NSW was managing nine major information technology projects, each with original budgets exceeding $20.0 million. Six of these are running behind original planned timeframes. eHealth NSW attributes the delays to the complexity of change management processes involved across health entities, as well as vendor/supplier capability and capacity issues.

Last year's Auditor-General's Report to Parliament recommended eHealth NSW capture reasons for the delays in its information technology projects as well as lessons learnt for application to future projects. eHealth NSW reports it has done this. However, the revised completion dates for six of the nine major information technology projects have been delayed from the dates advised last year. eHealth NSW needs to conduct this review again.

Over the next four years, eHealth NSW plans to spend more than $240 million completing the nine projects. It expects the NSW health sector will achieve $2.7 billion in quantitative benefits from its overall investment of $671 million, or $3.98 for every dollar spent.

The nine projects are summarised in the table below:

Project description	Original budgeted cost $m	Revised budgeted cost $m	Costs at 30 June 2015 $m	Original estimated completion year	Revised completion year	Original estimated quantitative benefits $m	Revised estimated quantitative benefits $m
Electronic Medication Management	170.3	170.3	75.0	2018	2018	369.6	479.2
Community Health and Outpatient Care	100.7	100.7	78.6	2016	2017	401.1	265.7
Rostering	94.8	89.6	85.0	2014	2019	451.6	469.3
Electronic Medical Record 2	85.4	85.4	57.6	2017	2017	590.7	590.7
Corporate System 2B	77.0	77.4	48.0	2017	2018	236.5	234.8
Infrastructure Strategy 3	51.1	51.1	50.8	2018	2017	30.9	28.3
Electronic Record for Intensive Care	43.1	43.1	12.6	2016	2020	211.4	481.5
Whole-of-Government Data Centre Migration	34.6	31.4	18.3	2017	2018	na	na
Incident Management System	22.2	22.2	4.6	2016	2018	121.9	121.9
Total	**679.2**	**671.2**	**430.5**			**2,413.7**	**2,671.4**

na Not available. Benefits realisation plan has not been developed by eHealth NSW.

Source: NSW Ministry of Health (unaudited).

Information Technology Projects Completed

eHealth NSW to measure benefits realised for information technology projects

Last year's Auditor-General's Report to Parliament recommended eHealth NSW have robust systems and processes to measure benefits realised from completed information technology projects. It recommended eHealth NSW clearly define roles and responsibilities for measuring benefits realisation, establish a timeline for regularly assessing and re-assessing the benefits realisation, and formally measure and document the benefit realisation for each completed project. eHealth NSW advises:

- it developed a benefits management framework that provides guidance on roles and responsibilities for measuring benefits realisation as well as guidance on establishing schedules for benefits measurement. The framework is currently being rolled out across the eHealth portfolio
- initial benefit realisation reviews have been conducted for projects, some of which may be part of an overall program, completed in the month of June 2015.

In 2014-15, the only significant information technology program completed by eHealth NSW was the Asset and Facilities Management Performance Improvement program. It was completed some 12 months late.

Post Implementation Reviews

Last year's Auditor-General's Report to Parliament recommended eHealth NSW conduct post implementation reviews of recently completed information technology projects and that the reviews be performed as soon as possible. eHealth NSW advises:

- it conducted post implementation reviews for three recently completed projects, four reviews are in progress and a further two are being planned. These include multi-year projects completed last financial year
- the post implementation reviews completed included: assessing the achievement of planned outcomes, reviewing the effectiveness of management practices and capturing lessons learnt. The lessons learnt are being reviewed for common themes to drive improvement in eHealth's program and project management methodology and tools
- it commenced implementing a new Program and Project Assurance Framework in May 2015. The Framework requires mandatory post implementation reviews be conducted for all eHealth programs and the significant projects within a program. eHealth NSW will commence monitoring compliance with this requirement by 31 December 2015.

NSW Ambulance's billing system

Issues with NSW Ambulance's revenue system are being addressed

Last year's Auditor-General's Report to Parliament recommended the review into the effectiveness of NSW Ambulance's revenue system and patient billing practices be completed by 31 March 2015. An external firm completed the review in June 2015 and made eleven recommendations. NSW Ambulance advises it has implemented seven of the recommendations, with the remaining four in progress. The recommendations include:

- establishing an action plan to resolve outstanding issues around patient encounter records not completely transferring from the various incident recording systems to the billing system
- establishing appropriate protocols to ensure customer invoices include the correct names and addresses
- providing appropriate training and awareness programs to relevant personnel on recording complete patient details in order to lessen billing and revenue issues
- establishing system change protocols to minimise/eliminate potential workarounds in the event of system changes.

Last year's report noted that due to the extent of its outstanding patient billings, NSW Ambulance had experienced cash flow problems and therefore received a financial loan from the Ministry of $17.0 million. In 2014-15, the Ministry waived NSW Ambulance's obligation to repay the loan.

NSW Ambulance's debt management

Office of State Revenue providing debt management services to NSW Ambulance

In June 2015, NSW Ambulance wrote off $67.5 million of aged patient encounter debts relating to the 2013-14 and earlier financial years. NSW Ambulance, in consultation with the Office of State Revenue (OSR), also recognised a provision for uncollectability of $27.0 million at 30 June 2015. New legislation gives OSR the authority to provide debt management and infringement processing services to NSW Ambulance. The OSR commenced debt recovery services from 1 October 2015, and NSW Ambulance management advises they anticipate a higher level of debt recovery compared to past efforts.

Procurement

Procurement Practices in NSW Health

Not all health entities are adequately monitoring purchase order usage

Recommendation (repeat issue)

Health entities not monitoring purchase order usage for each budget holder should do so by 31 March 2016. The entities should:

- **identify which budget holders are not using purchase orders and understand why**
- **implement targeted strategies to improve compliance with the Ministry of Health's purchase order target.**

Last year's Auditor-General's Report to Parliament recommended the Ministry document a policy on which goods and services require a purchase order and ensure this is reflected in monthly reporting for health entities. The Ministry advised it has reviewed NSW Health's purchase order policy, and that a purchase order usage report is provided to health entity Chief Executives on a monthly basis for monitoring.

Last year's report also recommended health entities monitor purchase order usage for each budget holder to further drive targeted action to improve compliance with the Ministry of Health's purchase order target. Thirteen health entities indicated they are monitoring this. Other health entities only monitor purchase order usage at an organisation wide level because they do not have reports detailing purchase order usage at a budget holder level. The Ministry advised it has included purchase order compliance in its 2015-16 'NSW Ministry of Health Financial Requirements and Conditions of Subsidy', issued to health entities with the their Service Agreements.

Health entities have improved their purchase order usage in 2014-15

In 2014-15, 97.6 per cent of health entities' invoices were processed with a purchase order (96.5 per cent in 2013-14). NSW Health's target is 100 per cent.

Purchase order compliance rates at local health districts and specialty networks ranged between 94.4 per cent and 98.8 per cent. Compliance rates at other agencies within NSW Health ranged between 71.8 per cent and 99.5 per cent.

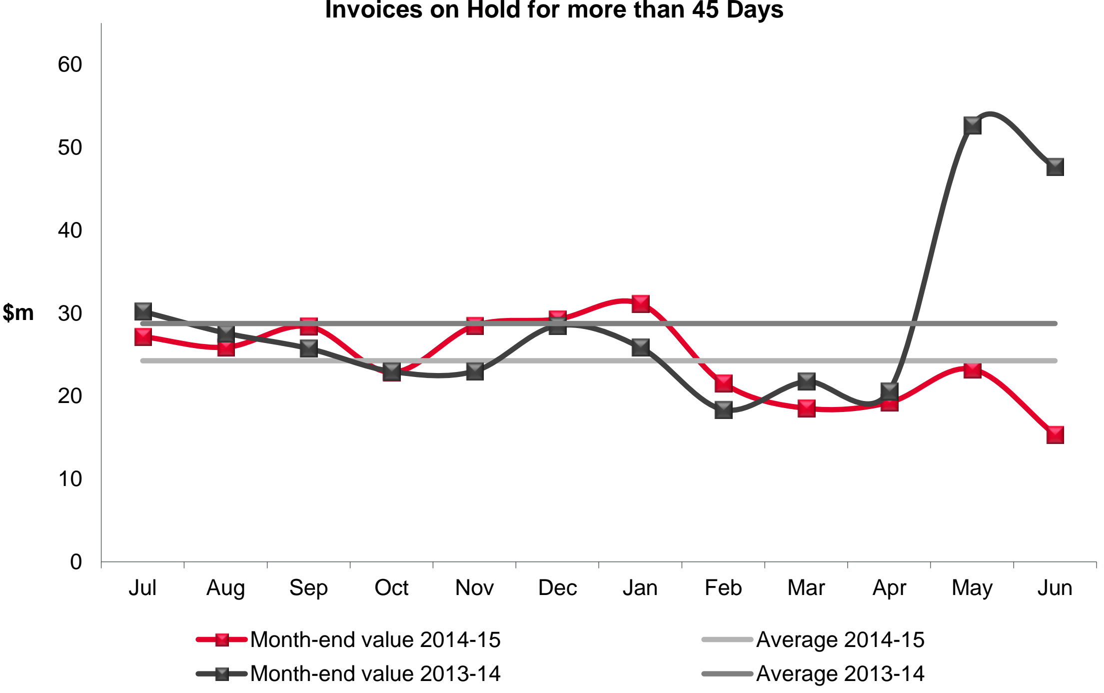
Last year's Auditor-General's Report to Parliament recommended NSW Ambulance and NSW Kids and Families significantly improve compliance with the Ministry of Health's purchase order target. Both entities have done this. The Ministry advised since February 2015, NSW Ambulance has processed 80 per cent of invoices with a purchase order (49 per cent in 2013-14). The purchase order usage for NSW Kids and Families also rose to 86 per cent in 2014-15 (65 per cent).

Invoices on Hold

At 30 June 2015, invoices on hold for more than 45 days had fallen to $15.3 million.

Since January 2015, invoices on hold for more than 45 days have been trending downwards. The average value of invoices on hold during the year was $24.3 million ($28.7 million in 2013-14). A significant increase in the last quarter of 2013-14 was due to the roll-out of upgraded NSW Health corporate systems.

The graph below shows invoices on hold for more than 45 days over the past two years.



Source: NSW Ministry of Health (unaudited).

Of all local health districts and specialty health networks, South Eastern Sydney Local Health District had the highest value of invoices on hold for more than 45 days with $3.2 million at 30 June 2015 (South Eastern Sydney Local Health District with $7.9 million at 30 June 2014).

Common reasons for invoices on hold are: awaiting approval; the invoice does not agree with price or quantity receipted by health entities; the health entity did not raise a purchase order; the supplier has not quoted the correct purchase order number on the invoice; over use of the purchase order; the quality of the good or service was inadequate; awaiting receipting in Oracle (proof of delivery of the good or service cannot be established); invalid purchase orders; pharmacy holds; and use of standing orders.

Special Purpose Accounts

Dormant special purpose accounts not yet resolved

Recommendations (repeat issues)

The Ministry should issue guidance and work with each health entity to determine what they should do with dormant special purpose funds or funds whose purpose is unclear.

Health entities should arrange appropriate approvals to move funds from special purpose accounts to the Public Contributions Trust Fund by 31 March 2016.

For the last two years, the Auditor-General's Reports to Parliament have recommended:

- the Ministry issue guidance and work with each health entity to determine what they should do with any dormant special purpose funds or funds whose purpose is unclear
- health entities arrange appropriate approvals to move funds from special purpose accounts to the Public Contributions Trust Fund.

The Ministry advises it is seeking legal guidance to ensure funds are appropriately used without breaching legislation or donor imposed conditions. Moving funds from dormant accounts into the Public Contributions Trust Fund requires the donors' permission. If this is not possible, permission is required from the Attorney General for funds of less than $500,000 or from the Courts for funds greater than $500,000.

In 2014-15, the Ministry implemented a new State-wide electronic registry of special purpose and trust accounts. Implementation at all health entities was completed in October 2015. The electronic registry will be used by health entities as a central repository of funds they hold. The benefits expected from the registry include:

- more consistent recording, monitoring and reporting of special purpose and trust accounts across NSW Health
- improved differentiation between health entity controlled and uncontrolled funds
- improved data integrity by significantly reducing manual data entry from paper based forms
- improved data accuracy by standardising management and recording practices
- easier identification of dormant funds through cost centre reports.

Almost 60 per cent of special purpose accounts were idle during 2014-15

Special purpose accounts with less than $100 in expenses during the year (5,241) totalled $215 million at 30 June 2015. Subject to restrictions by the donor/grantor, the money in these accounts could possibly be used more freely for health services.

The number and value of special purpose accounts and the level of expenses during the year is shown in the table below.

Number and value of special purpose accounts at 30 June 2015		
	Number of special purpose accounts	Closing balance $'000
<$100	5,241	215,300
$100 - $1,000	675	19,100
$1,001 - $10,000	1,245	102,600
$10,001 - $50,000	1,036	166,900
>$50,001	707	520,100
Total	**8,904**	**1,024,000**

Source: Ministry of Health (unaudited).

Governance

Governance refers to the high-level framework of processes and behaviours designed to ensure an entity performs by meeting its intended purpose, conforms with legislation and other requirements, and meets expectations of probity, accountability and transparency. Those charged with governance use these processes to hold Government and agencies to account.

The comments and observations in this chapter are based on the results and findings of our 2014-15 financial audits of entities in the Health cluster. The key observations, conclusions and recommendations are summarised in the following table.

Governance	
Observation	**Conclusion or recommendation**
The service agreements between the Secretary of NSW Health and health entities continue to be signed late.	**Recommendation:** The Secretary of NSW Health and health entities should finalise their service agreements by 31 July.
Four local health districts/specialty networks were not meeting performance expectations at 30 June 2015.	The Ministry is managing the four local health districts/specialty networks in accordance with its performance review process.
Two health entities do not have conflicts of interest registers.	**Recommendation:** Murrumbidgee Local Health District and the Justice Health and Forensic Mental Health Network should implement conflicts of interest registers immediately.
Conflicts of interest registers may be incomplete. The number of entries recorded in local health districts/specialty networks' conflicts of interest registers varied significantly at 30 June 2015.	**Recommendations:** Chief Executives should review, by 31 March 2016: • local procedures and ensure conflicts of interest are being managed effectively • the conflicts of interest registers maintained by the health entity to ensure all entries are being recorded. Chief Audit Executives should review conflicts of interest registers to ensure they are complete, all actions have been addressed, trends are analysed, and instances requiring further action are followed up.
The number of entries recorded in gifts and benefits registers varies significantly between health entities indicating they may be incomplete.	**Recommendations:** Chief Executives should review, by 31 March 2016: • local procedures and ensure gifts and benefits are being managed effectively • the gifts and benefits registers maintained by the health entity to ensure all entries are being recorded. Chief Audit Executives should regularly review gifts and benefits registers to ensure all actions have been completed, trends are analysed, and instances requiring further action are followed up.

Service Agreements in NSW Health

The Secretary of NSW Health has service agreements with local health districts/ specialty networks which outline performance requirements for safety and quality, service access and patient flow, finance and activity, population health, people and culture. Similarly, the Secretary of NSW Health has service compacts with Pillar agencies and shared State-wide services agencies detailing service responsibilities and accountabilities.

The Secretary agrees to provide funding and other support to health entities while they agree to meet the service obligations and performance requirements in the service agreement/compact. The service agreements/compacts outline how the Ministry monitors performance and holds health entities to account.

Service Agreements in NSW Health

Local health districts/specialty networks service agreements need to be signed earlier

Recommendation

The Secretary of NSW Health and health entities should finalise their service agreements by 31 July.

Many of the service agreements between the Secretary of NSW Health and local health districts/specialty networks continue to be signed late. The agreements were sent to the local health districts/specialty networks on 23 June 2015 and were due to be signed by 31 July 2015. Only eight local health districts/specialty networks met this date. Northern NSW Local Health District did not finalise its 2015-16 service agreement until 12 November 2015. In future years, local health districts/specialty networks should sign the service agreement by 31 July at the latest to clarify roles, responsibilities, performance measures, budget, service volumes and levels.

Of the other seventeen local health districts/ specialty networks, eight signed their 2015-16 service agreements in July 2015, seven in August 2015, one in September 2015 and one in November 2015. By comparison, ten signed their 2014-15 service agreements in July 2014, six in August 2014 and one in September 2014.

Service agreements for other health entities also need to be finalised earlier

The service agreements/compacts between the Secretary of NSW Health and other health entities also continue to be signed late. In future years, health entities should sign the service agreements/compacts by 31 July at the latest to clarify roles, responsibilities, services to be provided, service standards and pricing.

The agreements/compacts with Pillar agencies were redesigned after the start of the financial year. Consequently, the agencies were not able to sign their 2015-16 service agreements/compacts at the beginning of the financial year. The agreements/compacts were finalised in October 2015.

Last year's Auditor-General's Report to Parliament recommended the Secretary of NSW Health and health entities finalise the 2014-15 service agreements immediately and, in future, before the end of the previous financial year. The Ministry advises that finalising the service agreements/compacts is constrained by the release of the State budget and board meeting cycles. Better practice would see the agreements signed before the start of the financial year. The Ministry should ensure the future agreements are signed earlier than the 2015-16 and 2014-15 agreements.

Customer charters for the provision of shared State-wide services

HealthShare NSW and eHealth NSW's customer charters are not finalised

HealthShare NSW and eHealth NSW's customer charters were not finalised at the time of writing this report. The Ministry advises the charters will be finalised by December 2015.

NSW Health Pathology's customer charters were finalised and outline the services that will be provided by NSW Health Pathology to its customers, roles and responsibilities, dispute resolution and service offerings, pricing and key performance indicators.

Last year's Auditor-General's Report to Parliament noted that NSW Health's shared State-wide services (including HealthShare NSW, eHealth NSW and NSW Health Pathology) were introducing customer charters; replacing the service agreements with their customers.

Performance of Local Health Districts/Specialty Networks

Four local health districts/specialty networks not meeting performance expectations

At 30 June 2015, four local health districts/specialty networks (seven at 30 June 2014) were not meeting the performance expectations of the service agreements with the Secretary of NSW Health.

South Eastern Sydney was the only local health district/specialty network assessed as a serious underperformance risk (four local health districts at 30 June 2015). The District has a formal recovery plan, but fell short of both expenditure and revenue strategies in 2014-15.

Murrumbidgee, Northern Sydney, Nepean Blue Mountains, Central Coast, Southern NSW and Western NSW local health districts' performance level was de-escalated because their recovery plans were progressing well and previous performance issues were being satisfactorily resolved.

Sydney Children's Hospitals Network's performance level was escalated during the year due to concerns with clinical and finance indicators.

Finance was a common performance concern across the four local health districts deemed not to be performing at 30 June 2015. In some cases, Emergency Treatment Performance, National Elective Surgery Targets, service access and patient flow were also performance concerns.

The performance of the fifteen local health districts and two specialty health networks throughout the year is shown below.

Performance measure						
Quarter ending	**Jun 2015**	**Mar 2015**	**Dec 2014**	**Sep 2014**	**Jun 2014**	**Movement in escalation level**
Level 4 – Challenged and failing						
None	--	--	--	--	--	~
Level 3 – Serious underperformance risk						
South Eastern Sydney	3	3	3	3	3	~
Level 2 – Underperforming						
Murrumbidgee	2	3	3	3	3	↓
Northern Sydney	2	2	3	3	3	↓
Western Sydney	2	2	2	2	2	~
Level 1 – Under review						
Nepean Blue Mountains	1	1	2	2	2	↓
Sydney Children's Hospitals Network	1	1	1	1	--	↑
Level 0 – Performing						
Central Coast	--	--	1	1	2	↓
Southern NSW	--	--	--	--	1	↓
Western NSW	--	--	1	1	3	↓
Far West	--	--	--	--	--	~
Hunter New England	--	--	--	--	--	~
Illawarra Shoalhaven	--	--	--	--	--	~
Justice Health and Forensic Mental Health Network	--	--	--	--	--	~
Mid North Coast	--	--	--	--	--	~
Northern NSW	--	--	--	1	--	~
Sydney	--	--	--	--	--	~
South Western Sydney	--	--	--	--	--	~

↑ Performance escalated (deteriorated); ↓ Performance de-escalated (improvement); ~ No change

Source: NSW Ministry of Health (unaudited).

The Ministry of Health rates each local health districts/specialty network as performing, underperforming, serious underperformance risk or challenged and failing. No local health district/specialty network was assessed as challenged and failing in 2014-15.

The performance framework in the service agreements categorises health entities as either:

- level 1 – under review when a performance issue is identified
- level 2 – under performing when the Ministry considers that the original performance issue that triggered a Level 1 response warrants a formal recovery plan and/or other performance issues emerge warranting level 2
- level 3 – serious under performance risk when the recovery plan is not progressing well and is unlikely to succeed without additional support from the Ministry
- Level 4 – challenged and failing when the recovery strategy has failed and changes to the governance of the health entity may be required.

Governance Policies

Updating Policy Directives

The Ministry has reviewed its corporate governance policy directives

The 2012 Auditor-General's Report to Parliament recommended the Ministry update key corporate governance policy directives. The Ministry accepted the recommendation and advises it has reviewed all policy directives, including its corporate governance directives. In 2014-15, 66 policies were withdrawn and 29 policies were extended to allow for a comprehensive review of the content.

In November 2014, the Ministry issued a policy directive requiring health entities to develop and maintain policy documents in accordance with the guidance in its directive. Many health entities are reviewing policies and related procedures to ensure they reflect good practice and legal requirements.

Review of model by-laws

In December 2013, the Ministry issued a discussion paper on model by-laws to health entities and other relevant stakeholders. The discussion paper included the by-laws and the legislative structure for making and approving them. The Ministry released draft model by-laws in 2015 for further review following the diverse range of comments obtained through the consultation phase.

The *Health Services Act 1997* allows the Secretary to issue model by-laws, which provide guidance on the establishment of board sub committees including local health district audit and risk management committees, finance and performance committees and health care quality committees. A local health district may seek approval from the Secretary to amend model by-laws.

Application of Treasury's internal audit and risk management policy in NSW Health

In July 2015, Treasury released Treasury Policy Paper (TPP) 15-03 'Internal Audit and Risk Management Policy for the NSW Public Sector'. The TPP includes a number of core requirements that differ from NSW Health's current model. For example, the new TPP requires a fully independent Audit and Risk Committee, whereas the by-laws currently allow non-independent members and include a requirement for the Chief Executive to be a member of the audit and risk management committee.

The Ministry advises it is currently reviewing how the TPP will be applied in NSW Health. The 2015-16 audits will continue to focus on governance and include a review of NSW Health's implementation of the TPP's principles.

Risk Management

Enterprise Risk Management in NSW Health

Continued effort to improve Enterprise Risk Management in NSW Health

The Ministry continued to address recommendations from a 2013 independent review it commissioned to assess whether NSW Health had implemented effective risk management practices. In October 2015, the Ministry released an updated Enterprise Risk Management policy directive. The Ministry has also:

- enhanced the quarterly feedback it provides to health entities through linkage with the NSW Health Performance Framework
- tendered for a State-wide Enterprise Risk Management information technology solution.

Risk management is the process of identifying, assessing and prioritising risks to monitor and mitigate the impact of unforeseen events or maximise the realisation of opportunities. Embedding risk management within an organisations' culture, management systems and processes, can improve decision making and achieve significant efficiencies and cost savings. Risk management is a key component of good governance.

Risk Management Maturity

The 2014-15 audits considered risk management processes and risk management maturity of health entities. The results highlighted health entities are at different stages in their risk management journey. The entities advise their organisations have enterprise wide risk management frameworks covering major risks including clinical and non-clinical risk, and a strong commitment from the Board, Chief Executive and other senior management to drive a risk aware culture and attitude.

The audits identified opportunities for health entities to enhance risk management practices including moving from a reporting mindset to one that is more active in managing risks and understanding how risks impact the organisation. Health entities can also enhance how they articulate and communicate the level of risk they are willing to accept or tolerate to achieve objectives.

Effective risk management can improve decision making and lead to significant efficiencies and cost savings. By embedding risk management directly into processes, agencies can derive additional value from their risk management programs. The more mature an agency's risk management, the stronger its culture in balancing the tension between value creation and protection.

Treasury Policy Paper TPP 15-03 'Internal Audit and Risk Management Policy for the NSW Public Sector' requires agencies to establish and maintain appropriate risk management frameworks and related processes.

A mature risk management process should:

- foster an embedded risk aware culture
- align strategic and business decision making processes with risk management activities
- improve resilience in dealing with adversity
- increase agility in pursuing new opportunities.

Agencies will need to evaluate the costs and benefits of risk management capability if they are to achieve a desirable balance between risk and reward. Some agencies may need more sophisticated risk management processes than others to suit the size and complexity of their activities.

Conflicts of Interest and Gifts and Benefits

In October 2015, the Ministry updated its conflicts of interest and gifts and benefits policy directives. They require all staff to avoid actual or perceived conflicts of interest and not to accept gifts or benefits of a non-token value.

Managing Conflicts of Interest

Two health entities do not have conflicts of interest registers

> **Recommendation**
>
> **Murrumbidgee Local Health District and the Justice Health and Forensic Mental Health Network should implement conflicts of interest registers immediately.**

A conflict of interest occurs when the private interests of a public official come into conflict with their duty to act in the public interest. Murrumbidgee Local Health District and the Justice Health and Forensic Mental Health Network did not have registers to help identify, assess and manage conflicts of interest. All other health entities advise they have registers to some extent.

The Ministry's conflicts of interest and gifts and benefits policy directive requires health entities to maintain a conflicts of interest register. The register records details such as the name of the person declaring the conflict of interest and the nature of the declared conflict.

Conflicts of interest registers may be incomplete

Recommendations

Chief Executives should review, by 31 March 2016:

- **local procedures and ensure conflicts of interest are being managed effectively**
- **the conflicts of interest registers maintained by the health entity to ensure all entries are being recorded.**

Chief Audit Executives should review conflicts of interest registers to ensure they are complete, all actions have been addressed, trends are analysed, and instances requiring further action are followed up.

While most local health districts/specialty networks have conflicts of interest registers they may be incomplete. Some local health districts/specialty networks only have conflicts of interest registers for the board of directors or a sub-committee of the board. These registers do not capture conflicts of interest associated with secondary employment or relationships with suppliers.

There were 227 entries recorded in thirteen local health districts/specialty networks' registers at 30 June 2015. As noted above, two local health districts/specialty networks did not have registers while Illawarra Shoalhaven and Nepean Blue Mountains local health districts were unable to provide the total number of entries because their registers are maintained at individual facilities.

The number of entries in local health districts/specialty networks' registers varied significantly at 30 June 2015. Central Coast Local Health District had the most entries recorded in its register (44 entries). The average number of conflicts of interests recorded in local health districts/specialty networks' registers was 17 at 30 June 2015.

Health entities should review their registers to ensure they are complete and that they are recording and monitoring conflicts of interest in accordance with the Ministry's policy directive.

Managing Gifts and Benefits

A key element of good governance is fraud and corruption control and one important aspect is the effective management of gifts and benefits within public sector agencies.

The Ministry's conflicts of interest and gifts and benefits policy directive requires health entities maintain a gifts and benefits register, which records details of all matters declared and how they have been managed. Justice Health and Forensic Mental Health Network did not have registers to record gifts and benefits. All other health entities advise they have registers.

The number of entries in gifts and benefits registers varies significantly

Recommendations

Chief Executives should review, by 31 March 2016:

- **local procedures and ensure gifts and benefits are being managed effectively**
- **the gifts and benefits registers maintained by the health entity to ensure all entries are being recorded.**

Chief Audit Executives should regularly review gifts and benefits registers to ensure all actions have been completed, trends are analysed, and instances requiring further action are followed up.

The number of entries in local health districts/specialty networks' gifts and benefits registers varied significantly in 2014-15. A total of 359 entries were recorded in fourteen local health districts/specialty networks' registers. As noted above, Justice Health and Forensic Mental Health Network did not have registers while Illawarra Shoalhaven and Murrumbidgee local health districts were unable to provide the total number of entries because their registers are maintained at individual facilities.

Sydney Children's Hospitals Network recorded the most entries in its register in 2014-15 (250 entries). Nine local health districts each recorded less than ten entries.

To comply with the Ministry's policy directive, Chief Audit Executives should regularly review gifts and benefits registers to ensure all actions have been completed, trends are analysed, and instances requiring further action are followed up.

The 2015 audits identified areas where internal controls around gifts and benefits could be improved. These were reported to management. Further details are provided in the Financial Controls chapter of this report.

Service Delivery

This chapter outlines our key findings about Service Delivery in the Health cluster for 2014-15. The key observations and conclusions or recommendations are summarised in the following table.

Service Delivery	
Observation	**Conclusion or recommendation**
Triage response time: NSW Health, on average, met emergency department triage response time targets across all triage categories for the second consecutive year. Eight local health districts met all triage targets in 2014-15 compared to eleven in the prior year.	Fewer health entities met all triage targets in 2014-15. The Ministry continues to manage performance across NSW Health to reduce waiting times in emergency departments and improve access to clinical services.
Emergency treatment performance: In 2014-15, the State average emergency treatment performance was 74.3 per cent compared to 73.9 per cent in 2013-14. Only five local health districts achieved the 81 per cent target.	NSW Health improved its overall emergency treatment performance in 2014-15, but did not achieve its target of 81 per cent. The Ministry continues to manage performance across NSW Health to improve access to and the efficiency of public hospital services, and improve patient satisfaction.
Ambulance response times: The median (50th percentile) ambulance response time for potentially life threatening cases in New South Wales rose to its highest level in five years. It increased from 10.8 minutes in 2013-14 to 11.2 minutes in 2014-15. The national average response time reduced to 9.4 minutes in 2013-14.	NSW Ambulance response times are generally higher than the national average.
Transfer of care: The number of ambulance arrivals within 30 minute 'transfer of care' timeframe fell from 85 per cent in 2013-14 to 84.5 per cent in 2014-15. The Ministry's target is 90 per cent.	The rate of ambulance arrivals with a transfer of care time within 30 minutes remains below the Ministry's target.
Bed numbers and occupancy: Bed occupancy across NSW Health fell from 89 per cent in 2013-14 to 85.2 per cent in 2014-15. Metropolitan bed occupancy rates are higher than those in regional areas.	While a higher bed occupancy rate can reflect efficiency, it can also lead to increasing wait times in emergency departments and increasing cancellation of elective (planned) surgery.
Elective surgery waiting times: NSW Health only achieved one of three elective surgery targets, but its performance has improved against all three targets each year since 2012.	NSW Health continues to improve its elective surgery performance.
Unplanned re-admissions: In 2014-15, the rate of unplanned re-admissions increased from 6.8 per cent to seven per cent. This is higher than the Ministry target of five per cent.	None of the local heath districts/specialty networks achieved the unplanned re-admissions target for 2014-15.

Service Delivery	
Observation	**Conclusion or recommendation**
Mental health acute re-admissions: Only Far West, Murrumbidgee and Illawarra Shoalhaven local health districts and Sydney Children's Hospitals Network achieved the mental health acute re-admissions target of 13 per cent for 2014-15.	Twelve local health districts failed to meet the NSW Health target. High levels of re-admissions can reflect deficiencies in treatment and/or follow-up care. The Ministry continues to manage performance across NSW Health to reduce mental health acute readmissions and improve mental health and well-being through effective inpatient care and adequate post-discharge follow up in the community.
Emergency Department re-presentations: Far West, Western NSW, Mid North Coast and Northern NSW local health districts had the highest emergency department re-presentation rates.	Patients attending rural emergency departments are more likely to re-present within 48 hours of being discharged than those in regional or metropolitan emergency departments.
Hospital Associated Infection: The NSW average of 0.73 cases of *Staphylococcus aureus* bloodstream infection per 10,000 bed days was below the target and national benchmark of two cases per 10,000 bed days.	The rate of *Staphylococcus aureus* bloodstream infection in NSW hospitals was well below the national benchmark.
Hospital Associated Complications: The Clinical Excellence Commission identified opportunities to improve venous thromboembolism (VTE) prevention strategies in NSW Health. Commonly referred to as blood clot, VTE is a leading cause of death in Australia.	Significant opportunity exists to reduce VTE acquired by hospitalised patients.

State Priorities

The NSW Government released its new State priorities ‘NSW: Making it Happen’ in September 2015, replacing its previous ten year plan NSW 2021. It outlines two key priorities to improve health services in New South Wales including one personal priority of the Premier. By comparison, NSW 2021 contained two goals and twelve targets for the Health Cluster.

The two State priorities are to:

- improve service levels in hospitals – 81 per cent of patients through emergency departments within four hours
- cut waiting times for planned surgeries – increase on-time admissions for planned surgery.

The performance of NSW Health against these priorities, and a range of other targets and measures, is discussed in this chapter.

Emergency Department Response Times

NSW Health again, on average, met targets across all triage categories

In 2014-15, there were around 2,692,800 emergency department attendances at NSW hospitals compared to 2,656,300 in 2013-14, an increase of 36,500 or 1.4 per cent. NSW Health, on average, met the targets across all five triage categories for the second consecutive year.

NSW Health maintained or bettered its 2013-14 State averages for treating patients within triage target timeframes across triage categories T1, T3, T4 and T5. The State average for triage category T2 declined marginally (one per cent) compared to the previous year. The achievement of triage target timeframes across all triage categories reflects NSW Health's efforts in continuously reviewing models of care within emergency departments to improve performance, patient flow and access to care.

The table below shows State-wide emergency department triage performance over the last four years.

NSW State average Triage category	Percentage of patients treated within clinically appropriate timeframes %				
Year ended 30 June	**Target**	**2015**	**2014**	**2013**	**2012**
T1	100	100	100	100	100
T2	80	83	84	83	82
T3	75	76	76	73	71
T4	70	80	79	77	74
T5	70	94	93	92	89

Source: NSW Ministry of Health (unaudited).

Emergency departments use triage to determine the priority clinical care for each patient as they present to the emergency department. Appropriate triaging helps ensure patients are treated in a timely manner, according to the clinical urgency of their condition. NSW Health uses triage targets recommended by the Australasian College for Emergency Medicine as a measure of local health districts' and networks' performance.

Fewer health entities met all triage targets in 2014-15

Only eight local health districts namely, Far West, Hunter New England, Mid North Coast, Murrumbidgee, Northern NSW, Northern Sydney, South Eastern Sydney and Western NSW local health districts met all triage targets in 2014-15. By comparison, 11 local health districts met all triage targets in 2013-14).

In 2014-15, Far West, Murrumbidgee, Northern NSW, Northern Sydney and Western NSW local health districts maintained or improved the percentage of patients treated within clinically appropriate timeframes across all triage categories.

The table below shows how the fifteen local health districts and the Sydney Children's Hospitals Network performed against the five triage targets.

	Percentage of patients treated within clinically appropriate timeframes									
Category	**T1**		**T2**		**T3**		**T4**		**T5**	
Target	**100%**		**80%**		**75%**		**70%**		**70%**	
Year ended 30 June	**2015**	**2014**	**2015**	**2014**	**2015**	**2014**	**2015**	**2014**	**2015**	**2014**
Central Coast	100	100	● 78	● 74	● 67	● 66	74	71	95	92
Far West	100	100	90	85	84	82	85	81	94	91
Hunter New England	100	100	83	85	76	77	79	79	93	93
Illawarra Shoalhaven	100	100	86	89	● 73	75	76	77	91	92
Mid North Coast	100	100	87	89	84	84	86	88	96	97
Murrumbidgee	100	100	87	87	83	75	89	78	98	93
Nepean Blue Mountains	100	100	● 79	85	● 70	79	81	86	92	94
Northern NSW	100	100	87	87	79	79	82	81	95	93
Northern Sydney	100	100	86	86	81	81	84	83	95	94
South Eastern Sydney	100	100	85	87	79	80	88	87	97	97
South Western Sydney	100	100	● 76	85	76	80	82	81	95	94
Southern NSW	100	100	85	86	77	77	79	79	93	92
Sydney	100	100	● 74	● 75	● 68	● 66	77	76	94	93
Sydney Children's Hospitals Network	100	100	86	86	● 73	● 70	● 68	● 65	92	87
Western NSW	100	100	89	● 78	82	76	85	82	95	94
Western Sydney	100	100	● 76	83	● 61	● 65	72	73	92	92
NSW State Average	**100**	**100**	**83**	**84**	**76**	**76**	**80**	**79**	**94**	**93**

Key:

T1 Immediately life threatening - treatment required within two minutes - target = 100 per cent.

T2 Imminently life threatening - treatment required within ten minutes - target = 80 per cent.

T3 Potentially life threatening - treatment required within 30 minutes - target = 75 per cent.

T4 Potentially serious - treatment required within one hour - target = 70 per cent.

T5 Less urgent - treatment required within two hours - target = 70 per cent.

● Below target

Source: NSW Ministry of Health (unaudited).

An analysis of results shows:

- all local heath districts and the Sydney Children's Hospitals Network achieved the T1 target of 100 per cent for the fourth consecutive year
- five local health districts did not achieve the T2 target (three in 2013-14)
- five local health districts and the Sydney Children's Hospitals Network did not achieve the T3 target (three districts and the Sydney Children's Hospitals Network in 2013-14)
- only the Sydney Children's Hospitals Network did not achieve the T4 target in 2014-15 and in 2013-14
- all local heath districts and the Sydney Children's Hospitals Network achieved the T5 target (all in 2013-14).

The Central Coast Local Health District improved its triage performance for treating imminently life threatening (T2) and potentially life threatening (T3) incidents, but did not meet these targets for the fourth consecutive year.

Although Sydney Local Health District improved its triage performance for treating potentially life threatening (T3) incidents, it again did not meet the target. The District also did not achieve the target for treating imminently life threatening (T2) incidents.

The Sydney Children's Hospitals Network improved its triage performance for treating potentially life threatening (T3) and potentially serious (T4) incidents, but again did not meet these targets.

Last year's Auditor-General's Report to Parliament recommended Western NSW Local Health District implement appropriate strategies and controls to more accurately capture and record triage data over imminently life threatening (T2) incidents. The district advises it implemented targeted reviews and monitoring processes to ensure data over T2 incidents is accurately captured and recorded in a timely manner. The district achieved the T2 target in 2014-15.

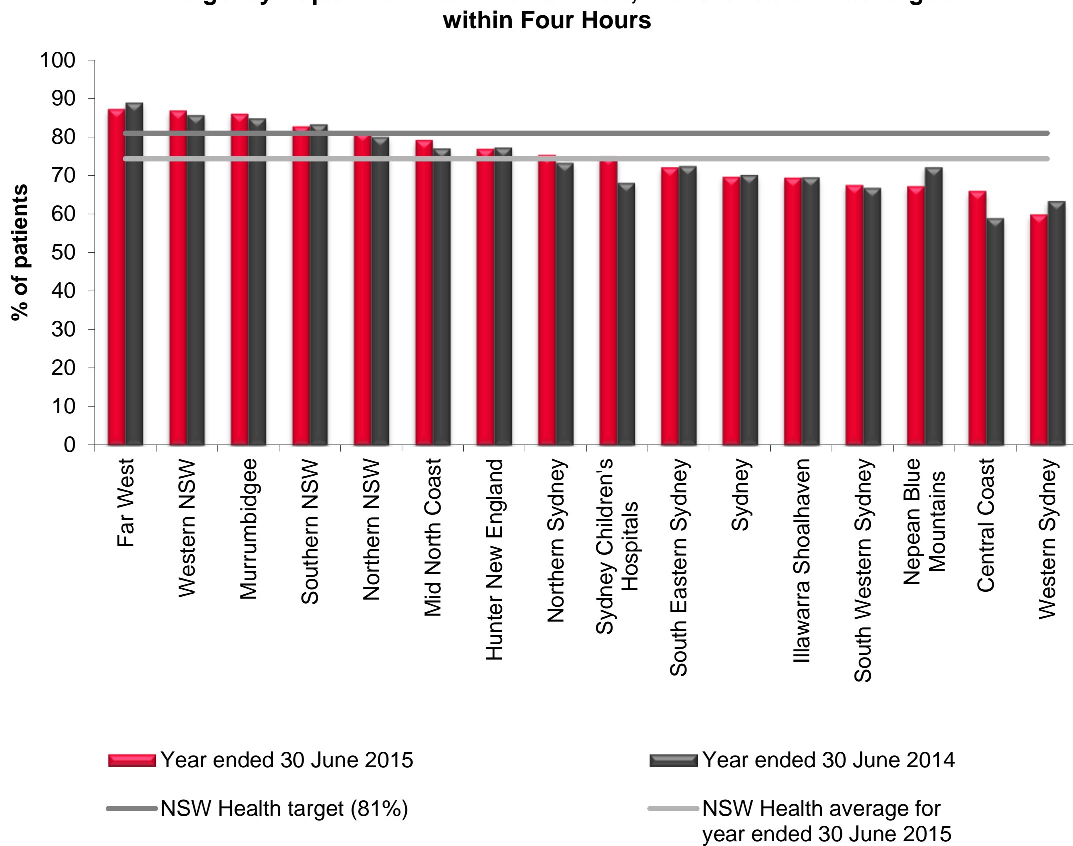
Emergency Treatment Performance

NSW Health's emergency treatment performance improving but below target

In 2014-15, the State average Emergency Treatment Performance (ETP) was 74.3 per cent, an improvement on the previous year's 73.9 per cent. However, only Far West, Western NSW, Murrumbidgee, Southern NSW and Northern NSW local health districts met the target of 81 per cent.

Far West Local Health District admitted, transferred or discharged the highest percentage of emergency department patients within four hours, achieving 87.1 per cent (88.9 per cent in 2013-14). Western Sydney Local Health District achieved the lowest percentage of 59.9 per cent (Central Coast Local Health District achieved 58.9 per cent in 2013-14).

Emergency Department Patients Admitted, Transferred or Discharged within Four Hours



Source: NSW Ministry of Health (unaudited).

The Ministry advises the 2014-15 emergency admission performance has been affected by:

- increases in emergency presentations
- inpatient process and models of care that did not support smooth patient movement
- inadequate inpatient capacity
- unnecessary length of stay for some patient groups
- slow discharge practices.

On 1 January 2015, the ‘National Emergency Access Target’ (NEAT) was replaced by NSW Health’s Emergency Treatment Performance (ETP). The ETP sets a target that 81 per cent of all patients presenting to a public hospital emergency department will either physically leave the emergency department for admission to hospital, be referred to another hospital for treatment or be discharged within four hours.

Ambulance Response Times

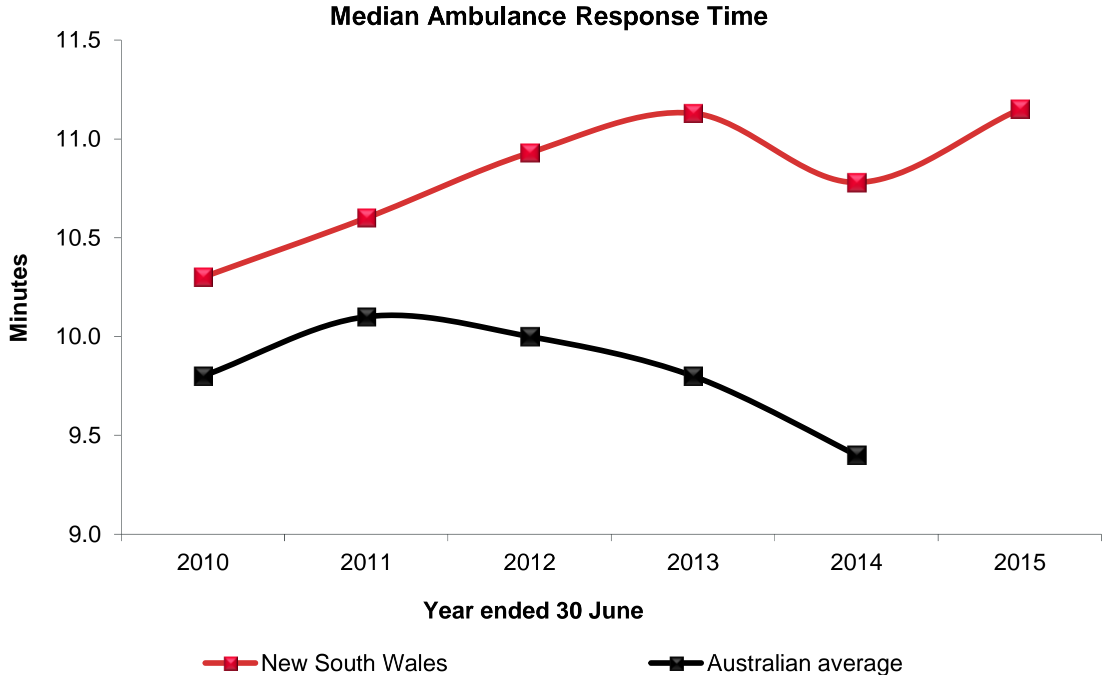
NSW Ambulance response times remain above the national average

The median (50th percentile) ambulance response time for potentially life threatening cases (Priority 1) in New South Wales rose to its highest level in five years. It increased from 10.8 minutes in 2013-14 to 11.2 minutes in 2014-15.

Since 2009-10, the national median ambulance response time has fallen 4.1 per cent, from 9.8 minutes in 2009-10 to 9.4 minutes in 2013-14. Over the same period, the New South Wales response time increased 4.7 per cent, from 10.3 minutes to 10.8 minutes.

NSW Ambulance advises the improvement in 2013-14 for Priority 1 cases was due to changes in the prioritisation of triple zero (000) calls in March 2013. The change reduced the proportion of Priority 1 calls from approximately 80 per cent in 2012-13 to 65 per cent in 2013-14. The improvement was not maintained in 2014-15 despite the proportion of Priority 1 calls falling to 55 per cent in March 2015.

The graph below shows NSW Ambulance response times compared to the national average.



Note: The Australian average response time for 2014-15 was not available at the time of preparing this report.

Source: Report on Government Services 2015, Volume D: Emergency Management, Table 9A.44 and NSW Ambulance (unaudited).

The ambulance emergency response time is measured as the period from when a triple zero (000) potentially life threatening case is recorded to the time the first ambulance resource arrives at the scene. In Australia, the median response time is the key measure, allowing performance to be compared with other states.

Transfer of Care

The time to transfer patients from ambulances to hospitals remains below target

The timely transfer of ambulance patients into hospital emergency departments is an important measure in the delivery of quality healthcare services. This measure is known as 'transfer of care'.

In 2014-15, total ambulance arrivals at NSW hospitals, where patients were transferred from the ambulance to the emergency department, increased marginally (0.2 per cent). The median transfer of care time increased from 12.8 minutes in 2013-14 to 13.0 minutes. The percentage of arrivals transferred into the care of emergency departments within 30 minutes declined marginally from 85 per cent in 2013-14 to 84.5 per cent, remaining below the Ministry's target of 90 per cent.

Some statistics on transfer of care time are shown below.

Year ended 30 June	2015	2014
Total ambulance arrivals with transfer of care time	487,019	486,245
Arrivals with transfer of care within 30 minutes (%)	84.5	85.0
Target (%)	90.0	90.0
Median transfer of care (minutes)	13.0	12.8

Source: Bureau of Health Information, Hospital Quarterly, Performance of NSW public hospitals July 2014 to June 2015, Emergency Departments (unaudited).

Transfer of care time is measured from the time the ambulance arrives at the emergency department to the time the patient is moved to the emergency department treatment space and responsibility for their care is transferred from ambulance staff to emergency department staff.

Bed Numbers and Occupancy

Fewer beds occupied across NSW Health in 2014-15

On average, 24,303 beds and treatment spaces were available across NSW Health in June 2015 (24,086 in June 2014). Bed occupancy, a measure of bed usage efficiency, fell from 89 per cent in 2013-14 to 85.2 per cent in 2014-15.

Hunter New England Local Health District had the most available beds and treatment spaces (3,490) and Far West Local Health District had the least (197).

The table below summarises available beds and treatment spaces, and bed occupancy rates across the State (excluding the Justice Health and Forensic Mental Health Network).

NSW State average	2015	2014	2013	2012
Average beds available for admission from emergency department (June)(1)	12,893	12,810	13,444	13,519
Average other hospital beds available (June)	5,370	5,263	5,409	5,312
Average other available beds (June)(2)	2,356	2,360	2,335	2,213
Average treatment spaces available (June)(3)	3,684	3,653	3,670	3,661
Total beds and treatment spaces	**24,303**	**24,086**	**24,858**	**24,705**
Bed occupancy (%) (June)	85.2	89.0	87.8	88.6

1 These categories of beds are usually required for admission from the emergency department. A small proportion of emergency department patients may be admitted to one of the other hospital bed categories as well.

2 Other beds include Hospital in the Home and Residential/Community Aged Care and Respite beds.

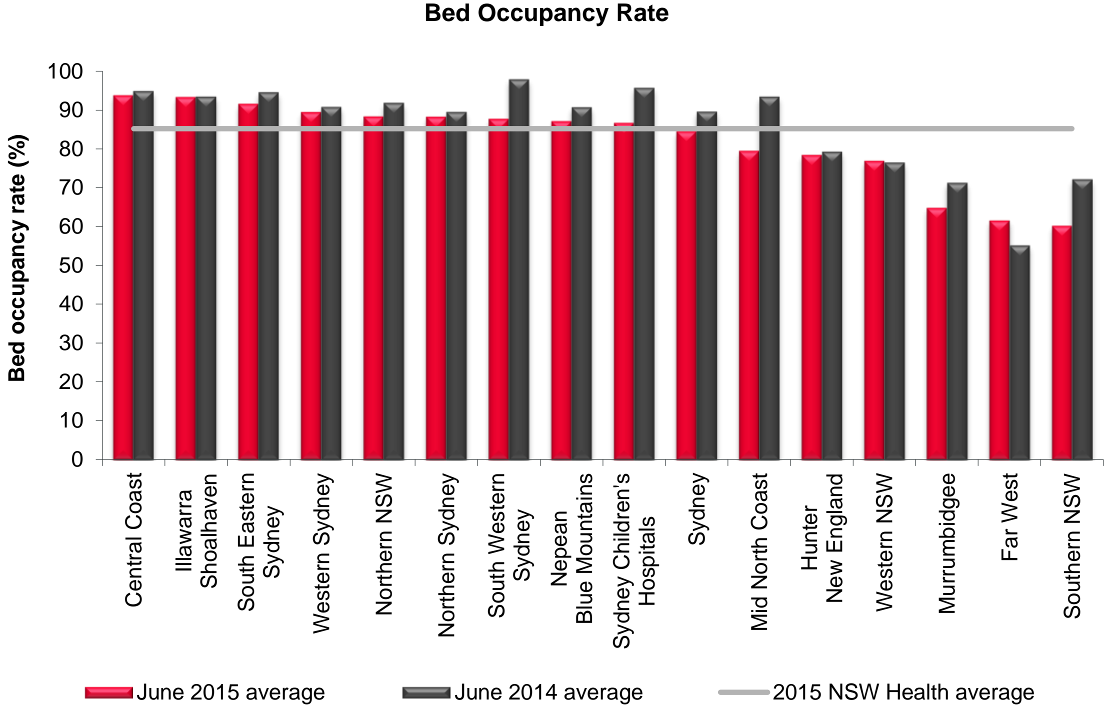
3 Treatment spaces include same day therapy/dialysis, emergency departments, operating theatre/recovery, delivery suites, bassinets and transit lounges.

Source: NSW Ministry of Health (unaudited).

The bed occupancy rate is the percentage of open and occupied beds available during the reporting period. It measures the use of hospital resources by inpatients and is based on major facilities.

Metropolitan bed occupancy rates were higher than those in regional areas

In June 2015, Central Coast Local Health District had the highest bed occupancy rate of 93.7 per cent while Southern NSW Local Health District had the lowest of 60.2 per cent. Metropolitan bed occupancy rates continue to be significantly higher than most rural areas.



Source: NSW Ministry of Health (unaudited).

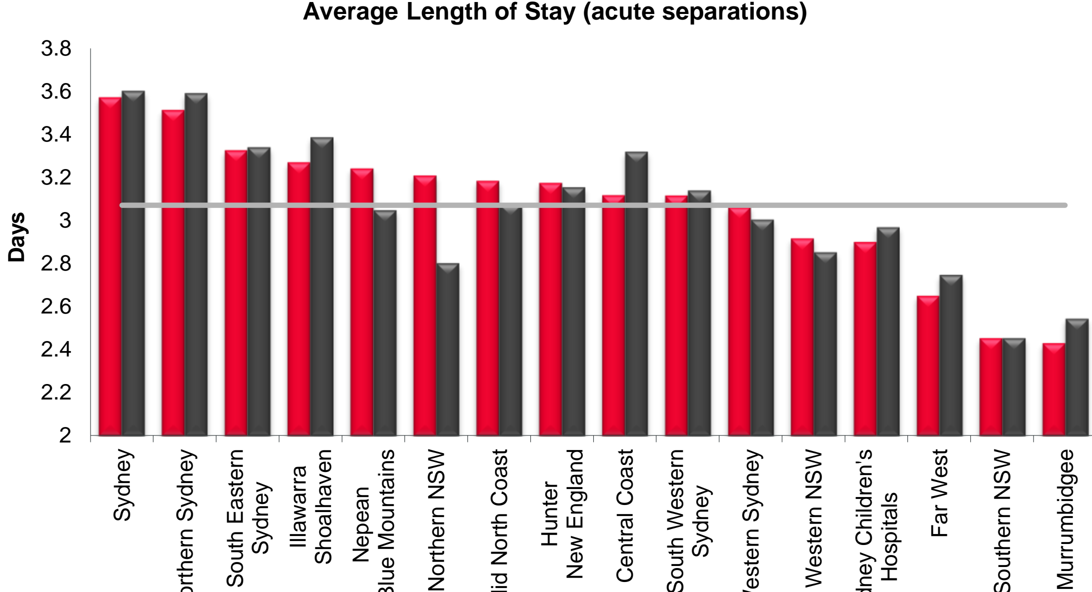
Average Length of Stay in Hospital

On average, acute care patients are spending 3.1 days in hospital

In 2014-15, the average length of stay for acute separations was 3.1 days (3.1 days in 2013-14). The State-wide average excludes the Justice Health and Forensic Mental Health Network.

Sydney Local Health District recorded the highest average length of stay for acute separations at 3.6 days (3.6 days for Sydney and Northern Sydney local health districts in 2013-14). Murrumbidgee Local Health District recorded the lowest average length of stay of 2.4 days (2.5 days for Southern NSW Local Health District in 2013-14).

The average length of stay in nine of the fifteen local health districts and the Sydney Children's Hospitals Network fell in 2014-15. Generally, metropolitan areas have a slightly higher average length of stay than rural areas, because they deal with more complex patient conditions.



Source: NSW Ministry of Health (unaudited).

Average length of stay measures the average time patients spend when admitted to hospital and is an indicator of hospital efficiency. The length of stay varies depending on the procedures undertaken and the patient's condition.

While there is no average length of stay target, local health districts continuously look at ways of minimising the length of stay, where appropriate. This is important given hospitals are funded based on activity. If the length of stay exceeds the benchmark it may increase patient treatment costs. However, inappropriate reductions in length of stay may lead to adverse outcomes for patients and higher readmission rates.

In April 2015, the Auditor-General tabled in Parliament a performance audit on managing the length of stay and unplanned readmissions in NSW public hospitals. Further information on the performance audit appears later in this chapter.

Interstate Comparison

Patients stay longer in NSW hospitals than the national average

In 2013-14, the average length of stay in NSW hospitals continued to be higher than the national average and was highest when compared to other jurisdictions. New South Wales continues to have more available public hospital beds per 1,000 of population than the national average.

The following information, based on 2013-14 statistics, compares NSW public acute hospitals with other jurisdictions. Each jurisdiction has a different patient mix and accounting mechanism, and the data should be considered in this context.

	Vic	Qld	NSW	National	NSW	National
Year ended 30 June	**2014**				**2013**	
Average available public hospital beds per 1,000 population	2.4	2.5	2.7	2.5	2.8	2.6
Average length of stay including day surgery (days)	3.1	3.0	3.7	3.3	3.7	3.4

Note: National statistics differ from the Ministry's statistics, partly because they are based on a selection of hospitals only.

Source: Australian Institute of Health and Welfare - Australian Hospital Statistics 2013-14 (unaudited).

The Australian Institute of Health and Welfare regards the average length of stay as an indicator of the efficiency of hospitals.

Elective Surgery Waiting Times

NSW Health continued improving its elective surgery performance

In 2014-15, there were 217,727 admissions (216,675 in 2013-14) for elective surgery in NSW public hospitals, representing a 0.5 per cent increase. Elective Surgery is defined as planned or scheduled, non-emergency surgical procedures generally performed in an operating theatre, by a surgeon, under some form of anaesthesia.

Three categories are used to classify patients who are ready for care, according to clinical priority, as assigned by the referring doctor:

- Category 1 - surgical procedure to occur within 30 days of booking for surgery
- Category 2 - surgical procedure to occur within 90 days of booking for surgery
- Category 3 - surgical procedure to occur within 365 days of booking for surgery.

NSW Health only achieved the Category 2 target in 2014-15, although performance continues to improve in all three categories. The table below shows the NSW State average of patients admitted for booked surgery within clinically recommended timeframes for the last four years.

NSW State average	Percentage of patients admitted for booked surgery within clinically recommended timeframes				
Year ended 30 June	Target*	2015	2014	2013	2012
Category 1	100	99.8	99.7	98.0	94.0
Category 2	97	97.1	96.9	94.0	90.0
Category 3	97	96.1	95.9	94.0	92.0

* National Elective Surgery Targets (NEST) at December 2014. NEST is a component of the National Partnership Agreement (NPA) on Improving Public Hospital Services. It aims to ensure surgical patients are treated within the recommended clinical priority timeframe. New South Wales is a signatory of the NPA.

Source: NSW Ministry of Health (unaudited).

The Ministry tracks the percentage of patients in each category who received treatment within the recommended timeframes and the number ready for care who waited longer than the benchmark.

Elective surgery wait times do not include the time it takes for patients to see a specialist and get onto the waiting list because data on surgical access time is not recorded. The Ministry is working with the Australian Institute of Health and Welfare to devise a national measure on surgical access time, being the time taken from seeing the general practitioner to surgical care.

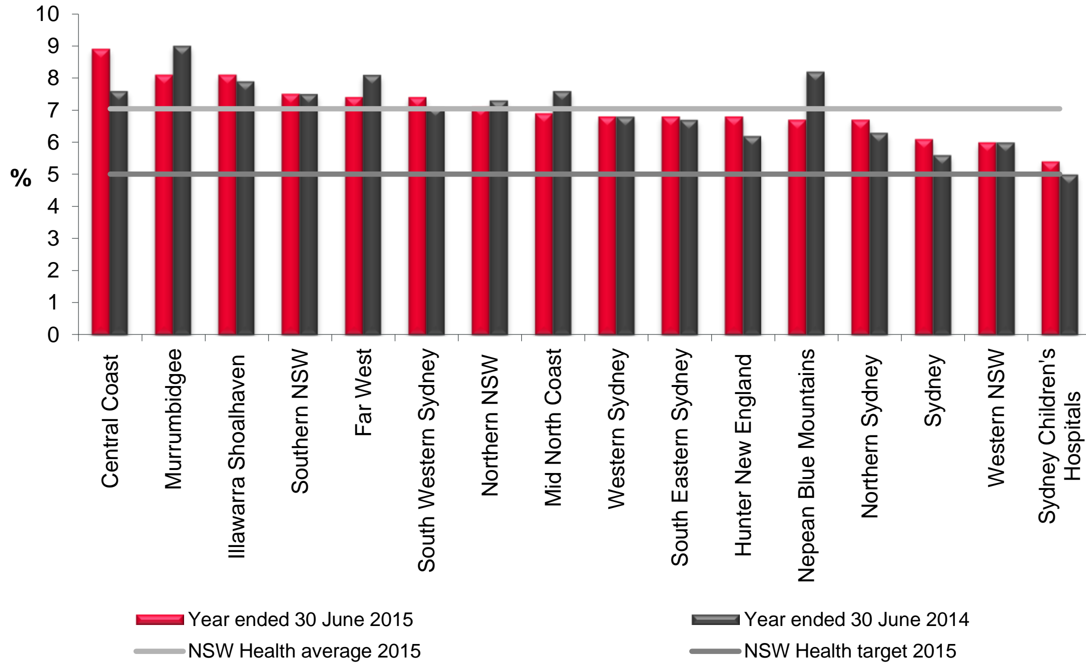
Unplanned Re-admissions

Unplanned re-admissions continue to be higher than the Ministry’s target

Across the State, approximately seven per cent of patients made an unplanned re-admission to the same facility within 28 days in 2014-15 (6.8 per cent in 2013-14), exceeding the target of five per cent. Unplanned re-admissions occur when discharged patients return to the same hospital unexpectedly. Monitoring the number of these patients is one way NSW Health measures the quality of hospital care.

All local health districts and the Sydney Children’s Hospitals Network failed to achieve the NSW Health target in 2014-15. The rate of unplanned hospital re-admissions at the Central Coast Local Health District was the highest at 8.9 per cent. The Sydney Children’s Hospitals Network had the lowest readmission rate of 5.4 per cent.

The graph below shows unplanned re-admissions for each local health district and the Sydney Children's Hospitals Network.



Source: NSW Ministry of Health (unaudited).

The Ministry advises unplanned re-admission figures have some limitations because they incorrectly include post-discharge care in the community and patient transfers between hospitals, not directly associated with the initial hospital admission. The local health districts continuously review unplanned re-admission statistics to improve accuracy.

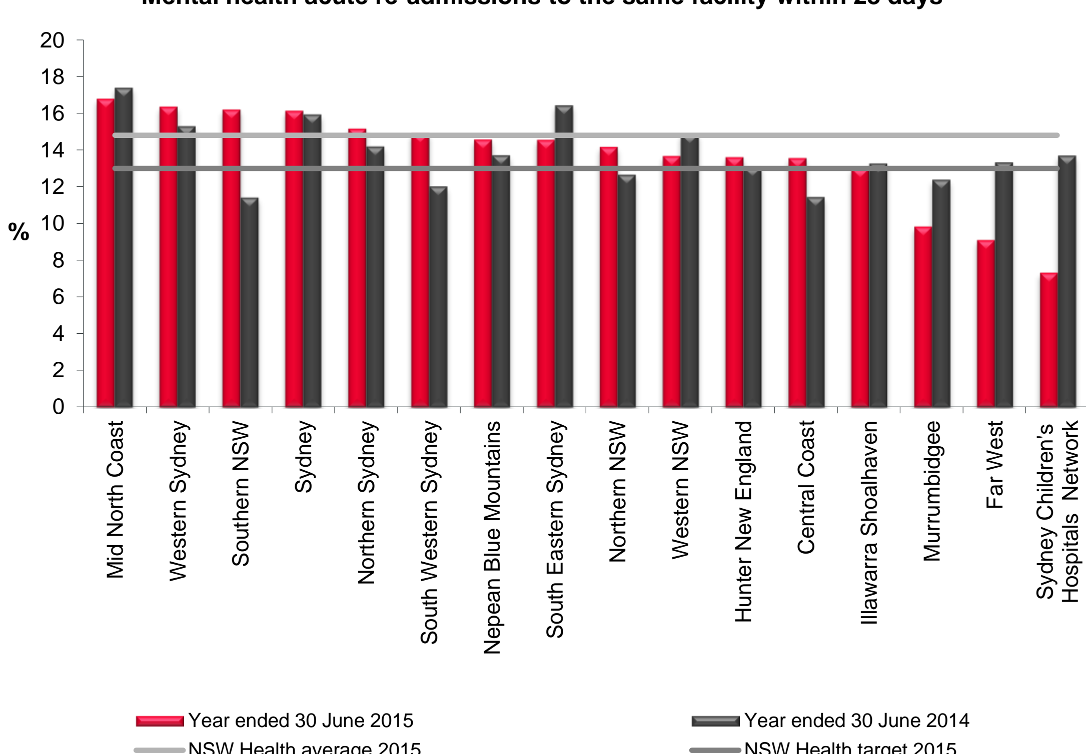
Mental Health Acute Re-admissions

Only four health entities achieved the mental health acute re-admissions target

Twelve local heath districts failed to achieve the NSW Health target of 13 per cent for mental health acute re-admissions in 2014-15. The State average was 14.8 per cent, a marginal increase on 14.3 per cent in the previous year.

Mid North Coast Local Health District had the highest re-admissions rate of 16.8 per cent (17.4 per cent in 2013-14), while the Sydney Children's Hospitals Network had the lowest rate of 7.3 per cent (Southern NSW Local Health District was 11.4 per cent in 2013-14).

The graph below shows mental health acute re-admissions within 28 days of being discharged for each local health district and the Sydney Children's Hospitals Network.



Source: NSW Ministry of Health (unaudited).

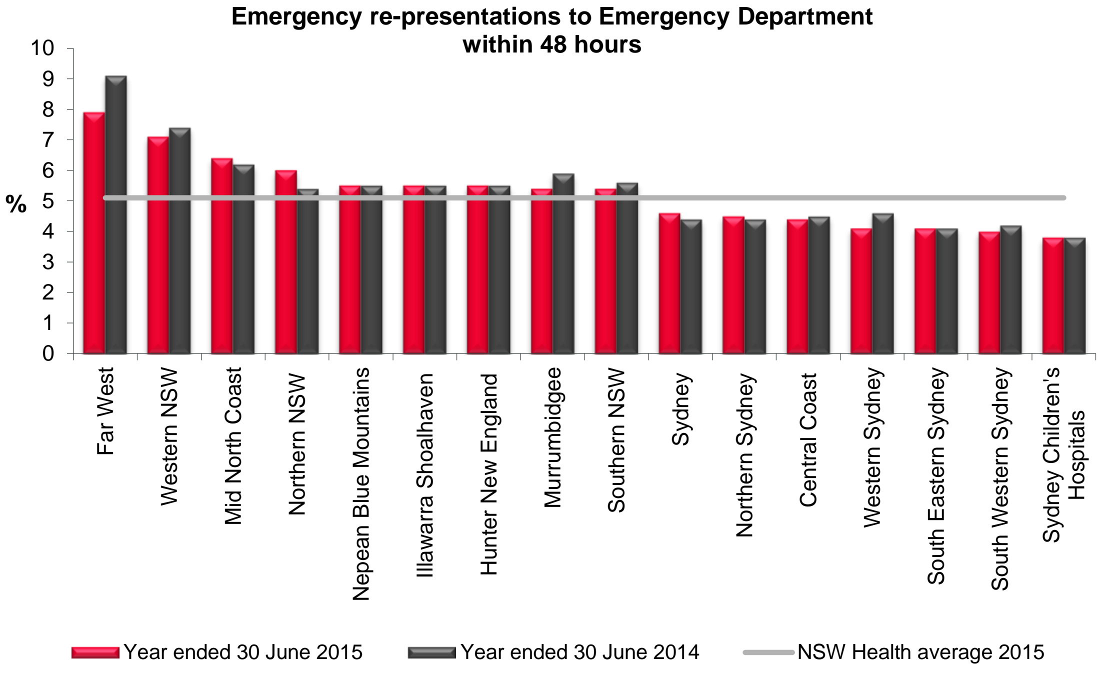
Mental health acute re-admissions occur when patients discharged from an acute mental health unit are re-admitted within 28 days. It is widely considered that high levels of re-admissions within short timeframes reflects deficiencies in inpatient treatment and/or follow-up care.

Unplanned Emergency Department Re-presentations

Rural emergency department patients are more likely to re-present within 48 hours

The Far West Local Health District again had the highest unplanned rate of re-presentations to the emergency department at 7.9 per cent (9.1 per cent in 2013-14). Sydney Children's Hospitals Network had the lowest rate of 3.8 per cent (3.8 per cent in 2013-14).

The graph below shows unplanned re-presentations to emergency departments within 48 hours of being discharged for each local health district and the Sydney Children's Hospitals Network in 2014-15.



Source: NSW Ministry of Health (unaudited).

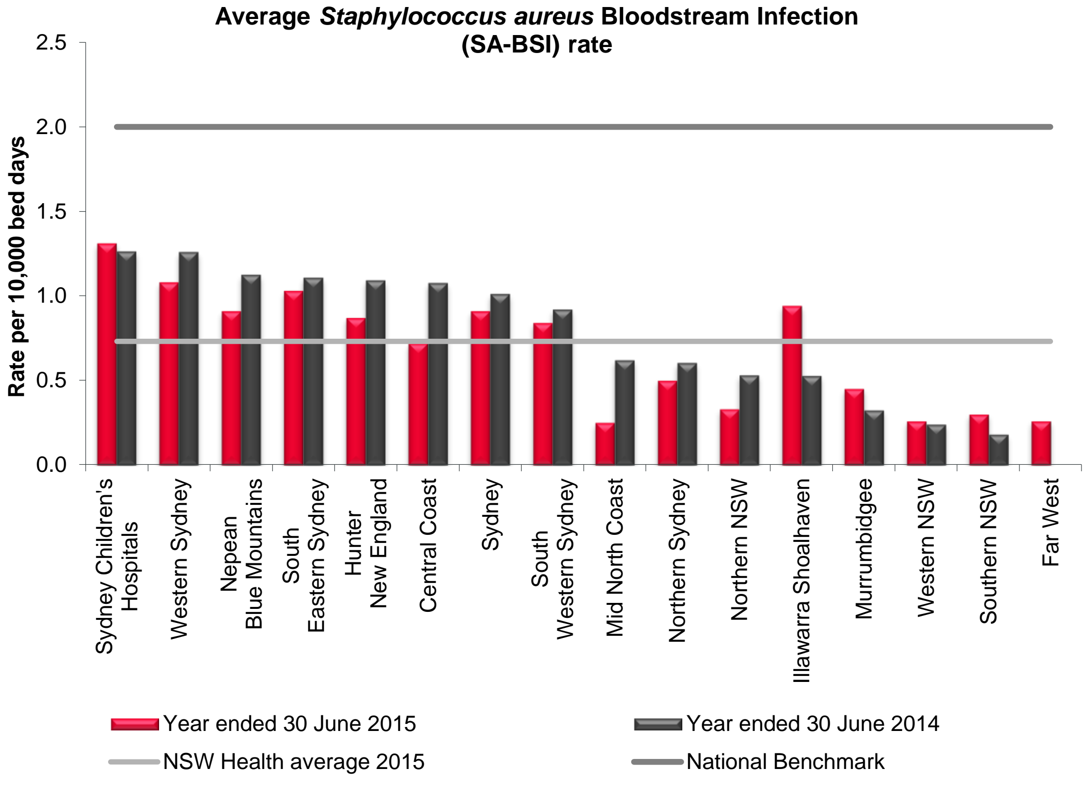
Patients attending rural emergency departments are more likely to re-present to the emergency department within 48 hours of being discharged than regional or metropolitan emergency departments. The Ministry advises unplanned re-presentations should be interpreted with caution, particularly in regional and rural hospitals. This is because higher than average rates of unplanned emergency re-presentations in these hospitals may reflect clinical models of care where emergency departments provide primary healthcare services, due to a lack of these services in those communities.

Healthcare Associated Infection

Staphylococcus aureus **infection rates were below the national benchmark**

For the fifth consecutive year, the rate of *Staphylococcus aureus* bloodstream infection (SA-BSI) in NSW Health was below the national benchmark of less than two SA-BSI cases per 10,000 bed days. The average was 0.73 cases per 10,000 bed days in 2014-15 (0.91 cases in 2013-14). Due to fewer incidents of infection, SA-BSI incidents fell from 594 in 2013-14 to 522 in 2014-15.The Sydney Children's Hospitals Network recorded the highest frequency in 2014-15, at 1.31 cases per 10,000 bed days. Mid North Coast Local Health District had the lowest frequency with 0.25 cases.

The graph below shows the rate of SA-BSI for each local health district and the Sydney Children's Hospitals Network.



Source: NSW Ministry of Health (unaudited).

Metropolitan local health districts and specialty networks have higher rates of SA-BSI because they include the major hospitals which treat more complex patients, who are more likely to have a SA-BSI. SA-BSI is one of the main indicators on healthcare associated infection as it is among the most common causes of community and healthcare associated sepsis (typically through infection of a wound). The incidence of SA-BSI is used as a surveillance indicator that may point to areas requiring further safety and quality investigation or action. The benchmark, set by the Council of Australian Governments, is two SA-BSI cases per 10,000 bed days.

Healthcare Associated Complications

Opportunities to reduce blood clots acquired by hospitalised patients

Venous thromboembolism (VTE) is a leading cause of death in Australia. Commonly referred to as blood clot, VTE occurs when blood pools and thickens inside normal, healthy veins blocking the flow of blood through the body. Hospitalisation has been found to be a major risk factor in the development of VTE, where the incidence in hospitalised patients is more than 100 times greater than in the community.

To improve the assessment and management of VTE risk, the Clinical Excellence Commission performed a detailed review of NSW Health data during 2015. The Commission identified a significant opportunity to improve VTE prevention strategies in New South Wales and to reduce the morbidity and mortality burden of this largely preventable event on the health system. These include:

- VTE is often thought of as a complication and not an adverse event
- the health information exchange data set does not capture missed diagnoses of VTE or positive radiological diagnoses which are not documented in the health record
- while up to two-thirds of VTE cases are preventable, data sets, like coding data, do not identify whether the case was preventable or not.

The Commission also identified limitations within the current data set in understanding the true incidence and impact of hospital-associated VTE.

To reduce the incidence of hospital-associated VTE and improve VTE reporting, the Commission made eight recommendations to NSW Health entities.

The Ministry advises it is not able to compare its performance against a national or state benchmark due to the unavailability of an appropriate benchmark.

Data Quality Audit and Assurance Program

Audits identified recurring quality issues with hospital data collected by the Ministry

In June 2015, an external firm delivered on the Ministry of Health's three year Data Quality Audit and Assurance Program. The program systematically assessed hospitals' compliance with the Ministry's data collection requirements and the accuracy of that data between 2012 and 2014.

Throughout the three year period, the external firm completed audits of 73 hospitals across the fifteen local health districts and two specialty networks.

The significant, recurring data quality issues and underlying root causes identified are summarised in the table below.

Data Quality Recurring Issues	Root Causes
People	
• Presentations should have been coded as planned/unplanned return visits, but were coded as emergency presentations • Invalid/incorrect Emergency Department (ED) 'first presentation' times – data input incorrectly into the Patient Admission System (PAS) causing inaccurate Ministry and hospital records.	• Human errors • Limitations of training • Resourcing.
Methodology / Process	
• Different hospitals use a number of reports to identify data quality issues • Incomplete data – data sets received from hospitals had missing data, and several hospitals had ED patients with no records of 'first seen' time and 'first seen' clinician time • Inconsistent use of PAS across hospitals – data input into the PAS differently across hospitals and local health districts.	• Limited scope of information analysed in data error reporting • Manual input of ED times • Parallel use of paper based and electronic patient records.

Data Quality Recurring Issues	Root Causes
System / Technology	
• Hospitals using paper forms for ED process and therefore 'first seen' time is not always accurately recorded • Arrival time subsequent to the first seen time • Departure or discharge time prior to the first seen time • Discrepancies between ED times on the hospital system and the extract obtained from the Ministry • Discrepancies between changes to Clinical Priority Categories on the hospital system and the extract obtained from the Ministry • Mismatch data between the Ministry and hospital data sets – data provided by the Ministry was not matched to data provided by the hospitals, and hospital amendments to data were not updated in the Health Information Exchange (HIE).	• Lack of business rules within source systems to ensure data quality at the point of entry • Differences in input data between ED and waiting lists • Flexibility in hospital data systems and use of paper forms in ED • Timing delay in HIE update • Legacy HIE architecture and functionality.

Source: Adapted from Ministry of Health Data Quality Audit and Assurance Program report (Unaudited).

The Ministry advises it will commence a Data Quality for Improved Performance Program in 2015-16 in conjunction with an external firm.

Recommendations from the Auditor-General's Performance Audit into 'managing length of stay and unplanned readmissions in NSW public hospitals'

In April 2015, the Auditor-General tabled in Parliament a performance audit on managing the length of stay and unplanned readmissions in NSW public hospitals. The report included six recommendations for NSW Health to:

- as soon as possible, address the limitations in the existing specifications for measuring unplanned readmissions within 28 days of discharge
- by December 2015, ensure the use of Relative Stay Index reports and Activity Based Management portal at the Local Health District level
- by December 2015, take appropriate actions to support local analysis and reporting of length of stay and unplanned readmissions, subject to cost-benefit considerations of providing more business intelligence tools to Local Health District and hospital staff
- by December 2015, identify and coordinate State-wide and local strategies to reduce unplanned readmissions. These strategies should be targeted at specific conditions and patient groups who would most benefit from reductions in unplanned readmissions
- by December 2015, ensure that out-of-hospital programs being rolled out have suitable evaluation programs attached
- by June 2016, commence formal reviews and evaluations on the effectiveness of HealtheNet in supporting continuity of patient services from hospital care to primary and community care. The reviews should include IT challenges encountered during implementation, effectiveness of training and education programs, take up/utilisation rates and evidence of success.

The Ministry advised they were actioning the recommendations. For a copy of the report, refer to: www.audit.nsw.gov.au/publications/performance-audit-reports/2015-reports/managing-length-of-stay-and-hospital-readmissions/managing-length-of-stay-and-hospital-readmissions.

Section Two

Appendices

Appendix One – Abridged Financial Statements

Local health district	Central Coast		Far West		Hunter New England		Illawarra Shoalhaven		Mid North Coast	
Year	2015 $'000	2014 $'000	2015 $'000	2014 $'000	2015 $'000	2014 $'000	2015 $'000	2014 $'000	2015 $'000	2014 $'000
Abridged statement of comprehensive income (year ended 30 June)										
Employee related expenses	496,481	467,247	61,960	62,695	1,170,499	1,114,102	534,924	508,006	322,936	309,629
All other expenses excluding losses	220,390	214,068	42,465	38,211	820,146	801,699	270,214	263,426	222,115	197,836
Total expenses	**716,871**	**681,315**	**104,425**	**100,906**	**1,990,645**	**1,915,801**	**805,138**	**771,432**	**545,051**	**507,465**
Government contributions	618,652	576,470	88,678	86,101	1,710,397	1,646,325	746,574	706,490	491,525	512,974
Other revenue	100,135	92,371	15,295	13,164	315,471	311,565	112,594	109,265	78,137	72,448
Total revenue	**718,787**	**668,841**	**103,973**	**99,265**	**2,025,868**	**1,957,890**	**859,168**	**815,755**	**569,662**	**585,422**
Gains/(losses)	(597)	(1,049)	(134)	23	(1,122)	(2,039)	(2,155)	(1,054)	(916)	37
Net result - surplus/(deficit)	**1,319**	**(13,523)**	**(586)**	**(1,618)**	**34,101**	**40,050**	**51,875**	**43,269**	**23,695**	**77,994**
Other comprehensive income	2,919	10,765	5,912	3,912	51,424	10,811	33,377	7,726	19,405	--
Total comprehensive income/(expense)	**4,238**	**(2,758)**	**5,326**	**2,294**	**85,525**	**50,861**	**85,252**	**50,995**	**43,100**	**77,994**
Abridged statement of financial position (at 30 June)										
Current assets	42,422	50,008	5,552	5,652	164,645	176,792	85,678	87,093	43,067	45,112
Non-current assets	527,420	524,813	99,770	93,457	1,402,250	1,301,317	600,509	521,749	420,230	375,892
Total assets	**569,842**	**574,821**	**105,322**	**99,109**	**1,566,895**	**1,478,109**	**686,187**	**608,842**	**463,297**	**421,004**
Current liabilities	106,749	116,287	15,582	14,729	317,323	304,374	112,958	121,249	81,945	82,950
Non-current liabilities	670	349	93	59	108,240	117,928	835	451	508	310
Total liabilities	**107,419**	**116,636**	**15,675**	**14,788**	**425,563**	**422,302**	**113,793**	**121,700**	**82,453**	**83,260**
Net assets	**462,423**	**458,185**	**89,647**	**84,321**	**1,141,332**	**1,055,807**	**572,394**	**487,142**	**380,844**	**337,744**

Local health district	Murrumbidgee		Nepean Blue Mountains		Northern NSW		Northern Sydney		South Eastern Sydney	
Year	2015 $'000	2014 $'000	2015 $'000	2014 $'000	2015 $'000	2014 $'000	2015 $'000	2014 $'000	2015 $'000	2014 $'000
Abridged statement of comprehensive income (year ended 30 June)										
Employee related expenses	278,371	282,668	415,526	390,788	420,152	396,642	897,710	864,154	1,029,765	989,026
All other expenses excluding losses	229,604	224,073	269,713	255,541	273,518	268,838	592,572	512,454	561,942	542,416
Total expenses	**507,975**	**506,741**	**685,239**	**646,329**	**693,670**	**665,480**	**1,490,282**	**1,376,608**	**1,591,707**	**1,531,442**
Government contributions	491,815	460,921	586,063	565,176	645,451	577,127	1,285,203	1,234,370	1,304,045	1,241,802
Other revenue	95,717	90,539	81,222	75,101	93,881	89,166	302,444	253,409	307,805	277,730
Total revenue	**587,532**	**551,460**	**667,285**	**640,277**	**739,332**	**666,293**	**1,587,647**	**1,487,779**	**1,611,850**	**1,519,532**
Gains/(losses)	(574)	(408)	6,719	(710)	(387)	(126)	(15,319)	(3,081)	(10,447)	(5,036)
Net result - surplus/(deficit)	**78,983**	**44,311**	**(11,235)**	**(6,762)**	**45,275**	**687**	**82,046**	**108,090**	**9,696**	**(16,946)**
Other comprehensive income	--	--	30,723	--	(5,322)	23,469	114,713	--	89,682	16,958
Total comprehensive income/(expense)	**78,983**	**44,311**	**19,488**	**(6,762)**	**39,953**	**24,156**	**196,759**	**108,090**	**99,378**	**12**
Abridged statement of financial position (at 30 June)										
Current assets	24,548	22,286	57,058	53,977	26,971	24,298	198,573	172,459	167,319	167,297
Non-current assets	454,712	379,101	527,818	507,089	476,726	438,236	2,025,342	1,824,146	1,157,928	1,067,845
Total assets	**479,260**	**401,387**	**584,876**	**561,066**	**503,697**	**462,534**	**2,223,915**	**1,996,605**	**1,325,247**	**1,235,142**
Current liabilities	66,069	65,362	113,225	106,175	100,560	99,672	241,277	232,878	273,887	282,704
Non-current liabilities	903	247	2,255	4,983	775	453	749,701	727,548	11,078	11,534
Total liabilities	**66,972**	**65,609**	**115,480**	**111,158**	**101,335**	**100,125**	**990,978**	**960,426**	**284,965**	**294,238**
Net assets	**412,288**	**335,778**	**469,396**	**449,908**	**402,362**	**362,409**	**1,232,937**	**1,036,179**	**1,040,282**	**940,904**

Local health district	South Western Sydney		Southern NSW		Sydney		Western NSW		Western Sydney	
Year	2015 $'000	2014 $'000	2015 $'000	2014 $'000	2015 $'000	2014 $'000	2015 $'000	2014 $'000	2015 $'000	2014 $'000
Abridged statement of comprehensive income (year ended 30 June)										
Employee related expenses	1,002,122	950,068	206,629	197,997	947,124	907,242	460,959	452,316	1,018,158	965,621
All other expenses excluding losses	566,824	523,402	141,105	135,710	583,517	538,879	352,448	340,659	510,025	482,975
Total expenses	**1,568,946**	**1,473,470**	**347,734**	**333,707**	**1,530,641**	**1,446,121**	**813,407**	**792,975**	**1,528,183**	**1,448,596**
Government contributions	1,351,977	1,299,313	403,502	322,676	1,230,522	1,198,473	766,318	688,070	1,336,011	1,262,790
Other revenue	205,072	190,206	49,291	46,497	265,948	254,831	118,001	111,492	237,635	218,347
Total revenue	**1,557,049**	**1,489,519**	**452,793**	**369,173**	**1,496,470**	**1,453,304**	**884,319**	**799,562**	**1,573,646**	**1,481,137**
Gains/(losses)	(2,393)	(443)	(34)	(141)	(6,989)	(16,196)	(7,179)	(894)	(9,710)	(3,135)
Net result - surplus/(deficit)	**(14,290)**	**15,606**	**105,025**	**35,325**	**(41,160)**	**(9,013)**	**63,733**	**5,693**	**35,753**	**29,406**
Other comprehensive income	17,682	--	--	--	16,041	22,845	71,813	21,333	62,558	(2,415)
Total comprehensive income/(expense)	**3,392**	**15,606**	**105,025**	**35,325**	**(25,119)**	**13,832**	**135,546**	**27,026**	**98,311**	**26,991**
Abridged statement of financial position (at 30 June)										
Current assets	107,247	102,078	26,028	20,395	251,113	257,788	45,203	48,989	141,185	137,344
Non-current assets	1,220,490	1,212,838	334,592	232,639	999,670	992,175	972,302	831,357	1,144,023	1,027,719
Total assets	**1,327,737**	**1,314,916**	**360,620**	**253,034**	**1,250,783**	**1,249,963**	**1,017,505**	**880,346**	**1,285,208**	**1,165,063**
Current liabilities	271,585	260,747	46,099	43,678	271,844	246,495	113,451	112,180	251,569	231,615
Non-current liabilities	28,193	29,602	310	170	1,743	1,153	162,837	162,495	6,882	5,002
Total liabilities	**299,778**	**290,349**	**46,409**	**43,848**	**273,587**	**247,648**	**276,288**	**274,675**	**258,451**	**236,617**
Net assets	**1,027,959**	**1,024,567**	**314,211**	**209,186**	**977,196**	**1,002,315**	**741,217**	**605,671**	**1,026,757**	**928,446**

Specialty health network	The Sydney Children's Hospitals Network		Justice Health and Forensic Mental Health	
Year	2015 $'000	2014 $'000	2015 $'000	2014 $'000
Abridged statement of comprehensive income (year ended 30 June)				
Employee related expenses	481,486	464,994	144,689	137,339
All other expenses excluding losses	208,269	199,144	51,255	48,521
Total expenses	**689,755**	**664,138**	**195,944**	**185,860**
Government contributions	521,548	498,991	186,819	180,620
Other revenue	173,801	153,315	12,230	10,032
Total revenue	**695,349**	**652,306**	**199,049**	**190,652**
Gains/(losses)	(769)	(778)	(306)	(285)
Net result - surplus/(deficit)	**4,825**	**(12,610)**	**2,799**	**4,507**
Other comprehensive income	34,574	--	--	3,356
Total comprehensive income/(expense)	**39,399**	**(12,610)**	**2,799**	**7,863**
Abridged statement of financial position (at 30 June)				
Current assets	144,526	147,439	39,704	36,727
Non-current assets	561,722	519,471	112,007	115,019
Total assets	**706,248**	**666,910**	**151,711**	**151,746**
Current liabilities	116,787	117,248	32,630	34,091
Non-current liabilities	865	465	77,184	78,557
Total liabilities	**117,652**	**117,713**	**109,814**	**112,648**
Net assets	**588,596**	**549,197**	**41,897**	**39,098**

Performance and Financial Indicators

Local health district	Central Coast		Far West		Hunter New England		Illawarra Shoalhaven		Mid North Coast	
Year	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014
Performance indicators (year ended 30 June)										
Emergency department attendances	120,536	116,812	26,377	27,223	394,330	392,738	147,066	144,687	112,276	106,976
Emergency department treatment completed within 4 hours (%)	66	59	87	89	77	77	69	70	79	77
Bed occupancy rate (%) (a)	93.7	94.8	61.5	55.1	78.4	79.2	93.3	93.3	79.4	93.3
Average length of stay (days) (b)	3.1	3.3	2.7	2.7	3.2	3.2	3.3	3.4	3.2	3.1
Elective surgery - booked surgery admissions	10,061	9,967	1,102	1,022	28,555	29,305	12,300	11,688	10,137	9,470
Unplanned readmissions and re-presentations within 28 days (%)	7.4	7.6	7.4	8.1	6.7	6.2	7.5	7.9	6.9	7.6
Mental Health acute readmissions within 28 days (%)	13.6	11.4	9.1	13.3	13.6	13.1	13.0	13.3	16.8	17.4
Emergency re-presentations to emergency department within 48 hours (%)	4.5	4.5	7.9	9.1	5.4	5.5	5.5	5.5	6.4	6.2
Average Staphylococcus aureus bloodstream infection (SA BSI) rate (c)	0.7	1.1	0.3	--	0.9	1.1	0.9	0.5	0.3	0.6
Financial indicators (year ended 30 June)										
Quick ratio at 30 June (d)	0.2	2.2	0.3	0.7	2.8	3.2	0.5	4.9	1.6	1.8
Capital replacement ratio	1.0	0.6	1.1	0.3	1.7	1.7	3.1	3.1	2.5	7.2
Overtime expense as a percentage of salaries and wages (%)	4.8	4.6	3.5	3.7	3.7	3.7	4.9	4.8	4.0	4.1

Local health district	Murrumbidgee		Nepean Blue Mountains		Northern NSW		Northern Sydney		South Eastern Sydney	
Year	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014
Performance indicators (year ended 30 June)										
Emergency department attendances	134,734	134,504	118,465	114,670	190,183	185,944	198,878	192,564	216,206	209,044
Emergency department treatment completed within 4 hours (%)	86	85	67	72	81	80	75	73	72	72
Bed occupancy rate (%) (a)	64.8	71.3	87.1	90.6	88.3	91.7	3.5	89.5	91.5	94.5
Average length of stay (days) (b)	2.4	2.5	3.2	3.0	3.2	2.8	3.5	3.6	3.3	3.3
Elective surgery - booked surgery admissions	7,232	7,216	9,482	9,465	14,224	13,496	12,264	12,368	19,920	19,709
Unplanned readmissions and re-presentations within 28 days (%)	8.1	9.0	6.7	8.2	6.9	7.3	6.7	4.4	6.8	6.7
Mental Health acute readmissions within 28 days (%)	9.8	12.4	14.6	13.7	14.2	12.7	15.2	14.2	14.6	16.4
Emergency re-presentations to emergency department within 48 hours (%)	6.0	5.9	5.5	5.5	5.4	5.4	4.4	4.4	4.0	4.1
Average Staphylococcus aureus bloodstream infection (SA BSI) rate (c)	0.5	0.3	0.9	1.1	0.3	0.5	0.5	0.6	1.0	1.1
Financial indicators (year ended 30 June)										
Quick ratio at 30 June (d)	0.3	1.1	0.2	0.7	0.5	0.7	2.6	2.9	0.7	1.0
Capital replacement ratio	5.6	4.3	0.3	0.9	3.2	1.4	2.3	3.3	1.1	1.3
Overtime expense as a percentage of salaries and wages (%)	3.8	4.0	4.2	4.9	3.5	3.7	4.6	4.4	4.3	4.3

Local health district	South Western Sydney		Southern NSW		Sydney		Western NSW		Western Sydney	
Year	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014
Performance indicators (year ended 30 June)										
Emergency department attendances	257,862	249,770	100,672	101,548	161,644	159,880	202,900	215,313	169,878	165,762
Emergency department treatment completed within 4 hours (%)	67	67	83	83	70	70	87	86	60	63
Bed occupancy rate (%) (a)	87.7	97.8	60.2	72.1	84.5	89.5	76.9	76.4	89.4	90.7
Average length of stay (days) (b)	3.1	3.1	2.5	2.5	3.6	3.6	2.9	2.9	3.1	3.0
Elective surgery - booked surgery admissions	21,231	21,701	5,830	5,580	24,177	24,245	9,548	9,522	19,070	18,734
Unplanned readmissions and re-presentations within 28 days (%)	7.4	7.1	7.5	7.5	6.0	5.6	6.0	6.0	6.8	6.8
Mental Health acute readmissions within 28 days (%)	14.9	12.0	16.2	11.4	16.1	15.9	13.7	14.9	16.4	15.3
Emergency re-presentations to emergency department within 48 hours (%)	4.1	4.2	5.5	5.6	4.1	4.4	7.1	7.4	4.6	4.6
Average Staphylococcus aureus bloodstream infection (SA BSI) rate (c)	0.8	0.9	0.3	0.7	0.9	1.0	0.3	0.2	1.1	1.3
Financial indicators (year ended 30 June)										
Quick ratio at 30 June (d)	0.2	2.6	3.8	2.7	0.2	1.2	1.3	1.6	1.3	1.9
Capital replacement ratio	0.8	1.5	11.6	4.8	0.8	1.6	2.5	1.2	2.0	1.6
Overtime expense as a percentage of salaries and wages (%)	4.9	5.1	3.3	3.3	5.3	5.1	4.6	4.3	4.7	5.1

Specialty health network	The Sydney Children's Hospitals Network		Justice Health and Forensic Mental Health Network	
Year	2015	2014	2015	2014
Performance indicators (year ended 30 June)				
Emergency department attendances	93,571	92,431	--	--
Emergency department treatment completed within 4 hours (%)	75	68	--	--
Bed occupancy rate (%) (a)	86.6	95.6	--	--
Average length of stay (days) (b)	2.9	3.0	--	--
Elective surgery - booked surgery admissions	9,056	9,306	--	--
Unplanned readmissions and re-presentations within 28 days (%)	5.4	5.0	--	--
Mental Health acute readmissions within 28 days (%)	7.3	13.7	--	--
Emergency re-presentations to emergency department within 48 hours (%)	3.8	3.8	--	--
Average Staphylococcus aureus bloodstream infection (SA BSI) rate (c)	1.3	1.3	--	--
Financial indicators (year ended 30 June)				
Quick ratio at 30 June (d)	0.2	1.8	13.3	16.5
Capital replacement ratio	0.7	0.5	0.4	1.2
Overtime expense as a percentage of salaries and wages (%)	3.6	3.7	5.6	6.0

a Bed occupancy rate - the average percentage of open and occupied acute beds available in June.

b Average length of stay (for acute separations) - average time patients spend when admitted to hospital.

c Average Staphylococcus aureus bloodstream infection (SA BSI) rate - the average number of SA-BSI cases per 10,000 bed days.

d Quick ratio - current assets excluding restricted assets and inventory divided by trade creditors (unaudited).

Source: Financial indicators from audited financial statements. Performance indicators from NSW Ministry of Health (unaudited).

Appendix Two – Abridged Financial Statements – Other Entities

	Total assets		Total liabilities		Total revenue*		Total expense**		Net result	
	2015 $'000	2014 $'000	2015 $'000	2014 $'000	2015 $'000	2014 $'000	2015 $'000	2014 $'000	2015 $'000	2014 $'000
Consolidated entity										
Ministry of Health	16,644,258	15,509,284	4,298,930	4,283,497	19,454,660	18,519,269	18,926,120	18,061,734	528,540	457,535
Pillar agencies										
Agency for Clinical Innovation	13,472	10,611	5,207	4,952	32,491	28,755	29,885	27,445	2,606	1,310
Bureau of Health Information	1,267	1,080	706	1,069	8,151	7,426	7,601	7,101	550	325
Cancer Institute NSW	50,042	57,234	9,190	5,903	166,406	157,757	176,885	147,250	(10,479)	10,507
Clinical Excellence Commission	7,799	7,921	3,103	2,672	17,267	16,337	17,820	16,447	(553)	(110)
Health Education and Training Institute	12,135	10,381	6,291	9,303	44,771	38,316	40,005	41,433	4,766	(3,117)
NSW Kids and Families	6,166	4,576	2,127	1,567	36,100	27,313	35,070	26,945	1,030	368
Shared State-wide services										
Health Administration Corporation	1,670,600	1,628,910	554,993	619,405	2,731,072	2,582,002	2,669,159	2,523,389	61,913	58,613
Other controlled health entities										
Albury Wodonga Health Employment Division	--	--	980	584	3,149	644	3,365	680	(216)	(36)
Albury Base Hospital	60,871	62,115	--	--	(61)	--	3,836	2,233	(3,897)	(2,233)
Graythwaite Charitable Trust	43,140	40,186	--	--	2,975	299	1,002	1,701	1,973	(1,402)
Other entities in the cluster										
Health Care Complaints Commission	1,394	1,788	1,642	1,401	12,376	12,160	12,487	12,176	(111)	(16)
Mental Health Commission of New South Wales	1,683	2,781	2,612	952	10,964	9,913	10,712	9,287	252	626
NSW Institute of Psychiatry	5,821	5,759	1,332	2,789	6,731	3,955	5,212	7,684	1,519	(3,729)
Health Professional Councils#	44,825	35,959	19,407	17,202	29,406	27,367	23,174	46,191	6,231	(18,824)

* Total revenue includes other gains, gains on disposal, and capital contributions which were shown separately on the financial statements.

** Total expense includes other losses, and losses on disposal which were shown separately on the financial statements.

Health Professional Councils is the aggregate of the Psychology, Podiatry, Physiotherapy, Pharmacy, Osteopathy, Optometry, Occupational Therapy, Nursing and Midwifery, Medical Radiation Practice, Medical, Dental, Chiropractic, Chinese Medicine, and Aboriginal and Torres Strait Islander Health Practice Councils.

Appendix Three – Financial Sustainability

Indicator	Formula	Description
Net result - suplus/(deficit) ($)	**Net result from the statement of comprehensive income**	A positive result indicates a surplus, while a negative result indicates deficit. Operating deficits cannot be sustained in the long term.
Government funding (%)	**Government grants and contributions / total revenue**	Indicates the proportion of total revenue which is contributed as grants, by State and Federal Government. A higher percentage means that the agency relies on the Government to fund its expenditure. This percentage is expected to be lower for self funding agencies.
Expense growth rate (%)	**(Total expenditure 2015 less total expenditure 2014) / total expenditure 2014**	This demonstrates the rate at which total expenditure for an agency has increased or decreased in the financial year 2014-15, compared to 2013-14. A positive growth rate indicates that expenses have increased compared to prior year, while a negative growth rate indicates that expenses have decreased compared to prior year.
Net cost of services favourable/(unfavourable variance ($)	**Budget less actual net cost of services**	Net cost of services is based on total expenses less third party revenue, excluding government contributions. A favourable variance means the agency operates broadly consistent with the accrual based budget result and manages the full range of resources under its management.
Quick (ratio)	**Current assets excluding restricted assets and inventory / trade creditors**	This measures the dollar amount of liquid assets available for each dollar of recognised liabilities. A ratio of one or more means there are more cash and liquid assets than short-term liabilities. Current liabilities exclude employee provisions and revenue in advance.
Capital replacement (ratio)	**Cash outflows for property, plant and equipment and intangibles / depreciation and amortisation**	Comparison of the rate of spending on infrastructure, property, plant and equipment and intangibles with their depreciation and amortisation. Ratios greater than one indicate that spending is greater than the depreciating rate. This is a long-term indicator, as capital expenditure can be deferred in the short term if there are insufficient funds available from operations, and borrowing is not an option. Cash outflows for infrastructure, property, plant and equipment and intangibles are taken from the cash flow statement. Depreciation and amortisation is taken from the Statement of Comprehensive Income.

Appendix Four – Cluster Information

Agency	Website
Cluster lead entity	
Ministry of Health	http://www.health.nsw.gov.au
Local health districts and specialty health networks	
Central Coast	http://www.cclhd.health.nsw.gov.au/
Far West	http://www.fwlhn.health.nsw.gov.au/
Hunter New England	http://www.hnehealth.nsw.gov.au/
Illawarra Shoalhaven	http://www.islhd.health.nsw.gov.au/
Justice Health and Forensic Mental Health	http://www.justicehealth.nsw.gov.au/
Mid North Coast	http://mnclhd.health.nsw.gov.au/
Murrumbidgee	http://www.mlhd.health.nsw.gov.au/
Nepean Blue Mountains	http://www.nbmlhd.health.nsw.gov.au/
Northern NSW	http://nnswlhd.health.nsw.gov.au/
Northern Sydney	http://www.nslhd.health.nsw.gov.au/
South Eastern Sydney	http://www.seslhd.health.nsw.gov.au/
South Western Sydney	https://www.swslhd.nsw.gov.au/
Southern NSW	http://www.snswlhd.health.nsw.gov.au/
Sydney	http://www.slhd.nsw.gov.au/
Sydney Children's Hospitals	http://www.schn.health.nsw.gov.au/
Western NSW	http://www.wnswlhd.health.nsw.gov.au/
Western Sydney	http://www.wslhd.health.nsw.gov.au/
Pillar agencies	-
Agency for Clinical Innovation	http://www.aci.health.nsw.gov.au/
Bureau of Health Information	http://www.bhi.nsw.gov.au/
Cancer Institute NSW	https://www.cancerinstitute.org.au/
Clinical Excellence Commission	http://www.cec.health.nsw.gov.au/
Health Education and Training Institute	http://www.heti.nsw.gov.au/
NSW Kids and Families	http://www.kidsfamilies.health.nsw.gov.au/
Shared State-wide services	-
Health Administration Corporation	
- eHealth NSW	http://www.ehealth.nsw.gov.au/
- Health Infrastructure	http://www.hinfra.health.nsw.gov.au/
- Health System Support Group	*
- HealthShare NSW	http://www.healthshare.nsw.gov.au/
- NSW Ambulance	http://www.ambulance.nsw.gov.au/
- NSW Health Pathology	http://www.pathology.health.nsw.gov.au/
Other controlled health entities	-
Albury Base Hospital	*
Albury Wodonga Health Employment Division	*
Graythwaite Charitable Trust	*
Other entities in the cluster	
Health Care Complaints Commission	http://www.hccc.nsw.gov.au/
Mental Health Commission of NSW	http://nswmentalhealthcommission.com.au/
Health Professional Councils	http://www.hpca.nsw.gov.au/
NSW Institute of Psychiatry	http://www.nswiop.nsw.edu.au/

* This entity has no website.

Our vision

Making a difference through audit excellence.

Our mission

To help parliament hold government accountable for its use of public resources.

Our values

Purpose – we have an impact, are accountable, and work as a team.

People – we trust and respect others and have a balanced approach to work.

Professionalism – we are recognised for our independence and integrity and the value we deliver.

Professional people with purpose

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