

TASMANIAN HEALTH SERVICE
ANNUAL REPORT
2016-17



ABOUT THIS REPORT

The Tasmanian Health Service is required under section 53 of the *Tasmanian Health Organisations Act 2011* to produce an annual report in respect of its operation, financial reports and other particulars as required under section 53 of the Act. This report is the second annual report for the Tasmanian Health Service since the amalgamation of the three Tasmanian Health Organisations on 1 July 2015.



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LETTER OF COMPLIANCE

Hon Michael Ferguson MP

Minister for Health

Minister for Information Technology and Innovation

Leader of Government Business in the House of Assembly

GPO Box 123

Hobart Tasmania 7001

Hon Peter Gutwein MP

Treasurer

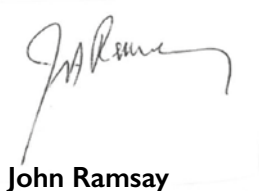
Level 9, Executive Building, 15 Murray Street

Hobart Tasmania 7000

Dear Ministers

In accordance with the requirements of section 53 of the *Tasmanian Health Service Organisations Act 2011* and section 27 of the *Financial Management and Audit Act 1990*, I am pleased to present the Annual Report 2016-17 and the financial statements for the Tasmanian Health Service.

Yours sincerely



John Ramsay

Chair Tasmanian Health Service Governing Council

30 September 2017

FACTS AND FIGURES



Population: approximately **519 100**

Total THS Spending: **1.5 billion**

Number of Paid Employees: **10 787**

Emergency Department Attendances: **157 066**

Raw Hospital Separations: **150 470**

Emergency Surgery: **10 847**

Elective Surgery Procedures: **19 180**

Outpatient Clinic Attendances: **380 548**

Patient Meals Served: **1 639 679**

Births in Tasmanian Public Hospitals: **4 460**

Scanned New Medical Record Pages Each Week: **157 498**

Breast Screen Tasmania: **31 491** eligible women screened

Alcohol and Drug Services Supported Clients: **2 591**

Supported Pharmacotherapy Program Clients: **650**

Mental Health Services Occasions of Service: **133 673**

Oral Health Services Occasions of Service:
Children **62 248** Adults **63 111**

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ONE STATE, ONE HEALTH SYSTEM, BETTER OUTCOMES



As a key component of the Tasmanian Government's *One State, One Health System, Better Outcomes* reform program, the Tasmanian Health Service (THS) was established in 2015 to improve patient outcomes by delivering better health services to Tasmanians.

Building upon the successful recruitment of its executive management team last year, the THS has undertaken significant staff engagement on the structures, processes and governance required to effectively facilitate statewide clinical service delivery and improvement, and strengthen local leadership at the facility level.

In the first instance the clinical stream structures will guide the management of clinical services at each of our hospital facilities. The streams are:

- Acute Medical
- Critical Care, Clinical Support and Investigations
- Cancer, Chronic Disease and Sub-Acute Care
- Mental Health Services
- Surgical and Perioperative Services
- Women's and Children's Services.

These streams will provide the foundation for the necessary clinical leadership to support the delivery of health care services to all Tasmanians.

In addition to mapping clinical services against the Tasmanian Role Delineation Framework and Clinical Services Profile, achievements this year also include:

- The transfer of birthing and inpatient maternity services from the Mersey Community Hospital (MCH) to the North West Private Hospital (NWPH) in November 2016 to improve sustainability, safety and quality.
- The establishment of an integrated trauma care service in Tasmania, led by a statewide Trauma Service Director and Trauma Nurse.

- The MCH now provides same day and overnight elective surgery admissions within the 23-hour Day Surgery Centre model.

A number of major infrastructure projects are also underway including the \$689 million redevelopment of the Royal Hobart Hospital, jointly funded by the Australian and Tasmanian Governments.

The THS is also taking action to address demand in Emergency Departments and to improve whole-of-hospital patient flow. Stage I of the Patients First initiative, announced in April 2016, included 18 specific actions aimed at improving patient flow issues across the Launceston General Hospital (LGH) and the Royal Hobart Hospital (RHH).

The areas of focus include timely movement of patients to the right place at the right time, staff training and recruitment, developing a statewide clinical handover framework, better supporting long stay patients, use of rural facilities, and more efficient discharge.

In recognition of continuing demand pressures in Emergency Departments statewide, Stage 2 of the Patients First initiative, announced in February 2017, includes a number of recurrent bed openings across the State to further improve whole-of-hospital patient flow.

Next year, the THS will continue to focus on consolidating activities necessary to create a climate for better coordination and integration of THS services across the state and build upon this year's activities with the aim of assisting the Government's vision for Tasmania to have the healthiest population in Australia by 2025.

GOVERNANCE

GOVERNING COUNCIL

The Governing Council is convened and operates in accordance with Divisions 1 and 2 and Schedule 3 of the *Tasmanian Health Service Act 2011*.

In addition to the Governing Council, the Audit and Risk Subcommittee is convened and operates in accordance with Division 3 and Schedule 5 of the *Tasmanian Health Organisation Act 2011*.



Governing Council members – Professor Judi Walker; Dr Judith Watson, Dr Emil Djakic, John Ramsay (Chair), Martin Wallace, Professor Denise Fassett, Mark Scanlon, Barbara Hingston, Associate Professor Dr Deborah Wilson, Dr David Alcorn (CEO)

REPORT FROM THE CHAIR



The creation of a single statewide health system is a key reform of the Tasmanian Government. Putting such a structure in place has been central to the work of the Tasmanian Health Service (THS) during the year. This has put significant pressure on our

people, particularly as the work has been over and above their primary day-to-day role of meeting the health care needs and expectations of the Tasmanian community.

I am pleased to advise that THS staff at all levels have embraced this challenging organisational task. The dedication shown has been outstanding.

During the year, the THS consulted widely with both its people and key stakeholders to settle on service models that are appropriate and sustainable for statewide purposes and effective local service delivery. The work has occupied the time of the Governing Council, the THS Executive team, clinical leaders and many other staff who have contributed to the discussions and decisions. The Governing Council welcomes and is thankful for these contributions.

This involvement enabled the THS to establish common statewide clinical streams, initially at the local major hospital level, while developing statewide primary and community care services and maintaining existing statewide services. This has been a significant achievement during a busy year and has laid the foundations for the additional work required in 2017-18 to develop the single, statewide health system. We will continue to implement, careful incremental changes that are considered, clear and safe as we recognise the importance of such an approach when services are working under pressure and particularly for critical operating systems.

While the Governing Council is not involved in the day-to-day operational matters of the THS, it has benefitted from the comprehensive advice provided to it during the year by the THS Executive, and the expertise and insight of senior clinicians. This continues to enhance the oversight and governance responsibilities of the Governing Council Subcommittees in the four areas of safety and quality, audit and risk, financial management and service performance, and partnerships.

Over the course of the year, the Governing Council has, thanks to the hard work of many, overseen ongoing improvements in safety and quality reporting and accountability, risk assessment and management, and financial and budgetary systems reform. There has also been positive engagement with Primary Health Tasmania on common service delivery matters. The THS has a developing relationship with consumers and consumer organisations that is essential to having significant patient/client input and engagement in the affairs of the THS. While there is still more to be done, foundation systems work to support the accountability and sustainability of a single statewide health service is well underway.

The redevelopment of the Royal Hobart Hospital has placed additional pressures on the staff at the hospital and they are to be commended for their commitment to ongoing service delivery while the new major facility is under construction.

The development and maintenance of essential health services infrastructure is an ongoing challenge, not only in Tasmania but around Australia. It follows that investing in contemporary business systems in order to continually improve the efficiency and quality of clinical practice and outcomes is essential. To this end, the THS introduced some new clinical business systems during the past year. Additionally and together with the Department of Health and Human Services, the THS has commenced the process of systems review, stability and enhancement. This will provide a solid foundation for building contemporary clinical practice and service delivery as an integral part of a statewide health system. The year ahead will see further work in this important area.

On behalf of the Governing Council, I wholeheartedly thank the THS Executive team led by Dr David Alcorn, for its untiring work in 2016-17, often in demanding circumstances. And of course, the work of the Executive team is supported and matched in action and intensity by staff right across the THS.

It is a privilege for the Governing Council members to acknowledge this commitment of staff to delivering high quality, safe, effective and efficient health care services to the Tasmanian community.

John Ramsay
Chair

GOVERNING COUNCIL MEMBERS



Dr Emil Djakic

*FRACGP BMed MBBS
DipObs Dip Anaesthetics
GAICD*

Dr Emil Djakic was born in Launceston and has been a Principal GP in Ulverstone for the past

20 years. He was the Chairman of the Australian General Practice Network for four years and was previously a member of the Tasmanian Health Organisation - North West (THO-NW) Governing Council from 1 July 2012 to 20 June 2015.

Emil is currently the Deputy Chair of the National RACGP Finance and Advocacy Committee. He has previously been a member of:

- The Board of GP North West
- State Based GP Organisation Board
- RACGP State Faculty Board
- Australian Medicare Local Alliance Board and
- The Mersey Community Hospital Board.

Emil graduated in Medicine from the University of Tasmania, completed a Diploma in Obstetrics at the Queen Victoria Hospital in Launceston and a Diploma in Anaesthetics in London. He also completed his Fellowship of General Practice in 1994. Emil is a graduate of the Australian Institute of Company Directors, a Fellow of the Royal Australian College of General Practitioners and a member of the Australian Medical Association.

Emil is a strong advocate for sustainable, safe, health systems and brings an excellent mix of committed local primary care clinical and governance expertise. Emil has a clear and concise understanding of primary health and health reform, as well as regional issues in North West Tasmania



Professor Denise Fassett

Professor Denise Fassett is a member of the Governing Council Quality and Safety Subcommittee. She was a former member of the Tasmanian Health Organisation - North

(THO-N) Governing Council (GC) from 1 July 2012 to 30 June 2015 and Chair of the THO-N GC Quality and Safety Subcommittee.

Denise is the Dean of the Faculty of Health at the University of Tasmania. Her role at the University require strategic and operational leadership; and responsibility for the Faculty which includes the disciplines of:

- Psychology
- Pharmacy
- Medicine
- Nursing and Midwifery
- Rural Health
- Exercise and Sport Science
- Biomedical Sciences.

The Faculty also includes Health Service Innovation Tasmania and the Wicking Dementia Research and Education Centre. Prior to her appointment as the Dean of Health, Denise was the Head of the School of Nursing and Midwifery.

Completing a General Nursing Certificate at the Royal Hobart Hospital, Denise is a Registered Nurse with a Bachelor of Health Science, Graduate Diploma in Aged Care Nursing and a Master of Nursing from the University of Tasmania. She also has a PhD from the University of Technology Sydney and is a Fellow of the Australian College of Nursing (FACN).

The former Chair of the Nursing Board of Tasmania from 2006, Denise is currently a member of the Nursing and Midwifery Board of Australia (NMBA) and Chair of the NMBA Registration and Accreditation Subcommittee. She is also a board member of both the Menzies Institute for Medical Research and Australian Institute of Health Service Management (AIHSM).

In 2014 Denise was appointed the inaugural Chair of the Health Council of Tasmania



Ms Barbara Hingston

BA (Admin), BSW, GAICD, MAASW

Barbara is a member of the Governing Council Financial Management and Service Performance Subcommittee.

Based in Hobart, Barbara is a highly experienced Non-Executive Director and consultant in health, social policy and community services. Her professional experience includes the delivery, management and governance of health and community service organisations across Australia.

Barbara is a past Director of Austin Health in Victoria (2005-13) and Director of Headspace the National Youth Mental Health Foundation and National Nursing and Midwifery and Physiotherapy Boards – Victoria Mercy Health Care Australia Ltd.

Her current Directorships include Dental Health Services Victoria, General Practice Training Tasmania; Public Trustee Tasmania and Lady Gowrie Tasmania. Barbara brings a range of capabilities to the Council. These reflect significant experience in governance of clinical quality and safety, finance, audit and risk management – consumer participation, community

partnership and stakeholder engagement.

She has high level management experience in developing business scope and structure and in the commissioning of health services including in mental health.

As a co-consultant to the Commission on Delivery of Health Services in Tasmania Barbara facilitated stakeholder consultation on sustainability of the Tasmanian health care system and reviewed organisational and clinical governance arrangements in and across the Tasmanian health care system. She also developed the strategy and framework for stakeholder consultation and the health consumer representation project in Tasmania. Recently she consulted to the University of Tasmania, informing their strategy for addressing health, allied health and community service workforce development needs, linked to reform in the disability, aged and mental health care sectors. Other consultancy roles include Breast Screen Australia on Future Directions for the Integration of Mammographic Density in Breast Screening.

Barbara is also an experienced allied health practitioner in public and community health settings. Her practice included therapeutic social work in complex mental health, violence against women and their children, child abuse and sexual assault. She is deeply aware of issues in access, reliability and affordability of whole of life health care and promotion for all Tasmanians, and the value of effective interrelationships between acute and primary health services and providers.

Barbara graduated with a Bachelor of Arts in Administration (with distinction) from the University of Canberra and a Bachelor of Social Work from the Australian Catholic University, Canberra. She is also a graduate of the Australian Institute of Company Directors 2007, a member of the Australian Association of Social Workers and Institute of Public Administration Australia.



Mr John Ramsay (Chair)

LL.B (UTas)

John Ramsay is the Chair of the Governing Council. John has significant experience in health and human service delivery in Tasmania.

In 2014, he chaired the Royal Hobart Hospital Redevelopment Rescue Taskforce and from 17 January 2015 until 30 June 2015, he was the Chair of the three Tasmanian Health Organisations.

John was Secretary of the Tasmanian Department of Health and Human Services from 1999-05.

During that time he was

- Deputy Chair and subsequently Chair of the Australian Health Minister's Advisory Council (AHMAC)
- Chair of the AHMAC Health Workforce Committees.
- Member of the Australian Medical Workforce Advisory Committee,
- Member of the 2002 National Review of Nursing Education, and
- Member of the Australian Medical Council.

On leaving the Tasmanian Public Service he established a consulting practice and undertook numerous consultancies for the Australian Commission on Safety and Quality in Healthcare and Health Workforce Australia. He was also a member of the Policy Committee of the Australian Medical Council and a member of the Board of the Menzies Research Institute Tasmania.

John was a Department Secretary in Tasmania

for 23 years. He was Secretary of what is now titled the Tasmanian Justice Department from 1982-89. In 1989 he was appointed the Secretary of the Department of Environment and Planning which subsequently became the Department of Primary Industries, Water and the Environment. His consultancy practice has also included work in the areas of environment, planning and natural resources, strategic planning and facilitation.

From 2008 until 2015, he was Chairperson of the Board of Environmental Management and Pollution Control. He is currently a member of the Tasmanian Planning Commission and the Chair of the Forest Practices Authority.

John is a Fellow of the University of Tasmania and an Honorary Member of the Planning Institute of Australia. While not practicing as a lawyer, John was admitted to practice in the Supreme Court of Tasmania in 1976.



Mr Mark Scanlon

MBA BBus FCPA FAICD

Mark Scanlon is the Chair of the THS Governing Council Audit and Risk Subcommittee. Mark was a member of the Tasmanian Health Organisation - North

(THO-N) Governing Council from 1 July 2012 to 30 June 2015.

During that period he was Chair of the THO-N Audit and Risk Subcommittee. He is Chairman of the Credit and Investments Ombudsman Service Limited and Independent Chairman of the Launceston City Council Audit Panel. Mark was also Managing Director of Tasmanian Perpetual Trustees Limited, Managing Director of Tasmanian Banking Services Limited and Joint Chief Executive Officer of MyState Limited.

Other positions held previously include:

- Director of the Motor Accidents Insurance Board (MAIB)
- Chairman of the MAIB Audit Committee
- Director of the Tasmanian Chamber of Commerce and Industry
- President of the Launceston Chamber of Commerce
- Director of the Heart Foundation, Tasmania, and
- Member of the Heart Foundation National Finance Advisory Committee

Mark has over 25 years senior executive experience in a variety of industry sectors including funds management, trustee services, banking, health insurance and general insurance. He has a broad set of skills including strategic planning, leadership, business management, marketing and corporate governance.

Mark graduated with a Bachelor of Business (with distinction) from Victoria University. He has a Master of Business Administration from RMIT University and completed a Harvard Club of Australia Leadership Program.

Mark is a Fellow of CPA Australia and the Australian Institute of Company Directors.



Professor Judith Walker

*PhD Grad Dip Ed BA (Hons)
FACE*

Professor Judi Walker is the Chair of the Governing Council Partnerships

Subcommittee. Judi has over 20 years' experience in senior academic and health leadership positions. She brings a wealth of knowledge of rural and regional health services, health workforce training and re-design, ageing well policy, community engagement

and innovative approaches to regional medical training and health service delivery.

Judi recently completed a five year term as Head of the School of Rural Health at Monash University, with academic, financial and human resource management for one of the largest and the most geographically dispersed school in the Faculty of Medicine. She designed and implemented the School's five year blueprint with a new committee governance structure and risk management framework. In 2015 she was the Vice Chancellor's nominee leading negotiations for a new funding framework – the Rural Health Multidisciplinary Training Program – with the Commonwealth Department of Health.

Prior to her appointment with Monash University she was Chief Executive of the University of Tasmania's Rural Clinical School, a conjoint appointment with the Tasmanian Department of Health and Human Services where she was responsible for the establishment of both the UTAS University Department of Rural Health and the Rural Clinical School (North West Regional Hospital, North West Private Hospital and the Mersey Community Hospital). Concurrently she was Deputy Dean, Faculty of Health Science and co-Executive Director, Partners in Health, the unique partnership between DHHS and UTAS driving strategic health services and workforce education reform. She was a member of the North West Regional Hospital Executive and has held senior positions on a number of Commonwealth and State Government health committees and working groups.

Judi was recently successful, as Principle Co-Investigator, in winning a major Victorian Government tender to undertake a 10 year longitudinal study into the health impacts of the recent Hazelwood Mine Fire in the Latrobe Valley. This study is now underway. As Chief Investigator, Judi has held a number of competitive research grants (National Health and Medical Research Council and Australian Research Council) at both Monash University and the University of Tasmania. She was the recipient of the Dean's 2014 Award

for Excellence in External Engagement and was nominee for the Vice Chancellor's Award for Excellence in Research Impact (Economic and Social Impact).

Judi has 15 years' experience as a Board Member/ Board Director of a number of government and private sector not for profit organisations. She is on the Board and immediate past Chair of the national Federation of Rural Australian Medical Educators (FRAME) and was Board Director of the national Australian Rural Health Education Network (ARHEN) and is currently Board Director of Latrobe Community Health Services (LCHS) in Victoria. She sat on the Council of the National Rural Health Alliance, the peak body for rural health organisations. She was Vice President of Monash Academic Board for four years. In Tasmania she was an inaugural Board Member of the Tasmania Together Progress Board, Board Director of the Tasmanian Polytechnic and Chair of the North West Institute of TAFE Council.

Judi is a Fellow of the Australian College of Education and an Associate Fellow of the Australian College of Health Services Executives. She has completed a number of Corporate Governance training courses and graduated from The University of the West Indies completing a Bachelor of Arts (Hons). She holds a Graduate Diploma in Distance Education from the University of South Australia and completed a PhD at the University of Tasmania in the area of health (disability) and education policy.

Judi and her family have been resident in north west Tasmania for over 35 years with established business and family interests and comprehensive knowledge and understanding of Tasmanian health issues.



Mr Martin Wallace

B Ec (Hons)

Martin Wallace is the Chair of the Governing Council Financial Management and Performance Subcommittee.

Martin is a former Secretary of the Department of Treasury and Finance, Deputy Secretary of the Department of Health and Human Services in Tasmania, and was previously the Director of Inter-government and Financial Policy in Treasury. Martin's diverse employment history also includes executive roles in energy and telecommunications. He was Chief of Staff to former Tasmanian Treasurer, Dr David Crean, between 1999 and 2002.

As well as substantial public administration, public policy, financial and budget management experience, Martin has excellent credentials in commercial and business practises. He has negotiated many major commercial contracts in energy, telecommunications as well as in the areas of procurement and supply. He has also been instrumental in the delivery of procurement and service provisions within public and private partnerships.

During his time in the Department of Health and Human Services he led a number of strategic and policy initiatives to improve the efficiency and effectiveness of health services, including in the areas of e-health, financial management, and business performance.

Martin has a strong background in corporate governance and is an experienced Board member. He is currently a Member of the National Competition Council and previously held directorships with Aurora Energy Pty Ltd; the Tasmanian Public Finance Corporation (Tascorp), Tastel Limited, and Auroracom Pty Ltd. He has also been a Member of the State Grants Commission. Martin holds an Honours degree in Economics.



Dr Judith Watson

*MBChB FRNZCGP DipObs
GAICD*

Dr Judith Watson is a member of the Governing Council Audit and Risk Subcommittee.

She is a General

Practitioner, practising in Launceston since 1994 and is the Deputy Chair of Primary Health Tasmania. Judith has been a member of not-for-profit primary health organisation boards since 2004 and is currently on the board of Tarmac Services, a Tasmanian practice management company.

Judith graduated from The University of Auckland School of Medicine, completing a Diploma of Obstetrics and Fellowship of the Royal New Zealand College of General Practitioners. She is a graduate of the Australian Institute of Company Directors and regularly participates in governance training activities.

She has a strong understanding of disconnects in the patient journey between primary and hospital care, the challenges in changing cultures and the need to pursue new opportunities and better ways of working for health. She is passionately committed to improving the wellbeing of Tasmanians and contributing to the successful working of the Tasmanian Health Service.



Associate Professor Dr Deborah Wilson

*MBBS, FANZCA, ARACMA,
Graduate Certificate in
Teaching and Learning for
Health Professionals*

Associate Professor Dr Deborah Wilson is the Chair of the Governing Council Quality and Safety Subcommittee. Deborah is the inaugural Director of the Tasmanian Rural and Regional Postgraduate Training Hub and a Visiting Medical Officer in Anaesthesia and Intensive Care, at the North West Regional Hospital, the Mersey Community Hospital and the North West Private Hospital. She was previously a member of the Tasmanian Health Organisation-North West (THO-NW) Governing Council from 1 July 2012 to 30 June 2015.

Deborah graduated from the University of Western Australia with a Bachelor of Medicine and a Bachelor of Surgery. She has a Post Graduate Certificate in Teaching and Learning for Health Professionals and holds the title of Supervisor of Training at the Australian and New Zealand College of Anaesthetists. Deborah was previously the Co-Director of the Rural Clinical School in North West Tasmania and maintains strong links to the university and undergraduate education.

Deborah was awarded the 2009 Clinical Teaching Award from the Rural Clinical School, University of Tasmania, the Abbotts Young Investigator Award in 1996 and the Australian and New Zealand College of Anaesthetists Formal Project Prize in 1996. Deborah is an Associate Fellow of the Royal Australasian College of Medical Administrators and a Fellow of the Australian and New Zealand College of Anaesthetists. Deborah has worked for over seventeen years on the North West Coast and has a deep understanding of the complexities of health services in rural and remote communities. She is committed to teaching, training and research to drive better treatments and innovation within our system.

GOVERNING COUNCIL ATTENDANCE RECORDS

Governing Council Meetings

A = apology L = leave of absence ✓ = attendance

Name	19 Jul 2016	16 Aug 2016	20 Sept 2016	18 Oct 2016	22 Nov 2016	20 Dec 2016	17 Jan 2017	21 Feb 2017	21 Mar 2017	19 Apr 2017	16 May 2017	20 Jun 2017
John Ramsay	✓	L	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Emil Djakic	✓	L	✓	L	✓	✓	✓	✓	✓	✓	✓	✓
Prof Denise Fassett	✓	✓	L	A	✓	✓	✓	✓	✓	✓	✓	✓
Barbara Hingston	✓	✓	✓	L	✓	✓	✓	✓	✓	✓	L	✓
Mark Scanlon	✓	✓	✓	✓	✓	✓	✓	✓	L	✓	✓	✓
Prof Judith Walker	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martin Wallace	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	L	✓
Dr Judith Watson	✓	✓	L	✓	✓	✓	✓	✓	✓	✓	✓	✓
Assoc Prof Dr Deborah Wilson	✓	✓	✓	✓	✓	✓	L	✓	✓	✓	✓	✓

Subcommittee Attendance Record Audit and Risk

Name	12 Jul 2016	10 Aug 2016	13 Sept 2016	21 Oct 2016	8 Nov 2016	13 Dec 2016	Jan 2017	14 Feb 2017	14 Mar 2017	11 Apr 2017	9 May 2017	13 Jun 2017
Mark Scanlon - Chair	✓	✓	✓	✓	✓	✓	No Meeting	✓	✓	✓	✓	✓
Dr Judith Watson	✓	✓	✓	✓	✓	✓	No Meeting	✓	✓	✓	✓	✓
John Ramsay	✓	L	✓	A	✓	✓	No Meeting	✓	✓	✓	✓	A

Quality and Safety

Name	5 Jul 2016	2 Aug 2016	6 Sept 2016	4 Oct 2016	1 Nov 2016	6 Dec 2016	Jan 2017	7 Feb 2017	7 Mar 2017	4 Apr 2017	2 May 2017	6 Jun 2017
Assoc Prof Dr Deborah Wilson - Chair	No Meeting	L	✓	✓	✓	✓	No Meeting	✓	✓	✓	✓	✓
Prof Denise Fassett	No Meeting	✓	✓	✓	✓	✓	No Meeting	✓	✓	✓	✓	✓
John Ramsay	No Meeting	✓	L	✓	✓	✓	No Meeting	✓	✓	✓	✓	✓

Financial Management and Performance

Name	18 Jul 2016	15 Aug 2016	19 Sept 2016	24 Oct 2016	28 Nov 2016	19 Dec 2016	16 Jan 2017	1 Mar 2017	27 Mar 2017	24 Apr 2017	12 May 2017	19 Jun 2017
Martin Wallace - Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	L	✓
Barbara Hingston	✓	✓	✓	L	✓	✓	✓	✓	✓	✓	✓	✓
John Ramsay	✓	L	✓	A	✓	✓	✓	A	✓	✓	✓	✓

Partnerships

Name	6 Jul 2016	3 Aug 2016	Sept 2016	Oct 2016	2 Nov 2016	9 Dec 2016	Jan 2017	8 Feb 2017	1 Mar 2017	12 Apr 2017	3 May 2017	7 Jun 2017
Prof Judith Walker - Chair	✓	✓	No Meeting	No Meeting	✓	✓	No Meeting	✓	✓	✓	✓	✓
Dr Emil Djacic	✓	L	No Meeting	No Meeting	A	✓	No Meeting	✓	✓	✓	✓	✓
John Ramsay	✓	L	No Meeting	No Meeting	✓	✓	No Meeting	✓	✓	✓	✓	✓

GOVERNING COUNCIL REMUNERATION

Band	Number of Committee Members	Aggregate Directors' Fees	Committee Fees	Superannuation	Other*	Total
> \$50,000	1	159 798	0	15 181	11 306	186 285
< \$50,000	8	288 437	0	27 401	25 649	341 487

* Other refers to all other forms of non-salary benefits such as motor vehicles, parking, allowances and reimbursements.

SUBCOMMITTEE REPORTS

Audit and Risk Subcommittee

The THS Audit and Risk Subcommittee (A&RS) was established by the Governing Council in 2015 pursuant to Section 26 of the Tasmanian Health Organisation Act 2011. The A&RS undertakes a key role in assisting the Governing Council discharge its duties and responsibilities, with due care, diligence and skill, in the areas of corporate governance, financial reporting processes and financial reports, risk management systems, and internal control structures, including fraud prevention, deterrence and detection, (financial and non-financial), internal audit activities, external audit and compliance with laws, regulations, ethical requirements, internal policies (including the code of conduct) and industry standards. Furthermore, the A&RS may perform other duties as requested by the Governing Council from time to time.

Meetings of the A&RS are held throughout the year, usually monthly, with appropriate advice and recommendations being made to the Governing Council on matters relevant to the A&RS Charter to facilitate well-informed, efficient and effective decision making by the Governing Council. There were no matters considered by the A&RS that would have a material effect on the financial condition or state of affairs of the THS.

During the period under review (or the 2016-17 financial year) the A&RS met with the external and internal auditors to consider financial reports, audit reports and progress on addressing audit findings and recommendations, audit plans and project scopes.

An important focus for the A&RS was overseeing developments in the consolidation of the three regional health services risk management systems to establish a statewide risk management framework. Work on this project has progressed very well and during the year a risk management module was added to the Safety Learning and Reporting System and rolled out across the THS. Furthermore, the THS has implemented a comprehensive legal

compliance register to control risks associated with legislative compliance.

The A&RS has an important role in ensuring there is a sound risk management culture in the business. To monitor, appraise and influence the risk culture the A&RS received briefings from THS senior management to ensure the A&RS has a broad understanding of the organisation's structure, business and risk management environment, policies, plans and practices.

Going forward, the A&RS will include in its work programme the undertaking of field inspections of areas identified as high risk to observe first hand that risk mitigation strategies are being actively monitored, reviewed and, where necessary, improved.

Mark Scanlon

Chair

Financial Management and Performance Subcommittee

The THS Financial Management and Performance Subcommittee is the subcommittee of the Governing Council charged with overseeing the financial and service performance of the THS and providing recommendations to the Governing Council on this performance.

The subcommittee comprises Governing Council members Martin Wallace, Barbara Hingston and John Ramsay and Deputy Secretary (Corporate Policy and Regulatory Services) of the Department of Health and Human Services in an ex-officio capacity. The CEO, CFO and Director Strategic Performance and Planning of the THS attend each meeting and assist the Committee. Other members of the THS Executive and senior management attend subcommittee meetings on specific issues relevant to their areas of responsibility.

The primary focus of the subcommittee is the budget management of the organisation and the delivery of the THS Service Agreement performance obligations and targets.

The Service Agreement sets out the funding available to the THS to deliver agreed activity targets and performance indicators.

The subcommittee met monthly during 2016-17. At each meeting, it considered the latest monthly financial report, trends in service activity, key financial aggregates and employment levels, and progress against the service performance measures set out in the 2016-17 Service Agreement.

In addition it considered or reviewed specific issues impacting on the overall performance of the THS. This included the delivery of elective surgery and access to emergency care targets and performance improvement plans in these areas and review of new major contracts and contracts for services with a cost in excess of \$1 million.

In 2016-17, the subcommittee continued to review the quality and timeliness of reports on which it bases its considerations and to consider improvements in the financial and service performance reporting of the THS.

In this regard, the work program of the THS Financial Reform Team will ensure substantially improved financial reporting and budgeting; and service performance reporting on a statewide basis. This was a major focus in the latter half of the financial year and will continue over 2017-18.

The subcommittee reviews its terms of reference and its operations on an annual basis. After consideration by the Governing Council, the subcommittee's terms of reference have now been expanded to include oversight of major ICT strategies and investments and to make recommendations to the Government Council on these matters.

Martin Wallace
Chair

Partnerships Subcommittee

The Partnerships Subcommittee promotes and supports collaboration and partnership between the THS and those organisations with which it can

develop a mutually beneficial relationship.

The role of the subcommittee is to:

- Identify partnership opportunities and make recommendations to the THS GC
- Establish and maintain relationships with partnership organisations
- Monitor and evaluate the effectiveness of existing partnerships
- Report to the THS GC on the status of partnerships
- Provide oversight on MOUs and Partnership Agreements between the THS and its partners
- Ensure all partnerships are in alignment with the THS Strategic Plan.

In 2016-17 the PSC developed, reviewed and maintained Work Plans for each of four established Priority Partnerships.

1. Health Consumers – THS Health Consumer Groups who are partners in collaboration and involvement at all levels of service planning, workforce composition and evaluation of THS performance. The first THS Health Consumers' Forum was held in October and the Groups are co-developing the THS Consumer and Community Engagement policy framework through the THS Strategy and Planning Unit which will be workshopped at the second Forum.
2. Primary Health Tasmania which is a partner in co-design and performance across a continuum of disease states for individual consumers. A tripartite MOU was signed in December and the Governance Monitoring Group is progressing three significant areas of collaboration in
 - Consumer Engagement
 - Data Sharing
 - Co-Design/Co-Commissioning.

3. University of Tasmania which is a partner in joint appointments, health workforce development, research, education and training, leadership and development, and health service delivery models. A statewide multi-partner research and education framework is being developed.
4. Department of Health and Human Services as regulator, funder and facilitator. The role of the PSC is to monitor progress of the partnership - for example there was increased collaboration and cooperation in the processes to develop the 2017-18 Service Agreement.

The PSC also undertook a project on the nature of the partnership relationship with the Private Hospitals sector, which included analysis of the current state of relationships, key issues and areas of concern, and observations about improving the structured interaction between the THS and these partners. Recommendations are now being progressed through the THS Executive.

The PSC has identified more organisations with the potential to develop partnerships in 2017-18.

Professor Judi Walker

Chair

Quality and Safety Subcommittee

The Governing Council formed the Quality and Safety Subcommittee in July 2015. Its purpose is to assist the Governing Council fulfil its clinical governance and oversight responsibilities in relation to quality, safety and clinical risk, to lead a culture that results in safer, more effective and more responsive care and services and promote to staff and consumers, the importance of safe, effective care.

Meetings of the subcommittee occurred monthly during 2016-17. Each meeting commenced with a patient story. These stories helped the subcommittee identify areas for quality improvement and understand the patient and carer perception of the quality of care the THS provides.

The subcommittee monitored a suite of Quality and Safety Indicators including the Quality Performance Indicators set out in the Service agreement. In 2016, under the direction of the subcommittee, the THS joined the Health Round Table (HRT) Consortium. This enabled benchmarking of the THS against peer hospitals throughout Australia on a number of key safety and quality indicators. The subcommittee reviews reports from HRT on a quarterly basis.

The subcommittee endorsed the Patient Safety Event Management Protocol and the Root Cause Analysis (RCA) Protocol. These protocols strengthen the governance of Safety Event management across the THS and introduced Root Cause Analysis as the methodology used in analysing serious clinical incidents. This has improved the way in which the THS learns from these serious incidents and develops and implements processes to prevent serious incidents from reoccurring.

The subcommittee approved THS involvement in a research collaborative with the famous Mayo Clinic in Rochester Minnesota. This international collaborative aims to help health services improve care quality by learning from death.

The subcommittee approved the engagement of Pascal Metrics to conduct a Safety Culture Survey involving all staff across the THS. The subcommittee received a briefing on the results of the first survey. The findings of the survey will enhance the safety culture in the THS.

The subcommittee received a monthly report on the results of accreditation processes across THS services. A number of services have been through successful accreditation events in 2016-17. All THS health services hold current and full accreditation.

An Integrated Risk Register, deployed during the year, incorporated statewide and local risks into a single database developed as a module of the

Safety Reporting and Learning System (SRLS). The subcommittee reviewed the clinical risks on a quarterly basis, concentrating on those risks rated as high or extreme.

Areas of clinical risk were included in the internal audit work plan. During 2016-17 an audit of the THS management of S8 Controlled Drugs was completed. The subcommittee will monitor the implementation of recommendation made in this report.

The subcommittee endorsed the Clinical Credentialing and Defining Scope of Clinical Practice for Health Professionals protocol. The protocol relates to all health professionals who have independent, advanced and/or extended scope of responsibility for patient care within health services in Tasmania. The THS established a Statewide Credentialing committee, supported by a new electronic database, Mercury eCredentiaLLing. These important changes ensure

clinicians are credentialed appropriately and have their scope of clinical practice defined in accordance with their level of skill and experience and the capability and need of the health service.

The subcommittee continued to oversee the consolidation of THS policies, procedures and protocols into statewide documents. The THS has a suite of 2 529 contemporary evidence based statewide policies.

The subcommittee approved the engagement of Press Ganey and Associates, an experienced provider of Patient Experience Surveys in Australian Hospitals. The THS will continuously survey patients against national Core Common Questions for Patient Experience. The subcommittee will review the results of these surveys on a quarterly basis

Associate Professor Dr Deborah Wilson
Chair



ORAL HEALTH SERVICES



As well as maintaining a focus on delivering increased levels of dental services to adults living on low incomes, Oral Health Services Tasmania (OHST) targets the oral health of children to prevent dental disease before it occurs.

Through the Fissure Sealant and Fluoride Varnish Outreach program, OHST has been visiting Tasmanian schools, providing preventive care to children, who are around age six or seven and twelve years of age. These are the ages at which the permanent central incisors and molars appear in the mouth.

Fissure Sealants are thin coatings that are 'painted' on the grooves (or fissures) of the back adult teeth, which is where decay often starts. They protect the chewing surface of the six year and 12 year old adult back teeth.

Fluoride Varnish strengthens and protects teeth, and is used to prevent and reduce tooth decay in baby and adult teeth.

Schools visited are selected according to the Index of Community Socio-Educational Advantage (ICSEA) to ensure those children living in most disadvantaged areas are prioritised. Over 15% of children seen through this program had not accessed OHST services before, and nearly 20% of the children seen required some form of follow up treatment as well as the preventive care provided.

Programs such as this have helped improve the oral health of Tasmanian children relative to their counterparts interstate. The National Child Oral Health Study 2012-14, released in early 2017,

showed that Tasmanian children aged 5–14 years had relatively better oral health status than the national average. The amount of untreated dental decay in the primary dentition is lower than the national average.

The Study found that the majority of Tasmanian children (74% vs 43% nationally) attended public dental services and parents of Tasmanian children were more likely to report excellent or very good dental care provided to their children than the national average. The proportion of children in Tasmania who received fissure sealants (as delivered through the FSFV program as well as in routine dental visits) was the highest in the country.

While these results are pleasing, too many Tasmanian children still experience poor oral health and OHST continues to work with its community partners to identify and target those children most at risk.

A pilot program delivered in the North West over 2016-17, called Healthy Smiles for Two, OHST is working with midwives to provide priority care to eligible pregnant women. In this way, the program aims to reduce the level of the mothers' decay causing bacteria during their prenatal period, after birth and prior to the babies' teeth erupting. As part of the program, OHST also sees the baby at 12 and 18 months of age for a dental check-up, and provides preventive advice to minimise oral health behavioural risks for the child. This program will be evaluated shortly with a view to making any necessary improvements prior to rolling it out statewide.

OPERATIONS

CEO REPORT



The Tasmanian Health Service (THS) continues to implement much-needed reforms that will transform our health system and provide improved care for Tasmanians regardless of where they live.

Our doctors, nurses, allied health professionals and clinical and operational support staff continue to do a magnificent job despite the challenges that arose during what was another busy year.

Tasmanians rightly expect to receive the best possible health care, and this is at the heart of the work to build a single, unified statewide structure with strong local hospital leadership and management to deliver on the Government's record investment in health. We have made significant progress and this work will continue through 2017-18. We are designing a structure that puts patients at the centre of decision-making, avoids duplication and makes the best use of our resources. Already we are seeing evidence of improvement across the health system as a result.

This is why we continue to work in partnership with the Department of Health and Human Services (DHHS) to develop and implement measures to reduce elective surgery waiting lists. During 2016-17, we saw a record low number of patients on the waiting list. At the beginning of 2016-17 there were 1 222 people waiting more than the clinically recommended time for elective surgery. As at 30 June 2017 this number has reduced to 794. In 12 months the THS has reduced the number of people waiting more than 400 days for elective surgery from 320 people to 12. However, there is much more work to be done and the THS will

implement a series of initiatives in the coming year to ensure those who have been waiting beyond the clinically recommended time continue to be prioritised and to address long-term challenges in the area of patient flow that will lead to patients receiving the right care, at the right time, in the right place.

The year saw significant achievements and good progress in a number of areas. The \$689 million RHH redevelopment is the largest ever health infrastructure project in Tasmania and will transform the hospital into a modern, contemporary health facility for future generations. The Government re-opened a 15 bed ward to alleviate pressures in the Emergency Department at the LGH. The THS and staff have worked together in order to minimise the impact on patients and staff while these initiatives are being implemented.

The establishment of a new integrated North West maternity service was a significant milestone during the year. The service was designed to deliver a safe and quality service that meets current and future demand.

In recognition of the increasing role Allied Health professionals play across the State, the sector is now represented in its own right as part of the THS statewide executive. Paula Hyland's appointment to the role of Executive Director was the last of four positions to be filled this year that completes the work on bedding down the THS leadership structure. The others who came on board this year were Susan Gannon, Executive Director of Nursing and Midwifery Professions, Nicola Dymond, Chief Operating Officer and Suzanne McCavanagh, Executive Director of Human Resources and Organisational Development.

The THS continues to build its relationship with the community and to ensure the voice of health consumers is heard. Following an

extensive process managed by Primary Health Tasmania, the THS will join the Department of Health and Human Services in supporting the founding of the state's first general health consumer organisation. It will provide health planners and decision makers in Tasmania with informed strategic policy, health system and service development advice, as well as being an independent voice for all consumers.

Finally, I would like to take this opportunity to thank the THS Executive for their efforts and commitment and to our Governing Council for their support and guidance during a challenging

year of change. I would also like to thank all those who contributed to the clinical advisory groups and their associated businesses cases, established under the White Paper Implementation Framework. Most importantly, I would like to recognise the hard work of all THS staff and to thank them for their professionalism and dedication to looking after our fellow Tasmanians.

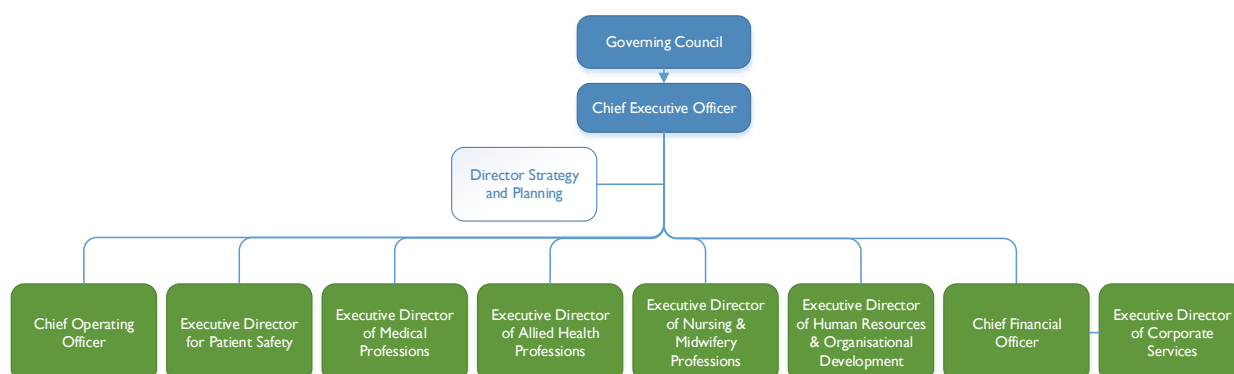


Dr David Alcorn



ORGANISATIONAL STRUCTURE

Tasmanian Health Service Executive Structure



EXECUTIVE MANAGEMENT TEAM*



Executive Team members: (Left to Right): Dr Tony Xabregas, Executive Director of Medical Professions; Dr Annette Pantle, Executive Director for Patient Safety; Susan Gannon, Executive Director of Nursing and Midwifery Professions; Suzanne McCavanagh, Executive Director of Human Resources and Organisational Development; Craig Watson, Chief Financial Officer; Nicola Dymond, Chief Operating Officer; Scott Adams, Executive Director of Corporate Services; Paula Hyland, Executive Director of Allied Health Professions; Dr David Alcorn, THS Chief Executive Officer.

**The Executive Director of Corporate Services is an ex-officio member of the THS Executive Management Team and has been included for reporting purposes.*



Dr David Alcorn
Chief Executive Officer

As CEO of the Tasmanian Health Service, Dr Alcorn is leading health system reforms and improving health outcomes for all

Tasmanians. Previously, David served at the Royal Melbourne Hospital as Executive Director and led the organisation through significant partnership and service expansion. He has previously led Queensland's largest university teaching hospital the Royal Brisbane and Women's Hospital, in the same role.

David is passionate about making a difference for communities and the people who need, or will need, healthcare in the future and those who care for them. The needs of patients and their families have been at the centre of David's professional life in healthcare management and in psychiatry.

David is an experienced health administrator who was awarded the Bernard Nicholson prize of the Royal Australasian College of Medical Administrators and has undertaken additional training in healthcare delivery at the Harvard Business School, Boston. He served for two terms on the RANZCP Board and its predecessor body. He continues to serve as Deputy Chair of the Accreditation Committee, RANZCP.

His qualifications include: MBBS, Bachelor of Laws (honours), Master of Laws, Doctor of Judicial Science, Masters of Business Administration (MBS), Fellowship RANZCP, and Fellowship RACMA. His blend of medical and business/organisational experience and sound reputation and expertise in healthcare present a strong capability for the THS CEO role.

He has also chaired the Postgraduate Medical Council of Queensland and served on the boards of Blue Care, a community nursing organisation and the Wesley Research Institute.



Scott Adams
Executive Director of
Corporate Services

As Executive Director of Corporate Services, Scott's portfolio covers the functions of Hotel Services

and Logistics, Information Technology, Facilities and Engineering and Procurement and Supply.

Prior to this, Scott was Group Manager, Corporate Services for the Tasmanian Health Organisation - South. Scott's previous experience includes 16 years in the Energy Industry with Aurora Energy, covering a number of senior management roles in finance, IT and other corporate functions, and over two years working in private industry running an IT consultancy business.

Scott is currently on the Board of Cancer Council Tasmania and has previously held board memberships on a range of not-for-profit enterprises. Scott's qualifications include Bachelor of Commerce (UTAS), Certified Practicing Accountant, MBA (Deakin) and he is currently studying for his graduate Diploma in Health and Human Services.



Nicola Dymond
Chief Operating Officer

Nicola trained as a Registered Nurse, Midwife and Health Visitor in the United Kingdom. Nicola's most recent roles have been as Group Chief

Operating Officer at Hamad Medical Corporation, and National Director for Continuing Care and System Integration within the Ministry of Public Health, Qatar; leading the development of Qatar's first national strategy to support transitional and ongoing care, system navigation and care co-ordination processes across the health continuum.

Nicola also has extensive executive operational experience within the United Kingdom National Health Service, across both hospital and community settings.

Nicola has a passion for service improvement, and is experienced in service development and planning, operational management and large scale quality improvement projects. She holds membership of the Institute of Healthcare Improvement, the International Society for Quality in Health Care, and holds a Masters of Business Administration with a focus on improvement culture within healthcare organisations. Nicola has been a regular contributor on the international conference circuit on these topics.

In her role as Chief Operating Officer Nicola leads the clinical services redesign and delivery programs; as well as introducing integrated operations centres to manage patient flow and access and improve utilisation of capacity across the state. Nicola is working to identify opportunities and strategies to enhance service delivery and models of care availability throughout the THS.



Susan Gannon
**Executive Director of
Nursing and Midwifery
Professions**

As Executive Director of Nursing and Midwifery Professions, Susan is

responsible for the professional development of nursing and midwifery across the State.

Susan leads the THS change strategy to patient centred care. Susan's diverse experience in Victoria and Queensland in both public and private healthcare will facilitate and strengthen the implementation of new models of practice and care, as well as promote greater cross collaboration, workforce flexibility, and consumer and stakeholder engagement.

Susan held the position of Divisional Director for the Women's and Children in Western Health which has the largest Midwifery Group Practice in Victoria including the pilot site for the homebirth program, perinatal mental health and the statewide rural education for midwives. Susan has considerable experience in both the public and private sector with a strong background in health service quality and safety she has held previous senior roles in regulation, education, directorships, policy, and project management. Susan has returned to Tasmania where she grew up and initially undertook her nursing education and training. Most recently Susan has performed the role of the Service Director for Women, Newborn and Children's Services at Gold Coast Health Service including child health school health and breast screen. In these roles she has been responsible for significant budgets and has been able to deliver effective innovative services while managing financial constraints.

Susan's vision for Tasmania is to implement Magnet Principles across the State and progress towards Magnet Accreditation for the THS. MAGNET designation is recognised as the highest and most prestigious credential or a healthcare organisation can achieve for nursing excellence and quality patient care. MAGNET is a system which will unite nursing and midwifery across the state.



Paula Hyland
Executive Director of
Allied Health Professions

Paula has a wealth of experience working in Allied Health within the Tasmanian health system. As the

Executive Director of the Allied Health Professions, she is responsible for the operational and strategic management of a number of professions with the THS. Although there are 26 recognised Allied Health professions Paula will focus mainly on Dietetics, Occupational Therapy, Orthotics and Prosthetics, Physiotherapy, Podiatry, Social Work and Speech Pathology.

Prior to this role, Paula was the Director of Allied Health in the North West for 14 years. Paula's professional background is in Speech Pathology and she has an undergraduate and Master's degree from the University of Sydney. Paula has clinical experience working in acute metropolitan hospitals such as the Royal Melbourne and Western Hospitals and regional services such as Wyong Hospital.



Suzanne McCavanagh
Executive Director of
Human Resources
and Organisational
Development

Suzanne's portfolio covers the functions of human resources, workplace health and safety, and industrial relations. She joins the THS with extensive human resources experience across the health, transport and education sectors.

With graduate and post graduate qualifications in industrial relations, human resource management and public administration, Suzanne is a strategic human resources, organisational development and workforce planning specialist with more than 25 years' experience.

She has held executive roles in human resources and industrial relations in the Western Australian public sector, including: Department of Productivity and Labour Relations; Department of Transport; Office of Public Sector Standards and South Metropolitan Health Service.



Dr Annette Pantle
Executive Director
for Patient Safety

Annette is responsible for the leadership and delivery of safe, sustainable health care by developing and managing the clinical governance frameworks for the THS including Clinical Standards, Safety and Quality and Accreditation.

Annette is a graduate of the University of Sydney medical program and has been involved in Australian health care for more than 30 years through rural general practice, hospital medical administration, the NSW Clinical Excellence Commission, NSW Department of Health and

St Vincent's Health Australia where she was the inaugural Group General Manager for Clinical Governance and Chief Medical Officer.

She is the immediate past president of the Australasian Association for Quality in Health Care. Annette is also a former Board Director of the Garvan Institute of Medical Research, a current Fellow and Board Director of RACMA and a former member of the NSW Medical Board.

She has undertaken a number of reviews of clinical governance systems. Annette holds a Master of Public Health degree from the University of NSW and is a fellow of the Australian Institute of Company Directors.



Craig Watson
Chief Financial Officer

Craig is responsible for providing strategic leadership in the development and implementation of financial management systems and

strategies that enable the THS to deliver safe, efficient, effective and high quality integrated patient and client care within sustainable budget allocations. Craig previously held the positions of Acting Chief Operating Officer and Executive Director of Services – South for the THS following several leadership roles with the former Tasmanian Health Organisation-South including Acting Chief Executive.

Craig is a Fellow of CPA Australia and has held a variety of senior and executive positions during a 25 year career in the Tasmanian public service, following completion of a Bachelor of Business at the University of Tasmania.



Dr Tony Xabregas
Executive Director of Medical Professions

Tony is responsible for professional behaviours of the Medical Profession across the THS, as well as education

and training, simulation training, support of other executive directors with medical matters and any other medical duties as determined by the Chief Executive Officer.

Prior to this, Tony was the Executive Director of Medical Services for the Southern services in Tasmania and past Executive Director of Surgical Services for the same region. Tony established the first cardiac surgical unit in North Queensland and as a cardiothoracic surgeon, served as Director of Cardiac Services both in the public and private environments.

Tony holds a Fellowship of the Royal Australasian College of Surgeons, an Associate Fellowship of the RACMA, is a member of the Australian Institute of Company Directors and a Fellow of the Cardiac Society of Australia and New Zealand. Tony has other University management qualifications and will soon complete a law degree.

TASMANIAN HEALTH SERVICE – SERVICE PROFILE

Services delivered by the Tasmanian Health Service include acute, sub-acute, rehabilitation, primary health care, palliative care, cancer screening, oral health, mental health and alcohol and drug services. The services provided are flexible enough to target specific needs at the different stages of a patient's health journey, in order to provide an integrated, holistic and patient-centered approach to health care delivery.

The THS operates four major hospitals and all have a clearly defined role in the system through the Tasmanian Role Delineation Framework (TRDF) with services mapped to a clinical profile:

- The Royal Hobart Hospital is the principal tertiary referral hospital for residents of Southern Tasmania and also provides a number of statewide services.
- The Launceston General Hospital is the principal referral hospital for the North and North West of Tasmania and also provides a number of tertiary services for residents of those areas.
- The North West Regional Hospital in Burnie provides acute general hospital services in the North West region.
- The Mersey Community Hospital at Latrobe provides a mix of general hospital services in the North West region.

Sub-acute inpatient care is provided at the major hospitals and through a network of rural hospitals (including multi-purpose services and multi-purpose centres). The rural hospitals provide a wide range of community health services. Some rural facilities include residential aged care.

Allied health, community nursing (including specialised nursing), home care, palliative care, dementia services, specialised case management services, aids and appliances and health promotion programs are provided at the community level from community health centres and rural facilities, and also in patients' homes, schools and workplaces.

In addition, other services delivered across the state include:

- Mental Health Services
- Alcohol and Drug Services
- Correctional Primary Health Services
- Forensic Mental Health Services
- Oral Health Services
- Population Screening and Cancer Prevention
- Primary Health Services
- Child Health and Parenting Services.

The map on the following page shows the locations and names of most THS services.

Our Services Locations



- 1 King Island Hospital & Health Centre
- 2 Smithton DH
- 3 James Muir CHC (Wynyard)
- 4 North West Regional Hospital
- 5 Parkside & Burnie CHC
- 6 Central Coast CHC (Ulverstone)
- 7 Devonport CHC
- 8 Mersey Community Hospital
- 9 Rosebery CHC
- 10 Zeehan CHC

- 11 West Coast District Hospital (Queenstown)
- 12 Strahan CNC
- 13 Flinders Island MPC
- 14 Cape Barren Island Nursing Centre
- 15 George Town DH
- 16 Beaconsfield MPS
- 17 North East Soldiers Memorial Hospital (Scottsdale)
- 18 St Helens DH
- 19 John L Grove Rehabilitation Unit
- 20 Mayne Street Day Centre
- 21 Ravenswood CHC
- 22 Deloraine DH
- 23 Westbury CHC
- 24 Public Palliative Care Beds at Calvary
- 25 LGH and NICS
- 26 Kings Meadows CHC
- 27 Toosey Inc. (Longford)
- 28 Longford CHC
- 29 St Marys CHC
- 30 Campbell Town MPS
- 31 Swansea CHC
- 32 May Shaw NC (Swansea)
- 33 Midlands MPC (Oatlands)
- 34 Ouse CHC
- 35 Spring Bay CHC (Triabunna)
- 36 Brighton CHC (Bridgewater)
- 37 New Norfolk DH
- 38 Glenorchy CHC
- 39 Clarence ICC (Rosny Park)
- 40 Risdon Vale CHC
- 41 Sorell CHC
- 42 Repatriation Centre (Hobart)
- 43 Kingston CHC
- 44 Huon CHC (Huonville)
- 45 Huon Eldercare Inc. (Franklin)
- 46 Cygnet CHC
- 47 Tasman CHC (Nubeena)
- 48 Esperance CHC (Dover)
- 49 Bruny Island CHC (Alonnah)
- 50 Royal Hobart Hospital

OUR SERVICES

The Tasmanian Health Service (THS) provides a wide range of health services and these are provided through inpatient, outpatient, community health, residential aged care and in-home settings.

Acute care is provided through the Launceston General, Mersey Community, North West Regional and Royal Hobart Hospitals.

Launceston General Hospital (LGH)

The Launceston General Hospital is Tasmania's second largest hospital and the major referral centre for Northern Tasmania. The hospital provides acute care, including emergency and intensive care and maternity services; outpatient; community, and sub-acute services.

Community and outpatient services include allied health, nursing, health promotion, home care and palliative and dementia services. These are provided from community health centres and rural facilities as well as at the LGH including the Northern Integrated Care Service (NICS).

The LGH is an accredited teaching hospital for undergraduate and postgraduate general and specialist medical and nursing.

In 2016-17 the LGH was involved in a number of innovative health-related activities including:

- Ward 4D permanently opened providing extra general medical beds. Work has commenced to build three single rooms on the ward to enhance infection prevention measures.
- An upgrade of the Department of Allied Health at the LGH was completed. The redevelopment provides a contemporary facility with modern consulting, treatment and therapy spaces. A model of Activity Based Working has been implemented which has greatly improved utilisation of office space and also expanded the availability of clinic rooms for patient intervention.
- The LGH tested its response to a mass casualty incident with a hospital-wide exercise. The Code Brown exercise involved more than 60 LGH staff with support from the Tasmania Fire Service, Ambulance Tasmania and volunteers from the University of Tasmania and Australian Red Cross.
- The LGH participated in a major national quality improvement research activity. The Researching Effective Approaches to Cleaning in Hospitals (REACH) trial was a National Health and Medical Research Council (NHMRC) partnership project led by the Queensland University of Technology and Wesley Medical Research. The REACH study will evaluate the effectiveness of a novel environmental cleaning bundle in 11 major Australian hospitals. The findings from this research will show clinicians and decision makers whether investing in the implementation of an environmental cleaning bundle in acute hospitals will improve cleaning performance, improve cost-effectiveness and reduce the risks of healthcare associated infections (HAIs).
- Clinicians continue to support overseas aid programs. An Australian-funded orthopaedic surgery team completed a week-long visit to the Vanuatu Central Hospital (VCH) to work with local counterparts to improve health care in Vanuatu. The team from the LGH included two orthopaedic surgeons Mr Roger Butorac and Mr John Batten, an anaesthetist Dr Henning Els, who specialises in children, and two specialist nurses Kate Taylor and Paul van Nynanten. The team went to Vanuatu under the Australian Pacific Islands Program, which provides clinical services to 11 Pacific Island countries.

- A project to encourage members of the Tasmanian Aboriginal community to engage with health services in Northern Tasmania was launched at the Launceston Community Health Centre. As part of the project a mural designed by Aboriginal artist Auntie Judith-Rose Thomas, with input from community members, was unveiled.
- The LGH's volunteer Historical Committee published the first in a series of books detailing different aspects of Launceston's medical past. The first book was entitled *Murder at the LGH* set in the 1800s and the second *Other Hospitals in Launceston 19th-21st Century*. Money raised from book sales goes to support the committee's work to document and preserve hospital history.
- Mr John Batten, an Orthopaedic Surgeon from LGH, with special interests in Paediatric Orthopaedics and Arthroplasty, was elected the 47th President of the Royal Australasian College of Surgeons (RACS). Currently the RACS Censor in Chief with overarching responsibility for the education and training of Fellows, Mr Batten was elected President following a vote of the RACS Council.
- Additional Urology Services are being provided at the MCH via an outreach model from the LGH (30 per cent increases over the past two years).
- Overnight gynaecological services have been consolidated to the North West Regional Hospital.
- Birthing and inpatient maternity services ceased at MCH and were consolidated to the North West Private Hospital (NWRPH). This inpatient service is a part of the new North West Integrated Maternity Service, supported by a strengthened antenatal and postnatal service in Burnie, Latrobe and a number of other rural sites.
- Neonatology Services have now ceased at the MCH.
- A bus link between the MCH and NWRH is now operational. A new patient lounge and covered walkway has also been constructed to allow patients and visitors a place to wait in comfort.
- Building of the Theatre two Endoscopy Reprocessing room began in June.
- Planning is well underway to establish new and enhanced subacute rehabilitation services with satellite services due to be established within the hospital's medical ward in July 2017.

Mersey Community Hospital (MCH)

In April, Prime Minister Malcolm Turnbull announced the MCH would transfer to the State Government on 1 July 2017, with a 10 year \$730.4 million funding deal for the operation of the hospital to 2026-27. From 2027-28 the MCH will then be funded in the same way as other public hospitals. That is, its operating costs will come under the state health Budget and regular Commonwealth health funding arrangements. MCH challenges and key achievements:

- As a dedicated elective surgery centre, the hospital has delivered almost 4 500 surgeries or other procedures, such as endoscopy.
- The High Dependency Unit has been repurposed to a Close Observation Unit to support medical and elective surgical services.

North West Regional Hospital (NWRH)

The NWRH at Burnie is an acute secondary hospital offering medical, surgical, paediatric and allied health services through inpatient and outpatient care.

The hospital is the receiving centre for North West trauma patients and has a well-equipped Emergency Department (ED) supported by an intensive care/high dependency unit and a 24/7 operating theatre. As a secondary level service, the hospital does transfer patients to tertiary hospitals in Launceston, Hobart and Melbourne

for some injuries and illnesses. It also has a close working relationship with the MCH in service delivery and patient care alongside community services.

NWRH challenges and key achievements:

- As part of the Patients First initiative, eight new beds were opened in April with the aim of easing pressure on the hospital's emergency department and ensuring patients get the care they need sooner. The eight beds are made up of four emergency department short stay beds and four surgical beds for elective surgery patients who need overnight stays.
- Capital works planning regarding the \$720 000 upgrade of the hospital's preadmission area is in progress.
- A new state-of-the-art helipad was built at the hospital and features special night vision technology and is designed to cater for larger rescue helicopters into the future.
- A new patient lounge was opened within the hospital to allow patients and visitors a place to wait in comfort.

Royal Hobart Hospital (RHH)

The RHH, Tasmania's largest and only tertiary hospital is the base for acute care. It provides training for numerous medical disciplines and is the State's centre for cardiothoracic surgery, vascular surgery, neurosurgery, burns, hyperbaric and diving medicine, neonatal and paediatric intensive care, and high-risk obstetrics.

In 2016-17 there were 62 055 Emergency Department presentations at the RHH, an increase of four per cent on the same period last year. Of these presentations, 35 per cent were admitted. There were also 6 793 more patients seen in its clinics and 3 172 fewer patients waiting for appointments.

The RHH was included in or delivered a number of administrative and clinical innovations during the past financial year, with staff participating in research and development projects including:

- The Medical Transcription Service entering 68 000 clinical communications between general practitioners and specialists at the RHH into a central system making it easier for THS to access data and make properly informed, timely clinical decisions.
- The Medical Services Department piloted a dedicated day procedure area called the Cardiac Day Unit. This inventive model of care accommodated not only pacemaker and angioplasty patients, but all Cardiology and Cardiothoracic day cases. This modification resulted in the RHH meeting best practice standards for performing same day cardiology procedures as well as boosting efficiency and patient flow.
- The hospital redevelopment also progressed through the 2016-17 financial year while still providing safe, high quality care. Some hospital services were transferred to new areas to allow B-Block to be demolished and the construction of K-Block.

Sub-acute and primary health services

There are a number of rural health sites across Tasmanian (i.e. district hospitals, community health centres and multipurpose centres) with 13 rural health sites providing 24/7 sub-acute inpatient care and a number which provide residential aged care services. All rural health sites provide a wide range of community health services. The THS, particularly in the south of the state, also contracted rural hospital beds from the private not for profit residential aged care sector.

District hospitals in Tasmania do not have Emergency Departments; rather they provide Tier One or Tier Two rural medical emergency response and care.

Apart from New Norfolk District Hospital (NNDH), all other THS managed and operated district hospitals are able to triage and respond to patients presenting for emergency care; this may range from first aid treatment, assessment and admission for ongoing care at the district hospital or emergency care. There must be capacity for resuscitation and stabilisation of a patient prior to referral and transfer to a facility that is able to provide a higher level of service.

Services provided at a community level include community allied health, community health nursing (including specialised nursing in spinal and continence, dementia, neurological, COPD, youth health), home care services, specialist palliative care, dementia support services, specialised assessment (Aged Care Assessment teams) and case management services, aids and appliances and health promotion programs. These services are provided from community health centres and rural facilities.

Sub-acute and primary health services key achievements:

- Community consultation regarding plans for the redevelopment of the St Helens District Hospital to meet the ongoing and future health service delivery for the region. Work on the 10 bed facility is expected to start in 2018.
- A formal evaluation of the Community Rapid Response Service (ComRRS) which commenced in May 2016 was completed. The evaluation provided strong evidence that ComRRS is achieving its overall aim of providing support for people requiring intermediate clinical care who would otherwise require hospital services. ComRRS continues in the North with the recommendation that the service be rolled out in other areas.
- Aged care services in the North East were strengthened with the transfer of aged care beds within the James Scott Wing at the North East Soldiers Memorial Hospital, Scottsdale, to May Shaw Centre Inc. to create an integrated aged care service in the region.
- With increasing demand on ED and hospital services, Community Nursing has implemented a service across the North and North West. The Community Nursing Enhanced Connections Service (CoNECs) model focusses on diverting patients from ED to Community Nursing clinics for any ongoing management and reduces the incidence of representations to the ED. This service commenced in the North West in November 2016 resulting in 300 presentations being diverted to the clinic to date.

- 'Hello My Name Is...' campaign is an initiative from the UK that has been implemented across primary health services. The founder Dr Kate Granger started the campaign, primarily using social media to encourage and remind healthcare staff about the importance of introductions.
- All services in the North West including District Hospitals, Residential Aged Care Services, Community Health Nursing and Home Care Services, and Specialist Palliative Care Services have undergone accreditation and quality reviews specific to the service with success in achieving the required standards for excellence in safe and quality health care delivery.
- In order to increase patient flow out of the RHH, in February 2017 the State Government allocated additional resources to the NNDH. This resource funded additional nursing, allied health and medical staff and has enabled the NNDH to more consistently take transfers from the RHH and maintain daily occupancy above 90%.

Statewide Services

The THS also coordinates a number of statewide clinical services including Oral Health Services Tasmania and Statewide Mental Health Services, both of whom operated under National Safety and Quality Health Services accreditation for the first time.

Oral Health Services Tasmania

Oral Health Services Tasmania provides dental services to eligible Tasmanians including adults who are holders of either a current health care card or pensioner concession card. The children's dental service is a universal service for all Tasmanians aged 0-17 years. The service operates from over thirty sites across Tasmania including major centres in Burnie, Devonport, Launceston, Clarence and

Hobart, a number of special care dental units and two mobile dental units.

Statewide Mental Health Services (SMHS)

SMHS supports a wide range of clients including people experiencing complex and chronic disease, severe mental health problems, alcohol and drug issues and people within the correction and justice system.

Many clients have complex needs that require multi-faceted support from a range of specialised services. For some these complexities can be exacerbated by societal stigma attached to social determinants, mental illness, alcohol and drug issues or contact with the correctional and/or justice system.

The SMHS group consists of the following clinical services:

- **Child and Adolescent Mental Health**

Child and Adolescent Mental Health Services assists infants, children and young people (up to 18 years old) who are experiencing severe and complex mental illness or disorders, and their families or care givers.

- **Adult Mental Health**

The Adult Mental Health Service delivers care to people aged between 18 to 65 years who have severe and complex mental health disorders. The service provides assessment, treatment, support and education via a range of community based services and inpatient services.

- **Older Persons Mental Health**

Older Persons Mental Health Services delivers care to people who are 65 years or older who have a mental illness and/or impaired cognitive functioning with challenging behavior. This service consists of the both community based and a statewide inpatient services through the Roy Fagan Centre (dedicated

inpatient facility) based in Lenah Valley in the south.

- **Alcohol and Drug Services**

Alcohol and Drug Services is managed statewide with services located in Hobart, Launceston and Ulverstone. It has four service delivery arms; Withdrawal Management, Opioid Pharmacotherapy Program, Consultation Liaison, Psychosocial Interventions, and operates other specialist programs as required.

- **Forensic Mental Health Services**

Forensic Mental Health Services operate statewide and undertake highly specialised interventions and clinical activities providing community and inpatient mental health care for people experiencing a mental health disorder, who are involved with or at risk of becoming involved with the criminal justice system. The secure mental health unit – the Wilfred Lopes Centre is based at Risdon in the south.

Forensic Mental Health Services is a specialist area of the mental health field. It has evolved due to the high prevalence of mental illness amongst prisoners and remandees in correctional settings and the complexities of providing care and treatment to offenders with a mental disorder who are a highly stigmatised and marginalised group within the community. The stigma and marginalisation of this group is often increased by sensational media representations that often give misleading accounts of forensic mental health issues.

Correctional Health Services

Correctional Health Services provides primary health care and treatment and specialist referral for men and women held within the Tasmanian Prison Services and across a range of correctional

facilities. Correctional Health Services provides a range of services across all facilities including:

- Emergency care
- General health assessments
- Medical officer consultations
- Diagnosis and treatment
- Specialist psychiatric consultations and treatment
- Mental health, emotional, suicide and self-harm assessments and treatments
- Drug and alcohol assessments, treatment and referral
- Opioid substitution
- Health promotion
- Inpatient care with six beds for primary health care and observation and outpatient nursing clinics.

Services provided by SMHS include the provision of inpatient, hospital based, and community-based services, with many provided in partnership with community sector organisations.

In the North West, the inpatient unit is based at NWRH, in the North it is based at the LGH, and in the South it is based at the RHH. SMHS have community bases in Hobart and surrounding suburbs, Launceston, Burnie and Devonport which provide services across all age groups.

SMHS also delivers the Mental Health Services Helpline to clients across the state, providing advice, assessment and referral. The Helpline is a central point of entry to Mental Health Services for all Tasmanians and is a 24-hours-a-day, seven-days-a-week phone line. It is supported by a dedicated crisis assessment and treatment team that operates across all services and who manage referrals from the Mental Health Services Helpline. The team also provides emergency

responses to urgent referrals seven days a week

Population Screening and Cancer Prevention

Population Screening and Cancer Prevention deliver population screening programmes for the prevention and early detection of cancers, so that the number of avoidable deaths from cancer amongst Tasmanians can be minimised. Population Screening and Cancer Prevention are partners in cancer prevention and cancer control in collaboration with local and national health care providers. The service is actively engaged in the development of national quality standards for monitoring of the outcomes and effectiveness of the screening programmes. BreastScreen Tasmania screened 31 491 eligible Tasmanian women (aged over 40) this year.

Child Health and Parenting Service (CHaPS)

On 1 January 2017, the CHaPS transferred from DHHS to the THS. Within the THS structure, CHaPS sits under the management of the Executive Director of Nursing and Midwifery until the service takes up its new position within the Statewide Primary and Community Care Structure, which is currently under development.

Statewide Sexual Health Service (SSHS)

The SSHS operates clinics in Hobart, Launceston and Devonport. The service is staffed by doctors, nurses, counsellors, psychologists and administrative officers who deliver a range of clinical and counselling services that relate to gender identity, HIV care, sexual activities and safety, sexual health checks, sexual response and desire, sex worker issues and STI diagnosis and treatment.

ROYAL HOBART HOSPITAL (RHH) REDEVELOPMENT

The RHH has been serving the Tasmanian community for more than 200 years. It moved to its present site in Hobart's CBD in 1820. The redevelopment and expansion of the site will help ensure the hospital can continue to meet the community's changing health needs.

The condition and configuration of the existing buildings have made it increasingly difficult to provide contemporary health services. Some of the hospital's buildings are nearing the end of their functional life.

The Australian and Tasmanian Governments have now committed a total of \$689 million to the RHH Redevelopment Project.

This substantial investment provides an opportunity to transform Australia's second oldest hospital so that it can deliver health services to Tasmanians into the future.

In 2016, approximately \$50 million worth of refurbishment works were completed across the RHH campus.

Level 2 of C-Block has been refurbished to create a new clinical area that will provide long-term accommodation for the acute Ambulatory Care Centre.

It is a contemporary clinical space that has 10 bed bays and 14 treatment chairs and provides more privacy for patients.

Mental Health inpatients are already benefitting from contemporary hospital amenities while K-Block is being built.

To ensure the best outcome for patients, design elements that are to be used in K-Block are now being tested in the Temporary Inpatient Facility and include a sensory modulation area, de-escalation room and areas for vulnerable patients.



Ambulatory Care Centre bed bays

The refurbishment works were undertaken to enable the decanting of B-Block so that it could be demolished to make way for the new inpatient facility known as K-Block.

Structural demolition of B-Block (including the B-Fan, B-Tail and main building) has now been completed and all demolition rubble has been removed from the site.

Bulk earthworks to prepare the site for the construction of K-Block are now substantially completed.

Construction of K-Block has commenced with the drilling of pilings and the installation of the structural footings of K-Block underway.

Consistent with contemporary health services delivery models, improved patient care and operating efficiencies will result from bringing together services in 'precincts' such as: women's, adolescent's and children's services; mental health services; medical services; and surgical services.

These new precincts will be located in close proximity to the new \$25 million Cancer Centre which was redeveloped during 2013-14 as part of an earlier phase of the redevelopment project.

There are significant benefits from the redevelopment including expanded space coupled with modern contemporary facilities and technology which will transform the way health care services are delivered and vastly improve the patient experience.

Importantly, K-Block will provide capacity for around 250 additional beds and will allow sufficient flexibility to accommodate any required changes to models of care or in response to future demand.

K-Block also provides an additional seven operating and procedure rooms.



Mental Health Patient Room in the Temporary Inpatient Facility



Sensory Modulation Room in the Temporary Inpatient Facility



New Operating Theatre in K-Block – Image courtesy of Lyons Terrior (Architects for the RHH Redevelopment Project)

OUR COMMUNITY AND VOLUNTEERS

Launceston General Hospital (LGH)

Volunteer Service

The LGH has 50 volunteers who assist and support staff, patients and their family members. Duties and tasks can vary widely depending on the ward or department they are assigned to.

There is a Volunteer Office located on level 3 of the hospital, which is occupied Monday to Friday from 9:00am to 4:00pm.

Some volunteers are responsible for collecting specimens and blood samples from wards and outpatient clinics and delivering to the Pathology Department. This invaluable service is carried out four times a day. The volunteers also deliver flowers; make up information packs for various wards and departments and escort patients and family members around the hospital.

Other activities include helping staff to deliver medication scripts to the Pharmacy, helping patients fill out their menus and assisting in stocking linen cupboards.

There are volunteers also assigned to the Intensive Care Unit. This involves meeting and greeting family members/visitors at the main entrance of the unit

and directing them to the Nurses Station.

Volunteers also work in the Specialist Clinic where they meet and greet patients. They also deliver information packs to new patients; this package is made up of The Australian Charter of Healthcare Rights brochure, LGH Consumer Feedback Form, Social Work information flyers and a bookmark from the Chaplaincy.

There are volunteers who distribute magazines to inpatients, offer refreshments to outpatients and visitors. A relatively new service is within the hospital's Food Services Department. These volunteers assist with the collection of patient menus from the wards and fill order forms.

Outside the main hospital there are volunteers at the Northern Integrated Care Service, John L Grove Centre and Spurr Wing. Volunteers assist with gardening and help out with patient activities.

The LGH ensures that volunteers obtain the knowledge and skills needed to carry out their responsibilities safely and effectively. It is mandatory for all volunteers to attend the hospital's induction (orientation) program, including all mandatory Work Health and Safety training.



Scottsdale Hospital Auxiliary Members receive long service awards.

North West Volunteer Services

Volunteer Services are spread further than the local hospitals with volunteer drivers based in the surrounding communities to transport patients to acute facilities. Volunteers provide services for the adult day centres in Ulverstone and Latrobe, arranging activities and outings for clients and a hospice service in Burnie who volunteer and assist with Palliative care.

There are a number of ways that volunteers assist THS:

- **Cancer Support and Wellbeing Centre**

The Cancer Support and Wellbeing Centre provides an oasis for patients, carers, families and others affected by cancer. Volunteers are the welcoming face of the Centre, they are available to make refreshments (tea and coffee) while providing a listening ear.

Wellbeing Centre volunteers also assist with maintaining the presentation of the centre with tasks such as tidying the inside area and outside courtyard, and keeping patient information, such as brochures, up to date. They also provide assistance to the centre's support groups and administrative tasks, such as putting patient information packages together, as required.

- **Meet and Greet Service**

Our Meet and Greet volunteers provide an important service to outpatients at the NWRH. They are also available to assist patients and visitors on arrival with way finding, wheelchair transfers and an escort to clinics or other services throughout the hospital.

Volunteers also assist with a range of activities such as administrative duties, couriership and providing a consumer opinion on some meeting panels.

- **Smithton District Hospital**

The hospital recognises and welcomes dedicated volunteers who wish to support patients and clients at Smithton District Hospital.

Volunteer tasks include spending time with patients, assisting them with minor tasks and preparing some refreshments (tea and coffee). Hospital can sometime be a lonely time for patients – to have someone available to sit and chat, adjust their pillow or help them find their glasses can give them just the boost they need in their recovery.



Tasmanian Hospital Auxiliary members .

Royal Hobart Hospital (RHH) Volunteer Service

In February 2017, the RHH Volunteer Program celebrated 50 years of volunteer support to the Southern Tasmanian community. It started with volunteers helping at the hospital in wake of the 1967 "Black Tuesday" bushfire. A positive outcome from such a tragedy was the continued volunteer support to the hospital from this time on. As many people continued to volunteer their time on a more permanent basis, the RHH Cherry Volunteer Service was born.

The RHH Volunteer Service has evolved into a contemporary volunteer service with membership consisting of 110 men and women, contributing over 20 000 hours annually towards delivering 44 individual services at the hospital, with the core value of providing support services dedicated to the people of Tasmania.

A sample of the services RHH Volunteers provide, Monday to Friday:

- **RHH Neonatal Intensive Care Unit (NNICU) - Volunteer Cuddles Program**

The RHH Volunteers are part of the NNICU newborn team and are trained to settle, comfort and cuddle babies when the parent or carer may not be able to be with their baby due to other commitments outside of the hospital.

- **Emergency Department (ED) Waiting Room Support**

Volunteers support consumers in ED by reducing anxiety while attending what can be an extremely intimidating area for many, the support the volunteer provides include:

- Meet and greet consumers attending the ED in a friendly and caring manner and guide to triage area.
- Liaise with ED staff on behalf of the consumer with general queries, such as an idea as to the length of waiting time and then communicate back to consumer.

- **General Wards - Meal Time Assistance Program**

The Volunteer Meal Time Assistance Program is an effective way to improve patient nutrition intake, especially in the most vulnerable patients, volunteers play a key role in increasing patient food intake by:

- Setting up and ensuring meals are within reach of the patient.
- Opening meal packaging.
- Providing social interaction.

- **RHH Cancer Support Centre (CSC)**

The CSC is staffed by friendly and compassionate volunteers from the RHH and Hospice Volunteers South. RHH Volunteers support consumers and staff visiting the Centre by:

- Welcoming patients, family and carers to the Centre in a friendly and caring manner.
- Providing social support and refreshments to consumers accessing the Centre.
- Assisting external cancer support groups to set up and operate functions and workshops.



RHH Hospital Volunteers Program.

- Ensure visitors are aware of material available to them from within the Centres Library

- **Consumer Engagement Committee (CEC)
Representative - Voluntary Position**

The THS Community Engagement Committee (CEC) aims to ensure health consumers contribute to the development of health policy, planning, research and service delivery through the provision of education, advocacy, training, information services and community participation.

- **Tasmanian Hospital Auxiliaries**

Supporting our services are the volunteers from our hospital auxiliaries who have been

operating across Tasmania for more than 80 years. There are currently more than 30 Auxiliaries across Tasmania.

These volunteers run kiosks at acute hospitals and fundraise across the State, from Bruny Island in the South to Flinders Island in the North East and King Island in the far North West.

They have raised extraordinary amounts of money this year that go towards the purchase of equipment for services. The Auxiliary members are all volunteers and their contribution to THS is appreciated.



BUILDING A SAFE AND SUSTAINABLE MATERNITY SERVICE FOR THE NORTH WEST.



On 1 November 2016, a new integrated North West maternity service was created to provide better, safer care for mothers and babies, as part of the Government's One Health System reforms to provide higher quality services and better outcomes.

The new single birthing and inpatient care service was established at the North West Private Hospital (NWPB), with all admissions to hospital for births or other pregnancy related issues in the North West being managed by the private hospital.

All out-of-hospital care, including antenatal visits, classes and postnatal care is provided by the THS through the Mersey Community Hospital and the North West Regional Hospital. The THS also added a low risk Midwifery Group Practice Model to the options available to women, meaning eligible women can receive care with a known midwifery team for the whole of their maternity care – pregnancy, labour, birth and postnatal care.

The new service has been designed based on clinical advice from specialists and offers many benefits to expectant mothers including expansion of services for antenatal and postnatal care across the North West, by providing greater levels of midwife led outreach and home visits after the birth. It also provides a structure to build a more stable health workforce and provide the inpatient care close to where other essential medical support services are available such as paediatrics and critical care services.

As of 30 June 2017, there were 621 births since its inception as an integrated service. Twenty per cent of these births (127) were conducted by THS Midwifery Group Practice.

The move to providing birthing in one location as part of the government's One Health System reforms comes after substantial consultation with medical professionals and the community. All expectant mothers were contacted directly about the change to birthing services and two 1800 telephone numbers for patients and general practitioners to access advice on pregnancy related issues were created. The THS continues to communicate with the community - in particular pregnant women and their families - about how to access maternity services throughout their pregnancy.

OUR PEOPLE

The THS acknowledges the dedication and significant contribution of its staff. The diverse and dispersed workforce is made up of a significant number of occupational groups, providing health services to the community across the State.

Across the course of the year, the THS has continued with a substantial change process and throughout this time, staff have continued to provide a high standard of care to our patients and clients, which demonstrates and reinforces our patient first philosophy.

Throughout the 2016-17 financial year, the THS has finalised the structure of its executive team, with particular attention given to key roles, which support and promote the development of our people, including:

- Dedicated Executive positions for key occupational groups of the Medical Profession, Allied Health, Nursing and Midwifery.
- Reshaping of the Human Resource portfolio to increase the focus on Work, Health and Safety.
- Building relationships with the relevant professional organisations and specialist institutions.
- Continuing to explore mutual benefits with the tertiary education sector and non-government advocacy and health care entities.

The health and well-being of staff remains a priority. There has been considerable effort harmonising our work health and safety systems across the state this year and will continue to make improvements in 2017-18.



HUMAN RESOURCES STATISTICS

Total number of full-time equivalent (FTE) paid employees

As at end of financial year	2014-15*	2015-16*	2016-17
	7 901.82	8 112.64	8 347.85

* Note due to organisational changes data has been remapped to the current organisational structure for the years 2014-15 and 2015-16.

Total number of FTE paid employees by award

As at end of financial year	2014-15*	2015-16*	2016-17
Allied Health Professional	851.68	880.25	888.56
Dental	33.38	33.83	32.19
Health and Human Services	2 798.47	2 817.60	2 861.78
Medical Practitioners	765.60	798.23	857.92
No Award	0.42	2.15	1.90
Nursing	3 351.20	3 478.92	3 602.78
Radiation Therapist	50.01	52.75	54.74
Senior Executive Service (SES)	6.00	5.00	6.00
Visiting Medical Officers**	45.06	43.91	41.99
Total	7 901.82	8 112.64	8 347.85

* Note due to organisational changes data has been remapped to the current organisational structure for the years 2014-15 and 2015-16.

** Includes Rural Medical Practitioners.

Total number (head count) paid by employment category: fixed-term/permanent, full time/part time/casual

As at end of financial year	2014-15*	2015-16*	2016-17
Permanent full-time	2 857	2 920	2 860
Permanent part-time	4 459	4 647	4 951
Fixed-term full-time	885	777	849
Fixed-term part-time	1 008	971	1 013
Part 6**	16	16	17
Casual	924	1 161	1 097
Total	10 149	10 492	10 787

* Note due to organisational changes data has been remapped to the current organisational structure for the years 2014-15 and 2015-16.

** Head of Agency, Holders of Prescribed Offices and Senior Executives and Equivalents.

Total Head Count - number paid by salary bands and award

Salary Band	Allied Health Professional	Dental Officer Award	Health and Human Services Award	Medical Practitioners Award	Nurses Award	Other	Radiation Therapist	Senior Executive Service	Visiting Medical Practitioner	Grand Total
19 001-23 000						12				12
40 001-45 000			70							70
45 001-50 000			938		81					1 019
50 001-55 000	3		770		32					805
55 001-60 000	55		929		105					1 089
60 001-65 000	74		449	97	810					1 430
65 001-70 000	45		48	60	398					551
70 001-75 000	32		40	36	310		4			422
75 001-80 000	42		122	23	1 438		3			1 628
80 001-85 000	11		86	63	1 041		8			1 209
85 001-90 000	220		7	51	113		2			393
90 001-95 000	314		10		46		2			372
95 001-100 000	122		85	55	241		5			508
100 001-200 000	188	43	59	462	208		36	5		1 001
200 001-400 000				101				1	175	277
400 001-500 000						1				1
Grand Total	1 106	43	3 613	948	4 823	13	60	6	175	10 787

*Based on salary for award classification; Head Count not FTE.

**Visiting Medical Practitioners work on a sessional basis < 20 hours per week and are paid on a pro rata basis.

NOTE: In addition to Salaries and allowances under contracts of employment, Medical Practitioners at the RHH may participate in the Private Patient Scheme (PPS) if eligible by Medicare and under the management of the PPS committee. Under this scheme, Medicare, private health funds and other insurance bodies are billed where appropriate for eligible procedures performed in the RHH. PPS revenue generated by Visiting Medical Practitioners is shared with the RHH; PPS revenue raised by Specialist Medical Practitioners is donated to the RHH and the participating Specialists are then paid an allowance, as determined by the scheme. Revenue in excess of that distributed to medical practitioners is also allocated to hospital unit trusts to support research, clinical training and continuing professional activities of medical and other health employees, medical outreach programs overseas, and specialist medical equipment for the RHH for which public funding is not available.

Total number (head count) paid by gender

As at end of financial year	2014-15*	2015-16*	2016-17
Female	7 816	8 103	8 362
Male	2 333	2 389	2 425
Total	10 149	10 492	10 787

* Note due to organisational changes data has been remapped to the current organisational structure for the years 2014-15 and 2015-16.

The Tasmanian Health Service is committed to Gender Diversity in the Tasmanian State Service. More detailed reporting will be provided in 2017-18 THS Annual Report.

Total number (head count) paid by age profile

As at end of financial year	2014-15*	2015-16*	2016-17
15-19 years	14	31	31
20-24 years	487	566	592
25-29 years	910	999	1 076
30-34 years	915	1 022	1 079
35-39 years	906	970	1 006
40-44 years	1 138	1 079	1 031
45-49 years	1 425	1 455	1 440
50-54 years	1 646	1 574	1 594
55-59 years	1 534	1 545	1 581
60+ years	1 174	1 251	1 357
Total	10 149	10 492	10 787

* Note due to organisational changes data has been remapped to the current organisational structure for the years 2014-15 and 2015-16.

Number of employees (head count) paid by award as at 30 June 2017

As at end of financial year	Total
Allied Health Professionals	1 106
Dental Officers	43
Health and Human Services Award	3 613
Medical Practitioners	948
No Award	13
Nursing	4 823
Radiation Therapist	60
Senior Executive Service	6
Visiting Medical Officers*	175
Total	10 787

*Includes Rural Medical Practitioners.

Average Personal Leave days per FTE*

As at end of financial year	2014-15**	2015-16**	2016-17
Personal leave days per average paid FTE	12.6	11.7	11.9

* Includes sick, carers leave and family leave.

** Note due to organisational changes data has been remapped to the current organisational structure for the years 2014-15 and 2015-16.

Total paid overtime* hours per average FTE

As at end of financial year	2014-15**	2015-16**	2016-17
Overtime/callback paid hours per averaged paid FTE	49.3	49.9	52.4

* Includes callback and overtime hours.

**Note due to organisational changes data has been remapped to the current organisational structure for the years 2014-15 and 2015-16.

Turnover Rate

The turnover rate is the rate at which people were leaving the THS as at 30 June 2017.

As at end of financial year	2014-15*	2015-16*	2016-17
Turnover rate = total number of separations (FTEs) divided by the average paid FTE	11.3%	10.1%	9.6%

*Note due to organisational changes data has been remapped to the current organisational structure for the years 2014-15 and 2015-16.

Wastage Rate

The wastage rate is similar to the turnover rate but takes into account the number of employees who joined THS as new starts. A negative result means more people are becoming employees than are exiting.

As at end of financial year	2014-15*	2015-16*	2016-17
Wastage rate = (separation FTE – Newstart FTE)/average paid FTE	2.4%	0%	-0.9%

*Note due to organisational changes data has been remapped to the current organisational structure for the years 2014-15 and 2015-16.

Long Service Leave

As at end of financial year	2014-15**	2015-16**	2016-17
Average number of days used per paid FTE*	3.3	3.8	3.5

*Includes Maternity Long Service Leave.

**Note due to organisational changes data has been remapped to the current organisational structure for the years 2014-15 and 2015-16.

Annual Leave

As at end of financial year	2014-15*	2015-16*	2016-17
Average number of days used per paid FTE	20.7	18.9	18.7
Number of FTEs with entitlements equal to the 2 year limit	5.8	5.7	5.2
Number of FTEs in excess of 2 year limit	403.6	435.2	482.1

*Note due to organisational changes data has been remapped to the current organisational structure for the years 2014-15 and 2015-16.

HUMAN RESOURCE POLICIES AND PROGRAMS

Across the year, the most significant human resource policy and program initiatives included:

- Harmonisation of human resource policies and protocols across the THS.
- Increased focus on Employee Relations (ER) and Workplace Health and Safety (WHS) including the creation of a Director - ER and WHS which provides high level direction and management in these complex areas.
- Working towards a single Statewide Medical Workforce Unit which will assist to improve the management and recruitment of the medical workforce, and ensure statewide consistency.
- Improving the return to work management for ill or injured employees with the creation of return to work coordinators who are set to commence early in 2017-18.
- Commenced repositioning and expanding the scope of the human resource function to incorporate an organisational development focus.
- Continued provision of support and assistance to key stakeholders in relation to a wide range of human resources matters such as grievances, performance and change management.

WORK HEALTH, SAFETY AND WELLBEING

The THS is committed to providing and maintaining a safe and healthy workplace for staff, contractors, and visitors. It aims to achieve high standards of health, safety, and rehabilitation in all its operations through safe systems of work.

The WHS aims to:

- Provide safe workplaces
- Prevent and reduce injury and illness within all areas of THS
- Improve injury management outcomes
- Improve the health and wellness of employees
- Encourage active senior executive leadership and commitment
- Improve WHS capability at all levels of the organisation
- Ensure WHS is a key organisational priority
- Maintain compliance with all applicable legislative frameworks.

2017 has seen the continuation of statewide WHS harmonisation projects including Manual Task Training and Aggression Management.

Currently THS has three WHS Consultants across the state and over 100 Employee Safety Representatives (ESRs).

Muscular stress and workplace stress (psychological) related injuries have the highest incidence and overall cost in both time lost and dollars.

Notable achievements during 2016-17 include the approval of the Injury Management Program by WorkCover Tasmania and a slight reduction in injury rates, particularly by muscular stress.

Progress against the THS Safety Management System KPI Targets

State WHS objectives (DPAC/SSMO) are for 3% reduction per year.

Objective	Measures/Targets	Benchmark (2014-15 FY)	Outcomes (2015-16 FY)	Outcomes (2016-17 FY)
Reduce the total number of workers compensation claims	Number of injuries resulting in workers compensation claims	444	450	429
Reduce the number of WC claims resulting in >1 week's absence (serious claims)	Number of claims resulting in greater than one week off work	196	205	179
Reduce the Lost Time Injury Frequency Rate (LTIFR)	% of injuries resulting in >1 day off work per 1 000 000 hours worked	23.00%	24.20%	22.75%
Reduce the Lost Time Injury Severity Rate (LTISR)	Number of days lost per 1 000 000 hours worked	1 249.50	1 247.08	1 231.22
Reduce Manual Task Related Injuries	Reduction of injury rate	210	231	212



AWARDS AND AGREEMENTS

Allied Health Professionals

Allied Health Professionals (Tasmanian State Service) Agreement 2016

Radiation Therapists (State Service) Union Agreement 2016

Nurses

Nurses and Midwives (Tasmanian State Service) Award

Caseload Midwifery Industrial Agreement 2012

Nurses and Midwives (Tasmanian State Service) Agreement 2016

Nurses and Midwives (Tasmanian State Service) Interim Agreement 2013

Nurses and Midwives Work Value Agreement 2015

Medical Practitioners

Medical Practitioners (Public Sector) Award

Rural Medical Practitioners (Public Sector) Agreement 2011 - 2014

Salaried Medical Practitioners Interim Agreement 2015

Salaried Medical Practitioners (AMA Tasmania/ DHHS) Agreement 2009

Tasmanian Visiting Medical Practitioners (Public Sector) Agreement 2016

Administrative and Operational

Health and Human Services (Tasmanian State Service) Award

Tasmanian State Service Award

Department of Health and Human Services
Mental Health Services NW Crisis Assessment
Team 10 Hour Shift Arrangements Agreement
2012

Department of Health and Human Services
Northside Clinic Attendant Shift Arrangements
Agreement 2010

Department of Health and Human Services -
Roy Fagan Centre Shift Work Arrangements
Agreement 2003

Department of Health and Human Services
- Wilfred Lopes Centre - Care Assistant Shift
Arrangements 2006

Tasmanian Health Service - Southern Region
Microbiology Laboratory Agreement 2016

PATIENT SAFETY

Strategic Overview

The THS Patient Safety Service began with the appointment of the Executive Director for Patient Safety on 23 May 2016. The intent with this appointment was to consolidate the activities of the three independent regional Quality and Safety Units in order to transition to a single statewide service with a focus on improving patient safety across the THS through:

- Leading the development and implementation of a patient safety and clinical quality strategy consistent with the organisational needs of the THS and in keeping with contemporary practice.
- Introducing innovative patient safety and clinical quality frameworks to ensure that the THS represents a best practice model for patient safety and clinical quality and clinical risk management, clinical reporting and innovation.
- Coordinating the activities of the Service Quality and Improvement units across the THS.
- Managing patient, family and carer feedback to achieve ongoing improvement and resolution of complaints.
- Managing clinical adverse outcomes including open disclosure practice and coronial response.
- Overseeing research activities in the THS and liaise with stakeholders including universities and private industry to ensure that research activities deliver benefit to the community.
- Attending the THS Governing Council Quality and Safety Subcommittee and champion actions arising from the Committee assigned to the THS.

The starting point for the development of a THS Patient Safety Strategy was the Tasmanian Minister for Health's vision articulated in the One Health System reforms that envisaged Tasmania "having the healthiest population by 2025 and a world class health system".

Working in collaboration with key medical, nursing, allied health and safety and quality staff, the development of the THS Patient Safety Strategic Plan 2016-21 identified six key principles for the THS and their accompanying statements of strategic intent:

1. **No Harm** – *provision of health care without experiencing preventable harm.*
2. **Effective clinical governance** – *deliver an integrated system of governance that actively manages patient safety and clinical quality.*
3. **Exceptional care** – *deliver healthcare that does not vary in quality because of personal characteristics such as gender, age, ethnicity, geographical location and socioeconomic status.*
4. **Clinical Education and Training** – *excellence in clinical education and training will deliver exceptional clinicians.*
5. **Patient Centred Care** – *provision of healthcare that is respectful of and responsive to individual patient preferences, needs and values and ensuring patient values guide all clinical decisions.*
6. **Research** – *foster innovation and improvement to ensure the highest quality and safety of healthcare within the THS and Tasmania.*

This ambitious strategy was prioritised to concentrate in the first year on principles 1, 2, 3 and 5.

Patient Safety Strategic Plan 2016-21

The One State, One Health System, Better Outcomes (One Health System) reforms envisage Tasmania having the nation's healthiest population by 2025 and a world class health system. Improvements to Patient Safety are one facet of this process.

Principle	Strategies	Areas of action
No Harm <i>Provision of healthcare without experiencing preventable harm.</i>	<ul style="list-style-type: none"> A single patient safety and clinical quality policy framework exists across the THS. Patient safety and clinical quality incidents are recognised, reported, analysed and used to change how care is delivered. THS will be a learning organisation focussed on whole system change, interdisciplinary learning, identification of system failures to promote patient safety. 	<ul style="list-style-type: none"> Clinical leaders, managers and staff take action for patient safety. RCA process implemented supported by consistent education and training. Annual Innovation and Improvement Awards process implemented against six key patient safety goals.
Effective Clinical Governance <i>Deliver an integrated system of governance that actively manages patient safety and clinical quality.</i>	<ul style="list-style-type: none"> A single credentialing system across the THS. Committee structures support safe, high quality patient care. Consistent process for undertaking clinical audit supported by appropriate software and technology. 	<ul style="list-style-type: none"> Statewide e-credentialing system implemented supported by a single statewide Credentialing and Defining Scope of Clinical Practice Committee. Develop a patient safety scorecard that allows measurement and monitoring of key indicators of patient safety at a Governing Council, Executive, Facility and ward/unit level. Consistent statewide Morbidity and Mortality processes.
Exceptional Care <i>Deliver healthcare that does not vary in quality because of personal characteristics such as gender, age, ethnicity, geographic location and socioeconomic status.</i>	<ul style="list-style-type: none"> Care provided across the THS is guided by the best available evidence. Implement National Clinical Care Standards across the THS. 	<ul style="list-style-type: none"> Implement the Australian Commission on Safety and Quality in Health Care Clinical Care Standards in: <ol style="list-style-type: none"> Acute Coronary Syndrome Stroke Delirium Hip Fractures Antimicrobial Stewardship Colonoscopy.
Clinical Education and Training. <i>Excellence in Clinical Education and training will develop exceptional clinicians.</i>	<ul style="list-style-type: none"> Postgraduate training in the THS will support achievement of specialist qualifications. All staff will actively participate in mandatory education and training. Strong links will be fostered and encouraged with external training providers to support quality undergraduate and postgraduate training. 	<ul style="list-style-type: none"> A learning management system will be implemented that encourages and facilitates education and training of clinicians. A strategic road map of clinical education programs underway and planned to meet the needs of the workforce will be developed.

Principle	Strategies	Areas of action
Patient Centred Care <i>Provision of healthcare that is respectful of and responsive to individual patient preferences, needs and values, and ensuring patient values guide all clinical decisions.</i>	<ul style="list-style-type: none"> Actively learn from patients' and carers' experiences. Care pathways and guidelines are developed with the patient at the centre of care and that improve both the patient experience and clinical outcomes. 	<ul style="list-style-type: none"> Implement a standardised Patient Experience Survey across the THS. Consumers engaged in guideline development and implementation work. Clinical handover processes based on best practice and standardised across the THS. Open disclosure principles and practices. Complaints management processes.
Research <i>Foster innovation and improvement to ensure the highest quality and safety of healthcare within the THS and Tasmania.</i>	<ul style="list-style-type: none"> Develop an overarching research strategy that links all facets of research across THS and informs research priorities. Ensure that research governance is transparent and supports excellence in research. The translation of research evidence into clinical practice to deliver care based on the best available evidence is facilitated and encouraged. 	<ul style="list-style-type: none"> The following actions will support THS research strategy development: <ol style="list-style-type: none"> Undertake review of research governance. Outcomes of the review informs research strategy development. Develop a communication strategy to inform researchers of revised processes. Ensure the THS Human Research Ethics Committee (HREC) is Harmonisation of Multi-Centre Ethical Review (HoMER) accredited. Site specific assessment processes for research are robust and a standardised process is applied across the THS that is consistent with the Tasmanian Role Delineation Framework (TRDF). Suite of research KPIs developed and monitored to ensure best practice approach to research.

Principle 1 – No Harm

Three key areas of focus were identified for the “no harm strategy” including the development of a clear policy framework for the THS on how to report and manage adverse events, a system for analysing adverse events to identify areas of system level improvement and education and training for key staff in Root Cause Analysis methodology.

Root Cause Analysis (RCA) is an internationally recognised approach to the analysis of serious clinical incidents such as unexpected death and serious injury. It is used effectively by modern health systems across the world to retrospectively analyse the sequence of events, identify any contributing factors, and to make recommendations to prevent similar events happening again. RCA was introduced to Tasmania in September 2016 with a series of two day workshops across the state and supported by a train the trainer program and specifically designed training resources to ensure the sustainability of the training across the state. Around 100 clinical staff were trained in this methodology by experienced trainers in the field from St Vincent’s Health Australia.

The workshops evaluated very strongly with a 71% improvement in knowledge and skills after the training, in relation to the following questions;

- I know the key steps to undertaking an RCA
- I feel comfortable in participating in an RCA.

RCA training pocket guide to incident management

An Integrated Risk Register was deployed during the year to encompass statewide and local risks into a single database developed as a module of the Safety Reporting and Learning System (SRLS).

The THS SRLS Integrated Risk Register was configured to meet THS specifications and the business requirements of the THS Risk Management Policy. The risk register was implemented across the THS on 1 December 2016 with a three month transition period

enabling local and statewide risks to be reviewed and transferred to the risk register. THS site coordinators conducted education and training sessions for managers, directors and service area teams during the transition period and ongoing support for staff continues to be coordinated by the THS patient safety service teams. THS staff implementation of the risk management program and integrated risk register is demonstrable through high level participation in education and training sessions and their ongoing review, management and communication of risks using the SRLS risk register.

The SRLS risk register is now the only reporting mechanism for the communication, listing, management and reporting of risks across THS. This includes the reporting and escalation of risks through THS integrated risk and quality governance structures.

Mayo Clinic Collaborative – Learning from every death

The THS has been working in collaboration with a team of researchers from the famous Mayo Clinic in Rochester Minnesota since April 2016 to trial their method for undertaking death reviews.

The Mayo Clinic has reviewed more than 10 000 consecutive deaths over 12 years using their multidisciplinary, multi-specialty review process. They have identified that 16.6% (95% CI: 15.7-17.5) of all patient mortalities are associated with one or more process of care failures. More than 80% of these are omissions of care; as opposed to the commissions considered to be a more traditional definition of adverse events. Several meaningful system changes have been made as a result of this work.

Mayo Clinic mortality review leadership believes that they have mined nearly all of the knowledge possible from studying deaths. It is time for the next generation tool that will:

1. facilitate learning from all patients in any setting
2. identify common causes for process of care failures.

Dr Jeanne Huddleston, Physician and clinical researcher at the Mayo Clinic has led the development of this methodology for death review that is multidisciplinary and supported by a purpose built information technology solution to enable higher level learning from every death. Her work has been published in international medical journals.

The THS four main hospitals – Launceston General Hospital, Mersey Community Hospital, North West Regional Hospital and the Royal Hobart Hospital, are all participating in this international collaborative research project to improve inpatient care for Tasmanians. During April 2017, Dr Huddleston conducted a series of introduction and reviewer training sessions across the THS outlining the aims of the research program and introducing staff to the case review process for death reviews in the THS acute care setting.

The THS is currently the only participating site in Australia or New Zealand along with a number of large health care systems in the USA. The work will be presented at an international conference in the USA in December 2017.

Principle 2 – Effective Clinical Governance

Clinical Governance was first defined by Scally and Donaldson in 1998 as “a framework through which ... organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”.¹

This broad statement is generally accepted to encompass a partnership between clinicians, executive and Board with a shared accountability, active participation by both clinicians and managers in evaluation and improvement and action to ensure there are systems in place that provide an environment that fosters quality, monitor quality of care, reports to a Board that monitors quality, minimises risk, identifies deficiencies in quality and effectively addresses these deficiencies.

At an organisational level this generally includes:

1. A policy framework that sets the standards.
2. Organisational structure that sets the accountability framework including delegations and reporting lines.
3. Committee structure that provides the mechanism for effecting clinical governance.
4. Performance and reporting framework that provides the measurement and accountability framework.

Snapshot on Policy

In May 2016 there were 3 907 policies in effect across the state with many duplicates and local variations. There was a clear strategic intent to move to a single suite of contemporary and evidence based policies across the state through a process of review and rationalisation. By 30 June 2017 there were 2 529 policies in effect. Key to this approach was the development of portfolios assigned to policy coordinators across the state.

The following list of policy portfolios (projects) represent the transition to a single suite of statewide policy documents that have been achieved as at June 2017:

- Burns suite
- Health Information Management Services suite
- Finance suite
- Mental Health – first stage
- Oral Health suite
- Human Resources
- Work Health and Safety.

There are a number of policy portfolios (projects) in progress:

- Transfusion/Blood suite
- Infection Control
- Medication Reform

- Alerts (Clinical)
- Patient Family Activated System
- Goals of Care
- Advanced Care Directives
- Grandfathered/DHHS
- Alerts and Recall.

There are a number of policy portfolios (projects) that recently commenced in June/July 2017 and are currently in various stages of development and consultation:

- Admission, Transfer and Discharge (including Discharge Summaries)
- Coroners Case
- Consent (including learning module)
- Open Disclosure (including learning module)
- Look Back
- Allied Health
- NSQHS Standards - Patient ID/ Clinical Communication
- Trauma suite
- Breast Screen suite
- Urology suite
- Endocrine suite
- Mental Health – second stage
- Media and Communications.

Focus on Credentialing

One of the key policies developed for the THS was the Clinical Credentialing and Defining Scope of Clinical Practice for Health Professionals protocol. This protocol builds on the National Standard for Credentialing and Defining the

Scope of Clinical Practice² to have a consistent statewide approach to meet the requirements of the National Registration and Accreditation Scheme (NRAS) and the National Safety and Quality Health Service Standards (NSQHS)⁴ Standard 1: Governance for Safety and Quality in Health Service Organisations which requires health service organisations to 'implement a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of clinical practice for the clinical workforce' (Actions 1.10.1–1.10.5)³.

Standard for Credentialing and Defining the Scope of Clinical Practice - Australian Council for Safety and Quality in Health Care (2004)
National Registration and Accreditation Scheme (NRAS) - Department of Health (2010)
Standard 1: Governance for Safety and Quality in Health Service Organisations (2012)

The THS is committed to ensuring there is strong governance and accountability in the delivery of publicly-funded health services. Under the Charter of Healthcare Rights, consumers have a right to be cared for by health professionals who are appropriately trained and working within their scope of clinical practice. A comprehensive system of credentialing and defining the scope of clinical practice is one mechanism by which the community can be assured that a competent clinical workforce services the health sector.

It is essential that all health professionals who have independent, advanced and/or extended scope of responsibility for patient care within health services in Tasmania are appropriately credentialed and have their scope of clinical practice defined in accordance with their level of skill and experience and the capability and need of the health service.

Notes:

2. Standard for Credentialing and Defining the Scope of Clinical Practice - Australian Council for Safety and Quality in Health Care (2004)

3. National Registration and Accreditation Scheme (NRAS) - Department of Health (2010)

4. Standard 1: Governance for Safety and Quality in Health Service Organisations (2012)

The implementation of the Credentialing Protocol was supported by two key initiatives during 2016-17:

1. The implementation of a single statewide Credentialing committee replacing three local hospital committees and a fourth committee that performed credentialing for GPs in rural inpatient facilities outside of the THS governance structures. The THS Credentialing Committee has met monthly since its first meeting in November 2016.
2. The acquisition of a commercial database product by the Mercury group of companies in September 2016. Mercury eCredential is currently used by health services in NSW, South Australia, Western Australia and some hospitals in Victoria and Queensland. Following a period of local configuration the database was deployed statewide in March 2017 and since April 2017 all THS Credentialing and Defining Scope of Clinical Practice Committee meetings have been conducted in the electronic environment.

All medical practitioners with independent responsibility for patient care, as well as nursing and allied health professionals with an extended scope of clinical practice are subject to the credentialing process on appointment, and at regular intervals throughout their employment/appointment but at least every three to five years or when a change to scope of clinical practice is sought.

Lawlex Legislation Alert

The THS has implemented the Lawlex Legislation Alert service which monitors and summarises in plain English the changes to and introduction of new legislation and regulations in every Australian jurisdiction, tracking and annotating to section level. The Lawlex Legislation Alerts are triggered based on the legislative profile of each user, emailed within 24 hours of notification.

The Lawlex Premium Research website (www.my.Lawlex.com.au) is used for searching and locating legislation, amendments and other primary source materials across all Australian jurisdictions and links to the official government websites for each jurisdiction.

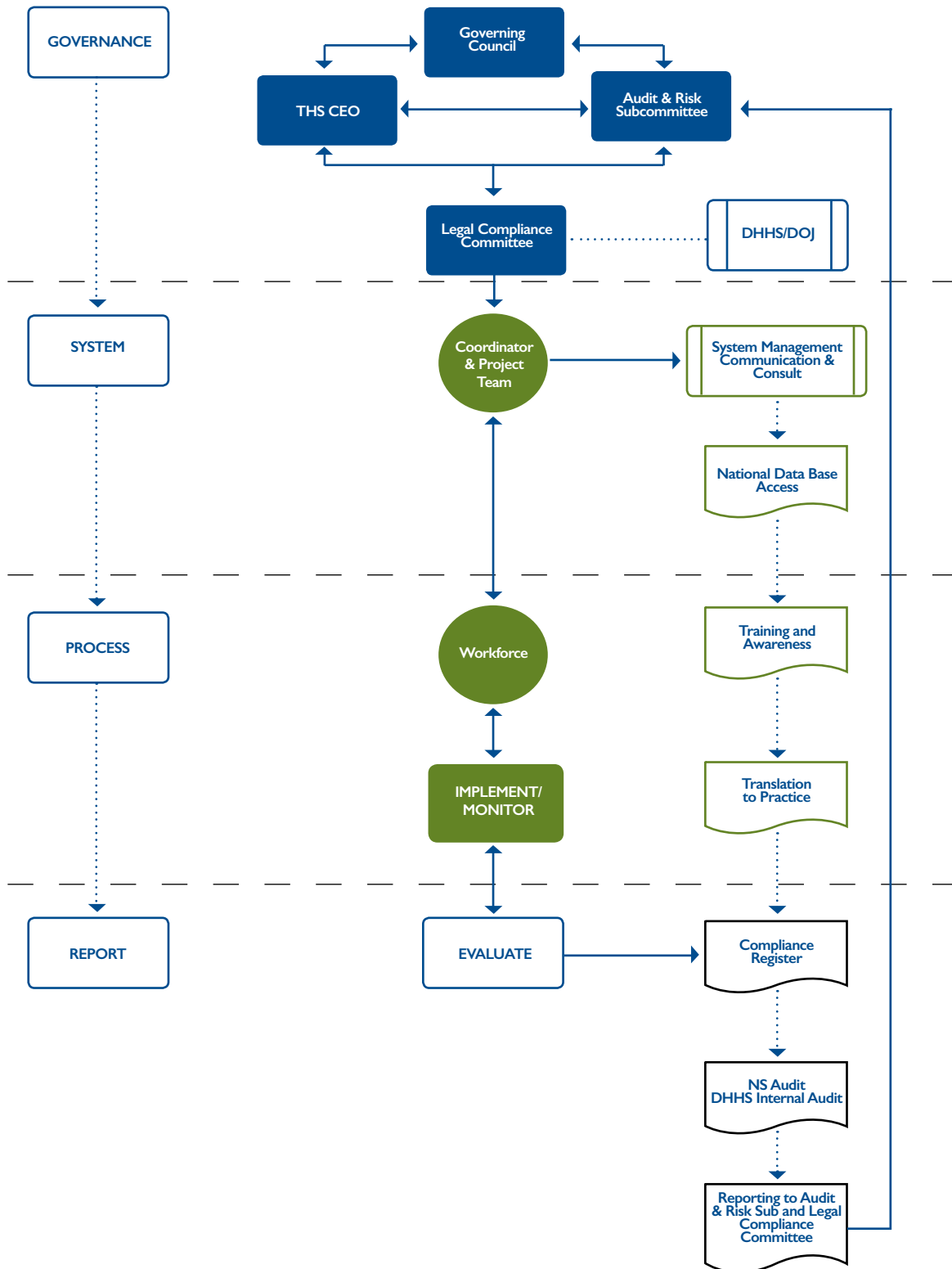
An interim tracking and monitoring register has been developed, through spreadsheet to monitor the:

- Potential impacts/reviews on current operational systems and policy/document (if any)
- Appropriate translation to practice from notification to implementation/finalisation
- Communication to the workforce.

To ensure compliance with the *Archives Act 1993* (Tas) and NSQHS Standard 1 Governance, two existing organisational systems, TRIM (Corporate Document Management System) and SRLS (Safety Reporting and Learning System), are being considered and reviewed for their capability and functionality to disseminate workflow notifications to relevant people for implementation and to close off actions.

Flowchart on next page outlines the process that has been implemented across the THS to manage the notifications that have been received through the Lawlex notification system and tracked through the Legal Compliance Register.

The flowchart below outlines the process that has been implemented across the THS to manage the notifications that have been received through the Lawlex notification system and tracked through the Legal Compliance Register.



Accreditation

Area	Service	Accreditation cycle	Comments
THS South	Midlands Multipurpose Health Centre – Residential Aged Care	Federal Government - Aged Care Standards	Full 3 years Accreditation Apr 2015 – Apr 2018 Full Audit Spot Audit Jan 2017
THS South	Community Nursing Centres (9) Home Care South Allied Health Community – Podiatry, Physiotherapy and Speech Pathology	Federal Government – (Aged Care) Home Care Common Standards	Full 3 years Accreditation Jul 2017 – Jul 2020
THS South	Mental Health – South Alcohol and Drug Statewide Services Forensic Health Statewide Services including Correctional Health Statewide Services	National Safety and Quality Health Service Standards	Full 4 years Accreditation Mar 2017 – Apr 2021
THS South	Oral Health Services Tasmania	National Safety and Quality Health Service Standards	Full 4 years Accreditation Mar 2016 - Apr 2020
THS South	Acute, Sub-Acute, Community Nursing - South	National Safety and Quality Health Service Standards	Full 4 years Accreditation Nov 2015 - Mar 2019
THS North West	District Hospitals (Smithton, King Island, Queenstown)	Organisational Wide Survey Jul 2016 National Safety and Quality Health Service (NSQHS) Standards	Four years accreditation awarded. Valid until 23 Aug 2020
THS North West	Community Health Nursing and Home Care Services	Organisational Wide Survey Oct 2016 NSQHS Standard 1 – 10, with documented exclusions	Full 3 year accreditation awarded. Valid until Nov 2019
THS North West	Lyell House (Queenstown)	Contact Visit Australian Aged Care Quality Agency (AACQA) Accreditation Standards	Unannounced visit completed Nov 2016
THS North West	Acute Hospitals – NWRH and MCH	Self-Assessment	Jan 2017 Progress assessment identifying changes in previous 12 months and progress towards previous recommendations
THS North West	Netherby Home (King Island)	Contact Visit Australian Aged Care Quality Agency (AACQA) Accreditation Standards	Unannounced visit completed Mar 2017
THS North West	Primary Health North – Rural Inpatient Facilities (8)	EQulPNational National Safety and Quality Health Service Standards	Organisation wide survey 2014 – full accreditation. Periodic Review Apr 2016 – full accreditation achieved
THS North	Launceston General Hospital and Mental Health North	National Safety and Quality Health Service Standards	Full 3 years accreditation Mar 2015
THS North	Primary Health North – Community Centres – HACC Services	Federal Government – Aged Care Quality Agency - Home Care Common Standards	Full 3 year accreditation Apr 2015
THS North	Primary Health North – Residential Aged Care Facilities – one facility – Flinders Island Multipurpose Centre	Federal Government – (Aged Care)	Full 3 years Accreditation Assessment dates: • 3 May 2016 (Announced) • 24 Apr 2018 (Unannounced)

Principle 3 – Exceptional Care

The Australian Commission on Safety and Quality in Health Care is a Commonwealth Government Agency that leads and coordinates national improvements in safety and quality in health care across Australia. The Commission has developed a number of clinical care standards over the past three years including:

- Antimicrobial Stewardship
- Acute Coronary Syndromes
- Acute Stroke
- Delirium
- Heavy Menstrual Bleeding
- Hip Fracture Care
- Osteoarthritis of the knee
- Venous Thromboembolism.

A further standard on Colonoscopy Quality and Safety is currently under development.

Clinical Care Standards can play an important role in delivering appropriate care and reducing unwarranted variation, as they identify and define the care people should expect to be offered or receive, regardless of where they are treated in Australia. The THS through the Exceptional Care Strategy aims to implement these national standards across Tasmania in a structured and coordinated fashion to ensure that care provided in the THS is guided by the best available evidence. During 2016 work commenced on the implementation of the first of these standards – Acute Coronary Syndrome - through the development of the HeartSafe project and also the draft colonoscopy clinical care standard via the Colonoscopy Access Strategy project. Both of these projects will continue in 2017.

Snapshot Colonoscopy Access Strategy (CAS) Project

- The CAS Project was initiated in August 2016 following development of a discussion document Patients First Colonoscopy Access Strategy 21 June 2016 addressing the increasing number of patients at the time waitlisted for services and the number of patients waiting longer than clinically recommended for procedures.
- In October 2016, The ACSQHC released a Draft model: A safety and quality model for colonoscopy service in Australia.
- An injection of \$3 million by the State Government in 2016-17 has enabled the THS to review an additional 1 544 patients who were waitlisted for colonoscopy services statewide.
- Waiting list data was comprehensively reviewed through improved mechanisms for reporting, monitoring and managing those patients who are waitlisted resulting in a decrease in the number of patients waiting for care.
- Further initiatives are planned over the coming six months in readiness for the implementation of the Clinical Care Standard.

Principle 5 – Patient Centred Care

Studies show that when providers of health services work in partnership with the patient, their family and/or carer the quality and safety of health care improves⁵. There is evidence of decreased re-admission rates and health care acquired infections along with reduced length of stay and reduced medical errors, improved delivery of preventative care services and adherence to treatment regimens⁶. Medical costs are suggested to be 8-21% more for patients who are not actively engaged in their own health care⁷.

In 2016-17 the THS implemented three key strategies to meet the principle of Patient Centered Care:

1. Patient Stories

All THS Quality and Safety Committee meetings and Governing Council Quality and Safety Subcommittee meetings begin with a patient story. These stories have helped to highlight and facilitate a precise focus on where quality improvement is needed. To further enhance this strategy the Patient Stories Video Project commenced in February 2017 utilising the medium of video to capture patients experiences during their hospital stay along with the patients' perceptions of the factors contributing to patient safety. These videos with the patient and family members consent will contribute to organisation wide learning and provide a vivid teaching tool to assist clinical staff to better understand how patients and their family perceive the quality of their care.

2. Statewide Patient Experience Survey (PES)

In late 2016, a request for quotation was sought to identify survey providers to partner with the THS to enable a continuous survey and quarterly reporting against national Core Common Questions for Patient Experience and the US based HCAHPS questions allowing national and international benchmark comparisons. Press Ganey and Associates, an experienced provider of Patient Experience Surveys in Australian Hospitals began working with the THS in 2017 with the first surveys sent out in June 2017.

3. Consumer Engagement Committees/ Consumer Reference Groups

There are three regionally based consumer engagement committees. In the north of the state, the THS Community Advisory Council (CAC) actively provides a consumer, carer and community perspective across varied areas including, during 2016-17:

- Development of Patient Centred Care framework of 'The Patient Will See You Now' to consolidate current and new person centred care initiatives and inform an agreed direction for the provision of person centred care practices across the organisation.
- Patient Stories Video Project – a focus on quality improvement inspired by patient experiences. Videos will be used as a learning tool with key message points to facilitate discussion and learning outcomes.
- Wayfinding resources developed; audits conducted at LGH and all Rural Inpatient Facilities by CAC members to identify opportunities to assist consumers who access our health facilities.
- Food Services Working Group (Right Patient Right Meal).
- Participation in Allied Health and Pathology refurbishment.
- Member of THS interview panels for senior staff positions.
- Health Literacy – review of written material developed for patients, families or carers.
- Participation in staff induction and orientation program.
- Review of patient complaints and the response provided to complainants to ensure transparency and accountability in this process.

Notes:

5. International Alliance of Patients' Organisations. What is Patient – Centred Health Care? A review of definitions and Principles. Second ed. London: IAPO, 2007: 1-34.
6. ACSQHC Standard 2 (2011 & 2012). Downloaded February 24th 2016
7. Hibbard, J, Green, J and Overton, V. (2013) Patients With Lower Activation Associated with Higher Costs; Delivery Systems Should Know their Patients' 'Scores'. Downloaded 30th December 2015 <http://content.healthaffairs.org/content/32/2/216?right> Volume 32 Issue 2

- Review of organisational audit results.
- Ongoing review of policies and protocols.
- Attendance at varied site and service meetings.
- Peter Sullivan appointed as a representative on the Governing Council subcommittee.
- Consumer engagement intranet page.
- Patient Family Escalation.

In the South of the state, the THS Consumer Engagement Committee (CEC) is comprised of very committed and passionate individuals who ably represent our health consumers and over the 2016-17 year have achieved:

- Review of over 150 separate documents such as information pamphlets and patient surveys, destined for consumer use. CEC members provide the document authors with constructive feedback with the aim of ensuring any consumer information materials are as user-friendly as possible.
- Advocated for patients and consumers who use the Hobart City Council-owned car park next to the Wellington Centre to lobby the council to have a Parking Ticket Pay Machine more easily accessible on the same level as the Clinics. Following 12 months of discussion, the Council has approved the installation of a machine.
- As part of their assistance in implementing the Arts in Health Program, CEC have been instrumental in the development of “pop-up singers”; a way of providing our patients and their families and carers with unexpected but very welcome, music throughout various sites of the RHH Campus.
- Diversified their membership to now include representation from the Tasmanian Prison Correctional Health Consumer Group and COTA - for older Australians.
- Working with front-line staff to improve our service to initiate a trial of protected mealtimes and meal assistance at the

RHH. Staff had identified that patients were constantly being interrupted during meal times to either have their blood taken, observations taken, clinical handover etc. Protected mealtimes will allow staff to dedicate all their attention to patients without these type of interruptions occurring. As part of the meal assistance program, coloured trays have been implemented to provide staff with a visual cue to identify those patients who need help and support from staff to eat their meals or have a poor dietary intake, and assist with opening packaging and pouring drinks.

Achievements of the Consumer Engagement Reference Group (CERG) in the North West during 2016-17 were guided by the CERG Quality Plan 2016-17 and included:

- Improving links and interaction with identified gaps in membership, such as young mothers and students via Youth Health Services and disability and multicultural persons via the Multicultural and Health Diversity Liaison Officer.
- Continued representation on committees and participation in audits including wayfinding.
- In response to community feedback to members, the management of patients' own medication, dispensing and discharge medications was referred to Pharmacy for investigation. The desired outcome to reduce the instances of patients needing to replace medication occurred and a brochure 'Use of Your Own Medicines while in Hospital' was produced to inform patients of the process and ensure patients were experiencing best practice.
- A large body of work occurred around the experience of staff and other patients in relation to visitors and overcrowding of a ward area. Survey results were discussed and brain storming occurred with the Nurse Unit Manager. Co-Director of Nursing - Medical and Surgical work-shopped issues identified

with nursing staff prior to attending CERG meeting. Possible solutions were identified.

- CERG members participated in forums, feedback sessions, panels or interviews on issues affecting or impacting on the delivery of services with the region.

Principle 6 - Research

The THS fosters innovation and improvement to ensure the highest quality and safety of Healthcare within the THS and Tasmania. For more information about education, research and clinical trials presently underway within the THS, refer to page 95.

Operational Framework

During late 2016, a new service model was developed with Quality and Safety staff and other key stakeholders that will provide the necessary clinical governance structure to support clinicians to provide safe and high quality health services to the Tasmanian Community.

The model consolidates three regional health Safety and Quality services into a single statewide Patient Safety Service with joint governance and leadership of the service throughout the THS.

The new Patient Safety Service led through the Office of the CEO by the Executive Director for Patient Safety incorporates five work streams:

- **Prevention and incident management:** includes the review and action for safety events that harm or have the potential to cause harm to patients in order to prevent them from happening again.
- **Innovation and Improvement:** will lead the THS development and implementation of innovative projects and programs to improve the quality of patient care; this workstream will also support an annual quality awards process.
- **Regulation:** includes responsibility for hospital accreditation such as national standards,

legislative compliance, credentialing, and policy development and implementation.

- **Consumer Engagement:** includes the management of all consumer complaints to the health system, coordination of patient experience surveys and working with consumers to ensure they are true partners in their healthcare.
- **Data and Information Management:** will support the patient safety service as a whole with up to date data and information.

The new service is planned to commence early in the 2017-18 financial year.

ELECTIVE SURGERY



The THS had achieved a further reduction in the elective surgery waiting list. The waiting list is now at a record low since data collection began.

Over the past 12 months, the THS has performed additional surgeries to reduce the waiting list to 5 430, down from 5 758 in June 2016; but a reduction of 3 100 people since June 2015.

During the 2016-17 financial year, the THS exceeded its annual target for surgeries by 331; delivering a total of 19 180 surgeries.

The THS made the following key achievements for elective surgeries during 2016-17:

- Reducing the waiting list from 5 779 to 5 416
- Reducing the number of patients waiting longer than clinically recommended from 1 222 to 794 in June 2017.
- Reducing the number of patients waiting for surgery for more than 400 days from 320 patients in June 2016 to 12 patients in June 2017, and
- Reducing the average overdue days from 146 days in June 2016 to 69 in June 2017.

To deliver these additional surgeries, the Tasmanian Government invested significant additional funding to boost elective surgery with its \$76 million election commitment. In addition to this, the Government is investing a further \$14.3 million in funding for elective surgeries and endoscopies, which includes \$6.4 million of Commonwealth funding.

Under the One Health System reforms, the THS is directing this funding towards opening more theatres, recruiting additional specialists and surgical support staff and is making better use of the hospital system to reduce waiting times.

The THS is implementing strategies to ensure that the people who have waited the longest for surgery are able to access surgery. To improve waiting times the THS has developed partnerships with private providers to provide surgeries to public Tasmanian patients in private facilities under a contract arrangement.

The THS will continue to look for innovative ways to ensure that Tasmanians can access surgery within clinically appropriate times and ensure patients receive equitable care which facilitates improved health outcomes.

OUR PERFORMANCE

PERFORMANCE AGAINST SERVICE AGREEMENT

In accordance with Section 44 of the *Tasmanian Health Organisations Act 2011* the Service Agreement between the Minister for Health and the THS Governing Council clearly sets out the service delivery and performance expectations for the funding provided to the THS for the 2016-17 financial year. As such, the Service Agreement is the key accountability agreement between the Minister for Health and the THS.

The 2016-17 Service Agreement for THS consisted of:

- Part A Tasmanian Public Sector Health System – Accountabilities
- Part B THS Profile
- Part C THS Key Performance Indicators
- Part D THS Funding Allocation and Activity Schedules.

THS Service Agreement 2016-17 performance

Performance Domain	KPI No.	KPI Name	KPI Target	1 st Quarter Result	2 nd Quarter Result	3 rd Quarter Result	4 th Quarter Result	Comments
Acceptability	AC1	Consumer experience - % of clients surveyed						Indicators not developed by DHHS
	AC2	Consumer experience – consistent and coordinated care						
	AC3	Consumer experience – discharge planning						
Accessibility	ACC1	Percentage of Triage I emergency department presentations seen within recommended time	100% (all specified facilities)					Target achieved by all facilities in each quarter
			RHH	100%	100%	100%	100%	
			LGH	100%	100%	100%	100%	
			NWRH	100%	100%	100%	100%	
			MCH	100%	100%	100%	100%	
	ACC2	Percentage of all emergency department presentations seen within recommended time	80% (all specified facilities)					Target not achieved in any quarter across all facilities
			RHH	60%	59%	58%	60%	
			LGH	69%	63%	71%	71%	
			NWRH	68%	72%	67%	72%	
			MCH	64%	65%	70%	77%	
	ACC3	Percentage of all emergency department presentations who do not wait to be seen	≤5% (all specified facilities)					Target achieved by all facilities in each quarter
			RHH	3%	4%	3%	2%	
			LGH	4%	5%	3%	2%	
			NWRH	4%	3%	3%	2%	
			MCH	3%	4%	3%	2%	
	ACC4	Percentage of all emergency patients with an ED length of stay less than four hours	80% (all specified facilities)					Target not achieved in any quarter across all facilities
			RHH	65%	63%	61%	62%	
			LGH	61%	59%	59%	62%	
			NWRH	64%	68%	66%	68%	

Performance Domain	KPI No.	KPI Name	KPI Target	1 st Quarter Result	2 nd Quarter Result	3 rd Quarter Result	4 th Quarter Result	Comments
			MCH	74%	76%	77%	78%	
	ACC5	Percentage of patients admitted through the ED with an ED length of stay less than eight hours	90% (all specified facilities)					Target not achieved in any quarter across all facilities
			RHH	68%	68%	63%	65%	
			LGH	51%	53%	50%	58%	
			NWRH	63%	69%	67%	72%	
			MCH	73%	82%	79%	82%	
	ACC6	Percentage of all ED patients with an ED length of stay less than 24 hours	100% (all specified facilities)					Target not achieved in any quarter across all facilities
			RHH	99.3%	99.2%	98.9%	98.7%	
			LGH	97.1%	98.4%	98.1%	97.8%	
			NWRH	99.7%	99.8%	99.9%	99.7%	
			MCH	99.6%	99.9%	99.9%	99.9%	
	ACC7	Elective Surgery - Average overdue days	Dec 16: 120 Jun 17: 69 (Statewide)	76		69		Target achieved in both six month periods
	ACC8	Elective Surgery - Maximum wait time	Dec 16: 550 Jun 17: 400 (Statewide)	679		520		Target not achieved in either six month period
	ACC9	Elective Surgery Category 1 admitted within the recommended time	Dec 16: 90% Jun 17 90% (Statewide)	80%		78%		Target not achieved in either six month period
	ACC10	Elective Surgery Category 2 admitted within the recommended time	Dec 16: 60% Jun 17: 70% (Statewide)	64%		59%		Target achieved in first six month period
	ACC11	Elective Surgery Category 3 admitted within the recommended time	Dec 16: 70% Jun 17: 80% (Statewide)	78%		81%		Target achieved in both six month periods
	ACC12	Elective Surgery Category 2 treat in turn rates	Dec 16: 45% Jun 17: 45% (Statewide)	32%		37%		Target not achieved in either six month period
ACC13	Elective Surgery Category 3 treat in turn rates	Dec 16: 45% Jun 17: 45% (Statewide)	46%		49%		Target achieved in both six month periods	
ACC14	Percentage of all Aged Care Assessment Team (ACAT) clients seen 'on time' in all settings	85% (Statewide)					Data unavailable due to issues transitioning to the Commonwealth database	
ACC15	Proportion of 'Emergency' clients managed on the same day that they are triaged (Oral Health)	80% (Statewide)	96%	97%	97%	97%	Target achieved in all four quarters	
ACC16	Percentage of clients assessed within 28 days of screening mammogram	>90% (Statewide)	88%	99%	82%	72%	Target achieved in one of four quarters	
ACC17	Count of over boundary patients (elective surgery)	Jan-Jun: 600 (Statewide)	1 069		837		Target not achieved	
Effectiveness	EF1	28 Day re-admission rate (Mental Health)	≤13.9% (all specified regions) (Statewide)	17%	15%	13%	9%	Target achieved in two of four quarters
	EF2	Acute 7 day post discharge community care (Mental Health)	75% (all specified regions)	76%	77%	82%	77%	Target achieved in all four quarters
	EF3	28 Day Readmission Rate – all patients (excludes mental health patients)	<5% (all specified facilities)					Indicator not developed by DHHS

Performance Domain	KPI No.	KPI Name	KPI Target	1 st Quarter Result	2 nd Quarter Result	3 rd Quarter Result	4 th Quarter Result	Comments	
Efficiency	EFF1	Admitted patient episode coding (clinical coding) including contracted care - timeliness	100% within 42 days of separation (Statewide)	100%	100%	79%	100%	Target achieved in two of three quarters available for reporting	
	EFF2	Admitted patient episode coding (clinical coding) including contracted care - accuracy	100% within 30 days of advice of error from the Department (Statewide)	100%	100%	100%	100%	Target achieved in all three quarters available for reporting	
	EFF3	Ambulance offload delay - 15 minutes	85% within 15 mins (all specified facilities)						
			RHH	87%	87%	82%	82%	Target achieved in two of four quarters	
			LGH	94%	95%	92%	91%	Target achieved in all four quarters	
			NWRH	87%	91%	91%	91%	Target achieved in all four quarters	
			MCH	88%	90%	92%	92%	Target achieved in all four quarters	
	EFF4	Ambulance offload delay - 30 minutes	100% within 30 mins (all specified facilities)						
			RHH	92%	91%	88%	86%	Target not achieved in any quarter across all facilities	
			LGH	97%	97%	95%	94%		
			NWRH	92%	95%	95%	96%		
			MCH	93%	94%	97%	96%		
	EFF5	Hospital initiated postponements (HIPs)	Dec 16: 12.6% Jun 17: 12.6% (Statewide)	12%		12%		Target achieved in both six month periods	
Safety	SAF1	Hand Hygiene compliance	≥75% increasing to 80% from 1/1/2017 (all specified facilities)						
			RHH	81%		81%	Result not yet available	Performance reported tri-annually through the Tasmanian Infection Prevention and Control Unit (June, March, October) Target not achieved by two facilities in one of two periods available for reporting	
			LGH	80%		81%			
			NWRH	80%		78%			
			MCH	80%		79%			
	SAF2	Healthcare associated staphylococcus aureus (including MRSA) bacteraemia infection rate	≤2.0 per 10 000 patient days (all specified facilities)						
			RHH	0.8	1.8	0.8	Result not yet available	Performance reported through the Tasmanian Infection Prevention and Control Unit Target achieved by all facilities in two periods available for reporting	
			LGH	0.6	0.3	0.9			
			NWRH	1.8	0.9	1.0			
			MCH	0.0	6.2	0.0			
	SAF3	Seclusion rates	< 8 per 1 000 patient days (all specified regions) Statewide	17	5	14	8	Target achieved in two of four quarters	
	SAF4	Percentage of discharge summaries transmitted within 48 hours of separation	100% (Statewide)	Result unavailable	76%	66%	64%	Target not achieved in any of the three quarters available for reporting	
	SAF5	Percentage of Initial Reportable Event Briefs sent to the Department's Clinical Governance Officer within the defined timeframe	80% (Statewide)	50%	100%	50%	Result not yet available	Target achieved in one of the three quarters available for reporting	
SAF6	Percentage of Reportable Event Brief Investigation	80%	0%	0%	0%	Result not yet	Target not achieved in any of the three quarters		

Performance Domain	KPI No.	KPI Name	KPI Target	1 st Quarter Result	2 nd Quarter Result	3 rd Quarter Result	4 th Quarter Result	Comments
		Reports sent to the Department's Clinical Governance Officer within the defined time frame	(Statewide)				available	available for reporting
Activity	ACT1	Acute admitted raw separations	95 580 (Statewide)	23 928	48 138	72 334	99 258	Target exceeded
	ACT2	Acute admitted inlier weighted units (same day and multi day)	95 889 (Statewide)	24 947	50 207	75 606	101 535*	Target exceeded * Quarter 4 performance indicative only due to 3,700 un-coded records for June (assigned weight of 1.0)
	ACT3	Baseline elective surgery admissions	15 026 (Statewide)	2 872	6 556	10 597	15 277	Target exceeded
	ACT4	Rebuilding Health Services in Tasmania admissions	2 042 (Statewide)	1 011	1 447	1 817	2 047	Target exceeded
	ACT5	Tasmanian Health Assistance Package admissions	1 767 (Statewide)	542	930	1 080	1 793	Target exceeded
	ACT6	State-wide endoscopies - increased funding target	1 500 (baseline of 6 440 and final target of 7 940) (Statewide)				8 289	Target exceeded
	ACT7	Ophthalmology-increased funding target	500 (baseline of 1 120 and final target of 1 620) (Statewide)				1 748	Target exceeded
Finance	FIN1	Variation from funding - full year projected	Expenditure within funding allocation (Statewide)	\$19.6 million deficit				Target not achieved. At 30 June 2017 the THS had a full year budget deficit of \$19.6 million. This was managed within the THS discretionary cash reserves and there was no requirement for budget supplementation.
	FIN2	Cash liquidity	THS Operating Account has a favourable balance (Statewide)	\$36.4 million surplus				Target achieved. At 30 June 2017 the THS had cash reserves of \$36.4 million in its Operating Account. Of this balance \$2.7 million related to discretionary (untied) funding, while the remaining \$33.7 million related to non-discretionary funding, and is therefore tied to specific commitments.



UPGRADE OF LGH CHILDREN'S WARD



The paediatric ward at the Launceston General Hospital will be upgraded to provide first class facilities for patients and their families across the North.

It is the first major work on the area since it was built more than 30 years ago. Planning for the project, which will bring the Paediatric Inpatient Unit (PIU) up to contemporary standards for the care of acutely ill children, is well underway. The new development on level four will incorporate specialist facilities for child and adolescent mental health patients.

The work upgrades the facility to Level 5 for the care of adult mental health patients as flagged in the Government's White Paper One State One Health System.

Current mental health inpatient facilities do not meet best practice guidelines in relation to room sizes and gender and age separation. There is also no communal space to promote socialisation.

Age groups within the unit are currently mixed and can include babies and adolescents in varying ratios

at any one time. Additional space developed for the ward will allow for the separation of younger general medical patients and teenagers, with facilities more appropriate for their care. There will be more single rooms and isolation areas for better infection control and all rooms will have ensuite bathrooms. A family area with lounge and kitchen is part of the plan and extra storage for equipment is included.

The redevelopment of the ward is planned over several stages to avoid disruption to patient care. Work is expected to start in 2018.

The PIU has always received generous community support. The Auxiliary which supports the Unit continues to raise funds to support patients, their families and the staff. For the past six years the Southern Cross Austereo Give Me Five for Kids appeal has also raised tens of thousands of dollars for the Unit enabling the purchase of much needed medical equipment. The Ponting Foundation is another supporter of child health in Northern Tasmania.

SUPPLEMENTARY INFORMATION

CLIMATE CHANGE

Commitment to Reducing Greenhouse Gas Emissions

The Tasmanian Health Service makes a proportional contribution toward Tasmania's greenhouse gas emissions reduction goals.

Total Tasmanian Health Service Emissions

Total THS	Current Position 2016-17		
Activity	Volume		tCO ₂ -e ²
Electricity	107.69	GWh	13 999
Natural gas	44 310	GJ	2 283
Unleaded petrol	444.62	kL	1 028
Diesel fuel	287.11	kL	781
Air travel	1 193	km	7.54
Total THS			19 285



CAPITAL WORKS AND ASSET MANAGEMENT

The THS utilise shared services provided by the Department of Health and Human Services (DHHS) for asset management.

DHHS Asset Management Services (AMS) is responsible for delivering key property management elements of planning, procurement and sustainability for the Tasmanian Health Service (THS).

Capital works are delivered by AMS and the RHH Redevelopment project team.

Many of the capital works projects delivered by AMS are on behalf of the THS.

AMS regularly undertakes projects and initiatives to improve asset management and safety as part of its proactive approach to the ongoing management of departmental and fixed assets.

Major Capital Works Program

In 2016-17, AMS commenced, progressed and delivered a number of significant capital works projects while the RHH Redevelopment project progressed its construction program on the new K-Block on the Royal Hobart Hospital campus.

Major capital works projects completed in 2016-17 include the Launceston General Hospital Allied Health Clinic and Special Care Dental Unit and the provision of a new Mobile Breast Screening Unit.

A new Helipad was constructed on the North West Regional Hospital (NWRH) site to facilitate the Transport initiatives identified under the Governments White Paper. Additionally a Patient Lounge was completed at the Mersey Community Hospital (MCH) and NWRH as part of the larger Health Transport infrastructure initiative, with the Patient Lounge in the LGH nearing completion.

An upgrade of the Ulverstone Oral Health Centre was completed during the year and construction started on a major redevelopment to increase the number of surgeries available at the Archer Street Oral Health Surgery Centre in North Hobart.

Works continued on a number of major projects including the Glenorchy Health Centre.

The St Helens District Hospital received Parliamentary Standing Committee Public Works approval and following an open tender process will commence construction in 2017-18.

Design has progressed for the construction of a new Kingston Health Centre with construction scheduled to commence in 2017-18.

The design and tender for the construction of a new Antenatal Centre at the MCH commenced with construction expected to be completed by the end of 2017.

Completed Major Capital Works 2016-17

Completed Major Capital Works in 2016-17	Total Cost \$'000
Launceston General Hospital – Allied Health Clinics ¹	3 400
National Health and Hospitals Network - Capital - Elective Surgery - Royal Hobart Hospital	3 660
Royal Hobart Hospital Redevelopment Fund	35 000
Rural Breast Screening Clinics	1 268

Notes:

¹ The Launceston General Hospital Allied Health Clinics project includes \$400,000 provided by Oral Health Services Tasmania to fund the completion of an Oral Health Special Care Dental Unit. This is in addition to the \$3 million provided by the State Government.

Ongoing Major Capital Works 2016-17

Ongoing Major Capital Works in 2016-17 ¹	2016-17 Expenditure \$'000	Estimated total cost \$'000	Estimated cost to complete \$'000	Estimated completion year
Essential Maintenance	1 604	N/A	N/A	Ongoing
Glenorchy Health Centre ²	10 635	21 000	6 043	2018
Health and Hospitals Centre Maintenance ³	4 334	8 340	1 861	2018
Health Transport Infrastructure ⁴	2 218	10 000	7 701	2018
Kingston Health Centre ⁵	106	6 500	5 960	2019 ⁶
Launceston General Hospital - Acute Medical and Surgical Unit ⁷	1 086	45 982	514	2018 ⁸
Launceston Integrated Care Centre ⁹	321	22 700	24	2018
Mersey Community Hospital – SCIF Project	38	1 900	1 360	2018
National Health and Hospitals Network - Capital - Emergency Department - Royal Hobart Hospital ^{10,11}	219	3 737	165	2017 ¹²
Royal Hobart Hospital – Inpatient Precinct Project ¹³	59 396	569 200	396 689	2019
Statewide Cancer Services ¹⁴	425	63 274	74	2018 ¹⁵
St Helens District Hospital	984	8 110	7 126	2020
Launceston General Hospital – Ward 4K Upgrade	147	7 850	7 703	2019

Notes:

- This table does not include expenditure prior to 1 July 2016. It reflects 2016-17 expenditure and anticipated expenditure in future periods.
- Completion of the Glenorchy Health Centre (formerly referred to as the Glenorchy Community Health Centre) was temporarily delayed while a review of the Integrated Care Centre model of care was undertaken. Construction commenced in early 2017 and is on track for completion in 2018.
- Projects under this program include the LGH substation upgrade; Launceston Ambulance Station Structural Works; Flinders Island Sewer Upgrade; Fire Systems Protection Upgrade; Body Protection Wiring Rectification; LGH Intensive Care Unit/Emergency Department Lift Upgrade; HPH Chiller and Heat Pump Installations; and Emergency Power Supplies.
- Expenditure for improved infrastructure is associated with changes to patient coordination, transport and accommodation arising from the One Health System reforms.

5. Completion of the Kingston Health Centre (formerly referred to as the Kingston Community Health Centre) was temporarily delayed as a result of ongoing negotiations for land acquisition and while a review of the Integrated Care Centre model of care was completed. Land negotiations and title transfer for the Kingston Health Centre have been finalised. This project is anticipated for completion in 2018-19.
6. The estimated completion date for this project has changed from that reported in last year's Annual Report due to delays in title negotiations.
7. The Launceston General Hospital Medical and Surgical Unit project was initially allocated \$40 million by the Australian Government. The THS has provided supplementation of approximately \$5.0 million, through internal sources. An additional \$960 000 was also contributed from the Crown Land Administration Fund.
8. The estimated completion date for this project has changed from that reported in last year's Annual Report due to payment of project funds.
9. The Australian Government contributed approximately \$15 million towards the project, \$4.5 million was provided by the University of Tasmania and \$3 million provided by the State Government.
10. The National Health Reform initiatives: Elective Surgery, Emergency Department and Sub-Acute were primarily funded by the Australian Government under the National Partnership Agreement on Improving Public Hospital Services.
11. The National Health and Hospitals Network – Emergency Department – Royal Hobart Hospital project experienced delays in acquisition of Emergency Department equipment in 2015-16, and this has impacted the completion date of the project.
12. The estimated completion date for this project has changed from that reported in last year's Annual Report due to payment of project funds.
13. The estimated total cost of this component of the RHH Redevelopment project is \$569.2 million, which reflects \$340 million of Australian Government funding and \$229.2 million of State Government funding. Construction of K-Block will now be finished in 2019 (reported in previous Annual Report as 2018).
14. The total Australian Government commitment to the Statewide Cancer Services project is \$36.3 million, with \$23.9 million funded by the State Government and \$2.8 million provided through donations.
15. The estimated completion date for this project has changed from that reported in last year's Annual Report due to payment of project funds.

Acquisitions

- During 2016-17, DHHS purchased land at 2 Annie Street, St Helens for the new hospital.
- The ownership of the Mersey Community Hospital was transferred back to the Crown from the Commonwealth Government.

In 2016-17, \$265 200 was allocated for essential maintenance to address disability access issues across the DHHS asset portfolio.

Access to the North West Regional Hospital, Clare House in New Town, and Adult Mental Health Services at Mistral Place in Hobart was improved.

Disposals

During 2016-17, the former West Coast Hospital at Queenstown was sold for \$159 091 with net proceeds of \$154 204 to be reinvested in the asset portfolio.

Properties listed for disposal with sale expected in 2017-18 include:

- a Community Hall at 17 Cambridge Road, Bellerive that will be sold to the Clarence City Council; and
- a former Mental Health Services property at 13 Cambridge Road, Bellerive; and
- a former Child Health Clinic in Mole Creek.

A number of DDA compliance audits were also undertaken to continue to identify a future program of improvement works. These audits will continue in future years, and will encompass all DHHS and THS facilities.

Transport

At 30 June 2017, THS operated 496 leased light vehicles, comprising 180 executive vehicles and 316 operational vehicles.

In 2016-17, THS Fleet costs decreased \$230 738 (excluding GST) on vehicle lease costs compared to 2015-16.

Asset Management and the Disability Action Plan

From the built-environment perspective, AMS is a key contributor to the DHHS Disability Action (DDA) Plan.

CONSULTANCIES, CONTRACTS AND TENDERS

The Tasmanian Health Service (THS) ensures procurement is undertaken in accordance with the mandatory requirements of the Treasurer's Instructions relating to procurement, including that Tasmanian businesses are given every opportunity to compete for business. It is THS policy to support Tasmanian businesses whenever they offer best value for money for the Government.

See Table 1 for a summary of the level of participation by local businesses for contracts, tenders and/or quotations with a value of \$50 000 or over (excluding GST). Tables 2 and 3 provide detailed information on consultancies and other contracts with a value of \$50 000 or over (excluding GST). Table 4 provides a summary of contracts awarded as a result of a direct/limited submission sourcing process approved in accordance with Instructions 1114 or 1217. Table 5 provides a summary of contract extensions approved in accordance with Instruction 1115(2). Table 6 provides a summary of contracts where approval to aggregate the procurement was obtained in accordance with Instructions 1119 and 1225.

Table 1 - Summary of Participation by Local Businesses

Below is a summary of participation by local businesses for contracts, tenders and/or quotation processes with a value of \$50 000 or over.

Total number of contracts awarded	47
Total number of contracts awarded to Tasmanian businesses	27
Value of contracts awarded	\$96 363 710
Value of contracts awarded to Tasmanian businesses	\$91 709 965
Total number of tenders called and/or quotation processes run	28
Total number of bids and/or written quotations received	106
Total number of bids and/or written quotations received from Tasmanian businesses	58

Note:

1. In accordance with the requirements of the Treasurer's Instructions, the values in this table do not include the value of options to extend.
2. All values exclude GST.

Table 2 - Consultancies Awarded

The following table provides information on consultancies awarded in the 2016-17 financial year with a value of \$50 000 or over:

Consultant Name	Location	Consultancy Description	Period of Consultancy	Total Value \$
Grosvenor Management Consulting Pty Ltd	ACT	John L Grove Rehabilitation Unit - Service Model Review	14/11/2016 - 31/01/2017	97 707
The Oak Group (UK) Ltd	UK	Tasmanian Health Service - Clinical Utilisation Study	07/08/2017 - 06/10/2017	209 670

Notes:

1. Where an overarching procurement process exists (for example Common Use Contracts and Agency Panel arrangements) individual engagements are not reported.
2. All values exclude GST.

Table 3 - Contracts Awarded

The following table provides information on contracts awarded in the 2016-17 financial year with a value of \$50 000 or over and excludes consultancy contracts.

Contractor Name	Location	Contract Description	Period of Contract	Total Value \$
Advanced Lifecare Pty Ltd	Tas	Launceston General Hospital - Overbed Patient Tables	01/08/2016 (one-off purchase)	99 999
Agfa Healthcare Australia Pty Ltd	Vic	Launceston General Hospital - Provision of Haemodynamic Monitoring and Cardiology Information System	21/03/2017 - 13/07/2027	976 874
Aidacare Pty Ltd	Tas	Royal Hobart Hospital - AED Defibrillators	09/05/2017 (one-off purchase)	168 000
Ambulance Private Pty Ltd	Tas	Panel of Commercial Providers of Non-Emergency Patient Transport	30/09/2016 - 29/09/2018 Option to extend 30/09/2018 - 29/09/2022	0 0
Chappell Dean Pty Ltd t/a Activity BarCoding. Com	NSW	Activity Management System for Nursing and Allied Health Professionals - Ongoing Maintenance	24/09/2016 - 23/09/2019	230 040
Contact Electrical Pty Ltd	Tas	Royal Hobart Hospital - Refrigeration & HVAC Maintenance Services	01/09/2016 - 31/08/2019 Option to extend 1/09/2019 - 31/08/2021	177 420 118 280
Cyclotek (Aust) Pty Ltd	Vic	Royal Hobart Hospital - Radiopharmaceuticals for PET	08/08/2016 - 07/08/2017	700 000
Draeger Medical Australia Pty Ltd	Vic	North West Regional Hospital - Theatre Lights	19/06/2017 (one-off purchase)	126 469
EBSCO International Inc	NSW	Electronic Portal for Online Clinical Help (EPOCH) and Associated Clinical Reference Material – Contract Extension	01/01/2017 - 31/03/2017	59 468
GE Healthcare Australia Pty Ltd	Vic	# Royal Hobart Hospital - Echocardiography System with 3D Capabilities	20/10/2016 - 19/10/2023 Option to extend 20/10/2023 - 19/10/2026	266 487 38 250
GE Healthcare Australia Pty Ltd	Vic	# Launceston General Hospital - Cardiovascular Ultrasound	05/06/2017 - 04/06/2023	257 166
Grace Information and Records Management	Vic	# Secure Storage - Medical and Corporate Records	15/06/2017 - 15/06/2019	92 400
Health Communication Network Pty Limited	NSW	Electronic Portal for Online Clinical Help (EPOCH) and Associated Clinical Reference Material – Contract Extension	01/01/2017 - 31/03/2017	60 758
Healthe Care Burnie Pty Ltd	Tas	North West Maternity Services	01/11/2016 - 31/10/2024 Option to extend 01/11/2024 - 31/10/2029	66 789 353 48 962 352

Contractor Name	Location	Contract Description	Period of Contract	Total Value \$
IBIS No.3 Pty Ltd	Tas	Provision of a Transition Care Program - Flexible Residential Care Packages	01/01/2017 - 31/01/2019 Option to extend 01/02/2019 - 31/01/2021	545 683 545 683
Imbros Pty Ltd	Tas	Launceston General Hospital - Pathology Anaerobic Chamber	23/03/2017 - 22/03/2022 Option to extend 23/03/2022 - 22/03/2027	62 455 25 956
International Teleradiology Corporation Pty Ltd	SA	Teleradiology Services - Oral Health Services	15/02/2017 - 31/10/2019	120 000
Ivoclar Vivadent Pty Ltd	Vic	Supply of Acrylic Resin Artificial Teeth for use in Dental Prostheses	01/04/2017 - 31/03/2020	156 000
Masters Contracting Pty Ltd	Tas	Royal Hobart Hospital - Chiller Upgrade J Block	19/06/2017 - 19/08/2018	224 008
MD Solutions Australasia Pty Ltd	Vic	Launceston General Hospital - Lithoclast System	31/05/2017 - 31/05/2018	71 978
Medical Edge Australia Pty Ltd	Tas	Panel of Commercial Providers of Non-Emergency Patient Transport	30/09/2016 - 29/09/2018 Option to extend 31/09/2018 - 29/09/2022	0 0
MIMS Australia Pty Ltd	NSW	Electronic Portal for Online Clinical Help (EPOCH) and Associated Clinical Reference Material – Contract Extension	01/01/2017 - 31/03/2017	16 062
MMS Security Pty Ltd	Tas	Security Services for Wilfred Lopes Centre	01/08/2016 - 31/01/2018 Option to extend 01/02/2018 - 31/01/2020	1 965 383 2 300 937
Moreton Group Medical Services	Tas	Panel of Commercial Providers of Non-Emergency Patient Transport	30/09/2016 - 29/09/2018 Option to extend 30/09/2018 - 30/09/2022	0 0
Multivac Australia Pty Ltd	Vic	Packing Machine and Accessories - Cambridge Production Centre	31/05/2017 (one-off purchase)	160 000
Paragon Care Group Pty Ltd t/a Scanmedics	Vic	Launceston General Hospital - Holman Clinic - Ultrasound Unit for High Dose Rate Brachytherapy	01/06/2017 - 31/05/2022	188 528
Philips Electronics Australia Ltd	NSW	# Launceston General Hospital - Angiographic Suite - Upgrade and Maintenance	01/07/2016 - 30/06/2021	715 000
Philips Electronics Australia Ltd	Vic	# Royal Hobart Hospital - Mobile Image Intensifiers	01/04/2017 - 30/06/2023	507 500
Press Ganey Associates Pty Ltd	Qld	Patient Experience Survey	11/04/2017 - 11/04/2018	197 012

Contractor Name	Location	Contract Description	Period of Contract	Total Value \$
RBD Contracting Services Pty Ltd	Tas	Royal Hobart Hospital - Master Clock System Replacement	07/07/2017 - 29/09/2017	113 316
Regethermic Australia	NSW	Launceston General Hospital - Pneumatic Food Pump Filler	09/05/2017 (one-off purchase)	68 479
Regional Imaging Pty Ltd	Vic	# Launceston General Hospital - Provision of Radiologist Services	18/07/2016 - 17/07/2021 Option to extend 18/07/2021 - 17/07/2026	13 900 000 16 000 000
Royal Flying Doctor Service Tasmania Inc	Tas	Panel of Commercial Providers of Non-Emergency Patient Transport	30/09/2016 - 29/09/2018 Option to extend 30/09/2018 - 29/09/2022	0 0
Siemens Healthcare Pty Ltd	Vic	# Launceston General Hospital - Supply and Installation of Digital Radiography Machines	04/09/2017 - 03/09/2027	1 099 600
Siemens Healthcare Pty Ltd	Vic	# Launceston General Hospital - MRI Upgrade and Maintenance	30/09/2017 - 29/09/2027	2 213 000
Siemens Healthcare Pty Ltd	Vic	# Launceston General Hospital - Ultrasound Machines	01/11/2016 - 30/10/2021	291 600
Siemens Healthcare Pty Ltd	Vic	Royal Hobart Hospital - Haemodynamic Monitoring Equipment	12/05/2017 (one-off purchase)	125 000
Siemens Healthcare Pty Ltd	Vic	# Royal Hobart Hospital - CT Scanner - Service Maintenance Agreement	11/10/2016 - 10/10/2017	157 000
St John Ambulance Tasmania	Tas	Panel of Commercial Providers of Non-Emergency Patient Transport	30/09/2016 - 29/09/2018 Option to extend 30/09/2018 - 29/09/2022	0 0
Taleb Enterprises Pty Ltd t/a Taleb Medical	Vic	Transport and Intensive Care Ventilator Equipment	22/06/2017 (one-off purchase)	417 600
Tas Gas Retail Pty Ltd	Tas	Provision of Natural Gas Retail	01/07/2017 - 31/12/2017	300 000
The Health Roundtable	NSW	Health Roundtable Subscription	04/04/2017 - 31/12/2017 Option to extend 01/01/2018 - 31/12/2020	164 600 495 000
Uniting Church in Australia Property Trust (Tas)	Tas	Provision of Flexible Community Packages for Transition Care Program	01/01/2017 - 31/01/2019 Option to extend 01/02/2019 - 31/01/2021	1 592 224 1 592 224
USL Medical Pty Ltd	Qld	Transport and Intensive Care Ventilator Equipment	22/06/2017 (one-off purchase)	507 500
Varian Medical Systems Australasia Pty Ltd	NSW	# North West Cancer Centre - Real Time Respiratory Position Management (RPM) Gating System	28/07/2017 - 06/12/2025	172 371

Notes:

1. Where an overarching procurement process exists (for example Common Use Contracts and Agency Panel arrangements) individual engagements are not reported.
2. A '0' contract value signifies a contract for which a value cannot be estimated, being dependent on future requirements.
3. A '#' adjacent to a 'Location' denotes an organisation whose principal place of business is not in Tasmania but has a permanent office or presence in Tasmania and employs Tasmanian workers.
4. Where a commencement date is after 1 July 2017, the contractual arrangements for the procurement were finalised in 2016-17.
5. Contracts with a value of less than \$50 000 reported above are those that form part of a combined procurement valued at \$50 000 or over.
6. In accordance with Treasurer's Instruction 1111, the period of a contract for reporting purposes includes the value, or estimated value, of any possible options to extend. Where applicable, the principal period of the contract is identified as well as any options to extend; this does not signify that the options have been or will be exercised by the THS.
7. All values exclude GST.

Table 4 - Direct/limited submission sourcing

Treasurer's Instructions 1114 and 1217 provide heads of agencies with the discretion, where specified circumstances exist, to approve the direct sourcing, or seeking of limited submissions from a supplier or suppliers, without the need to seek quotations or call for tenders. For the purpose of Instructions 1114 and 1217 the Head of Agency for the THS is the Secretary of the Department of Health and Human Services.

The following table provides details of contracts awarded by the THS in 2016-17 as a result of a process approved in accordance with Instructions 1114 and 1217.

Contractor Name	Contract Description	Reasons for Approval	Total Value \$
Aidacare Pty Ltd	Royal Hobart Hospital - AED Defibrillators	Additional deliveries of goods or services by the original supplier or authorised representative that are intended either as replacement parts, extensions or continuing services for existing equipment, software, services or installations, where a change of supplier would compel the agency to procure goods or services that do not meet requirements of interchangeability with existing equipment.	168 000
Chappell Dean Pty Ltd t/a Activity BarCoding.Com	Activity Management System for Nursing and Allied Health Professionals - Ongoing Maintenance	The goods or services can be supplied only by a particular supplier and no reasonable alternative or substitute goods or services exist due to an absence of competition for technical reasons.	230 040
Cyclotek (Aust) Pty Ltd	Royal Hobart Hospital - Radiopharmaceuticals for PET	The goods or services can be supplied only by a particular supplier and no reasonable alternative or substitute goods or services exist due to an absence of competition for technical reasons.	700 000
Healthe Care Burnie Pty Ltd	North West Maternity Services	Where a procurement is not impacted by a free trade agreement as set out in Instruction 1102 and exceptional circumstances exist that justify the use of a direct/limited submission sourcing process rather than a quotation or tender process as prescribed in Instructions 1106 and 1107.	115 751 705

Contractor Name	Contract Description	Reasons for Approval	Total Value \$
Philips Electronics Australia Ltd	Launceston General Hospital - Angiographic Suite - Upgrade and Maintenance	The goods or services can be supplied only by a particular supplier and no reasonable alternative or substitute goods or services exist due to an absence of competition for technical reasons.	715 000
Siemens Healthcare Pty Ltd	Launceston General Hospital - MRI Upgrade and Maintenance	The goods or services can be supplied only by a particular supplier and no reasonable alternative or substitute goods or services exist for the protection of patents, copyrights, or other exclusive rights, or proprietary information.	2 213 000
Siemens Healthcare Pty Ltd	Royal Hobart Hospital - CT Scanner - Service Maintenance Agreement	The goods or services can be supplied only by a particular supplier and no reasonable alternative or substitute goods or services exist due to an absence of competition for technical reasons.	157 000
Siemens Healthcare Pty Ltd	Royal Hobart Hospital - Haemodynamic Monitoring Equipment	Additional deliveries of goods or services by the original supplier or authorised representative that are intended either as replacement parts, extensions or continuing services for existing equipment, software, services or installations, where a change of supplier would compel the agency to procure goods or services that do not meet requirements of interchangeability with existing equipment.	125 000
The Health Roundtable	Health Roundtable Subscription	The goods or services can be supplied only by the particular supplier and no reasonable alternative or substitute goods or services exist due to an absence of competition for technical reasons.	659 600
Varian Medical Systems Australasia Pty Ltd	North West Cancer Centre - Real Time Respiratory Position Management (RPM) Gating System	(i) Upgrade - additional deliveries of goods or services by the original supplier or authorised representative that are intended either as replacement parts, extensions or continuing services for existing equipment, software, services or installations, where a change of supplier would compel the agency to procure goods or services that do not meet requirements of interchangeability with existing equipment; and	115 000
		(ii) Maintenance Support Services - the goods or services can be supplied only by a particular supplier and no reasonable alternative or substitute goods or services exist due to the protection of patents, copyrights, or other exclusive rights, or proprietary information.	57 371

Notes:

1. The values in this table include the value, or estimated value, of any possible options to extend.
2. All values exclude GST.

Table 5 - Contracts Extensions

Treasurer's Instruction 1115 provides heads of agencies with the discretion to approve the extension of contracts beyond existing provisions for a period of no longer than one year. For the purpose of Instruction 1115 the Head of Agency for the THS is the Secretary of the Department of Health and Human Services.

The following table provides details of contracts awarded by the THS in 2016-17 as a result of approval in accordance with Instruction 1115(2).

Contractor Name	Contract Description	Period of Extension	Total Value \$
EBSCO International Inc	Electronic Portal for Online Clinical Help (EPOCH) and Associated Clinical Reference Material	01/01/2017 - 31/03/2017	59 468
Health Communication Network Pty Limited	Electronic Portal for Online Clinical Help (EPOCH) and Associated Clinical Reference Material	01/01/2017 - 31/03/2017	60 758
MIMS Australia Pty Ltd	Electronic Portal for Online Clinical Help (EPOCH) and Associated Clinical Reference Material	01/01/2017 - 31/03/2017	16 062
Tas Gas Retail Pty Ltd	Provision of Natural Gas Retail	01/07/2017 - 31/12/2017	300 000

Note:

1. All values exclude GST.

Table 6 – Disaggregation Exemptions

Treasurer's Instructions 1119(5) and 1225(5) provide heads of agencies with discretion to approve an exemption from the requirement to disaggregate substantial contracts where the benefits of aggregation clearly outweigh the potential negative impact on local SME suppliers/the local economy.

The following table provides details of contracts awarded by the THS in 2016-17 as a result of such an approval.

Contract Description	Total Value \$
Launceston General Hospital - Provision of Haemodynamic-Monitoring and Cardiology Information System	976 874
Launceston General Hospital - Provision of Radiologist Services	29 900 000
Launceston General Hospital - Supply and Installation of Digital Radiography Machines	1 099 600
Launceston General Hospital - Ultrasound Machines	291 600
Royal Hobart Hospital - Echocardiography System with 3D Capabilities	304 737
Royal Hobart Hospital - Mobile Image Intensifiers	507 500
Royal Hobart Hospital - Refrigeration & HVAC Maintenance Services	295 700
Security Services for Wilfred Lopes Centre	4 266 320
Transport and Intensive Care Ventilator Equipment	925 100

Notes:

1. The values in this table include the aggregated value and the value, or estimated value, of any possible options to extend.
2. All values exclude GST.

RIGHT TO INFORMATION

Right to Information Act 2009

Annual Reporting Statistics – 2016-17

Section A: Number of Applications			
1.	Number of applications for assessed disclosure of information received during 2016-17		68
Section B: Applications Accepted			
2.	Number of applications for assessed disclosure received during 2016-17 accepted for decision		68
3.	Number of applications for assessed disclosure received during 2016-17 not accepted for decision		0
	3.1.	Number of applications transferred to another public authority prior to acceptance for decision	0
	3.2.	Number of applications withdrawn by the applicant prior to acceptance	0
	3.3.	Number of applications where fee not paid , and no agreement to waive the fee.	0
	3.4.	Despite assistance under s 13(6), number of applications not in writing or not containing the minimum information as prescribed in the regulations	0
	3.5.	Number of applications still under negotiation (s13(7)) prior to acceptance	0

Notes The sum of the numbers recorded at questions 2 and 3 must equal the number recorded at question 1.
The sum of the numbers recorded at questions 3.1 to 3.4 must equal the number recorded at question 3.

Section C: Applications Decided			
4.	Number of applications accepted for assessed disclosure and decided during 2016-17		72
4.1.	Number of applications accepted during 2016-17 and decided during 2016-17	62	
4.2.	Number of applications accepted during 2015-16 and decided during 2016-17	10	

Notes The total recorded at question 4 must equal the sum of 4.1 and 4.2.

5.	The number of accepted applications decided during 2016-17 where the outcome was:		
5.1	The information requested was provided in full	48	
5.2	The information requested was provided in part .	6	
5.3	None of the information requested was provided	18	

Notes The sum of 5.1 to 5.3 must equal the total recorded at question 4.

Section D: Reasons for Decisions

For applications **decided** during 2016-17 (ie those counted for questions 5.2 and 5.3) the reasons why the information requested was not provided in full:

Not in possession, exempt information

6.	The number of accepted applications decided during 2016-17 where information requested was not in the possession of the public authority or Minister (s.5) including when the information requested is located at the Archives Office and is available for inspection at that Office (s.11(3)).		10
	6.1	Number of applications where no information requested was in possession	10
	6.2	Number of applications where some of information requested was not in possession	0
7.	The number of accepted applications decided during 2016-17 where information requested related to an excluded person or body (s.6)		0
	7.1	Number of applications where all information requested related to an excluded person or body	0
	7.2	Number of applications where some of the information requested related to an excluded person or body	0

Transferred

8.	The number of accepted applications decided during 2016-17 where the application was transferred (s.14)		0
	8.1	Number of applications transferred in full	0
	8.2	Number of applications transferred in part	0

Deferred

9.	The number of accepted applications where the provision of information requested was deferred (s.17)		0
	9.1	Number of applications where provision of all of the information requested was deferred	0
	9.2	Number of applications where provision of some of the information requested was deferred	0

Refused

10.	The number of accepted applications refused during 2016-17			6
For applications refused during 2016-17 the reasons for refusal were:				
	10.1	Information requested was already available for inspection or purchase (s.9)	1	
	10.2	Information requested cannot be produced using normal computer means and producing it would substantially and unreasonably divert resources (s.10)	0	
	10.3	Information requested was or is to be disclosed by other means, eg by active or routine disclosure (s.12)	0	
	10.4	Providing the information requested would substantially and unreasonably divert resources (s.19)	5	
	10.5	Information requested is a repeat of a previous application (s.20(a))	0	
	10.6	The application for information is vexatious or lacks definition even after negotiation (s.20(b))	0	

Notes More than one reason for refusal may be used in relation to a single application.

The sum of the numbers recorded for questions 10.1 to 10.6 must be equal to or be greater than the total recorded at question 10.

Exemptions		
11.	The number of applications decided during 2016-17 where information requested was exempted from disclosure in full or part	14
For applications exempted in full or in part during 2016-17 the number of applications for which the following sections were used as reasons for exempting information from disclosure was:		
11.1	Executive Council Information (s.25)	0
11.2	Cabinet Information (s.26)	1
11.3	Internal briefing information of a Minister (s.27)	0
11.4	Information not relating to official business (s.28)	0
11.5	Information affecting national or state security, defence or international relations (s.29)	0
11.6	Information relating to the enforcement of the law (s.30)	2
11.7	Legal professional privilege (s.31)	0
11.8	Information relating to closed meetings of council (s.32)	0
11.9	Information communicated by other jurisdictions (s.34)	0
11.10	Internal deliberative information (s.35)	4
11.11	Personal information of a person other than the applicant (s.36)	2
11.12	Information relating to the business affairs of a third party (s.37)	2
11.13	Information relating to the business affairs of a public authority (s.38)	0
11.14	Information obtained in confidence (s.39)	4
11.15	Information on procedures and criteria used in certain negotiations of public authority (s.40)	0
11.16	Information likely to affect the State economy (s.41)	1
11.17	Information likely to affect cultural, heritage and natural resources of the State (s.42)	0

Notes If a section is used one or more times in assessing the information requested in a single application, it is counted as one.

More than one reason for exemption (if applicable) may be counted in relation to a single application.

The sum of the numbers recorded for questions 11.1 to 11.17 must be equal to or be greater than the total recorded at question 11.

Withdrawn		
12.	The number of accepted applications where the application was withdrawn by the applicant before a decision	3
12.1	Number of applications withdrawn in full	3
12.2	Number of applications withdrawn in part	0

Section E: Time to Make Decisions

13.	Number of accepted applications decided between 1 and 20 working days of the application being accepted	25
14.	Number of accepted applications decided after 20 working days of the application being accepted	47
Of the applications decided after 20 working days		
14.1	Number of applications that involved an extension negotiated with the applicant under s.15(4)(a)	28
14.2	Number of applications that involved an extension gained through an application to the Ombudsman under s.15(4)(b)	0
14.3	Number of applications that involved consultation with a third party under s.15(5)	0

Notes The sum of the numbers recorded for questions 13 and 14 must equal the total recorded at question 3.

The sum of the numbers recorded for questions 14.1 to 14.3 must be equal to or less than the total recorded at question 14.

Section F: Reviews

Internal Reviews		
15.	Number of internal reviews that were requested in 2016-17	2
16.	Number of internal reviews that were decided in 2016-17	2
16(a)	Number of internal reviews that were requested in 2016-17 and decided during 2016-17	2
16(b)	Number of internal reviews that were requested in 2015-16 and decided during 2016-17	0
For the internal reviews that were decided in 2016-17		
16.1	Number where the original decision upheld in full	1
16.2	Number where the original decision upheld in part	1
16.3	Number where the original decision reversed in full	0
16.4	Number resolved by other means	0

Notes The sum of the numbers recorded for questions 16(a) and 16(b) must equal the total recorded at question 16.

The sum of the numbers recorded for questions 16.1 to 16.4 must be equal the total recorded at question 16.

An application for a review may also be resolved by being withdrawn by an applicant, the reaching of a negotiated agreement, the issuing of a direction for a new decision to be made, or information being released by other means.

External Reviews (Ombudsman)			
17.	Number of external reviews that were requested in 2016-17		4
18.	Number of external reviews that were decided in 2016-17		3
	18(a)	Number of external reviews that were requested in 2016-17 and decided during 2016-17	3
	18(b)	Number of external reviews that were requested in 2015-16 and decided during 2016-17	1
For the external reviews that were decided in 2016-17			
	18.1	Number where the original decision upheld in full	3
	18.2	Number where the original decision upheld in part	0
	18.3	Number where the original decision reversed in full	0
	18.4	Number resolved by other means	0

Notes The sum the numbers recorded for questions 18(a) and 18(b) must equal the total recorded at question 18.

The sum the numbers recorded for questions 18.1 to 18.4 must be equal the total recorded at question 18.

An application for a review may also be resolved by being withdrawn by an applicant, the reaching of a negotiated agreement, the issuing of a direction for a new decision to be made, or information being released by other means.



MINISTERIAL DIRECTIONS AND PERFORMANCE ESCALATIONS

Register of Ministerial Directions from 1 July 2016

Date	Title	Details
February 2017	Performance Escalation	<p>During 2015-16, a level one performance escalation was initiated for unsatisfactory performance against the following service agreement Key Performance Indicator (KPI):</p> <ul style="list-style-type: none"> <i>Time until most admitted patients (90%) departed the emergency department.</i> <p>In the 2016-17 service agreement, the above KPI was re-defined as:</p> <ul style="list-style-type: none"> <i>Percentage of patients admitted through the ED with an ED length of stay less than eight hours.</i> <p>The level one performance escalation initiated in 2015-16 transferred to this re-defined KPI and remains in place</p> <p>In February 2017, a level one performance escalation was initiated for unsatisfactory performance against four additional service agreement KPIs:</p> <ul style="list-style-type: none"> <i>Percentage of all emergency department presentations seen within recommended time</i> <i>Percentage of all emergency patients with an ED length of stay less than four hours</i> <i>Percentage of all ED patients with an ED length of stay less than 24 hours</i> <i>Ambulance offload delay – 30 minutes</i> <p>Consistent with the requirements of a level one performance escalation, the THS was required to submit performance improvement plans for all five KPIs to the Minister for Health, outlining the strategies that would be implemented to remediate performance and a timeframe for the achievement of KPI targets specified in the 2016-17 service agreement.</p>

EDUCATION, RESEARCH AND CLINICAL TRIALS

Allied Health Professional Education and Research 2016-17

Education and Training

Allied health professional, allied health assistant and related support staff have maintained a high level of engagement in education, training and research activity in the last year. A range of 'in-house' activities including, 'in-service' programs, e-learning opportunities, journal clubs, profession-specific rounds, communities of practice, mentoring and professional supervision relationships, has been well supported. There has also been strong interest in externally provided training workshops and in conference attendance and presentation.

Over 50 allied health staff from around the state are engaged in or have recently completed postgraduate education beyond their vocational entry level qualifications, with work often at masters and doctoral level. Over half of this number is enrolled with the University of Tasmania (UTAS), the majority taking the opportunity to further develop leadership and management skills or develop knowledge and skills in public health. Several are completing doctoral research degrees. Generally those studying at interstate universities are completing postgraduate degrees in a variety of clinical specialty areas.

Staff in all departments have been active in developing and delivering training and education. Of note is the focus on training extending beyond profession-specific boundaries (e.g. Podiatry training of AHAs in basic foot screening; Nutrition and Dietetics' development of a 'portion size' training package for Food Service staff; OT/AHPDU collaboration in ongoing delivery of 'Teaching on the Run', a supervision training program open to all THS staff) and on

community education sessions (eg two public health forums in the north west by Social Work to improve health literacy and chronic disease self-management; further development of the annual community education program from Speech Pathology in the south on management of speech and swallowing disorders; Physiotherapy Department involvement in the development and review of the Chronic obstructive pulmonary disease (COPD) Online Patient Education Project. Chaplaincy has participated in a national consensus conference on standards for healthcare in chaplaincy to inform chaplaincy training and curriculum development.

Input by allied health staff into teaching programs offered by the University of Tasmania has continued to grow, supported by the development of links between the THS Allied Health Professions Development Unit (AHPDU) and various university departments (eg Physiotherapy in the north provides and leads education on neurology and neurological conditions to the UTAS Exercise Science Course; AHPDU coordinates a postgraduate unit on clinical supervision in the UTAS Leadership and Management Course-Health and Human Services).

Allied health professionals have provided in excess of 140 student placements, for periods ranging from a couple of weeks to several months depending on the profession's requirement, and in a variety of work settings around the state. A large proportion of these students are from interstate universities where the professional entry training for many allied health professions is located.

Research

A strong program of quality improvement and service evaluation by allied health professionals is in evidence around the state, and there is growing involvement in research collaborations with other health care providers and the university sector.

Collaboration between northern clinical psychology staff and the Launceston Clinical School of UTAS has produced several obesity-focussed research projects, some in the development stage and others at completion. Physiotherapy staff at Launceston General Hospital, in conjunction with UTAS, have completed and published work on the use of technology in neurological rehabilitation.

Others from that department are involved in an international observational study on the incidence of post-operative pulmonary complications following upper abdominal surgery. Podiatry in the north west is supporting a prospective cohort study of diabetes-related foot health in rural areas, a collaboration with Latrobe University and UTAS.

Examples in the southern region include the Department of Nutrition and Dietetics in the south participation in the Menzies Centre Lifestyle Choices study and Speech Pathology's participation in the ASK study, a multi-site, NHMRC-funded, trial concerned with reducing the impact of aphasia in stroke patients and their caregivers.

Conference Presentations

Best, R. *Effectiveness of a tailored Evidence Based Practice (EBP) education program for Speech Pathologists*. Poster presentation at the Victorian Allied Health Research Conference, 2017.

Callisaya, M. *Concurrent Gait and Cognitive Impairment as an Emerging Geriatric Syndrome*. Presidential symposium, International Association for Geriatrics and Gerontology Conference, San Francisco, 2017.

Callisaya, M. *Thinking on your feet – the interplay between cognition, gait and falls*. Plenary speaker, Australian and New Zealand Falls Prevention Conference, Melbourne 2016.

Callisaya, M. *Motoric Cognitive Risk Syndrome and Falls Risk - a multicenter study*. First Australian and NZ conference on Sarcopenia and Frailty, Melbourne, November 2016.

Callisaya, M. *Frailty and Cerebral Small Vessel Disease: a cross-sectional analysis of the Tasmanian Study of Cognition and Gait (TASCOG)*. First Australian and NZ conference on Sarcopenia and Frailty, Melbourne, November 2016.

Carter, D., Ahuja, K., Williams, A & Bird, M-L. *Exertion, gait regularity and balance in people with COPD: Pilot study protocol*. 7th Biennial Australian and NZ Falls Prevention Conference.

Chen, P. *Health Literacy and its association with diabetic foot disease*. Invited speaker, Australian Podiatry Association (Tasmania).

Dorward, C. & May, J. *Activities of Daily Living: Health, Home, Hospital*. Tasmanian Health Conference, Hobart, 2017.

Gould, SD. *Social Work Input into Pain Management in Palliative Patients*. 9th International Conference on Social Work in Health and Mental Health, Singapore.

Handbury, C. *Keeping kid's teeth out of the bucket (Oral Health)*. Tasmanian Health Conference, Hobart, 2017.

Jones, I. *Getting our teeth into health professional education (Oral Health)*. Tasmanian Health Conference, Hobart, 2017.

McCausland, H. *Podiatry and wound care*. ACN Wound Management.

McKibben, J. *Partnering for prevention (Oral Health)*. Tasmanian Health Conference, Hobart, 2017.

Nash, T. *Podiatry South Services Update*. APODA Conference.

O'Keeffe, F. *Toilet refusal*. Victoria – Tasmania Occupational Therapy Conference, 2017.

Prins, K. & Schrale, R. *Nutrition and the burns injured patient at the Royal Hobart Hospital*. Poster presented at DAA National Conference, May, 2017.

Ramsden, C., Denehey, S., Owen, L., Rowell, M., & Tuck D. *HIV-Associated Neurocognitive Disorder: Establishing a screening and diagnostic service for HAND in Tasmania*. Australasian Society for the Study of Brain Injury (ASSBI).

Publications

Cameron-Tucker, HL. et al. (2016). A randomised controlled trial of telephone-mentoring with home-based walking preceding rehabilitation in COPD. *International Journal of Chronic Obstructive Pulmonary Disease* 11, 1991.

Cameron-Tucker, H, Alison, JA., et al. (2017). Australian and New Zealand Pulmonary Rehabilitation Guidelines. *Respirology*, 22.4, 800-819.

O'Meagher, S., Kemp, N., Norris, K., Anderson, P. and Skilbeck, C. (2017). Risk factors for executive function difficulties in preschool and early school-age preterm children. *Acta Paediatrica*. Accepted Author Manuscript. doi:10.1111/apa.13915.

Smith, LJ., Kearvell, R., Arnold, AJ., Choma, K., Cooper, A., Young, MR., Matthews, DL., Hilder, B., Howson, D., Fox, K. & Churcher, K. Radiation therapy staffing model 2014, *Journal of Medical Radiation Sciences*, 63, 209-216.



Current Research North West

Research	Summary	Lead Investigator/s
Building Advantage for Medical Specialists at Regional Health Service	This study is to describe the medical specialist workforce in North West Tasmania; demographic characteristics, duration of employment and factors most likely to contribute to retention of medical specialists in the region. The study will utilise quantitative analysis of THS-North West medical specialist workforce data and interviews with medical specialists who have both ceased employment and those who have continued in their posts.	Dr Penny Allen
Co-Led Redesigned Stroke Services in North West Tasmania	Purpose of the study is to redesign Stoke Services in the North West basis of three inputs: 1) The patients and their families who are receiving care/treatment for their stroke; 2) Existent data on the nature of the service, including view about the service from clinical staff involved in delivering care/treatment and 3) National/ international standards/guidelines on provision of stroke care treatment.	Prof S Campbell
Outcomes of a Pilot Study into the Introduction of a Functional maintenance program into an acute medical ward	Aim is to identify the impact for patients who participate in a functional conditioning program (FCP) whilst admitted to an acute medical ward. The FCP will be run as an open group with people entering and exiting the group in accordance with admissions and discharges on the medical ward. Assessments and outcomes will be completed on each patient.	B Birleson
The impact of Emergency Department discharge processes for non-life threatening conditions, injuries or illnesses on patient compliance and satisfaction, re-presentation rate and resource utilisation	The Study aims to improve outcomes for non-life threatening conditions, injuries or illnesses and include;1) Develop clinical decision making pathways and tools to inform Emergency Department discharge policies and guidelines2) Improvement in patient compliance and satisfaction	Leahanna Stevens
The Assessment and Management of Obesity and Self Maintenance (AMOS) Clinic: Implementation and Evaluation of the AMOS Model of Care	The aim of this project is to assess the effectiveness of an integrated model of obesity care of adult patients with type 2 diabetes who also have obesity. The research is a randomised clinical trial. The active intervention group will receive an integrated multidisciplinary model of care for obesity management. Dedicated bariatric surgery may form part of the model, however the project will continue regardless of surgery.	Giuliana Murfet
Accuracy of Patient Medications in GP Referrals to North West Regional Hospital	Study is to explore the Emergency Department processes and patient compliance with health management discharge information. The objective of the study will include determining discharge information and intervention strategies used by ED clinicians; how ED practitioners advise, prescribe and manage conditions and/or injuries for patients being discharged home; determine patient satisfaction of ED discharge processes, treatment and management; determine patient understanding of reasons for returning to the ED for further management of their condition/ illness or injury.	Leahanna Stevens
The Perception of Preparedness of Medical Interns for the Responsibilities of Internship in a Rural Hospital	The purpose of this study is to determine: (1) if the new graduates feel they are prepared for the role of medical intern in a rural hospital; (2) what deficiencies they perceive in their preparedness as an intern and (3) what supports they identify are available to them in the first year as an intern.	Luanne Steven / Colleen Cheek
Staff Perceptions of Transitional Care in an Acute Psychiatric Inpatient Facility	To examine whether the discharge planning nurse role has made an impact upon discharges from the unit and to understand staff perceptions on ways the discharge process can be improved.	David Lees
Prospective Data Collection of off-label use of Rituximab in Renal Disease and Vaculitides in the Tasmanian Health Service	The purpose of this study is to collect prospective information on the statewide use of rituximab within Tasmanian Public Hospitals for renal diseases and vaculitides to determine the appropriateness of use, variations in practice and amount of rituximab usage in these patient groups.	Dr Geoffrey Kirkland, Head of Neurology THS-South
Investigation of intoxicated mental health presentations to Emergency Departments in Tasmania	To determine the number of intoxicated mental health patient presentations to Emergency Departments in Tasmania and describe patient demographic characteristics and mental health assessment pathways. This work will build on unpublished research, conducted by (HSI) Tasmania that will describe the numbers of mental health related ED presentations to Tasmanian hospitals between January 2011 and December 2015.	Dr Penny Allen Dr Marielle Ruigrok

Research	Summary	Lead Investigator/s
Micrological contamination of non-disposable sphygmomanometer cuffs in a rural emergency department	THS-North West Region is seeking to adopt the use of disposable sphygmomanometer cuffs in Emergency Departments (ED). This study is to demonstrate that the microbial contamination of non-disposable sphygmomanometer cuffs can be negated after effective cleaning and subsequently removing the need for the purchase of disposable cuffs.	Michael Browne
Prescribing oral anticoagulants (for atrial fibrillation) by Australian Clinicians - online survey to prescribers at NWRH. Currently three sites.	The project aims to assess the attitudes of Australian doctors towards the use of anticoagulants, especially the Novel Oral Anticoagulants for stroke prevention in patients with atrial fibrillation. It is a survey involving cardiologists, other hospital based doctors and GPs that asks them about their attitudes towards various statements regarding stroke prevention in AF, and then to choose an agent for several patients described in hypothetical case scenarios. The survey will take about 10 minutes to complete - being conducted as an online survey with hospitals.	Colin Curtain
A focused ultrasound curriculum for students in a regional emergency department. A prospective evaluation of knowledge and skill acquisition.	The study is to determine the feasibility of focussed curriculum component teaching of Point of Care Ultrasound to medical students of the RCS in association with their Emergency Medicine rotation with THS - North West.	Dr John Ang
Keeping them: Factors that contribute to the long term retention of the allied health workforce in rural and remote areas.	The aim of this cross-sectional study is to investigate the personal and work-related factors that contribute to the long term retention of an allied health workforce in the rural and remote areas of Tasmania. These factors will then be evaluated according to their relative importance with respect to the long-term retention allied health staff.	A/Prof. Tony Barnett
A Randomised Control Trial investigating if intra-operative patient matched tibial instrumentation validation improves tibial alignment in total knee arthroplasty	Patient Matched Instrumentation (PMI) in total knee arthroplasty may be subjectively assessed intra-operatively to validate the position of instrumentation prior to bone resection. The orthopaedic research is to determine whether the PMI tool allows immediate feedback or validation of position and whether this improves tibial alignment in total knee arthroplasty. Sample size estimation is 100 randomly allocated participants. Postoperative CT scan at the six week interval will be conducted to determine if improved alignment was achieved.	Mr Scott Fletcher
The genetic basis of epilepsy: Infantile epileptic encephalopathies in Tasmania. Is a Austin Health HREC	Determine the frequency of specific infantile epileptic encephalopathies (IEEs), phenotype specific genetics IEEs and describe their electro-clinical patterns. To discover new genes responsible for IEEs of unknown aetiology and understand the genetic architecture of IEEs. Funded by Epilepsy Tasmania	Dr Dean Jones (UTAS) Prof. Samuel Berkovic Prof. Ingrid Scheffer
Measuring mental health literacy of people who work in Rural Aged Care settings - short interview	Proposed study is an exploration of issues. Data from the questionnaire will be examined and the percentage of correct responses found. The quantitative data will provide an idea of whether the assessment tool is appropriate or useful for this population.	Heather Bridgman
Reducing hospital readmission rates: community based approaches to facilitating sustained Mental Health in rural areas.	Investigate the relationship between the patient, clinical treatment and community factors that impact on the Mental Health readmission of patients attending the North West Adult Community Health Service to better inform treatment planning. Additionally aims to investigate how these multi-level factors interact to influence readmissions.	Ella Anderson supervised by Prof. Douglas Paton, Heather Bridgman
Managing the "revolving door" problem in rural psychiatric services: A multiagency collaboration approach	Study designed to assist Mental Health Services in North West Tasmania explore possible organisational changes that could help target and reduce the current high psychiatric readmission rates.	Madeline Rowell supervised by Prof. Douglas Paton & Dr Heather Bridgman

Research	Summary	Lead Investigator/s
The effects of pre-operative physiotherapy on the incidence of post-operative pulmonary complications in high and low risk patients following major open upper abdominal surgery: A randomised controlled trial. (LIPPSMAck POP) Addition of 2 sites: NWRH and RHH	Does education from a physio before your operation reduce your chance of getting a chest infection whilst recovering in hospital afterwards? A randomised placebo blinded controlled trial.	Ilanthe Boden
Prolonged laparoscopic and lower abdominal surgery trial – Incidence of complications determining the rate of post-operative pulmonary complications (PPC), other complications and length of hospital stay in the prolonged laparoscopic, open lower abdominal surgery (LAS) & open .. (Additional sites: North West Regional Hospital & Royal Hobart Hospital listed).	Prolonged laparoscopic and lower abdominal surgery trial – Incidence of complications determining the rate of post-operative pulmonary complications (PPC), other complications and length of hospital stay in the prolonged laparoscopic, open lower abdominal surgery (LAS) & open .. (Additional sites: North West Regional Hospital & Royal Hobart Hospital listed).	Ilanthe Boden
Tasmanian study of Echocardiographic detection of Left Ventricular dysfunction (TAS-ELF)	Study to identify whether an additional investigation designed to identify the early stages of heart muscle damage can avoid heart failure or its consequences in people at risk of heart failure.	Prof. Tom Marwick
Haemochromatosis in Australia - A cost of illness study	Data request - Patients who attended NWRH in preceding 5 years with hereditary haemochromatosis. Project is documenting the medical, non-medical and indirect costs associated with hereditary haemochromatosis in Australia from societal in health payer's perspectives.	Prof. Andrew Palmer
ED Interdisciplinary Insitu-simulation non-technical skill training. Developing a culture of safety.	This study will explore the concept that participation in simulated interdisciplinary training scenarios improves team performance in a rural emergency department. It will quantify the attributes of team performance during simulated exercises using a skill based tool and a validated NTS tool (Flowerdew et al.2013).	M Browne
Audit of Asthma Clinic and related activity at THO-North West	Survey of breathing, nose and skin problems in children 6-8 years, living in regional and rural areas, via a questionnaire. A spirometry test will then be conducted in order to understand more about the major problems of respiratory symptoms. Clifford Craig Medical Trust Grant. Amendment - additional lung function parameters added.	Dr Heinrich Weber
Right @ home - a randomised controlled trial of sustained, nurse home visiting measuring the benefit on parenting and the home environment when offered to vulnerable Australian mothers from the antenatal period to child age 2 years	A national sustained nurse home visiting trial to promote family wellbeing and child development	A/Prof. Sharon Goldfeld & Dr Anna Price
Audit of Treatment of Febrile Neutropenia in Cancer Patients in North West Tasmania	Research is to evaluate the level of compliance in the NWRH and MCH to the THO-North West guidelines for the initial management of febrile neutropenia in adult haematology and oncology patients. The audit data will be retrospective for both inpatient and emergency presentations of febrile neutropenia over the last 12 months.	Dr Sanjay Dutta
Validation of the Palliative Prognostic Index (PPI)	Determine the accuracy of the Palliative Prognostic Index (PPI) in predicting prognosis in patients with advanced cancer. The PPI allows the calculation of likely death and this date will be compared to the actual date of death to determine the effect of the PPI tool. The desired outcome is to help the physician and patients in planning, prioritising and preparing their respective needs.	Dr Thiru Thirukkumaran

Research	Summary	Lead Investigator/s
Clinical Audit of referrals to THS - North West Paediatric Clinic for behavioural/mental health issues.	Perform a clinical audit of children currently referred to the paediatric clinic at NWRH for behavioural/mental health issues. This will determine what primary care services are being utilised by those waiting to be seen at the THS -North West clinic. Ultimately describe the structure and process for children accessing care for mental health problems within THS - North West. This will achieve a better matching of health services to community needs.	A/Prof. Bert Shugg
The prevalence of asthma in 6-8 year old children in rural Tasmania: A Pilot study	Survey of breathing, nose & skin problems in children 6-8 years, living in regional and rural areas, via a questionnaire. A spirometry test will then be conducted in order to understand more about the major problems of respiratory symptoms. Clifford Craig Medical Trust Grant. Amendment - additional lung function parameters added.	Dr Heinrich Weber
Tasmanian Quality Care Program 2013 (TQC)	A research based initiative to assist institutions in reviewing transfused patients. Aims of the TQC are by reviewing transfused patients' records to quantify the number of transfusions received by individual patients; review the serum ferritin levels in transfused patients; review primary diagnosis of transfused patients; review whether patients receiving >20 units have received any type of chelation therapy; help sites identify user-friendly tracking tools that may be used prospectively. The data review phase will run for three months.	Dr Michael Beamish LGH, MCH & NWRH Dr John Kwan, Westmead Hospital in Sydney
Evaluation of the psychosocial needs and feasibility of a screening tool in oncology patients in North West Regional Tasmania	A prospective study of ambulatory oncology patients to ascertain and quantify their unmet needs, in the areas of physical, psychological, social, information and daily living, as well as determine the feasibility of implementing a supportive care screening tool into clinical practice.	Dr Sheryl Sim
Examine the experiences of community nurses caring for clients in the rural community setting	This Research study will examine the experiences of community nurses caring for clients in the rural community settings. The findings from the study will provide the opportunity for current practices, needs and feedback regarding the community nursing service which may help to inform directions for developing better healthcare provision, in ways that address rural workforce needs and the identified health needs of rural communities, particularly older citizens. August - December 2013	Quynh Lê,
Life Support Training: A Cross-sectional Survey	The maintenance of Life support skills is important for healthcare professionals. These skills can save lives. There is a lack of research evidence to know how often doctors, nurses and others need to update their knowledge and skills to maintain competency in this area. This cross-sectional study aims to find out how often this training should be provided and the preferred mode of delivery. In 2015 The Life Support Training research project is being conducted in the North West in conjunction with the "In situ simulation for health service development" research project for which grant funding was obtained from the Virtual Tasmanian Academic Health Science Precinct.	Associate Professor Tony Barnett
Observational study of Patient Management with Oralair in subject with Allergic Rhinoconjunctivitis	This is an observational study of about 300 subjects from approximately 25-30 sites across Australia who have been diagnosed as suffering from Allergic Rhino-conjunctivitis and have been prescribed treatment with Oralair®. North West Regional Hospital is one of the sites. Oralair® is a tablet taken under the tongue from where it will be absorbed into the system. Treatment should be commenced several months before the pollen season begins to enable the optimum benefit. Oralair® is used for treatment of patients who suffer allergy symptoms such as rhinitis with or without conjunctivitis which are caused by grass pollens. It is made from 5 different grass pollen allergen extract and works by stimulating the immune system to respond against the allergen for which you are being treated.	Dr Heinrich Weber

Research	Summary	Lead Investigator/s
Thromboprophylaxis and Outcomes Following Orthopaedic Surgery	The project is a retrospective review of thromboprophylaxis prescribing across different hospitals in Tasmania, Victoria and New South Wales. The review is looking at the first 30 joint replacements (15 hips, 15 knee) and what thromboprophylaxis they received (agent, dose, duration) with associated demographic details.	Professor Gregory Peterson
Play Skills Intervention and Language Development in Language Impaired Children	Investigate whether using play skills therapy with children who have language impairments will indirectly improve their language skills.	Ms Claire Stonell
Management of Glioma in Tasmania (2006-2008) Retrospective Cohort Study	The aim of this study is to identify the pattern of care for patients with glioma in Tasmania. It includes looking at whether patients, who have been identified by the Tasmanian Cancer Registry, have been referred to palliative service after their diagnosis.	Rosemary A Harrup
Outcomes of antithrombotic therapy in a new era: the Tasmanian experience	Medical records review. Use of anticoagulant and antiplatelet medications in patients with AF across Hobart, Launceston and Burnie. Subjects to be identified based on coding data admitted from 1/1/11 to 31/12/11 with diagnosis at discharge of AF	Dr Leanne Chalmers
The foot-health of people with diabetes in regional and rural Australia		Dr Judi Parson
Neonatal jaundice: an exploratory study of jaundice-related neonatal morbidity in Australia	Aims to explore the experiences of these professionals in the detection and management of neonatal jaundice and of jaundice-related neonatal morbidity through interview with clinicians involved in the care (direct or indirect) of neonates, and personnel involved in the education and training and/or development of policy relating to the care of infants with neonatal jaundice.	Claudia Trasancos
A description of the epidemiology of hydatid disease in Tasmania since the state was declared 'provisionally free' of the disease in 1996.	Medical record review of people diagnosed with hydatid disease in Tasmania since 1996.	Dr Jen O'Hern
Snapshot Acute Coronary Syndrome Registry	Will collect clinical data on every patient over the age of 18 years admitted to hospital with a suspected acute coronary syndrome from 14 - 27 May 2012 (however patients may opt-out of record review). Project is Australia-wide and organised by the Cardiac Clinical Network for South Australia.	Dr Michael Buist
Evaluation of Pregnancy in Diabetes Model Maternal and Neonatal Health Outcomes following implementation of an Innovative Model for Diabetes in Pregnancy	Involved a retrospective audit of cases deemed to having diabetes in pregnancy (pre-existing, GDM or 'suspect' GDM) over a three year period to ascertain the effectiveness of present screening and management procedures for women with GDM or pre-existing diabetes in pregnancy, residing in the rural, remote area of the north west of Tasmania. Amendment and extension to project It was identified that to create a clinically applicable economics analysis other data (not previously collected) was required to form an appropriate metabolic clinical profile. This includes rates of hyperbilirubinemia and APGAR scores of neonates	Giuliana Murfet

Current Clinical Trials South

Anaesthetics

ITAC Trial	IV Iron for Treatment of Anaemia before Cardiac Surgery. This randomised, double-blind, controlled, phase 4 trial will compare the efficacy, safety and cost-effectiveness of preoperative IV iron with placebo in patients with anaemia before elective cardiac surgery.
PADDI	The Perioperative Administration of Dexamethasone and Infection. The purpose of this study is to determine whether the use of the drug Dexamethasone is associated with more or less infections after surgery. At this time we are not sure why the immune system is affected, hence we are doing this study. Some research suggests that Dexamethasone increases the risk of developing infection after surgery, but other research suggests that it may in fact decrease the risk of infection. We need to undertake this study to find an accurate answer.

Breast Cancer

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Cardiology

AGRI5	A Cluster Randomisation Trial of Objective Risk Assessment versus standard care for Acute Coronary Syndromes. Modern sophisticated acute coronary syndrome (chest pain/heart attacks – ACS) care has relied on expert clinical intuition for the timely provision of optimal care. Contemporary data indicate under-utilization of early invasive management and proven pharmaco-therapies in ACS care among the highest risk patients. Faced with increasing patient complexity, relative risks and benefits associated with current treatments are often difficult to weigh. Refining risk-based decision-making to reduce “misperceptions” of risk leading to under-treatment of high-risk patients is the core objective of this study.
CKD-519	A Multicenter, parallel-group, double-blind, randomised, active-controlled, dose-ranging study to assess the safety, efficacy, and tolerability of CKD-519, administered with HMG-CoA reductase inhibitors, in subjects with dyslipidemia. The current treatments for reducing risk of cardiovascular diseases focus mainly on reducing LDL-C levels. The correlation between HDL-C levels and cardiovascular disease risk is still being investigated, and extensive clinical data support this correlation. HDL has anti-atherogenic, anti-inflammatory, and anti-oxidant effects. CKD-519 as an agent that decreases LDL-C levels and increases HDL-C levels in combination with any LDL-lowering drug so that it can be potentially used to prevent cardiovascular diseases.
SPHInX	A Multi-Centre Double-Blind Randomised Placebo-Controlled Trial of Oral Anticoagulation with Apixaban in Systemic Sclerosis-Related Pulmonary Arterial Hypertension. Scleroderma-Pulmonary Arterial Hypertension Intervention with Apixaban
The COPS Study Amendment #1	A multicentre, double-blind, randomised, placebo-controlled trial to assess the impact of low-dose colchicine on long-term cardiovascular outcomes in patients presenting with acute coronary syndromes. This prospective multicentre study aims to investigate the long-term effects of adding low-dose colchicine to current medical therapy after a heart attack. If proven clinically beneficial, colchicine has the potential to become an inexpensive medical therapy that will improve outcomes of many patients who suffer from a heart attack.
PARADISE-MI	A Multicentre, randomised, double-blind, active-controlled, parallel-group Phase 3 study to evaluate the efficacy and safety of LCZ696 compared to Ramipril on morbidity and mortality in high risk patients following an acute myocardial infarction. The purpose of the study is to evaluate the efficacy and safety of the investigational drug LCZ696 compared to Ramipril in reducing the occurrence of cardiovascular death and heart failure in patients who have had an Acute Myocardial Infarction and who also have evidence of left ventricular dysfunction.
INOvation	A Phase 3, Placebo Controlled, Double-Blind, Randomised, Clinical Study to Determine the Efficacy, Safety and Tolerability of Pulsed, Inhaled Nitric Oxide (iNO) Versus Placebo in Symptomatic Subjects with Pulmonary Arterial Hypertension (PAH). In this study, inhaled nitric oxide (iNO) will be delivered via the INOpulse delivery device, a portable, integrated system that uses cartridges containing NO at a concentration of 6.0 mg/L (4880 ppm), in precise, preset NO doses over time independently of the subject's respiration rate and tidal volume.
CATALYST	A Phase III Study of the Efficacy and Safety of Bardoxolone Methyl in Patients with Connective Tissue Disease-Associated Pulmonary Arterial Hypertension. This phase III double-blind randomised, placebo controlled trial will study the safety, tolerability and efficacy of bardoxolone methyl in patients with connective tissue disease-associated pulmonary arterial hypertension.
TDE-PH-310	A Phase III, International, Multi-Centre, Randomised, Double-Blind, Placebo-Controlled, Clinical Worsening Study of UT-15C in Subjects with Pulmonary Arterial Hypertension Receiving Background Oral Monotherapy.
Dal-GenE Trial	A phase III, double-blind, randomised placebo-controlled study to evaluate the effects of dalcetrapib on cardiovascular (CV) risk in a genetically defined population with a recent Acute Coronary Syndrome (ACS). The primary objective of this trial is to evaluate the potential of dalcetrapib to reduce cardiovascular morbidity and mortality (cardiovascular death, resuscitated cardiac arrest, non-fatal myocardial infarction (MI) and non-fatal stroke) in subjects with a documented recent Acute Coronary Syndrome (Myocardial Infarction or Unstable Angina) and the AA genotype at variant rs1967309 in the ADCY9 gene.
EXPERT	A prospective, non-interventional registry trial to assess the safety of Adempas in real life clinical practice.
Compass	A randomised controlled trial of Rivaroxaban for the prevention of major cardiovascular events in patients with coronary or peripheral artery disease.
2015 Vanguard Grant	A randomised trial of benefit and cost-effectiveness of Cardiac Resynchronization Therapy (CRT) optimization in heart failure. This study uses a multicentre design to study functional capacity, quality of life and economic analysis of CRT optimization. The aim is to determine whether sequential optimization of cardiac resynchronization therapy (CRT) can improve outcome in advanced chronic heart failure (CHF). The cost-effectiveness will also be assessed.

ESPERION	A randomised, double-blind, placebo-controlled, Phase 3 study to evaluate the effects of Bempedoic Acid (ETC-1002) on the occurrence of major cardiovascular events in patients with, or at high risk for, Cardiovascular Disease who are statin intolerant. The purpose of the study is to evaluate whether long-term treatment with bempedoic acid 180 mg/day versus placebo reduces the risk of major adverse cardiovascular events (MACE) in patients with, or at high risk for, cardiovascular disease (CVD) who are statin intolerant.
RANGER	An extended access program to assess long-term safety of bardoxolone methyl in patients with pulmonary hypertension
ARENA: APD811	An Open-Label Extension Study of APD811-003 in Patients with Pulmonary Arterial Hypertension.
CMR Guide HF	Cardiac Magnetic Resonance GUIDEd Management of mild –moderate Heart Failure. The purpose of this Study is to determine if the insertion of an Implantable Cardioverter Defibrillator (ICD) based on the presence of ventricular scar/fibrosis identified by Late Gadolinium Enhancement Cardiac Magnetic Resonance (LGE CMR), will reduce sudden cardiac death and/or ventricular arrhythmia in patients with mild-moderate LV systolic dysfunction. A health economic evaluation of costs will also be carried out.
GRIPHON OL	Long-term single-arm open-label study, to assess the safety and tolerability of ACT-293987 in patients with pulmonary arterial hypertension.
VICTORIA Study	The primary objective of the VICTORIA Study is to evaluate the efficacy of the oral soluble guanylate cyclase (sGC) stimulator MK-1242 (vericiguat) in comparison to placebo on a background of standard of care in increasing the time to first occurrence of death or heart failure hospitalisation in subjects with HFrEF. Riociguat has been studied in 65 pre-clinical studies, and has been administered to over 500 healthy subjects, and 740 heart failure subjects. Results of the SOCRATES-REDUCED study, (also conducted at this site) support the rationale for the phase III VICTORIA Study in subjects with HFrEF.
CANTOS	This trial is a randomised, double-blind, placebo-controlled, event-driven trial of quarterly subcutaneous canakinumab in the prevention of cardiovascular events among stable post-myocardial infarction patients with elevated hsCRP. A minimum of fifteen patients are expected to be recruited.
ARENA APD811-003	A Randomised, Double-blind, Parallel-group, Placebo-controlled Phase 2 Trial of APD811, an Oral IP Receptor Agonist, in Patients with Pulmonary Arterial Hypertension
GRIPHON OL	Long-term single-arm open-label study, to assess the safety and tolerability of ACT-293987 in patients with pulmonary arterial hypertension.
VICTORIA Study	The primary objective of the VICTORIA Study is to evaluate the efficacy of the oral soluble guanylate cyclase (sGC) stimulator MK-1242 (vericiguat) in comparison to placebo on a background of standard of care in increasing the time to first occurrence of death or heart failure hospitalisation in subjects with HFrEF. Riociguat has been studied in 65 pre-clinical studies, and has been administered to over 500 healthy subjects, and 740 heart failure subjects. Results of the SOCRATES-REDUCED study, (also conducted at this site) support the rationale for the phase III VICTORIA Study in subjects with HFrEF.
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Critical Care

PEPTIC	Proton Pump Inhibitors vs. Histamine-2 Receptor Blockers for Ulcer Prophylaxis Therapy in the Intensive Care Unit. This study will establish which of the two types of medicines that are commonly used for stress ulcer prophylaxis in ICU patients who require life support leads to the lowest risk of upper gastrointestinal bleeding, prolonged mechanical ventilation, and Clostridium difficile infection. The study will use a design known as a 'cluster crossover registry design'. In this type of study, data are collected primarily from existing data sources rather than the medical records of individual patients. This study will establish which of the two types of medicines that are commonly used for stress ulcer prophylaxis in ICU patients who require life support leads to the lowest risk of upper gastrointestinal bleeding, prolonged mechanical ventilation, and Clostridium difficile infection.
TARGET Study	The Augmented versus Routine approach to Giving Energy Trial: A randomised controlled trial. Nutrition therapy is an essential standard of care for all ICU patients who are mechanically ventilated and remain in ICU for more than a few days. Enteral nutrition (via a nasogastric tube) is usually initiated within 24 hours of ICU admission with a formula containing 1.0 kcal/ml and prescribed at an approximate rate of 1 ml/kg/hour. However, standard enteral nutrition practice typically results in the delivery of only ~60% of the full recommended calorie requirement.

Endocrinology

Adult Multicentre Hybrid Closed Loop Study	Evaluation of the efficacy and cost effectiveness of long term hybrid closed loop insulin delivery in improving glycaemia, psychosocial wellbeing, sleep quality, cognition, and biochemical markers of vascular risk in adults with Type 1 Diabetes compared with standard care. 2. The primary study rationale is to fill a gap in our knowledge regarding the quality of sugar control with the use of the HCL system vs standard therapy (ie manually entered insulin pump therapy where the wearer determines how much has to be delivered or multiple daily dose injections of insulin). This will include the % time in target sugar range, as well as excursions (either hypoglycaemia or hyperglycaemia).
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Hyperbaric

Wound ELECT	Non Inferiority Randomised Control Trial Comparing Wound healing with compression therapy to electric stimulation therapy. Compression therapy is gold standard and currently recommended to help heal an ulcer. Electric stimulation therapy has been used by physiotherapists to improve circulation in the legs which is also the goal of compression therapy. Electric stimulation therapy involves the application of low intensity electric currents to the skin via the application of electrode pads that stick on the stick with an adhesive but are removed between treatments. The clinical effectiveness of the treatments will be considered as will the cost effectiveness.
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Neonatal and Paediatric

Regeneron REGN 2222	A phase 3, randomised, double-blind placebo-controlled study evaluating the efficacy and safety of a human monoclonal antibody, REGN2222, for the prevention of medically attended RSV infection in preterm infants
TESTOV	TESTOV- PNEUMO. Evaluation of the effectiveness of the 13-valent pneumococcal vaccine against pneumococcal pneumonia in children
Janssen Research and Development	A Phase 1b, randomised, partially double blind, placebo-controlled study to assess the pharmacokinetics, safety, and tolerability of multiple doses of orally administered JNJ-53718678 in infants hospitalized with RSV infection
PAEAN NHMRC Clinical Trials Centre Dr H Liley Mater Hospital, Brisbane	Preventing Adverse Outcomes of Neonatal Hypoxic Ischaemic Encephalopathy with Erythropoietin: a Phase III Randomised Placebo controlled multicentre clinical trial
Optimist A Menzies Research Centre	Multicentre randomised controlled trial of minimally-invasive surfactant therapy in preterm infants 25-28 weeks gestation on continuous positive airway pressure
NEST Dr R Hunt RCH Melbourne	A randomised controlled trial comparing the treatment of electrographic and clinical seizures, to the treatment of clinical seizures alone, in term or near term encephalopathic infants and measuring the impact on death and neuro development at 2 years
MAGENTA Prof C Crowther University of Adelaide Robinson Institute	Magnesium Sulphate at 30 to 34 weeks gestational age: Neuroprotection trial
Moral Distress - survey of staff Dr J Miller RCH Melbourne	Moral Distress in Paediatric Intensive Care Practitioners – a Multicentre Cross Sectional Evaluation

Nephrology

REDUCTION	Reducing the Burden of Dialysis Catheter Complications. Our understanding of the burden of mortality and morbidity complicating dialysis catheter use in Australia and New Zealand is limited and the current scope for improvement is poor. There are guideline recommendations and emerging international evidence around multifaceted strategies to reduce dialysis catheter complications but a systematic approach is required to define the burden of disease and test the application of interventions to improve patient outcomes.
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Oncology

ALL 06	A Phase II trial of an intensive paediatric protocol incorporating post-induction stratification based on MRD levels for the treatment of adolescents aged 15 years and above, and young adults aged up to 40 years, with newly diagnosed Acute Lymphoblastic Leukaemia.
Checkmate 384	A Dose Frequency Optimisation, Phase IIIB/IV Trial of Nivolumab 240 mg Every 2 Weeks vs Nivolumab 480 mg Every 4 Weeks in Subjects with Advanced or Metastatic Non-small Cell Lung Cancer who Received 4 Months of Nivolumab at 3 mg/kg or 240 mg Every 2 Weeks. The purpose of this study is to test whether a less frequent, but higher dosing of Nivolumab (also known as BMS-936558) has similar safety and efficacy than the currently approved dose. Nivolumab is an antibody (a type of human protein) that has been proven to aid the body's immune system in fighting against tumour cells.
REMARc (NHL 25)	A Double Blind Randomised Phase III Study of Lenalidomide (Revlimid) Maintenance versus Placebo in Responding Elderly Patients with DLBCL and treated with R-CHOP in first line.
CLEAR	A Multicenter, Open-label, Randomised, Phase 3 Trial to Compare the Efficacy and Safety of Lenvatinib in Combination with Everolimus or Pembrolizumab Versus Sunitinib Alone in First-Line Treatment of Subjects with Advanced Renal Cell Carcinoma
E7080-G000-307	A Multicenter, Open-label, Randomised, Phase 3 Trial to Compare the Efficacy and Safety of Lenvatinib in Combination with Everolimus or Pembrolizumab Versus Sunitinib Alone in First-Line Treatment of Subjects with Advanced Renal Cell Carcinoma (CLEAR)
SPARTAN	A Multicenter, Randomised, Double-Blind, Phase III Study of ARN-509 in Men with Non-Metastatic (M0) Castration-Resistant Prostate Cancer.
BL12 (ANZUP)	A Multicentre randomised Phase II Trial comparing Nab-Paclitaxel to Paclitaxel in patients with advanced urothelial cancer progressing on or after a platinum containing regimen.
MURANO	A multicentre, phase III, open-label, randomised study in Relapsed/Refractory patients with Chronic Lymphocytic Leukaemia to evaluate the benefit of GDC-0199 (ABT-199) plus Rituximab compared with Bendamustine plus Rituximab.
ENSPiRiT	A Multinational, Randomised, Open-Label Phase III Study of Custirsén (TV-1011/OGX-011) in Combination with Docetaxel Versus Docetaxel As A Second-Line Treatment in Patients with Advanced or Metastatic (Stage IV) Non-Small Cell Lung Cancer.
OPAL	A National, Patient-Randomised Controlled Trial to compare relative effectiveness of treatment arms (support and information provided by a trained oncology nurse as support for patients recently diagnosed with lung cancer).
MEDIIMMUNE	A Phase I/2, Open-label Study to Evaluate the Safety and Antitumor Activity of MEDI0680 (AMP-514) in Combination with MEDI4736 and MEDI0680 Monotherapy in Subjects with Select Advanced Malignancies. MEDI0680 and MEDI4736 are monoclonal antibodies that are similar to antibodies that are made by the human body. Antibodies are natural proteins made by our immune system that bind to other proteins and molecules to fight infection and its ill effects. MEDI4736 binds to the PD-L1 protein in the body and may prevent cancer growth by helping certain blood cells of the immune system eliminate the tumour. MEDI0680 works to block PD-1 from attaching to the PD-L1 and PD-L2 proteins within the tumour thereby allowing the T cells and the body's immune system to attack the tumour. MEDI0680 may also work by making the T cells kill the tumours better.
REPLY (NHL 26)	A Phase 2 Study of patients treated for relapsed Follicular Lymphoma: with Revlimid® consolidation added to Rituximab maintenance therapy in those remaining PET positive (RePLY).
GILEAD Gastric 2013	A Phase 2, Open-Label, Randomised Study to Evaluate the Efficacy and Safety of Adeciximab (GS-5745) Combined With Nivolumab Versus Nivolumab Alone in Subjects With Unresectable or Recurrent Gastric or Gastroesophageal Junction Adenocarcinoma.
GS-US-296-2013	A Phase 2, Open-Label, Randomised Study to Evaluate the Efficacy and Safety of GS-5745 Combined with Nivolumab versus Nivolumab Alone in Subjects with Unresectable or Recurrent Gastric or Gastroesophageal Junction Adenocarcinoma. GS-5745 is a monoclonal antibody that inhibits MMP9, an extracellular enzyme involved in matrix remodelling, tumor growth, and metastasis. Preclinical studies demonstrate that MMP9 inhibition alters the tumor microenvironment, is associated with greater chemotherapy penetration, and improved anti-tumor immunity. Nivolumab is a fully human anti-PD-1 IgG4 monoclonal antibody with a favourable safety profile and efficacy in melanoma, non-small-cell lung cancer, and renal cell carcinoma.

AMETHYST (MIRATI)	A Phase 2, Parallel-Arm Study of MGCD265 in Patients with Locally Advanced or Metastatic Non-Small Cell Lung Cancer with Activating Genetic Alterations in Mesenchymal-Epithelial Transition Factor.
GILEAD Gastric 1080	A Phase 3 Randomised, Double-Blind, Placebo-Controlled Study to Evaluate the Efficacy and Safety of Andecaliximab (GS-5745) Combined with mFOLFOX6 as First Line Treatment in Patients with Advanced Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma.
ABBVIE Breast (III)	A Phase 3 Randomised, Placebo-Controlled Trial of Carboplatin and Paclitaxel with or without the PARP Inhibitor Veliparib (ABT-888) in HER2-Negative Metastatic or Locally Advanced Unresectable BRCA-Associated Breast Cancer
ABBVIE MM	A Phase 3, Multicenter, Randomised, Double Blind Study of Bortezomib and Dexamethasone in Combination with Either Venetoclax or Placebo in Subjects with Relapsed or Refractory Multiple Myeloma Who are Sensitive or Naïve to Proteasome Inhibitors.
MMII	A Phase 3, Multicentre, Randomised, Controlled Study to Determine the Efficacy and Safety of Cyclophosphamide, Lenalidomide and Dexamethasone (CRD) Versus Melphalan (200 mg/m ²) Followed By Stem Cell Transplant In Newly Diagnosed Multiple Myeloma Subjects.
LUMIERE	A Phase 3, Randomised, Two-Arm, Open-Label, Multicenter, International Trial of Alisertib (MLN8237) or Investigator's Choice (Selected Single Agent) in Patients with Relapsed or Refractory Peripheral T-Cell Lymphoma.
BGB-3111-AU-003	A Phase I, Open Label, Multiple Dose, Dose Escalation and Expansion Study to Investigate the Safety and Pharmacokinetics of the BTK Inhibitor BGB-3111 in Subjects with B-Cell Lymphoid Malignancies. This is a study of a new drug called BGB-3111 to see what effects it has on B Cell haematologic malignancies in combination with Ibrutinib and how it is tolerated. The purpose of this study is to (1) determine if this study drug is safe for human use and how well the study drug is tolerated after dosing, and (2) find the most effective dose of this study drug as a treatment for these malignancies. The RHH is only participating in Part 2 of the study as Part 1 has concluded. Participants enrolled in Part 2 will receive a dose of the study drug at a level that was determined to be appropriate in Part 1.
BEIGENE B CELL	A Phase I, Open Label, Multiple Dose, Dose Escalation and Expansion Study to Investigate the Safety and Pharmacokinetics of the BTK Inhibitor BGB-3111 in Subjects with B-Cell Lymphoid Malignancies.
HARMONY	A PHASE Ib/II STUDY evaluating the safety and Efficacy of Obinutuzumab in combination with Polatuzumab Vedotin and Venetoclax in participants with relapsed or refractory Follicular or Diffuse Large B-Cell Lymphoma.
ACED	A Phase II randomised placebo-controlled, double blind, multisite study of Acetazolamide versus placebo for management of cerebral oedema in recurrent and/or progressive High Grade Glioma requiring treatment with Dexamethasone. This study proposes to explore the role of oral acetazolamide as a corticosteroid-sparing agent (without compromising clinical outcomes) and in ameliorating steroid side effects. To explore whether the addition of oral acetazolamide allows for dexamethasone dose reduction without clinical deterioration in performance status in the management of raised intracranial pressure in recurrent and/or progressive HGG.
NHL 29 (IRiC)	A Phase II study in patients ≥75 years with newly diagnosed Diffuse Large B Cell Lymphoma. Ibrutinib has demonstrated efficacy in inhibiting the B-cell-receptor pathways characterising the poor prognosis ABC subtype which is highly prevalent in the very elderly.
ZOSTER 039	A Phase II, randomised, observer-blind, placebo-controlled, multicentre study to assess the safety, immunogenicity and efficacy of GSK Biologicals' Herpes Zoster HZ/su candidate vaccine when administered intramuscularly on a two-dose schedule to adults aged 18 years and older with haematologic malignancies.
JAVELIN Gastric 300	A Phase III open-label, multicenter trial of Avelumab (MSB0010718C) as a third-line treatment of unresectable, recurrent, or metastatic gastric or gastroesophageal junction adenocarcinoma.
JAVELIN Gastric 100	A Phase III Open-label, Multicenter Trial of Maintenance Therapy With Avelumab (MSB0010718C) Versus Continuation of First-line Chemotherapy in Subjects With Unresectable, Locally Advanced or Metastatic, Adenocarcinoma of the Stomach, or of the Gastro-esophageal Junction.
BR.31 Lung	A phase III prospective double blind placebo controlled randomised study of adjuvant MEDI4736 in completely resected Non-Small Cell Lung Cancer.
BIG 1.98	A Phase III Study to Evaluate Letrozole as Adjuvant Endocrine Therapy for Postmenopausal Women With Receptor (ER and/or PgR) Positive Tumors.
OVAR 16	A Phase III Study to Evaluate the Efficacy and Safety of Pazonpanib Monotherapy versus Placebo in Women who have not progressed after first line chemotherapy for epithelial ovarian, fallopian tube, or primary peritoneal cancer.
SOLE	A Phase III Trial Evaluating the Role of Continuous Letrozole Versus Intermittent Letrozole Following 4 to 6 Years of Prior Adjuvant Endocrine Therapy for Postmenopausal Women With Hormone-Receptor Positive, Node Positive Early Stage Breast Cancer (SOLE, Study of Letrozole Extension).

TEXT	A Phase III Trial Evaluating The Role Of Exemestane Plus GnRH Analogue As Adjuvant Therapy For Premenopausal Women With Endocrine Responsive Breast Cancer.
SOFT	A phase III trial evaluating the role of ovarian function suppression and the role of exemestane as adjuvant therapies for premenopausal women with endocrine responsive breast cancer: Suppression of Ovarian Function Trial (SOFT).
CoBRIM	A Phase III, Double Blind, Placebo-Controlled Study of Vemurafenib Versus Vemurafenib plus GDC-973 in Previously Untreated BRAFv600 Mutation Positive Patients with Unresectable Locally Advanced or Metastatic Melanoma.
PRAN 16-52 AML	A Phase III, Double-Blind, Placebo-Controlled, Multicenter, Randomised Study of Pracinostat in Combination with Azacitidine in Patients ≥18 Years with Newly Diagnosed Acute Myeloid Leukemia unfit for Standard Induction Chemotherapy. Common approaches for patients with AML unfit to receive standard induction therapy regimens consist of low intensity therapies but their benefit is limited. New treatment approaches are needed.
ONCONOVA MDS 04-30	A Phase III, International, Randomised, Controlled Study of Rigosertib versus Physician's Choice of Treatment in Patients with Myelodysplastic Syndrome after Failure of a Hypomethylating Agent (INSPIRE).
RESIDUUM (CLL 6)	A Phase III, Multicentre, Randomised Trial Comparing Lenalidomide Consolidation Vs No Consolidation in Patients with Chronic Lymphocytic Leukaemia and Residual Disease Following Induction Chemotherapy.
IMPOWER 150	A Phase III, Open-Label, Randomised Study of MPDL3280A (anti-PD-L1 Antibody) in combination with Carboplatin + Paclitaxel with or without Bevacizumab compared with Carboplatin + Paclitaxel + Bevacizumab in Chemotherapy-Naïve Patients with Stage IV Non-Squamous Non-Small Cell Lung Cancer (IMpower 150).
IMPOWER 132	A Phase III, Open-Label, Randomised Study Of Atezolizumab (MPDL3280A, Anti-Pd-L1 Antibody) In Combination With Carboplatin Or Cisplatin + Pemetrexed Compared With Carboplatin Or Cisplatin + Pemetrexed In Patients Who Are Chemotherapy Naïve And Have Stage IV Non-Squamous Non-Small Cell Lung Cancer. This study will evaluate the efficacy, safety, and pharmacokinetics of atezolizumab in combination with carboplatin or cisplatin + pemetrexed compared with carboplatin or cisplatin + pemetrexed in patients who are chemotherapy-naïve and have Stage IV NSCLC.
KEYNOTE 204 CHL	A Phase III, Randomised, Open-label, Clinical Trial to Compare Pembrolizumab With Brentuximab Vedotin in Subjects With Relapsed or Refractory Classical Hodgkin Lymphoma.
GO28141- CoBRIM	A phase III, double-blind, placebo-controlled study of vemurafenib versus vemurafenib plus GDC-0973 in previously untreated BRAFV600 mutation-positive patients with unresectable locally advanced or metastatic melanoma G028141.
Contralto	A phase II, open-label study evaluating the safety and efficacy of GDC-0199 (ABT-199) plus bendamustine plus rituximab (BR) in comparison with BR alone or GDC-0199 plus rituximab (R) in patients with relapsed and refractory follicular non hodgkin's lymphoma.
AML M20	A Programme of Development for Older Patients with Acute Myeloid Leukaemia and High Risk Myelodysplastic Syndrome: A Phase II study assessing the complete remission rate and overall survival of older patients with acute myeloid leukaemia and high risk myelodysplastic syndrome that undergo less intensive treatment.
SENTINAL Node (Vulval)	A prospective Audit of Sentinel Node Biopsy for Vulval Carcinoma in Australia and New Zealand.
MM14	A prospective randomised Phase II study of single agent pomalidomide maintenance versus combination pomalidomide and low dose dexamethasone maintenance following induction with the combination of pomalidomide and low dose dexamethasone in patients with relapsed and refractory myeloma previously treated with lenalidomide.
OVAR 2.21	A prospective randomised Phase III trial of carboplatin/ gemcitabine/ bevacizumab vs. carboplatin/ pegylated liposomal doxorubicin/ bevacizumab in patients with platinum-sensitive recurrent ovarian cancer.
STARS	A Randomised Comparison of Anastrozole Commenced Before and Continued During Adjuvant Radiotherapy for Breast Cancer Versus Anastrozole and Subsequent Anti-oestrogen Therapy Delayed Until After Radiotherapy.
NIVORAD	A randomised phase 2 trial of nivolumab and stereotactic ablative body radiotherapy in advanced non-small cell lung cancer; progressing after first or second line chemotherapy.
INTEGRATE OGC	A Randomised Phase II Double-Blind Study of Regorafenib or Placebo in Refractory Advanced Oesophago-Gastric Cancer (AOGC).
MDS4	A Randomised Phase II study comparing the efficacy of 5azacitidine alone versus combination therapy with lenalidomide and 5azacitidine in patients with higher risk myelodysplastic syndromes (MDS) and low marrow blast count acute myeloid leukaemia (AML).

NAB NEC II	A Randomised Phase II Study Of nab-paclitaxel In Combination With Carboplatin As First Line Treatment Of Gastrointestinal Neuroendocrine Carcinomas.
RAIDER	A Randomised phase II trial of Adaptive Image guided standard or Dose Escalated tumour boost Radiotherapy in the treatment of transitional cell carcinoma of the bladder (RAIDER).
ALT-GIST	A randomised phase II trial of Imatinib alternating with Regorafenib compared to Imatinib alone for the first line treatment of advanced gastrointestinal stromal tumour.
DOCTOR	A Randomised phase II trial of Pre-operative Cisplatin, 5 Fluorouracil and Docetaxel or Cisplatin, 5 Fluorouracil, Docetaxel plus Radiotherapy based on poor early response to standard chemotherapy for resectable adenocarcinoma of the oesophagus and/or OG Junction.
TOP GEAR	A randomised phase II/III trial of preoperative chemoradiotherapy versus preoperative chemotherapy for resectable gastric cancer.
INTEGRATE II	A Randomised Phase III Double-Blind Placebo-Controlled Study of Regorafenib in Refractory Advanced Gastro-Oesophageal Cancer (AGOC).
BIG 3.07 (DCIS)	A Randomised Phase III Study of Radiation Doses and Fractionation Schedules for Ductal Carcinoma in Situ (DCIS) of the Breast.
CHISEL	A Randomised phase III trial of highly conformal hypofractionated image guided ("stereotactic") radiotherapy (HypoRT) versus conventionally fractionated radiotherapy (ConRT) for inoperable early stage I non small cell lung cancer.
PT-I	A Randomised Trial to Compare Aspirin vs Hydroxyurea/Aspirin in 'Intermediate Risk' Primary Thrombocythaemia and Aspirin Only With Observation in 'Low Risk' Primary Thrombocythaemia.
OLYMPIA Breast	A randomised, double blind, parallel group, placebo controlled multicenter phase III study to assess the efficacy and safety of olaparib versus placebo as adjuvant treatment in patients with high risk germline BRCA mutated HER2-negative breast cancer who have completed definitive local and systemic neoadjuvant/ adjuvant treatment.
ALTTO	A randomised, multi-centre, open-label, phase III study of adjuvant lapatinib, trastuzumab, their sequence and their combination in patients with HER2/ErbB2 positive primary breast cancer.
ROBIN	A randomised, open label, multi-centre, phase III study to investigate the efficacy of Bendamustine compared to treatment of physician's choice in the treatment of subjects with indolent Non-Hodgkin's Lymphoma (NHL) refractory to Rituximab.
CDX-011 (The METRIC Study)	A Randomised Multicenter Pivotal Study of CDX-011 (CRO11-vcMMAE) in Patients with Metastatic, GPNMB Over-Expressing, Triple-Negative Breast Cancer (The "METRIC" Study)
APHINITY Breast	A randomised multicenter, double-blind, placebo-controlled comparison of chemotherapy plus trastuzumab plus placebo versus chemotherapy plus trastuzumab plus pertuzumab as adjuvant therapy in patients with operable HER2-positive primary breast cancer.
HD8 RATHL	A Randomised Phase III Trial to Assess Response Adapted Therapy Using FDG-PET Imaging in Patients With Newly Diagnosed, Advanced Hodgkin Lymphoma.
DENOSUMAB MM	A Randomised, Double-Blind, Multicenter Study of Denosumab Compared With Zoledronic Acid (Zometa) in the Treatment of Bone Disease in Subjects with Newly Diagnosed Multiple Myeloma.
APOMAB	A Randomised, Double-Blind, Phase II Trial of Paclitaxel + Carboplatin + Bevacizumab With or Without PRO95780 in Patients With Previously Untreated, Advanced-Stage Non-Small Cell Lung Cancer.
PHOENIX	A Randomised, Double-Blind, Placebo-controlled Phase 3 Study of the Bruton's Tyrosine Kinase (BTK) Inhibitor PCI-32765 (Ibrutinib), in Combination with R-CHOP in Subjects with Newly Diagnosed Non-Germinal Center B-Cell Subtype of DLBC Lymphoma.
CHECKMATE 577 OJC	A Randomised, Multicenter, Double Blind, Phase III Study of Adjuvant Nivolumab or Placebo in Subjects With Resected Esophageal, or Gastroesophageal Junction Cancer.
ACE-CL-309	A Randomised, Multicenter, Open-Label, Phase 3 Study of Acalabrutinib (ACP-196) Versus Investigator's Choice of Either Idelalisib Plus Rituximab or Bendamustine Plus Rituximab in Subjects with Relapsed or Refractory Chronic Lymphocytic Leukemia. The primary objective of this study is to evaluate the efficacy of acalabrutinib monotherapy (Arm A) compared with idelalisib/rituximab or bendamustine/rituximab (Arm B). Clinical studies have shown that acalabrutinib is an orally bioavailable Btk inhibitor with fast absorption and rapid clearance. Acalabrutinib has been well tolerated in healthy volunteers and subjects with CLL or Richter's syndrome in previous studies.

ABBVIE Lung	A Randomised, Open-Label, Multicenter, Phase 3 Trial Comparing Veliparib Plus Carboplatin and Paclitaxel Versus Investigator's Choice of Standard Chemotherapy in Subjects Receiving First Cytotoxic Chemotherapy for Metastatic or Advanced Non-Squamous Non-Small Cell Lung Cancer (NSCLC) and Who Are Current or Former Smokers.
Echelon	A Randomised, Open-label, Phase 3 Trial of A+AVD Versus ABVD as Frontline Therapy in patients with advanced Classical Hodgkin Lymphoma.
CML 12 (DIRECT)	A single arm phase II study to individualise dasatinib dosing based on trough levels and molecular response to maintain efficacy whilst minimising toxicity. The Direct study aims to minimise the cumulative incidence of adverse events, especially pulmonary toxicities, of dasatinib therapy by using therapeutic drug monitoring to adjust the dasatinib dose without compromising efficacy in elderly CML-CP patients.
IMPOWER 132	A Study of Atezolizumab in Combination With Carboplatin or Cisplatin + Pemetrexed Compared With Carboplatin or Cisplatin + Pemetrexed in Participants Who Are Chemotherapy-Naive and Have Stage IV Non-Squamous Non-Small Cell Lung Cancer (NSCLC) (IMpower 132).
TABITHA	A study to develop a prospective multi-site registry to evaluate clinical features, types of treatment, outcomes and survival in participants with HER2 positive metastatic breast cancer managed in routine practice in Australia.
ABBVIE GBM	ABT-414 Alone or ABT-414 Plus Temozolomide vs. Lomustine or Temozolomide for Recurrent Glioblastoma: A Randomised Phase II Study of the EORTC Brain Tumor Group (Intelligence2).
NBCR (AML M18)	ALLG National Blood Cancer Registry - for all patients with a "suspected, or known, or diagnosed blood cancer" (previously only AML - has been expanded to encompass others).
CAMMERAY (CLL7)	An Australasian, phase II, multicentre, randomised, study investigating efficacy and safety for dose reduced fludarabine, cyclophosphamide and intravenous obinutuzumab (G-FC3) versus oral chlorambucil and intravenous obinutuzumab (G-Clb) in previously untreated, comorbid, elderly patients with chronic lymphocytic leukaemia (CLL).
TRACC	An Australian Prospective, Non-interventional Registry to Evaluate Clinical Outcomes and Bevacizumab Use in Metastatic Colorectal Cancer from Routine Clinical Practice.
TRITON2	An International Multicentre Open Label Randomised Phase II Advanced Anal Cancer Trial Comparing Cisplatin plus 5-fluorouracil versus Carboplatin plus Weekly Paclitaxel in Patients with Inoperable Locally Recurrent or Metastatic Disease. The objective of the clinical trial is to assess the efficacy of rucaparib based on the response rate in mCRPC patients with HRD who progressed on AR-targeted therapy (abiraterone acetate, enzalutamide, or investigational AR-targeted agent) and taxane-based chemotherapy in the castration resistant setting.
InterAACT	An International Multicentre Open Label Randomised Phase II Advanced Anal Cancer Trial Comparing Cisplatin plus 5-fluorouracil versus Carboplatin plus Weekly Paclitaxel in Patients with Inoperable Locally Recurrent or Metastatic Disease.
SAUL	An Open Label, Single Arm, Multicenter, Safety Study Of Atezolizumab In locally advanced or Metastatic Urothelial or Non-Urothelial Carcinoma of the Urinary Tract ("Saul"). This study is being conducted to evaluate the safety and efficacy of atezolizumab as second-line treatment for locally advanced or metastatic urothelial or non-urothelial carcinoma of the urinary tract. In addition the trial will explore potential tumour biomarkers related to atezolizumab.
RESONATE III6 (EXT)	An Open-label Extension Study in Patients 65 Years or Older with Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL) Who Participated in Study PCYC-III15-CA (PCI-32765 versus Chlorambucil).
APLASTIC ANAEMIA	Aplastic Anaemia Registry (registry to build consensus regarding incidence, natural history and clinical outcome of AA in Australia to better define optimal management of AA patients).
ASCOLT	Aspirin for Dukes C and High Risk Dukes B Colorectal Cancer: An International, Multi-Centre, Double Blind, Randomised Placebo Controlled Phase III Trial.
HD4	BEACOPP (4 Cycles Escalated + 4 Cycles Baseline) Versus ABVD (8 Cycles) In Stage III & IV Hodgkin's Lymphoma.
BIOGRID	Biogrid Australia: Health through information (platform for TRACC and TABITHA Registries).
DYNAMIC	Circulating Tumour DNA Analysis Informing Adjuvant Chemotherapy in Stage II Colon Cancer (DYNAMIC).
CHECKMATE 401 Mel	Clinical Trial of Nivolumab (BMS-936558) Combined with Ipilimumab Followed by Nivolumab Monotherapy as First-Line Therapy of Subjects with Histologically Confirmed Stage III (Unresectable) or Stage IV Melanoma.

FUTuRE Fertility	Fertility Understanding through Registry and Evaluation (FUTuRE Fertility).
GLANCE	Global Longitudinal Assessment of Treatment Outcomes in Squamous Cell Carcinoma of the Head and Neck (GLANCE-H&N) Study. The Global Longitudinal Assessment of Treatment Outcomes in Squamous Cell Carcinoma of the Head and Neck (GLANCE-H&N) Study will provide an opportunity to explore treatment patterns over the whole course of treatment to assess HCRU and overall survival and to yield further insights on treatment choice and reasons for discontinuation in patients with R/M HNSCC who are ineligible for curative loco-regional treatment.
Harmony	GO29833 A phase Ib/II study evaluating the safety and efficacy of obinutuzumab in combination with polatuzumab vedotin and venetoclax in participants with relapsed or refractory follicular or diffuse large b-cell lymphoma. 'HARMONY'.
ECHELON	Hodgkins Lymphoma(Replaces RATHL). Brentuximab vedotin. A Randomised, Open-label, Phase 3 Trial of A+AVD Versus ABVD as Frontline Therapy in Patients With Advanced Classical Hodgkin Lymphoma.
GIST	Intermediate and High Risk Localized, Completely Resected, Gastrointestinal Stromal Tumors (GIST) Expressing KIT Receptor: A Controlled Randomised Trial on Adjuvant Imatinib Mesylate (Glivec) Versus No Further Therapy After Complete Surgery.
GENZYME (Gaucher)	International Collaborative Gaucher Group (ICGG) Gaucher Registry (registry to build consensus regarding incidence, natural history and effects of available therapies on disease manifestation in Australia, to better define optimal management).
MRDR Registry	Myeloma and Related Diseases Registry (registry for Myeloma, Plasmacytoma, Plasma Cell Leukaemia and MGUS - to better determine patterns of treatment and variation in patient outcomes - both survival and quality of life - across Australia and New Zealand).
MPN01 Registry	Myeloproliferative Neoplasms Registry: A cancer registration scheme to aid in the planning of health service resources and cancer control programmes and the assessment of their efficacy.
BIOGRID	Not an active/recruiting registry - BioGrid is the federated platform that other registries sit on (such as TRACC for Colorectal and TABITHA for Breast).
FUTuRE Fertility	Oncofertility registry aimed at - collecting demographic info for patients of childbearing potential (<45 yrs) who seek fertility preservation; monitoring return of reproductive function; and to perform mathematical modelling of fertility preservation to determine costs of providing FP program for patients at diagnosis.
PALLAS	Palbociclib Collaborative Adjuvant Study: A Randomised Phase III Trial of Palbociclib With Standard Adjuvant Endocrine Therapy Versus Standard Adjuvant Endocrine Therapy Alone for Hormone Receptor Positive (HR+) / Human Epidermal Growth Factor Receptor 2 (HER2)-Negative Early Breast Cancer.
PCYC-114-CA	PCYC-1141-CA: A Multicenter, Randomised, Double-blind, Placebo-controlled Phase 3 Study of the Bruton's Tyrosine Kinase (BTK) Inhibitor, Ibrutinib, in Combination with Rituximab versus Placebo in Combination with Rituximab in Treatment Naïve Subjects with Follicular Lymphoma. The aim of this randomised clinical trial is to evaluate whether the addition of ibrutinib to rituximab will result in prolongation of progression-free survival when compared with rituximab alone in treatment naïve subjects with follicular lymphoma.
P3BEP	Phase 3 Accelerated BEP: A Randomised Phase 3 Trial of Accelerated Versus Standard BEP Chemotherapy for Patients With Intermediate and Poor-risk Metastatic Germ Cell Tumours.
ASCEND (ACE 309)	Phase 3 Open-Label Study of Acalabrutinib (ACP-196) versus Investigator's Choice of Either Idelalisib Plus Rituximab or Bendamustine Plus Rituximab in Subjects with Relapsed or Refractory Chronic Lymphocytic Leukemia.
CASTOR	Phase 3 Study Comparing Daratumumab, Bortezomib and Dexamethasone (DVd) vs Bortezomib and Dexamethasone (Vd) in Subjects With Relapsed or Refractory Multiple Myeloma.
PINNACLE (CML II)	Phase II study of nilotinib plus pegylated interferon alfa-2b as first-line therapy in chronic phase CML aiming to maximize CMR and MMR.
KEYNOTE 199 Prostate	Phase II Trial of Pembrolizumab (MK-3475) in Subjects With Metastatic Castration-Resistant Prostate Cancer (mCRPC) Previously Treated With Chemotherapy (KEYNOTE-199).
CONTRALTO	Phase II, Open Label, Randomised Study Evaluating the Safety and Efficacy GDC-0199 (ABT-199) plus Rituximab (R) or Bendamustine plus Rituximab (BR) in comparison with BR alone in patients with relapsed and refractory Follicular Non-Hodgkin's Lymphoma.
CATNON	Phase III trial on Concurrent and Adjuvant Temozolomide Chemotherapy in non-1p/19q deleted anaplastic glioma (The CATNON Intergroup Trial).
CRC Transporter	Profiling and Functional Studies of Drug Transporters in Colorectal Cancer: A Pilot Study in Tasmanian Patients.

ENZAMET	Randomised phase 3 trial of enzalutamide in first line androgen deprivation therapy for metastatic prostate cancer.
ENZARAD	Randomised phase 3 trial of radiation plus androgen deprivation therapy with or without enzalutamide for high risk clinically localised prostate cancer.
ELIMINATE	Randomised phase II trial of neoadjuvant chemotherapy +/- concurrent aromatase inhibitor endocrine therapy to down-stage oestrogen receptor positive breast cancer.
PORTEC-3	Randomised Phase III Trial Comparing Concurrent Chemoradiation and Adjuvant Chemotherapy With Pelvic Radiation Alone in High Risk and Advanced Stage Endometrial Carcinoma: PORTEC-3.
NHL 24	Rituximab in primary central nervous system Lymphoma. A randomised Dutch/Belgian Hemato-Oncology Cooperative Group (HOVON) / Australasian Leukaemia and Lymphoma Group (ALLG) intergroup study.
SCOT	Short Course Oncology Therapy – A Study of Adjuvant Chemotherapy in Colorectal Cancer.
MM18	Single arm, multicentre study of Carfilzomib in combination with Thalidomide and Dexamethasone (CaTD) in patients with relapsed and/or refractory multiple myeloma (RRMM) Multiple myeloma (MM) is a haematological malignancy characterised by an abnormal serum and/or urine paraprotein or free immunoglobulin light chain as a result of clonal expansion of plasma cells. It is often accompanied by significant comorbidities including bone lesions, renal failure, hypercalcaemia, immune suppression and anaemia, features that are used to define "symptomatic myeloma" requiring treatment. The introduction of the proteasome inhibitor (PI) bortezomib and immunomodulatory drugs including thalidomide, lenalidomide and pomalidomide has significantly improved survival for patients with MM. However, all patients are destined to relapse even with the best available approved novel agents.
AML M16	Sorafenib in combination with intensive chemotherapy for previously untreated adult FLT3-Internal Tandem Duplication (FLT3-ITD) - positive AML: A Phase II randomised placebo-controlled multi-centre study evaluating two year progression-free survival.
SAFRON II	Stereotactic ablative fractionated radiotherapy versus radiosurgery for Oligometastatic Neoplasia to the lung: A randomised phase II trial.
AGOG Epidemiology	The AGOG (Australian Genomics and Clinical Outcomes of Glioma) Epidemiology Study - investigating lifestyle and environmental exposures and genetic variants and glioma risk in those with and without glioma.
GLANCE	The Global Longitudinal Assessment of Treatment Outcomes in Squamous Cell Carcinoma of the Head and Neck (GLANCE-H&N) Study will provide an opportunity to explore treatment patterns over the whole course of treatment to assess HCRU and overall survival and to yield further insights on treatment choice and reasons for discontinuation in patients with R/M HNSCC who are ineligible for curative loco-regional treatment.
CASTOR	This is a Phase 3 study comparing Daratumumab, Bortezomib Dexamethasone Vs Bortezomib and Dexamethasone in subjects with relapsed or refractory multiple myeloma.
GS-5745	This study aims to assess in a randomised, blinded fashion whether GS-5745 in combination with mFOLFOX6 improves therapeutic outcomes in subjects with previously untreated locally advanced or metastatic gastric and GEJ adenocarcinoma. A total of 430 eligible subjects with advanced gastric and GEJ adenocarcinoma. A total of 430 eligible subjects with advanced gastric and GEJ adenocarcinoma will be randomised in a 1:1 manner to m FOLFOX6 plus GS-5745 or mFOLFOX plus placebo.
SPARTAN/ ARN 509-003	This study is a multi-centre, randomised, double-blind, placebo-controlled, phase 3 study of ARN-509 in men with non-metastatic (MO) castration-resistant prostate cancer and was approved to commence at THO-South in June 2013. The proposed amendments relate to slightly increased payments to compensate for dosing of Zytiga in accordance with Protocol Amendment #3 and include compensation for unscheduled visits and tumour assessments.
DERMA	This Trial is a double-blind, randomised, placebo-controlled Phase III study to assess the efficacy of recMAGE - A3+AS15 ASCI as adjuvant therapy in patients with MAGE-A3 positive resected stage III melanoma.
Ovar2.2I	This trial is A prospective randomised Phase III trial of carboplatin/gemcitabine/bevacizumab vs cardoplatin/peglyated liposomal doxorubicin/bevacizumab in patients with platinum sensitive recurrent ovarian cancer.
VERTU GBM	Veliparib, Radiotherapy and Temozolomide trial in Unmethylated MGMT Glioblastoma: A Randomised Phase II study of veliparib + radiotherapy (RT) with adjuvant temozolomide (TMZ) + veliparib versus standard RT + TMZ followed by TMZ.
WBRTMeI	Whole Brain Radiotherapy following local treatment of intracranial metastases of melanoma - a randomised phase III trial.

Paediatrics

RSV -I005	A Phase Ib, randomised, partially double-blind, placebo-controlled study to assess the pharmacokinetics, safety, and tolerability of multiple doses of orally administered JNJ-53718678 in infants hospitalized with RSV infection. This Phase Ib study will determine the pharmacokinetics, safety, tolerability, antiviral activity, and impact on the clinical course of RSV infection after multiple oral doses of JNJ-53718678 at different doses and/or dosing regimens in infants (>1 month to ≤24 months of age) who are hospitalized with RSV infection.
MedImmune (NPICU)	A Phase 2b Randomised, Double-blind, Placebo-controlled Study to Evaluate the Safety and Efficacy of MEDI8897, a Monoclonal Antibody With an Extended Half-life Against Respiratory Syncytial Virus, in Healthy Preterm Infants. To assess the efficacy of MEDI8897 when administered as a single 50 mg IM dose to healthy preterm infants born between 29 weeks 0 days and 34 weeks 6 days GA and entering their first RSV season for the reduction of medically attended Lower Respiratory Tract Infection due to RT-PCR-confirmed RSV, compared to placebo.
PAEAN	Preventing Adverse Outcomes of Neonatal Hypoxic Ischaemic Encephalopathy with Erythropoietin. This study is to find out whether Epa plus induced hypothermia (cooling) of near-term newborn babies who have suffered from low blood or oxygen supply to the brain at birth reduces death and disability in survivors at two years of age.
Regeneron2222-PartB	This is a phase 3 Randomised double blind placebo controlled study evaluating the efficiency and safety of a human monoclonal antibody, Regn2222 for the prevention of medically attended RSV infection in preterm infants. The study is completed in two parts. Part A is an open-label 1-cohort multicentre PK study. Subjects in Part A may enrol anytime during the RSV season. Part B is a randomised placebo controlled 3-arm multicentre study.
The Silver Diamine Fluoride Trial	This trial involves the testing the efficacy of Silver Diamine Fluoride under different treatment modalities in arresting dental decay.

Current Research South

PALLAS	Palbociclib Collaborative Adjuvant Study: A Randomised Phase III Trial of Palbociclib With Standard Adjuvant Endocrine Therapy Versus Standard Adjuvant Endocrine Therapy Alone for Hormone Receptor Positive (HR+) / Human Epidermal Growth Factor Receptor 2 (HER2)-Negative Early Breast Cancer.
New Australian Provisional Patent	Automated control of oxygen therapy in newborn infants with respiratory insufficiency. - Proposal for an advanced control algorithm and a simple and cheap device.
Merino II	Pilot Randomised Controlled Trial of Meropenem versus Piperacillin-Tazobactam for Definitive Treatment of Bloodstream Infections caused by AmpC beta-lactamase producing Enterobacter spp., Citrobacter freundii, Morganella morganii, Providencia spp. or Serratia marcescens. in low-risk patients.
SANTO - RI	The SANTO-RI trial is a study using a device to automatically adjust the amount of oxygen a preterm baby is receiving soon after delivery, in response to changes in their oxygen levels and their breathing pattern
Dementia Care in Hospitals Program (DHCP)	This is a Commonwealth Department of Social Services funded project to introduce the DCHP to 4 hospitals across Australia and conduct an evaluation of its impact on patients, carers and staff. The research component of the study is an evaluation of The Dementia Care in Hospitals Program (DCHP) to determine the impact of the program on hospital costs and adverse events.
EXERTION the EXERCISE stress Test collaboraTION Tasmanian Pilot Study	The Exercise stress Test collaboration aims to link clinical exercise testing results to cardiovascular disease outcomes, to provide the first-ever evidence based.
Mixed Meal Challenge: A new diagnostic test for screening pre-diabetes	Pre-diabetes is diagnosed using the oral glucose tolerance test. We have data demonstrating this test causes acute microvascular insulin-resistance in healthy people reducing the effectiveness of this test for screening at-risk individuals. We will determine whether a liquid mixed meal challenge (carbohydrate, protein and fat) is a more sensitive test.
TasGANS The Tasmanian Gynaecological & Anal Neoplasia study	We previously showed a significant association of post-toilet front-to-back and dabbing behaviours with occurrence of anal cancer precursors and cancer-causing HPV types. We want to substantiate the within-person autoinoculation route by comparing HR-HPV types present in stored cervical excision samples with those found in TasGANS anal samples.
SANTO-B	We have developed an automated inspired oxygen controller, which in preliminary studies is very effective in keeping oxygen levels in the desired range in premature infants. The function of the controller has been further enhanced, allowing it to self-tune to an infant's needs, to predict drops in oxygen levels, and to be operated by bedside caregivers. We will now conduct a further evaluation of the device, operated independently by bedside caregivers under standard clinical conditions.

Investigating the physical and chemical Y-site incompatibility antifungals and parenteral nutrition solution	Simultaneous intravenous administration of parenteral nutrition solution and injectable antifungals is often required in cancer patients. The compatibility between newer antifungals and parenteral nutrition is unknown. Hence, timely administration of lifesaving antifungals or much needed nutrition can be delayed awaiting separate intravenous line access. Therefore, it is important to urgently study their compatibilities to facilitate the timely administration of antifungals and parenteral nutrition to cancer patients.
Dietitian Survey re current enteral feeding practices in Paed. Intensive Care Units	The research involves an online survey to dietitians working in Paediatric Intensive Care Units and is therefore of negligible risk. The survey is asking about clinical practices in the Paediatric Intensive Care Units and is part of a larger research study.
Prevalence Study	A prevalence study of inflammatory neuropathies at different latitudes and would like to include Tasmania as a region of interest. This study will involve contacting neurologists at Royal Hobart Hospital and requesting them to identify cases.
ESSA Study	To investigate the effects of early antivenom administration in Australian snakebite. OBJECTIVE: To prevent major clinical envenoming effects such as myotoxicity and neurotoxicity from occurring.
PSP Study	Our aim is to determine whether conservative management of primary spontaneous pneumothorax is an acceptable therapeutic option. Our specific hypotheses are that by eight weeks the resolution of uncomplicated large PSP will be equivalent between approaches and that conservative management will demonstrate substantial advantages, specifically reduced resource utilisation, lower complication rates, reduced risk of PSP recurrence and higher levels of patient satisfaction.
Positive Wards: Making Health Care Encounters Visible - Pilot Study	A research study into ways that healthcare professionals can improve communication with patients, in order to provide high quality care and improve the patient experience.
CF Agreement	This will be a five-year study based in 21 CF centres in Australia. These centres care for >95% of all known patients with CF in Australia. This research will provide definitive data on the clinical implications of, and identify risk factors for, the acquisition of NTM. This will be achieved by linking epidemiology, molecular microbiology and mycobacteriology, genomics and clinical sciences.
REFRESH	Restricted Fluid Resuscitation in Sepsis-associated Hypotension (REFRESH) Trial.
GDM Self insulin Adjustment tool	The Endocrinology Dept is planning to modify our outpatient insulin titration process by incorporating a patient self titration protocol. We are proposing to trial this in the context of Gestational Diabetes patients.
TRIM 16/01795 – Medtronic agreement	Evaluate the validity and acceptability of the Medtronic Mini Link transmitter, and ENLITE sensor (a device for monitoring continuously glucose level) throughout a hyperbaric treatment in the patient with diabetes.
Direct Wire Guided Intubation	Participants undergoing non-cardiac surgery will receive a routine general anaesthetic. Participants will be fully anaesthetised during the procedure whilst a breathing tube is placed in their trachea. The breathing tube has been modified with a side channel guidewire in order to facilitate the passage of the breathing tube over the guidewire and placed under direct vision using a video laryngoscope. The process of inserting the breathing tube inside their mouth will be video recorded.
Cancer Australia's Lung Cancer Demonstration Project.	This was a three-year project completed in end of financial year June 2017. The study looked at improving access to timely, evidenced-based care to lung cancer patients. This was very successful in Hobart and saw the introduction of a full time lung cancer nurse specialist, multidisciplinary meeting coordinator; weekly multidisciplinary meetings, weekly lung cancer clinic and weekly dedicated lung cancer biopsy slots. Medicare billing of multidisciplinary meetings was introduced with funds generated to sustain the lung cancer service into the future. Patients satisfaction surveys completed over the course of the project showed high levels of patient satisfaction with their care.
Investigating the physical and chemical Y-site incompatibility antifungals and parenteral nutrition solution	Simultaneous intravenous administration of parenteral nutrition solution and injectable antifungals is often required in cancer patients. The compatibility between newer antifungals and parenteral nutrition is unknown. Hence, timely administration of lifesaving antifungals or much needed nutrition can be delayed awaiting separate intravenous line access. Therefore, it is important to urgently study their compatibilities to facilitate the timely administration of antifungals and parenteral nutrition to cancer patients.
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Exploring patients experiences of clinical deterioration	This study explores hospitalised patients' experiences of deterioration requiring escalation of care. By speaking up about changes in condition patients and their relatives may be able to contribute to their own safety. However, there is little known about the factors that influence patients 'speaking up'.
Positive Wards: Making health care encounters visible – a pilot study	A research study into ways that healthcare professionals can improve communication with patients, in order to provide high quality care and improve the patient experience.
Getting the job done	Ways of working in the operating room and implications for patient safety and nursing practice.
Study of the Experience of the Nursing Graduate	The purpose of this study is to gain a deeper understanding of the experience and needs of the nursing graduate during their transition year, and describe how this affects ongoing graduate retention.
Exercise & Airway Clearance Practices of Adults with Cystic Fibrosis	This project aims to determine the current practice of adults with cystic fibrosis (CF) in Australia in relation to airway clearance techniques (ACTs) and exercise and to determine the belief and practices in these patients in relation to the use of exercise as a form of airway clearance.
JumpVax	A dose ranging study of sting challenge and specific IgE and IgG4 responses to Jack Jumper Ant (JJA) (<i>Myrmecia pilosula</i>) Venom immunotherapy (VIT) with and without delta-insulin as an adjuvant.
EPICCS	EPICS will describe the epidemiology of critical care referral and admission after inpatient surgery in Australia/New Zealand and the UK, and will estimate the clinical effectiveness of planned postoperative critical care admission as an intervention to reduce postoperative mortality. A secondary benchmarking exercise will be done for descriptive purposes.
Australian Genomics Health Alliance: Preparing Australia for Genomic Medicine	The AGHA has been established to provide a strong evidence base to applying genomics to clinical medicine in a number of disease areas.

Personality traits, staff attitudes and their association with absenteeism and presenteeism rates in public sector hospital based nurses in Hobart, Tasmania	An online cross sectional survey examining the association between nurse's personalities and rates of sick leave and attendance at work when sick. This study also seeks to examine staff attitudes to absence from work and attendance while unwell.
The National Echo Database Australia (NEDA)	The newly developed NEDA database is designed to obtain measurement and report data, but no images from each digital echo laboratory across Australia and transfer them to a secure database, matched against national mortality data.
Evaluation of the Contour• Next Link glucometer in hyperbaric oxygen.	Accurate identification of blood glucose concentration -particularly at lower levels - is very important in a clinical hyperbaric oxygen environment. A significant proportion of the hyperbaric patient population is diabetic and Hyperbaric Oxygen Therapy (HBOT) has been noted to acutely lower the blood glucose concentration in patients with diabetes. The reasons for this have not yet been elucidated
Identifying reversible barriers to uptake of clinical guideline to prevent venous thromboembolism, at a public, medium sized tertiary hospital	This project is a qualitative study using semi-structured interviews with doctors, to identify reversible barriers to the uptake of the venous thromboembolism guidelines at the Royal Hobart Hospital.
Catheter Associated Urinary Tract Infection (CAUTI) among long term catheter users living in the community	This study aims to engage patients and health professionals in the development of a best practice care bundle for patients in the community with suprapubic catheters. The study has the potential to reduce catheter associated infection and trauma.
Medical Emergency Teams – improving communication between critical care and the wards	This is one of the few studies which has explored the role of the ICU nurse in the RRT. It has the potential to improve RRT functioning and therefore patient outcomes.
Good Clinicians Don't Necessarily Make Good Managers...Do They?	Most managers are promoted to management positions due to their skills in clinical practice. This study will explore the basic social process at play in this situation and the needs of clinicians who become managers. This will be of relevant to health services and may illuminate how to reduce executive churn and improve management practice.
What facets of the lung cancer nurse specialist role are perceived by Australian patients with lung cancer as enhancing and facilitating their health care experience?	The findings of this study will be used to inform lung cancer nurse standards of practice and practice guidelines nationally. The study uses a novel participatory co-design methodology.
Does undergraduate nursing students' mental health placement experience influence their decisions about mental health nursing as a future career option?	Mental health nursing is undergoing a recruitment crisis. This study may shed light on one aspect of this phenomenon.

Several other projects are underway in a working partnership with UTAS including:

1. What benefits could Advanced Radiation Therapist roles contribute to Tasmanian radiation oncology departments? The intended output of the study is a role statement, indicating how the role aligns with other professions in radiation oncology and the current career path.
2. Magnet Hospital Readiness. The project aims to identify Magnet readiness in the THS based on the Magnet criteria.
3. Investigating Presentism and Absenteeism in Nursing Staff in the Royal Hobart Hospital.
4. Out-of-hospital cardiac arrest (OHCA) is a significant public health issue. In Australia, the yearly incidence of OHCA is about 30,000 every year and survival rate is less than 10%. There only have been few interventions proven to increase the chance of survival including early cardiopulmonary resuscitation and defibrillation. In order to improve patient outcomes, it is crucial to monitor our performance, identify problems and track the progress. This can be achieved through a registry where we can measure the ambulance response time, treatments and outcomes of patients with OHCA. The OHCA registry will assist identify the system issues; monitor the quality of medical care and also to ensure we have adequate short and long term follow up for OHCA survivors.

PUBLICATIONS

Journal Articles, Books and Book Chapters by THS Staff 2016-17

Author, Unit or Area	Year	Title	Publication
Al-Shawi, M, Timm, B, Saykao, S, Brough, S	2017	The effectiveness of Intraoperative Hyocine Butylbromide (Buscopan) in reducing postoperative catheter-related bladder discomfort in urological patients: a prospective, randomised, placebo-controlled, double-blinded study	<i>BJU International</i> , 2017; 119(suppl 2): 75 Abstract from the Urological Society of Australia and New Zealand Annual Scientific Meeting 2017 February 24-27, Canberra
Bawa Mohamed, M	2016	Hyposplenic changes and pseudo-Pelger-Huët anomaly following allogeneic stem cell transplantation	<i>British Journal of Haematology</i> , 2016; published online October 10
Bawa Mohamed, M	2016	Intravenous immunoglobulin-associated hemolysis: risk factors, challenges, and solutions	<i>International Journal of Clinical Transfusion Medicine</i> , 2016; 4: 121-131
Bawa Mohamed, M, Bates, G, Johnson, B, Morse, M	2016	Single centre retrospective analysis of super-urgent laboratory blood testing system in massively transfused patients	Poster presented at the 58th American Society of Hematology Annual Meeting & Exposition, December 3-6, San Diego, California. Published in <i>Blood</i> , 2016; 128(22): 1461
Boden, I	2017	Phase I evaluation of tubing PEP as an improvised positive expiratory pressure device: pressures generated through oxygen tubing across a range of flow rates and lengths	<i>Pulmonology and Respiratory Research</i> , 2017; 5(1)
Brain, M	2016	Physicochemical acid-base at the bedside	<i>Anaesthesia & Intensive Care Medicine</i> , 2016; published online September 12
Brain, M, Winson, E		Non anti-coagulant factors associated with filter life in continuous renal replacement therapy (CRRT): a systematic review and meta-analysis	<i>BMC Nephrology</i> , 2017; published online February 20
Clark, F	2016	Hysterectomy morbidities: a training perspective	<i>Australian and New Zealand Journal of Obstetrics and Gynaecology</i> , 2016; 56(suppl 1):23. Platform Poster abstract presented at the RANZCOG 2016 Annual Scientific Meeting, October 16-19, Perth
Els, I	2016	Do children with cystic fibrosis receiving outreach care have poorer clinical outcomes than those treated at a specialist cystic fibrosis centre?	<i>Australian Journal of Rural Health</i> , 2016; published online November 17
Fernando, R, Brain, T	2016	Characterisation of colonic dysplasia-like epithelial atypia in murine colitis	<i>World Journal of Gastroenterology</i> , 2016; 22(37): 8334-8348
Filgate, R	2017	Lung transplant survival in Tasmania: 1990-2016	<i>Respirology</i> , 2017; 22(2): 160 Poster presentation at The Australian & New Zealand Society of Respiratory Science and The Thoracic Society of Australia and New Zealand (ANZSRS/TSANZ) Annual Scientific Meeting March 24-28, Canberra

Author, Unit or Area	Year	Title	Publication
Flanagan, K	2016	The global challenge of keeping the world's aging population healthy by vaccination	Transactions of the Royal Society of Tropical Medicine and Hygiene, 2016; 110(8): 427-431
Flanagan, K	2016	Safety and Immunogenicity of ChAd63 and MVA ME-TRAP in West African children and infants	Molecular Therapy, 2016; 24(8): 1471-1477
Flanagan, K	2016	Sex-differential non-vaccine specific immunological effects of diphtheria-tetanus-pertussis and measles vaccination	Clinical Infectious Diseases, 2016; 63(9): 1213-1226
Flanagan, K	2016	Sex differences in immune responses	Nature Reviews. Immunology, 2016; 16(10): 626-638
Flanagan, K	2016	Utility of antenatal clinical factors for prediction of postpartum outcomes in women with gestational diabetes mellitus (GDM)	Australian & New Zealand Journal of Obstetrics and Gynaecology, 2016; published online August 23
Flanagan, K	2017	The economics of malaria vaccine development	Trends in Parasitology, 2017; 33(3): 154-156
Flanagan, K	2017	Sex-differential heterologous (non-specific) effects of vaccines: an emerging public health issue that needs to be understood and exploited	Expert Review of Vaccines, 2017; 16(1): 5-13
Flanagan, K	2017	Viral vector malaria vaccines induce high-level T cell and antibody responses in West African children and infants	Molecular Therapy, 2017; 25(2): 547-559
Flanagan, K	2017	Measles vaccination is effective at under nine months of age, and provides non-specific immunological benefits	Journal of Infectious Diseases, 2017; 215(8): 1177-1178
Flanagan, K		Vaccination with Altered Peptide Ligands of a <i>Plasmodium berghei</i> Circumsporozoite Protein CD8 T-Cell Epitope: A Model to Generate T Cells Resistant to Immune Interference by Polymorphic Epitopes	Frontiers in Immunology, 2017; published online February 14
Gurusinghe, N	2016	Improved scores for observed teamwork in the clinical environment following a multidisciplinary operating room simulation intervention	New Zealand Medical Journal, 2016; 129(1439): 59-67
Frohman, T	2017	Structures, processes and outcomes of the Aussie Heart Guide Program: A nurse mentor supported, home based cardiac rehabilitation program for rural patients with acute coronary syndrome	Australian Critical Care, 2017; published online May 6
Frohman, T	2017	Nurse mentor perceptions in the delivery of a home-based cardiac rehabilitation program to support patients living in rural areas: An interpretive study	Nurse Education in Practice, 2017; 24: 77-83

Author, Unit or Area	Year	Title	Publication
Khalafallah, A	2016	Definition of functional iron deficiency and intravenous iron supplementation – author's reply	The Lancet Haematology, 2016; 3(11): e504-505
Khalafallah, A	2017	Long-term safety of monthly zoledronic acid therapy beyond 1 year in patients with advanced cancer involving bone (LoTESS): A multicentre prospective phase 4 study	European Journal of Cancer Care, 2017; published online January 30
Khalafallah, A, Kirkby, BE, Wong, S, Foong, YC, Ranjan, N, Luttrell, J, Sharp, C, Hannan, T	2016	Venous thromboembolism in medical patients during hospitalisation and 3 months after hospitalisation: a prospective observational study	BMJ Open, 2016; published online August 3
Khalafallah, A, Yan, C, Al-Badri, R, Robinson, E, Kirkby, BE, Ingram, E, Gray, Z, Khelgi, V, Kirkby, BP	2016	Intravenous ferric carboxymaltose versus standard care in the management of postoperative anaemia: a prospective, open-label, randomised controlled trial	The Lancet Haematology, 2016; published online August 4
Kinghorn, V	2016	What do clinical dietitians want in order to use the nutrition care process (NCP),	Revista Espanola de Nutricion Humana y Dietetica, 2016; 20(suppl 1): 103-104. Lecture sequence 4 from 17th International Congress of Dietetics "Going to Sustainable Eating", September 7-10, 2016, Granada, Spain
Koshy, K	2017	Expanding the phenotypic spectrum associated with mutations of DYNC1H1	Neuromuscular Disorders, 2017; published online May 5
Lim, C, Landon, K, Chan, G	2016	Bilateral quadriceps femoris tendon rupture in a patient with chronic renal insufficiency: a case report	Journal of Emergency Medicine, 2016; published online July 29
Lim, K	2016	Predictors of central venous catheter associated blood stream infection and impact of prevention bundle in reducing infection rates	Journal of Paediatrics and Child Health; 2016; 52(suppl 2): 94-95 Poster presentation at the 20th Annual Meeting of the Perinatal Society of Australia and New Zealand (PSANZ), 22-25 May 2016, Townsville, Queensland
Markos, J	2017	The interaction between air pollution and smoking in chronic obstructive pulmonary disease (COPD)	Respirology, 2017; 22(2): 140 Poster presentation at The Australian & New Zealand Society of Respiratory Science and The Thoracic Society of Australia and New Zealand (ANZSRS/TSANZ) Annual Scientific Meeting March 24-28, Canberra
Markos, J	2017	The dose-response association between nitrogen dioxide exposure and serum Interleukin-6 concentrations	International Journal of Molecular Sciences, 2017; 18(5)
Mathew, M	2016	Does pre-eclampsia predispose patients to the development of focal segmental glomerulosclerosis? "The chicken and the egg?"	Journal of Clinical Nephrology and Renal Care, 2016; 2(2)
Mercer, J	2016	"Food for thought": weight, psychology and public health	InPsych, 2016; 38(3)

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Mulford, J	2016	Isolated scaphoid dislocation	Trauma Cases and Reviews, 2016; 2(3): 34-36
Mulford, J	2016	Response to Re: Short-term outcomes of local infiltration anaesthetic in total knee arthroplasty: a randomised controlled double-blinded controlled trial	ANZ Journal of Surgery, 2016; 86(9): 733
Mulford, J	2016	Response to Re: Local infiltration analgesia in total knee arthroplasty: why it may not be effective in surgical practice	ANZ Journal of Surgery, 2016; 86(10): 845
Mulford, J	2016	Response to Re: Short-term outcomes of local infiltration anaesthetic in total knee arthroplasty: a randomised controlled double-blinded controlled trial	ANZ Journal of Surgery, 2016; 86(10): 846
Ng, C, Mathew, M	2016	Pseudoporphyria induced by furosemide in a chronic kidney disease patient on maintenance haemodialysis	Nephrology, 2016; 21(s2): 249 Poster Abstract 238 from The 15th Asian Pacific Congress of Nephrology (APCN) and 52nd ANZSN ASM, September 17-21, 2016, Perth
Ng, C, Mathew, M	2016	Retrospective analysis of native and transplant kidney biopsies performed at single centre in Tasmania between January 2011 and December 2015	Nephrology, 2016; 21(s2): 239 Poster Abstract 213 from The 15th Asian Pacific Congress of Nephrology (APCN) and 52nd ANZSN ASM, September 17-21, 2016, Perth
Oakley, C, Vote, BJ	2017	Demodex species in human ocular disease: new clinicopathological aspects	International Ophthalmology, 2017; 37(1):303-312
Oakley, C, Vote, BJ	2016	Demodex treatment in external ocular disease: the outcomes of a Tasmanian case series	International Ophthalmology, 2016; 36(5):691-6
Padinharakam, S	2016	Patterns of care and outcomes among non-clear cell renal cell carcinoma patients in South Western Sydney	Asia-Pacific Journal of Clinical Oncology, 2016; 12(suppl 4): 64. Poster presented at MOGA's Annual Scientific Meeting "Implementation + Innovation in Immunotherapy", August 3-5, 2015, Surfers Paradise
Pande, G	2016	Hepatic resection for predominantly large size hepatocellular carcinoma: Early and long-term results from a tertiary care center in India	Indian Journal of Gastroenterology, 2016, published online August 12
Power, J	2016	The impact of bevacizumab in metastatic colorectal cancer with an intact primary tumor: results from a large prospective cohort study	Asia-Pacific Journal of Clinical Oncology, 2016, published online November 25
Raj, R	2016	Older patient considering treatment for advanced renal disease: protocol for a scoping review of the information available for shared decision-making	BMJ Open, 2016, published online December 8
Raj, R, Brown, B	2016	Patients managed with conservative, non-dialysis care: symptoms and comorbidities	Nephrology, 2016; 21(s2): 177 Poster Abstract 068 from The 15th Asian Pacific Congress of Nephrology (APCN) and 52nd ANZSN ASM, September 17-21, 2016, Perth
Raj, R, Brown, B, Challenor, S	2016	Establishing a renal supportive care pathway: a nephrology-led initiative	Nephrology, 2016; 21(s2): 177 Poster Abstract 067 from The 15th Asian Pacific Congress of Nephrology (APCN) and 52nd ANZSN ASM, September 17-21, 2016, Perth

Author, Unit or Area	Year	Title	Publication
Reid,C, Penn, D	2016	Hydrogen peroxide in orthopaedic surgery – is it worth the risk?	Acta Chirurgica Belgica, 2016; 116(4):247-250
Rooney, K	2017	Preparedness for practice: the perceptions of graduates of a regional clinical school	Medical Journal of Australia, 2017; 206(10):447-452
Sullivan, K, Boden, I	2016	Physiotherapy following emergency abdominal surgery	In D. V. Garbuzenko (ed.), <i>Actual problems of emergency abdominal surgery</i> (pp. 109-128)
Unwin, M, Rigby, S, Kinsman,L	2016	Why are we waiting? Patients' perspectives for accessing emergency department services with non-urgent complaints	International Emergency Nursing, 2016; published online September 13
Yuen, L, McLucas, C	2017	Investigation of X-ray focal spot alignment using a jig of novel design	Australasian Physical & Engineering Sciences in Medicine, 2017; published online April 13
Professor Michael Buist	2016	Patient-centred care: just ask a thoughtful question and listen	<i>Joint Commission Journal on Quality and Patient Safety</i> , 2016; 42(6): 286-7
Karen Thompson	2016	Nurses – are we ever off duty?	<i>Australian Nursing and Midwifery Journal</i> , 2016; 24(3): 9
Dr Albert Nwaba et al	2016	Effect of airplane transport of donor livers on post-liver transplantation survival	<i>Journal of Gastroenterology</i> 2016; 22(41) 9154-61
Mr Matt Wooler	2016	Pseudoporphyria induced by furosemide in a chronic kidney disease patient on maintenance haemodialysis	Nephrology, 2016; 21(s2): 249 Poster Abstract 238 from The 15th Asian Pacific Congress of Nephrology (APCN) and 52nd ANZSN ASM, September 17-21, 2016, Perth
Associate Professor Heinrich Weber	2016	Do children with cystic fibrosis receiving outreach care have poorer clinical outcomes than those treated at a specialist cystic fibrosis centre?	<i>Australian Journal of Rural Health</i> 2016; (published online November 17)
Ms Teresa Beck-Swindale	2016	Beyond the shelf: opportunities for connections outside the library walls	<i>Health Inform</i> 2016; 25(2): 21-25
Marcus Dixon	2017	Chilling effect of 'ice' on emergency care provision	<i>Emergency Nurse</i> 2017; 24(10): 16
Dr Anutosh Shee and others	2017	Infant with a circumferential constricting limb-threatening band	<i>Journal of Paediatrics and Child Health</i> 2017; 53(4): 428-429
Dr Anutosh Shee and others	2017	Human Parechovirus infection in neonates and children: an overview	<i>Journal of Pediatric Infectious Diseases</i> 2017; 12(2): 99-103
Dr Anutosh Shee and others	2017	Maternal chronic hepatitis B and entecavir therapy associated with meconium peritonitis in a neonate	<i>Asia-Pacific Journal of Clinical Oncology</i> , 2016, published online November 25
Dr Mark Wilson	2017	Exercise as therapy for gestational diabetes: what's the evidence?	<i>International Journal of Applied Physiology</i> 2017; 6(1): 8-15
Dr Thiru Thirukkumaran	2016	Decision making with a complex ethical dilemma: palliative care – case based discussion	<i>Brunei Darussalam Journal of Health</i> 2016; 6(2) 114-120
Dr Rosemary Ramsay	2016	Establishing a renal supportive care pathway: a nephrology-led initiative	Nephrology, 2016; 21(s2): 177 Poster Abstract 067 from The 15th Asian Pacific Congress of Nephrology (APCN) and 52nd ANZSN ASM, September 17-21, 2016, Perth

Author, Unit or Area	Year	Title	Publication
Dr Thiru Thirukkumaran	2017	Integrating exposure to palliative care in an undergraduate medical curriculum: student perspectives and strategies	International Journal of Medical Education 2017; 8: 151-152
Jose, Matthew; Marshall, Mark R; Read, Gail; Lioufas, Nicole; et. Al	2017	Fatal Dialysis Vascular Access Hemorrhage.	American journal of kidney diseases : the official journal of the National Kidney Foundation (June 30, 2017)
Foong, Yi Chao; Murdolo, Vince; Naiman, Nusa; et. Al	2017	Sinonasal teratocarcinoma: a case report.	Journal of medical case reports 11.1 (June 22, 2017): 167.
McArdle, David J T; Karia, Sumit J	2017	Computed Tomography Diagnosis of Terson Syndrome.	The Journal of emergency medicine (June 7, 2017).
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Morrisroe, Kathleen; Stevens, Wendy, Huq, Molla; Prior, David; et. Al	2017	Survival and quality of life in incident systemic sclerosis-related pulmonary arterial hypertension.	Arthritis research & therapy 19.1 (June 2, 2017): 122.
Cooper, P David; Smart, David R	2017	Identifying and acting on potentially inappropriate care? Inadequacy of current hospital coding for this task.	Diving and hyperbaric medicine 47.2 (June 2017): 88-96.
Ashby, Michael	2017	Sex, Drugs, and a Few Other Things.	Journal of bioethical inquiry 14.2: 163-165. (June 2017)
Jeganathan, V Swetha; Langford, Tim; Sefo, Lucilla Ah-Ching; et. Al	2017	Screening for Diabetic Eye Disease among Samoan Adults: A Pilot Study.	Ophthalmology and therapy 6.1 (June 2017): 187-194.
Kirk, Katherine M; Martin, Felicity C; Mao, Amy; Parker, Richard; et. Al	2017	The Anorexia Nervosa Genetics Initiative: Study description and sample characteristics of the Australian and New Zealand arm.	The Australian and New Zealand journal of psychiatry 51.6 (June 2017): 583-594.
Kornaczewski Jackson, Elena R; Pointon, Owen P; Bohmer, Robert; Burgess	2017	Utility of FDG-PET Imaging for Risk Stratification of Pancreatic Neuroendocrine Tumors in MEN1.	The Journal of clinical endocrinology and metabolism 102.6 (June 1, 2017): 1926-1933.
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Bradstock, Kenneth F; Link, Emma; Di Iulio, Juliana; Szer, Jeff; Marlton, Paula; et. Al	2017	Idarubicin Dose Escalation During Consolidation Therapy for Adult Acute Myeloid Leukemia.	Journal of clinical oncology : official journal of the American Society of Clinical Oncology 35.15 (May 20, 2017): 1678-1685.

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O'Meagher, Saril; Kemp, Nenagh; Norris, Kimberley; et. Al	2017	Risk factors for executive function difficulties in preschool and early school-age preterm children.	Acta paediatrica (Oslo, Norway : 1992) (May 14, 2017).
Hong, AI (ORCID: 0000-0001-6307-0661); Stokes, B; Otahal, P; Owens, D; Burgess, J	2017	Temporal trends in thyroid-stimulating hormone (TSH) and thyroid peroxidase antibody (ATPO) testing across two phases of iodine fortification in Tasmania (1995-2013).	Clinical endocrinology (May 13, 2017).
Bishop, David P; Blanes, Lucas; Wilson, Alexander B; Wilbanks, Thor; et. Al	2017	Microfluidic high performance liquid chromatography-chip hyphenation to inductively coupled plasma-mass spectrometry.	Journal of chromatography. A 1497 (May 12, 2017): 64-69.
Law, Matthew H; Medland, Sarah E; Zhu, Gu; Yazar, Seyhan; et. Al	2017	Genome-Wide Association Shows that Pigmentation Genes Play a Role in Skin Aging.	The Journal of investigative dermatology (May 11, 2017).
Morrisroe, Kathleen; Stevens, Wendy; Huq, Molla; Sahhar, Joanne; et. Al	2017	Validity of the Workers Productivity and Activity Impairment Questionnaire: Specific Health Problem (WPAI:SHP) in patients with systemic sclerosis.	Clinical and experimental rheumatology (May 8, 2017).
Perret, Jennifer L; Bowatte, Gayan; Lodge, Caroline J; Knibbs, Luke D; et. Al	2017	The Dose-Response Association between Nitrogen Dioxide Exposure and Serum Interleukin-6 Concentrations.	International journal of molecular sciences 18.5 (May 8, 2017).
Conduit, Ciara; Yew, Steven; Jose, Matthew; Jayne, David; Kirkland, Geoffrey	2017	A case of de novo diagnosis anti-neutrophil cytoplasmic antibody-negative pauci-immune necrotising glomerulonephritis in pregnancy.	Internal medicine journal 47.5: 600-601. (May 2017)
Tan, Xuan Nil; Harrup, Rosemary	2017	Follicular lymphoma in pregnancy presenting as multiple aneuploidy on non-invasive prenatal testing.	Internal medicine journal 47.5: 601-602. (May 2017)
Gottrup, Finn; Dissemond, Joachim; Baines, Carol; et. Al	2017	Use of Oxygen Therapies in Wound Healing.	Journal of wound care 26 (May 1, 2017): S1-S43.
Cadilhac, Dominique A; Kilkenny, Monique F; Levi, Christopher R; Lannin, Natasha A; et. Al	2017	Risk-adjusted hospital mortality rates for stroke: evidence from the Australian Stroke Clinical Registry (AuSCR).	The Medical journal of Australia 206.8 (May 1, 2017): 345-350.
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Sorbello, M (ORCID: 0000-0002-9331-2788); Pulvirenti, G S; Pluchino, D; Skinner, M	2017	State of the Art in Airway Management During GI Endoscopy: The Missing Pieces.	Digestive diseases and sciences 62.5: 1385-1387. (May 2017)
Bereznicki, Bonnie J; Chapman, Millicent P; Bereznicki, Luke R E	2017	Factors associated with overestimation of asthma control: A cross-sectional study in Australia.	The Journal of asthma : official journal of the Association for the Care of Asthma 54.4 (May 2017): 439-446.
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Cooper, Wendy A; Russell, Prudence A; Cherian, Maya; Duhig, Edwina E;	2017	Intra- and Interobserver Reproducibility Assessment of PD-L1 Biomarker in Non-Small Cell Lung Cancer.	Clinical cancer research : an official journal of the American Association for Cancer Research (April 18, 2017).
Conduit, Ciara; Harrup, Rosemary; Ragg, Scott; Johnston, Anna	2017	An audit of patients with mature T-cell non-Hodgkin lymphoma by transplant status in Tasmania.	Internal medicine journal 47.4 (April 2017): 464-466.
Signori, Alessio; Izquierdo, Guillermo; Lugaresi, Alessandra; Hupperts, Raymond;	2017	Long-term disability trajectories in primary progressive MS patients: A latent class growth analysis.	Multiple sclerosis (Houndmills, Basingstoke, England) (April 1, 2017): 1352458517703800.
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Baines, Carol R; McGuinness, William; O'Rourke, Geraldine A	2017	An integrative review of skin assessment tools used to evaluate skin injury related to external beam radiation therapy.	Journal of clinical nursing 26.7-8 (April 2017): 1137-1144.

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Fathabadi, Omid Sadeghi (ORCID: 0000-0002-7238-6235); Gale, Timothy; Wheeler, Kevin; Plottier, Gemma; et. Al	2017	Hypoxic events and concomitant factors in preterm infants on non-invasive ventilation.	Journal of clinical monitoring and computing 31.2 (April 2017): 427-433.
Messmer, A; Ishak, D	2017	Nasal capnography during remifentanyl patient-controlled analgesia in labour.	International journal of obstetric anesthesia (March 16, 2017)
Au, Lewis; Turner, Natalie; Wong, Hui-Li; Field, Kathryn; et. Al	2017	How accurate are medical oncologists' impressions of management of metastatic colorectal cancer in Australia?	Asia-Pacific journal of clinical oncology (March 16, 2017).
Chow, Clara K; Thakkar, Jay; Bennett, Alex; Hillis, Graham; et. Al	2017	Quarter-dose quadruple combination therapy for initial treatment of hypertension: placebo-controlled, crossover, randomised trial and systematic review.	Lancet (London, England) 389.10073 (March 11, 2017): 1035-1042.
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Crombie, Duncan E; Daniszewski, Maciej; Liang, Helena H; et. Al	2017	Development of a Modular Automated System for Maintenance and Differentiation of Adherent Human Pluripotent Stem Cells.	SLAS discovery (March 1, 2017): 2472555217696797.
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Ashby, Michael	2017	The Ninth Circle: Who and What Do We Trust In Today's World?	Journal of bioethical inquiry 14.1: 7-12. (March 2017)
Siedler, Declan G; Ibbett, Imogen M; Thani, Nova B	2017	Surgical Management of Spontaneous Spinal Cerebrospinal Fluid Epidural Fistula.	World neurosurgery 99 (March 2017): 810.e5-810.e10.
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Lee, Adrian Ys; Cassar, Paul M; Johnston, Anna M; Adelstein, Stephen	2017	Clinical use and interpretation of serum protein electrophoresis and adjunct assays.	British journal of hospital medicine (London, England : 2005) 78.2 (February 2, 2017): C18-C20.

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Jo, Helen EI (ORCID: 0000-0003-1183-2729); Glaspole, Ian; Grainge, Christopher; Goh, Nicole; et. Al	2017	Baseline characteristics of idiopathic pulmonary fibrosis: analysis from the Australian Idiopathic Pulmonary Fibrosis Registry.	The European respiratory journal 49.2 (February 2017)
Lemyre, Brigitte; Davis, Peter G; De Paoli, Antonio G; Kirpalani, Haresh	2017	Nasal intermittent positive pressure ventilation (NIPPV) versus nasal continuous positive airway pressure (NCPAP) for preterm neonates after extubation.	The Cochrane database of systematic reviews 2 (February 1, 2017): CD003212.
Sharman, Melanie; Hensher, Martin; Wilkinson, Stephen; Williams, Danielle; et. Al	2017	What are the support experiences and needs of patients who have received bariatric surgery?	Health expectations : an international journal of public participation in health care and health policy 20.1 (February 2017): 35-46.
Truong, Steven L; Saad, Nivene F; Robinson, Philip; Cowderoy, Greg; et. Al	2017	Consensus statements on the imaging of axial spondyloarthritis in Australia and New Zealand.	Journal of medical imaging and radiation oncology 61.1 (February 2017): 58-69
Weber, Heinrich C; Robinson, Philip F; Saxby, Nicole; Beggs, Sean A; et. Al	2017	Do children with cystic fibrosis receiving outreach care have poorer clinical outcomes than those treated at a specialist cystic fibrosis centre?	The Australian journal of rural health 25.1 (February 2017): 34-41
Arora, Varun; Hannan, Richard; Beaver, Richard; Fletcher, Timothy; Harvie, Paul	2017	A cadaver study validating CT assessment of acetabular component orientation: the Perth CT hip protocol.	Skeletal radiology 46.2 (February 2017): 177-183.
Stewart, Tamasine; Spelman, Tim; Havrdova, Eva; Horakova, Dana; et. Al	2017	Contribution of different relapse phenotypes to disability in multiple sclerosis.	Multiple sclerosis (Houndmills, Basingstoke, England) 23.2 (February 2017): 266-276.
Maung, Hein; Buxey, Kenneth Nicholas; Studd, Corrie; Ket, Shara	2017	Acute gastric dilatation in a bulimic patient.	Gastrointestinal endoscopy 85.2 (February 2017): 455-457.
Springelkamp, Henriët; Iglesias, Adriana I; Mishra, Aniket; Höhn, René; et. Al	2017	New insights into the genetics of primary open-angle glaucoma based on meta-analyses of intraocular pressure and optic disc characteristics.	Human molecular genetics 26.2 (January 15, 2017): 438-453.
Rauschert, Sebastian; Uhl, Olaf; Koletzko, Berthold; Mori, Trevor A; et. Al	2017	Sex differences in the association of phospholipids with components of the metabolic syndrome in young adults.	Biology of sex differences 8 (2017): 10.
Zhou, Tiger (ORCID: 0000-0001-6495-8865); Souzeau, Emmanuelle; Sharma, Shiwani; Landers, John; et. Al	2017	Whole exome sequencing implicates eye development, the unfolded protein response and plasma membrane homeostasis in primary open-angle glaucoma.	PloS one 12.3 (2017): e0172427.
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Beasley, Richard; Chien, Jimmy; Douglas, James; Eastlake, Leonie; et. Al	2017	Target oxygen saturation range: 92-96% Versus 94-98.	Respirology (Carlton, Vic.) 22.1 (January 2017): 200-202.

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Plottier, Gemma K; Wheeler, Kevin I; Ali, Sanoj K M; Fathabadi, Omid Sadeghi; et. Al	2017	Clinical evaluation of a novel adaptive algorithm for automated control of oxygen therapy in preterm infants on non-invasive respiratory support.	Archives of disease in childhood. Fetal and neonatal edition 102.1 (January 2017): F37-F43.
Bacharova, Ljuba; Bell, Samuel J; Lipton, Jonathan; Eisenstein, Eric; et. Al	2017	The Research Practicum and International Research Interdisciplinary School (IRIS) initiatives: In memory of Professor Galen S. Wagner M.D., PhD.	Journal of electrocardiology 50.1: 5-10. (2017 Jan - Feb)
Wagner, Marilyn; Wagner, Laura; Wagner, Chris; Bell, Samuel J; et. Al	2017	In memory of Professor Galen S. Wagner M.D., Ph.D. (1939-2016): our mentor, colleague and friend.	Journal of electrocardiology 50.1: 3-4. (2017 Jan - Feb)
McArdle, David J T; Paterson, Felix L J; Morris, Lloyd L	2017	Ductus Arteriosus Aneurysm Thrombosis with Mass Effect Causing Pulmonary Hypertension in the First Week of Life.	The Journal of pediatrics 180 (January 2017): 289-289.e1.
Bowatte, Gayan; Lodge, Caroline J; Knibbs, Luke D; Lowe, Adrian J; et. Al	2017	Traffic-related air pollution exposure is associated with allergic sensitization, asthma, and poor lung function in middle age.	The Journal of allergy and clinical immunology 139.1 (January 2017): 122-129.e1.
Khan, Faisal Saeed; Ali, Ijaz; Afridi, Ume Kalsoom; Ishtiaq, Muhammad; Mehmood, Rashid	2017	Epigenetic mechanisms regulating the development of hepatocellular carcinoma and their promise for therapeutics.	Hepatology international 11.1 (January 2017): 45-53.
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Odenthal, Cara; Simpson, Steve; Oughton, Justin (ORCID: 0000-0001-7296-9783); van der Mei, Ingrid; et. Al	2016	Midsagittal corpus callosum area and conversion to multiple sclerosis after clinically isolated syndrome: A multicentre Australian cohort study.	Journal of medical imaging and radiation oncology (December 20, 2016).
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Gabbe, Belinda J; Cleland, Heather; Watterson, Dina; Schrale, Rebecca; et. Al	2016	Predictors of moderate to severe fatigue 12 months following admission to hospital for burn: Results from the Burns Registry of Australia and New Zealand (BRANZ) Long Term Outcomes project.	Burns : journal of the International Society for Burn Injuries 42.8 (December 2016): 1652-1661.

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Lippmann, John; Lawrence, Christopher; Fock, Andrew; Jamieson, Scott; et. Al	2016	Provisional report on diving-related fatalities in Australian waters in 2011.	Diving and hyperbaric medicine 46.4 (December 2016): 207-240.
Smith, Leigh J; Kearvell, Rachel; Arnold, Anthony J; Choma, Kevina; et. Al	2016	Radiation therapy staffing model 2014.	Journal of medical radiation sciences 63.4 (December 2016): 209-216.
Tao, Chunrong; Simpson, Steve (ORCID: 0000-0001-6521-3056); van der Mei, Ingrid; Blizzard, Leigh; et. Al	2016	Higher latitude is significantly associated with an earlier age of disease onset in multiple sclerosis.	Journal of neurology, neurosurgery, and psychiatry 87.12 (December 2016): 1343-1349.
Nolan, Mark T; Russell, David J; Negishi, Kazuaki; Marwick, Thomas H	2016	Meta-Analysis of Association Between Mediastinal Radiotherapy and Long-Term Heart Failure.	The American journal of cardiology 118.11 (December 1, 2016): 1685-1691.
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McArdle, David J T; Karia, Sumit J	2016	Ruptured intracranial dermoid cyst.	Practical neurology 16.6 (December 2016): 478-479.
Tran, Viet; Mackenzie, Sara; Hamilton, Suzanne; Edmonds, Michael Jr; Brichko, Lisa	2016	Emergency departments and alcohol: The perpetual hangover.	Emergency medicine Australasia : EMA 28.6 (December 2016): 735-738.
Ashby, Michael A; Rich, Leigh E	2016	Which Lane Should We Be In?	Journal of bioethical inquiry 13.4: 461-465. (December 2016)
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Davies, Nicholas; Nuwayhid, Fadi; Froelich, Jens J	2016	Idiopathic high-flow priapism due to bilateral internal pudendal artery shunting.	ANZ journal of surgery 86.12 (December 2016): 1059-1061.
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Olsen, Michael H; Angell, Sonia Y; Asma, Samira; Boutouyrie, Pierre; et. Al	2016	A call to action and a lifecourse strategy to address the global burden of raised blood pressure on current and future generations: the Lancet Commission on hypertension.	Lancet (London, England) 388.10060 (November 26, 2016): 2665-2712.

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Zhou, Tiger; Souzeau, Emmanuelle; Sharma, Shiwani; Siggs, Owen M; Goldberg, Ivan; et. Al	2016	Rare variants in optic disc area gene CARD10 enriched in primary open-angle glaucoma.	Molecular genetics & genomic medicine 4.6 (November 2016): 624-633.
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Conduit, Ciara; Hardikar, Ashutosh; Prasad, Ritam; Nott, Louise	2016	Occam's Razor and Hickam's Dictum: A Rare Case of Synchronous Solid and Hematological Malignancies and Transformed EGFR-Mutated NSCLC.	Journal of thoracic oncology : official publication of the International Association for the Study of Lung Cancer 11.11 (November 2016): e131-e133.
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Esposito, James; Brown, Zoe; Stevens, Wendy; Sahhar, Joanne; et. Al	2016	The association of low complement with disease activity in systemic sclerosis: a prospective cohort study.	Arthritis research & therapy 18.1 (October 22, 2016): 246.
Han, Weiyu; Aitken, Dawn; Zhu, Zhaohua; Halliday, Andrew; et. Al	2016	Hypointense signals in the infrapatellar fat pad assessed by magnetic resonance imaging are associated with knee symptoms and structure in older adults: a cohort study.	Arthritis research & therapy 18.1 (October 12, 2016): 234.
Carrington, Melinda J; Jennings, Garry L; Harris, Mark; Nelson, Mark; et. Al	2016	Impact of nurse-mediated management on achieving blood pressure goal levels in primary care: Insights from the Valsartan Intensified Primary care Reduction of Blood Pressure Study.	European journal of cardiovascular nursing : journal of the Working Group on Cardiovascular Nursing of the European Society of Cardiology 15.6 (October 2016): 409-416.
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Munday, Emily; Walker, Stuart	2016	Mortality outcomes of ruptured abdominal aortic aneurysms and rural presentation.	Vascular 24.5 (October 2016): 449-453.
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Han, Weiyu; Aitken, Dawn; Zhu, Zhaohua; Halliday, Andrew; et. Al	2016	Signal intensity alteration in the infrapatellar fat pad at baseline for the prediction of knee symptoms and structure in older adults: a cohort study.	Annals of the rheumatic diseases 75.10 (October 2016): 1783-1788.
Landowski, Lila M; Dyck, P James B; Engelstad, JaNean; Taylor, Bruce V	2016	Axonopathy in peripheral neuropathies: Mechanisms and therapeutic approaches for regeneration.	Journal of chemical neuroanatomy 76 (October 2016): 19-27.
Prior, David L; Adams, Heath; Williams, Trevor J	2016	Update on pharmacotherapy for pulmonary hypertension.	The Medical journal of Australia 205.6 (September 19, 2016): 271-276.
McArdle, David John Tobias; Cottier, David; Beasley, Anthony	2016	Digital ischaemia secondary to steal syndrome from a brachiocephalic arteriovenous fistula.	BMJ case reports 2016 (September 9, 2016).
Lonie, Sarah; Niumsawatt, Vachara; Castley, Andrew	2016	A Prognostic Dilemma of Basal Cell Carcinoma with Intravascular Invasion.	Plastic and reconstructive surgery. Global open 4.9 (September 2016): e1046.
Picone, Dean; Schultz, Martin; Otahal, Petr; Black, J Andrew; et. Al	2016	OS 07-03 principal findings of the invasive blood pressure meta-analysis consortium (inspect) on the accuracy of brachial cuff blood pressure devices.	Journal of hypertension 34 Suppl 1 - ISH 2016 Abstract Book (September 2016): e65-e66.
Mutluoglu, Mesut; Uzun, Gunalp; Bennett, Michael; et. Al	2016	Poorly designed research does not help clarify the role of hyperbaric oxygen in the treatment of chronic diabetic foot ulcers.	Diving and hyperbaric medicine 46.3: 133-134. (September 2016)
Thakkar, Vivek; Stevens, Wendy; Prior, David; Rabusa, Candice; et. Al	2016	The role of asymmetric dimethylarginine alone and in combination with N-terminal pro-B-type natriuretic peptide as a screening biomarker for systemic sclerosis-related pulmonary arterial hypertension: a case control study.	Clinical and experimental rheumatology 34 Suppl 100.5 (2016 Sep-Oct): 129-136.
Owen, Claire; Ngian, Gene-Siew; Elford, Kathleen; Moore, Owen; et. Al	2016	Mycophenolate mofetil is an effective and safe option for the management of systemic sclerosis-associated interstitial lung disease: results from the Australian Scleroderma Cohort Study.	Clinical and experimental rheumatology 34 Suppl 100.5 (2016 Sep-Oct): 170-176.
Giovannoni, Gavin; Butzkueven, Helmut; Dhib-Jalbut, Suhayl; Hobart, Jeremy; et. Al	2016	Brain health: time matters in multiple sclerosis.	Multiple sclerosis and related disorders 9 Suppl 1 (September 2016): S5-S48.

Author, Unit or Area	Year	Title	Publication
White, V M; Bibby, H; Green, M; Anazodo, A; et. Al	2016	Inconsistencies and time delays in site-specific research approvals hinder collaborative clinical research in Australia.	Internal medicine journal 46.9 (September 2016): 1023-1029.
Menezes, Manoj P; Rahman, Shamima; Bhattacharya, Kaustuv; Clark, Damian; et. Al	2016	Neurophysiological profile of peripheral neuropathy associated with childhood mitochondrial disease.	Mitochondrion 30 (September 2016): 162-167.
Ashby, Michael	2016	Transition and Dialectic: A Farewell, A Big Thank You, Some Medical Ethics and Some Reproduction.	Journal of bioethical inquiry 13.3: 357-359. (September 2016)
McCaughey, Tristan; Chen, Christine Y; De Smit, Elisabeth; Rees, Gwyneth; et. Al	2016	Participant understanding and recall of informed consent for induced pluripotent stem cell biobanking.	Cell and tissue banking 17.3 (September 2016): 449-456.
Wong, Shu Fen; Wong, Hui Li; Field, Kathryn M; Kosmider, Suzanne; et. Al	2016	Primary Tumor Resection and Overall Survival in Patients With Metastatic Colorectal Cancer Treated With Palliative Intent.	Clinical colorectal cancer 15.3 (September 2016): e125-e132.
Dhir, Shalini; Sondekoppam, Rakesh V; Sharma, Ranjita; et. Al	2016	A Comparison of Combined Suprascapular and Axillary Nerve Blocks to Interscalene Nerve Block for Analgesia in Arthroscopic Shoulder Surgery: An Equivalence Study.	Regional anesthesia and pain medicine 41.5 (2016 Sep-Oct): 564-571.
Kuzminov, Alexandr; Palmer, Andrew J; Wilkinson, Stephen; et. Al	2016	Re-operations after Secondary Bariatric Surgery: a Systematic Review.	Obesity surgery 26.9 (September 2016): 2237-2247.
Pham, D; Hardcastle, N; Foroudi, F; Kron, T; et. Al	2016	A Multidisciplinary Evaluation of a Web-based eLearning Training Programme for SAFRON II (TROG 13.01): a Multicentre Randomised Study of Stereotactic Radiotherapy for Lung Metastases.	Clinical oncology (Royal College of Radiologists (Great Britain)) 28.9 (September 2016): e101-e108.
Emdin, Connor A; Odutayo, Ayodele; Wong, Christopher X; et. Al	2016	Meta-Analysis of Anxiety as a Risk Factor for Cardiovascular Disease.	The American journal of cardiology 118.4 (August 15, 2016): 511-519.
Saito, Makoto; Khan, Faisal; Stoklosa, Ted; et. Al	2016	Prognostic Implications of LV Strain Risk Score in Asymptomatic Patients With Hypertensive Heart Disease.	JACC. Cardiovascular imaging 9.8 (August 2016): 911-921.
Liou, Kevin; Negishi, Kazuaki; Ho, Suyen; et. Al	2016	Detection of Obstructive Coronary Artery Disease Using Peak Systolic Global Longitudinal Strain Derived by Two-Dimensional Speckle-Tracking: A Systematic Review and Meta-Analysis.	Journal of the American Society of Echocardiography : official publication of the American Society of Echocardiography 29.8 (August 2016): 724-735.e4.
Kornaczewski, E R (ORCID: 0000-0002-6929-7266); Pointon, O P; Burgess, J	2016	Utility of FDG-PET imaging in screening for succinate dehydrogenase B and D mutation-related lesions.	Clinical endocrinology 85.2 (August 2016): 172-179.
Robiyanto, Robiyanto; Zaidi, Syed Tabish R; Shastri, Madhur D; et. Al	2016	Stability of Tigecycline in Different Types of Peritoneal Dialysis Solutions.	Peritoneal dialysis international : journal of the International Society for Peritoneal Dialysis 36.4 (2016 Jul-Aug): 410-414.

Author, Unit or Area	Year	Title	Publication
Yousaf, Farzana; Zaidi, Syed T R; Wanandy, Troy; Jose, Matthew D; Patel, Rahul P	2016	Stability of Cefepime in pH-Neutral Peritoneal Dialysis Solutions Packaged in Dual-Compartment Bags.	Peritoneal dialysis international : journal of the International Society for Peritoneal Dialysis 36.4 (2016 Jul-Aug): 457-459.
Mackey, David A; Kearns, Lisa S; Hewitt, Alex W	2016	Gene-Based Therapies for Leber Hereditary Optic Neuropathy. Hype or Hope?	Asia-Pacific journal of ophthalmology (Philadelphia, Pa.) 5.4 (2016 Jul-Aug): 253-255.
Froelich, Jens J; Neilson, Sam; Peters-Wilke, Jens; et. Al	2016	Size and Location of Ruptured Intracranial Aneurysms: A five-year Clinical Survey.	World neurosurgery 91 (July 2016): 260-265.
Dobromilsky, Kim C; Allen, Penny L; Raymond, Stephen H; Maindiratta, Bhavna	2016	A prospective cohort study of early postpartum etonogestrel implant (Implanon®) use and its effect on duration of lochia.	The journal of family planning and reproductive health care 42.3 (July 2016): 187-193.
Dargaville, Peter A; Gerber, Angela; Johansson, Stefan; De Paoli, Antonio G; et. Al	2016	Incidence and Outcome of CPAP Failure in Preterm Infants.	Pediatrics 138.1 (July 2016).
Effing, Tanja W; Vercoulen, Jan H; Bourbeau, Jean; Trappenburg, Jaap; et. Al	2016	Definition of a COPD self-management intervention: International Expert Group consensus.	The European respiratory journal 48.1 (July 2016): 46-54.
Nolan, Mark T; Russell, David J; Marwick, Thomas H	2016	Long-term Risk of Heart Failure and Myocardial Dysfunction After Thoracic Radiotherapy: A Systematic Review.	The Canadian journal of cardiology 32.7 (July 2016): 908-920.
Mudge, David W (ORCID: 0000-0002-4112-5550); Boudville, Neil; Brown, Fiona; Clayton, Philip; et. Al	2016	Peritoneal dialysis practice in Australia and New Zealand: A call to sustain the action.	Nephrology (Carlton, Vic.) 21.7 (July 2016): 535-546.
Segelov, Eva; Thavaneswaran, Subotheni; Waring, Paul M; Desai, Jayesh; et. Al	2016	Response to Cetuximab With or Without Irinotecan in Patients With Refractory Metastatic Colorectal Cancer Harboring the KRAS G13D Mutation: Australasian Gastro-Intestinal Trials Group ICECREAM Study.	Journal of clinical oncology : official journal of the American Society of Clinical Oncology 34.19 (July 1, 2016): 2258-2264.
Van Zundert, A; Skinner, M; Van Zundert, T Luney, et. Al	2016	Value of knowing physical characteristics of the airway device before using it.	British journal of anaesthesia 117.1: 12-16. (July 2016)
Veloudi, Panagiota; Blizzard, Leigh; Srikanth, Velandai K; McCartney, Paul; et. Al	2016	Associations of blood pressure variability and retinal arteriolar diameter in participants with type 2 diabetes.	Diabetes & vascular disease research 13.4 (July 2016): 299-302.

GLOSSARY

A&RS	Audit and Risk Subcommittee
AAS	Australian Accounting Standards
AASB	Australian Accounting Standards Board
ABF	Activity Based Funding
ABS	Australian Bureau of Statistics
ACAA	Aged Care Association Australia
ACC	Acute Care Certificates
ACGB	Australian Centre for Grief and Bereavement
ACHS	Australian Council on Healthcare Standards
ACP	Advance Care Planning
ACSQHC	Australian Commission on Safety and Quality in Healthcare
Activity Based Funding (ABF)	Activity Based Funding (ABF) is the model of reimbursing a health care service for the cost of patient care. The ABF system provides payment for acute patients treated within hospitals. Hospitals are paid a set amount for each patient treated based on the relative cost of the group (DRG) to which the separation is allocated.
Acute admission	Acute care is care in which the primary clinical purpose or treatment goal is to: manage labour (obstetric), cure illness or provide definitive treatment of injury, perform surgery, relieve symptoms of illness or injury (excluding palliative care), reduce severity of an illness or injury, protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function, perform diagnostic or therapeutic procedures
Admission	An admission is a process whereby a hospital accepts responsibility for a patient's care or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight (or multi-day) care or treatment. An admission may be formal or statistical. A formal admission is the administrative process by which a hospital records the commencement of treatment/care or accommodation of a patient. A statistical admission is the administrative process by which a hospital records the commencement of treatment/care or accommodation of a patient.
Admissions from elective surgery waiting lists:	Patients on waiting lists for elective surgery are assigned a clinical urgency status which indicates the clinical assessment of the urgency with which a patient requires elective hospital care. On admission, they will also be assigned an urgency of admission category, which may or may not be elective.
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
AIHSM	Australian Institute of Health Service Management
AMS	Asset Management Services
ANZSPM	Australia and New Zealand Society for Palliative Medicine
APHCRI	Australian Primary Health Care Research Institute
AMS	Asset Management Services
ATO	Australian Taxation Office
ATS	Australasian Triage Scale
BEIMS	Building Engineering Information Management System
CAC	Consumer Advisory Council
CAGs	Clinical Advisory Groups
CALD	Culturally and linguistically diverse
CEAG	Community Engagement Advisory Group
CEC	Consumer Engagement Committee
CEO	Chief Executive Officer
CERG	Consumer Engagement Reference Group
CFO	Chief Financial Officer
CHaPS	Child Health and Parenting Services
CHC	Community Health Centre

CIP	Capital Improvements Program
CIP-EM	Capital Improvements Program - Essential Maintenance
CNC	Clinical Nurse Consultant
COAG	Council of Australian Governments
CoNECs	Community Nursing Enhanced Connections Service
COO	Chief Operating Officer
COPE	Commonwealth Own Purpose Expenditure
Cost weight	A measure of the relative cost of a Diagnosis Related Group (DRG). Usually the average cost across all DRGs is chosen as the reference value, and given a weight of 1.
CPI	Consumer Price Index
CSC	Royal Hobart Hospital Cancer Support Centre
CSO	Community Sector Organisation
DCHSC	Devonport Community and Health Services Centre
DFA	Disability Framework for Action 2005 -2010
DH	District Hospital
DHHS	Department of Health and Human Services
Diagnosis Related Group (DRG)	DRGs are a patient classification system that provide a clinically meaningful way of relating the types of patients treated in a hospital to the resources required by the hospital. DRGs were developed for use in acute inpatient settings. The latest version of the Australian Refined-Diagnosis Related Group (AR-DRG) Classification (Version 6.0x is to be used from 1 July 2012)
DMR	Digital Medical Record
DON	Director of Nursing
Dr	Doctor
ECO	Employee Contact Officer
ED	Emergency Department
Elective admission (Urgency status assigned)	Elective admissions: If an admission meets the definition of elective below, it is categorised as elective, regardless of whether the admission actually occurred after 24 hours or more, or it occurred within 24 hours. The distinguishing characteristic is that the admission could be delayed by at least 24 hours.
ER	Employee Relations
FACN	Fellow of the Australian College of Nursing
FBT	Fringe Benefits Tax
FRAME	Federation of Rural Australian Medical Educators
FTE	Full Time Equivalent
GC	Governing Council
GEM	Geriatric Evaluation and Management
GGs	General Government Sector
GHC	Glenorchy Health Centre
GM5	Give Me Five For Kids
GP	General Practitioner
GPLO	General Practice Liaison Officer
GST	Goods and Services Tax
HACC	Home and Community Care
HIV	Human immunodeficiency virus
HOA	Heads of Agreement
HoMER	Harmonisation of Multi-Centre Ethical Review
HR	Human Resources
HRT	Health Round Table
HSO	Health Service Officer

HSR	Health and Safety Representative
HVAC	Heating, Ventilation and Air Conditioning
IAS	International Accounting Standards
IASB	International Accounting Standards Board
ICC	Integrated Care Centre
ICU	Intensive Care Unit
IFRS	International Financial Reporting Standards
IHPA	Independent Hospital Pricing Authority
KIHCHC	King Island Hospital and Community Health Centre
KPI	Key Performance Indicator
LGH	Launceston General Hospital
M&M	Morbidity and Mortality
MAIB	Motor Accidents Insurance Board
MAGNET	MAGNET designation is recognised as the highest and most prestigious credential of healthcare organisation can achieve for nursing excellence and quality patient care.
MCH	Mersey Community Hospital
MGP	Midwifery Group Practice
MHS-N	Mental Health Services - North
MOC	Models of Care
MOU	Memorandum of Understanding
MPC	Multipurpose Centre
MPS	Multipurpose Service
MRI	Magnetic Resonance Imaging
NEP	National Efficient Price
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
NICU	Neonatal Intensive Care Unit
NICS	Northern Integrated Care Service
NMBA	Nursing and Midwifery Board of Australia
NPA-IHST	National Partnership Agreement on Improving Health Services in Tasmania
NPICU	Neonatal Paediatric Intensive Care Unit
NPPs	National Partnership Payments
NSQHSS	National Safety and Quality Health Service Standards
NWPH	North West Private Hospital
NWRH	North West Regional Hospital
PAH	Pulmonary arterial hypertension
PHN	Primary Health North
PIU	Paediatric Inpatient Unit
PSC	Partnerships Subcommittee
QI	Quality Improvement
QS&CRS	Quality Safety and Clinical Risk Subcommittee
RACMA	The Royal Australasian College of Medical Administrators
RANZCP	The Royal Australian and New Zealand College of Psychiatrists
RBF	Retirement Benefit Fund
RCA	Root Cause Analysis
RCS	Rural Clinical School
RHH	Royal Hobart Hospital
RJRP	Right Job Right Person

RTI	Right to Information
SAAP	Supported Accommodation Assistance Program
SAB	Staphylococcus Aureus bacteraemia
SAMP	Strategic Asset Management Plan
Scheduled admissions:	A patient who expects to have an elective admission will often have that admission scheduled in advance. Whether or not the admission has been scheduled does not affect the categorisation of the admission as emergency or elective, which depends only on whether it meets the definitions above. That is, patients both with and without a scheduled admission can be admitted on either an emergency or elective basis.
SCIF	Special Capital Investment Fund
SDH	Smithton District Hospital
SEIFA	Socio-Economic Indexes for Areas
SIIRP	Structured Infrastructure Investment Review Process
SLA	Service Level Agreement
SME	Small Medium Enterprise
SMHS	Statewide Mental Health Services
SPA	Superannuation Provision Account
SRLS	Safety Reporting and Learning System
STD	Sexually transmitted disease
Sub-acute activity	Sub-acute care in this data set specification is identified as admitted episodes in rehabilitation care, palliative care, geriatric evaluation and management care and psychogeriatric care whereas maintenance care is identified as non-acute care. The scope of the collection is: 1) Same day and overnight sub-acute and non-acute care episodes in designated sub-acute and non-acute care units, programs or hospitals. 2) Admitted public patients provided on a contracted basis by private hospitals in designated sub-acute and non-acute care units, programs or hospitals. 3) Admitted patients in rehabilitation care, palliative care, geriatric evaluation and management, psychogeriatric and maintenance care designated programs treated in the hospital-in-the-home.
TCP	Transitional Care Program
TasEquip	An accessible, equitable, sustainable and efficient statewide service delivery platform that enables individuals who require equipment and assistive technology to live safely at home and participate in the community.
Tasmanian Health Organisations / THOs	Three Tasmanian Health Organisations (THOs) were established under the national health reforms to provide hospital, primary and community health services to Tasmanians.
Tasmanian Health Service / THS	The Tasmanian Health Service (THS) was established on 1 July 2015 under the One State, One Health System, Better Outcomes reforms that will see hospitals working together to provide access to better care and higher quality services.
THEO	Tasmania Health Education Online
THO - S	Tasmanian Health Organisation-South
THO - N	Tasmanian Health Organisation-North
THO - NW	Tasmanian Health Organisation-North West
THP	Tasmania's Health Plan
THS	Tasmanian Health Service
THS GC	Tasmanian Health Service Governing Council
TI	Treasurer's Instruction
TIPCU	Tasmanian Infection Prevention and Control Unit
TML	Tasmania Medicare Local
Transfer	A transfer is when the physical location of the patient changes. Patients can be transferred between health care facilities, between wards or from bed to bed within a ward. Within these KPIs transfers between wards are counted only.
TRDF	Tasmanian Role Delineation Framework
TRMF	Tasmanian Risk Management Fund
UTAS	University of Tasmania

WACS	Women's and Children's Services
Waitlist clinical urgency categories	<p>Category 1 - Urgent patients who require surgery within 30 days.</p> <p>Category 2 - Semi-urgent patients who require surgery within 90 days.</p> <p>Category 3: Non-urgent patients who need surgery at some time in the future. For reporting purposes, these patients are counted as requiring surgery with 365 days</p>
WCDH	West Coast District Hospital
Weighted cost	Is the cost weight multiplied out by the average cost of patient care.
Weighted separation	The aggregate number of DRGs in any time period, multiplied by the cost weight of each, results in a number called a weighted separation.
WHS	Workplace Health and Safety
YTD	Year to Date

LEGISLATION

Legislation Governing the Operations of THS

<i>Aged Care Act 1997</i>
<i>Alcohol and Drug Dependency Act 1968</i>
<i>Ambulance Service Act 1982</i>
<i>Anatomical Examinations Act 2006</i>
<i>Anti-Discrimination Act 1998</i>
<i>Audit Act 2008</i>
<i>Blood Transfusion (Limitation of Liability) Act 1986</i>
<i>Control Board (See the department of Justice under the Minister for Justice)</i>
<i>Disability Discrimination Act 1992</i>
<i>Fee Units Amendment Act 2002</i>
<i>Financial Management and Audit Amendment Act 2012</i>
<i>Fluoridation Act 1968</i>
<i>Food Act 1968</i>
<i>Health Act 1997</i>
<i>Health Complaints Amendment Act 2005</i>
<i>Health Insurance Act (1973) 1974 No. 42 (CTH)</i>
<i>Health Practitioner Regulation National Law (Tasmania) Act 2010</i>
<i>Health Practitioners Tribunal Act 2010</i>
<i>Health Professionals (Special Events Exemption) Act 1998</i>
<i>Health Service Establishments Act 2006</i>
<i>HIV/AIDS Preventative Measures Act 1993</i>
<i>Human Cloning for Reproduction and Other Prohibited Practices Act 2003</i>
<i>Human Embryonic Research Regulation Act 2003</i>
<i>Human Tissue Act 1985</i>
<i>Industrial Relations Act 1984</i>
<i>Medical Radiation Science Professionals Registration Act 2000</i>
<i>Mental Health Act 2013</i>
<i>Model Work Health and Safety (WHS) Act 2012</i>
<i>National Health Act 1953 No. 95 (CTH)</i>
<i>Obstetric and Paediatric Mortality and Morbidity Act 1994</i>
<i>Optometry Offences Act 2010</i>
<i>Personal Information Protection Act 2004</i>
<i>Pharmacy Control Act 2001</i>
<i>Poisons Act 1971 - except in so far as it relates to the Poppy Advisory</i>
<i>Public Health Act 1997</i>
<i>Public Interest Disclosures Act 2002</i>
<i>Radiation Protection Act 2005</i>
<i>Racial Discrimination Act 1975</i>
<i>Right to Information Act 2009</i>
<i>Sex Discrimination Act 1984</i>
<i>State Service Act 2000</i>
<i>Tasmanian Health Organisations Act 2011</i>
<i>Therapeutic Goods Act 2001</i>
<i>Workers Rehabilitation and Compensation Act 1988</i>
<i>Workplace Health and Safety Act 2012</i>

Other Tasmanian Health Legislation

<i>Adoption Act 1988</i>
<i>Child Protection (International Measurements) Act 1997</i>
<i>Children, Young Persons and Their Families Act 1997</i>
<i>Constitution (State Employees) Act 1994</i>
<i>Disability Services Act 1992 (new Act 11/11/12)</i>
<i>Guardianship and Administration Amendment Act 1997</i>
<i>Misuse of Drugs Act 2001</i>
<i>Motor Accidents (Liabilities and Compensations) Act 1973 (Tasmania)</i>
<i>Royal Derwent Hospital (Sale of Land) Act 1995</i>
<i>Surrogacy Contract Act 1993</i>
Broadly Applicable Legislation
<i>Acts Interpretation Act 1931</i>
<i>Archives Act 1983</i>
<i>Building Act 2000</i>
<i>Civil Liability Amendment Act 2008</i>
<i>Coroners Act 1995</i>
<i>Copyright Act 1968</i>
<i>Dangerous Substances (Safe Handling Act) 2005</i>
<i>Defamation Act 2005</i>
<i>Economic Regulator Act 2009</i>
<i>Emergency Management Act 2006</i>
<i>Fire Damage Relief Act 1967</i>
<i>Guide Dogs and Hearing Dogs Act 1967</i>
<i>Homes Act 1935</i>
<i>Integrity Commission Act 2009</i>
<i>Judicial Review Act 2000</i>
<i>Long Service Leave (State Employee) Act 1994</i>
<i>Long Service Leave Act 1976</i>
<i>Mutual Recognition (Tasmania) Act 1993</i>
<i>Ombudsman Act 1978</i>
<i>Payroll Tax Act 2008</i>
<i>Pensioners (Heating Allowance) Act 1971</i>
<i>Public Account Act 1986</i>
<i>Public Sector Superannuation Reform Act 1999</i>
<i>Retirement Benefits Act 1993</i>
<i>Statutory Holidays Act 2000</i>
<i>Trades Union Act 1997</i>
<i>Youth Justice Act 1997</i>

SUPERANNUATION DECLARATION

I, John Ramsay, Chair, Tasmanian Health Service Governing Council hereby certify that the Tasmanian Health Service has met its obligations under the *Superannuation Industry (Supervision) Act 1993* in respect of those employees who are members of complying superannuation schemes to which the Agency contributes.



John Ramsay

Chair, Tasmanian Health Service Governing Council

PRICING POLICIES

The Tasmanian Health Service (THS) undertakes activities for which the pricing of goods and services is required. Each fee charging program is based on the full cost recovery model in accordance with the Government's policy on fees and charges.

The THS levy fees and charges in accordance with the provisions of the following Acts:

- ▶ *Adoption Act 1988*
- ▶ *Anatomical Examinations Act 2006*
- ▶ *Health Act 1997*
- ▶ *Pharmacy Control Act 2001*
- ▶ *Public Health Act 1997*
- ▶ *Tasmanian Health Organisations Act 2011*
- ▶ *Ambulance Service Act 1982*
- ▶ *Food Act 2003*
- ▶ *Health Services Establishments Act 2006*
- ▶ *Poisons Act 1971*
- ▶ *Radiation Protection Act 2005*

The THS maintain a Revenue Policy that provides information on the financial requirements for funding a program from sources outside of the Organisation. This policy is subject to ongoing review.

Fees are charged in accordance with Tasmanian legislation including the Health Act 1997 and the Tasmanian Health Organisations Act 2011.

PUBLIC INTEREST DISCLOSURE

The Public Interest Disclosures Act 2002 encourages and facilitates disclosures about any improper conduct of public officers or public bodies and protects public officers who make disclosures regarding such conduct. The THS will afford natural justice to all parties involved in the investigation of a disclosure. The THS is committed to the aims and objectives of the Public Interest Disclosures Act. We recognise the value of transparency and accountability in our administrative and management practices.

We support the making of disclosures that reveal corrupt conduct, conduct involving substantial mismanagement of public resources or conduct involving a substantial risk to public health and safety or the environment.

In 2016-17 the THS received one disclosure which was assessed by the THS as a public interest disclosure. The THS did not refer any disclosed matters to, or receive referrals from the Ombudsman in 2016-17. No investigations of disclosures determined by the THS to be public interest disclosures were completed in the reporting period, with one investigation ongoing as at 30 June 2017.

The THS Public Interest Disclosure Policy and Protocol were prepared in accordance with Guidelines and Standards published by the Tasmanian Ombudsman. The Policy and Protocol are available via the THS Strategic Document Management System and are reviewed by the Ombudsman every three years.

GLENORCHY HEALTH CENTRE



Community health centres are designed to relieve demand pressure on acute services by providing services responsive to the increasing demand from patients with complex and multiple conditions as a result of chronic disease. This model of delivering services breaks down barriers to access for patients, resulting in healthier communities.

One major population area identified was the Glenorchy Municipality. Subsequently, the construction of the new \$21 million Glenorchy Health Centre (GHC) at 404 Main Road Glenorchy commenced in early 2017.

The new facility will be 3 950m² spread over three levels with a further on site car parking allocation for approximately 42 vehicles. The lot is located in the central business area of Glenorchy with a number of major surrounding facilities and a significant quantity of existing Council Car parking as well as easy walking distance to the Glenorchy Bus Mall.

The building has been designed with a central atrium to enable as much natural light to filter into the building and allowing natural light into the majority of the treatment and consulting spaces throughout what is a densely planned facility.

The GHC has been designed with flexibility and encouragement of inter-disciplinary interrelationships to occur with a strong focus on keeping specific service teams collocated.

Services delivered upon completion will include Physiotherapy, Oral Health, Occupational Therapy, Renal Self Dialysis, Pathology, Child Health and Parenting Services, Podiatry, Social Work, Youth Health Services and Specialist Nursing Services. The centre will also include various visiting services and a bookable community space, providing a much-needed facility to the local community and outlying regions.

The new centre is on track for completion in 2018.

FINANCIAL STATEMENTS

For the year ended 30 June 2017

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Statement of Certification

The accompanying Financial Statements of the Tasmanian Health Service (THS) and its related bodies are in agreement with the relevant accounts and records and have been prepared in compliance with the Treasurer's Instructions issued under the provisions of the *Financial Management and Audit Act 1990* to present fairly the financial transactions for the year ended 30 June 2017 and the financial position as at the end of the year.

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



Mr John Ramsay
Chair of the Governing Council
13 September 2017



Mr Craig Watson
Acting Chief Executive Officer
13 September 2017

Statement of Comprehensive Income for the year ended 30 June 2017

	Notes	2017 Budget \$'000	2017 Actual \$'000	2016 Actual \$'000
Continuing operations				
Revenue and other income from transactions				
Grants	5.1	1 160 953	1 251 219	1 248 734
Sales of goods and services	5.2	140 275	195 914	160 794
Interest		302	198	258
Contributions received	5.3	0	0	28
Other revenue	5.4	30 642	32 482	38 043
Total revenue and other income from transactions		1 332 172	1 479 813	1 447 857
Expenses from transactions				
Employee benefits	6.1	933 086	1 006 196	948 973
Depreciation and amortisation	6.2	39 536	41 047	39 340
Supplies and consumables	6.3	368 281	445 367	394 575
Grants and subsidies	6.4	7 494	6 858	7 178
Finance costs		0	2	0
Other expenses	6.5	19 684	25 659	22 786
Total expenses from transactions		1 368 081	1 525 129	1 412 852
Net result from transactions (net operating balance)		(35 909)	(45 316)	35 005
Other economic flows included in net result				
Net gain/(loss) on non-financial assets	7.1	0	(29 499)	208
Net gain/(loss) on financial instruments and statutory receivables/payables	7.2	0	(9)	(446)
Total other economic flows included in net result		0	(29 508)	(238)
Net result from continuing operations		(35 909)	(74 824)	34 767
Other comprehensive income				
<i>Items that will not be reclassified subsequently to profit or loss</i>				
Changes in property, plant and equipment revaluation surplus	11.1	48 058	17 025	13 681
Total other comprehensive income		48 058	17 025	13 681
Comprehensive result		12 149	(57 799)	48 448

This Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

Budget information refers to original estimates and has not been subject to audit.

Explanations of material variances between budget and actual outcomes are provided in Note 3 of the accompanying notes.

Statement of Financial Position
as at 30 June 2017

	Notes	2017 Budget \$'000	2017 Actual \$'000	2016 Actual \$'000
Assets				
<i>Financial assets</i>				
Cash and deposits	12.1	67 819	55 658	89 535
Receivables	8.1	20 718	24 847	21 280
Other financial assets	8.2	18 824	17 161	12 210
<i>Non-financial assets</i>				
Inventories	8.3	8 713	9 748	11 055
Assets held for sale	8.4	0	82	95
Property, plant and equipment	8.5	1 000 340	973 379	986 527
Intangibles	8.6	610	4 344	700
Other assets	8.7	4 249	5 279	4 375
Total assets		1 121 273	1 090 498	1 125 777
Liabilities				
Payables	9.1	61 791	63 446	64 306
Employee benefits	9.2	213 591	244 161	224 895
Other liabilities	9.4	9 121	18 028	14 028
Total liabilities		284 503	325 635	303 229
Net assets		836 770	764 863	822 548
Equity				
Contributed capital	11.3	469 459	581 894	581 593
Reserves	11.1	286 270	223 494	206 463
Accumulated funds		81 041	(40 525)	34 492
Total equity		836 770	764 863	822 548

This Statement of Financial Position should be read in conjunction with the accompanying notes.

Budget information refers to original estimates and has not been subject to audit.

Explanations of material variances between budget and actual outcomes are provided in Note 3 of the accompanying notes.

Statement of Cash Flows for the year ended 30 June 2017

	Notes	2017 Budget \$'000	2017 Actual \$'000	2016 Actual \$'000
Cash flows from operating activities		Inflows (Outflows)	Inflows (Outflows)	Inflows (Outflows)
Cash inflows				
Grants - continuing operations		1 155 901	1 220 662	1 175 954
Sales of goods and services		141 289	189 854	156 713
GST receipts		30 552	39 320	35 561
Interest received		302	198	258
Other cash receipts		30 642	32 482	38 043
Total cash inflows		1 358 686	1 482 516	1 406 529
Cash outflows				
Employee benefits		(931 623)	(990 867)	(929 456)
Finance costs		0	(2)	0
GST payments		(30 538)	(39 723)	(36 456)
Grants and transfer payments		(7 494)	(6 858)	(7 178)
Supplies and consumables		(368 752)	(442 036)	(398 718)
Other cash payments		(20 006)	(25 398)	(22 796)
Total cash outflows		(1 358 413)	(1 504 884)	(1 394 604)
Net cash from/(used by) operating activities	12.2	273	(22 368)	11 925
Cash flows from investing activities				
Cash inflows				
Proceeds from the disposal of non-financial assets		0	13	80
Total cash inflows		0	13	80
Cash outflows				
Payment for acquisition of non-financial assets		(5 039)	(11 523)	(1 959)
Total cash outflows		(5 039)	(11 523)	(1 959)
Net cash from/(used by) investing activities		(5 039)	(11 510)	(1 879)
Cash flows from financing activities				
Cash outflows				
Repayment of borrowings		0	0	(5 000)
Total cash outflows		0	0	(5 000)
Net cash from/(used by) financing activities		0	0	(5 000)
Net increase/(decrease) in cash and cash equivalents held		(4 766)	(33 878)	5 046
Cash and deposits at the beginning of the reporting period		72 585	89 535	84 453
Cash transferred in due to restructure		0	1	36
Cash and deposits at the end of the reporting period	12.1	67 819	55 658	89 535

This Statement of Cash Flows should be read in conjunction with the accompanying notes.

Budget information refers to original estimates and has not been subject to audit.

Explanations of material variances between budget and actual outcomes are provided in Note 3 of the accompanying notes.

Statement of Changes in Equity
for the year ended 30 June 2017

	Notes	Contrib Equity \$'000	Reserves \$'000	Accum Funds \$'000	Total Equity \$'000
Balance as at 1 July 2016		581 593	206 463	34 492	822 548
Net Result		0	0	(74 824)	(74 824)
Other Comprehensive Income		0	17 025	0	17 025
Total comprehensive result		0	17 025	(74 824)	(57 799)
Transfers from asset revaluation reserve to accumulated surplus	11.1	0	6	(6)	0
Transfer sale proceeds to the Crown Lands Administration Fund (CLAF)		0	0	(187)	(187)
Transactions with owners in their capacity as owners:					
Administrative restructure - net assets received	11.2	301	0	0	301
Balance as at 30 June 2017		581 894	223 494	(40 525)	764 863

	Notes	Contrib Equity \$'000	Reserves \$'000	Accum Funds \$'000	Total Equity \$'000
Balance as at 1 July 2015		0	0	0	0
Net Result		0	0	34 767	34 767
Other Comprehensive Income		0	13 681	0	13 681
Total comprehensive result		0	13 681	34 767	48 448
Transfers from asset revaluation reserve to accumulated surplus	11.1	0	(210)	210	0
Transfer sale proceeds to the Crown Lands Administration Fund (CLAF)		0	0	(485)	(485)
Transactions with owners in their capacity as owners:					
Equity contributions		581 777	192 992	0	774 769
Administrative restructure - net assets received	11.2	(184)	0	0	(184)
Balance as at 30 June 2016		581 593	206 463	34 492	822 548

This Statement of Changes in Equity should be read in conjunction with the accompanying notes.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2017

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NOTE I TASMANIAN HEALTH SERVICE OUTPUT SCHEDULES

I.1 Establishment of the Tasmanian Health Service

The Tasmanian Health Service (THS) is a Statutory Authority that commenced operations on 1 July 2015 as a key component of the Tasmanian Government's *One State, One Health System, Better Outcomes* reform program. Prior to this, health services in Tasmania were provided through three regionally based Tasmanian Health Organisations (THOs), being THO-North, THO-North West and THO-South. The THOs were established under the *Tasmanian Health Organisation Act 2011* as a result of the National Health Reform Agreement, and commenced on 1 July 2012. Upon commencement, the THS replaced the THOs and appointed a single Governing Council and Chief Executive Officer to oversee the provision of health services in Tasmania state wide.

The THOs were combined pursuant to an Order (Tasmanian Health Organisations (Tasmanian Health Service) Order 2015) made by the Governor of Tasmania. Under the Order, THO-South and THO-North West were amalgamated into THO-North on 1 July 2015. The establishment of the THS was accounted for as an amalgamation of the THOs and not as an acquisition of THO-South and THO-North West by THO-North because:

- (i) the combination was imposed pursuant to the Governor's Order without any of the THOs involved in the decision;
- (ii) the formation of the new THS Governing Council precludes THO-North from gaining control of THS operations at the time the combination occurred; and,
- (iii) the economic substance of the combination is that a new entity (THS) was established notwithstanding the legal form of the resulting entity.

On 1 July 2015, the THS recognised the identifiable assets and liabilities that were recognised in the financial statements of the THOs as at that date after eliminating the effects of all transactions between the THOs. The THS measured the identifiable assets and liabilities of the THOs at their carrying values in the financial statements of the THOs at 1 July 2015, subject to any adjustments required to conform to THS accounting policies.

I.2 Output Group Information

Comparative information has not been restated for external administrative restructures.

Budget information refers to original Budget estimates reflected in the 2016-17 Budget Papers and has not been subject to audit.

	2017 Budget \$'000	2017 Actual \$'000	2016 Actual \$'000
Expense by Output			
I.1 Admitted Services	772 698	835 206	788 755
I.2 Non-admitted Services	167 534	215 495	183 874
I.3 Emergency Department Services	115 194	138 317	123 535
I.4 Community and Aged Care Services	194 407	215 224	198 814
I.5 Statewide and Mental Health Services	116 813	119 456	116 300
I.6 Forensic Medicine Services	1 435	1 431	1 452
Total	1 368 081	1 525 129	1 412 730

NOTE 2 EXPENDITURE UNDER AUSTRALIAN GOVERNMENT FUNDING ARRANGEMENTS

	State Funding		Australian Govt Funding	
	2017 Actual \$'000	2016 Actual \$'000	2017 Actual \$'000	2016 Actual \$'000
Specific Purpose Payments				
Activity Based Funding	366 470	367 543	311 565	488 260
Block Funding	313 521	222 384	59 309	0
National Partnership Payments				
Health Services	0	0	32 556	35 213
Commonwealth Own Purpose Expenditures				
Mersey	0	0	74 029	74 861
Other	4 155	3 589	39 971	35 638
Total	684 146	593 516	517 430	633 972

Specific Purpose Payments (SPPs) are payments from the Australian Government to the Tasmanian Government arising from national agreements that set out the Australian Government's agreed objectives and outcomes, outputs, roles and responsibilities and performance indicators for each sector. SPPs are distributed to the states on the basis of their population shares.

National Partnership Payments (NPPs) are similar to SPPs but are provided for the purpose of the delivery of specified projects, facilitate reforms or reward jurisdictions that deliver nationally significant reforms.

Commonwealth Own Purpose Expenditure is funding paid directly from the Australian Government to the states and territories for the provision of services identified by the Australian Government.

NOTE 3 EXPLANATIONS OF MATERIAL VARIANCES BETWEEN BUDGET AND ACTUAL OUTCOMES

Budget information refers to original estimates as disclosed in the 2015-16 Budget Papers and is not subject to audit.

Variances are considered material where the variance exceeds the greater of 10 per cent of Budget estimate and \$1 million.

3.1 Statement of Comprehensive Income

	Note	Budget \$'000	2017 Actual \$'000	Variance \$'000	Variance %
Sales of goods and services	(a)	140 275	195 914	55 639	39.7%
Employee benefits	(b)	933 086	1 006 196	(73 110)	(7.8%)
Supplies and consumables	(c)	368 281	445 367	(77 086)	(20.9%)
Other expenses	(d)	19 684	25 659	(5 975)	(30.4%)
Net gain/(loss) on non-financial assets	(e)	0	(29 499)	(29 499)	n/a

Notes to Statement of Comprehensive Income variances

- (a) The variance in Sales of Goods and Services primarily reflects additional revenue as a result of the Hepatitis C medication being made available on the Pharmaceuticals Benefits Scheme (PBS) list (\$49.8 million). In addition to this, improvements have been made in relation to recoveries of private patient revenues which include previously unbilled revenue being recovered and the implementation of the Eclipse system which allows for the direct billing to Medicare which is currently being rolled out across the state.
- (b) The increase in Employee Benefits against budget is attributable to a number of factors, the most prominent being the increased usage of third party staff resultant from difficulties in recruiting to positions (\$31.2 million), staffing costs associated with the transfer of Child Health and Parenting Services from the DHHS to the THS (\$5.2 million), staffing costs associated with the opening of additional beds at the LGH (\$2.4 million), the accrual of leave expenditure (\$10.9 million), termination payments made throughout the 2017 financial year primarily associated with the sale of the James Scott Wing Residential Aged Care facility (\$2.5 million) and the continuation of the NPA – IHST Reducing Elective Surgery Wait Lists program which was originally scheduled to end 2015-16 (\$2.3 million). The remaining variance is associated with the increase in the FTE for the THS for the 2017 financial year.
- (c) The increase in Supplies and consumables is reflective of the inclusion of cross border expenses (\$17.2) for which the budget was originally included in Grants and subsidies as well as increased expenditure in relation to Hepatitis C medication (\$53.3 million). There was also a significant investment made in statewide information technology (IT) projects, which resulted in increased expenditure relating to consultants, IT and communications costs which had not been fully included in the Budget Papers. Finally, the NPA – IHST Reducing Elective Surgery Wait Lists program was extended to the 2017 financial year, resulting in the THS incurring \$15.4 million of costs for which there was no budget included in the Budget Papers.
- (d) The increase in Other expenses is primarily due to the Tasmanian Risk Management Fund (TRMF) premium expenditure being greater than budgeted (\$3.6 million). The remaining variance is related to the legal fees and settlement of medical negligence claims.
- (e) The variance in Net gain/(loss) on non-financial assets is related to the demolition of B Block of the Royal Hobart Hospital (RHH), which is a key component of the RHH Redevelopment plan. The value of the demolished section of the hospital was \$28.7 million.

3.2 Statement of Financial Position

Budget estimates for the 2016-17 Statement of Financial Position were compiled prior to the completion of the actual outcomes for 2016-17. As a result, the actual variances from the Budget estimate will be impacted by the difference between estimated and actual opening balances for 2016-17. The following variance analysis therefore includes major movements between the 30 June 2016 and 30 June 2017 actual balances.

	Note	Budget \$'000	2017 Actual \$'000	2016 Actual \$'000	Budget Variance \$'000	Actual Variance \$'000
Cash and deposits	(a)	67 819	55 658	89 535	(12 161)	(33 877)
Receivables	(b)	20 718	24 847	21 280	4 129	3 567
Other financial assets	(c)	18 824	17 161	12 210	(1 663)	4 951
Inventories	(d)	8 713	9 748	11 055	1 035	(1 307)
Intangibles	(e)	610	4 344	700	3 734	3 644
Other assets	(f)	4 249	5 279	4 375	1 030	904
Employee benefits	(g)	213 591	244 161	224 895	30 570	19 266
Other liabilities	(h)	9 121	18 028	14 028	8 907	4 000

Notes to Statement of Financial Position Budget Variances

- (a) The decrease in Cash and deposits as at 30 June 2017 to budget reflects the THS utilising funds held in cash reserves to undertake additional activity in the 2017 financial year (\$30.1 million).
- (b) The increase in Receivables of \$4.129 million relates to improvements in patient billing and a reduction in the provision for doubtful debts, as well as a delay in patient billing in the South stemming from resourcing issues which resulted in a large number of invoices being raised in May 2017, of which a number were still outstanding as at 30 June 2017.
- (d) The increase in Inventories is attributable to the high cost of Hepatitis C medication, which was included in the PBS for the first time in the 2016 financial year for which no budget was included in the Budget Papers.
- (e) The increase in Intangibles is related to the completion of the statewide TrackED project (\$2.7 million) which improves patient movement and data collection throughout the state.
- (f) The increase in Other assets is attributable to higher than expected maintenance contract prepayments for the 2017 financial year.
- (g) The variance to budget for Employee benefits reflects the transfer of Child Health and Parenting Services staff from the DHHS to the THS on 1 January 2017, resulting in an increase of 98 full time equivalent (FTE) staff. The THS also increased its FTE levels outside of this restructure to meet patient demand and maintain heightened activity levels. The variance is also related to increases in annual and long service leave entitlements reflecting a general increase in staff numbers.
- (h) The increase in Other liabilities to budget is primarily related to the inter-entity creditor (\$3.2 million) and revenue received in advance. Revenue received in advance is attributed to the Mersey Community Hospital antenatal clinic and lift upgrades for which funding was received prior to 30 June 2017 with works not yet begun.

Notes to Statement of Financial Position Actual Variances

- (a) The decrease in Cash and deposits year on year of \$33.8 million relates to a decrease in cash held due to operating activities.
- (b) The increase in Receivables of \$3.567 million relates to improvements in patient billing and a reduction in the provision for doubtful debts, as well as a delay in patient billing in the South stemming from resourcing issues which resulted in a large number of invoices being raised in May 2017, of which a number were still outstanding as at 30 June 2017.
- (c) The increase in Other financial assets of \$4.951 million when compared to the 2016 balance is attributable to accrued revenue for the THS, with the THS not receiving its final Tasmanian Health Assistance Package (THAP) payment from the Commonwealth prior to June 2017 of \$4.5 million.
- (d) The decrease in Inventories year on year is largely attributable to Hepatitis C medication being listed on the PBS in the 2015-16. Due to the nature of the treatment, higher levels of this particular medication being held in inventory was not required in the 2017 financial year.
- (e) The increase in Intangibles year on year is related to the completion of the statewide TrackED project (\$2.7 million) which improves patient movement and data collection throughout the state for which this amount was included in work in progress (WIP) in the 2016 financial year.
- (g) The variance to 2016 for Employee benefits reflects the transfer of Child Health and Parenting Services staff from the DHHS to the THS on 1 January 2017, resulting in an increase of 98 full time equivalent (FTE) staff. The THS also increased its FTE levels outside of this restructure by 137 FTE as compared to 30 June 2016 in order to meet patient demand and maintain heightened activity levels. The variance is also related to increases in annual and long service leave entitlements reflecting a general increase in staff numbers.
- (h) The increase in Other liabilities year on year is attributable to increased revenue in advance, attributed to projects at the Mersey Community Hospital for which funding was received in advance of works beginning (\$2.1 million).

3.3 Statement of Cash Flows

	Note	Budget \$'000	2017 Actual \$'000	Variance \$'000	Variance %
Sales of goods and services	(a)	141 289	189 854	48 565	34.4%
GST receipts	(b)	30 552	39 320	8 768	28.7%
GST payments	(c)	(30 538)	(39 723)	9 185	(30.1%)
Supplies and consumables	(d)	(368 752)	(442 036)	73 284	(19.9%)
Other cash payments	(e)	(20 006)	(25 398)	5 392	(27.0%)
Payment for acquisition of non-financial assets	(f)	(5 039)	(11 523)	6 484	(128.7%)

Notes to Statement of Cash Flows variances

- (a) Refer to note 3.1 (a).
- (b) The increase in Goods and Services Tax (GST) receipts is to be offset against the increase in GST payments.
- (c) The increase in GST payments it to be offset against the increase in GST receipts.
- (d) Refer to note 3.1 (c).
- (e) Refer to note 3.1 (d).
- (f) The increase in Payment for acquisition of non-financial assets it due to the THS acquiring additional items of property, plant and equipment than originally anticipated, including patient monitors, ultrasounds and angiography equipment.

NOTE 4 UNDERLYING NET OPERATING BALANCE

Non-operational capital funding is the income from transactions relating to funding for capital projects. This funding is classified as income from transactions and included in the net operating balance. However, the corresponding capital expenditure is not included in the calculation of the net operating balance. Accordingly, the net operating balance will portray a position that is better than the true underlying financial result.

For this reason, the net operating result is adjusted to remove the effects of funding for capital projects.

Non-operational expenditure that is removed from the net operating balance consists of capital transfers to the THS.

	Notes	2017 Budget \$'000	2017 Actual \$'000	2016 Actual \$'000
Net result from transactions (net operating balance)		(35 909)	(45 316)	35 005
<i>Less impact of:</i>				
Non-operational capital funding				
Assets transferred	5.1	5 052	30 557	72 780
Total		5 052	30 557	72 780
Underlying Net operating balance		(40 961)	(75 873)	(37 775)

NOTE 5 INCOME FROM TRANSACTIONS

Income is recognised in the Statement of Comprehensive Income when an increase in future economic benefits related to an increase in an asset or a decrease of a liability has arisen that can be measured reliably.

5.1 Grants

Grants payable by the Australian Government are recognised as revenue when the THS gains control of the underlying assets. Where grants are reciprocal, revenue is recognised as performance occurs under the grant.

Non-reciprocal grants are recognised as revenue when the grant is received or receivable. Conditional grants may be reciprocal or non-reciprocal depending on the terms of the grant.

	Notes	2017 \$'000	2016 \$'000
Continuing Operations			
Grants from the Australian Government			
Commonwealth Recurrent Grants - Block Funding		59 309	55 913
Commonwealth Recurrent Grants - Activity Based Funding		320 502	311 424
COPES Receipts		34 574	35 798
Specific Grant - Mersey Community Hospital		76 002	74 861
Other Commonwealth Grants		32 299	32 993
Total		522 686	510 989
Grants from the State Government			
State Grants - Block Funding		312 024	366 682
State Grants - Activity Based Funding		385 427	295 672
Total		697 451	662 354
Capital grants			
Assets Transferred	8.5, 8.6	30 557	72 780
Total		30 557	72 780
WIP expensed grants			
Expenses Transferred		525	2 611
Total		525	2 611
Total revenue from Grants		1 251 219	1 248 734

5.2 Sales of goods and services

Amounts earned in exchange for the provision of goods are recognised when the significant risks and rewards of ownership have been transferred to the buyer. Revenue from the provision of services is recognised in proportion to the stage of completion of the transaction at the reporting date. The stage of completion is assessed by reference to surveys of work performed.

	2017 \$'000	2016 \$'000
Residential Rent Income	669	556
Commercial Rent Income	862	1 031
Pharmacy Non-Pharmaceutical Benefits Scheme	1 334	1 409
Prostheses	7 507	8 209
Inpatient, Outpatient Nursing Home Fees	55 301	50 609
Dental	8 039	8 085
Pharmaceutical Benefits Scheme Co-payments	833	900
Pharmaceutical Benefits Scheme Revenue from Medicare	75 021	46 260
Private Patient Scheme	32 391	28 140
Other Client Revenue	732	787
Hobart Private Hospital Revenue	942	827
Other user charges	12 283	13 981
Total	195 914	160 794

5.3 Contributions received

Services received free of charge by the THS, are recognised as income when a fair value can be reliably determined and at the time the services would have been purchased if they had not been donated. Use of those resources is recognised as an expense.

Contributions of assets at no cost of acquisition or for nominal consideration are recognised at their fair value when the THS obtains control of the asset, it is probable that future economic benefits comprising the contribution will flow to the THS and the amount can be measured reliably. However, where the contribution received is from another government agency as a consequence of restructuring of administrative arrangements, they are recognised as contributions by owners directly within equity. In these circumstances, book values from the transferor agency have been used.

	2017 \$'000	2016 \$'000
Fair Value of assets assumed at no cost or for nominal consideration	0	28
Total	0	28

5.4 Other revenue

Other revenue is primarily the recovery of costs incurred and is recognised when an increase in future economic benefits relating to an increase in an asset or a decrease of a liability has arisen that can be reliably measured.

	2017 \$'000	2016 \$'000
Wages and Salaries Recoveries	14 763	18 303
Food recoveries	5 096	5 412
Multipurpose Centre Recoveries	321	255
Workers Compensation Recoveries	2 785	3 349
Operating Recoveries	4 743	5 465
Donations	1 445	1 684
Industry Funds	3 329	3 575
Total	32 482	38 043

NOTE 6 EXPENSES FROM TRANSACTIONS

Expenses are recognised in the Statement of Comprehensive Income when a decrease in future economic benefits related to a decrease in an asset or an increase of a liability has arisen that can be measured reliably.

6.1 Employee benefits

Employee benefits include, where applicable, entitlements to wages and salaries, annual leave, sick leave, long service leave, superannuation and any other post-employment benefits.

(a) Employee expenses

	2017 \$'000	2016 \$'000
Wages and salaries including FBT	799 475	756 497
Annual leave	51 345	49 439
Long service leave	14 750	14 373
Sick leave	27 521	25 646
Other employee expenses - recruitment & staff development	12 763	7 941
Other employee expenses - other staff allowances	832	929
Superannuation expenses - defined contribution and benefits schemes	99 510	94 148
Total	1 006 196	948 973

(b) Remuneration of key management personnel

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the THS, directly or indirectly.

Remuneration during 2016-17 for key personnel is set by the *State Service Act 2000*. Remuneration and other terms of employment are specified in employment contracts. Remuneration includes salary, motor vehicle and other non-monetary benefits. Long term employee expenses include long service leave, superannuation obligations and payments made on departure.

Acting Arrangements

When members of key management personnel are unable to fulfil their duties, consideration is given to appointing other members of senior staff to their position during their period of absence. Individuals are considered members of key management personnel when acting arrangements are for more than a period of four weeks.

The following were key management personnel of the THS at any time during the financial year and unless otherwise indicated were key management personnel for the entire year.

	Short-term benefits		Long-term benefits			
2017	Salary ¹ \$'000	Other Benefits ² \$'000	Super- annuation ³ \$'000	Other Benefits and Long- Service Leave ⁴ \$'000	Termination Benefits ⁵ \$'000	Total \$'000
Key management personnel						
Governing Council						
- John Ramsay (Governing Council Chair)	160	11	15	0	0	186
- Dr Emil Djakic	34	11	3	0	0	48
- Professor Denise Fassett	34	0	3	0	0	37
- Barbara Hingston	48	0	5	0	0	53
- Mark Scanlon (Chair Audit and Risk Sub-Committee)	34	1	3	0	0	38
- Professor Judith Walker (Chair Partnerships Sub-Committee)	34	2	3	0	0	39
- Martin Wallace (Chair Financial Management and Performance Sub-Committee)	34	2	3	0	0	39
- Dr Judith Watson	34	9	3	0	0	46
- Assoc. Professor Deborah Wilson (Chair Quality and Safety Sub- Committee)	34	2	3	0	0	39
Total Governing Council Remuneration	446	38	41	0	0	525

2017	Short-term benefits		Long-term benefits		Termination Benefits ⁵ \$'000	Total \$'000
	Salary ¹ \$'000	Other Benefits ² \$'000	Super-annuation ³ \$'000	Other Benefits and Long-Service Leave ⁴ \$'000		
Executive Directors						
Chief Executive Officer - Dr David Alcorn	411	37	41	11	0	500
Chief Operations Officer - Craig Watson (01/07/2016 - 15/08/2016)	27	4	4	1	0	36
- Nicola Dymond (08/11/2016 - 30/06/2017)	139	68	13	0	0	220
Chief Financial Officer - Eleanor Patterson (01/07/2016 - 15/08/2016)	20	5	3	1	0	29
- Craig Watson (16/08/2016 - 30/06/2017)	195	30	25	4	0	254
Executive Director Human Resources and Organisational Development - Matthew Double (01/07/2016 - 06/11/2016)	61	4	6	4	0	75
- Suzanne McCavanagh (22/05/2017 - 30/06/2017)	13	6	1	0	0	20
Executive Director Nursing & Midwifery - Susan Gannon (22/08/2016 - 30/06/2017)	129	42	13	0	0	184
Executive Director Allied Health - Paula Hyland (05/06/2017 - 30/06/2017)	5	1	1	3	0	10
Executive Director Patient Safety - Dr Annette Pantle	210	194	36	5	0	445
Executive Director Medical Profession - Dr Antonio Xabregas (19/09/2016 - 30/06/2017)	160	138	36	5	0	339
Executive Director Corporate System - Scott Adams	160	30	15	4	0	209
Total Executive Management Remuneration	1 530	559	194	38	0	2 321
Acting Key management personnel - Wendy Rowell (Chief Operations Officer, 16/08/2016 - 07/11/2016)	47	7	6	0	0	60
- Rebecca Howe (Executive Director Human Resources and OD, 07/11/2016 - 30/04/2017)	72	12	9	1	0	94
Total Key Management Personnel Remuneration	2 095	616	250	39	0	3 000

	Short-term benefits		Long-term benefits			
	Salary¹ \$'000	Other Benefits² \$'000	Super- annuation³ \$'000	Other Benefits and Long- Service Leave⁴ \$'000	Termination Benefits⁵ \$'000	Total \$'000
2016						
Key management personnel						
Governing Council						
- John Ramsay (Governing Council Chair)	160	10	15	0	0	185
- Dr Emil Djakic	34	2	3	0	0	39
- Professor Denise Fassett	34	9	3	0	0	46
- Barbara Hingston	33	0	3	0	0	36
- Mark Scanlon (Chair Audit and Risk Sub-Committee)	34	2	3	0	0	39
- Professor Judith Walker (Chair Partnerships Sub-Committee)	33	3	3	0	0	40
- Martin Wallace (Chair Financial Management and Performance Sub-Committee)	33	2	3	0	0	39
- Dr Judith Watson	33	9	3	0	0	46
- Assoc. Professor Deborah Wilson (Chair Quality and Safety Sub- Committee)	34	0	3	0	0	38
Total Governing Council Remuneration	429	37	42	0	0	508
Executive Directors						
Chief Executive Officer						
- Dr Anne Brand (01/07/2015 - 31/01/2016)	144	98	21	0	10	274
- Dr David Alcorn (01/02/2016 - 30/06/2016)	155	0	15	0	0	169
Chief Operating Officer						
- Craig Watson (18/04/2016 - 30/06/2016)	53	5	5	-1	0	61
Chief Financial Officer						
- Eleanor Patterson (04/01/2016 - 30/06/2016)	79	12	8	4	0	103
Executive Director Human Resources and Organisational Design						
- Matthew Double (02/10/2015 - 30/06/2016)	114	13	11	4	0	142
Executive Director Nursing, Midwifery & Allied Health						
- Catherine Schofield (18/04/2016 - 30/06/2016)	21	4	2	0	0	27
Executive Director Patient Safety						
- Dr Annette Pantle (23/05/2016 - 30/06/2016)	27	4	3	0	0	34
Executive Director Corporate Systems						
- Scott Adams (18/04/2016 - 30/06/2016)	30	7	3	0	0	40
Executive Director of Services						
- Craig Watson (South, 01/07/2015 - 17/04/2016)	212	18	20	-6	0	245

2016 Cont'd	Short-term benefits		Long-term benefits		Termination Benefits ⁵ \$'000	Total \$'000
	Salary ¹ \$'000	Other Benefits ² \$'000	Super-annuation ³ \$'000	Other Benefits and Long-Service Leave ⁴ \$'000		
- Sonia Purse (North, 01/07/2015 - 18/04/2016)	217	19	21	3	0	260
- Dr Anne Brand (North West, 01/07/2015 - 12/07/2015)	8	5	1	0	0	14
- Pat Martin (North West, 13/07/2015 - 31/10/2015)	61	34	8	0	2	105
- Sue Wyeth (North West, 09/11/2015 - 03/01/2016)	41	1	4	0	0	46
- Dr Annette Pantle (North West, 04/01/2016 -22/05/2016)	97	14	10	0	0	120
Total Executive Management Remuneration	1 259	235	131	4	11	1 640
Acting Key management personnel						
- Adrienne Belchamber (Executive Director of Services, South, 28/09/2015 - 13/11/2015)	27	2	3	0	0	31
Total Key Management Personnel Remuneration	1 715	274	176	4	11	2 180

1 Salary includes all forms of consideration paid and payable for services rendered and compensated absences during the period.

2 Other benefits includes all other forms of non-salary benefits such as motor vehicles and parking, fringe benefit tax payable in respect of these benefits, payments in lieu of leave, annual leave movements and any other compensation paid or payable.

3 Superannuation means the contribution to the superannuation fund of the individual.

4 Other long term benefits and long service leave includes the movements in the discounted long service leave balances.

5 Termination Benefits include accrued annual and long service leave entitlements and termination payments.

(c) Related party transactions

There are no material related party transactions requiring disclosure.

6.2 Depreciation and amortisation

All applicable Non-financial assets having a limited useful life are systematically depreciated over their useful lives in a manner which reflects the consumption of their service potential. Land and Artwork, being assets with unlimited useful lives, are not depreciated.

Key estimate and judgment

Depreciation is provided for on a straight line basis, using rates which are reviewed annually. Major depreciation periods are:

Vehicles	5 years
Plant and equipment	2-20 years
Medical equipment	4-20 years
Buildings	40-50 years

All intangible assets having a limited useful life are systematically amortised over their useful lives reflecting the pattern in which the asset's future economic benefits are expected to be consumed by the THS.

Major amortisation periods are:

Software	3-20 years
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(a) Depreciation

	2017 \$'000	2016 \$'000
Plant, equipment and vehicles	10 852	10 304
Buildings	30 025	28 923
Total	40 877	39 227

(b) Amortisation

	2017 \$'000	2016 \$'000
Intangibles	170	113
Total	170	113
Total depreciation and amortisation	41 047	39 340

6.3 Supplies and Consumables

	2017 \$'000	2016 \$'000
Consultants	2 007	934
Property Services	30 071	31 967
Maintenance	18 695	17 193
Communications	7 774	6 431
Information Technology	6 236	5 132
Travel and Transportw	11 143	10 209
Medical, Surgical and Pharmacy Supplies	276 625	235 914
Advertising and Promotion	103	171
Patient and Client Services	30 222	28 222
Leasing Costs	3 596	3 524
Equipment and Furniture	6 733	5 049
Administration	7 865	6 899
Food Production Costs	9 560	9 208
Other Supplies and Consumables	6 012	5 241
Corporate Overhead Charge	27 048	26 600
Service Fees	1 424	1 642
Audit Fees - financial audit	253	239
Total	445 367	394 575

Audit Fees includes expenditure realted to the audit of these financial statements. The total audit fee for this financial year is \$194,000 (2016: \$190,200).

6.4 Grants and subsidies

Grant and subsidies expenditure is recognised to the extent that:

- the services required to be performed by the grantee have been performed; or
- the grant eligibility criteria have been satisfied.

A liability is recorded when the THS has a binding agreement to make the grants but services have not been performed or criteria satisfied. Where grant monies are paid in advance of performance or eligibility, a prepayment is recognised.

	2017 \$'000	2016 \$'000
Other Grants		
Grant - Other	6 858	7 178
	6 858	7 178
Total	6 858	7 178

6.5 Other expenses

Other expenses are recognised when a decrease in future economic benefits related to a decrease in an asset or an increase of a liability has arisen that can be reliably measured.

	2017 \$'000	2016 \$'000
Salary on-costs	10 653	8 994
Tasmanian Risk Management Fund premium	13 731	13 242
Other	1 275	550
Total	25 659	22 786

NOTE 7 OTHER ECONOMIC FLOWS INCLUDED IN NET RESULT

Other economic flows measure the change in volume or value of assets or liabilities that do not result from transactions.

7.1 Net gain/(loss) on non-financial assets

Gains or losses from the sale of non-financial assets are recognised when control of the assets has passed to the buyer.

Key Judgement

All non-financial assets are assessed to determine whether any impairment exists. Impairment exists when the recoverable amount of an asset is less than its carrying amount. Recoverable amount is the higher of fair value less costs to sell and value in use. The THS' assets are not used for the purpose of generating cash flows; therefore value in use is based on depreciated replacement cost where the asset would be replaced if the THS was deprived of it.

All impairment losses are recognised in Statement of Comprehensive Income.

In respect of other assets, impairment losses recognised in prior periods are assessed at each reporting date for any indications that the loss has decreased or no longer exists. An impairment loss is reversed if there has been a change in the Estimates used to determine the recoverable amount. An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

	2017 \$'000	2016 \$'000
Net gain/(loss) on disposal of physical assets	(29 499)	208
Total net gain/(loss) on non-financial assets	(29 499)	208

7.2 Net gain/(loss) on financial instruments and statutory receivables/payables

Financial assets are assessed at each reporting date to determine whether there is any objective evidence that there are any financial assets that are impaired. A financial asset is considered to be impaired if objective evidence indicates that one or more events have had a negative effect on the estimated future cash flows of that asset.

Key Judgement

An impairment loss, in respect of a financial asset measured at amortised cost, is calculated as the difference between its carrying amount, and the present value of the estimated future cash flows discounted at the original effective interest rate.

Impairment losses are recognised in the Statement of Comprehensive Income.

An impairment loss is reversed if the reversal can be related objectively to an event occurring after the impairment loss was recognised. For financial assets measured at amortised cost, the reversal is recognised in the Statement of Comprehensive Income.

	Notes	2017 \$'000	2016 \$'000
Impairment of loans and receivables	8.1	(9)	(446)
Total		(9)	(446)

NOTE 8 ASSETS

Assets are recognised in the Statement of Financial Position when it is probable that the future economic benefits will flow to the THS and the asset has a cost or value that can be measured reliably.

8.1 Receivables

Receivables are recognised at amortised cost, less any impairment losses. However, due to the short settlement period, receivables are not discounted back to their present value.

	2017 \$'000	2016 \$'000
Receivables	25 692	22 292
Less: Provision for impairment	(845)	(1 012)
Total	24 847	21 280
Sales of goods and services (inclusive of GST)	18 608	15 170
Tax assets	6 239	6 110
Total	24 847	21 280
Settled within 12 months	24 847	21 280
Total	24 847	21 280

Reconciliation of movement in provision for impairment of receivables	2017 \$'000	2016 \$'000
Carrying amount at 1 July	1 012	0
Amounts written off during the year	(181)	(246)
Amounts recovered during the year	5	0
Net transfers through restructure	0	812
Increase/(decrease) in provision recognised in profit or loss	9	446
Carrying amount at 30 June	845	1 012

8.2 Other financial assets

Other financial assets are recorded at fair value.

	2017 \$'000	2016 \$'000
Accrued Revenue	17 161	12 210
Total	17 161	12 210
Settled within 12 months	17 161	12 210
Total	17 161	12 210

8.3 Inventories

Inventories held for distribution are valued at cost adjusted, when applicable, for any loss of service potential. Inventories acquired for no cost or nominal consideration are valued at current replacement cost.

	2017 \$'000	2016 \$'000
Pharmacy	6 127	6 935
Catering	287	344
Linen	1 360	1 693
General Supplies	1 974	2 083
Total	9 748	11 055
Consumed within 12 months	9 748	11 055
Total	9 748	11 055

8.4 Assets held for sale

Assets held for sale (or disposal groups comprising assets and liabilities) that are expected to be recovered primarily through sale rather than continuing use are classified as held for sale. Immediately before classification as held for sale, the assets (or components of a disposal group) are remeasured at the lower of carrying amount and fair value less costs to sell.

(a) Carrying amount .

	2017 \$'000	2016 \$'000
Land	38	71
Buildings	44	24
Total	82	95
Settled within 12 months	82	95
Settled in more than 12 months	0	0
Total	82	95

(b) Fair value measurement of assets held for sale (including fair value levels)

2017	Carrying value at 30 June \$'000	Fair value measurement at end of reporting period		
		Level 1 \$'000	Level 2 \$'000	Level 3 \$'000
Land	38	0	38	0
Buildings	44	0	44	0
Total	82	0	82	0

2016	Carrying value at 30 June \$'000	Fair value measurement at end of reporting period		
		Level 1 \$'000	Level 2 \$'000	Level 3 \$'000
Land	71	0	71	0
Buildings	24	0	24	0
Total	95	0	95	0

8.5 Property, plant and equipment*Key estimate and judgement**(i) Valuation basis*

Property, plant and equipment is recorded at fair value less accumulated depreciation. All other non-current physical assets, including work in progress, are recorded at historic cost less accumulated depreciation and accumulated impairment losses. All assets within a class of assets are measured on the same basis.

Cost includes expenditure that is directly attributable to the acquisition of the asset. The costs of self-constructed assets includes the cost of materials and direct labour; any other costs directly attributable to bringing the asset to a working condition for its intended use and the costs of dismantling and removing the items and restoring the site on which they are located. Purchased software that is integral to the functionality of the related equipment is capitalised as part of that equipment.

When parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate items (major components) of property, plant and equipment.

Fair value is based on the highest and best use of the asset. Unless there is an explicit Government policy to the contrary, the highest and best use of an asset is the current purpose for which the asset is being used or occupied.

(ii) Subsequent costs

The cost of replacing part of an item of property, plant and equipment is recognised in the carrying amount of the item if it is probable that the future economic benefits embodied within the part will flow to the THS and its costs can be measured reliably. The carrying amount of the replaced part is derecognised. The costs of day-to-day servicing of property, plant and equipment are recognised in the Statement of Comprehensive Income as incurred.

(iii) Asset recognition threshold

The asset capitalisation threshold adopted by the THS is:

Vehicles	\$10,000
Plant and equipment	\$10,000
Land and buildings	\$10,000
Intangibles	\$50,000
Artwork	\$10 000

Assets valued at less than \$10 000 (or \$50 000 for intangible assets) are charged to the Statement of Comprehensive Income in the year of purchase (other than where they form part of a group of similar items which are material in total).

(iv) Revaluations

The THS' land and building assets were revalued independently by the Valuer-General of Tasmania as at 30 June 2017 using an adjustment indice of 1.080 for land and 1.065 for buildings. This was based on market movement factors and building cost indices. This revaluation was in accordance with the Treasurer's Instruction 303 *Recognition and Measurement of Non-Current Assets* and the Australian Accounting Standard (AASB 116). Revaluations are shown on a net basis and will continue to do so until the next full revaluation is performed. This is due to occur as at 30 June 2018.

(a) Carrying amount

	2017 \$'000	2016 \$'000
Land		
Land at fair value	61 276	57 339
Total land	61 276	57 339
Buildings		
Buildings at net fair value	834 426	851 474
Less: Accumulated depreciation	(868)	(72)
Total	833 558	851 402
Leasehold Improvements at fair value	26 587	23 160
Less: Accumulated depreciation	(11 079)	(9 118)
Total	15 508	14 042
Total buildings	849 066	865 444
Plant, equipment and vehicles		
At cost	103 455	97 179
Less: Accumulated depreciation	(49 433)	(39 287)
Total plant, equipment and vehicles	54 022	57 892
Work in progress		
Buildings	2 754	3 438
Plant, equipment and vehicles	6 261	2 414
Total work in progress	9 015	5 852
Total property, plant and equipment	973 379	986 527

(b) Reconciliation of movements (including fair value levels)

Reconciliations of the carrying amounts of each class of property, plant and equipment at the beginning and end of the current and previous financial year are set out below. Carrying value is defined as the net amount after deducting accumulated depreciation and accumulated impairment losses.

2017	Notes	Land Level 2 \$'000	Buildings Level 3 \$'000	Plant equipment & vehicles \$'000	Work in progress \$'000	Total \$'000
Carrying value at 1 July		57 339	865 444	57 892	5 852	986 527
Additions - THS acquisition		0	610	5 062	3 606	9 278
Additions - DHHS capital grant	5.1	0	23 954	2 539	2 747	29 240
Disposals		0	(28 732)	(872)	0	(29 604)
Net transfers through restructuring	11.2	1 544	1 441	(4)	4	2 985
Revaluation increments (decrements)	11.1	2 429	14 603	0	0	17 032
Assets held for sale		(36)	(46)	0	0	(82)
Transfers to Intangibles	8.6(b)	0	(92)	(167)	0	(259)
WIP transfers		0	1 909	425	(2 334)	0
WIP expensed		0	0	0	(860)	(860)
Depreciation		0	(30 025)	(10 853)	0	(40 878)
Carrying value at 30 June		61 276	849 066	54 022	9 015	973 379

2016	Notes	Land Level 2 \$'000	Buildings Level 3 \$'000	Plant equipment & vehicles \$'000	Work in progress \$'000	Total \$'000
Carrying value at 1 July		0	0	0	0	0
Additions - THS acquisition		0	0	915	1 044	1 959
Additions - DHHS capital grant		1 450	63 924	7 406	0	72 780
Disposals		0	0	(17)	0	(17)
Net transfers through restructuring		54 000	816 236	58 251	8 890	937 377
Revaluation increments (decrements)		1 889	11 793	0	0	13 681
WIP transfers		0	2 415	1 641	(4 056)	0
WIP expensed		0	0	0	(26)	(26)
Depreciation		0	(28 923)	(10 304)	0	(39 227)
Carrying value at 30 June		57 339	865 444	57 892	5 852	986 527

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at measurement date. It is based on the principle of exit price, and refers to the price an entity expects to receive when it sells an asset, or the price an entity expects to pay when it transfers a liability.

Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets of liabilities that the entity can access at the measurement date.

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

Level 3 inputs are unobservable inputs for the asset or liability. Unobservable inputs shall be used to measure fair value to the extent that relevant observable inputs are not available.

(c) Level 3 significant valuation inputs and relationship to fair value

Description	Fair Value at 30 June \$'000	Significant unobservable inputs used in valuation	Possible alternative values for level 3 inputs	Sensitivity of fair value to changes in level 3 inputs
Buildings	849 066	A - Construction costs B - Age and condition of asset C - Remaining useful life	When valuing these assets, their existing and alternative uses are taken into account by valuers. As a result, it is unlikely that alternative values will arise unless there are changes in known inputs.	Tasmanian construction indexes have remained stable over the last 12 months. Design and useful lives are reviewed regularly but generally remain unchanged. As a result, it is unlikely that significant variations in values will arise in the short term.

8.6 Intangibles

An intangible asset is recognised where:

- it is probable that an expected future benefit attributable to the asset will flow to the THS; and
- the cost of the asset can be reliably measured.

Intangible assets held by the THS are valued at fair value less any subsequent accumulated amortisation and any subsequent accumulated impairment losses where an active market exists. Where no active market exists, intangible assets held by the THS are valued at cost less any subsequent accumulated amortisation and any subsequent accumulated impairment losses.

Intangible assets with a finite useful life held by the THS principally comprise computer software.

(a) Carrying amount

	2017 \$'000	2016 \$'000
Intangibles with a finite useful life		
Other non-current assets at cost	3 956	937
Less: Accumulated amortisation	(598)	(428)
Total	3 358	509
Capital Work in progress	986	191
Total Intangibles	4 344	700

(b) Reconciliation of movements

	Notes	2017 \$'000	2016 \$'000
Carrying amount at 1 July		700	0
Intangible Assets - Purchases		1 830	29
Additions - DHHS Capital Grant	5.1	1 316	0
Work in progress at cost		409	0
Net transfers through restructuring		0	784
Transfers between classes	8.5(b)	259	0
Amortisation - Intangible assets		(170)	(113)
Carrying amount at 30 June		4 344	700

8.7 Other assets

Other assets are recorded at fair value and include prepayments.

(a) Carrying amount

	2017 \$'000	2016 \$'000
Prepayments	5 279	4 375
Total	5 279	4 375
Recovered within 12 months	4 812	3 759
Recovered in more than 12 months	467	616
Total	5 279	4 375

(b) Reconciliation of movements

	2017 \$'000	2016 \$'000
Carrying amount at 1 July	4 375	0
Additions	5 130	4 375
Utilised	(4 226)	0
Carrying amount at 30 June	5 279	4 375

NOTE 9 LIABILITIES

Liabilities are recognised in the Statement of Financial Position when it is probable that an outflow of resources embodying economic benefits will result from the settlement of a present obligation and the amount at which the settlement will take place can be measured reliably.

9.1 Payables

Payables, including goods received and services incurred but not yet invoiced, are recognised at amortised cost, which due to the short settlement period, equates to face value, when the THS becomes obliged to make future payments as a result of a purchase of assets or services.

	2017 \$'000	2016 \$'000
Creditors	35 252	34 541
Accrued Expenses	28 194	29 765
Total	63 446	64 306
Settled within 12 months	42 075	64 306
Settled in more than 12 months	21 371	0
Total	63 446	64 306

Bank loans and other loans are initially measured at fair value, net of transaction costs. Bank loans and other loans are subsequently measured at amortised cost using the effective interest rate method, with interest expense recognised on an effective yield basis.

The effective interest rate method is a method of calculating the amortised cost of a financial liability and allocating interest expense over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash payments through the expected life of the financial liability, or where appropriate, a shorter period.

9.2 Employee benefits

Liabilities for wages and salaries and annual leave are recognised when an employee becomes entitled to receive a benefit. Those liabilities expected to be realised within 12 months are measured at the amount expected to be paid. Other employee entitlements are measured as the present value of the benefit at 30 June, where the impact of discounting is material and at the amount expected to be paid if discounting is not material.

A liability for long service leave is recognised, and is measured as the present value of expected future payments to be made in respect of services provided by employees up to the reporting date.

	2017 \$'000	2016 \$'000
Accrued salaries	35 874	31 828
Annual leave	77 864	72 704
Long service leave	115 137	107 447
Sabbatical leave	7 906	6 701
Other Employee Benefits	7 380	6 215
Total	244 161	224 895
Expected to settle wholly within 12 months	106 623	101 652
Expected to settle wholly after 12 months	137 538	123 243
Total	244 161	224 895

Other employee benefits is comprised of Purchased Leave, Development Leave, TOIL provisions and State Service Accumulated Leave Scheme (SSALS) entitlements.

9.3 Superannuation

(i) Defined contribution plans

A defined contribution plan is a post-employment benefit plan under which an entity pays fixed contributions into a separate entity and will have no legal or constructive obligation to pay further amounts. Obligations for contributions to defined contribution plans are recognised as an expense when they fall due.

(ii) Defined benefit plans

A defined benefit plan is a post-employment benefit plan other than a defined contribution plan.

Key estimate and judgement

The THS does not recognise a liability for the accruing superannuation benefits of State Service employees. This liability is held centrally and is recognised within the Finance-General Division of the Department of Treasury and Finance.

9.4 Other liabilities

Other liabilities and other financial liabilities are recognised in the Statement of Financial Position when it is probable that an outflow of resources embodying economic benefits will result from the settlement of a present obligation and the amount at which the settlement will take place can be measured reliably. Other liabilities include revenue received in advance and on-costs associated with employee benefits. Revenue received in advance is measured at amortised cost. On-costs associated with employee benefits expected to be realised within 12 months are measured at the amount expected to be paid. Other on-costs associated with employee benefits are measured at the present value of the cost at 30 June 2017, where the impact of discounting is material, and at the amount expected to be paid if discounting is not material.

	2017 \$'000	2016 \$'000
Revenue received in advance		
Other revenue received in advance	3 122	797
Other Liabilities		
Employee benefits - on-costs	2 750	2 489
Inter entity balance	3 187	3 035
Other liabilities	8 969	7 707
Total	18 028	14 028
Settled within 12 months	16 200	12 432
Settled in more than 12 months	1 828	1 596
Total	18 028	14 028

Other liabilities represents funds held by the THS for distribution under the Private Patients Scheme, as well as Tasmanian Government Card outstanding balances.

NOTE 10 COMMITMENTS AND CONTINGENCIES

The THS has entered into a number of operating lease agreements for property, plant and equipment, where the lessors effectively retain all the risks and benefits incidental to ownership of the items leased. Equal instalments of lease payments are charged to the Statement of Comprehensive Income over the lease term, as this is representative of the pattern of benefits to be derived from the leased property.

The THS is prohibited by Treasurer's Instruction 502 *Leases* from holding finance leases.

10.1 Schedule of Commitments

	2017 \$'000	2016 \$'000
By Type		
<i>Operating Lease Commitments</i>		
Motor Vehicles	5 039	5 346
Medical Equipment	1 935	2 760
Rent on Buildings	29 409	32 724
Information Technology	9 463	6 618
Total Lease Commitments	45 846	47 448
<i>Other Commitments</i>		
Miscellaneous Grants	23 879	8 007
Miscellaneous Goods and Services contracts	176 194	120 845
Total Other Commitments	200 073	128 852
Total	245 919	176 300
By Maturity		
<i>Operating Lease Commitments</i>		
One year or less	12 598	10 378
From one to five years	28 316	28 483
More than five years	4 932	8 587
Total Operating Lease Commitments	45 846	47 448
<i>Other Commitments</i>		
One year or less	46 723	39 163
From one to five years	110 971	67 210
More than five years	42 379	22 479
Total Other Commitments	200 073	128 852
Total	245 919	176 300

Motor Vehicles (Operating lease)

The THS' Motor Vehicle Fleet is managed by LeasePlan Australia as part of a Whole-of-Government arrangement with the Department of Treasury and Finance as lessor. Lease payments vary according to the type of vehicle and, where applicable, the price received for trade-in vehicles. Lease terms for the majority of existing vehicles are for a period of three years or 60 000 km's, whichever comes first, with no change to the lease rate. No restrictions or purchase options are contained in the lease.

Medical Equipment

The THS is party to a Master Facility Agreement. No restrictions, provisions for price adjustments or purchase options are contained in the lease agreement. Terms of leases are set for specific periods. The average period of a lease is six years with an option to renew for a period of twelve months or the initial term, whichever is the lesser.

Rent on Buildings (Operating lease)

The THS leases a range of properties/tenancies around the State for service delivery purposes.

Information Technology

The THS is party to a number of IT related contracts to support clinical and non clinical IT systems.

Miscellaneous Grants

The THS provides Grants to external services providers to deliver alcohol and drug rehabilitation services, as well as palliative, respite and community care.

Miscellaneous goods and services contracts

The THS is party to contracts for the supply of various clinical and non clinical services, including security, pathology, radiology, maternity and other medical services.

10.2 Contingent assets and liabilities

Contingent assets and liabilities are not recognised in the Statement of Financial Position due to uncertainty regarding any possible amount or timing of any possible underlying claim or obligation.

Quantifiable contingencies

A quantifiable contingent asset is any possible asset that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the entity.

A quantifiable contingent liability is any possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the entity; or any present obligation that arises from past events but is not recognised because it is not probable that an outflow of resources embodying economic benefits will be required to settle the obligation. To the extent that any quantifiable contingencies are insured, details provided below are recorded net.

	2017 \$'000	2016 \$'000
Quantifiable contingent liabilities		
<i>Contingent claims</i>		
Medical negligence and workers compensation claims	6 217	4 574
Total quantifiable contingent liabilities	6 217	4 574

As at 30 June 2017, the THS had a number of legal claims against it for medical negligence and workers compensation. These claims are reported at the net cost to the THS.

The THS manages its legal claims through the Tasmanian Risk Management Fund (TRMF). An excess of \$50,000 remains payable for every claim and amounts over that excess are met by the TRMF.

NOTE II RESERVES

II.1 Reserves

2017	Land	Building	Artwork	Total \$'000
Asset revaluation reserve				
Balance at the beginning of financial year	3 438	202 985	41	206 463
Transfers to/from accumulated surplus	53	(47)	0	6
Revaluation increments/(decrements)	2 377	14 647	0	17 025
Balance at the end of financial year	5 868	217 585	41	223 494

2016	Land	Building	Artwork	Total \$'000
Asset revaluation reserve				
Balance at the beginning of financial year	0	0	0	0
Transfers to accumulated surplus	0	(210)	0	(210)
Revaluation transferred in on establishment	1 549	191 402	41	192 992
Revaluation increments/(decrements)	1 889	11 793	0	13 681
Balance at the end of financial year	3 438	202 985	41	206 463

(a) Nature and purpose of reserves

Asset Revaluation Reserve

The Asset revaluation reserve is used to record increments and decrements on the revaluation of non-financial assets, as described in Note 8.5.

II.2 Administrative Restructuring

Net assets received under a restructuring of administrative arrangements are designated as contributions by owners and adjusted directly against equity. Net assets relinquished are designated as distributions to owners. Net assets transferred are initially recognised at the amounts at which they were recognised by the transferring agency immediately prior to the transfer.

On 1 January 2017, as a result of a restructuring of administrative arrangements, Child Health and Parenting Services transferred from the Department of Health and Human Services (DHHS) to the THS. Prior year's restructuring of administrative arrangements relate to the transfer of the Cancer Screening and Control Services from the DHHS to the THS.

The transfer of assets and liabilities for Child Health and Parenting Services took place on 1 January 2017. These are detailed in the Statement of Changes in Equity under the heading Administrative restructure, and are detailed in the following Balance Sheet:

Total Transfer to THS	2017 \$'000	2016 \$'000
Assets		
<i>Financial assets</i>		
Cash and deposits	1	36
Receivables	13	48
Property, plant and equipment	2 985	642
Other assets	0	38
Total assets	2 999	764
Liabilities		
Payables	28	74
Employee benefits	2 640	874
Other liabilities	30	0
Total liabilities	2 698	948
Net assets transferred	301	(184)

Administrative Restructures

	2017 \$'000	2016 \$'000
Revenues		
Recognised by the Tasmanian Health Service	592	823
Recognised by the Department of Health and Human Services	5 867	10 176
Total Revenues	6 459	10 999
Expenses		
Recognised by the Tasmanian Health Service	6 008	6 777
Recognised by the Department of Health and Human Services	6 072	10 833
Total Expenses	12 080	17 610

The revenues and expenditure recorded for the THS in the 2016 financial year are directly related to the administrative restructure for Cancer Screening and Control Services.

11.3 Contributed Capital

	2017 \$'000	2016 \$'000
Contributed capital		
Balance at the beginning of financial year	581 593	0
Capital contributions	0	581 777
Administrative restructure - net assets received	301	(184)
Balance at the end of financial year	581 894	581 593

NOTE 12 CASH FLOW RECONCILIATION

Cash means notes, coins, any deposits held at call with a bank or financial institution, as well as funds held in the Special Deposits and Trust Fund, being short term of three months or less and highly liquid. Deposits are recognised at amortised cost, being their face value.

12.1 Cash and deposits

Cash and deposits includes the balance of the Special Deposits and Trust Fund Accounts held by the THS, and other cash held, excluding those accounts which are administered or held in a trustee capacity or agency arrangement.

	2017 \$'000	2016 \$'000
Special Deposits and Trust Fund balance		
T477 THS Patient Trust & Bequest Account	19 152	17 777
T533 THS Operating Account	36 464	71 266
Total	55 616	89 043
Other cash held		
Other Cash equivalents not included above	42	492
Total	42	492
Total cash and deposits	55 658	89 535

Other cash equivalents represents cash held by the THS derived from Private Patient Scheme debtor payments, as well as petty cash and cash floats.

12.2 Reconciliation of Net Result to Net Cash from Operating Activities

	2017 \$'000	2016 \$'000
Net result from transactions (net operating balance)	(45 316)	35 005
Depreciation and amortisation	41 048	39 340
Recognition of assets as a result of stocktake/donations	0	(28)
Capital grants income	(30 557)	(72 780)
WIP expensed	860	26
Doubtful debts	(9)	(446)
Transfer of assets due to restructure	(2 685)	(236 803)
Decrease (increase) in Receivables	(3 567)	(21 280)
Decrease (increase) in Other assets	(5 855)	(20 248)
Decrease (increase) in Inventories	1 307	(11 055)
Increase (decrease) in Employee entitlements	19 266	224 895
Increase (decrease) in Payables	(860)	64 306
Increase (decrease) in Other liabilities	4 000	10 993
Net cash from/(used by) operating activities	(22 368)	11 925

NOTE 13 FINANCIAL INSTRUMENTS

13.1 Risk Exposures

(a) Risk management policies

The THS has exposure to the following risks from its use of financial instruments:

- credit risk;
- liquidity risk; and
- market risk.

The Governing Council and the Chief Executive Officer have overall responsibility for the establishment and oversight of the THS' risk management framework. Risk management policies are established to identify and analyse risks faced by the THS, to set appropriate risk limits and controls and to monitor risks and adherence to limits.

(b) Credit risk exposures

Credit risk is the risk of financial loss to the THS if a customer or counterparty to a financial instrument fails to meet its contractual obligations.

Financial Instrument	Accounting and strategic policies (including recognition criteria and measurement basis)	Nature of underlying instrument (including significant terms and conditions affecting the amount, timing and certainty of cash flows)
Financial Assets		
Receivables	Receivables are recognised at the nominal amounts due, less any provision for impairment. Collectability of debts is reviewed on a monthly basis. Provisions are made when the collection of the debt is judged to be less rather than more likely.	Receivables credit terms are generally 30 days.
Other financial assets	Other financial assets are recognised at the nominal amounts due, less any provision for impairment.	Other financial assets credit terms are generally 30 days.
Cash and deposits	Cash and deposits are recognised at face value.	Cash means notes, coins and any deposits held at call with a bank or financial institution.

The THS has made no changes to its credit risk policy during 2016-17. The THS does not hold any security instrument for its Cash and deposits, Other financial assets and Receivables.

The carrying amount of financial assets recorded in the Financial Statements, net of any allowances for losses, represents the THS' maximum exposure to credit risk without taking into account any collateral or other security.

The following tables analyse financial assets that are past due but not impaired.

Analysis of financial assets at 30 June 2017 but not impaired	Not past due \$'000	Past due 30-120 days \$'000	Past due >120 days \$'000	Total \$'000
Receivables	12 725	7 821	4 301	24 847
Other financial assets	17 161	0	0	17 161
Total	29 886	7 821	4 301	42 008

Analysis of financial assets at 30 June 2016 but not impaired	Not past due \$'000	Past due 30-120 days \$'000	Past due >120 days \$'000	Total \$'000
Receivables	10 332	7 557	3 391	21 280
Other financial assets	15 873	0	0	15 873
Total	26 205	7 557	3 391	37 153

(c) Liquidity risk

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

Financial Instrument	Accounting and strategic policies (including recognition criteria and measurement basis)	Nature of underlying instrument (including significant terms and conditions affecting the amount, timing and certainty of cash flows)
Financial Liabilities		
Payables	Payables, including goods received and services incurred but not yet invoiced, are recognised at amortised cost, which due to the short settlement period equates to face value, when the THS becomes obliged to make future payments as a result of a purchase of assets or services..	Settlement of invoices is usually made within 30 days.
Other financial liabilities	Other financial liabilities are recognised at amortised cost, which due to the short settlement period equates to face value, when the THS becomes obliged to make payments as a result of the purchase of assets or services. The THS regularly reviews budgeted and actual cash outflows to ensure that there is sufficient cash to meet all obligations.	Settlement is usually made within 30 days

The following tables detail the undiscounted cash flows payable by the THS by remaining contractual maturity for its financial liabilities. It should be noted that as these are undiscounted, totals may not reconcile to the carrying amounts presented in the Statement of Financial Position.

Maturity analysis for financial liabilities 2017	1 Year \$'000	2 Years \$'000	3 Years \$'000	4 Years \$'000	5 Years \$'000	More than 5 Years \$'000	Undis- counted \$'000	Carrying Amount \$'000
Financial liabilities								
Payables	42 075	9 332	12 039	0	0	0	63 446	63 446
Other financial liabilities	16 200	1 828	0	0	0	0	18 028	18 028
Total	58 275	11 160	12 039	0	0	0	81 474	81 474

Maturity analysis for financial liabilities 2016	1 Year \$'000	2 Years \$'000	3 Years \$'000	4 Years \$'000	5 Years \$'000	More than 5 Years \$'000	Undis- counted \$'000	Carrying Amount \$'000
Financial liabilities								
Payables	64 306	0	0	0	0	0	64 306	64 306
Other financial liabilities	9 397	1 596	0	0	0	0	0	10 993
Total	73 703	1 596	0	0	0	0	64 306	75 299

(d) Market risk

Market risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in market prices. The primary market risk that the THS is exposed to is interest rate risk.

The THS currently has no financial liabilities at fixed interest rates.

13.2 Categories of Financial Assets and Liabilities

	2017 \$'000	2016 \$'000
Financial assets		
Cash and cash equivalents	55 658	89 535
Receivables	42 008	37 153
Total	97 666	126 688
Financial Liabilities		
Financial liabilities measured at amortised cost	63 446	64 306
Total	63 446	64 306

The THS' maximum exposure to credit risk for its financial assets is \$97.7 million (2016: \$162.4 million). It does not hold nor is a party to any credit derivatives and no changes have occurred to the fair value of its assets as a result of market risk or credit risk. While interest rates have changed during the financial year, the value of security held is significantly more than the value of the underlying asset and no loan advances are impaired. The value of receivables is not affected by changes in interest rates. The THS actively manages its credit risk exposure for the collectability of its receivables and outstanding loans.

13.3 Reclassification of Financial Assets

No reclassification of Financial Assets occurred during 2016-17.

NOTE 14 ADJUSTMENT OF PRIOR PERIOD ERROR

Comparative figures have been restated in the Statement of Financial Position and Statement of Changes in Equity. These changes are a result of prior period errors in accordance with AASB 108 *Accounting Policies, Changes in Accounting Estimates and Errors*.

Prior to the establishment of the THS, health services in Tasmania were delivered through three separate health organisations - Tasmanian Health Organisation South, Tasmanian Health Organisation North and Tasmanian Health Organisation North-West (THOs). The THOs commenced operations on 1 July 2012 as a Statutory Authority under the *Tasmanian Health Organisation Act 2011*, as a result of National Health Reform. To establish the THOs as Statutory Authorities the Department of Health and Human Services (the Department) transferred assets and liabilities directly attributable to the delivery of these health services as an administrative restructure. In 2016-17 two misstatements were identified in relation to the administrative restructure transfer.

The first misstatement relates to inter-entity transactions. Although the THOs and the Department became separate entities at 1 July 2012, the THS continues to share a number of system related services with the Department. As a result, both entities process a number of transactions on each other's behalf. Inter-entity balances enable each entity to account for these transactions. For instance, payments made by the Department on the THS' behalf form a liability in the THS' accounts and an asset in the Department's accounts

The administrative restructure transferred from the Department to the THOs at commencement contained an opening inter-entity balance. Investigations into this balance have revealed that it was incorrect. The identified misallocations to the inter-entity balance primarily relate to:

- A number of THO inventory/stores purchases were recorded in the Department's accrual ledger prior to 1 July 2012 that were not included in the administrative restructure inter-entity balance. Cash payments for these items were made after 1 July 2012 and were processed as inter-entity transactions, creating a discrepancy; and,
- The Department settles the THS' Business Activity Statement (BAS) requirements on its behalf and allocates the resultant GST payments across the two entities via an automated system. This system was implemented in 2013-14 and records payments through inter-entity transactions. The 2012-13 BAS was settled in 2013-14, which created a discrepancy between years as inter-entity transactions were used in 2013-14 but not 2012-13.

As these errors were made in a reporting period prior to the comparative period, the Statement of Financial Position balances as at 30 June 2016 have been restated as follows:

- Inter-entity receivables decreased by \$3.663 million to reflect reduced revenue owed to the THS by the Department;
- Inter-entity payables increased by \$3.035 million to reflect added revenue the THS owed the Department; and,
- Contributed capital decreased by \$6.697 million to recognise the resultant overstatement of net assets received.

The second misstatement relates to the transfer of land and buildings to the THS. During the 2016-17 financial year, land and buildings were identified on the Department's asset register that should have been included in the transfer of assets to the THOs at 1 July 2012. These properties had a carrying value at 1 July 2012 of \$4.495 million. As this error was made in a reporting period prior to the comparative period, the Statement of Financial Position balances as at 30 June 2016 are restated as follows:

- Land and Buildings increased by \$4.305 million to reflect the transfer of assets to the THS that should have occurred at 1 July 2012. The increase to Land and Buildings is as follows:
 - Land and building carrying value is increased by \$4.495 million, to reflect the transfer of land and buildings to the THS as at 1 July 2012;
 - Buildings carrying value is decreased by the net revaluation decrement from 01/07/2012 to 30/06/2016 of \$0.190 million.
- Reserves – Land and Buildings decreased by \$0.068 million as follows;
 - Building revaluation reserve is decreased by the net revaluation decrement from 01/07/2012 to 30/06/2016 of \$0.190 million.
 - Building revaluation reserve is increased by the net revaluation depreciation offset from 01/07/2012 to 30/06/2016 of \$0.122 million.
- Establishment of THS - Equity Contributions is increased by \$4.495 million to reflect the transfer of land and buildings from the DHHS to the THS as at 1 July 2012;
- Depreciation expense is increased to add the 2015-16 building depreciation expense in relation to the transferred assets of \$0.122 million.

The following tables disclose the impact of these restatements on the relevant 2015-16 notes.

Statement of Financial Position

2016	As previously reported \$'000	Restated \$'000	Prior period error \$'000
Assets			
<i>Financial assets</i>			
Cash and deposits	89 535	89 535	0
Receivables	21 280	21 280	0
Other financial assets	15 873	12 210	(3 663)
<i>Non-financial assets</i>			
Inventories	11 055	11 055	0
Assets held for sale	95	95	0
Property, plant and equipment	982 222	986 527	4 305
Intangibles	700	700	0
Other assets	4 375	4 375	0
Total assets	1 125 135	1 125 777	642
Liabilities			
Payables	64 306	64 306	0
Interest bearing liabilities	0	0	0
Employee benefits	224 895	224 895	0
Other liabilities	10 993	14 028	3 035
Total liabilities	300 194	303 229	3 035
Net assets	824 941	822 548	(2 393)
Equity			
Contributed capital	583 796	581 593	(2 203)
Reserves	206 531	206 463	(68)
Accumulated funds	34 614	34 492	(122)
Total equity	824 941	822 548	(2 393)

Statement of Changes in Equity

2016	As previously reported \$'000	Restated \$'000	Prior period error \$'000
Balance as at 1 July 2015	0	0	0
Net Result	34 889	34 767	(122)
Changes to revaluation reserve	13 749	13 681	(68)
Total comprehensive result	48 638	48 448	(190)
Transfer sale proceeds to the Crown Lands Administration Fund (CLAF)	(485)	(485)	0
Transactions with owners in their capacity as owners:			
Establishment of THS - Equity Contributions	776 972	774 769	(2 203)
Administrative restructure - net assets received	(184)	(184)	0
Balance as at 30 June 2016	824 941	822 548	(2 393)

NOTE 15 TRANSACTIONS AND BALANCES RELATING TO A TRUSTEE OR AGENCY ARRANGEMENT

Transactions relating to activities undertaken by the THS in a trust or fiduciary (agency) capacity do not form part of the THS' activities. Trustee and agency arrangements, and transactions/balances relating to those activities, are neither controlled nor administered.

Fees, commissions earned and expenses incurred in the course of rendering services as a trustee or through an agency arrangement are recognised as controlled transactions.

15.1 Activities Undertaken Under a Trustee or Agency Relationship

Account/Activity	Opening balance \$'000	Net transactions during 2016-17 \$'000	Closing balance \$'000
T477 Patient Trust and Hospital Bequest Account	6 120	(712)	5 408
Royal Hobart Hospital Patients Trust Account	4	(4)	0
Mental Health Services Client Trust Account	46	(25)	21

NOTE 16 EVENTS OCCURRING AFTER BALANCE DATE

The Mersey Community Hospital Heads of Agreement between the Commonwealth of Australia and State of Tasmania expired on 30 June 2017. A National Partnership Agreement (NPA) was signed on 15 June 2017 between the Commonwealth of Australia and the State of Tasmania to transfer ownership of the Mersey Community Hospital to the State of Tasmania from 1 July 2017. The State of Tasmania will receive funding of \$730.4 million from the Commonwealth of Australia for the ongoing operation of the facility over a period of 10 years. This funding will be quarantined for the use at the Mersey Community Hospital and will be invested by the State of Tasmania through the Tasmanian Public Finance Corporation. Annual drawdowns by way of special dividend, paid in monthly instalments, will be provided to the THS to fund the operation of the Mersey Community Hospital for the term of the agreement.

The Commonwealth of Australia has advised the THS that the estimated value of the Mersey Community Hospital is \$31.84 million. The transfer of the Hospital will be recorded in the THS' 2017-18 financial statements. Consideration to be paid for the transfer of the property has been agreed at one dollar.

NOTE 17 OTHER SIGNIFICANT ACCOUNTING POLICIES AND JUDGEMENTS

17.1 Objectives and Funding

Under the National Health Reform Agreement (NHRA), funding is provided to the THS on the basis of activity through Activity Based Funding (ABF) wherever practicable. Funding for smaller regional or rural hospitals is provided on a block funding basis. Funds for teaching, training and research are also provided on a block funding basis. Pricing under the NHRA is determined by an Independent Hospitals Pricing Authority (IHPA). Funding due to the THS under Australian Government National Partnership Agreements and Commonwealth Own Purpose Expenditure programs is paid as grants. The THS also provides services to fee paying privately insured patients, or patients who will receive compensation for these expenses due to the circumstances surrounding their injury. The financial statements encompass all funds through which the THS controls resources to carry on its functions.

As legislated, the principal purpose of the THS is to:

- promote and maintain the health of persons; and
- provide care and treatment to, and ease the suffering of, persons with health problems;

as agreed in the THS' Service Agreement and within the budget provided in the Service Agreement.

In addition, Child Health and Parenting Services was transferred to the THS from the DHHS on 1 January 2017. Details of the restructure, and the associated transfer of assets and liabilities, can be found at Note 11.2.

17.2 Basis of Accounting

The Financial Statements are a general purpose financial report and have been prepared in accordance with:

- Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board; and
- The Treasurer's Instructions issued under the provisions of the *Financial Management and Audit Act 1990*.

The Financial Statements were signed by the Chair of the Governing Council and the Acting Chief Executive Officer on 13 September 2017.

The Financial Statements have been prepared on an accrual basis and, except where stated, are in accordance with the historical cost convention. The accounting policies are generally consistent with the previous year except for those changes outlined in Note 17.4.

The Financial Statements have been prepared on a going concern basis. The continued existence of the THS in its present form, undertaking its current activities, is dependent on Government policy and on continuing appropriations by Parliament for the THS' administration and activities.

The THS has made no assumptions concerning the future that may cause a material adjustment to the carrying amounts of assets and liabilities within the next reporting period.

17.3 Functional and Presentation Currency

These Financial Statements are presented in Australian dollars, which is the THS' functional currency.

17.4 Changes in Accounting Policies

(a) Impact of new and revised Accounting Standards

In the current year, the THS has adopted all of the new and revised Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that are relevant to its operations and effective for the current annual reporting period. These include:

- 2015-6 *Amendments to Australian Accounting Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities* – The objective of this Standard is to make amendments to AASB 124 *Related Party Disclosures* to extend the scope of that Standard to include not-for-profit public sector entities. This Standard applies to annual reporting periods beginning on or after 1 July 2016. The impact is increased disclosure in relation to related parties. There is no financial impact.

(b) Impact of new and revised Accounting Standards yet to be applied

The following applicable Standards have been issued by the AASB and are yet to be applied:

- AASB 9 *Financial Instruments* and 2014-7 *Amendments to Australian Accounting Standards arising from AASB 9* (December 2014) - the objective of these Standards is to establish principles for the financial reporting of financial assets and financial liabilities that will present relevant information to users of financial statements for their assessment of the amounts, timing, uncertainty of an entity's future cash flows, and to make amendments to various accounting standards as a consequence of the issuance of AASB 9. These standards apply to annual reporting periods beginning on or after 1 January 2018. The THS has not yet assessed the financial impact.

- *AASB 15 Revenue from Contracts with Customers* – The objective of this Standard is to establish the principles that an entity shall apply to report useful information to users of financial statements about the nature, amount, timing, an uncertainty of revenue and cash flows arising from a contract with a customer. In accordance with *2015-8 Amendments to Australian Accounting Standards - Effective Date of AAS 15*, this Standard applies to not-for-profit entities for annual reporting periods beginning on or after 1 January 2019. Where an entity applies the Standard to an earlier annual reporting period, it shall disclose that fact. The THS has not yet assessed the financial impact.
- *2014-5 Amendments to Australian Accounting Standards arising from AASB 15* – The objective of this Standard is to make amendments to Australian Accounting Standards and Interpretations arising from the issuance of *AASB 15 Revenue from Contracts with Customers*. This Standard applies when AASB 15 is applied, except that the amendments to AASB 9 (December 2009) and AASB 9 (December 2010) apply to annual reporting periods beginning on or after 1 January 2018. This Standard shall be applied when AASB 15 is applied. The THS has not yet assessed the financial impact.
- *2016-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107* – The objective of this Standard is to amend AASB 107 *Statement of Cash Flows* to require entities preparing statements in accordance with Tier 1 reporting requirements to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This Standard applies to annual periods beginning on or after 1 January 2017. The impact is increased disclosure in relation to cash flows and non-cash changes.
- *2016-3 Amendments to Australian Accounting Standards - Clarifications to AASB 15* - The objective of this Standard is to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. This Standard applies to annual periods beginning on or after 1 January 2018. The impact is enhanced disclosure in relation to revenue. The THS has not yet assessed the financial impact.
- *AASB 16 Leases* – The objective of this Standard is to introduce a single lessee accounting model and require a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. This Standard applies to annual reporting periods beginning on or after 1 January 2019. The impact is enhanced disclosure in relation to leases. The THS has yet to calculate the financial impact due to the expected movements in operating lease balances between 30 June 2017 and 30 June 2019. Operating leases currently listed in the Commitments note are likely to be recognised as assets and liabilities under the new standard.
- *2016-4 Amendments to Australian Accounting Standards - Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities* - The objective of this Standard is to amend AASB 136 *Impairment of Assets* to remove references to depreciated replacement cost as a measure of value in use for not-for-profit entities and to clarify that the recoverable amount of primarily non-cash-generating assets of not-for-profit entities which are typically specialised in nature and held for continuing use of their service capacity, is expected to be materially the same as fair value determined under AASB 13 *Fair Value Measurement*, with the consequence that AASB 136 does not apply to such assets that are regularly revalued to fair value under the revaluation model in AASB 116 and AASB 138, and AASB 136 applies to such assets accounted for under the cost model in AASB 116 and AASB 138. This Standard applies to annual reporting periods beginning on or after 1 January 2017. The impact is enhanced disclosure in relation to non-cash-generating specialised assets of not-for-profit entities. The THS does not believe there will be any financial impact.

- AASB 1058 *Income of Not-for-Profit Entities* - The objective of this Standard is to establish principles for not-for-profit entities that apply to transactions where the consideration to acquire an asset is significantly less than fair value principally to enable a not-for-profit entity to further its objectives, and the receipt of volunteer services. This Standard applies to annual reporting periods beginning on or after 1 January 2019. The impact is enhanced disclosure in relation to income of not-for-profit entities. The THS has not yet assessed the financial impact.

17.5 Foreign Currency

Transactions denominated in a foreign currency are converted at the exchange rate at the date of the transaction. Foreign currency receivables and payables are translated at the exchange rates current as at balance date.

17.6 Comparative Figures

Comparative figures have been adjusted to reflect any changes in accounting policy or the adoption of new standards at Note 17.4.

Where amounts have been reclassified within the Financial Statements, the comparative statements have been restated.

Restructures of Outputs within the THS (internal restructures) that do not affect the results shown on the face of the Financial Statements are reflected in the comparatives in the Output Schedule at Notes 1.1 and 1.2.

17.7 Rounding

All amounts in the Financial Statements have been rounded to the nearest thousand dollars, unless otherwise stated. Amounts less than \$500 are rounded to zero.

17.8 Departmental Taxation

The THS is exempt from all forms of taxation except Fringe Benefits Tax (FBT) and the Goods and Services Tax (GST).

17.9 Goods and Services Tax

Revenue, expenses and assets are recognised net of the amount of GST, except where the GST incurred is not recoverable from the Australian Taxation Office (ATO). Receivables and payables are stated inclusive of GST. The net amount recoverable, or payable, to the ATO is recognised as an asset or liability within the Statement of Financial Position.

In the Statement of Cash Flows, the GST component of cash flows arising from operating, investing or financing activities which is recoverable from, or payable to, the ATO is, in accordance with the Australian Accounting Standards, classified as operating cash flows.

INDEPENDENT AUDITOR'S REPORT



Independent Auditor's Report

To the Members of Parliament

Tasmanian Health Service

Report on the Audit of the Financial Statements

Opinion

I have audited the financial statements of the Tasmanian Health Service (the THS), which comprise the statement of financial position as at 30 June 2017 and statements of comprehensive income, changes in equity and cash flows for the year then ended, notes to the financial statements, including a summary of significant accounting policies, other explanatory notes and the statement by the Chair of the Governing Council and the Chief Executive Officer.

In my opinion, the accompanying financial statements:

- (a) present fairly, in all material respects, the THS' financial position as at 30 June 2017 and of its financial performance and its cash flows for the year then ended
- (b) are in accordance with the *Tasmanian Health Organisation Act 2011*, *Financial Management and Audit Act 1990* and Australian Accounting Standards.

Basis for Opinion

I conducted the audit in accordance with Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I am independent of the THS in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial statements in Australia. I have also fulfilled my other ethical responsibilities in accordance with the Code.

The *Audit Act 2008* further promotes the independence of the Auditor-General. The Auditor-General is the auditor of all Tasmanian public sector entities and can only be removed by Parliament. The Auditor-General may conduct an audit in any way considered appropriate and is not subject to direction by any person about the way in which audit powers are to be exercised. The Auditor-General has for the purposes of conducting an audit, access to all documents and property and can report to Parliament matters which in the Auditor-General's opinion are significant.

INDEPENDENT AUDITOR'S REPORT

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

My audit is not designed to provide assurance on the accuracy and appropriateness of the budget information in the THS' financial statements.

Responsibilities of the Governing Council and the Chief Executive Officer for the Financial Statements

The Chair of the Governing Council and the Chief Executive Officer are jointly responsible for the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards, Section 34 of *Tasmanian Health Organisation Act 2011* and the financial reporting requirements of Section 27 (1) of the *Financial Management and Audit Act 1990*. This responsibility includes such internal control as determined necessary to enable the preparation of the financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Chair of the Governing Council and the Chief Executive Officer are responsible for assessing the THS' ability to continue as a going concern unless the THS' operations will cease as a result of an administrative restructure. The assessment must disclose, as applicable, matters related to going concern and the appropriateness of using the going concern basis of accounting.

Auditor's Responsibilities for the Audit of the Financial Statements

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

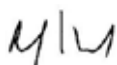
As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the THS' internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Chair of the Governing Council and the Chief Executive Officer.

INDEPENDENT AUDITOR'S REPORT

- Conclude on the appropriateness of the Chair of the Governing Council and the Chief Executive Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the THS' ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusion is based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the THS to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Chair of the Governing Council and the Chief Executive Officer regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.



Rod Whitehead
Auditor-General

Tasmanian Audit Office

18 September 2017
Hobart

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TASMANIAN
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