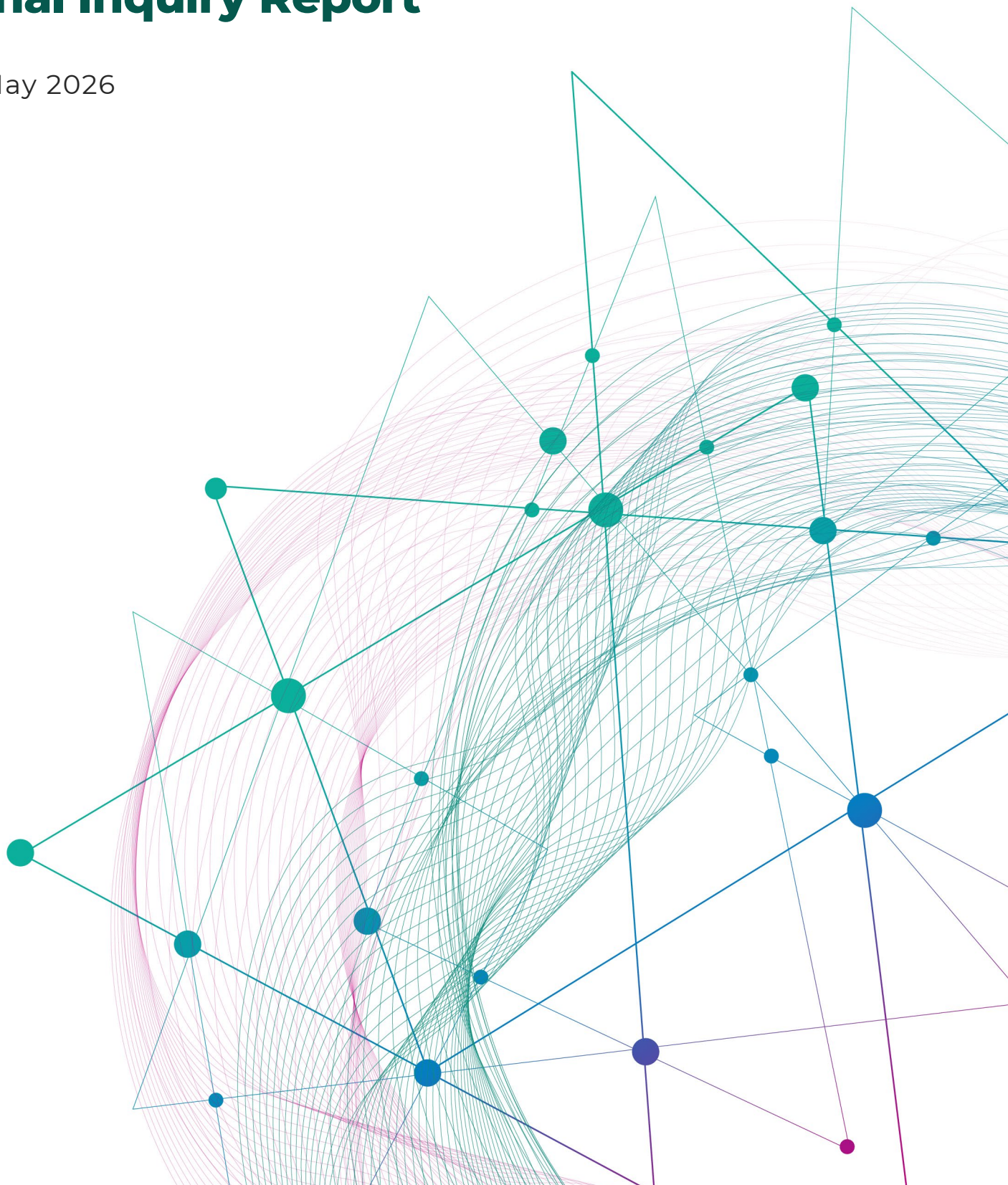
Inquiry into ACT health system data, demand and processes

Final Inquiry Report

8 May 2026



Acknowledgement of Country

We formally acknowledge the Ngunnawal people as the traditional custodians of the Canberra region, recognising their enduring connection to the land and their ongoing cultural contributions.

Acknowledgement of contributions

I would like to extend my sincere gratitude to all individuals and organisations who have contributed their time and expertise to the Inquiry into ACT health system data, demand and processes. Your valuable insights, provided through consultation sessions and submissions, have been instrumental in shaping my understanding and findings. Comprehensive details of the categories of stakeholders engaged throughout this Inquiry, as well as the submissions received, are included in the appendices of this Final Report.

Ms Rachel Stephen-Smith MLA
Minister for Health and Minister for Mental Health
ACT Legislative Assembly
London Circuit
CANBERRA ACT 2601

8 May 2026

Dear Minister

I am pleased to provide you with the Inquiry into ACT health system data, demand and processes – Final Report: 8 May 2026 (the Inquiry Final Report). This has been provided to you in sufficient time for you to table it in the ACT Legislative Assembly before 30 June 2026, as required in the Terms of Reference (see **Appendix A**).

I would like to thank all the staff and members of the public who have taken the time to meet with me and/or provided written input into the Inquiry. The contributions of everyone have made undertaking the Inquiry a privilege and honour. Stakeholder feedback is reflected throughout the report and underpins the findings and recommendations.

The Inquiry Final Report provides a comprehensive descriptive and thematic summary of the qualitative and quantitative data received throughout this Inquiry. This includes 115 consultation sessions undertaken with 259 participants (noting some stakeholders participated in more than one consultation session). In addition to this, a total of 29 written submissions were received. Insights were distilled from data analysis to arrive at 49 recommendations.

You will note in the Inquiry Final Report that the consultations and submissions allowed a set of organising themes to be developed, against which the Terms of Reference have been mapped. The themes are:

- ACT health system governance
- Clinical quality and safety
- Service planning, demand and sustainability
- Planned Care Reforms
- Workforce and culture
- Data collection and reporting
- Digital Health Record (DHR)

Implementation of the 49 recommendations identified through this Inquiry will require a structured, phased approach underpinned by formal endorsement from the ACT Government to ensure clear authority, prioritisation and resourcing across the system.

There are recommendations for each of the Report's organising themes and Terms of Reference. There are also common threads running through the recommendations that are essential to their successful implementation:

- Open engagement with clinicians, other staff, health consumers, and external stakeholders.
- Strong collaboration between the Health and Community Services Directorate, Canberra Health Services, Digital Canberra and Infrastructure Canberra.
- Clarity and transparency in the way things are organised, governed and changed.

The sustainability of the improvements arising from the recommendations will require a strong focus on and shared commitment to these common threads throughout implementation.

The recommendations provide an opportunity for further continuous improvement in the ACT health system.

Yours sincerely

Michael Walsh PSM
Independent Chair
Inquiry into ACT health system data, demand and processes

Contents

Executive summary

Inquiry background and context

On 24 June 2025, the Australian Capital Territory (ACT) Legislative Assembly passed a motion calling for an independent inquiry into health data and processes. The motion included that the Legislative Assembly notes the growing concerns among clinicians and patients about issues such as lengthy Elective Surgery waiting lists, limited access to data on wait times for specialist procedures and appointments, delays in accessing urgent care, and reports of interference in clinical decision-making. The Inquiry is intended to inform the public, clinicians, and policymakers on how the ACT health system functions and opportunities for improvement.[1]

Inquiry scope and deliverables

A Terms of Reference (ToR) was developed to define the scope of the Inquiry that included considering the following areas:

1. Make recommendations for any required improvements to the health data made publicly available, including but not limited to wait times for specialist appointments. This will be supported by:
    a. undertaking inter-jurisdictional comparisons of publicly available health data.
    b. considering centralisation of the publication of health data.
    c. considering improvements in the presentation of data to enable longitudinal comparisons and changes and segmentation to better understand determinants.
2. Determine the extent and impact of any interference – administrative, managerial or political – in clinical care decisions at Canberra Health Services (CHS) and make recommendations as relevant.
3. Determine the effectiveness, risks, and any unintended consequences of Planned Care Reforms and the Digital Health Record (DHR) implementation, including potential improvements in data, updates to privacy legislation and oversight required to facilitate patients' treatment.
    a. This will include investigating concerns raised publicly regarding the cardiology and orthopaedic surgery groups in the ACT public health system.

[1] Legislative Assembly for the Australian Capital Territory 2025, *Notice Paper No. 22: Tuesday, 24 June 2025*, ACT Parliament, Canberra.

4. Investigate current and projected resourcing needs (including workforce, theatres, equipment and beds) relative to demand. To support this analysis, the Inquiry will seek to:
    a. understand drivers of waiting list growth, including referral pathways and any peri-operative capacity constraints.
    b. consider inter-jurisdictional comparisons of drivers of waiting-list growth, including referral pathways and peri-operative capacity constraints.
5. Investigate factors affecting recruitment, retention and morale of medical, nursing and allied health staff.
6. Make evidence-based recommendations to improve governance, resourcing and data required to facilitate patient, policy and clinical outcomes, and staff wellbeing.[2]

Inquiry methodology

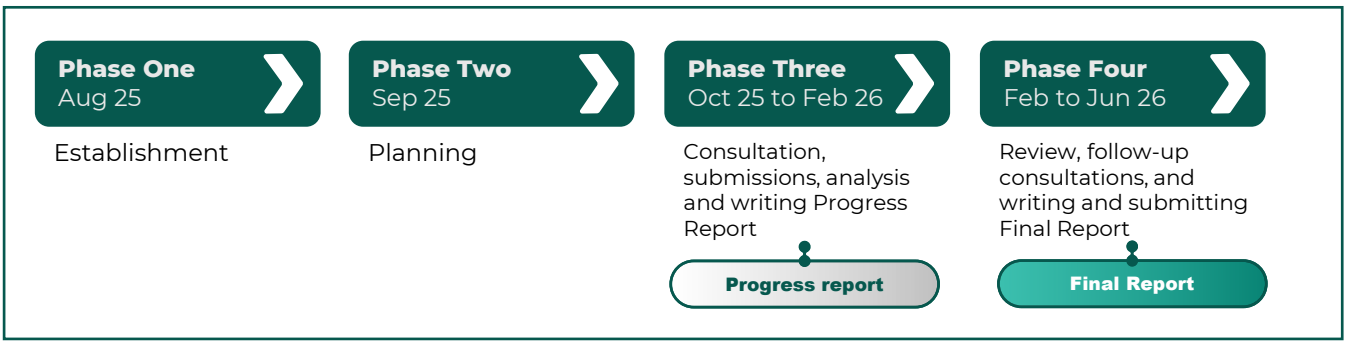
The Inquiry commenced on 25 August 2025 and has been completed in time to enable the Minister for Health and Mental Health to table the report in the ACT Legislative Assembly by 30 June 2026. The Inquiry was delivered over four phases (refer **Figure 1**), with the Inquiry Final Report the conclusion of Phase Four. The Inquiry Final Report provides comprehensive analysis based on:

- 115 consultations facilitated with 259 participants across the ACT health system, including clinicians and staff, consumers, key partners and industrial representatives[3]
- 29 written submissions
- Desktop review of qualitative and quantitative data, including publicly available information, public health data and reports and documents provided by CHS and the Health and Community Services Directorate (HCSD)

A summary of stakeholder groups consulted with is provided in **Appendix B**. To maintain confidentiality, no individuals are identified in this report.

Thematic analysis of the stakeholder consultations and written submissions was undertaken, to identify seven organising themes against which the Inquiry ToR have been mapped. Inquiry findings informed the development of recommendations associated with each organising theme. Further details on ToR and organising themes are provided below.

Figure 1: Summary of phases and timelines



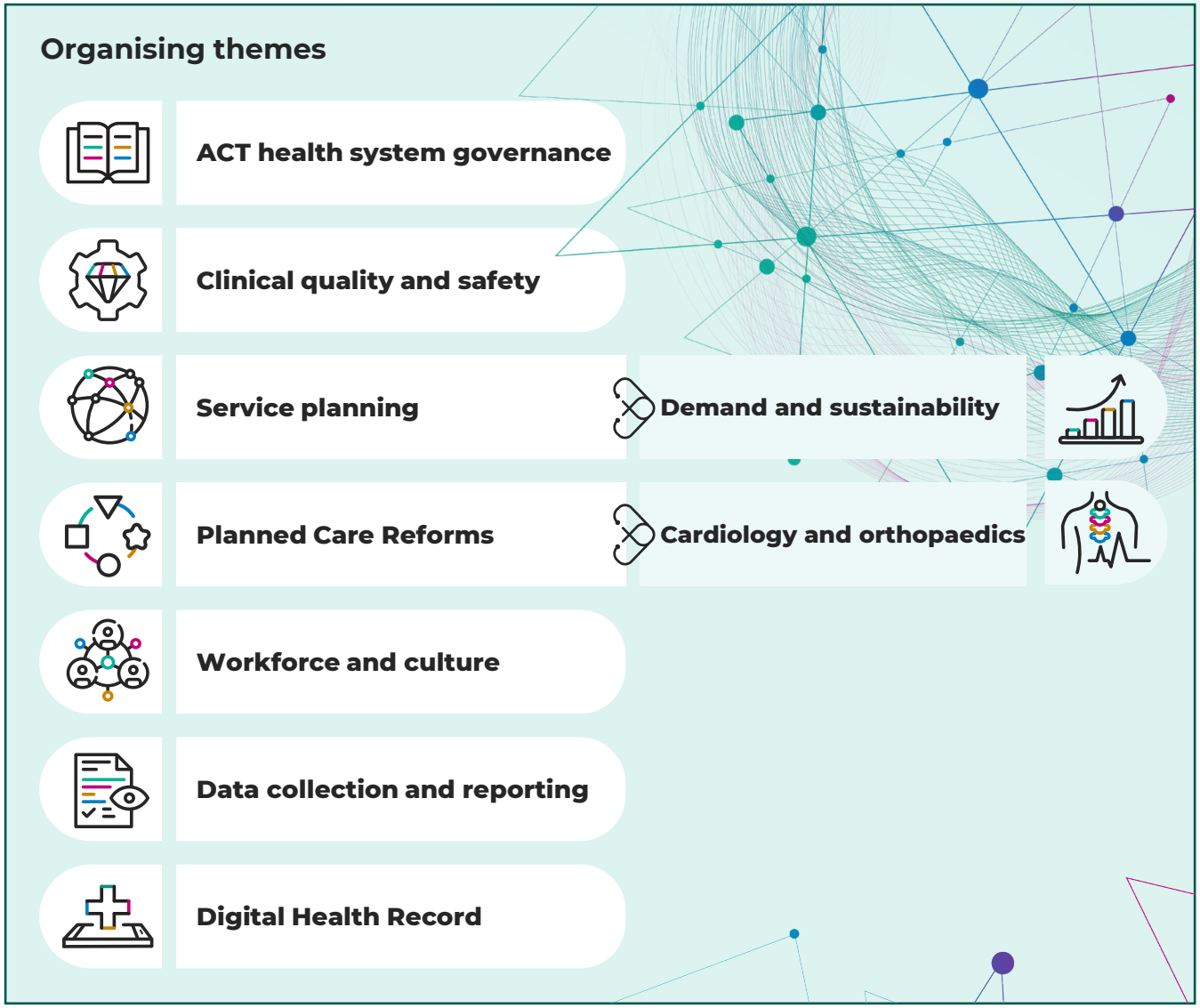
[2] ACT Government, Terms of Reference, Inquiry into ACT health system, data, demand and processes, ACT Government.

[3] The participants are not all unique, as some individuals have attended multiple meetings and/or participated in different roles and capacities.

Inquiry organising themes

Consultations and written submissions allowed a set of organising themes to be developed, against which the ToR have been mapped. The recommendations, along with mapping to primary and ancillary ToR are captured in following section.

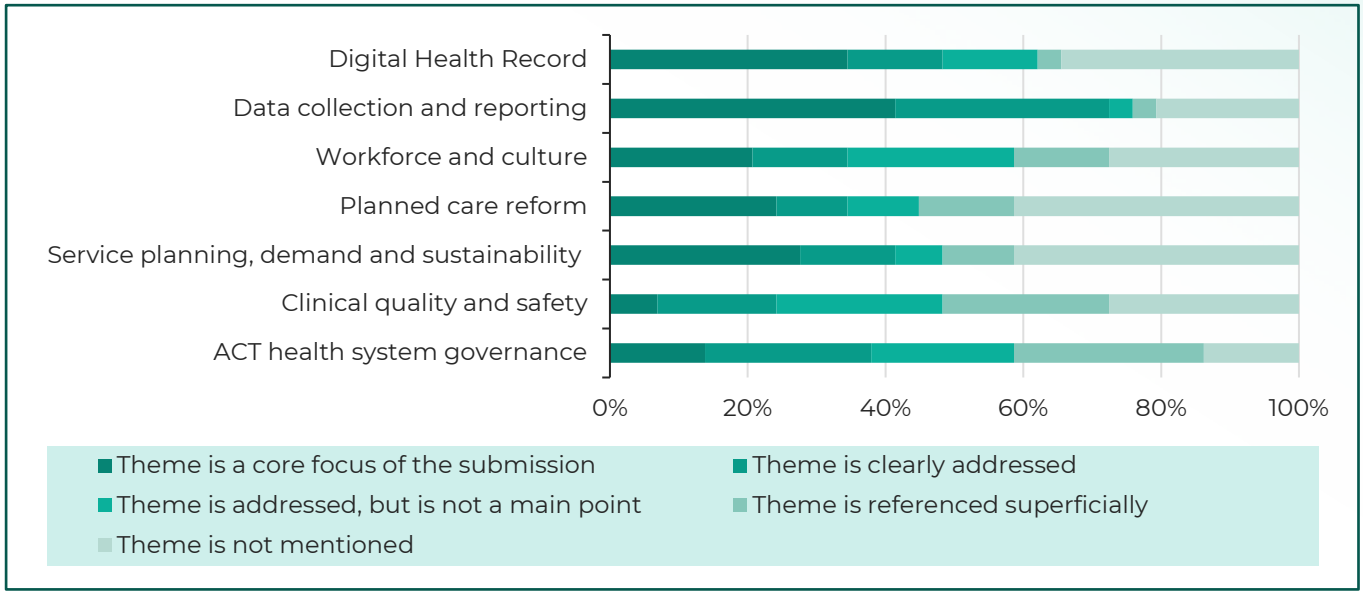
Figure 2: Organising themes



Thematic analysis of written submissions

The Inquiry received 29 written submissions, all of which were carefully considered in the preparation of the Final Report. A thematic analysis was undertaken to identify key topics and issues captured by stakeholders through written submission. The output of this comprehensive analysis is provided in **Figure 3**. This illustrates the extent to which each theme was identified across the written submissions received. Refer to **Appendix C** for more detail regarding the logic that supported this thematic analysis.

Figure 3: Thematic analysis of submissions received



Inquiry findings and recommendations

The findings of the Inquiry have identified genuine strengths and meaningful accomplishments of the ACT health system across key themes examined. These achievements were delivered in the midst of significant change to the ACT health system, particularly during the last eight years. This includes the structural separation of the ACT health system into two separate agencies, delivery of the first DHR, acquisition and operation of Calvary Public Hospital Bruce by the government (now known as the North Canberra Hospital (NCH)), Machinery of Government (MoG) changes and the global COVID-19 pandemic from 2020 to 2023.

The Inquiry has also identified areas for improvement arising from consultation and analysis in relation to the ToR.

Through broad engagement across the ACT health system, document review and analysis of written submissions, the Inquiry acknowledges the dedication of the ACT health system's staff to delivering exceptional patient outcomes and a commitment to drive improvements that build a stronger, better equipped and more collaborative health system. Alongside these strengths, the Inquiry identified opportunities to build upon this existing capability to ensure that the ACT health system is positioned for long-term success and sustainability, in an increasingly complex and demanding health landscape.

A total of 49 recommendations have been made by the Inquiry and are listed below. These recommendations serve as practical and actionable steps that can be implemented to support ongoing improvement to the ACT health system. Recommendations listed below are organised according to key theme and mapped to ToR; ToR are identified as core or ancillary to the theme, to reflect the strength of the relationship between the ToR and the theme. Most ToR appear several times as they relate to multiple themes.

Implementation of the 49 recommendations identified through this Inquiry will require a structured, phased approach underpinned by formal endorsement from the ACT Government to ensure clear authority, prioritisation and resourcing across the system.

There are recommendations for each of the Report's organising themes. There are also common threads running through the recommendations that are essential to their successful implementation:

- Open engagement with clinicians, other staff, health consumers, and external stakeholders.
- Strong collaboration between the Health and Community Services Directorate, Canberra Health Services, Digital Canberra and Infrastructure Canberra.
- Clarity and transparency in the way things are organised, governed and changed.

The sustainability of the improvements arising from the recommendations will require a strong focus on and shared commitment to these common threads throughout implementation.

The recommendations provide an opportunity for further continuous improvement in the ACT health system.

ACT health system governance

Recommendation 1 HCSD, in collaboration with CHS, develop a System Governance Framework that clearly describes at least the following governance components:

- Full details of health-related roles and accountabilities of HCSD as system coordinator, CHS as Local Hospital Network (LHN) service provider, Digital Canberra and Infrastructure Canberra as system enablers and how collaboration will operate for the health portfolio as a whole.
- The arrangements to meet the National Health Reform Agreement (NHRA) commitments, including service agreements, managing the NHRA national and ACT health funding, collaboration by HCSD and CHS with the Primary Health Network (PHN) and Aboriginal Community Controlled Health Organisation (ACCHO), collaboration across related sectors, and performance monitoring and reporting, and other requirements such as collaboration across the ACT Government.
- The arrangements for HCSD, CHS, Digital Canberra and Infrastructure Canberra to coordinate health-related functions including prioritising activities and making whole of health portfolio decisions involving two or more of the four entities.
- Description of how the Clinical Quality and Safety Framework (CQSF) and governance, data governance and digital health governance (and other system frameworks and governance arrangements) are embedded in the System Governance Framework.

Recommendation 2 In consultation with the National Health Funding Administrator, discontinue the use of the ACT LHN Directorate as an entity of HCSD, and, consistent with the ACT Administrative Arrangements, HCSD is the system coordinator (managing the Reserve Bank account and national funding), and CHS is the health service provider.

Recommendation 3 Combine the current two agreements (Service Agreement and Service Funding Agreement) into a single agreement signed by the Minister for Health, Director-General HCSD, and CEO CHS.

Mapping to primary ToR	**6**	**Mapping to ancillary ToR**	**1, 2, 3 and 5**

Clinical quality and safety

Recommendation 4 Using models operating in jurisdictions such as New South Wales (NSW), Victoria (Vic), Queensland (Qld) and Western Australia (WA), HCSD lead, in close collaboration with CHS, and with input from primary care, Non-Governmental Organisations (NGOs), health consumers, and private hospitals, the development of a Clinical Quality and Safety Framework (CQSF) to include the common jurisdictional features of leading practice quality and safety arrangements described in this report.

Recommendation 5 CHS undertake a review of the current clinical quality and safety arrangements to ensure they are consistent with the new CQSF and updated legislation.

Recommendation 6 The *Health Records Act 1997* be amended to meet the requirements of the CQSF, including as they relate to the requirement for designated persons in CHS and HCSD to have access to patient identifiable information for the legislated purpose of quality and safety operations, monitoring and improvement.

Recommendation 7 The *Health Act 1993* be amended to meet the requirements of the CQSF, including as they relate to:

- The undertaking of root cause analysis (RCA) reviews
- The undertaking of Clinical Reviews
- The undertaking of Health Service Reviews
- Quality Assurance Committees (QACs)
- Obligations and protections for the different types of reviews and the reviewers who undertake them

Recommendation 8 The *Public Health Act 1997* be reviewed and amended in line with the new CQSF to reflect the role of the Chief Health Officer (CHO), the role leading the oversight of clinical quality and safety for the system, as well as personnel involved in quality and safety operations and oversight activities.

Mapping to primary ToR	**2 and 3**	**Mapping to ancillary ToR**	**6**

Service planning

Recommendation 9 HCSD, in collaboration with CHS, undertake a refresh of the ACT Health Service Plan 2022-30, with an updated timeframe of 2027-35.

Recommendation 10 CHS, in collaboration with HCSD, develop a whole of network Clinical Services Plan (CSP) for all services in CHS, including walk-in-centres, Mental Health Justice Health Alcohol and Drug Services (MHJHADS) and other CHS services.

Recommendation 11 CHS, in collaboration with HCSD, undertake a refresh of the Clinical Services Plans (CSPs) for The Canberra Hospital (TCH), NCH and University of Canberra Hospital that will be nested into the CHS whole of network CSP.

Mapping to primary ToR	**2 and 3**	**Mapping to ancillary ToR**	**6**

Demand and sustainability

Recommendation 12 HCSD and CHS collaborate to undertake further analysis (and improvement activities) of the cost bucket breakdown of the ACT costs per Weighted Activity Unit (WAU) compared to the Australian average costs.

Recommendation 13 CHS, in collaboration with HCSD, Capital PHN, Royal Australian College of General Practitioners (RACGP) and the Australian Medical Association (AMA), explore initiatives such as the Qld eConsult service to provide access to specialist advice as a way of reducing the number of patients needing to be seen in CHS services.

Recommendation 14 CHS strengthen the operation of hospital, Outpatient, and walk-in centre services as a network of services that optimises the use of clinical resources and provides more timely access for patients.

Recommendation 15 CHS and HCSD continue to collaborate with NSW Health, particularly Southern NSW Local Health District (LHD), to progress initiatives to support patients receiving specialist services closer to where they live in NSW.

Recommendation 16 CHS undertake a quality improvement activity for rostering to identify opportunities to reduce overtime and the use of locum and agency staff and encourage best-practice rostering practices.

Recommendation 17 CHS continue to implement sustainability measures in collaboration with the LHN Assurance Committee.

Mapping to primary ToR	**3 and 4**	**Mapping to ancillary ToR**	**6**

Planned Care Reforms

Recommendation 18 CHS develop an updated set of documented Health Service Improvements for Planned Care, using a process that is open and transparent, and is undertaken in collaboration with all clinical groups across CHS.

Recommendation 19 The updated Planned Care documentation should include a clear CHS policy and procedures outlining that people on the Outpatient, and Elective Surgery and Planned Procedure waiting lists have been consistently and transparently clinically assessed for urgency and will be seen in order of their waiting time within their specialty area and clinical urgency category so that people who have waited longer are seen first in each category within a specialty area.

Recommendation 20 CHS undertake a refresh of the operating model of the Integrated Operations Centre (IOC) to clearly confirm the centre as a patient-focused team working in collaboration with other hospital staff to assist with patient flow and access to quality and timely care.

Recommendation 21 The refresh of the IOC operating model to be undertaken in close collaboration with clinicians working in all CHS hospitals and health consumers, and the new arrangements to operate in all hospitals within CHS.

Recommendation 22 CHS further develop the Central Health Intake (CHI) team to strengthen the coordination of all Outpatient referrals and work with each specialist area to operationalise the Planned Care principles of consistent categorisation of urgency and treated in order of being placed on the list within each category.

Recommendation 23 CHS extend the role of the CHI team to administratively support the communication with patients and the administrative coordination of Elective Surgery and Planned Procedures waiting lists to provide a whole of CHS view of the waiting lists and to enhance and streamline communication with patients.

Recommendation 24 CHS explore options to expand the number of Outpatient appointments undertaken including:

- Further use of virtual Outpatient appointments.
- Further use of nursing and allied health professionals or GPs with special interests (GPSI) to undertake initial assessments.
- Contracting with private specialists to undertake Outpatient assessments as part of the CHS Central referral and waitlist management arrangements.
- Considering options to expand and/or rearrange the physical space for Outpatients so that more public Outpatient clinics can be operated.

Recommendation 25 The master-planning for TCH and NCH be revisited to identify opportunities to re-purpose or develop areas to allow for the expansion of the physical space for Outpatients so that more public Outpatient clinics can be operated.

Recommendation 26 CHS undertake quarterly clinical reviews of people on the Outpatient waitlist to review their circumstances and make adjustments as required.

Recommendation 27 CHS explore the use of electronic communication with patients in Outpatients and Elective Surgery to increase the speed of communication, allow for increased levels of communication with patients and streamline the communication process.

Recommendation 28 CHS work with specialist clinical groups to analyse the current relationships between diagnosis, treatment, and number and frequency of Outpatient review appointments for Elective Surgery and Planned Procedures. Following this activity, including analysis from other jurisdictions, clinical protocols should be developed for each specialty group regarding the number of Outpatient review appointments before patients are fully referred back to primary care.

Recommendation 29 CHS, in full consultation with specialty clinicians, further develop the e-Referral and DHR systems to allow the analysis of pathways for patients to enter and flow through the public Outpatient, Elective Surgery and Planned Procedure lists. The analysis of these pathways and flows should then lead to agreed arrangements for each specialty area regarding how these pathways are managed.

Mapping to primary ToR	**3 and 4**	**Mapping to ancillary ToR**	**6**

Cardiology and orthopaedics

Recommendation 30 CHS should continue to work with the Orthopaedic services across TCH and NCH, to further progress improvements in how services are networked across locations. This should seek to also continue to improve quality, equity and timeliness of services.

Recommendation 31 CHS should continue to work with the Cardiology services across TCH and NCH, to further progress improvements in how services are networked across locations. This should seek to also continue to improve quality, equity and timeliness of services.

Mapping to primary ToR	**2 and 3**	**Mapping to ancillary ToR**	**5**

Workforce and culture

Recommendation 32 CHS reviews its current leadership development programs to enhance the leadership development offerings and opportunities in CHS.

Recommendation 33 The Human Resources (HR)/Payroll and Rostering systems being rolled out within CHS be progressed to cover all staff as soon as possible, so that all staff are using the same systems and that systems are as fully digital as possible.

Recommendation 34 CHS develop a whole of workforce view of medical, nursing, allied health and other employee streams.

Recommendation 35 CHS create a work effort model that allows all staff (including Visiting Medical Officers (VMOs) and other contract staff) to be allocated a Full-Time Equivalent (FTE) value.

Recommendation 36 HCSD finalise the development of the First Nations Workforce Strategy for the ACT health system.

Recommendation 37 CHS develop a First Nations Workforce Plan to support recruitment, retention, professional development, and career pathways for First Nations peoples.

Mapping to primary ToR	**5**	**Mapping to ancillary ToR**	**4 and 6**

Data collection and reporting

Recommendation 38 HCSD update its Health Performance Website to include the indicators and arrangements outlined in the Inquiry report.

Recommendation 39 HCSD, in collaboration with CHS, develop a forward program of work that expands the set of data reported on the ACT Health Performance website.

Recommendation 40 HCSD and CHS develop a joint Health Data Governance Framework (HDGF) that is consistent with the ACT Government Data Governance Management Policy Framework and includes the following elements:

- Data Strategy
- Clear roles including: Executive Data Lead (or Chief Data Officer), Data Users, Data Custodians, Data Stewards, System Owners
- A data and system register
- A data delegations register

The HDGF should clearly describe the following:

- The enterprise level data sets
- Where the enterprise level data sets are stored
- Where the single point of truth is for each defined data set that is used for performance monitoring and reporting
- The work group responsible for providing reports from the enterprise level data sets

Recommendation 41 That legislative changes be undertaken to ensure that designated roles within the HDGF can access the data they require to fulfil their roles, along with obligations for confidentiality and sharing, and penalties as appropriate.

Recommendation 42 That HCSD and CHS jointly develop a Performance Framework that outlines the health service key performance indicators. This Performance Framework should leverage the following categorisation system for the initial planning but move to align with the national Performance Framework (to be developed as part of the NHRA when it is finalised). This initial categorisation system should include:

- Equity
- Effectiveness
- Efficiency
- Sustainability
- Intersectoral Collaboration
- Transparency and Reporting

Recommendation 43 HCSD and CHS undertake work, in collaboration with Digital Canberra, to collect and report all required Mental Health services activity, performance and expenditure data to the Australian Institute of Health and Welfare (AIHW) and for the Report on Government Services (RoGS) report.

Mapping to primary ToR	**1**	**Mapping to ancillary ToR**	**3 and 6**

Digital Health Record (DHR)

Recommendation 44 CHS, in collaboration with Digital Canberra and HCSD, lead a DHR Optimisation Project to achieve the following goals:

- Agreed models of care, pathways of care and DHR workflows for each clinical area.
- Agreed common definitions and requirements for clinical data items within and across clinical areas.
- Agreed common definitions and requirements for data items to be used for operational, performance and other reporting.
- Enhanced reporting for clinicians, for hospital and service operations, for internal and external performance reporting, and for external obligatory performance and financial reporting.

Recommendation 45 HCSD, in collaboration with CHS and Digital Canberra, develop a Digital Health Governance Framework (DHGF) that outlines the roles and responsibilities of all entities, their work units and staff.

Mapping to primary ToR	**3**	**Mapping to ancillary ToR**	**6**

Implementation considerations

To support the translation of Inquiry recommendations into meaningful and sustainable system-wide change, formal endorsement from the ACT Government is required to provide clear authority. Successful implementation of recommendations will also require deliberate planning, leadership and clear financial investment from the ACT Government. This is required to ensure implementation efforts are supported by dedicated funding, resourcing and capacity and infrastructure.

To maintain clear focus throughout the three-year implementation period, a comprehensive implementation plan should be developed, along with responsibility allocated to a dedicated oversight group, such as the ACT Health System Council. This oversight group should ensure strong governance and accountability arrangements, through regular monitoring and reporting of implementation progress.

When considering the overarching enabler of transformation within any health system, the importance of change management and sustained leadership cannot be underestimated. The effective implementation of Inquiry recommendations is strongly reliant on the ACT Government's attention to change management and workforce culture. As many recommendations are tied to organisational behaviours, ways of working and workforce culture, policy levers alone are insufficient to prompt meaningful and sustainable change. Collaboration, co-creation with clinical and non-clinical stakeholders across the ACT health system and proactive and sustained strategic communication, supplemented by leadership at all levels of the organisation, will be vital.

Recommendation 46 Develop a comprehensive implementation plan that clearly outlines specific actions, timelines, and assigns accountability by identifying the individuals or teams responsible for leading the activities related to each recommendation.

Recommendation 47 Allocate responsibility to an oversight group, such as the ACT Health System Council, to undertake regular monitoring of the progress of implementation of the recommendations.

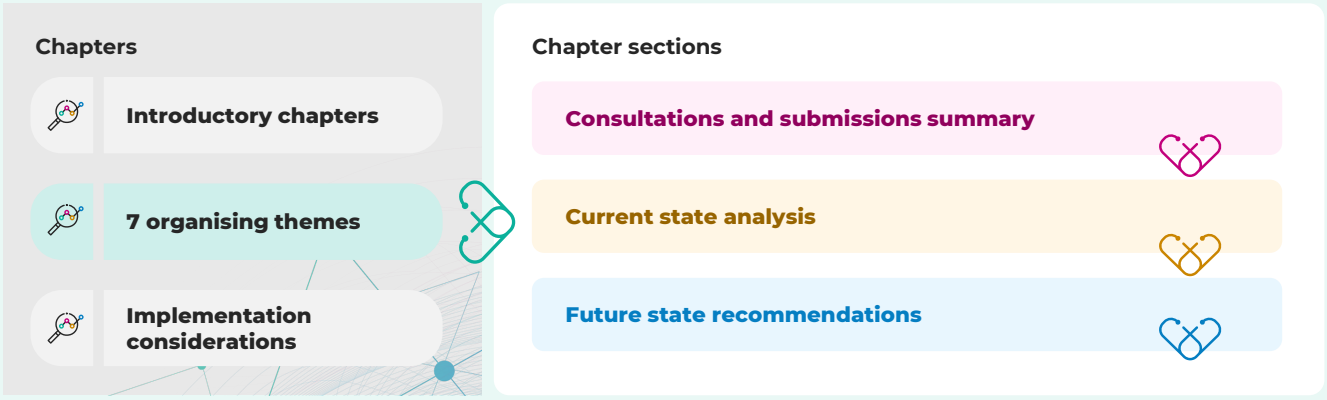
Recommendation 48 Undertake an 18-month implementation progress review with a public report to be completed by 30 June 2028.

Recommendation 49 Undertake a 3-year implementation progress review with a public report to be completed by 31 December 2029.

How to navigate this report

The Inquiry Final Report provides a detailed chapter on each organising theme, as well as implementation considerations. Each chapter is structured into three sections as detailed in **Figure 4.**

Figure 4: Report structure



Navigate directly to a chapter by selecting from the list below.

Within the report select this chapter icon to return here or the arrows to move between chapters

Chapters

Chapter 1 Introduction

This section provides an introduction on the independent Inquiry into ACT health system data, demand and processes (the Inquiry). This includes the scope of the Inquiry based on the Terms of Reference (ToR) and the methodology for conducting the Inquiry.

1.1 Commissioning and scope of the Inquiry

On 24 June 2025, the Australian Capital Territory (ACT) Legislative Assembly passed a motion calling for an independent inquiry into health data and processes. The motion included that the Legislative Assembly notes the growing concerns among clinicians and patients about issues such as lengthy Elective Surgery waiting lists, limited access to data on wait times for specialist procedures and appointments, delays in accessing urgent care, and reports of interference in clinical decision-making. The Inquiry is intended to inform the public, clinicians, and policymakers on how the ACT health system functions and how it can be improved.[4]

A ToR was developed to define the scope of the Inquiry that included considering the following areas:

- Improvements for public health data reporting.
- Any interference in clinical decision making.
- Effectiveness, risks and any unintended consequences of Planned Care Reforms and the Digital Health Record (DHR) implementation.
- Current and projected resourcing needs (including workforce, theatres, equipment and beds).
- Factors affecting recruitment, retention and morale of medical, nursing and allied health staff.
- Governance, resourcing and data required to facilitate patient, policy and clinical outcomes, and staff wellbeing.

The full ToR is provided at **Appendix A**.

The Inquiry was commissioned through the Health and Community Services Directorate (HCSD), on behalf of the ACT Government. The Minister for Health and Mental Health appointed Michael Walsh PSM as the Independent Chair to lead the Inquiry. Consultancy support was appointed by HCSD to support the Independent Chair to maintain independence for the Inquiry.

1.2 Methodology for the Inquiry

The Inquiry commenced on 25 August 2025 and has been completed in time to enable the Minister for Health and Mental Health to table the report in the ACT Legislative Assembly by 30 June 2026. The Inquiry was delivered over four phases (refer **Figure 5**), with the Inquiry Final Report the conclusion of Phase Four.

The Inquiry Final Report provides comprehensive analysis based on broad stakeholder engagement. 115 consultations were facilitated with 259 participants across the ACT health system landscape, including clinicians and staff, consumers, key partners and industrial representatives.[5] Consultations were carried out in-person and virtually, through focus group discussions, in-depth interviews and regular updates provided at the ACT Health System Council meeting.

[4] Legislative Assembly for the Australian Capital Territory 2025, *Notice Paper No. 22: Tuesday, 24 June 2025*, ACT Parliament, Canberra.

[5] Noting that the participants are not all unique, as some individuals have attended multiple meetings and/or participated in different roles and capacities.

Insights gained through stakeholder consultations were supplemented by the analysis of 29 written submissions. For more details on stakeholders involved in consultations and written submissions received see **Appendix B** and **Appendix C**. To maintain confidentiality, no individuals are identified in this report.

The insights gained through stakeholder consultations and submissions were augmented by a comprehensive desktop review. The desktop review included an examination of qualitative and quantitative data. This included publicly available information, public health data and reports and documents provided by Canberra Health Services (CHS) and HCSD, to provide contextual insights into the functioning of the ACT health system. The desktop review also compared national and international health system practices applicable to ToR of the Inquiry.

Thematic analysis of the stakeholder consultations and written submissions was then undertaken, to identify seven organising themes against which the Inquiry ToR have been mapped. These findings informed the development of recommendations associated with each organising theme of the Inquiry. Further details on ToR and organising themes are provided below.

Figure 5: Summary of phases and timelines

1.3 Terms of Reference (ToR) of Inquiry

The following extract of the ToR contains the core deliverables of the Inquiry and have been numbered to provide easier cross-reference with the themes.[6] The core deliverables of the Inquiry are to:

1. Make recommendations for any required improvements to the health data made publicly available, including but not limited to wait times for specialist appointments. This will be supported by:
    a. undertaking inter-jurisdictional comparisons of publicly available health data
    b. considering centralisation of the publication of health data
    c. considering improvements in the presentation of data to enable longitudinal comparisons and changes and segmentation to better understand determinants
2. Determine the extent and impact of any interference – administrative, managerial or political – in clinical care decisions at CHS and make recommendations as relevant.

[6] ACT Government, Terms of Reference, Inquiry into ACT health system data, demand and processes.

3. Determine the effectiveness, risks, and any unintended consequences of Planned Care Reforms and the DHR implementation, including potential improvements in data, updates to privacy legislation and oversight required to facilitate patients' treatment.
    a. This will include investigating concerns raised publicly regarding the cardiology and orthopaedic surgery groups in the ACT public health system
4. Investigate current and projected resourcing needs (including workforce, theatres, equipment and beds) relative to demand. To support this analysis, the Inquiry will seek to:
    a. understand drivers of waiting list growth, including referral pathways and any peri-operative capacity constraints
    b. consider inter-jurisdictional comparisons of drivers of waiting-list growth, including referral pathways and peri-operative capacity constraints
5. Investigate factors affecting recruitment, retention and morale of medical, nursing and allied health staff.
6. Make evidence-based recommendations to improve governance, resourcing and data required to facilitate patient, policy and clinical outcomes, and staff wellbeing.

1.4 Terms of Reference (ToR) mapped to the themes emerging from consultations and submissions

Through the analysis of stakeholder consultations and written submissions received, seven organising themes were identified relevant to ToR of this Inquiry. These themes are used to structure the Inquiry Final Report. Themes include:

- ACT health system governance
- Clinical quality and safety
- Service planning, demand and sustainability
- Planned care reforms
- Workforce and culture
- Data collection and reporting
- Digital Health Record (DHR)

The following table (**Table 1**) provides a mapping of the ToR to the organising themes. The ToR have been identified as core or ancillary to the theme to reflect the strength of the relationship between the ToR and the theme. Most ToR appear several times as they relate to multiple themes.

Table 1: Mapping of ToR against organising themes

Organising theme	Core ToR	Ancillary ToR
ACT health system governance	6	1, 2, 3 and 5
Clinical quality and safety	2 and 3	6
Service planning, demand and sustainability	3 and 4	6
Planned care reforms	3	6
Workforce and culture	5	4 and 6
Data collection and reporting	1	3 and 6
DHR	3	6

Chapter 2 ACT health system context

This section provides an overview on the ACT health system. This includes recent structural changes and reviews, audits, investigations and inquiries. This section also provides an overview of the current roles and responsibilities of CHS and HCSD.

2.1 Previous structural changes to the ACT health system and reviews undertaken

The ACT health system has undergone significant change within the last eight years. During this period, there was also the Global COVID-19 pandemic from 2020 to 2023 that significantly disrupted all health systems, placing staff under significant pressure and forcing services to prioritise the care and safety of the community and staff. The recent major changes in the ACT health system include:

- On 1 October 2018, ACT Health was separated into two separate directorates, CHS and the ACT Health Directorate. CHS became responsible for the delivery of health services, while the ACT Health Directorate became responsible for stewardship of the health system including policy and planning.[7]
- On 12 November 2022, the first DHR in the ACT went live, delivered by software company Epic. This was implemented to improve clinical care for patients including enabling patient journeys to be streamlined across the public health system and improving information sharing between hospitals and community-based services.[8]
- On 11 May 2023, the ACT Government announced that the Calvary Public Hospital Bruce (its land and its assets) were being acquired by the government, following the introduction of the *Health Infrastructure Enabling Act 2023*.[9]
- On 3 July 2023, the ACT Government formally acquired the former Calvary Public Hospital Bruce, which is now known as the North Canberra Hospital (NCH), and commenced operating as part of CHS.[10]
- On 1 July 2025, Machinery of Government (MoG) changes merged the ACT Health Directorate with the Community Services Directorate to form HCSD.

Over the past 15 years, the ACT health system has been the subject of numerous reviews, audits, investigations, and inquiries, covering a wide array of issues including data integrity, workplace culture, financial sustainability, service delivery, and governance arrangements. Some of these reviews are explored further in the relevant sections of this report.

Figure 6 provides an overview of significant changes to the ACT health system together with previous reviews, investigations, and inquiries. The ACT Auditor-General regularly publishes audit reports relating to health. The reports listed below include all health-related Auditor-General reports published between 2011 and 2025, with **Figure 7** highlighting those that are relevant to the ToR.

[7] Canberra Health Services 2019, Canberra Health Services Annual Report 2018-19, ACT Government, Canberra.
[8] Stephen-Smith, R 2022, Less than two months until ACT's Digital Health Record goes live, ACT Government, Canberra.
[9] Australian Capital Territory 2023, Health Infrastructure Enabling Act, Act No. 17 of 2023 (ACT), ACT Government, Canberra.
[10] Stephen-Smith, R 2025, Settlement reached with Calvary Health Care, ACT Government, Canberra.

2.2 ACT Auditor-General's health-related reports published between 2011 – 2025:

- Report No. 1/2011: Waiting Lists for Elective Surgery and Medical Treatment
- Report No. 6/2011: Management of Food Safety in the Australian Capital Territory
- Report No. 6/2012: Emergency Department Performance Information
- Report No. 4/2014: Gastroenterology and Hepatology Unit, Canberra Hospital
- Report No. 5/2015: Integrity of Data in the Health Directorate
- Report No. 1/2016: Calvary Public Hospital Financial and Performance Reporting and Management
- Report No. 6/2017: Mental Health Services – Transition from Acute Care
- Report No. 5/2019: Management of the System-Wide Data Review Implementation Program
- Report No. 7/2020: Management of Care for People Living with Serious and Continuing Illness
- Report No. 1/2022: Management of Detainee Mental Health Services in the Alexander Maconochie Centre
- Report No. 7/2022: ACT Childhood Healthy Eating and Active Living Programs
- Report No. 2/2023: Management of Operation Reboot (Outpatients)
- Report No 4/2024: Planning and Delivery of Services for Young People with Moderate to Severe Mental Illness
- Report No. 13/2024: Invoicing and Payment for Digital Health Record Hosting Services
- Report No. 5/2025: Specialist Assessment Services for Dementia and Cognitive Decline

Figure 6: Overview significant changes to the ACT health system and previous reviews investigations and inquiries

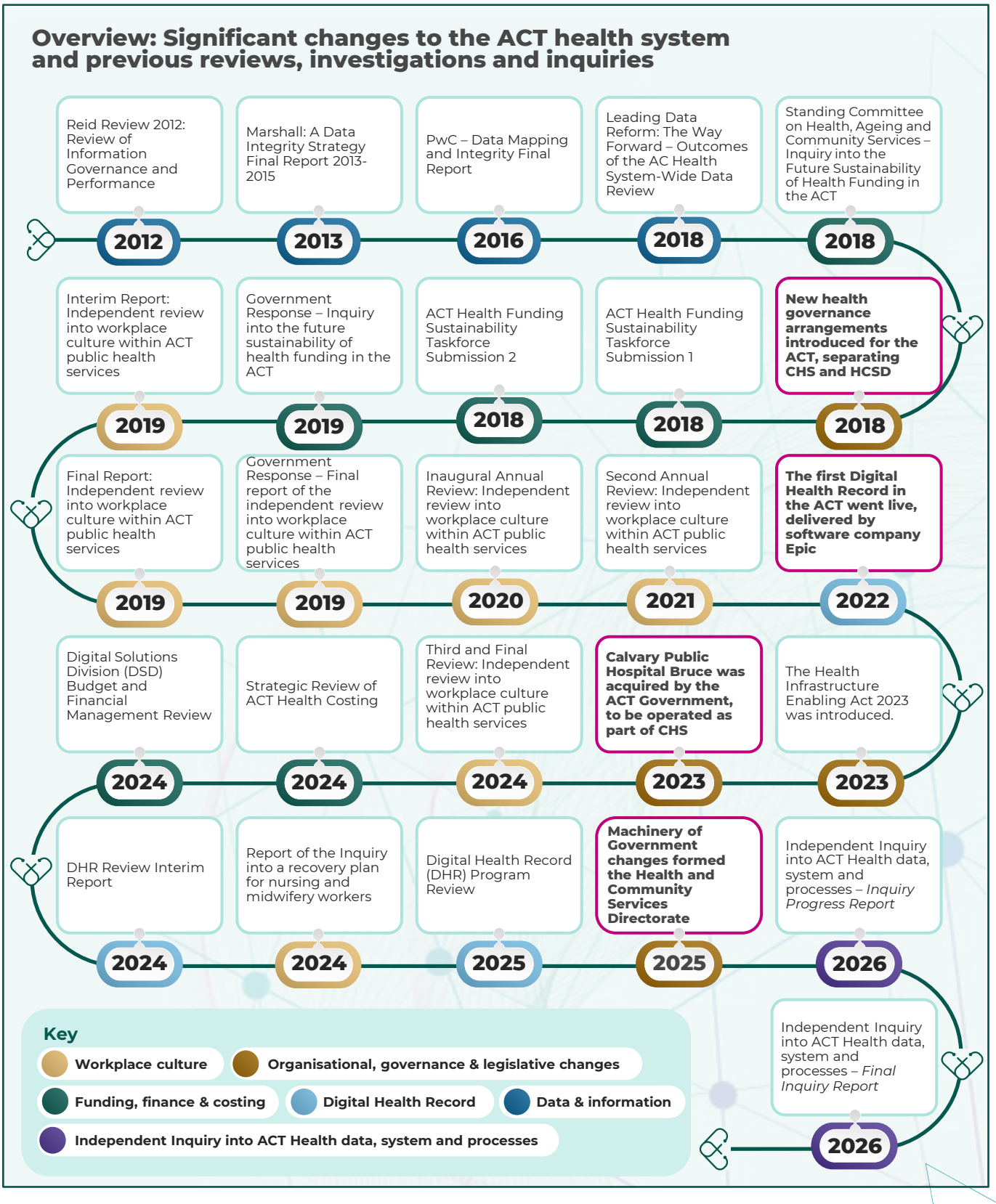
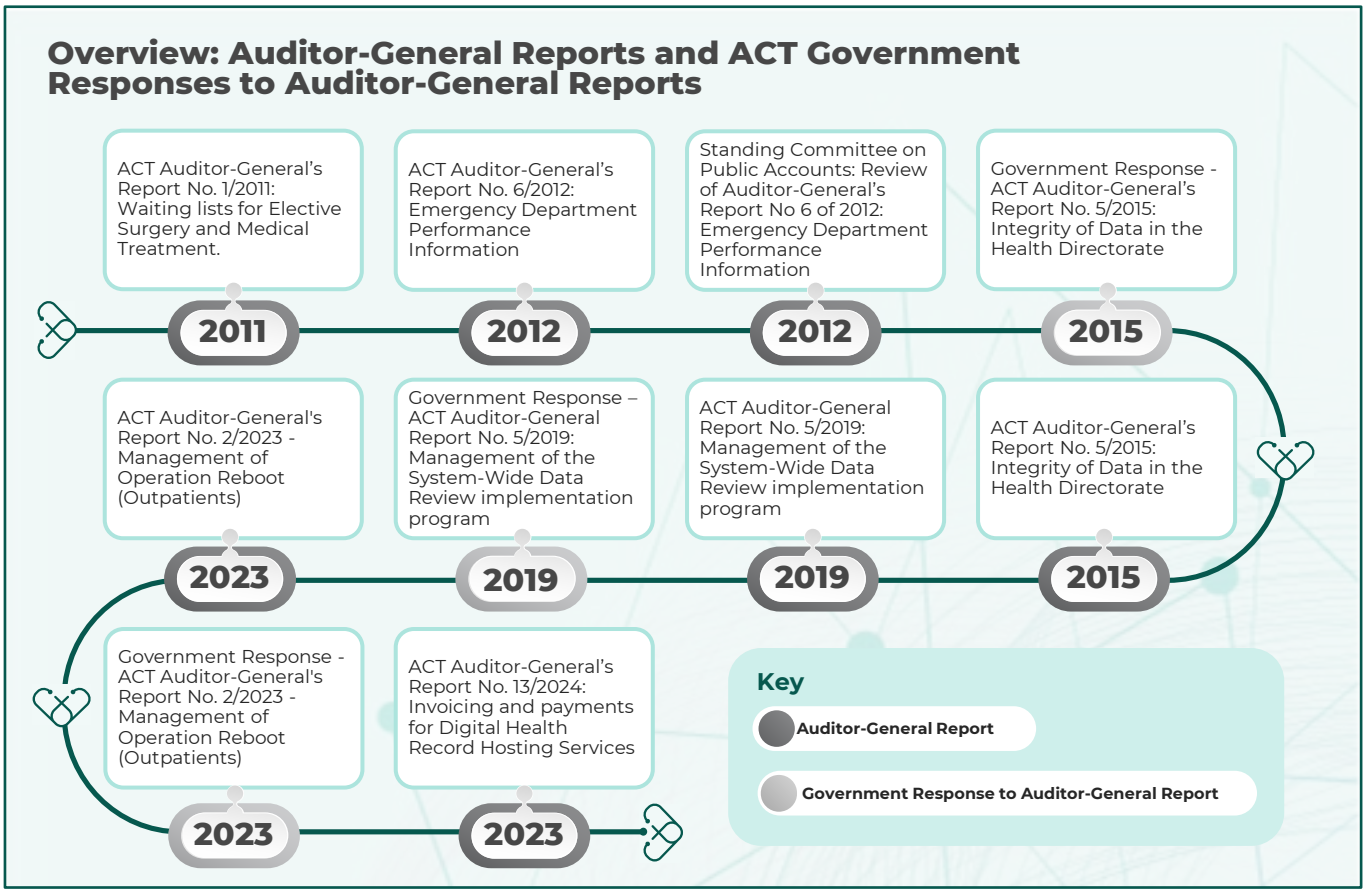


Figure 7: Overview of the Auditor-General reports and ACT Government responses to Auditor-General reports



2.3 Current roles and responsibilities of CHS and HCSD

The current roles and responsibilities of CHS and HCSD are provided in **Table 2**. These have been sourced from their websites, publicly available strategic plans and documentation. Further detail regarding the roles, responsibilities and relationships within the ACT health system are provided in the ACT health system governance section of this Report.

Table 2: Current roles and responsibilities of CHS and HCSD

	Canberra Health Services (CHS)	Health and Community Services Directorate (HCSD)
Role	• CHS operates as the primary service provider for public health care in the ACT. • CHS delivers acute, specialist, and community-based health services directly to the public and works to ensure patients receive coordinated and quality-focused care.	• HCSD is primarily responsible for system leadership, strategic policy formulation, planning, regulation, and governance of health and community services in the ACT. • HCSD ensures the delivery of high-quality health services to the community while shaping long-term directions for public health and wellbeing in the ACT.
Responsibilities	• Managing and delivering primary healthcare, community care, hospital services, and specialised clinical services within the ACT. • Coordinating a wide range of acute and elective healthcare services through facilities such as Canberra Hospital, University of Canberra Hospital, and other health centres. • Providing allied health services, aged care, and rehabilitation. • Maintaining high standards of clinical excellence and patient-centred care. • Supporting the training and education of health professionals in collaboration with educational institutions.	• Developing and implementing strategic policies in public health, mental health, and other health priorities. • Oversight and governance of CHS and other contracted health services. • Managing health infrastructure investments and workforce planning for the ACT. • Collaborating with federal, state, and territory governments on intergovernmental health funding and reform agreements. • Monitoring the performance and accountability of public and private health services in the ACT. • Promoting public health through campaigns, prevention programs, and regulatory activities.
Purpose	• CHS aims to provide comprehensive health services that meet the immediate and ongoing needs of the ACT community. Its focus is on delivering safe and effective care that supports both the physical and mental wellbeing of patients while operating as a trusted provider within the health system.	• HCSD exists to deliver on the ACT Government's broader health and wellbeing priorities. Its goal is to guide the development and implementation of innovative health reforms, ensuring a holistic, patient-centred approach while achieving equitable access to high-quality services for the ACT population.

It is important to note that the public ACT health system does not operate in isolation and has interdependencies with the private health sector, primary health care, and other social service sectors (e.g., disability, housing support and aged care) including services provided by Non-Governmental Organisations (NGOs).

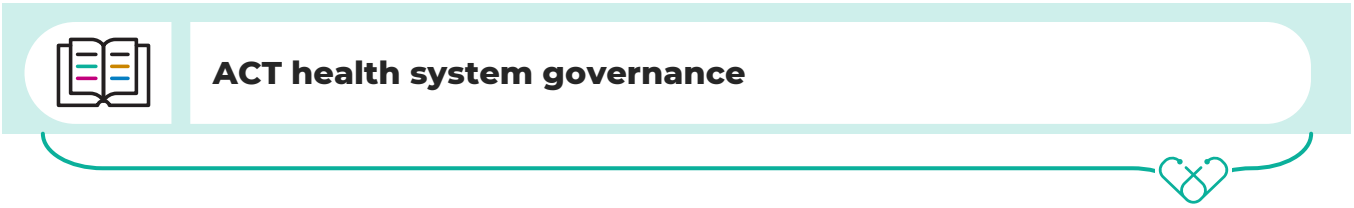
Chapter 3 ACT health system governance

As noted by the World Health Organization (WHO),[11] health system governance ensures that strategic policy frameworks exist with effective oversight, regulations, accountability and system design. Health system governance shapes how decisions are made and underpins health system transparency, responsiveness and performance. Clear and streamlined governance is a foundation for good culture and workforce productivity and satisfaction.

Clearly described system governance allows everyone in the health system to see how their work contributes to the operational and strategic goals of the system. In the ACT health system context, decision making can be streamlined, and activity duplication and gaps can be minimised with a clearly described set of roles and responsibilities. In addition to this, there are opportunities to provide greater clarity on who makes what decisions, and how those decisions are made.

Navigating this chapter

The following visual provides an overview of the structure of this chapter.



Consultations and submissions summary	Thematic findings distilled from stakeholder consultations and written submissions.
Current state analysis	Comprehensive description of current-state arrangements derived from a desktop review of qualitative and quantitative data. This included publicly available information, public health data and reports and documents provided by CHS and HCSD, to provide contextual insights into the functioning of the ACT health system.
Future state recommendations	Considering findings from consultations and submissions, alongside the current state analysis, this section outlines future state recommendations, which serve as opportunities to uplift and enhance the ACT health system.

[11] World Health Organization (WHO) n.d., Health systems governance, World Health Organization, Geneva.

3.1 Consultations and submissions summary

Clarity regarding health system governance emerged in consultations as a strong pillar impacting most of the other emerging themes described in the Inquiry Final Report. Consultations identified that stakeholders are looking for greater clarity of roles and responsibilities between CHS, HCSD and Digital Canberra (with the recent transfer of health technology implementation and project delivery). This includes increasing clarity relating to roles and responsibilities for clinical quality and safety, the DHR and data reporting, which are explored further in the relevant chapters of this report.

Stakeholders noted that there is a strong link between clarity in roles and responsibilities and workforce culture. Stakeholders reflected that ambiguity in roles and responsibilities can lead to inefficiencies, as individuals take longer to navigate arrangements to understand responsibilities and authority for decision making. Stakeholders noted that this lack of clarity can also be a potential barrier in undertaking their roles effectively. Consultations reflected optimism that improvements in the clarity of system governance could enable cultural and operational improvements.

3.2 Current state analysis

ACT Administrative Arrangements

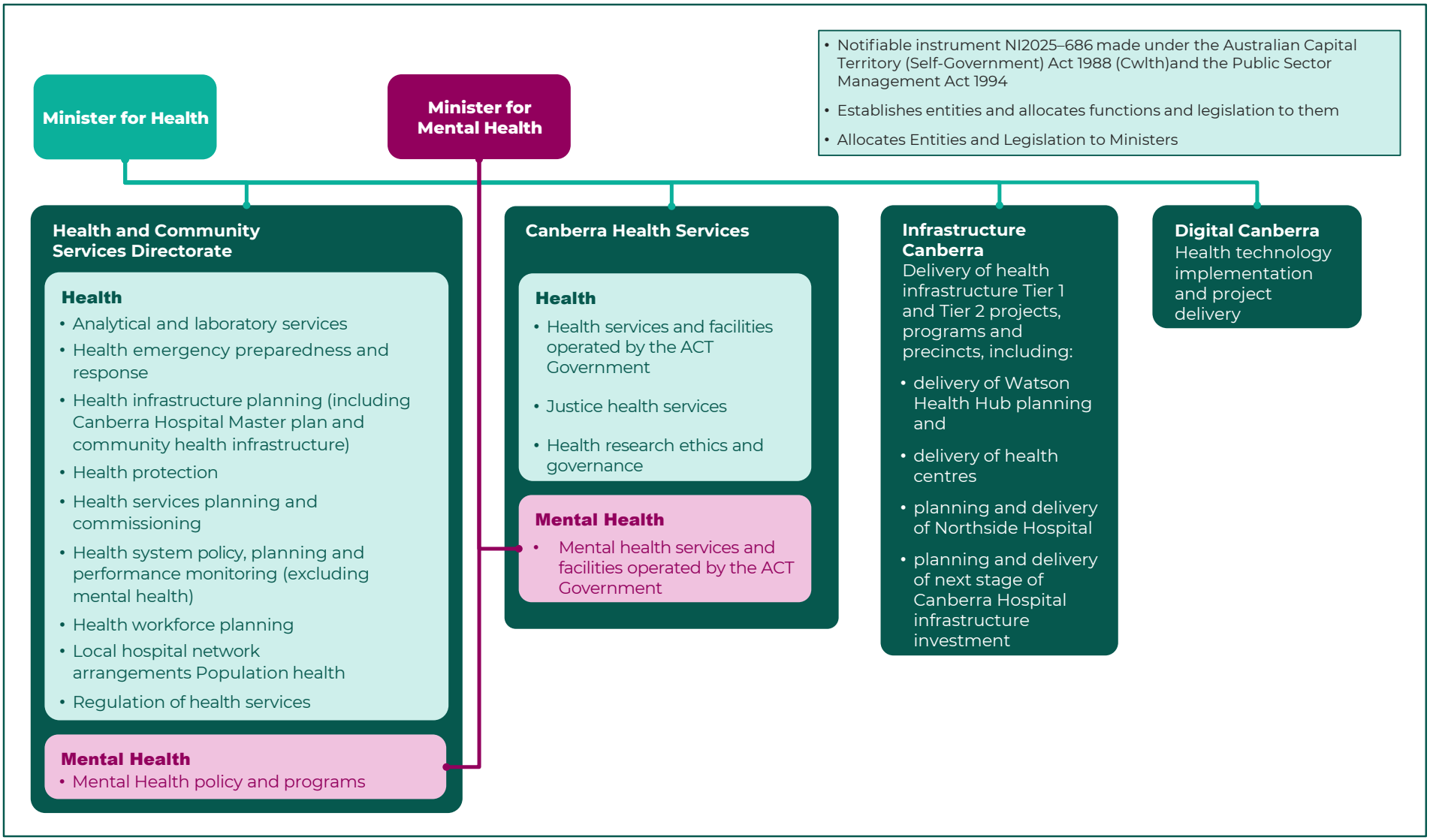
Governance arrangements that underpin the ACT health system are formalised through the ACT Administrative Arrangements. The Administrative Arrangements establish the ACT public health entities and assign functions and legislation to them. These Administrative Arrangements also allocate the entities, functions and legislation to Ministers. ACT Government Administrative Arrangements are published under the *Australian Capital Territory (Self-Government) Act 1988 (Cwlth)* and the *Public Sector Management Act 1994*. The current Administrative Arrangements were issued on 19 December 2025.[12]

As illustrated in **Figure 8**, the ACT Administrative Arrangements establish four entities that are allocated health-related functions. These include HCSD, CHS, Digital Canberra and Infrastructure Canberra. As noted earlier in this Inquiry, the establishment of HCSD and CHS as two distinct organisations that make up ACT Health commenced 1 October 2018, following the review titled *New Health Governance Arrangements for the ACT*.[13] Under the Administrative Arrangements, HCSD and CHS are of equal status. The functions allocated to CHS identify this organisation as the health service provider, while HCSD is identified as the system planner, service commissioner and system performance monitor.

The Administrative Arrangements confirm two Ministerial roles in relation to health: Minister for Health and Minister for Mental Health. Currently, these roles are undertaken by a single person. The functions allocated to each of these Ministerial roles is described in **Figure 8**. The Minister for Health role is allocated responsibility for all health-related functions (except Mental Health) in all four entities. The Minister for Mental Health role is allocated responsibility for the Mental Health functions in HCSD and CHS.

[12] Australian Capital Territory 2025, Administrative Arrangements 2025 (No 2), ACT Government, Canberra.
[13] Nous Group 2018, New health governance arrangements for the ACT, ACT Government, Canberra.

Figure 8: ACT Administrative Arrangements



Note: HCSD is also allocated non health-related functions that are not included in this diagram.

Commitments from the National Health Reform Agreement (NHRA)

The current NHRA Addendum 2020-25 was extended to end on 30 June 2026. State and Territory First Ministers and the Prime Minister have signed a new agreement, NHRA Addendum 2026-31, which commences from 1 July 2026.[14]

The NHRA is the core agreement for the provision of Commonwealth funding to the states and territories for public health and hospital services. The agreement outlines the roles and responsibilities of states and territories and the Commonwealth. The NHRA also documents states and territories commitment to organisational and governance arrangements within their jurisdictions, that are conditions to receive Commonwealth Funding.

The NHRA Addendum 2026-31 introduces a strong focus of collective stewardship of the whole health system by the Commonwealth and State and Territory Governments. This focus on stewardship is referenced twice in the Objectives and Outcomes section of the NHRA Addendum 2026-31:

> The Parties recognise this Addendum provides an opportunity for all governments to work together to ensure their collective investments in healthcare can advance reform that delivers: … stronger shared stewardship of the whole health system.
>
> The Parties commit to working in partnership to implement arrangements to achieve the following health system outcomes: …. Robust governance enables innovation and collective stewardship across the continuum of care, particularly across adjacent care systems including primary, acute, aged and disability care settings **(Outcome 5.1).**[15]

The ACT has developed governance arrangements in response to the NHRA commitments that include a system coordinator role (fulfilled by HCSD) and a service provider role (fulfilled by CHS), along with service agreements and two advisory committees to the Minister that oversee the activities of the ACT health system.

Figure 9 provides a graphical summary of the organisational and governance commitments within the NHRA Addendum 2026-31 and that are relevant to the scope of this Inquiry. The first NHRA was signed in 2011 and commenced on 1 July 2012. The commitments have remained largely unchanged since then, although each addendum has made minor adjustments. At the time of the first NHRA (when activity based funding for hospitals was introduced), new governance arrangements included establishing a separation between the System Manger and LHNs in each State and Territory, and the establishment of two additional national health bodies to bring the total number of national health bodies to four:[16]

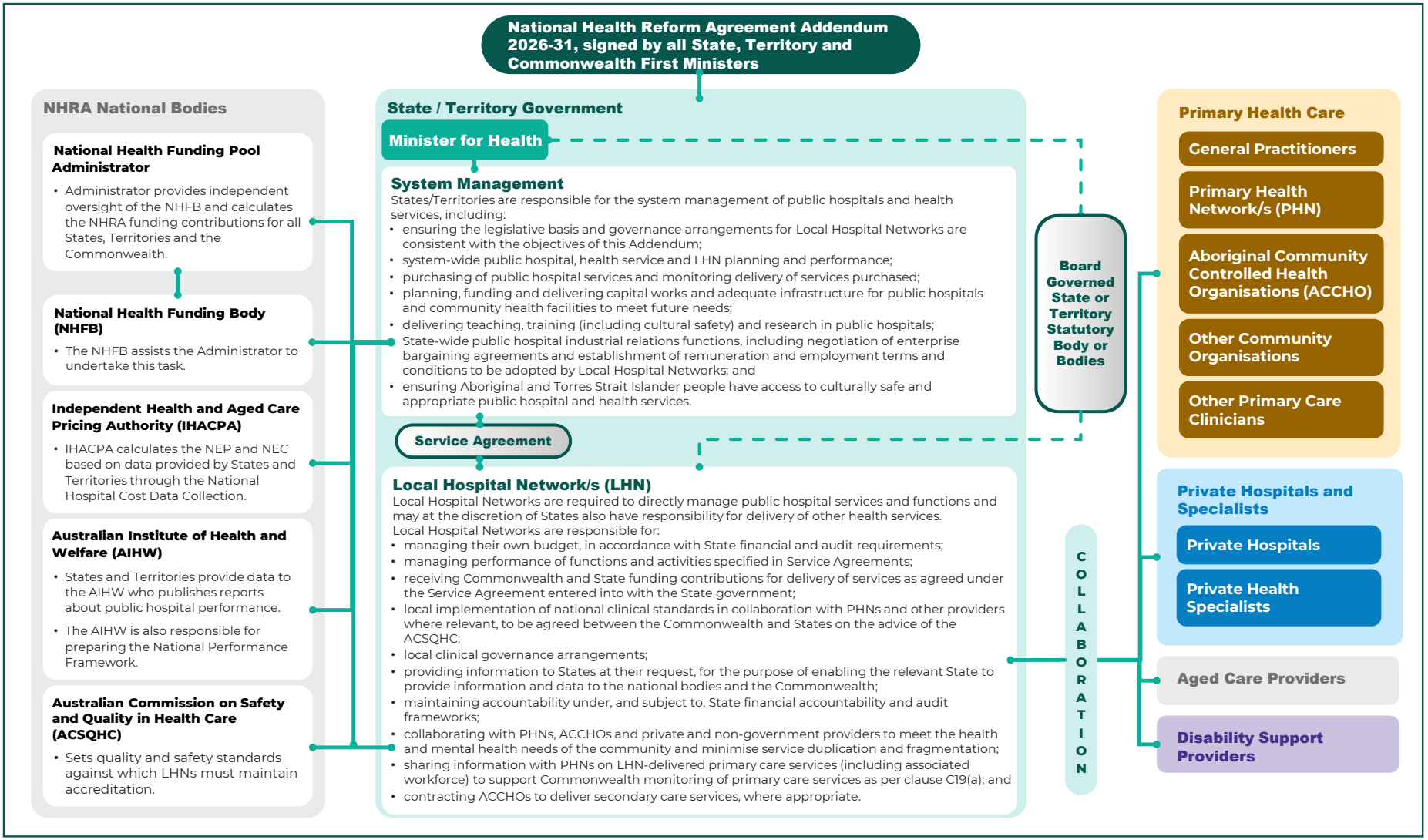
- Australian Commission on Safety and Quality in Health Care (ACSQHC) – existing
- Australian Institute of Health and Welfare (AIHW) – existing
- National Health Funding Pool Administrator (NHFPA) and National Health Funding Pool Body (NHFPB) – new 2012
- Independent Health and Aged Care Pricing Authority (IHACPA) – new 2012

[14] Australian Government, 2026, National Health Reform Agreement (NHRA), Australian Government, Canberra.
[15] Australian Government, 2026, National Health Reform Agreement (NHRA), Australian Government, Canberra, p. 8-9.
[16] These bodies have undergone changes since they were established but the current arrangements are what is relevant to this Inquiry.

The national bodies provide transparency and independence in relation to the funding, performance and accountability within the national public health and hospital system. The NHRA commitments made by States, Territories and the Commonwealth are complex, and the following provides a high-level summary of the commitments that are relevant to the Inquiry:

- States and Territories to have a separation between the roles of System Manager and LHN with the functions as described in **Figure 9**. The LHNs to be a State/Territory statutory body governed by a Board.
- States and Territories, through their System Manager, to provide activity and costing data as part of the annual National Hospital Cost Data Collection (NHCDC) that is managed by IHACPA.
- IHACPA to use this data to determine the National Efficient Price (NEP) for each unit of clinical activity, known as a Weighted Activity Unit (WAU), and the National Efficient Cost (NEC) for Block Funded Hospitals.
- The System Manager in each State and Territory to provide past activity reconciliations, and future activity forecasts to the National Health Funding Body (NHFB), who determines the Commonwealth funding contributions based on the NEP and NEC, and in accordance with the rules outlined in the NHRA. The National Health Funding Administrator is a statutory appointment to oversee the work of the NHFB, and it is the Administrator who approves the funding allocations.
- The activity reconciliations and forecasts, and the funding allocations, to be broken down by each LHN within each jurisdiction.
- Each State and Territory to establish a Reserve Bank of Australia account through which all Commonwealth, State and Territory funding must flow for each jurisdiction for activity based funding and Block Funding of Public Hospitals. Collectively, these bank accounts are known as the National Health Funding Pool.
- Payments to LHNs to be made from each jurisdiction's bank account by the NHFB after receiving advice from each jurisdiction's System Manager.
- There is required to be a Service Agreement at the State/Territory level with each LHN that is consistent with the activity forecasts and funding allocations, and includes activity, funding, and performance requirements. These Service Agreements to be publicly available on the Internet.
- The AIHW to develop, in collaboration with States, Territories and the Commonwealth, a national health Performance Framework. States and Territories to provide data to the AIHW in line with the Performance Framework. The AIHW publishes this data.
- The ACSQHC to work collaboratively with all jurisdictions to improve the safety and quality of health services and establish the standards against which all public hospitals must be accredited.
- LHNs to collaborate with other areas within the health ecosystem (e.g. primary health care, ACCHO, and private hospitals), and aged care and disability support sectors.

Figure 9: Commitments within the National Health Reform Agreement (NHRA)



As shown in **Figure 9**, the National Health Funding Administrator, NHFB, IHACPA and AIHW work directly with the System Manager in each State and Territory. The ACSQHC also works with each System Manager but has a direct link with each LHN because of their role in setting accreditation standards.

States and Territories work collaboratively with IHACPA and the NHFB through several working groups. These working groups provide for all jurisdictions and the national bodies to understand how each jurisdiction works, clarify activity and funding queries, and to make evidence-based quality improvement decisions within the parameters of the NHRA.

In relation to the work of the AIHW, it is important to note that the States and Territories data provided to the AIHW is also provided to the Australian Productivity Commission. The Productivity Commission also collects additional data. The Productivity Commission publishes an annual report of performance known as the Report on Government Services (RoGS).

Jurisdictional implementation of NHRA commitments

The NHRA acknowledges that there may be variation in how a State or Territory implements the commitments. **Table 3** describes how each State and Territory has implemented the arrangements in relation to System Manager, LHN, Service Agreement and Performance Monitoring. To meet the reporting requirements of Section 240 of the *National Health Reform Act 2011*, the Administrator is required to publish the basis of each State and Territory's NHRA funding and payments. The Administrator does this each year in their National Health Funding Pool Annual Report.

Table 3: Description of how each State and Territory has implemented the arrangements in relation to System manager, LHN, Service agreement and Performance monitoring

Jurisdiction	Service agreement arrangements	System manager	LHN arrangements	Performance monitoring
Australian Capital Territory (ACT) 	Service Agreement between Minister for Health and Director-General HCSD, as head of the ACT LHN Directorate. A Service Funding Agreement between the Minister for Health, the Chief Executive Officer Canberra Health Services, and the Director-General HCSD, as head of the ACT LHN Directorate.	Minister for Health (System Leader) HCSD (Commissioner)	Directorate established by Administrative Arrangements under the *Australian Capital Territory (Self-Government) Act 1988 (Cwlth)* and the *Public Sector Management Act 1994*.	Undertaken by the ACT LHN Directorate as outlined in the Commissioning Framework for activity based funded services in the ACT.
New South Wales (NSW) 	Service Agreement between Secretary Ministry of Health and each Local Health District (LHD).	Ministry of Health	State statutory bodies governed by a board	Undertaken by the Ministry of Health as outlined in the NSW Health Performance Framework.
Victoria (Vic) 	For public healthcare services, Statements of Priority (SoPs) are agreed annually between the Minister for Health and each board chair. For sub-regional and local health services and small rural health services, SoPs are agreed between the Secretary Department of Health and each board chair.	Department of Health	State statutory bodies governed by a board	Undertaken by the Department of Health as outlined in the Victorian Health Services Performance Monitoring Framework.
Queensland (Qld) 	Service Agreement between Director-General Department of Health and each Hospital and Health Service.	Department of Health	State statutory bodies governed by a board	Undertaken by the Department of Health as outlined in the Qld Health Performance and Accountability Framework.

Jurisdiction	Service agreement arrangements	System manager	LHN arrangements	Performance monitoring
Western Australia (WA) 	Service Agreement between Director-General Department of Health and each health service provider.	Department of Health	State statutory bodies governed by a board	Undertaken by the Department of Health as outlined in the WA Health Performance Policy Framework.
South Australia (SA) 	Service Agreement between Chief Executive Department of Health and Wellbeing, and each Local Health Network.	Department of Health and Wellbeing	State statutory bodies governed by a board	Undertaken by the Department of Health and Wellbeing as outlined in the SA Health Performance Framework.
Tasmania (Tas) 	Service Agreement between the Minister for Health and the Secretary Department of Health.	Department of Health	Tasmania Health Service is a Tasmanian legislated statutory body responsible to the Secretary Department of Health. The Secretary Department of Health can appoint an advisory body.	Undertaken by the Department of Health in line with the monitoring arrangements outlined in the Service Agreement.
Northern Territory (NT) 	Service Plan between the Chief Executive Officer of Department of Health and the NT Regional Health Services.	Department of Health	NT Regional Health Services is an NT legislated organisational entity of the Department of Health, and the Chief Executive Officer Department of Health can appoint an advisory body.	Undertaken by the Department of Health as outlined in the NT Health Performance Framework.

The ACT is one of three small jurisdictions in Australia. With a land mass of approximately 2,400km^2 [17] and a population of approximately 500,000[18] it is the smallest jurisdiction by land mass and the second smallest jurisdiction by population. The Northern Territory is the smallest jurisdiction by population[19] but is the third largest (behind WA and Qld) by land mass.[20] The third small jurisdiction is Tas with a population of approximately 570,000[21] and a land mass of approximately 65,000km^2.[22] In line with the NHRA Addendum 2026-31, allowing variation to the commitments, the three small jurisdictions (Tas, ACT and NT) do not have LHNs that are a Board governed State/Territory statutory body. However, they all provide a separation between the System Manager and the LHN with a Service Agreement in place.

In all but three jurisdictions (Vic, ACT and Tas), the Service Agreement is between the Head of the organisation undertaking the System Manager role (usually the Department of Health or equivalent) and each LHN in their State or Territory.

In Victoria, the Minister for Health agrees the equivalent of a Service Agreement, known as a Statement of Priorities, with large LHNs, and for sub-regional and local health services and small rural health services, Statements of Priorities are agreed between the Secretary Department of Health and the LHN. In Tasmania, the Minister signs a Service Agreement with the Secretary Department of Health (as System Manager), outlining what is to be provided to, and required by, the LHN.

In the ACT, there are two agreements. These agreements are listed here and described in more detail in the following section:

1. A Service Agreement between the Minister for Health and Director-General HCSD, as head of the ACT LHN Directorate.
2. A Service Funding Agreement between the Minister for Health, the Chief Executive Officer Canberra Health Services, and the Director-General HCSD, as head of the ACT LHN Directorate.

Under the *ACT Health (National Health Funding Pool and Administration) Act 2013,*[23] the ACT has established the ACT LHN Directorate, which is part of the Health and Community Services Directorate. The Director-General of HCSD manages the ACT health pool account which is established within the ACT LHN Directorate.

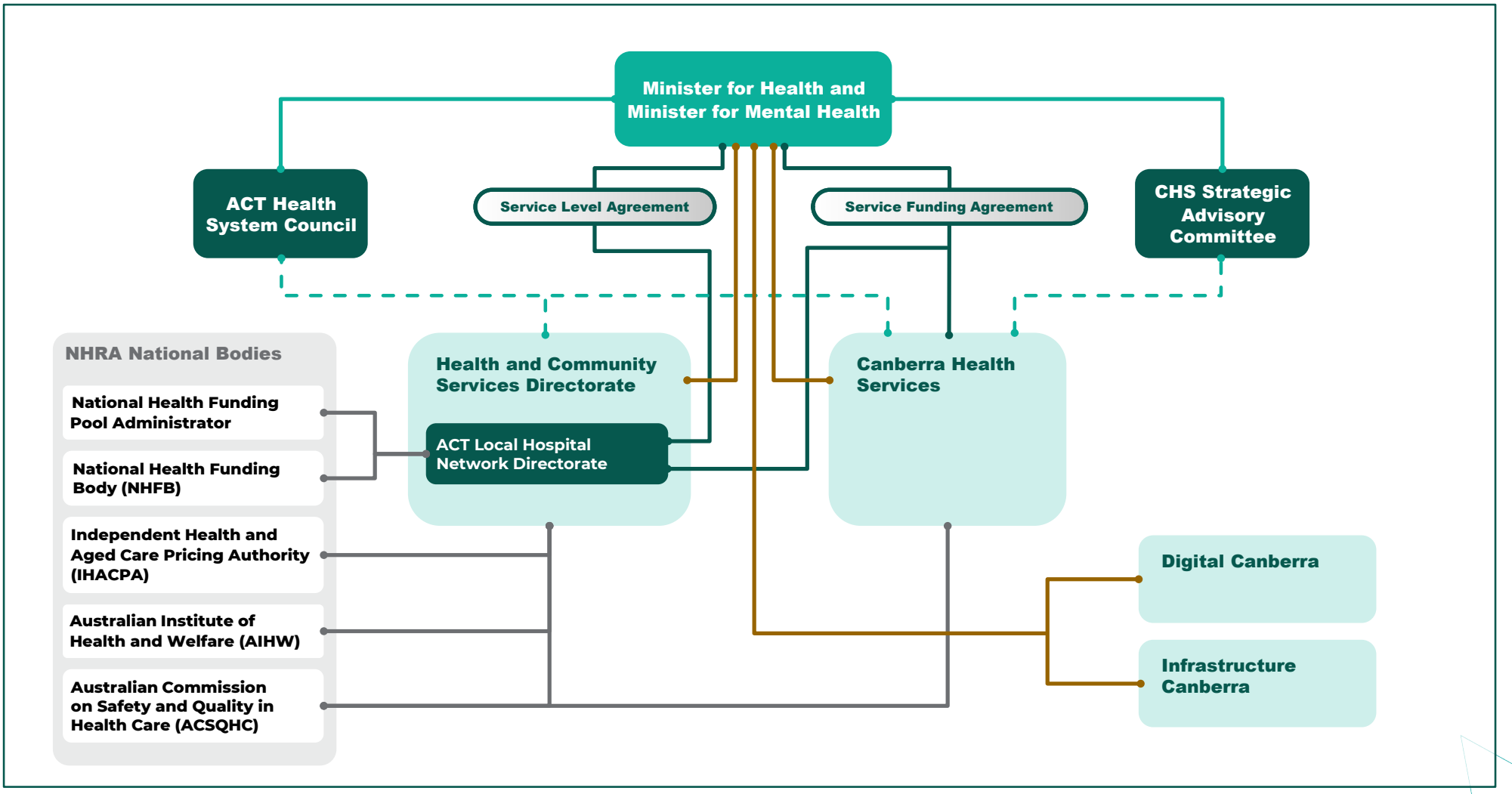
Health system governance in the ACT

Figure 10 shows the health system governance arrangements in place in the ACT, that combines the ACT Government Administrative Arrangements with the commitments within the NHRA.

The Minister for Health and Minister for Mental Health is directly responsible for HCSD and CHS, and the health-related functions in Digital Canberra and Infrastructure Canberra.

[17] Geoscience Australia 2014, Area of Australia – States and Territories, Australian Government.
[18] Australian Bureau of Statistics 2026, National, state and territory populations, Australian Government.
[19] Australian Bureau of Statistics 2026, National, state and territory populations, Australian Government.
[20] Geoscience Australia 2014, Area of Australia – States and Territories, Australian Government.
[21] Australian Bureau of Statistics 2026, National, state and territory populations, Australian Government.
[22] Geoscience Australia 2014, Area of Australia – States and Territories, Australian Government.
[23] Australian Capital Territory 2013, Health (National Health Funding Pool and Administration) Act 2013, ACT no. 2 of 2013, ACT Government, Canberra.

Figure 10: ACT health system governance combining Administrative Arrangements and NHRA commitments



The Minister for Health and Minister for Mental Health has two Service Agreements in place. The first is a Service Level Agreement with the Director-General HCSD as the Head of the ACT LHN Directorate. The purpose of the Service Level Agreement, as stated in the agreement[24] is to:

1. describe the strategic priorities and Government commitments for the Minister and LHN and the mutual responsibilities of both Parties
2. describe the key services and accountabilities that the LHN is required to deliver including particulars of the volume, scope and standard of services
3. describe the performance indicators, associated reporting arrangements and monitoring methods that apply to both Parties
4. describe the sources of funding that the Agreement is based on and the manner in which these funds will be provided to the LHN, including the commissioned activity
5. detail any other matter the Minister considers relevant to the provision of the services by the LHN

The second agreement is the *2025–26 Service Funding Agreement*.[25] This agreement is between the Minister for Health, the Chief Executive Officer Canberra Health Services, and the Director-General HCSD, as Head of the ACT LHN Directorate. The stated purpose of the agreement is described as follows:

> The purpose of this agreement is to ensure the provision of equitable, safe, high-quality, patient-centred and financially sustainable healthcare services at Canberra Health Services.
>
> The agreement achieves this by formally setting out the performance expectations and funding arrangements for the term of the Agreement. The agreement reflects a commitment to a high standard of governance through transparency and accountability to the Minister for Health and through the publication of this document, and performance against key indicators to the ACT Community.[26]

The relationship between the ACT health system and the national bodies is as outlined in the NHRA commitments section.

The Minister for Health and Minister for Mental Health has established two advisory bodies:

- ACT Health System Council
- CHS Strategic Advisory Committee

[24] Australian Capital Territory 2025, 2025–26 ACT Local Hospital Network Service Level Agreement, ACT Government, Canberra.
[25] Australian Capital Territory 2025, 2025–26 Service Funding Agreement, ACT Government, Canberra.
[26] Australian Capital Territory 2025, 2025–26 Service Funding Agreement, ACT Government, Canberra, p. 3.

The ToR of the ACT Health System Council[27] describe the role of the Council as follows:

> The Council has been established to provide advice on how better integration between services can improve the effectiveness of the ACT's health system.

The Council is established to provide the Minister for Health and Mental Health with strategic advice on health service planning and the commissioning of services across the ACT health system. This will include the provision of advice to inform the development of service level agreements between the ACT Government and health services. The Council will provide advice on where the health system could create better value through strengthened integration and changes in culture. Advice will also be provided on system leadership and the performance and future directions of the health system.

The role of the CHS Strategic Advisory Committee, as described in its ToR, is to:

> ... provide advice to the CEO and report to the Minister on matters related to the organisation's strategic direction and performance and other matters that may be referred for advice.[28]

3.3 Future state recommendations

Creation of an ACT Health System Governance Framework

The governance of health systems in Australia is complex and requires meeting local jurisdictional legislative and policy requirements, as well as commitments under the NHRA Addendum 2026-31. For small jurisdictions such as the ACT, this complexity presents additional challenges arising from the lack of economies of scale. The ACT Government has designed an ACT health system that meets the requirements of the NHRA Addendum 2026-31 as well as leveraging whole of ACT Government economies of scale in areas such as digital and infrastructure capability.

The consultation and submission analysis undertaken as part of the Inquiry has indicated that the governance of the ACT health system would benefit from a clear description of how the system is organised, what and where major decisions are made, and how whole of system matters are identified, prioritised and decided upon. An ACT Health System Governance Framework (referred to in this section as a System Governance Framework) would describe all these arrangements.

Consultations also identified the importance of a System Governance Framework describing how HCSD and CHS work with the broader health ecosystem in the ACT (i.e primary care, NGOs, ACCHOs and private hospitals) and adjacent care sectors (i.e aged care and disability care). Including this in the System Governance Framework would also be consistent with the stewardship objectives of the NHRA Addendum 2026-31, outlined earlier in this report.

To support this process, HCSD should lead the development of a System Governance Framework, in collaboration with CHS, Digital Canberra and Infrastructure Canberra. This System Governance Framework should not remove the requirement for local governance frameworks to be owned and maintained at an organisational level (i.e. by HCSD, CHS, Digital Canberra and Infrastructure Canberra). Rather, the System Governance Framework will provide an overarching structure that describes the governance arrangements through a coherent, coordinated and whole-of-system

[27] Australian Capital Territory 2026, ACT Health System Council, ACT Government, Canberra.
[28] Canberra Health Services 2026, Governance, ACT Government, Canberra.

approach. As part of implementation, it is expected that entity-level governance frameworks may require review and adjustment to ensure alignment with system-wide governance principles, roles and responsibilities, and organisational accountabilities.

HCSD is the appropriate entity to lead (in collaboration with other entities allocated health-related functions) the establishment of the System Governance Framework because it is given the following system-wide health-related responsibilities in the ACT Administrative Arrangements 2025:

1. Health system policy, planning and performance monitoring
2. Health services planning and commissioning
3. Regulation of health services
4. Health workforce planning
5. Health infrastructure planning (including Canberra Hospital Master plan and community health infrastructure)

Development of a System Governance Framework provides the opportunity to enhance the clarity of strategic and structural accountability across the ACT health system. To do this, the System Governance Framework should clearly delineate the roles, responsibilities and obligations of HCSD, CHS, Digital Canberra and Infrastructure Canberra, to clarify accountability and avoid overlap. The roles of HCSD as system coordinator and CHS as LHN service provider are currently captured in the ACT Administrative Arrangements and NHRA commitments.

The System Governance Framework should identify decision-making authorities, including how decisions are made, how matters are prioritised, and how performance is monitored. Importantly, the System Governance Framework should clarify and document how expertise is leveraged and integrated across HCSD (as the system planner, service commissioner and system performance monitor) and CHS (as the service provider), to achieve system-wide outcomes and ensure alignment between the ACT health system's legislative, policy and ethical obligations, and operational reality.

Implementation of a robust and collaborative System Governance Framework is likely to have positive downstream impacts on clinical quality and safety, management of the DHR and data reporting, and workforce culture (an interplay which is explored in more detail in subsequent chapters). The System Governance Framework is also likely to serve as an important input each time the ACT Government Administrative Arrangements are re-affirmed, to support clarity of roles, responsibilities and obligations of HCSD and CHS, and the other entities with health-related functions.

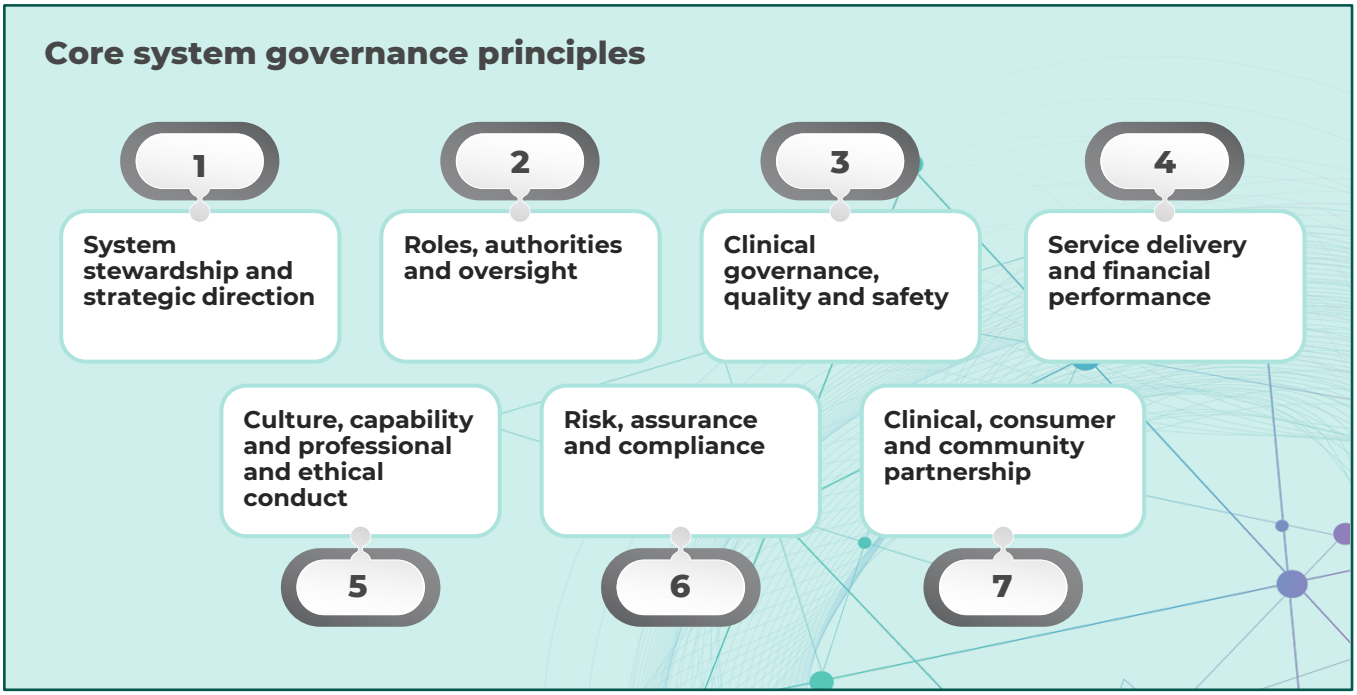
The System Governance Framework would include the ACT Health System Council and the CHS Strategic Advisory Committee. The ACT Health System Council was established by the Minister for Health to be able to receive advice from a group with an independent view of the ACT health system. Maintaining this group going forward is a matter for the Minister for Health. However, it has been an excellent oversight group for this Inquiry and could be the oversight group for the implementation of the recommendations. It is important that the group has independent membership with the right skill mix.

The CHS Strategic Advisory Group should also be included in the System Governance Framework. The CHS Strategic Advisory Group's scope is CHS, whereas the ACT Health System Council is the entire ACT health system, inclusive of CHS. The CHS Strategic Advisory Group has an advisory, assurance and support role for the CHS Chief Executive, along with a health consumer and other stakeholder engagement role. It is possible to separate these two roles (advisory and engagement) into two separate groups. Whatever the final arrangements, they should be documented in the System Governance Framework.

Elements of a System Governance Framework

The System Governance Framework developed for the ACT health system should be developed using a principles-based approach, drawn from national and international leading practice. Seven high-level principles or standards that could guide development are provided visually in **Figure 11** and explored in more detail below. These principles are informed by frameworks reviewed nationally and internationally and have been shaped to be relevant to the ACT health system. They are provided here as a guide only.

Figure 11: Core system governance principles



Principle 1: System stewardship and strategic direction

It is important that all health systems have clear, articulate and relevant plans for meeting overarching legal, policy and ethical obligations, along with strategic goals. This ensures alignment among stakeholders, fosters transparency, supports effective decision-making and enables the system to deliver coordinated, high-quality and patient-centred care while meeting its overarching responsibilities. The System Governance Framework provides the opportunity for the ACT health system to describe the:

- Overarching legislative and policy obligations of the system.
- Relevant plans that exist to capture the purpose, priorities, strategic goals and long-term vision of the ACT health system and its services.

Principle 2: Roles, authorities and oversight

It is essential for health systems to clearly define and centralise information regarding authority and the respective roles and responsibilities of executive and management across the organisations tasked by Government to undertake health-related functions. This supports accountability, streamlined decision-making and enhanced organisational efficiency.

The System Governance Framework provides the opportunity for the ACT health system to improve the clarity and collaboration related to:

- Health-related functions carried out by HCSD, CHS, Digital Canberra and Infrastructure Canberra.
- Role, responsibilities, authority and lines of reporting of key participants in the ACT health system.
- Legislative and policy obligations of the ACT health system and how responsibilities for compliance are allocated across entities.
- Role, function and reporting lines of top-level committees, groups or other decision-making elements established by HCSD, CHS, Digital Canberra, and Infrastructure Canberra to prioritise, refine and make decisions that involve more than one entity.
- Role and operating arrangements for oversight bodies such as the ACT Health System Council and CHS Strategic Advisory Committee.
- Financial and administrative authorities, including the flow of funds into and through the ACT health system from ACT government sources and the National Health Funding Pool, and how the management and administration of this funding occur by HCSD.
- Systems in place to ensure policies, plans and procedures of the ACT health system are documented, endorsed and accessible to staff.

Principle 3: Clinical governance, quality and safety

Public health organisations that deliver clinical services must ensure clinical responsibilities are clearly defined, allocated and understood. This fosters accountability, enhances transparency and enables the delivery of care that consistently prioritises patient safety, quality and optimal health outcomes. The System Governance Framework provides the opportunity for the ACT health system to improve clarity and transparency by having a Quality and Safety Governance Framework nested under the System Governance Framework. The following elements are usually part of a Quality and Safety Governance Framework, and are included here for guidance:

- Lines of accountability for clinical care.
- Roles, responsibilities and data access and decision rights for roles within the Quality and Safety Governance Framework.
- Reporting and responsibilities of committees and groups established to undertaken quality and safety activities.
- Incident management systems, including a structured and standardised approach to the identification and management of clinical incidents and minimisation of risk across CHS and HCSD.
- Structure and composition of forums to facilitate the involvement and collaboration between, clinicians and other health staff involved in quality and safety oversight at all levels of the ACT health system.
- Safety and quality reporting and utilisation of a central, system-wide issues management system.
- Practices that guide accreditation of healthcare facilities and services, along with licensing and registration requirements.

Principle 4: Service delivery and financial performance

Health systems must establish clear and collaborative frameworks to regularly evaluate both service delivery and financial performance. This ensures transparency, drives accountability and supports the optimisation of resources to deliver high-quality and sustainable health outcomes. Through establishment of the System Governance Framework, there is an opportunity for the ACT health system to improve the clarity and coordination of:

- Processes and procedures in place to ensure the efficiency and effectiveness of resource utilisation within the ACT health system.
- Processes and procedures in place to review the financial and service delivery performance of the ACT health system.
- Service delivery metrics, including key performance indicators (KPIs) to assess the quality, efficiency and accessibility of healthcare services, patient outcomes and data on waiting times, service availability and equity of access.
- Mechanisms used to monitor financial performance, including financial reporting and investment plans.
- Systems to measure and report on desired outcomes, including publicly available data and dashboards.

Principle 5: Culture, capability and professional and ethical conduct

It is essential that health organisations have systems and processes in place to ensure the capability and professional and ethical conduct of staff and contractors, to ensure the delivery of high quality, safe and effective care. Through establishment of the System Governance Framework, there is an opportunity for the ACT health system to improve the clarity and coordination of:

- Systems and processes that instil a culture of acting lawfully, ethically and responsibly, and in line with professional registration and licencing requirements.
- Processes and escalation mechanisms in place to ensure any alleged breaches of legislation or standards are managed effectively and appropriately.

Principle 6: Risk assurance and compliance

Health systems must ensure robust processes and protocols for risk assurance and compliance, to enhance transparency, efficiency and regulatory adherence, while fostering trust among stakeholders. Through establishment of the System Governance Framework, there is an opportunity for the ACT health system to improve the clarity and coordination of:

- Risk management frameworks and processes, to support the workforce to take a proactive approach to identify, assess and mitigate strategic and operational risks.
- Compliance processes, to ensure adherence to legislation, regulations and internal policies.
- Internal and external audit programs, to assess the effectiveness of controls.

Principle 7: Clinical, consumer and community partnership

Health organisations must implement robust systems and processes to foster a collaborative and consultative approach in sharing the evolution of the healthcare system. This ensures that clinicians, consumers and community members are engaged and provided with clear, balanced and accessible information to support informed decision-making and drive meaningful change. Through the establishment of the System Governance Framework, there is an opportunity for the ACT health system to improve the clarity and coordination of:

- Consultation and communication strategies to ensure collaboration and input of consumers and members of the community, where appropriate.
- Consultation and communication strategies to involve clinical and non-clinical staff in decisions that impact them.
- Strategies to ensure information on key policies, plans and initiatives of the ACT health system are available to the public.

Possible structure of an ACT Health System Governance Framework

The System Governance Framework should clearly describe the roles and functions of the entities within the system, along with governance committees and how decisions are made. It is acknowledged that most of these committees are already in place and that reviewing them and including them in the governance framework is what is required.

Checklist for the development of the System Governance Framework

The following checklist is provided as a guide only.

☑ Describe the entities and functions in the ACT health system, operating under the leadership of the Minister for Health:

- HCSD: System coordinator
- CHS: Health Service Provider Network
- Digital Canberra: Digital health enablement
- Infrastructure Canberra: Health infrastructure enablement

☑ Describe the top tier of system governance entities including ToR that include, but are not limited to:

- Name
- Purpose and scope of role
- Chair and membership
- Meeting frequency
- Relationship to other health system governing entities
- Approach to decision making

The number and scope of the coordinating entities will be determined as the governance framework is developed.

Coordinating functions top tier of governance

The following list describes the types of coordinating functions that would benefit from being in the top tier of governance. It is not a list of coordinating entities, and one entity may undertake multiple coordinating functions:

- ACT health system coordination between HCSD and CHS
- ACT health system coordination between HCSD, CHS, health-related NGOs, ACCHOs and Primary Care
- Quality and safety coordination between HCSD and CHS
- Whole of health system coordination including how HCSD and CHS work with primary care, NGOs, ACCHOs and private hospitals
- Collaboration across care sectors including how HCSD and CHS will work with aged care and disability care
- Digital health coordination between HCSD, CHS and Digital Canberra
- Health data coordination between HCSD, CHS and Digital Canberra
- Infrastructure coordination between HCSD, CHS and Infrastructure Canberra

Recommendation 1

HCSD, in collaboration with CHS, develop a System Governance Framework that clearly describes at least the following governance components:

- Full details of health-related roles and accountabilities of HCSD as system coordinator, CHS as LHN service provider, Digital Canberra and Infrastructure Canberra and how collaboration will operate for the health portfolio as a whole.
- The arrangements to meet the NHRA commitments, including service agreements, managing the NHRA national and ACT health funding, collaboration by HCSD and CHS with the PHN and ACCHO, collaboration across related sectors, and performance monitoring and reporting and other requirements such as collaboration across the ACT Government.
- The arrangements for HCSD, CHS, Digital Canberra and Infrastructure Canberra to coordinate health-related functions including prioritising activities and making whole of health portfolio decisions involving two or more of the four entities.
- Description of how the Clinical Quality and Safety Framework (CQSF) and governance, data governance and digital health governance (and other system frameworks and governance arrangements) are embedded in the System Governance Framework.

Discontinuation of the ACT LHN Directorate

Across Australian jurisdictions, LHNs are generally structured as separate, independent legal entities under the NHRA. This is also the case in the ACT, with CHS established as a separate entity through the ACT Administrative Arrangements and performing the role of the LHN as described in the NHRA 2026-31. In larger states, there are multiple LHNs, each with a defined geographic footprint, to cover the entire state. The three small jurisdictions each have one LHN to cover the entire state or territory.

The ACT LHN Directorate commenced operation in July 2011, during a time in which the ACT health system existed as a single Directorate (the ACT Health Directorate) led by the Director General. The ACT LHN Directorate was established as a direct result of the NHRA signed in 2011, as a separate legal entity (the ACT Local Health Network Directorate) within the Department. The consultation regarding the establishment of the LHN Directorate indicates that it was established within the single department to ensure transparency of ACT and Commonwealth funding as required by the NHRA. As a separate legal entity established under the *Health (National Health Funding Pool and Administration) Act 2013* (*ACT LHN Directorate Act 2013*), it provided assurance that funding from the Commonwealth and the ACT was being allocated to the LHN and other health services in accordance with the purpose of the funding.

In 2018, the ACT Health Directorate was split into two legal entities, the ACT Health Directorate (now known as HCSD) as the system coordinator and CHS as the LHN service provider. The ACT Local Health Network Directorate remained as an independent entity of the ACT Health Directorate (now known as HCSD).

Now that the system coordination functions are within a separate Directorate (HCSD) to the service provider functions (CHS), the ACT LHN Directorate is no longer required. The continuation of the ACT LHN Directorate also contributes to challenges understanding the governance of the health system in the ACT. Using the term LHN, when describing both a funding mechanism (ACT LHN Directorate) and a service provider (CHS), can cause confusion when describing entities and functions within the ACT.

The *ACT LHN Directorate Act 2013*, requires, among other things, the establishment of two bank accounts:

- A State Pool Account: a bank account with the Reserve Bank of Australia.
- A State Managed Account: a bank account with an authorised deposit-making institution.

These two bank accounts need to be continued and would both continue to be within HCSD. This arrangement continues to provide the transparency of the flow of funding, and the separation of the system coordination role from the service provider role, as required by the NHRA.

The National Health Funding Pool Administrator already recognises these arrangements, without reference to, or the need for, the ACT LHN Directorate. In the National Health Funding Pool Annual Report 2024-25, the Administrator describes the funding arrangements in the ACT as follows:

> “The Territory determines when payments are made into the Pool and State managed fund. Payments are made from the Pool account to the Australian Capital Territory Health Directorate (ACT Health Directorate) and State managed fund in accordance with the Service Agreement agreed between the Australian Capital Territory Minister for Health and the Director-General of the ACT Health Directorate (‘System Manager’).[29]

[29] Administrator National Health Funding Pool, 2024-25 ANNUAL REPORT: Improving the transparency of public hospital funding in Australia, p. 231.

The National Health Funding Pool Annual Report 2024-25 is the most recently released annual report and relates to the organisational arrangements prior the MoG changes to establish HCSD.

The *ACT LHN Directorate Act 2013* will require a new title and amendment to continue the requirement of the two bank accounts (National Pool Account and State Managed Account), and the other commitments from the NHRA and place these functions directly within HCSD.

Recommendation 2

In consultation with the National Health Funding Administrator, discontinue the use of the ACT LHN Directorate as an entity of HCSD, and, consistent with the ACT Administrative Arrangements, HCSD is the system coordinator (managing the Reserve Bank account and national funding), and CHS is the health service provider.

Creation of a single, tri-party ACT Health Service Agreement

As described earlier, within the ACT health system, the Minister for Health and Minister for Mental Health has two Service Agreements in place:

- The Service Level Agreement with the Director-General HCSD as the Head of the ACT LHN Directorate.
- The 2025–26 Service Funding Agreement with the CEO CHS and the Director-General HCSD (as Head of the ACT LHN Directorate).

Both agreements include funding arrangements, performance requirements, and other obligations and Ministerial expectations of HCSD and CHS. Combining the two agreements into one will result in a clearer and more practical and streamlined agreement between the Minister, HCSD and CHS. The scope of the two current agreements would form the basis of the single agreement. A single agreement needs to clearly describe the purpose of the agreement, including that the agreement documents the Minister's requirements of both HCSD and CHS; describes the role of the Minister as health system leader, HCSD as health system coordinator and CHS as the LHN service provider.

A single, tri-party agreement enables information about funding allocations, scope and scale of services to be delivered, outcomes expected, and performance reporting and monitoring requirements to be contained in one document. This enables increased simplicity and clarity of the relationship between funding appropriation, allocation of funding, services or activities delivered and outcomes achieved. This in turn supports improved governance and transparency around roles and responsibilities (in line with the ACT Health System Governance Framework), whilst decreasing administrative burden associated with managing and reporting on two separate agreements.

Recommendation 3

Combine the current two agreements (Service Agreement and Service Funding Agreement) into a single agreement signed by the Minister for Health, Director-General HCSD, and CEO CHS.

Chapter 4 Clinical quality and safety

Clinical quality and safety encompass the structures, processes, standards, and governance that ensure health services deliver effective, safe and person-centred care across the health system. It includes statewide policy and standard setting (i.e. clinical governance frameworks, accreditation, and safety and quality standards), system-level oversight, measurement and reporting (i.e. KPIs, clinical audits, incident reporting and sentinel event review), workforce capability (i.e. training, credentialing, clinical supervision), and coordinated improvement programs targeting harm prevention (i.e. infection control, medication safety, falls prevention) and equity of outcomes for priority populations.

The role of clinical quality and safety is to protect patients, support staff, and improve population health by embedding continuous risk management, evidence-based practice and transparent accountability into service delivery. Through the aggregation of data, clinical quality and safety activities support the early identification and management of risk and supporting proactive intervention.

Navigating this chapter

The following visual provides an overview of the structure of this chapter.

Consultations and submissions summary	Thematic findings distilled from stakeholder consultations and written submissions.
Current state analysis	Comprehensive description of current-state arrangements derived from a desktop review of qualitative and quantitative data. This included publicly available information, public health data and reports and documents provided by CHS and HCSD, to provide contextual insights into the functioning of the ACT health system.
Future state recommendations	Considering findings from consultations and submissions, alongside the current state analysis, this section outlines future state recommendations, which serve as opportunities to uplift and enhance the ACT health system.

4.1 Consultations and submissions summary

Consultations underscored the value all stakeholders place in providing high-quality and safe patient care, informed by the best available evidence. As many stakeholders communicated, clinical quality and safety is at the core of a well performing health system. Consultations identified several opportunities to improve current system governance of quality and safety and how this will flow-on to policies and practices. Strengthening the quality and safety arrangements system-wide will also have a positive impact on organisational culture. As noted below under Data Collection and Reporting, stakeholders discussed ways to improve the use of clinical data to improve quality and safety, including the use of legislation.

Stakeholders highlighted the fundamental connection between clinical quality and safety and broader systemic challenges such as workforce culture, and system and data governance processes.

Governance and accountability in quality and safety oversight

Opportunities to improve quality and safety oversight were identified, particularly relating to the operation of systemic governance and accountability arrangements. Stakeholders pointed to arrangements in other States and Territories as a way of describing how things could be improved.

Stakeholders also commented that the core focus of health services and systems is on quality and safety. Stakeholders noted that, while it is important that time is devoted to this at all levels of CHS and HCSD, there should be an appropriate balance with other discussions such as financial sustainability, activity targets, and other key performance indicators. Stakeholders identified that excellent quality and safety systems are based on openness with the absence of a culture of blame. They also said that good systems engage with other health service providers to undertake reviews and quality and safety improvement activities.

Many stakeholders identified the need to make improvements in the provision of safety and quality data to staff within and across CHS and HCSD who have roles in the oversight of clinical quality and safety. These improvements included looking at the ACT legislation and other jurisdictional legislation. Stakeholders communicated that the current legislation covering health data could be updated to allow the full operation of the ACT Clinical Governance Arrangements and the CHS policies, procedures and guidelines to function optimally.

Workplace culture and its impact on clinical quality and safety

Workplace culture was frequently identified as a critical contributing factor, particularly regarding staff wellbeing and their ability to deliver safe and effective care. Stakeholders raised the need to improve the confidence of clinicians to escalate safety concerns. Stakeholders reflected that there have been clinicians who have left the ACT health system as result of their belief in the need to improve clinical quality and safety arrangements, including the escalation processes.

Administrative burden and clinician wellbeing

During consultations, stakeholders highlighted the potential that the administrative burden faced by senior clinicians could impact clinical time. Stakeholders noted that there is a need to balance the administrative workload with time spent undertaking other responsibilities such as mentoring junior doctors, direct patient care, and research. Some stakeholders believe administrative pressures are contributing to workforce challenges, which could affect both staff wellbeing and the quality of care provided.

Clinical documentation and data quality

Stakeholders spoke positively about the DHR, particularly in relation to moving from a range of paper-based systems to a single record, and the availability of patient information. However, stakeholders identified opportunities to further improve the quality of clinical documentation, including continuing to improve the consistency of documentation in the DHR. Stakeholders identified the importance of having agreed models of care and pathways for patient care that are reflected in the DHR and supported by documented data definitions and data entry requirements.

4.2 Current state analysis

Australia's national standards for clinical safety and quality

In Australia, clinical quality and safety within hospital settings are guided by a nationally consistent framework, the National Safety and Quality Health Service (NSQHS) Standards, developed by the ACSQHC.[30]

The NSQHS Standards (2nd ed.) outlines eight nationally consistent standards designed to protect patients from harm and improve the safety and quality of health care across Australian health service organisations. The standards are periodically reviewed by the ACSQHC in collaboration with the States and Territories. The eight standards currently cover:

1. Clinical governance
2. Partnering with consumers
3. Preventing and controlling infections
4. Medication safety
5. Comprehensive care
6. Communicating for safety
7. Blood management
8. Recognising and responding to acute deterioration

Each standard describes required systems, criteria and actions to ensure safe, person-centred, evidence-based care and reliable clinical processes across the patient journey. The ACSQHC sets the standards against which all public hospital systems must be accredited. Accreditation assessments are conducted by independent accrediting agencies, approved by the Commission, as part of the AHSSQA Scheme. This ensures a uniform approach to patient safety and care quality across jurisdictions.[31] In relation to the accreditation process, the ACSQHC makes the following point:

> "Being accredited does not guarantee there is no risk of a patient being harmed. It means safety and quality systems that support safe and good quality care are in place, and risks of harm are identified and managed.[32]

[30] Australian Commission on Safety and Quality in Health Care 2010, Australian Safety and Quality Framework for Health Care, ACSQHC, Sydney.

[31] Australian Commission on Safety and Quality in Health Care 2026, About us, ACSQHC, Sydney.

[32] Australia Commission on Safety and Quality in Health Care 2017, Fact Sheet 2: Accreditation of health services in Australia, ACSQHC, Sydney.

These arrangements are underpinned by State and Territory legislation, which defines the interconnected roles of health service providers and system oversight entities. This legislative foundation ensures that governance structures, responsibilities, and escalation pathways are clearly articulated, supporting accountability and transparency throughout the health system.

Common jurisdictional features of leading practice quality and safety arrangements

In addition to the accreditation process, leading practice in clinical quality and safety is characterised by a whole-of-system approach that places patients at the centre of care and fosters integration between service providers and system custodians. Common features include openness with patients and families, candour in all activities, and a commitment to continuous improvement rather than blame.

While accreditation occurs periodically, robust quality and safety governance arrangements in State and Territory health systems operate every day, supported by independent oversight entities that monitor performance, support service providers and provide guidance. These entities operate within clear legislative frameworks that set out their protections and obligations, ensuring both confidentiality and appropriate access to patient information for quality review purposes. Transparent performance reporting and a culture of openness and accountability reinforce public trust and drive ongoing improvements in healthcare delivery.

Table 4 below provides an overview of common jurisdictional features of leading practice quality and safety arrangements. These features have evolved over time in response to major reviews and inquiries into healthcare performance across Australia. Jurisdictional approaches continue to develop in line with the guidance, standards, and ongoing work of the ACSQHC.

Table 4: Common jurisdictional features of leading practice quality and safety arrangements

National Clinical Quality and Safety	• The ACSQHC sets the clinical quality and safety standards against which all public hospital systems must be accredited • The Inter-Jurisdictional Committee (IJC) is a forum of safety and quality officials from federal, state and territory health agencies. It provides advice to the ACSQHC on its policies, programs, standards, guidelines and indicators, supports their implementation, and helps maintain effective working relationships with key stakeholders to facilitate the Commission's work[33]
Legislation	• State/Territory Health Clinical Quality and Safety arrangements are underpinned by legislation • The interconnected entities in the Quality and Safety System (covering the health service delivery and system oversight roles) is outlined in the legislation
Operating Principles	Clinical Quality and Safety arrangements based on the following principles: • A whole of system approach that places the patient at the centre and is integrated between service providers and system custodians • All quality and safety activities undertaken with an attitude of candour • A focus on quality improvement rather than blame • An open approach with patients and their families • A willingness to apologise for mistakes • Data is accessible to people working on the quality and safety of the health system • There is an open and up to date reporting of Quality and Safety and Performance data to support the transparent process to improve services

[33] Australian Commission on Safety and Quality in Health Care 2026, Committees, ACSQHC, Sydney.

Governance	• Service providers are required to have clinical quality and safety arrangements in place • Monitoring and oversight is undertaken by an entity separate to the service provider that has a dual role of supporting the health service provider/s and working to improve the quality and safety of the services • A designated person within the external monitoring and oversight entity who leads the quality and safety work • There are governance structures and processes across the system to support and assure the operation of the Quality and Safety arrangements • There are clear roles, responsibilities and structures in place so that every person and entity knows what they can do to support and improve the quality and safety of healthcare • There are clear escalation and intervention steps (including increased monitoring and the issuing of directions to service providers) when quality and safety standards are not met • The NHRA contains requirements linking funding to specified clinical performance

Reviews	• Identifiable patient information protections are outlined in legislation
	• People who are involved in the quality and safety arrangements have legislative obligations and protections. These arrangements include the requirements regarding confidentiality and the circumstances when the provision of information is mandatory
	• Specified people can have access to identifiable patient information for the purposes of undertaking Quality and Safety activities. Specified people include:
	  ○ Clinicians undertaking a root cause analysis (RCA)
	  ○ Appointed clinical reviewers
	  ○ Other designated people within a health service
	  ○ Other designated people within the monitoring and oversight entity separate from the health service provider
	• Scaled reviews outlined in legislation:
	  ○ RCA: a short review undertaken by clinicians not involved in the care of the patient following a serious adverse event
	  ○ Clinical Reviews: longer reviews focused on the clinical quality and safety of a specified clinical area, undertaken by externally appointed clinical reviewers. Clinical Reviews can focus on a specific patient case, a group of patient cases, a type of procedure across multiple sites, or any other type of focused clinical treatment matter.
	  ○ Health Service Reviews: larger scale reviews usually focused on a group of services within a health service, a whole hospital, or a whole health service provider undertaken by externally appointed reviewers.

Quality Assurance Committees (QACs)	• QACs are usually ongoing entities to monitor Quality and Safety at a system level in a particular area such as Cancer, Perinatal Care, Surgical Activity and Mental Health Services • QACs and their members are usually covered by legislative protections and obligations
Reporting	• Reporting of clinical key performance indicators is provided to the AIHW, the Productivity Commission and the ACSQHC

ACT Health legislative arrangements

Across the ACT, three key pieces of legislation form the foundation for ensuring the quality, safety and integrity of health services:

- The *Health Records (Privacy and Access) Act 1997*
- The *Public Health Act 1997*
- The *Health Act 1993*

These laws regulate how personal health information is used and accessed, how public health risks are controlled and how health services conduct quality-improvement activities. They establish rights and responsibilities for consumers, providers and regulatory authorities. Collectively, these legislative arrangements aim to protect individual privacy, uphold public health, promote transparent and accountable governance and ensure that healthcare services continually improve the safety and quality of care delivered to the ACT community.

The three Acts have been in place for approximately three decades, with minor amendments over this time. Since their commencement, many changes have occurred in clinical quality and safety, health data, health services, and public health. These changes to strengthen clinical quality and safety arrangements include: clear jurisdictional level monitoring and oversight; the establishment of the Australian Commission on Safety and Quality; commencement of the national My Health Record; rollout of hospital based digital health records; responding to a global pandemic; the establishment of the Australian Centre for Disease Control; and the commencement of the NHRA. These changes mean that there is a need to review and update the ACT Acts, as described later in this chapter.

The following sections provide summaries of each legislation and highlight areas for improvement in line with gaps identified during the consultations and analysis undertaken as part of the Inquiry.

ACT Health Act 1993

The ACT *Health Act 1993* establishes the legal framework under which ACT health services conduct quality improvement activities. Under the Act, the Minister may approve an activity as a 'quality assurance activity' if satisfied that the activity is intended to support structured, quality improvement functions and identify opportunities to improve service delivery. Examples of the types of activities that fall under this definition include:

- Clinical audits
- Record audits
- Peer review
- Quality review
- Investigation into disease and death

Quality Assurance Committees (QACs)

The *Health Act 1993* provides the mechanism for establishing QACs, which can receive statutory protections when they are formally approved by the Minister. These committees are designed to evaluate, monitor or improve the quality of a health service and may be granted protections relating to:

- The confidentiality of information provided to the committee
- Protection from disclosure (except where permitted by the Act)
- Protection from liability for committee members acting in good faith

These protections only apply when an activity is conducted within an approved QAC. If an activity, such as RCA, is conducted outside this formal structure, protections outlined above do not automatically extend to participants. Approval of a QAC requires the committee to meet specified criteria mandated by the Act, along with ensuring compliance with operational procedures. There are currently 27 active QACs across the ACT Health system, covering a broad range of clinical matters. The QACs currently operating within the ACT Health system are listed in **Table 5**.

Table 5: QACs currently operating within the ACT health system

Hospital	The Canberra Hospital (TCH)	North Canberra Hospital (NCH) Quality Assurance Committees (QACs)
Quality Assurance Committees (QACs)	• Canberra Health Services Clinical Ethics Committee • Canberra Health Services Clinical Review Committee • DonateLife ACT Clinical Case Review Committee • Haematology • Medical Oncology • Radiation Oncology • Diabetes and Endocrinology • Emergency Medicine • General Medicine • Neurology • Renal Services • Respiratory and Sleep Medicine • Rheumatology, Immunology, Dermatology • Geriatric Medicine • Anaesthesia, Perioperative Medicine and Pain Management • Intensive Care Unit • Neurosurgery • Pre-Hospital and Retrieval • Urology • Gynaecology • Neonatal • Obstetric • Paediatric	• Gynaecology • Maternity/Obstetrics and Perinatal • Anaesthetics • Colorectal Cancer (CRC)
Total count	23	4

ACT Health Records (Privacy and Access) Act 1997

The ACT *Health Records (Privacy and Access) Act 1997*[34] sets the legal framework for how personal health information is collected, stored, used, disclosed and accessed in the ACT. Its purpose is to protect privacy, maintain data integrity and ensure consumers can access their own health records.

The ACT *Health Record Act 1997* contains 12 legally enforceable privacy principles covering how information may be collected, how it must be stored and secured, who may access it, limits on use and disclosure, processes for altering records, requirements when health services relocate or close and how records are transferred when a consumer or provider moves.

Health information may only be collected for lawful, necessary purposes directly related to a provider's functions. Members of a consumer's treating team may access records only as needed to provide care. Unlawful access is an offence, with possible penalties including fines and imprisonment. The 12 privacy principles are outlined below.

[34] Legislation ACT 2025, *Health Records (Privacy and Access) Act 1997*, ACT Government.

ACT Health Records Act 1997 - 12 Privacy Principles[35]

1. Manner and purpose of collection of personal health information
2. Purpose of collection of personal health information to be made known
3. Solicitation of personal health information generally
4. Storage, security and destruction of personal health information:
    - 4.1 Safekeeping requirement
    - 4.2 Register of destroyed or transferred records
    - 4.3 Destruction of health information
5. Information relating to records kept by record keeper
6. Access to health records by people other than the consumer
7. Alteration of health records
8. Record keeper to check accuracy etc of personal health information before use etc
9. Limits on use of personal health information
10. Limits on disclosure of personal health information
11. Relocation and closure of health service practice
12. Consumer moves to another health service provider
    - 12.1 Health service provider moves to another health service practice

Public Health Act 1997

The *Public Health Act 1997*[36] provides the legislative framework for protecting public health in the ACT. It aims to prevent and manage public health risks, support rapid responses to emerging threats, ensure decisions are made professionally and minimise unnecessary impacts on individual rights. Key objectives include protecting the community from unregulated risks, monitoring population health, informing the public and ensuring responsible public health decision-making.

The Act establishes major public health roles, including the Chief Health Officer (CHO), who leads public health strategy, administers legislation, advises the Minister and prepares biennial indicator reports. The CHO must be a medical practitioner and public servant; an acting CHO may be appointed as needed. Public health officers, authorised medical officers, and analysts support inspection, enforcement, and risk assessment functions.

The Act sets out processes for reporting and managing notifiable conditions, giving the CHO powers to issue public health directions. It also includes provisions for public health emergencies, sanitation issues, drinking water and sewage risks, needle and syringe programs, and investigations. Together, these systems create a flexible and accountable framework for preventing, identifying, and managing public health threats across the ACT.

[35] Legislation ACT 2025, *Health Records (Privacy and Access) Act 1997*, ACT Government.
[36] Legislation ACT 2025, *Public Health Act 1997*, ACT Government.

Codes of practice

The *Public Health Act 1997* regulates activities that pose public health risks by requiring licences or registrations and enforcing compliance with codes of practice.[37] A code of practice, determined by the Minister under section 133 of the *Public Health Act 1997*, sets out the minimum standards and procedures for regulated activities and is enforceable under section 20.

These codes provide practical, legally binding guidance on how activities must be conducted to prevent or manage public health risks. They apply across areas such as public health risk activities, notifiable conditions, investigations, and sanitation.

Once the Minister establishes or amends a code, including by adopting external standards, it becomes a disallowable instrument. This means it is published on the ACT Legislation Register and can be reviewed or disallowed by the Legislative Assembly, ensuring both flexibility and transparency. If the instrument is not disallowed within the disallowance period, it comes into effect.
Table 6 describes the current, in-force, instruments under the *Public Health Act 1997*.

Table 6: Public health codes of practice[38]

Code of practice	Description
Cooling Towers, Evaporative Condensers and Warm Water Storage Systems (Specialised Systems) Code of Practice 2005	Provides guidance for managing public health risks associated with cooling towers, evaporative condensers, and warm water storage systems in the ACT. Its primary purpose is to prevent the growth and spread of Legionella and other harmful microorganisms by setting minimum standards for the safe operation and maintenance of these systems.
ACT Healthcare Facilities Code of Practice 2021	Sets minimum standards for managing public health risks in ACT healthcare facilities, including places performing medical or dental procedures and those providing overnight care. It ensures facilities operate safely by requiring systems that minimise infection risks, support safe clinical practices, and maintain environments that protect patient health and wellbeing, consistent with broader public health objectives.
ACT Health Infection Control for Office Practices and other Community-based Services Code of Practice 2005	Sets minimum standards for ACT businesses performing skin penetration and similar procedures. It outlines clear infection-prevention requirements for non-clinical settings, such as beauty salons, tattoo studios, and community service environments, including hygiene practices, sterilisation, equipment maintenance, and safe work procedures to protect staff, clients, and the wider community.
Public Health (Community Pharmacy) Code of Practice 2016	Sets mandatory public health standards for ACT community pharmacies, supporting licensing requirements under the *Public Health Act 1997*. It ensures pharmacies operate safely and hygienically by regulating how medicines are stored, handled, and supplied to protect public health.
Public Health (Drinking Water) Code of Practice 2007	Provides minimum requirements for ACT drinking water utilities to manage water quality through consistent monitoring, treatment, reporting, and risk-management practices. The framework aims to ensure a safe, reliable drinking water supply and protect public health by reducing contamination risks.
ACT Public Swimming and Spa Pools Code of Practice 1999	Sets health and safety requirements for operating and maintaining public swimming pools and spas in the ACT. It outlines essential measures for water quality, hygiene, facility maintenance, and operational monitoring to prevent illness and injury by ensuring proper treatment and management of pool and spa environments.

[37] Legislation ACT 2025, *Public Health Act 1997*, ACT Government.
[38] HCSD 2025, Public health codes of practice, ACT Government.

Code of practice	Description
Notifiable Conditions Reporting Code of Practice	Outlines the requirements for reporting notifiable diseases in the ACT, specifying the duties of health professionals and responsible carers to notify the CHO. It ensures timely, accurate reporting to support effective disease surveillance, outbreak control, and public health response.

Catalysts for change in clinical safety and quality

Clinical safety and quality of care are fundamental pillars of every health system, yet hospitals remain inherently complex environments where risks can arise, not only from individual errors but also from systemic weaknesses in governance, oversight, and accountability. Over the past two decades, several high-profile inquiries and reports across Australia have exposed system vulnerabilities following serious incidents that have eroded public confidence in hospital care. These inquiries and reviews have played a pivotal role in shaping and strengthening clinical safety, quality and governance, and embedding a culture of safety and transparency across Australia's health systems.

In Qld, NSW, and Vic reform of clinical safety and quality legislation and guidelines have been driven by independent inquires and reviews. These include the *Queensland Public Hospitals Commission of Inquiry* in 2005 (the Patel Inquiry), the *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* in 2008 (the Garling Report) and *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of Care* (Targeting Zero Report), published 2016. These inquiries and reviews were all triggered by crises that revealed significant gaps in quality and safety systems.

Western Australia (WA) presents a slightly different quality improvement trajectory. In 2017, WA Health undertook a significant independent quality and safety review to strengthen its clinical safety and quality framework proactively by seeking to build a more robust system before a major failure occurred.[39] Even with such proactive work, there are always risks that poor quality and safety outcomes occur, as was described in the Inquest into the Death of Aishwarya Aswath Chavittupara.[40] The WA Health example illustrates an important approach of investing in stronger systems not only in response to tragedy, but to reduce the likelihood of future crises. Along with Qld, NSW and Vic, these jurisdictions demonstrate two complementary drivers for reform, reactive change following system failure, and proactive reform aimed at preventing harm before it occurs.

The Patel Inquiry, the Garling Report, and the Targeting Zero Report each examined the underlying causes of major system failures and proposed wide-ranging reforms to prevent their recurrence. Across all jurisdictions, these inquiries prompted new legislation, strengthened governance frameworks, and updated operating principles aimed at improving accountability, increasing transparency, and supporting continuous improvement.

As previously outlined, the reforms have helped establish a shared understanding of leading practice in quality and safety, contributing to greater consistency across jurisdictions. They have also driven a shift toward patient-centred care and stronger clinical oversight, underscoring the need for system-wide approaches to quality and safety.

Table 7 summarises the three inquiries and reports, outlining their triggers, identified issues, key recommendations, and resulting outcomes.

[39] Western Australian Department of Health 2017, Review of Safety and Quality in the WA health system, Government of Western Australia, Perth.

[40] Coroners Court of Western Australia 2023, Inquest into the death of Aishwarya Aswath Chavittupara, State of Western Australia, Perth.

Table 7: NSW, Vic and Qld landmark inquiries driving clinical safety and quality reform

	Garling Report (NSW, 2008)[41]	Targeting Zero Report (VIC, 2016)[42]	The Patel Inquiry (Qld, 2005)[43]
Trigger event/s	Public concern over safety in NSW hospitals following the death of 16-year patient and a high-profile miscarriage case at Royal North Shore Hospital in 2005.	A series of avoidable perinatal deaths at Djerriwarrh Health Services between 2012-2014, exposing serious failures in clinical governance and oversight.[44]	The Patel Inquiry was triggered by a series of deaths and serious complaints about Dr Jayant Patel's surgical practices at Bundaberg Base Hospital and the failure of hospital administrators and Qld Health to act on those concerns.
Issues identified	The Garling Report found that patient safety and care quality in NSW public hospitals were compromised by systemic issues, including inadequate supervision of junior clinicians, poor communication and record-keeping, medication errors, and high rates of hospital-acquired infections. Workforce shortages, outdated work practices, and insufficient training exacerbated these risks, while fragmented models of care and weak discharge planning contributed to inefficiencies and adverse outcomes. The Garling Report emphasised the urgent need for cultural change, evidence-based clinical protocols, and robust information systems to ensure consistent, safe, and patient-centred care across all facilities.	The Targeting Zero Report revealed systemic failures in governance and oversight that compromised patient safety. Avoidable harm was widespread, with fragmented monitoring, over-reliance on accreditation, and poor use of routine data leaving serious risks undetected. Boards often lacked clinical governance expertise, particularly in smaller hospitals, while cultural barriers discouraged reporting and transparency. Budget cuts eroded departmental capacity, resulting in inconsistent improvement strategies and isolated success stories rather than system-wide learning. These deficiencies created unsafe conditions and highlighted the urgent need for robust governance, data-driven oversight, skilled boards, and a culture prioritising patient safety over operational convenience.	The Patel Inquiry identified significant systemic failures in governance and patient safety across the state. Hospitals lacked effective credentialing and privileging processes and did not adequately monitor clinical performance or investigate complaints. Budget-driven priorities placed Elective Surgery targets ahead of safety, while ineffective complaints systems and a culture of concealment delayed critical interventions. These deficiencies created unsafe conditions for patients and underscored the need for stronger governance, rigorous credentialing, robust performance monitoring, improved complaint management, and a fundamental shift from financial imperatives to patient safety as the primary focus.

[41] Garling, P 2008, Final report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, NSW Government, Sydney.
[42] Duckett, S 2016, Targeting zero: The review of hospital safety and quality assurance in Victoria, Grattan Institute, Melbourne.
[43] Queensland Public Hospitals Commission of Inquiry 2005, Report of the Queensland Public Hospitals Commission of Inquiry, Queensland Government, Brisbane.
[44] Victorian Auditor-General's Office 2021, Clinical governance: Department of Health, Victorian Government, Melbourne.

	Garling Report (NSW, 2008)[41]	Targeting Zero Report (VIC, 2016)[42]	The Patel Inquiry (Qld, 2005)[43]
Key recommendations	The Garling Report presented 139 recommendations with a focus on improving patient safety, clinical practices and workforce culture.[45]	The Targeting Zero Report presented 59 recommendations, including a number of structural recommendations focused on creating new governance and accountability structures, consolidating existing committees, and improving statewide coordination for safety, quality, and performance in healthcare.[46]	The Patel Inquiry presented 39 recommendations focused on strengthening hospital governance, improving oversight of clinical standards, ensuring rigorous checks on medical practitioners, creating effective complaint and whistleblower systems, and embedding patient safety as the core priority across Qld's health system.
Outcomes	The Garling Report identified four key pillars of reform to strengthen the NSW health system:[47] • **Agency for Clinical Innovation** was established as the lead agency for NSW Health to identify, promote, and implement evidence-based clinical practices. • **The Clinical Excellence Commission** received strengthened role to oversee patient safety and quality across health services. The role includes monitoring clinical incidents, delivering statewide harm-reduction programs, and building staff capability. • **The Clinical Education and Training Institute** was established to lead multidisciplinary postgraduate education,	The Targeting Zero Review resulted in four key structural outcomes to strengthen safety, quality, and governance across the health system.[49] • **Safer Care Victoria** was established as the lead agency for clinical quality and safety improvement, driving statewide initiatives, best-practice guidelines, and harm-reduction programs in partnership with clinicians.[50] • **Victorian Agency for Health Information (VAHI)** was established as an independent body to manage health data, publish transparent performance reports, and drive benchmarking, clinical improvement, and accountability across Victoria's health system.[51] • **The Victorian Clinical Council** was formed to provide strategic, multi-disciplinary	The Patel Inquiry resulted in four key structural and governance reforms to strengthen safety, accountability and governance reforms to strengthen safety, accountability and workforce management across Qld's health system: • **Health Quality and Complaints Commission (HQCC)** (now known as the Office of the Health Ombudsman) was established as an independent body to monitor health service quality, investigate complaints, and drive statewide safety and quality improvements.[54;55] • **Strengthened Clinical Governance Frameworks** were introduced, including mandatory. credentialing and privileging systems, outcome monitoring, and public reporting of clinician performance to improve transparency and patient safety.

[45] Skinner, CA, Braithwaite, J, Frankum, B, Kerridge, RK & Goulston, KJ 2009, Reforming New South Wales public hospitals: an assessment of the Garling inquiry, Medical Journal of Australia, vol. 190, no. 2, pp. 78–79.

[46] Duckett, S 2016, Targeting zero: The review of hospital safety and quality assurance in Victoria, Grattan Institute, Melbourne.

[47] Skinner et al., Reforming New South Wales public hospitals: an assessment of the Garling inquiry, pp. 78–79.

[49] Duckett, S 2016, Targeting zero: The review of hospital safety and quality assurance in Victoria, Grattan Institute, Melbourne.

[50] Safer Care Victoria n.d., About the Safer Together program, Victorian Government, Melbourne.

[51] Victorian Agency for Health Information 2019, Strategic plan 2019–2022, Victorian Government, Melbourne.

[54] Health Quality and Complaints Commission 2011, Response to request for information from the Health and Disabilities Committee, Queensland Parliament, Brisbane, committee document.

[55] Office of the Health Ombudsman 2014, Office of the Health Ombudsman opens, Queensland Government, Brisbane.

	Garling Report (NSW, 2008)[41]	Targeting Zero Report (VIC, 2016)[42]	The Patel Inquiry (Qld, 2005)[43]
	with a strong focus on ongoing training for junior doctors. • **Bureau of Health Information** was established in 2009 to independently measure and report on patient care, including access to treatment, clinical performance, safety and quality, cost, patient and staff experience, and sustainability.[48]	advice from clinicians and consumers to the Government, the department and health services, ensuring strong clinical engagement and collaboration across specialties and regions.[52] • **Ministerial Board Advisory Committee** was introduced to provide advice to the Minister for Health on proposed appointments to public hospital boards, ensuring diversity, appropriate skill mix, and ongoing professional development for governance excellence.[53]	• **Reforms to Recruitment and Registration Processes** for overseas-trained doctors, tightening 'area of need' provisions and introducing robust supervision and competency checks to prevent credentialing failures. • **Legislative Amendments to the *Medical Practitioners Registration Act* and *Coroners Act,*** enhancing investigative powers, mortality reporting, and regulatory oversight of clinical practice.

[48] Bureau of Health Information n.d., Our role, NSW Government, Sydney.
[52] Safer Care Victoria 2018, Victorian Clinical Council: Terms of reference, Victorian Government, Melbourne.
[53] Victorian Government 2025, Boards Ministerial Advisory Committee, Victorian Government, Melbourne.

ACT Clinical Governance Arrangements[56]

The ACT Clinical Governance Arrangements September 2024[57] (ACT Clinical Governance Arrangements) outline how HCSD (formerly the ACT Health Directorate) undertakes work for safe, high-quality, person-centred care across the ACT health system. The following is a description of the arrangements.

The arrangements are based on the National Model Clinical Governance Framework and the NSQHS Standards. The ACT Clinical Governance Arrangements outline the structures, responsibilities, and cultural expectations required to maintain accountability, transparency, and continuous improvement in healthcare delivery.

The ACT Clinical Governance Arrangements include the importance of engaging with consumers as equal participants in their care and in shaping the health system.

HCSD's role is to provide whole-of-system leadership, oversight, and strategic direction. HCSD's responsibilities include embedding a strong safety culture, promoting consumer engagement, monitoring safety and quality performance, providing timely policy advice, sharing information across the system, and using research to drive improvement.

The ACT Clinical Governance Arrangements includes five core components of clinical governance:

1. Consumer and Carer Engagement – embedding consumer perspectives in policy, service design, incident review, and system improvement, supported by legislation and national frameworks.
2. Leadership and Safety Culture – fostering systems thinking, open disclosure, just culture, multidisciplinary teamwork, and leadership development. Senior leaders must model transparency and support staff to speak up.
3. Health Care Sustainability – ensuring a skilled workforce, strong financial stewardship, environmentally responsible practices, and preparedness for emergencies. Sustainability includes staff wellbeing, credentialling, performance management, and reducing low-value care.
4. Risk Management – identifying hazards, analysing risks, and preventing harm through structured frameworks, clinical audits, incident reporting, quality registries, and adherence to risk management standards.
5. Quality Assurance and Effectiveness – monitoring clinical outcomes, reducing unwarranted variation, maintaining accreditation, using data for decision-making, and regularly reviewing clinical policies, pathways, and innovations.

The ACT Health clinical governance structure includes the Executive Board, the ACT Health System Council, the Clinical System Governance Committee (CSGC), and the Quality and Safety Leadership Network (QSLN). These bodies provide strategic oversight, expert advice, and mechanisms for escalation, collaboration, and system-wide improvement.

[56] Australian Capital Territory 2024, ACT clinical governance arrangements, ACT Government, Canberra.
[57] Australian Capital Territory 2024, ACT clinical governance arrangements, ACT Government, Canberra.

Canberra Health Services Patient Quality and Safety policies, procedures, guidelines and legislation

CHS operates under the Exceptional Care Framework 2024-29, which outlines what exceptional care looks like in practice and the everyday actions staff take to provide care that is personal, connected, accessible, safe and effective. CHS clinical quality and safety is further underpinned by a number of policies, documented procedures, guidelines and legislation relating to quality and safety, which are outlined in the sections below. The information in this report provides a summary of publicly available documentation only and does not assess the quality of the policies, procedures, guidelines or legislation themselves, nor their implementation in practice.

Policies

Risk Management Policy

The *Risk Management Policy* outlines how CHS manages clinical and organisational risks to support safe and effective service delivery. It describes governance structures, roles and processes for identifying, documenting, monitoring and escalating risks across all clinical and corporate areas. RiskMan is the system used to record risk ratings, controls and treatment actions, and to support regular review and escalation of operational and enterprise risks. The policy integrates risk management with clinical governance, incident management, business planning and auditing to ensure risks related to clinical quality and safety are consistently managed.

Consumer Feedback Management Policy

The *Consumer Feedback Management Policy* outlines CHS' commitment to a person-centred approach by ensuring all consumer feedback is managed effectively, confidentially, and within required timeframes. It establishes consistent expectations for staff to receive, respond to, and act on feedback, emphasising respectful communication, early resolution, accurate documentation in RiskMan, and executive oversight where required. The policy supports system-wide learning by ensuring themes and trends are monitored, quality improvement actions are implemented, and feedback processes do not negatively impact future care. It applies across all CHS services and works in partnership with the *Consumer Feedback Management Procedure* and the *NCH – Feedback (Complaints, Compliments) Management Procedure*.

Health Practitioner Credentialing and Scope Practice Policy

The *Health Practitioner Credentialing and Scope Practice Policy* ensures the delivery of person-centred, safe and effective care by ensuring there is a system in place to confirm a health practitioners credentials scope of clinical practice are regularly reviewed. This policy provides a broad understanding of credentialing as it applies to the allied health, medical, nursing and midwifery professional workforce across all clinical settings within CHS.

This system includes but is not limited to verifying and monitoring the qualifications, experience, professional standing and other relevant professional attributes of health professionals as set out in the NSQHS Standards, Clinical Governance Standard.

Clinical Supervision Policy

The purpose of this policy is to provide a broad understanding of clinical supervision as it applies to all disciplines and across all settings within CHS. There are a number of models of clinical supervision. Each discipline and work unit applies a model appropriate to their profession and service area. The provision of clinical supervision should be appropriate to staff position level and clinical service provided by the staff member.

The ultimate purpose of clinical supervision is to improve consumer care, experience and outcomes at CHS and support staff professional development within the organisation.

CHS Employee Underperformance Policy

The *CHS Underperformance Policy* outlines a fair, transparent process to support employees whose performance falls below expected standards, requiring managers to raise concerns early, document all steps, and work with employees on an Action Plan while ensuring procedural fairness and confidentiality. It applies to all non-casual staff and clearly defines the responsibilities of employees, managers, the CEO/delegate, and People & Culture in addressing ongoing performance issues. The Underperformance Policy is supported by the *Reviewing the Clinical Scope of Practice of a Practitioner Procedure* (see under 'Procedures' below).

Clinical Incident Management Policy

The *Clinical Incident Management Policy* provides a consistent management process for staff to follow in the event of a clinical incident to support patient safety and reduce the risk of patient harm. This includes timely identification, reporting, and management of all clinical incidents. The policy is currently supported by two procedures: the *NCH - Incident Management Clinical Procedure,* which applies to NCH, and the *Incident Management – Clinical Procedure,* which applies to all other CHS facilities.

CHS is currently undertaking a project to improve and align clinical incident management processes across CHS, as a result the *Clinical Incident Management Policy* is being reviewed, as are both supporting procedures, which are being unified into one *Incident Management Clinical Procedure* (see under 'Procedures' below). The CHS Clinical Incident Management Model outlining the CHS organisation-wide clinical incident management system was approved by Network Executive in December 2025 and is currently being implemented.

Policies supporting CHS' commitments under the Australian Commission on Safety and Quality in Healthcare National Safety and Quality Health Service (NSQHS) Standards

CHS has a number of policies that support meeting the NSQHS standards. These include the *Blood Management Policy, Clinical Governance Policy, Communicating for Safety Policy Comprehensive Care Policy, Medication Safety Policy, Partnering with Consumers and Carers Policy, Preventing and Controlling Infections Policy* and the *Recognising and Responding to Acute Deterioration Policy.* Each of these policies details the systems and processes CHS has in place to meet each standard. They detail the roles and responsibilities of CHS staff, education and training requirements, and the management, documentation and governance processes relating to each standard.

Information Privacy Policy

The *Information Privacy Policy* sets out how CHS collects, holds, uses, and discloses personal information to carry out functions or activities, in accordance with the organisation's legal obligations under the *Information Privacy Act 2014* and *Freedom of Information Act 2016*.

Clinical Records Management Policy

The *Clinical Records Management Policy* establishes the framework for the creation and management of CHS Network clinical records and personal health information. Effective clinical record keeping practices are vital for the CHS Network to support the delivery of high-quality patient care, operational efficiency, accountability, and transparency.

Corporate Records Management Policy

CHS follows the ACT Health Records Management Policy to ensure implementation of the requirements of the *Territory Records Act 2002*.

Procedures

Credentialing and Defining the Scope of Clinical Practice for Senior Medical and Dental Practitioners - Procedure, and NCH - Credentialing and Defining the Scope of Clinical Practice for Senior Medical and Dental Practitioners Procedure

Senior Medical and Dental Practitioners (SMDPs) are required to comply, and co-operate, with the scope of clinical practice processes as established by CHS in accordance with the *Health Act 1993 (ACT)*. This procedure defines the process for credentialing and defining the scope of clinical practice.

This procedure provides a standardised process for verifying and monitoring the qualifications, experience, professional standing and other relevant professional attributes of a doctor or dentist and guarantees SMDPs have a defined scope of clinical practice.

The Credentialing and Defining the Scope of Clinical Practice for Senior Medical and Dental Practitioners - Procedure is currently being reviewed by CHS and will incorporate the current *NCH - Credentialing and Defining the Scope of Clinical Practice for Senior Medical and Dental Practitioners Procedure*.

Credentialing and Defining the Scope of Clinical Practice for Nurse Practitioners (NPs) and Endorsed Midwives (EMs) Procedure

This procedure provides a standardised and consistent approach for verifying and monitoring the qualifications, experience, professional standing and other relevant professional attributes of a NP or EM to ensure the staff member has a defined scope of clinical practice at CHS Network.

Credentialing and Defining the Scope of Clinical Practice for Allied Health Procedure

The purpose of this procedure is to set out the process for the credentialing and defining of scope of clinical practice for eligible allied health professionals (AHPs) and allied health assistants (AHAs) employed within CHS and working at Canberra Hospital, University of Canberra Hospital and community services. The procedure provides a standardised and professionally led governance process for verifying and monitoring the qualifications, experience, professional standing and other relevant professional attributes of allied health professionals

This procedure is currently being reviewed by Allied Health within CHS, and consideration given to incorporating *the NCH - Credentialing and Defining the Scope of Clinical Practice for Allied Health Procedure*.

NCH - Credentialing and Defining the Scope of Clinical Practice for Allied Health Procedure.

This procedure is similar to the Credentialing and Defining the Scope of Clinical Practice for Allied Health Procedure and is currently being considered for incorporation into a CHS-wide document, refer to point above.

Reviewing the Clinical Scope of Practice of a Practitioner Procedure

CHS maintains *Reviewing the Clinical Scope of Practice of a Practitioner,* a dedicated procedure for reviewing a practitioner's clinical scope of practice when concerns arise about their clinical competence, ensuring patient safety and service quality remain paramount. This process involves formal assessment by the Medical and Dental Appointments Advisory Committee (MDAAC), which evaluates whether a practitioner's scope of practice should remain unchanged, be amended, or be withdrawn.

This procedure is currently being reviewed by CHS.

Incident Management - Clinical Procedure

The *Incident Management -Clinical Procedure* provides a standardised framework for managing clinical incidents at all CHS facilities other than NCH. Its purpose is to ensure timely identification, reporting, investigation, and resolution of incidents that result from healthcare provision and could lead to unintended harm to patients. The procedure applies to staff across inpatient, mental health, justice health, and community services. By using the RiskMan system and following principles of open disclosure and just culture, it aims to reduce patient harm, support staff, and drive continuous improvement in healthcare quality and safety.

NCH - Incident Management Clinical Procedure

The *NCH - Incident Management Clinical Procedure* details the process for managing clinical incidents at NCH. It establishes a consistent, timely approach to identifying, reporting, and addressing all clinical incidents, supporting patient safety and minimising the risk of harm.

Open Disclosure Procedure

The *Open Disclosure Procedure* outlines how CHS staff should communicate openly and transparently with consumers and/or their carers when harm or potential harm occurs during healthcare. It provides a structured, person-centred approach for acknowledging incidents, offering an apology, explaining what is known, and outlining next steps, ensuring conversations occur promptly and respectfully. The procedure applies across all CHS facilities and is closely linked to the clinical incident management process, guiding staff through both clinician-led initial disclosure and, when required, formal Open Disclosure with senior clinicians and executives. It also details roles and responsibilities, documentation requirements, follow-up expectations, and support for both consumers and staff. Overall, it aims to maintain trust, support patient-centred care, and ensure consistent, high-quality communication after adverse events.

Quality Assurance Committee (QAC) Compliance Under the Health Act 1993 Procedure

The *Quality Assurance Committee (QAC) Compliance Procedure* outlines how CHS committees must establish and operate as authorised QACs under the *Health Act 1993*. It explains when a committee should seek QAC approval, the protections and obligations that come with QAC status, including strict secrecy requirements, management of protected information, and protection from liability, and the legislative processes for approval, renewal, reporting, and record-keeping.

This procedure is currently being reviewed to align with new CHS Clinical Incident Management Model.

Consumer Feedback Management Procedure

The *Consumer Feedback Management Procedure* outlines how CHS receives, records, investigates, and responds to consumer feedback to improve the safety and quality of care. It applies to all of CHS other than NCH and Clare Holland House (CHH), and provides a structured process for capturing feedback, acknowledging it promptly, and ensuring responses are completed within required timeframes. The procedure emphasises respectful communication, early resolution where possible, appropriate escalation, and consistent documentation through RiskMan.

NCH – Feedback (Complaints, Compliments) Management Procedure

The *NCH – Feedback (Complaints, Compliments) Management Procedure* outlines the management of consumer feedback at NCH and CHH. It provides instruction for gathering and responding to feedback, including investigation and escalation when required. The procedure highlights the importance of respectful communication, consent and confidentiality, and treating feedback as an opportunity to improve the healthcare experience.

Policy Document (Policies, Procedures, Guidelines, and Placeholders) Development and Review

This procedure sets out the policy governance process to ensure our suite of documents address key safety and quality risks and exceeds the requirements of the NSQHS Standards, Clinical Governance Standard. Policy documents (i.e., policies, procedures, guidelines, and placeholders) provide a consistent approach for work undertaken by CHS team members that align with CHS vision, role, and values. CHS seeks to ensure that evaluation measures are integrated into the approval process for all policy documents.

Occupational Violence Prevention and Management Procedure

The purpose of this procedure is to provide CHS staff, students, volunteers and contractors with clear direction on Occupational Violence (OV) Prevention, Management, and Support.

Management of Recalls, Product Alerts, Product Corrections and Quarantine Procedure

The *Management of Recalls, Product Alerts, Product Corrections and Quarantine Procedure* provides team members with a process for managing recalls, product alerts, product correction and quarantine notifications (referred to as 'notifications' in this document) of medical devices, medicine, blood and biological products across CHS.

Safety Broadcast System Procedure

The CHS Safety Broadcasting System (SBS) is the mechanism for communicating information affecting, or with the potential to significantly affect, or have widespread impact on clinical service delivery and/or staff safety throughout CHS.

This procedure is intended to guide staff across CHS on when and how to submit a Safety Alert, Safety Notice and Safety Information for assessment and communication throughout the organisation.

Clinical Records Management Procedure

Effective clinical record keeping practices are vital for CHS to support the delivery of high-quality patient care, operational efficiency, accountability, and transparency.

The purpose of this procedure is to outline the required processes for all CHS staff (excluding NCH and CHH) to ensure consistent, effective, and appropriate clinical record and health information management across CHS.

This procedure, in conjunction with the CHS Clinical Records Management Policy, and the CHS Clinical Record Management Program ensure CHS meets its responsibilities under Section 16 (2) of the *Territory Records Act 2002*.

Mandatory, Role Required and Area Specific Training Procedure

CHS is responsible for providing education and training, and monitoring compliance with relevant health legislation, CHS Network and ACT Government policies, procedures and NSQHS Standards accreditation requirements. The purpose of this procedure is to outline the governance processes for mandatory training, role required and area specific training. This procedure is currently being reviewed by CHS.

Guidelines

Morbidity and Mortality Committee Guideline

CHS Morbidity and Mortality (M&M) Committees Guideline provides a structured framework for establishing and operating effective M&M committees across CHS. Its purpose is to support consistent, system-focused review of clinical care, enabling learning, identifying opportunities for improvement, and enhancing patient safety and quality. The guideline outlines roles and responsibilities, core principles such as creating a safe, blame-free learning environment and using systems thinking, and sets expectations for governance, systematic case selection, robust discussion, and clear documentation. It also emphasises sharing lessons learned, integrating actions into broader quality and safety systems, and ensuring M&M activities contribute meaningfully to organisational improvement.

The M&M guideline expects clinicians to actively participate in and contribute to M&M processes as a core component of safe, high-quality healthcare. Clinician responsibilities within M&M committees include to:

- Attend and actively participate in M&M meetings
- Champion a safe, blame-free learning environment
- Prepare and present cases when required
- Use systems thinking, not individual blame
- Identify and support improvement actions
- Engage in proper governance and reporting pathways
- Maintain confidentiality and accurate documentation
- Collaborate across disciplines and contribute to organisation-wide learning

Psychological Support for Staff – Manager's Guide

The *Psychological Support for Staff – Manager's Guide* outlines how CHS managers can recognise, respond to, and support staff experiencing stress or psychological impacts from workplace events. It explains risk and protective factors, introduces tools and describes available support options. The guideline also provides direction for managing specific situations such as distress, suicidal ideation, life-limiting illness, or the death of a colleague, ensuring staff receive timely and appropriate support.

Audit Program – Clinical and Non-Clinical Guideline

This guideline is intended to inform all auditing conducted across CHS and therefore is designed to standardise the approach to both clinical and non-clinical auditing.

The Clinical Audit Program:

- provides a timetable for collecting audit data—the CHS Clinical Audit Program Schedule
- maintains Quality and Safety dashboards for displaying and monitoring audit results
- develops, tests and reviews clinical audits that align with best practice, policies, procedures, and national standards
- uses validated data to identify and support timely action that will improve patient care
- utilises a risk-based approach to conducting clinical audits effectively and to identify areas for implementing improvement actions where performance is consistently low
- consumers should be involved in the development of clinical audits that drive consumer focused projects

Consent for Healthcare Treatment Guideline

The *Informed Consent for Healthcare Treatment Guideline* provides operational guidance to support staff working within CHS. This Guideline is intended to assist staff in meeting their professional and legal obligations, in seeking and obtaining consent to healthcare treatment (which includes treatment, procedures, assessment and other care), from people or their substitute decision makers.

Patient Experience Surveys – Development and Review Guideline

This guideline aims to provide guidance to staff on how to develop a patient experience survey for improvement purposes and to ensure CHS meets the requirements for consumer feedback as outlined in the Partnering with Consumers Standard of the NSQHS Standards.

Patient experience surveys within CHS use nationally agreed Patient Reported Experience Measures (PREMs) to evaluate the consumer's experience and baseline consumer demographics to interpret feedback. These are service evaluation tools which capture both quality assurance measures and quality improvement views when captured consistently over time.

Factsheet

An internal Factsheet is used by CHS clinical staff (Clinical Variation Assessment for Quality and Safety Performance Data Factsheet) to inform work in relation to clinical variation assessment. The Factsheet explains how CHS measures and reports on performance, including assessing and responding to unwarranted clinical variation.

Summary of current state

The ACSQHC has developed eight standards against which public hospitals are required to be accredited. TCH and NCH are both accredited against these standards. As noted by the ACSQHC, these standards do not guarantee that a patient will not be harmed but require the best-known policies and procedures to be in place to reduce the risk of harm.

The *ACT Clinical Governance Arrangements September 2024*[58] (ACT Clinical Governance Arrangements) outlines how HCSD (formerly the ACT Health Directorate) undertakes work for safe, high-quality, person-centred care across the ACT health system.

[58] Australian Capital Territory 2024, ACT clinical governance arrangements, ACT Government, Canberra.

CHS has clinical incident management arrangements in place that are widely available. There is a specific organisational unit, under the responsibility of the Deputy Chief Executive Officer that oversees and coordinates the clinical quality and safety arrangements.

An analysis of policies and legislation in States and Territories has identified that there are common features in large State and Territory clinical quality and safety arrangements. In Qld, NSW and Vic, these arrangements were significantly strengthened following the publication of reviews into quality and safety failures.

4.3 Future state recommendations

Creation of a Clinical Quality and Safety Framework (CQSF)

To further support the delivery of high-quality care and ensure safety, there is an opportunity for the ACT health system to update the current arrangements through the development of a Clinical Quality and Safety Framework (CQSF). The CQSF should include strengthened arrangements for the current governance oversight of clinical quality and safety provided by HCSD for the ACT health system, including CHS. The CQSF should also include the elements described in **Table 4** (Common jurisdictional features of leading practice quality and safety arrangements). The development of the CQSF should be led by HCSD, in close collaboration with CHS, and with input from health consumers and other stakeholders (including primary care and private hospitals).

The CQSF should be developed using a principles-based approach that includes the common elements of a robust clinical governance framework (i.e. **Table 4**), drawing on the experience and learnings from other jurisdictions and tailored to the ACT health system context. This includes drawing on the Clinical Governance, Safety and Quality Policy Frameworks from other jurisdictions, such as the framework developed by the Western Australian Department of Health.[59] This Framework is based on the following principles:

- Consumer partnership is evident at all levels of the organisation.
- Relevant, accurate information is available and used at all organisational levels of the Health Service Providers (HSPs) to guide quality improvement activities.
- Executive and clinical staff have the right qualifications and skills to provide safe, high quality health care and to foster a culture of openness, collaboration and continuous improvement.
- Minimisation of clinical risks and incidents as a systems approach to harm minimisation.[60]

[59] Department of Health, Clinical Governance, Safety and Quality, Government of Western Australia.
[60] Department of Health, Clinical Governance, Safety and Quality, Government of Western Australia.

The CQSF should cover the following core components:

- Refer to and be aligned with relevant legislation (noting that the ACT legislation will require substantial amendment to reflect current leading practice – see Recommendation 6).
- Specify the clinical governance, safety and quality mandatory requirements all service providers operating in the ACT health system must comply with.
- Be owned by a named custodian within HCSD, responsible for leading a collaborative process for ongoing review and revision of the framework, to ensure the framework remains relevant and contemporary.
- Outline processes of compliance and processes by which audits will occur.
- Be consistent with the ACT Health System Governance Framework, underneath which, the CQSF sits.

The Framework should be consistent with the roles and responsibilities that will be described in the ACT Health System Governance Framework. The CQSF will also require changes in legislation to capture the updated arrangements, including roles and responsibilities, data sharing, data privacy and quality and safety activities (see Recommendation 6). Unlike larger jurisdictions such as NSW, Victoria and Qld, who have separate clinical quality and safety entities, the ACT does not require the establishment of a separate entity. The rationale for this includes the fact there is only one LHN in the ACT (i.e. CHS), whereas the larger jurisdictions have many LHNs. Within the ACT, the health ecosystem across hospital and primary care is more manageable, and the resources saved from not having a separate entity can be available for clinical services. Clearly establishing (and providing the right level of oversight authority) within HCSD provides for the independence from the service provider but with a strong understanding of the ACT health system context and culture.

Critically, the CQSF must be developed in an open, collaborative and clinically led manner. This development will require significant engagement with the clinical workforce within CHS as well as with the broader ACT health system. It is important that the intent and purpose of the CQSF is to primarily support and enable clinicians to delivery effective, safe and patient-centred care, rather than a managerial and operational exercise.

The CHS will continue to operate its clinical quality and safety arrangements and for these to feed into the system-wide quality and safety oversight arrangements. It will be necessary for CHS to review and update the current arrangements to reflect the CQSF and the new legislation. The CQSF will support and oversee the CHS clinical quality and safety arrangements. This will require ongoing regular interaction of HCSD and CHS staff who will require access to quality and safety data and reports within strict privacy and confidentiality requirements outlined in updated legislation.

Stakeholder consultation highlighted the importance of the use of RiskMan in quality and safety. RiskMan is where all clinical incidents are recorded, tracked and managed. RiskMan is also used for non-clinical incidents. Stakeholders identified that the current version of RiskMan is very old, making it challenging to use and difficult to configure or adjust as enhancements are required. A newer, cloud-based version of RiskMan is available and consideration should be given to updating to this version to support the development and implementation of the new Quality and Safety Framework and arrangements.

Recommendation 4

Using models operating in jurisdictions such as NSW, Vic, Qld and WA, HCSD lead, in close collaboration with CHS, and with input from primary care, NGOs, health consumers health consumers, and private hospitals, the development of a CQSF to include the common jurisdictional features of leading practice quality and safety arrangements described in this report.

Recommendation 5

CHS undertake a review of the current clinical quality and safety arrangements to ensure they are consistent with the new CQSF and updated legislation.

Updating of ACT health-related legislation: Health Records Act 1997

To meet new clinical quality and safety arrangements under the CQSF, there will need to be a formal review of the three key health-related Acts in the ACT: *Health Act 1993*, *Health Records Act 1997*, and *Public Health Act 1997*, with amendments implemented as an outcome to ensure clinical quality and safety, and data arrangements are fit-for-purpose in the new arrangements.

Developing the CQSF, with the inclusion of the common features of leading practice, will require a sound legislative foundation. The legislation needs to reflect all aspects of clinical quality and safety starting with the culture of transparency and candour, and including:

- Data access and privacy
- Roles, protections and obligations of clinical reviewers
- Roles and arrangements for critical incident reviews, clinical review and health system review

The *Health Records Act 1997* will need particular attention as it was established when there was one entity responsible for health within the ACT. Today, with four entities (HCSD, CHS, Digital Canberra and Infrastructure Canberra) it is essential that the Act be reviewed to ensure that the access and use of data is being undertaken in accordance with the Act and supports the running of health services and the ACT health system in the digital era.

Consultations with stakeholders have identified improvements that can be made to the *Health Records Act 1997* for staff within CHS and HCSD who have responsibility for clinical quality and safety operations and oversight to support access to appropriately identified or de-identified data. Amending the *Health Records Act 1997* in line with the CQSF will provide clarity and consistency for appropriate access, storage and use of health-related data. Relevant staff within Digital Canberra who provide maintenance and enhancement services for the DHR and other clinical systems, will need to be included in the amended *Health Records Act 1997* to ensure that the work they do is compliant with data privacy and security requirements. The amendment of the *Health Records Act 1997* will be substantial and will need to be undertaken at the same time as the *Health Act 1993* and *Public Health Act 1997* are amended to ensure that all three acts are consistent and support the operation of the CQSF, and other improvements including data governance and digital health governance.

Specific changes to the *Health Records Act 1997* include:

- The requirement for designated persons within CHS, HCSD, Digital Canberra and externally (e.g. Australian Commission on Safety and Quality in Healthcare (ACSQHC), and Private Hospitals for transfer of patients) to have access to patient identifiable information for the legislated purpose of clinical care, quality and safety operations, monitoring, evaluation, improvement, and quality and safety oversight. Designated persons include, but are not limited to, staff in CHS who are involved in quality and safety operations, oversight bodies (e.g. HCSD and ACSQHC), peak leads in quality and safety, data analysis and reviewers.
- The requirement for 'need to know' principles to be applied, including requirements to provide de-identified data or minimum necessary data fields when this meets the functional requirements of a role.
- The importance of robust safeguards and obligations to be observed, including sharing powers, audit logs, secure environments and penalties for misuse or if breaches of these obligations occur.
- The requirements for external parties to access data for research purposes, including clear governance and authorising arrangements.

Recommendation 6

The *Health Records Act 1997* be amended to meet the requirements of the CQSF, including as they relate to the requirement for designated persons in CHS and HCSD to have access to patient identifiable information for the legislated purpose of quality and safety operations, monitoring and improvement.

Updating of ACT health-related legislation: Health Act 1993

To meet the requirements of the CQSF, a comprehensive review and amendment of the *Health Act 1993* is required. This update will ensure that all quality and safety activities embedded within legislation are contemporary, fit-for-purpose and capable of supporting the ACT's transition to strengthened, system-wide clinical governance arrangements. Amendments should be consistent with leading practice quality and safety arrangements in place in other jurisdictions, recognising that in a small jurisdiction, they may be organised or undertaken differently. Even if these activities are undertaken differently, they will still deliver on the intent and principles underpinning the leading practice arrangements. The amendments will also enable a culture that supports learning, prevention, and psychological safety and encourages open dialogue about quality and safety concerns.

Central to this legislative modernisation is the documentation of the need for clinicians and other staff to participate freely in the formal review processes that will be part of the CQSF (e.g. RCAs, clinical reviews and broader health service reviews) without fear that their contributions could lead to blame, disciplinary action or litigation. Staff must be able to speak candidly about system vulnerabilities, errors, and adverse events if improvement processes are to be effective. Legislation must therefore provide clarity about the respective obligations, protections and expected functions of the various review types, and the people who undertake them, within the CQSF.

Quality Assurance Committees (QACs) to remain for specific purposes

The *Health Act 1993* contains provisions for the establishment of Quality Assurance Committees (QACs). Within the ACT health system, QACs are currently the only mechanism through which confidential reviews regarding quality and safety matters can occur. QACs are formally established groups responsible for conducting quality and safety audits, reviews, investigations relating to morbidity and mortality, and health services more broadly. As a result, they have become the default vehicle for all forms of clinical quality and safety review.

This reliance on QACs as the sole mechanism for protected discussions constrains the ACT's ability to create sustainable, system-wide improvements. There are currently 28 active QAC's across the ACT health system. The breadth of matters assigned to QACs has resulted in overly complex pathways for conducting reviews, inconsistent access to protections and a potential lack of flexibility in responding to emerging safety risks.

An updated legislative approach would:

- Ensure clinical reviews are protected processes focused purely on quality improvement.
- Provide a clear mechanism to exit improvement-focused reviews when blameworthy or potential disciplinary conduct is identified.
- Reduce the number of QACs to a limited set of core committees, such as morbidity and mortality (M&M), perinatal mortality, cancer etc, while establishing separate, fit-for-purpose legislative arrangements for other types of reviews, including RCAs and health service reviews.

Comparison of ACT and Qld legislative protections

The ACT does not have dedicated RCA provisions in the *Health Act 1993*. Instead, the protection of RCA-style activities relies on the broader quality assurance provisions contained within the *Health Act 1993*. Under this framework, RCA processes receive statutory protection only if they are conducted within a formally approved QAC.

This model creates a potentially restrictive environment for undertaking quality and safety reviews, and, unless a QAC has been formally established and approved by the Minister, and the RCA is conducted within that committee's functions, the statutory protections for confidentiality, privilege, and participant immunity do not apply to staff. The findings and recommendations arising from RCAs undertaken within the powers of a QAC also make it difficult to have a health system improvement approach to quality and safety as this information is not shared with people involved in quality and safety oversight.

By relying on this mechanism, the ACT places an administrative burden on services to create and maintain QACs and results in uncertainty for staff about whether protections apply. As a result, protections may be inconsistent across services and incident types, and staff may be less confident that their participation is protected. Undertaking a review using a QAC also means that the details of the review are unable to be disclosed to any other parties, including the Coroner. There are circumstances where providing the details to the Coroner may assist with improving the quality and safety of services and reduce the need for undertaking two reviews covering the same matters, while still meeting the requirements of the Clinical Quality and Safety Framework.

By contrast, Qld has implemented a purpose-built legislative framework that directly regulates and protects RCA functions through Part 6 of the *Hospital and Health Boards Act 2011*.[61]
This statutory framework:

- Establishes clear legislative authority for conducting RCAs.
- Provides explicit confidentiality protections over RCA documents.
- Grants immunity from liability for individuals participating in RCA processes.
- Ensures that RCA reports and information are managed within a structured, patient-safety governance system.

Qld's system is clear, direct, and comprehensive, offering reliable, automatic protections for RCA participants. The legislative intent is explicit: to support robust, candid incident analysis by providing strong legal privilege for staff involved in RCA processes.

Impact on staff willingness to participate

The effectiveness of RCAs depends on clinicians providing open, honest, and detailed accounts of events, and on suitably qualified staff volunteering to serve as reviewers. Without strong, automatic legislative protections, staff may fear professional repercussions, disciplinary outcomes, reputational damage, or litigation. In an environment already characterised by cultural challenges around transparency and psychological safety, these concerns are heightened.

Such dynamics undermine the feasibility and quality of RCAs. Jurisdictions with more mature safety systems, such as Qld, identify legislative protections as foundational to enabling candid participation and maintaining a learning-focused safety culture.

Implications for patient safety

If clinicians do not feel safe speaking openly, RCAs may be constrained, superficial, incomplete, or avoided entirely. This directly weakens the ACT health system's ability to identify systemic risks, address latent failures, and implement meaningful improvements. Inadequate RCA processes also compromise the effectiveness of open disclosure conversations and reduce opportunities for learning following serious incidents.

RCAs require a confidential, privileged environment that allows staff to explore system weaknesses without fear. Without appropriate protections, the ACT risks lower reporting rates, diminished insights, and reduced capability to prevent future harm.

Achieving the right balance: protection and transparency

While confidentiality and privilege are essential for RCA effectiveness, legislative arrangements must also balance these protections with appropriate transparency. Lessons arising from RCAs must be shared across the system to strengthen safety practice, and the health system must retain public trust through clear, accountable governance.

As indicated in the example earlier, Qld's legislative model supports this balance through strong protections for participants while enabling system-wide reporting of patient-safety insights, trends, and improvement actions. A similar approach in the ACT would support safety learning without compromising staff protections.

[61] Queensland Legislation, *Hospital and Health Boards Act 2011*, Queensland Government.

The ACT's current reliance on broad QAC mechanisms can be improved for staff participating in serious adverse event investigations, and for the patients who are at the centre of an RCA. This will improve confidence, increase transparency, and strengthen the effectiveness of clinical incident reviews.

Overseeing quality and safety in a health system

There is a link between the *Health Act 1993* and the *Public Health Act 1997*. The *Public Health Act 1997* establishes the role of the CHO (see details relating to Recommendation 8).

In most Australian jurisdictions, oversight responsibilities for safety and quality are separate from the role of the CHO. In those systems, incident reviews and clinical safety information typically flow to a dedicated head of a clinical quality and safety branch within a department, or head of a separate agency. This role is the nominated lead for quality and safety and sits within the health department in smaller jurisdictions and some large jurisdictions, or is in a separate system-wide organisation unit in large jurisdictions. For example, Victoria has the head of Safer Care Victoria, NSW has the head of the Clinical Excellence Commission and Agency for Clinical Innovation, and Qld has the head of Clinical Excellence Queensland which is part of Queensland Health. In the ACT, the Chief Medical Officer (or equivalent role) within HCSD could undertake this role.

The ACT arrangements can be clarified and strengthened by the *Health Act 1993* and *Public Health Act* 1997 clearly separating the CHO regulatory functions from quality and safety functions and clarifying the role of the CHO when it has specific quality and safety responsibilities, along with the role nominated to lead quality and safety improvement in the ACT health system.

Amendment of the *Health Act 1993* is therefore necessary to clarify roles, strengthen quality and safety governance and operations, and align ACT arrangements with contemporary best practice. The nature of these amendments is captured in the description of the common features of contemporary quality and safety arrangements in jurisdictions.

A modernised legislative framework, one that introduces clear, automatic, and consistent protections for RCA and clinical review participants, would enable more rigorous investigations, promote open participation, and support healthier reporting and learning cultures. Strengthening the *Health Act 1993* to reflect contemporary CQSF requirements is therefore essential to improving patient safety and building a more resilient ACT health system.

Recommendation 7

The *Health Act 1993* be amended to meet the requirements of the CQSF, including as they relate to:

- The undertaking of RCA reviews
- The undertaking of Clinical reviews
- The undertaking of Health Service Reviews
- QACs
- Obligations and Protections for the different types of reviews and the reviewers who undertake them

Updating of ACT health-related legislation: Public Health Act 1997

To meet the clinical quality and safety requirements of the CQSF, a review and amendment of the *Public Health Act 1997* is required to ensure that public health legislation appropriately reflects contemporary arrangements and regulatory practice for the functions of a Chief Health Officer.

The *Public Health Act 1997* establishes the statutory framework for protecting and promoting public health in the ACT. It provides authority for public health decision-making, the development of codes of practice, and the exercise and delegation of regulatory powers by the CHO, who is established under the Act as the principal statutory officer responsible for public health regulation and advice.

The CHO has important, broad and statutory responsibilities, including but not limited to, statutory public health powers (emergency directions, notifiable disease control etc) and the ability to issue binding public health directions. The CHO also has a strong population level public health, prevention, surveillance and emergency control focus. These functions, and all other functions of the CHO, are contained in the *Public Health Act 1997.*

The *Public Health Act 1997* will require amendment resulting from the establishment of the CQSF and subsequent amendments to the *Health Records Act 1997* and *Health Act 1993*. The CHO needs to lead the development of the amendments to the *Public Health Act 1997* in collaboration with the work to be undertaken to amend the other two acts. When all three Acts have been updated, the ACT will have a leading practice legislative, policy and operational framework for public health and health system quality and safety.

Recommendation 8

The *Public Health Act 1997* be reviewed and amended in line with the new CQSF to reflect the role of the CHO, the role leading the oversight of clinical quality and safety for the system, as well as personnel involved in quality and safety operations and oversight activities.

Chapter 5 Service planning, demand and sustainability

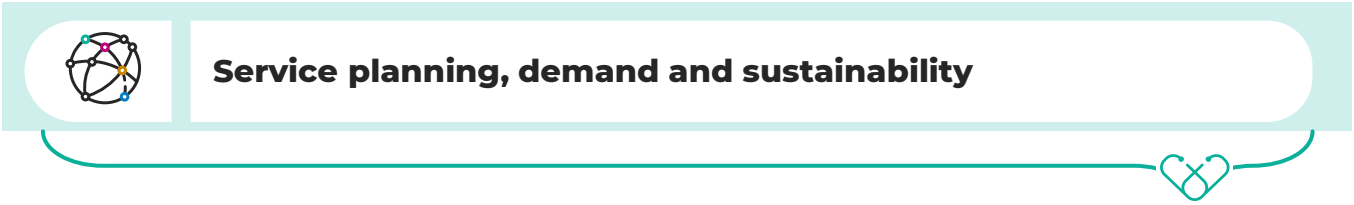
Effective service planning, demand management and sustainability are key enablers of health system performance. Mature health systems have robust service plans in place to outline the strategic direction for health services over a period. Service plans provide a disciplined framework for a health system to design and configure services in a way that meets needs now and into the future.

Demand management is equally important and is comprised of strategies that a health system employs to contend with the changing nature of patient acuity and demographics. Across Australia, demand is rising faster than population growth and health needs are becoming increasingly more complex; driven largely by an aging population, chronic conditions, advances in medical technology and increasing community expectations. Demand management is focused on understanding where demand for services is changing, and what investment is required across acute, primary care, prevention and early intervention and community-based services to contend with this demand.

Sustainability (both performance and financial) describes a health system's ability to ensure long-term viability. This includes robust processes are in place to ensure financial stewardship, along with the system's ability to improve and innovate services overtime, ensuring the delivery of safe, high quality and timely services that are accessible and equitable.

Navigating this chapter

The following visual provides an overview of the structure of this chapter.



5.1 Consultations and submissions summary

Stakeholders discussed how the increasing population size in Canberra is placing additional burden on the public health system. Some stakeholders identified an opportunity for greater clarity on the plan for the building of the new NCH. This includes how this, and the broader health system, will support the growing population size in the ACT and any changing demographics or service need in the community, and service arrangements across the NCH and TCH.

Some stakeholders noted the importance of maintaining strong collaboration between the public health system in the ACT and the bordering NSW towns and regions, noting the significant number of cross-border services being provided.

There was an opportunity raised by some stakeholders to improve the balance of flow of demand across the NCH and TCH. Some stakeholders noted an opportunity to improve system efficiency through maximising the use of Outpatient clinics and strengthening referral pathways, including referrals out of tertiary care into primary and community care. Stakeholders also noted opportunities to improve the uptake of walk-in clinics to avoid Emergency Department presentations, where appropriate.

There was commentary from some stakeholders on ACT's usage of NSW tertiary services for some services not available in the ACT. There were different viewpoints provided on this subject. Some stakeholders noted that providing all specialist services in the ACT is not sustainable for a small jurisdiction, with accessing specialist services via NSW hospitals a critical part of sustainability of the system. However, others noted that this limits accessibility for those services locally. Stakeholders commented that the safety of service provision is critically important.

Stakeholders noted that there are currently extensive wait times for some surgeries and procedures, however this is not always clearly communicated. Stakeholders noted an opportunity to improve communication for patients on waiting lists, including providing updates or check-ins during a patient's time on the waiting list.

Stakeholders said that providing more documentation on the purpose, scope, activities and timelines relating to the Planned Care Reforms would help with staff being able to engage in the process. Many stakeholders communicated support for what they understand are the underlying principles upon which the reforms are based. However, many stakeholders said that the initial implementation phase had little consultation and would have benefitted from being undertaken in a more collaborative manner.

Some stakeholders have raised the issue of the reforms potentially impacting on individual clinical practice. Some stakeholders also identified that if the reforms were recast, in collaboration with clinical staff, and with an open and engaged implementation approach, they could have a better opportunity to improve the quality and safety, and sustainability of the system.

5.2 Current state analysis

Service planning

Service planning is essential for guiding decisions related to infrastructure investments, service level planning, workforce management and preventive health care intervention strategies. By guiding policy decisions and ensuring cost-effectiveness, service planning supports sustainable health outcomes, continuous improvement and accountability, ultimately enhancing the quality, accessibility and equity of healthcare for all Australians.

The following sections provide an overview of service planning, demand, sustainability and Planned Care Reforms within the ACT health system.

Service planning methodology

The ACT Health Services Plan 2022–2030 outlines the strategic direction for health services in the ACT over an eight-year period. The plan provides a roadmap for how the ACT Government should redesign, invest and redevelop health services.[62] Key objectives and focus areas of the plan include health services that:

- ensure equitable access to care and respond to the evolving needs of the Canberra community, by focusing on key areas of service demand and reform
- support seamless transitions of care, as patients and carers interact with the service system, including primary, community, acute, Outpatient and residential healthcare settings
- strengthen and reinforce ACT's role as a local, Territory and regional service provider
- encourage innovation and efficient use of resources to maintain long-term viability, including core ACT Government-funded clinical support services[63]

The ACT Health Services Plan 2022–2030 was developed through a structured and systematic approach to designing, delivering and optimising services. This included extensive consultation and engagement with health services, consumers and carers, along with detailed research and analysis. [64] An external health planning organisation (HardesData) was contracted to undertake the health demand modelling.[65] The service plan modelling and analysis methodology used by HardesData is consistent with methodologies used by other States and Territories. The service planning methodology that underpins the ACT Health Services Plan 2022–2030 is detailed in **Table 8** below.

[62]Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra.
[63] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra.
[64] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra.
[65] Note that in the Inquiry Progress Report, it was stated that the modelling was undertaken by Health Data Analysis, this has been corrected in the Inquiry Final Report.

Table 8: ACT Health Services Plan 2022–2030 service planning methodology.[66]

Service planning step	Description
1. Needs assessment	Needs analysis is a process where opportunities for service development and redesign are identified. These service needs are identified by considering the local and national strategic, policy and operational context, including how models of care are expected to evolve overtime. Other factors that are considered include population, demographic and socioeconomic considerations, health status and burdens of disease, current service profiles and trends, current challenges identified across the Territory and capacity and capability of public hospitals across the ACT. An example of how the ACT public health system forecasts public hospital demand is detailed below.
2. Determine priorities	Following the identification of service needs, a process of prioritisation occurs to allow decision-makers to identify interventions that generate the greatest value and positive change. To do this, service needs are prioritised against a set of weighted criteria. This validates the identified service need and considers its alignment with strategic priorities and planning principles, opportunity to improve health outcomes, urgency, risk of not implementing and opportunities to address need through utilisation or realignment of existing services.
3. Analyse options and agree direction	Once service needs are prioritised, associated actions are identified. These are the specific steps, interventions and activities required to address actions.
4. Develop plan for change	Once agreed-upon, actions are incorporated into a services plan. Currently, this is the ACT Health Services Plan 2022–2030. A Services Plan supports coordination between differences services and sectors, a clear framework for accountability and transparency and ensures actions are delivered in a systematic and efficient way.
5. Implementation	To ensure services continue to evolve in alignment with planned health service development (captured in the Service Plan), an Implementation Plan is developed. This ensures strategic goals and priorities are translated into actionable outcomes. This document is dynamic, allowing evidence-based adjustments to occur to ensure services evolve in line with new and emerging health needs.
6. Evaluation	A supporting Evaluation Framework is also developed to enable regular progress evaluations to ensure the plan is achieving its intended objectives. This document is also dynamic and reviewed and refined on an ongoing basis.

Forecasting public hospital demand in the ACT 2022-32

To support the needs analysis, Appendix C of the ACT Health Services Plan 2022–2030 outlines the data-driven and evidence-informed approach to predict future public hospital demand in the ACT. This is identified in the ACT Health Services Plan 2022–2030 as a key area that requires infrastructure and service planning.

Forecasting public hospital demand is achieved by extrapolating existing trends. Planners consider factors such as past service activity data, past service utilisation data, population projections, NSW/ACT flow patterns and clinical trends. Acknowledging the changeable nature of trends, such as the impact of a growing and aging population and increasing burden of chronic disease on health service utilisation, forecasts are reviewed every two to five years by HCSD to ensure they are as up to date as possible.[67]

As outlined in Appendix C of the ACT Health Services Plan 2022–2030, the ACT public health system has placed increased focus on modelling specialised service streams, such as Emergency Department presentations. Modelling of these service streams is required as they are influenced by

[66] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra.
[67] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra.

additional factors, such as (for minor, non-urgent presentations) the availability of walk-in health centres and bulk-billing General Practitioners. The ACT Government primarily uses the ACT Acute Inpatient Model (ACTAIM) and an Emergency Department Model (ED Model) as forecasting tools. The ACTAIM supports proactive forecasting to predict demand for inpatient care and the ED Model supports hospital Emergency Departments.[68]

Figure 12 and **Figure 13** are extracts from the ACT Health Services Plan 2022-2030 showing the forecast inpatient and Emergency Department activity for CHS and the NCH (previously the Calvary Public Hospital Bruce). The projections show the forecast annual growth between 2022 and 2030 (for CHS and the NCH combined) for Multi-day separations was forecast to be 3.2%, for same-day separations it was forecast to be 2.7% and for all Emergency Department triage categories it was forecast to be 3.0% over the life of the Plan.

The forecasts indicate that the growth for the NCH was forecast to be higher than the growth for the remainder of CHS.

Figure 12: Extract from ACT Health Services Plan 2022-2030 – Inpatient activity projections[69]

ACT public hospital base-case forecasting for key areas of demand

The analysis below shows some of the key areas of clinical service demand in ACT public hospitals. The data does not include non-admitted activity or activity for community-based health services.

The forecasts represent a base case scenario, meaning that they are the expected outcomes in the absence of any government intervention. The forecasts are for Canberra Health Services (CHS) and Calvary Public Hospital Bruce (CPHB) and are provided for 2026–27 and 2031–32, with a breakdown of multi-day separations, multi-day bed-days and same-day separations. Underlying data to inform forecasts has been grouped into clinical specialties.

Inpatient summary

	Actual 2017-18			Projection 2021-22			Projection 2026-27			Projection 2031-32			Average % change per annum		
	CHS	CPHB	Total	CHS	CPHB	Total	CHS	CPHB	Total	CHS	CPHB	Total	CHS	CPHB	Total
Multi-day separations	37,223	12,945	**50,168**	43,492	15,774	**59,266**	49,527	18,811	**68,338**	56,173	22,211	**78,384**	3.0	3.9	**3.2**
Multi-day bed-days	216,881	69,619	**286,501**	246,207	83,965	**330,172**	279,031	99,735	**378,766**	315,474	117,443	**432,917**	2.7	3.8	**3.0**
Same-day separations	39,439	8,658	**48,097**	44,806	10,199	**55,005**	50,367	11,883	**62,250**	55,877	13,588	**69,465**	2.5	3.3	**2.7**

Figure 13: Extract from ACT Health Services Plan 2022-2030 – Emergency Department activity projections[70]

Emergency Department

Canberra Hospital and Calvary Public Hospital Bruce each have EDs that address urgent and life-threatening situations. People presenting to Calvary Public Hospital Bruce's ED will be transferred to the Canberra Hospital ED if tertiary level care is required. Forecasting for emergency care is broken down by triage category, where the triage category 1 is the most serious.

	Actual 2017-18			Projection 2021-22			Projection 2026-27			Projection 2031-32			Average % change per annum		
Presentations	CHS	CPHB	Total	CHS	CPHB	Total	CHS	CPHB	Total	CHS	CPHB	Total	CHS	CPHB	Total
Triage 1	539	213	**752**	513	215	**728**	575	259	**834**	645	313	**958**	1.3	2.8	**1.7**
Triage 2	9,771	4,966	**14,737**	10,991	6,281	**17,271**	12,698	7,597	**20,295**	14,633	9,049	**23,682**	2.9	4.4	**3.4**
Triage 3	34,643	27,463	**62,106**	35,589	30,268	**65,857**	43,351	36,870	**80,221**	52,441	44,119	**96,561**	3.0	3.4	**3.2**
Triage 4	35,427	22,572	**57,999**	38,562	26,074	**64,636**	43,320	29,893	**73,213**	48,792	33,633	**82,425**	2.3	2.9	**2.5**
Triage 5	8,281	3,903	**12,184**	10,721	6,855	**17,576**	11,406	7,543	**18,950**	12,177	8,138	**20,315**	2.8	5.4	**3.7**
Presentations Total	**88,661**	**59,117**	**147,778**	**96,376**	**69,694**	**166,069**	**111,350**	**82,163**	**193,513**	**128,688**	**95,252**	**223,941**	**2.7**	**3.5**	**3.0**

Table notes: The Australasian Triage Scale Category (ATS) aims to ensure that patients presenting to EDs are treated in the order of their clinical urgency and allocated to the most appropriate assessment and treatment area. The ATS is only used to describe clinical urgency. The ATS utilises five categories from Category 1 – an immediately life-threatening condition that requires immediate simultaneous assessment and treatment – to Category 5 - a chronic or minor condition which can be assessed and treated within two hours.

[68] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra.
[69] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra.
[70] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra.

Forecast future infrastructure needs

The Health Services Plan 2022-30 forecast activity should be used to project infrastructure needs across CHS, particularly for TCH, NCH and University of Canberra Hospital. The Inquiry could not identify any publicly available information regarding forecast bed/treatment spaces for the three main hospitals within CHS.

The Inquiry has been provided details regarding the NCH infrastructure requirements contained in the Northside Hospital Clinical Services Plan 2024-2041.[71] **Table 9** provides the details of the total current and forecast built capacity for beds and treatment spaces (including inpatient, Emergency Department, ICU, operating rooms etc) and agreed between CHS and HCSD. The forecasts are based on the forecast activity demands and are designed to support the changing models of care and other service improvement opportunities. The forecasts are provided here as an aggregated total, but the actual forecast has the capacity broken into the different areas and broad specialities of the hospital.

Table 9: Current and forecast built capacity (beds and treatment spaces) for NCH

	2024/current	2031	2041	Growth 2024-31	Growth 2024-41
North Canberra Hospital (NCH)	389	585	742	196	353

Similar infrastructure forecasts are required to be developed using forecast activity demand and models of care changes for TCH and University of Canberra Hospital. These forecasts should be made public so that HCSD and CHS can show that infrastructure enhancements are occurring is a way to meet the forecast demand in the ACT health system.

Future service directions

The Health Services Plan 2022-30 outlines four future service directions that are intended to assist the management of the forecast future growth and improve the health care services in the ACT. Actions are listed for each direction. The four future service directions are:

1. Addressing key areas of service demand and reform
2. Transitions of Care
3. ACT's role as a local, Territory and regional service provider
4. Strengthening Core ACT Government-Funded Clinical Support Services

Demand

The AIHW publishes activity data for all States and Territories. The most recent activity data tables are from 2023-24 for inpatient data and 2024-25 for Emergency Department activity.[72] The AIHW data includes State and Territory comparisons for the current year and previous four years.

The data over this period is significantly impacted by the COVID-19 pandemic, particularly in the 2021-22 and 2022-23 financial years. As can be seen in **Table 10** to **Table 12**, the number of separations in 2021-22 for overnight acute separations is lower for the ACT and Australia than it was two years previously in 2019.20. For Emergency Departments, the number of presentations is lower in both 2021-22 and 2022-23 than they were in 2020-21 for both ACT and Australia (**Table 13** and **Table 14**).

[71] Northside Hospital Clinical Services Plan 2024-2041 dated February 2025, held by Canberra Health Services and the Health and Community Services Directorate.

[72] AIHW, Data Downloads Website, Australian Government.

The impact of the COVID-19 pandemic makes it difficult to use recent publicly reported activity data to make confident future forecasts. This is affecting all States and Territories.

Table 10: Overnight acute separations – public hospitals[73]

	2019–20	2020–21	2021–22	2022–23	2023–24	Average change (%) since 2019–20	Change (%) since 2022-23
ACT	52,247	54,554	49,898	52,934	59,902	3.5	13.2
Australia	2,753,024	2,805,679	2,747,366	2,827,243	2,963,598	1.9	4.8

Table 11: Same-day acute separations – public hospitals[74]

	2019–20	2020–21	2021–22	2022–23	2023–24	Average change (%) since 2019–20	Change (%) since 2022-23
ACT	58,876	67,120	63,987	67,983	78,948	7.6	16.1
Australia	3,632,374	3,824,477	3,744,087	3,947,234	4,144,077	3.4	5.0

Table 12: All separations – public hospitals[75]

	2019–20	2020–21	2021–22	2022–23	2023–24	Average change (%) since 2019–20	Change (%) since 2022-23
ACT	118,737	129,547	121,079	129,467	148,295	5.7	14.5
Australia	6,730,042	6,969,187	6,837,095	7,128,005	7,479,408	2.7	4.9

Table 13: Emergency Department presentations – total – public hospitals[76]

	2020–21	2021–22	2022–23	2023–24	2024–25	Average change (%) since 2020–21	Change (%) since 2023-24
ACT	153,713	143,693	145,718	156,029	167,603	2.2	7.4
Australia	8,808,357	8,789,877	8,800,919	9,018,401	9,094,312	0.8	0.8

Table 14: Emergency Department presentations – age standardised rate per 1,000 population – total – public hospitals[77]

	2020–21	2021–22	2022–23	2023–24	2024–25	Average change (%) since 2020–21	Change (%) since 2023-24
ACT	346.0	317.4	316.9	332.4	350.8	0.3	5.6
Australia	339.6	339.1	333.9	332.7	327.9	-0.9	-1.4

The AIHW provides scheduled data releases. 2023-24 is the latest year available for admitted patient data. The AIHW has announced a scheduled release of the 2024-25 admitted patient data in late May, after this report has been provided to the Minister for Health. The Emergency Department data is available for 2024-25.

As noted previously, the COVID-19 pandemic has significantly impacted the ability to accurately forecast future demand. For the first few years covered by the ACT Health Services Plan, it is possible to compare the annual percentage growth forecasts contained in the Plan, with the actual annual percentage activity growth that is now available and reported on the AIHW website.

[73] AIHW, Admitted Patient Care 2023-24 2: How much Activity was there? Table 2.16.
[74] AIHW, Admitted Patient Care 2023-24 2: How much Activity was there? Table 2.14.
[75] AIHW, Admitted Patient Care 2023-24 2: How much Activity was there? Table 2.2.
[76] AIHW, Emergency department care 2024-25 data tables, Table 2.2.
[77] AIHW, Emergency department care 2024-25 data tables, Table 2.2.

The annual growth forecasts contained in the ACT Health Services Plan are lower than the annual activity growth that has been experienced between 2019-20 and 2023-24 for the following two forecasts:

- Multi-day separations: Services Plan 3.2%pa – Reported Activity 3.5%pa
- Same-day separations: Services Plan 2.7%pa – Reported Activity 7.6%pa

For Emergency Department presentations the ACT Health Services Plan forecasts are higher, with 3.0%pa forecast and the reported activity being 2.2%pa.

The Health Services Plan was prepared and released during the COVID-19 pandemic which made it difficult to forecast activity. Also, the plan was released ahead of the NCH becoming part of CHS. Integrating NCH into CHS provides the opportunity to review clinical service arrangements across the two campuses. There is also the opportunity to build future service arrangements and models of care improvements into the new build of the NCH.

Another factor potentially impacting the ACT forecasts is the commencement of activity based funding in the ACT. The ACT moved to the use of activity based funding at the service level in July 2025. Leading up to this time, there was an increased focus on how current practice interacted with activity based funding. Experience from other jurisdictions indicates that activity increases with the full implementation of activity based funding due to more attention being paid to the relationship between clinical activity and the funding it generates, resulting in increased documentation relating to activity. This could be a factor that has led to the recording of more activity, although the actual activity may not have increased as much.

It will be important to undertake a refresh of the ACT Health Services Plan along with a CHS whole of network clinical services plan (with nested clinical services plans for TCH, NCH and University of Canberra Hospital) including activity forecasts and potential infrastructure needs. The CHS whole of network clinical services plan should identify specific requirements for mental health, alcohol and other drug services and walk-in centres.

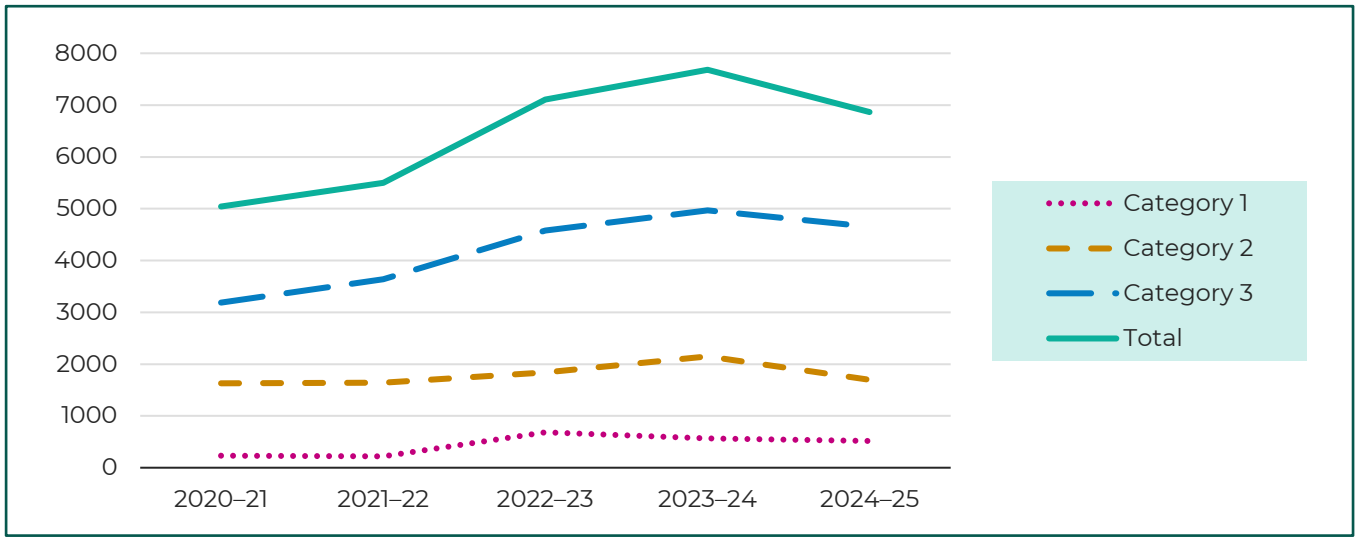
The refresh of the ACT Health Services Plan will include updated activity forecasts that will be based on the most recent recorded activity, analysis regarding the impact of COVID-19, analysis of the impact of the implementation of activity based funding, and any other relevant factors. As with the current ACT Health Services Plan, the refreshed plan should be developed in collaboration with a recognised external health activity modelling organisation.

Elective surgery activity

Figure 14 shows the number of people remaining on the Elective Surgery waiting list from 2020-21 to 2024-25. As can be seen from the figure, the number of people waiting was approximately 5,500 in 2020-21 and was approximately 6,800 in 2024-25, an increase of 1,300 people. The increase over this time is consistent with the available data from Qld and NSW. The Qld Elective Surgery waiting lists were approximately 56,000 in February 2020 and were approximately 60,000 in February 2026.[78] In NSW, the Elective Surgery waiting lists were approximately 90,000 in December 2020 and 92,800 in December 2025.[79] Each of these states have higher numbers on their Elective Surgery waiting lists in 2025-26 than in 2020.

[78] Queensland Health, Planned Surgery Activity, Queensland Government.
[79] Bureau of health information, Data Portal, Elective Surgery, NSW Government.

Figure 14: Patients remaining on the Elective Surgery waiting list[80]



ACT and non-ACT resident activity

Many consultations and submissions provided comments about the proportion of ACT and non-ACT resident activity undertaken in CHS. The Inquiry has been provided details of this cross-border activity as it relates to Emergency Department presentations, Outpatients, Elective Surgery, emergency surgery, and admitted patients. **Figures 15** to **Figure 19** show the proportion of ACT and non-ACT residents accessing these services.

The provision of cross-border services is an agreed component of the NHRA. There is a cross-border agreement in place covering the provision of health services by the ACT for NSW residents who represent the largest proportion of the non-ACT resident activity in the ACT. This cross-border agreement also covers the provision of health services by NSW for ACT residents. Generally, the provision of services by NSW for ACT residents is for Tertiary and very specialised services. The cross-border agreement includes the payment arrangements by each jurisdiction.

As the volume of health activity in the ACT for NSW residents is higher than that provided by NSW for ACT residents, NSW provides a payment to the ACT each year. The exact amount of this payment varies each year as it is calculated using the NEP and the aggregated WAU value of the activity undertaken in each jurisdiction for residents from the other jurisdiction. However, the net payment to the ACT is approximately $100 million each year, representing a significant revenue source to the ACT.

The challenge that this cross-border activity presents for the ACT is that the cost per WAU in the ACT is higher than the NEP, but the payment by NSW to the ACT is based on the NEP. This results in the ACT making up the difference in cost for NSW residents. Using the NEP as the basis for making payments for cross-border activity is consistent with the NHRA.

The ACT is in discussions with IHACPA, who has been tasked by Australian health ministers to undertake work to understand the higher costs for small jurisdictions (ACT, Tas and NT), to see if the higher costs per WAU for smaller jurisdictions can be explained by factors unable to be changed or if they can be reduced by increases in efficiency. This work is currently underway, and the outcome can inform future sustainability initiatives. These cost differences are discussed in more detail in the Sustainability section of this report.

[80] Internal data provided to the Inquiry by HCSD.

The following summarises the average percentages of non-ACT resident activity over recent years:[81]

Emergency Department presentations:	**14.0%** non-ACT residents
Outpatient appointments:	**17.5%** non-ACT residents
Admitted patients	**26.8%** non-ACT residents
Elective Surgery admissions:	**35.0%** non-ACT residents
Emergency Surgery admissions:	**34.0%** non-ACT residents

The percentage of Elective and Emergency surgery admissions is significant at 35% and 34% respectively. The significant difference between the percentage of non-ACT resident Outpatient appointments (17.5%) and Elective Surgery admissions (35.0%) requires further exploration. The consultations have identified possibilities for this difference including:

- The proportion of non-ACT residents presenting to Outpatients who subsequently require Elective Surgery is higher. This could be because of factors such as non-ACT residents only seeking an Outpatient appointment when they are likely to need surgery and/or clinicians referring non-ACT residents for Outpatient appointments after screening-out patients who are less likely to require surgery.
- A greater proportion of non-ACT residents are being referred directly onto the Elective Surgery waiting list after a private specialist appointment and therefore not attending a public Outpatient appointment.

These possibilities are only speculative, and further work is required to understand the reasons behind the difference between the proportion of Outpatient presentations and Elective Surgery admissions for non-ACT residents. The same variation occurs in relation to non-ACT resident Emergency Department presentations (14.0%) and emergency surgery admissions (34.0%).

When undertaking the Outpatient and Elective Surgery patient pathways work, the inclusion of analysing the pathways for ACT and non-ACT residents would be highly valuable.

In relation to admitted patients (26.8% non-ACT residents) it is noteworthy that this is less than the Elective Surgery percentage (35.0% non-ACT residents). As with the variation between Outpatient and Elective Surgery percentages, there are many possible reasons for this variation including that there may be a higher percentage of non-surgery patients from the ACT than from outside the ACT therefore reducing the admitted patient percentage.

As with understanding the Elective Surgery to Outpatient difference, further analysis is required to understand the Elective Surgery to admitted patient difference.

[81] Internal data provided to the Inquiry by HCSD.

Figure 15: Emergency Department presentations by ACT and non-ACT residency[82]

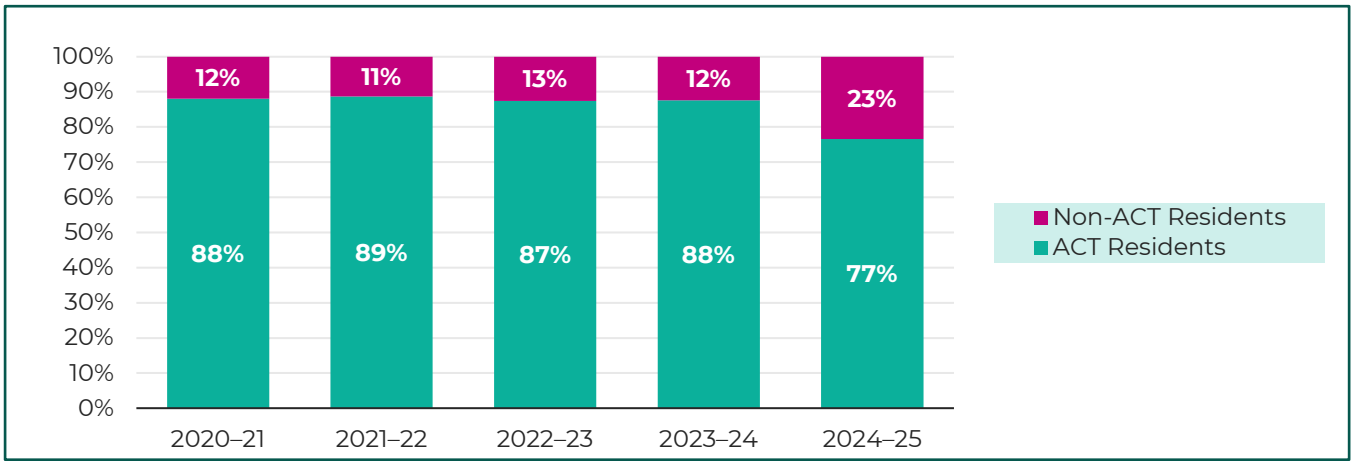


Figure 16: Outpatient appointments by area of usual residence: ACT and non-ACT[83]

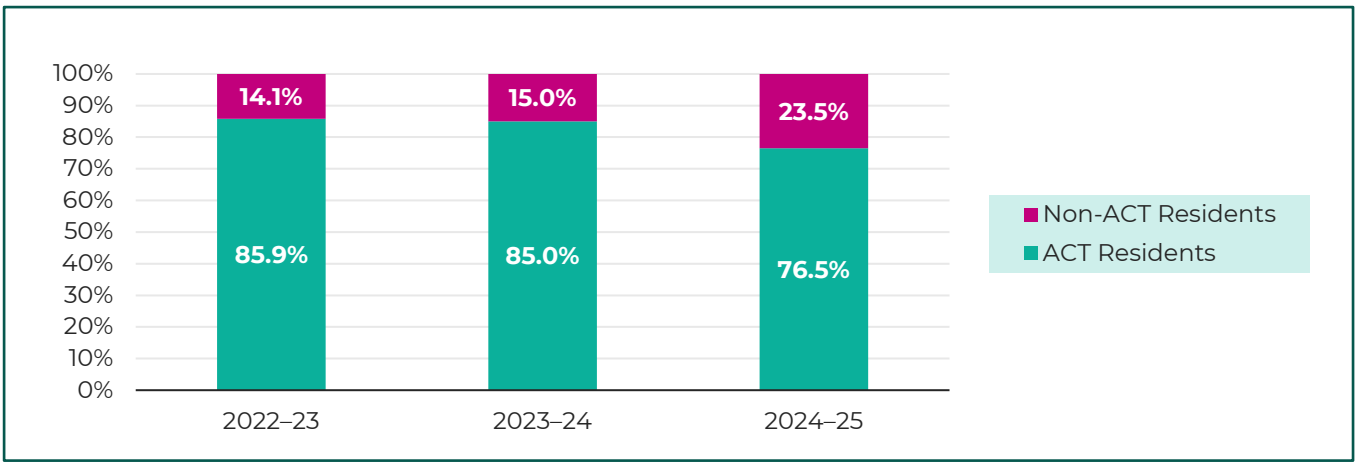
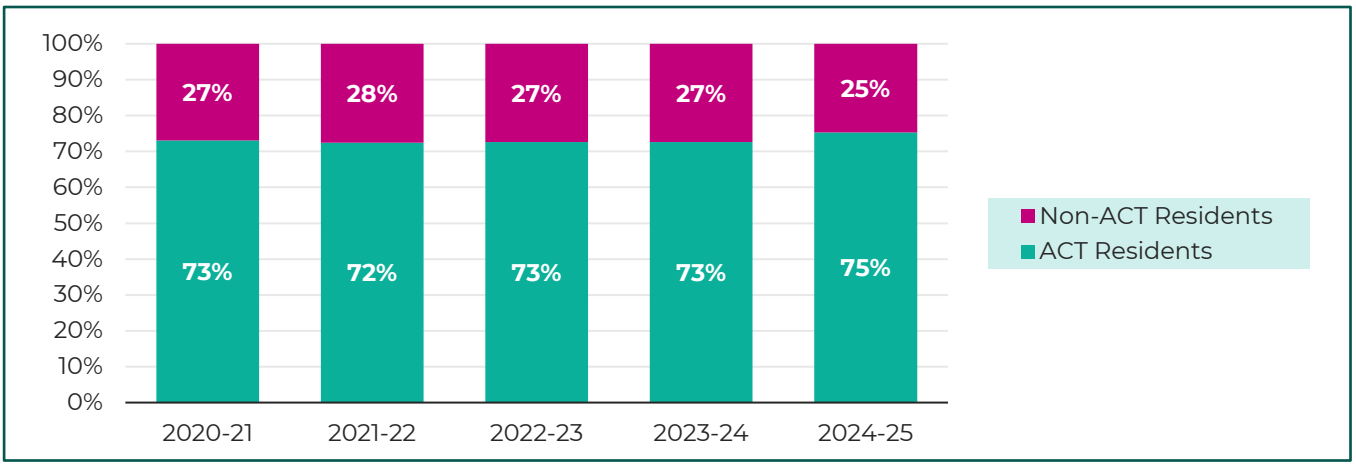


Figure 17: Admitted patients by usual residence ACT and non-ACT[84;85]



[82] Internal data provided to the Inquiry by HCSD.

[83] Internal data provided to the Inquiry by HCSD.

[84] Please note that admitted patients with unknown residency have been excluded from the total. Between FY 2020–21 and FY 2024–25, patients with unknown residency accounted for an average of 0.5% of all admitted patients.

[85] Internal data provided to the Inquiry by HCSD.

Figure 18: Removals from the Elective Surgery waiting list for their scheduled surgery, by area of usual residence: ACT and non-ACT[86]

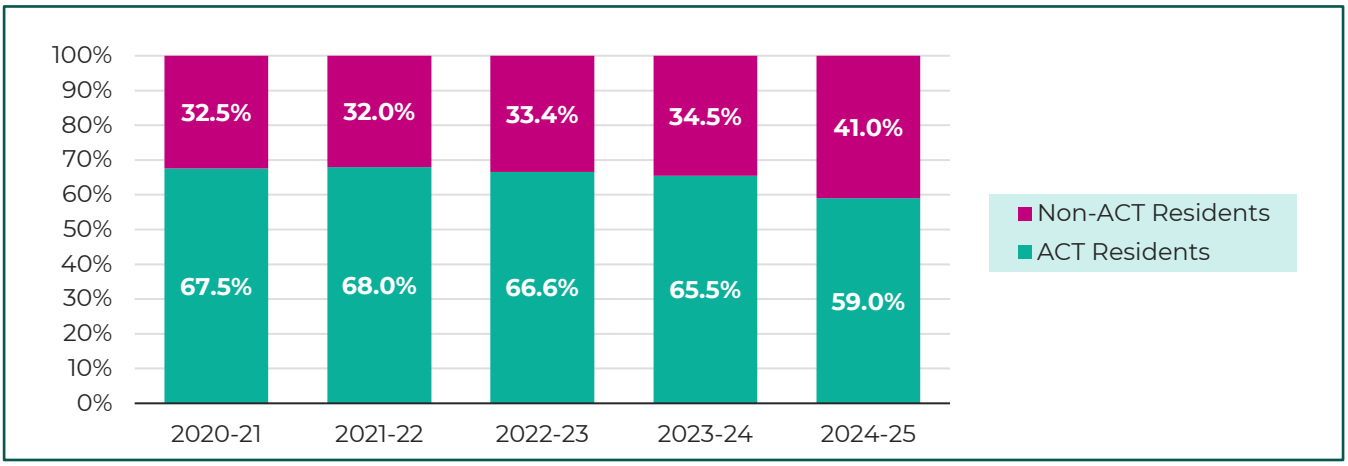
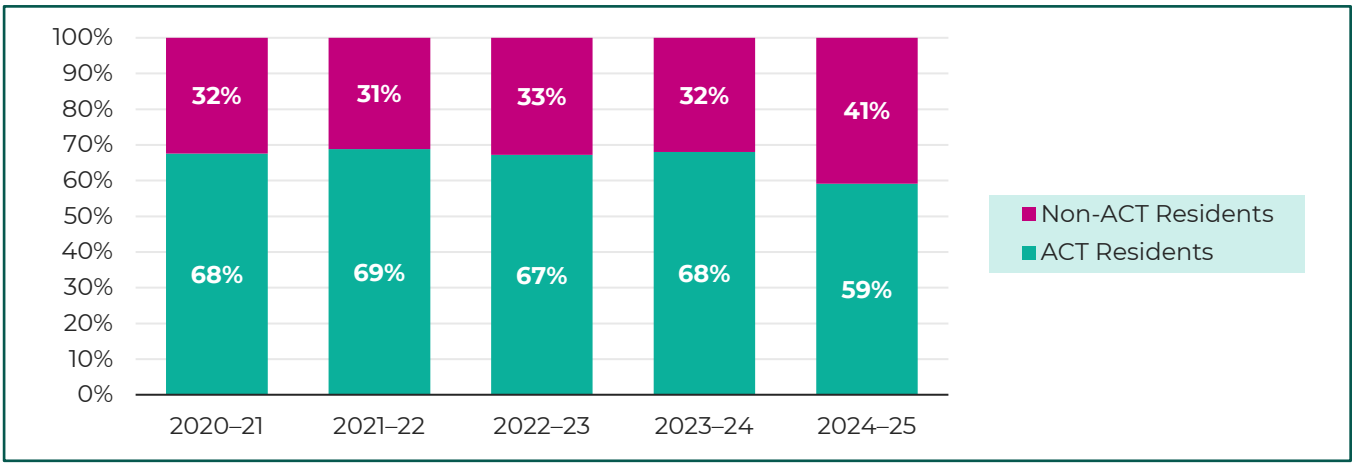


Figure 19: Emergency surgeries undertaken by area of usual residence: ACT and non-ACT[87]



In summary, there is a significant demand for services in the ACT arising from non-ACT residents. This demand has benefits and challenges for the ACT health system. One benefit is that the increased demand leads to increased activity and this allows the ACT to provide more services than if there were lower levels. The volume of activity is the main driver of establishing a service and being able to attract and retain clinicians to effectively and efficiently run the service.

However, given the ACT has a higher cost per WAU, the ACT is having to subsidise the cost of the activity related to non-ACT residents, using solely ACT funds. Also, the NHRA places the full responsibility of the capital costs of services with the State or Territory. This means that the ACT hospitals are fully funded by the ACT health system even though 26.8% of admitted patients are non-ACT residents. To put this in perspective, if the ACT was to build a $1.0 billion hospital, approximately one quarter of this cost is related to non-ACT residents, representing approximately $250 million of the cost of building the hospital.

[86] Internal data provided to the Inquiry by HCSD.
[87] Internal data provided to the Inquiry by HCSD.

Sustainability

Sustainability for the Inquiry is being analysed from two perspectives. The first is performance sustainability and the second is financial sustainability. Although these two components can be related, they may also change independently.

Performance sustainability

The ACT health system provides data to the AIHW in line with the National Health Performance Framework.[88] The Framework has quality and safety, timeliness, access and other measures to provide an understanding of the performance of Australia's health system, and in particular the public hospital systems run by State and Territories.

Table 15 and **Table 16** provide a summary of some performance indicators for emergency care, Elective Surgery and inpatient care for the ACT in comparison with other States and Territories. The data show that in 2024-25 the ACT performed well in comparison with other States and Territories in relation to some indicators but there are others where the ACT's performance is below average. No State or Territory performs above average in all indicators.

In 2024-25, the ACT's performance in relation to Emergency Department waiting times is the best in the country. The rate of Emergency Department presentations per 1,000 population (350.8) is the third highest in the country. However, as discussed in the Demand section of this report, the percentage of non-ACT residents being counted in the ACT Emergency Department presentation data is approximately 14.0%. If the Emergency Department presentations per 1,000 population is adjusted to remove those presentations from non-ACT residents, the result would be 301.7 Emergency Department presentations per 1,000 population meaning that the ACT has the second lowest rate of Emergency Department presentations per 1,000 population for ACT residents.

The impact of non-ACT residents can also be seen in the data relating to admissions from waiting lists for Elective Surgery per 1,000 population. **Table 15** shows that the ACT has the second highest rate of admissions from waiting lists for Elective Surgery per 1,000 population (34.6). When this indicator is adjusted for the approximately 35% of patient admissions for Elective Surgery that are non-ACT residents, the rate is 22.6 which is the lowest for all jurisdictions.

It would be beneficial to develop an agreed nationally consistent methodology regarding how per capita and per 1,000 population performance indicators are calculated so that cross-border activity does not have a significant impact. The ACT is the only jurisdiction where cross-border activity has such a big impact on activity data, and in the absence of an agreed national methodology, the ACT may consider developing a methodology of their own.

From most performance indicators, the ACT has improved its relative performance to other States and Territories from 2021-22 to 2024-25. However, the ACT performance in relation to Elective Surgery waiting times is below the Australian average in 2024-25. Also, the ACT performance has declined since 2021-22.

In summary, the ACT relative performance to other States and Territories has generally improved over the last five years except in Elective Surgery waiting times. The performance indicator data generally supports that the ACT health system is sustainable in relation to performance, although improvements in Elective Surgery access are required.

[88] Australian Institute of Health and Welfare 2024, Australia's Health Performance Framework, AIHW, Canberra.

Table 15: Summary of emergency care, Elective Surgery and inpatient care comparisons (FY 2024-25)

Median wait time to be seen in Emergency Department (ED) (time in minutes)[89]		Percentage of patients seen within clinically recommended times in the ED[90]		Percentage of Indigenous patients seen within clinically recommended times in the ED[91]		ED Presentations (rate per 1000 population)[92]		Percentage of patients whose care was completed in the ED within 4 hours[93]		Percentage of patients whose care was completed in the ED and were admitted to hospital within 4 hours[94]		Percentage of patients who waited longer than 365 days for Elective Surgery[95]		Percentage of patients who were admitted for public hospital Elective Surgery within clinically recommended times[96]		Admissions from waiting lists for Elective Surgery (by 1,000 population)[97]		Average length of stay in public hospitals (excludes same-day discharges) (FY 2023-24)[98]		Average public cost weights for acute separations in public hospitals (FY 2023-24)[99]	
Qld	15	NSW	73.30%	NSW	73.10%	Vic	278.7	**ACT**	**60.80%**	**ACT**	**48.70%**	Qld	3.40%	Vic	84.40%	Tas	39.2	Qld	5	NT	0.58
Vic	15	Qld	72.40%	Qld	73.00%	Qld	313.1	NSW	56.30%	Vic	36.80%	Vic	4.20%	NSW	82.60%	**ACT**	**34.6**	NT	5.4	Vic	0.97
NSW	15	Vic	71.50%	Vic	66.70%	Tas	314.2	WA	53.90%	Qld	31.40%	Tas	5.00%	Qld	81.10%	SA	32.6	WA	5.5	Tas	1.01
ACT	**25**	**ACT**	**61.70%**	WA	60.70%	SA	323.7	NT	53.60%	NT	29.20%	WA	5.30%	WA	80.00%	VIC	30.5	**ACT**	**5.6**	Qld	1.01
SA	29	SA	53.40%	SA	60.10%	WA	342.8	Vic	52.70%	SA	27.90%	SA	6.00%	SA	71.80%	WA	30.1	Vic	5.8	**ACT**	**1.04**
Tas	35	NT	48.20%	**ACT**	**59.90%**	**ACT**	**350.8**	Qld	49.90%	NSW	24.50%	NT	8.20%	NT	68.30%	NSW	27.4	NSW	6.3	SA	1.09
NT	37	Tas	46.00%	NT	52.80%	NSW	361.5	SA	49.60%	WA	23.10%	NSW	9.20%	**ACT**	**66.50%**	Qld	26.8	SA	6.4	WA	1.1
WA	44	WA	45.60%	Tas	44.90%	NT	739.5	Tas	47.50%	Tas	20.50%	**ACT**	**9.40%**	Tas	65.10%	NT	24.6	Tas	6.5	NSW	1.15

Table 16: Summary of emergency care, Elective Surgery and inpatient care comparisons (FY 2021-22)

Median wait time to be seen in ED (time in minutes)[100]		Percentage of patients seen within clinically recommended times in the ED[101]		Percentage of Indigenous patients seen within clinically recommended times in the ED[102]		ED Presentations (rate per 1000 population)[103]		Percentage of patients whose care was completed in the ED within 4 hours[104]		Percentage of patients whose care was completed in the ED and were admitted to hospital within 4 hours[105]		Percentage of patients who waited longer than 365 days for Elective Surgery[106]		Percentage of patients who were admitted for public hospital Elective Surgery within clinically recommended times[107]		Admissions from waiting lists for Elective Surgery (by 1,000 population)[108]		Average length of stay in public hospitals (excludes same-day discharges) (FY 2021-22)[109]		Average public cost weights for acute separations in public hospitals (FY 2021-22)[110]	
NSW	14	NSW	77%	NSW	77%	Vic	279.6	WA	64.60%	SA	39.10%	Qld	3.30%	Vic	79.60%	Tas	35.8	Qld	5	NT	0.59
Qld	18	Qld	68%	Qld	68%	Tas	305.3	NSW	64.20%	Qld	39%	Vic	4.70%	NSW	82.70%	**ACT**	**31.0**	NT	5.4	Vic	0.96
Vic	22	Vic	63%	WA	63%	SA	313.2	Qld	61.40%	Vic	36.90%	WA	4.90%	Qld	84.50%	SA	29.3	WA	5.5	Qld	0.96
SA	26	NT	57%	SA	63%	**ACT**	**317.4**	NT	58.80%	WA	34%	**ACT**	**5.80%**	WA	81.40%	NT	27.0	Vic	5.8	Tas	1.02
NT	29	SA	55%	Vic	62%	Qld	359.3	SA	57.60%	**ACT**	**33%**	SA	6.20%	SA	75.90%	WA	25.8	SA	6.1	SA	1.07
Tas	31	Tas	53%	NT	61%	WA	360.6	Vic	55.30%	NSW	28.70%	NT	7.20%	NT	67.90%	Qld	24.5	**ACT**	**6.3**	**ACT**	**1.08**
WA	40	WA	50%	Tas	51%	NSW	365.6	Tas	55.20%	NT	27.40%	NSW	9.60%	**ACT**	**77.70%**	NSW	22.6	Tas	6.5	WA	1.12
ACT	**47**	**ACT**	**48%**	**ACT**	**48%**	NT	707.8	**ACT**	**52.40%**	Tas	24.50%	Tas	12.00%	Tas	57.20%	Vic	22.6	NSW	6.6	NSW	1.17

[89] AIHW, Emergency department care 2024–25 data tables, Table 5.1.
[90] AIHW, Emergency department care 2024–25 data tables, Table 5.3.
[91] AIHW, Emergency department care 2024–25 data tables, Table 5.5
[92] AIHW, Emergency department care 2024–25 data tables, Table 2.2
[93] AIHW, Emergency department care 2024–25 data tables, Table 6.3.
[94] AIHW, Emergency department care 2024–25 data tables, Table 6.3.
[95] AIHW, Elective surgery waiting times 2024-25 data tables, Table 4.2.
[96] AIHW, Elective surgery waiting times 2024-25 data tables, Tables 4.11 to 4.18.
[97] AIHW, Elective surgery waiting times 2024-25 data tables, Table 2.4.
[98] AIHW, Admitted patient care 2023–24 2: How much activity was there?, Table S2.8.
[99] AIHW, Admitted patient care 2023-24 7: Costs and funding, Table 7.2.
[100] AIHW, Emergency department care 2024–25 data tables, Table 5.1.
[101] AIHW, Emergency department care 2021-22 data tables, Table 5.3.
[102] AIHW, Emergency department care 2021-22 data tables, Table 5.5.
[103] AIHW, Emergency department care 2024–25 data tables, Table 5.5.
[104] AIHW, Emergency department care 2024–25 data tables, Table 6.3.
[105] AIHW, Emergency department care 2024–25 data tables, Table 6.3.
[106] AIHW, Elective surgery waiting times 2021-22 data tables, Table 4.2.
[107] AIHW, Elective surgery waiting times 2021-22 data tables, Tables 4.11 - 4.18.
[108] AIHW, Elective surgery waiting times 2024-25 data tables, Table 2.4.
[109] AIHW, Admitted patient care 2021-22 2: How much admitted patient activity? Table S2.8.
[110] AIHW, Admitted patient care 2021-22: Costs and funding, Table 7.2.

Public hospital activity

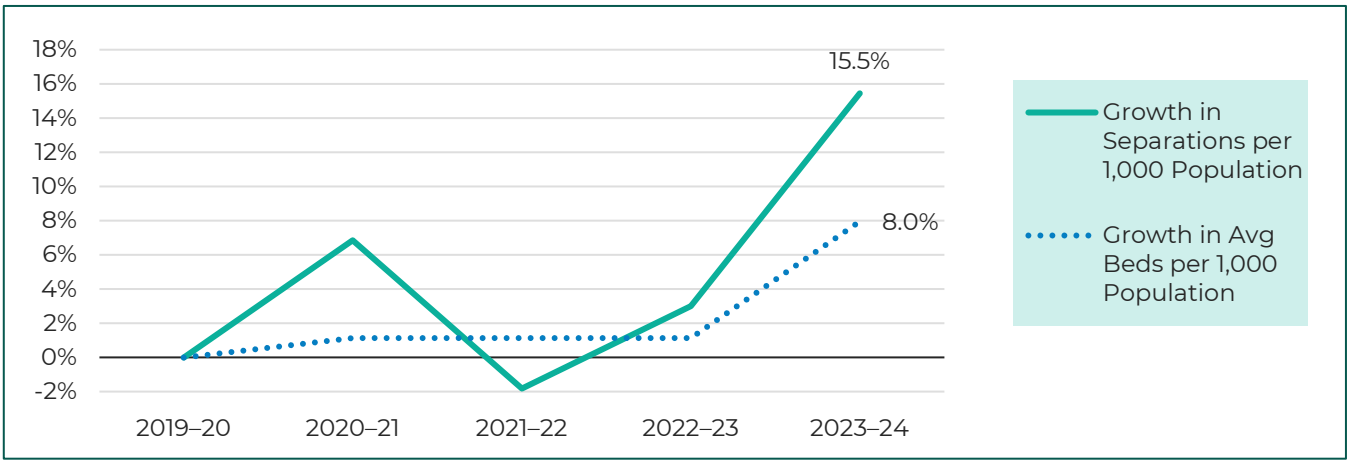
The NHRA Mid-Term Review published in October 2023, proposed an interim Performance Framework using the following structure:

- **Equity:** Ensures fair access to healthcare services for all individuals, regardless of socioeconomic, geographic, or demographic factors.
- **Effectiveness**: Focuses on delivering evidence-based healthcare services that achieve desired health outcomes.
- **Efficiency:** Aims to maximise the value of healthcare resources by optimising time, workforce, and financial investments.
- **Sustainability:** Builds a resilient system capable of adapting to future challenges while maintaining long-term viability.
- **Intersectoral collaboration:** Encourages partnerships across sectors to address complex health challenges and improve population health.
- **Transparency and reporting:** Establishes mechanisms for clear communication, accountability, and performance measurement to build trust among stakeholders.

The NHRA Addendum 2026-31 commits to developing a new Australian health system Performance Framework. To assist the analysis for this Inquiry, selected performance indicators from the (NHRA) Mid-Term Review interim Performance Framework have been calculated and are presented in **Figures 20** to **Figure 33**. These indicators provide a way of analysing the performance sustainability of the ACT health system compared to all Australian jurisdictions.

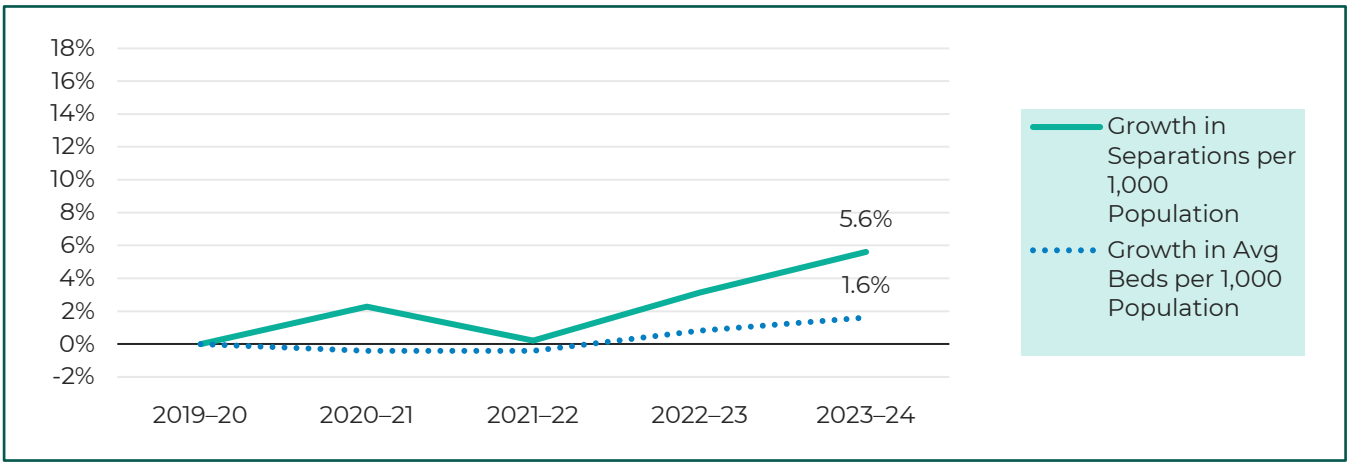
As visualised in **Figure 20** and **Figure 21**, since 2019-20, public hospital activity in the ACT and hospital bed capacity has proportionally grown faster in the ACT compared to national growth. Growth in hospital separations per 1,000 population in the ACT is 3 times higher and growth in average bed capacity per 1,000 population is 5 times higher than the per capita growth observed nationally.

Figure 20: How has public hospital activity changed relative to hospital beds on a per 1,000 population basis in the ACT?[111;112;113]



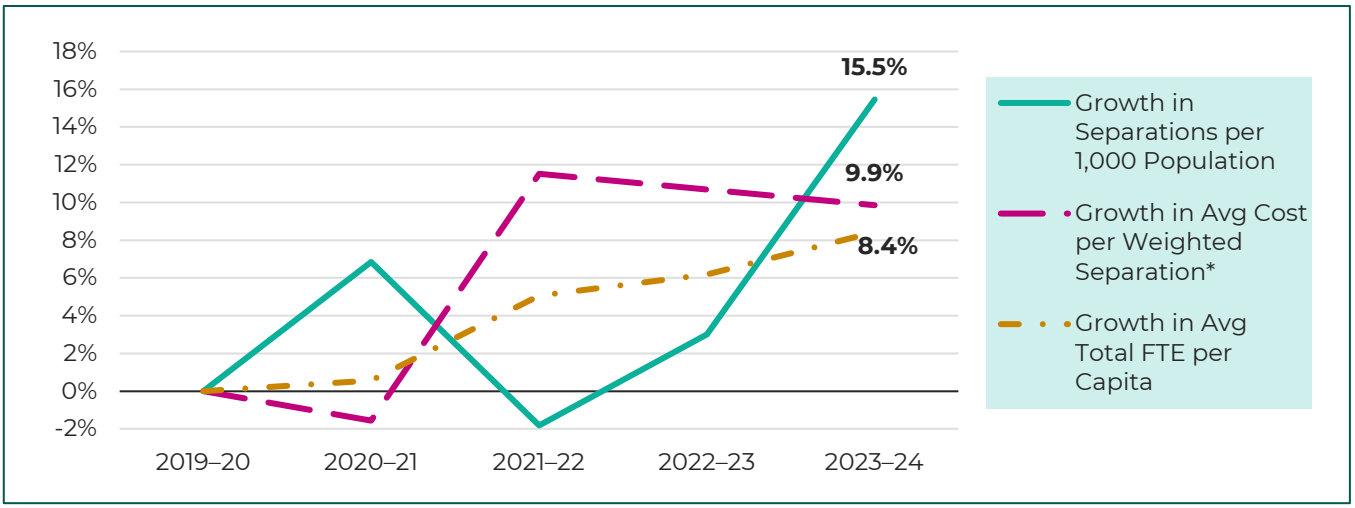
[111] AIHW, Admitted patient Care 2023-24 2: How much activity was There? Table 2.2. Accessed 11 February 2026.
[112] ABS, National, state and territory population. Table 4 Estimated Resident Population, States and Territories, Data1. Accessed 6 March 2026.
[113] AIHW, Hospital resources 2023-24 data tables, Table 4.6. Accessed 12 February 2026.

Figure 21: How has public hospital activity changed relative to hospital beds on a per 1,000 population basis in Australia?[114;115;116]



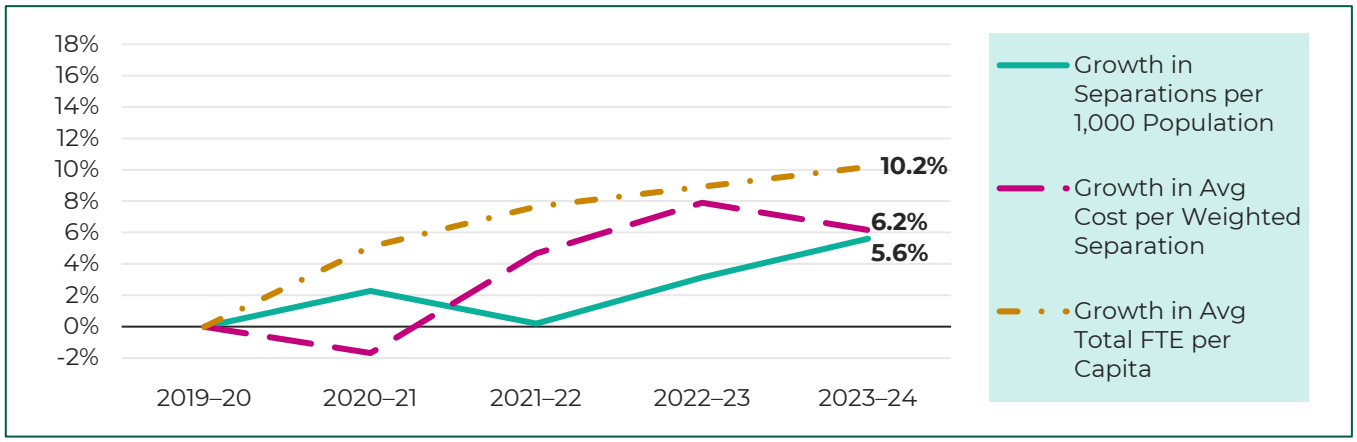
As shown in **Figure 22** and **Figure 23**, in the ACT since 2019-20, separations per 1,000 population grew at a significantly higher rate compared to the growth of FTE per capita. FTE per capita growth was slightly lower in the ACT compared to Australia, and the growth of cost of weighted separation is slightly higher in ACT compared to Australia. The ACT has observed a significantly higher growth in separations per 1,000 population compared to Australia. If the trend continues and growth in separations per 1,000 population in the ACT continue to grow at a higher rate than FTE per capita, this is an indication of increasing efficiency in the ACT system.

Figure 22: How have key hospital activity measures changed relative to key supply measures in the ACT?[117;118;119;120]



[114] AIHW, Admitted patient Care 2023-24 2: How much activity was There? Table 2.2. Accessed 11 February 2026.
[115] ABS, National, state and territory population. Table 4 Estimated Resident Population, States and Territories, Data1. Accessed 6 March 2026.
[116] AIHW, Hospital resources 2023-24 data tables. Table 4.6. Accessed 12 February 2026.
[117] *Growth in Average Cost per Weighted Separation for FY 2022-23 is interpolated due to data not being available.
[118] RoGS 2026. Part E, Section 12 Public Hospitals. Table 12A.9. Accessed 18 February 2026.
[119] AIHW, Admitted patient Care 2023-24 2: How much activity was there? Table 2.2. Accessed 11 February 2026.
[120] RoGS 2026. Part E, Section 12 Public Hospitals. Table 12A.55. Accessed 18 February 2026.

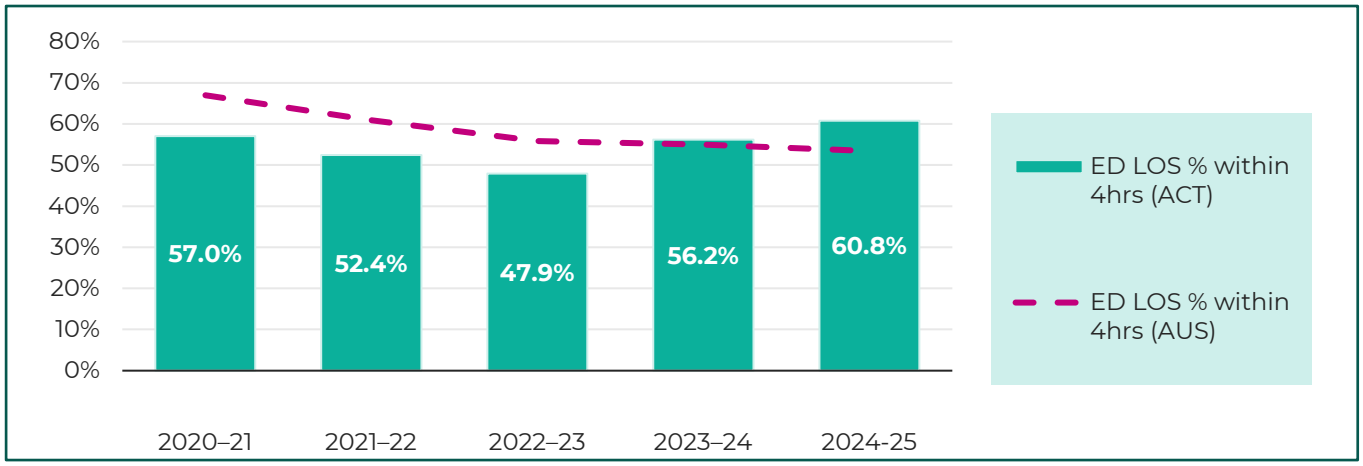
Figure 23: How have key hospital activity measures changed relative to key supply measures in Australia?[121;122;123]



Emergency Department presentations

As illustrated in **Figure 24**, since 2020-21, the proportion of ACT Emergency Department presentations that depart the Emergency Department within four hours has been relatively consistent, whereas the national proportion declined over the years to a level that is below the rate of Emergency Department presentations departing within 4 hours in the ACT.

Figure 24: Has the proportion of Emergency Department presentations that depart Emergency Department within 4 hours changed over time?[124]

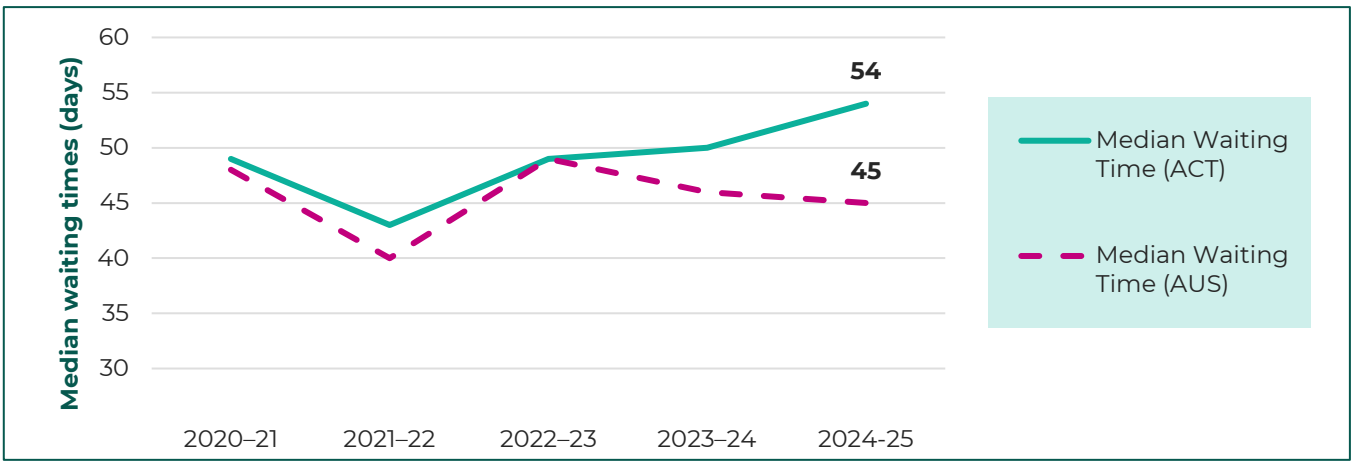


[121] RoGS 2026. Part E, Section 12 Public Hospitals. Table 12A.9. Accessed 18 February 2026.
[122] AIHW, Admitted patient Care 2023-24 2: How much activity was there? Table 2.2. Accessed 11 February 2026.
[123] RoGS 2026. Part E, Section 12 Public Hospitals. Table 12A.55. Accessed 18 February 2026.
[124] RoGS 2026. Part E, Section 12 Public Hospitals. Table 12A.18. Accessed 18 February 2026.

Elective Surgery waiting times

Figure 25 shows that between 2020-21 and 2024-25, median wait times for Elective Surgery increased in the ACT while the Australian median wait times reduced during this period. In 2024-25, the median wait time was 54 days in the ACT, compared with 45 days nationally. This data indicates that Elective Surgery wait times is an area for improvement in the ACT.

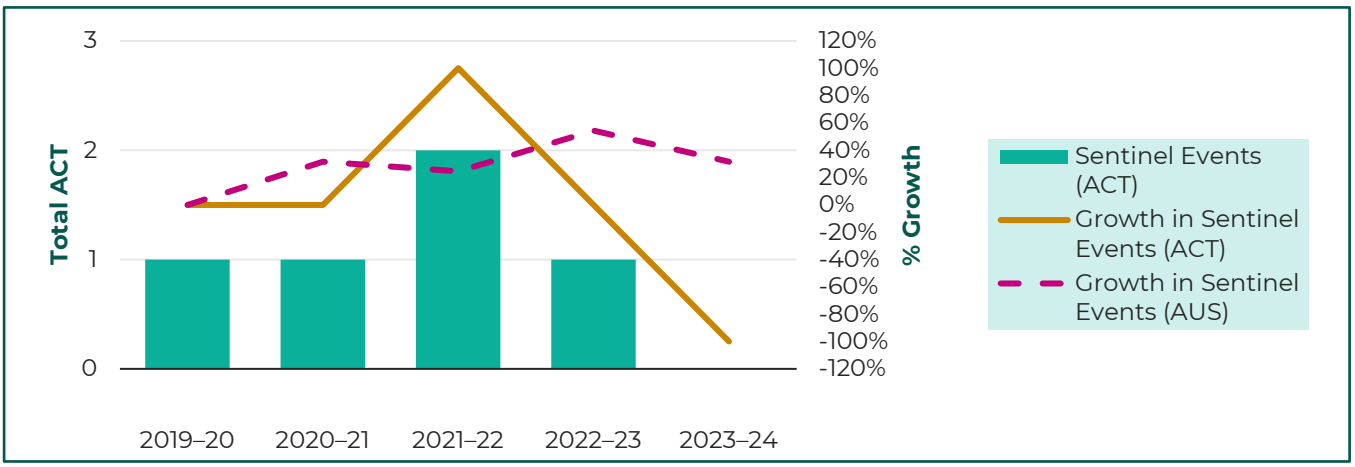
Figure 25: Have Elective Surgery waiting times improved over time?[125]



Quality and safety into public hospital funding

As shown in **Figure 26**, since 2019-20, the ACT rate of sentinel events was consistently lower than the national average, except for 2021-22 which measured higher. No sentinel events have been reported for the 2023-24 period in the ACT.

Figure 26: How has linking of quality and safety into public hospital funding impacted performance?[126]

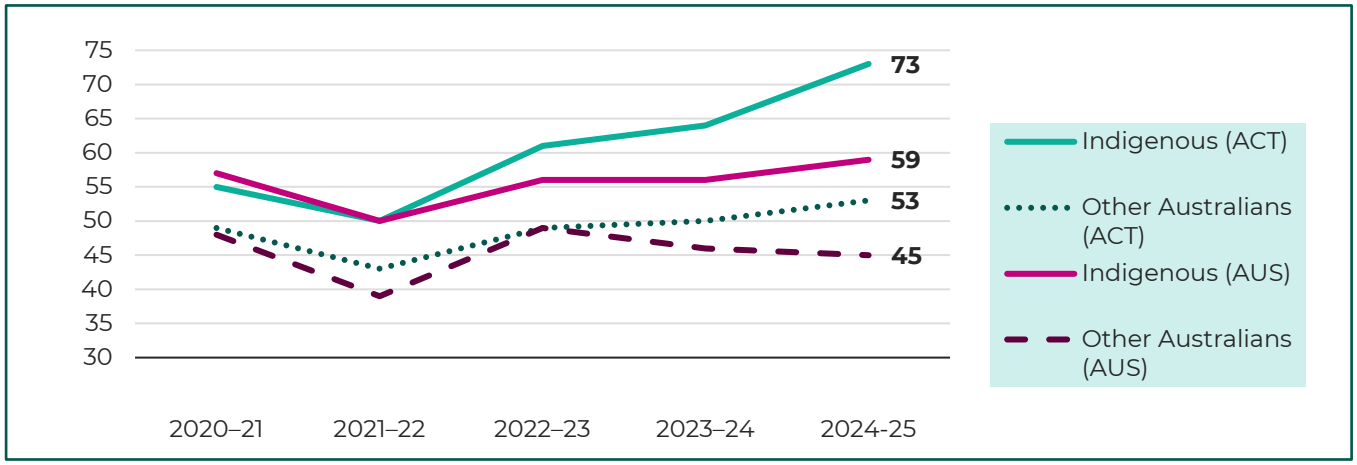


[125] RoGS on Government Services 2026. Part E, Section 12 Public Hospitals. Table 12A.34. Accessed 18 February 2026.
[126] RoGS 2026. Part E, Section 12 Public Hospitals. Table 12A.42. Accessed 18 February 2026.

Indigenous patient equity and equality

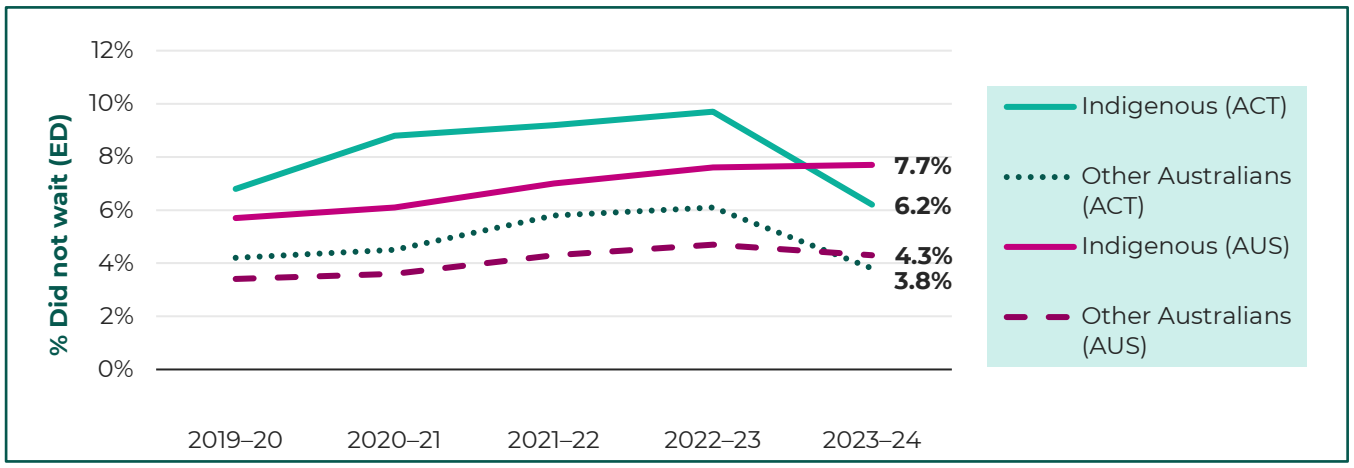
As shown in **Figure 27**, Indigenous patients in the ACT are waiting longer for Elective Surgery than non-Indigenous patients. The gap increased in the ACT from 2020-21 to 2024-2025, whereas the national difference between Indigenous and non-Indigenous patients remained reasonably consistent over this time. It is important that work is undertaken to address the increasing difference in wait times in the ACT for Indigenous and non-Indigenous patients.

Figure 27: Are Indigenous patients waiting longer for Elective Surgery than non-Indigenous patients?[127]



As shown in **Figure 28**, since 2019-20, Indigenous patients in the ACT left Emergency Departments at their own risk at higher rates than non-Indigenous patients. In 2023-24, the rates for Indigenous patients leaving Emergency Department in the ACT have decreased below nationally reported levels.

Figure 28: Are Indigenous patients compared to non-Indigenous patients leaving without receiving care at elevated rates? (% Patients did not wait to be seen in Emergency Department)[128]

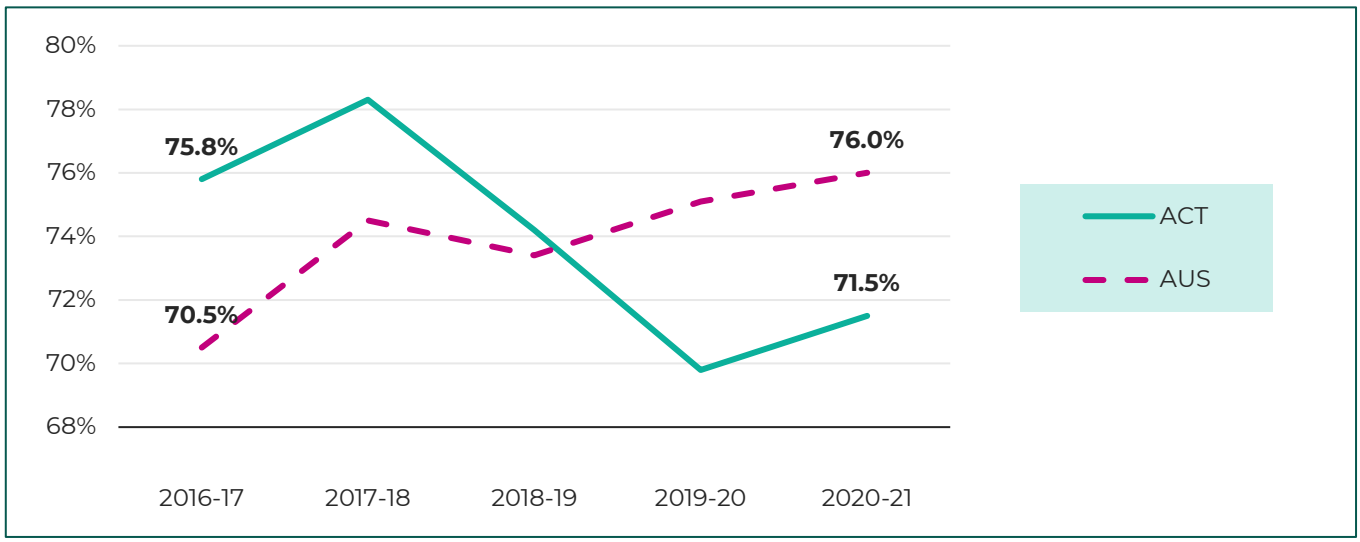


[127] RoGS 2026. Part E, Section 12 Public Hospitals. Table 12A.24. Accessed 18 February 2026.
[128] RoGS 2026. Part E, Section 12 Public Hospitals.. Table 12A.37. Accessed 18 February 2026.

Mental health follow-up rates

As illustrated in **Figure 29**, since 2016-17, the rate of follow-up for mental health patients within seven days of discharge has declined in the ACT and fell below the national average in 2019-20 and 2020-21. More recent data is not available from the ACT due to data reporting issues following the implementation of the DHR.

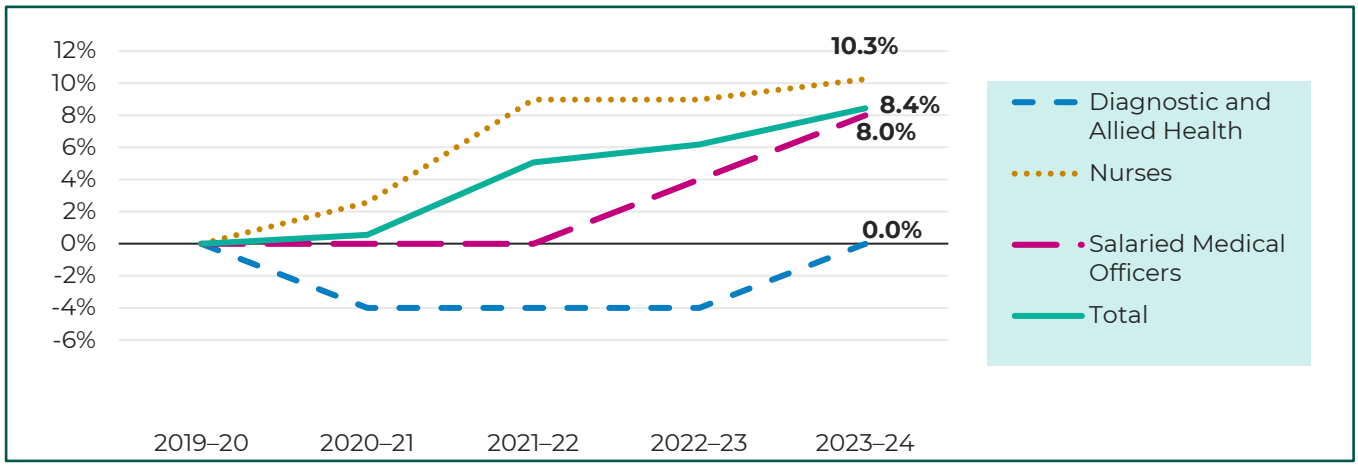
Figure 29: Has the rate of follow-up for mental health patients after acute inpatient episode of care changed over time?[129]



Workforce growth

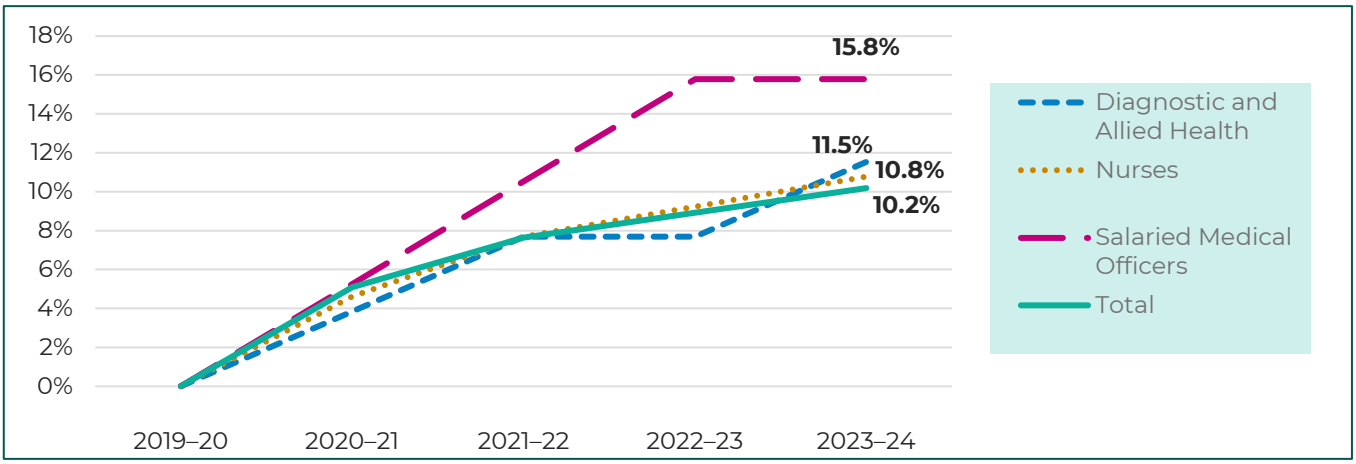
As shown in **Figure 30** and **Figure 31**, since 2019-20, the health workforce in the ACT has grown by 8.4% average FTE per capita, compared to a 10.2% growth across all of Australia. Compared to the national growth in average FTE per capita, which observed growth across all workforce types, the growth in the ACT is driven by growth in average FTE per capita mainly for nurses. Nationally, salaried medical officers observed the highest growth of average FTE per capita.

Figure 30: How have medical practitioners, nurses, allied health professionals and total health workforce grown over time in the ACT?[130]



[129] RoGS 2026. Part E, Section 13 Services for Mental Health. Table 13A.35. Accessed 18 February 2026.
[130] RoGS 2026. Part E, Section 12 Public Hospitals. Table 12A.9. Accessed 18 February 2026.

Figure 31: How have medical practitioners, nurses, allied health professionals and total health workforce grown over time in Australia?[131]



Financial sustainability

As noted in the ToR, the Inquiry provided updates to the Health System Sustainability Taskforce (now known as the LHN Assurance Committee). The LHN Assurance Committee consists of representatives from ACT Treasury, HCSD and CHS. The recommendations contained in this report relating to sustainability would best be overseen by the LHN Assurance Committee, in collaboration with the nominated Inquiry implementation oversight committee.

Table 17 provides a comparison of the growth in total expenditure as reported to the AIHW. The national annual average growth in total expenditure from 2019-20 to 2023-24 is 4.9% compared to the ACT which was slightly higher at 5.0%. It needs to be noted that during this time, the ACT Government took over the running of the NCH, which may affect these figures. The closeness of the expenditure growth rates for the ACT and Australia indicate that the ACT is growing its health expenditure at a rate comparable to other States and Territories.

Table 17: Recurrent expenditure on public hospitals ($ million, constant prices) - public hospitals[132]

	2019–20	2020–21	2021–22	2022–23	2023–24	Average change (%) since 2019–20	Change (%) since 2022-23
ACT	1,777	1,808	1,938	2,000	2,162	5.0	8.1
Australia	59,964	54,065	56,627	60,739	64,173	4.9	5.7

Another expenditure comparison between States and Territories is the average annual salaries for hospital staff by work group. **Table 18** and **Table 19** are extracts from the AIHW data tables: Hospital Resources 2022–23: Australian hospital statistics.[133] The data in these tables is difficult to compare because of the different enterprise agreements in place, appointment methods (e.g. salaried versus contract), and methodologies to calculate a Full Time Equivalent comparator. The most variation because of these challenges relates to the comparison of medical officers.

[131] RoGS 2026. Part E, Section 12 Public Hospitals. Table 12A.9. Accessed 18 February 2026.
[132] AIHW, Hospital resources 2023-24 data tables, Table 2.5.
[133] AIHW, Hospital resources 2023-24 data tables, Table 3.4.

Table 18: Extract from the AIHW data tables: Hospital Resources 2023–24, Table 3.4 [Extract]: Average salaries(a)(b)[134] ($), full-time equivalent (FTE) staff, public hospital services, states and territories, 2023–24[135]

	NSW(c)	Vic(d)	Qld	WA(e)	SA(f)	Tas(g)	ACT	NT	Total
All levels of reporting									
Specialist salaried medical officers(h)	314,216	476,737	524,736	0	507,410	277,386	439,494	330,227	426,990
Other salaried medical officers(h)	162,206	179,468	180,349	256,710	186,997	372,704	174,501	0	193,347
Salaried medical officers—total(h)	212,282	288,989	280,043	256,710	302,506	341,257	253,789	330,227	264,126
Nurses—total(i)	111,788	125,172	135,744	117,823	127,676	130,856	121,571	153,726	123,453
Diagnostic and allied health professionals	97,679	113,575	126,454	108,166	141,973	134,184	119,648	120,947	110,809
Administrative and clerical staff(j)	91,489	105,340	102,461	98,926	83,241	88,361	111,933	98,582	97,892
Domestic and other personal care staff	66,384	78,715	95,063	81,455	48,715	72,841	86,402	104,450	79,209
Total	**112,280**	**136,911**	**142,877**	**126,842**	**137,425**	**139,823**	**133,825**	**155,259**	**129,852**
Administrative level									
Public hospital	120,123	0	147,901	125,455	137,425	141,789	133,825	157,790	132,182
Local hospital network	107,683	137,047	117,884	137,609	0	129,176	0	144,725	134,410
Jurisdiction	72,217	105,118	183,406	96,626	0	0	0	0	74,923
Total	**112,280**	**136,911**	**142,877**	**126,842**	**137,425**	**139,823**	**133,825**	**155,259**	**129,852**

[134] Note that the letters in brackets refer to footnotes for the table that can be viewed in the full table. AIHW, Hospital resources 2023-24 data tables, Table 3.4.
[135] AIHW, Hospital resources 2023-24 data tables, Table 3.4.

Table 19: Extract from the AIHW data tables: Hospital Resources 2020-21, Table 3.4 [Extract]: Average salaries(a)(b)[136] ($), FTE staff, public hospital services, states and territories, 2020-21[137]

	NSW[(c)]	Vic[(d)]	Qld	WA[(e)]	SA[(f)]	Tas[(g)]	ACT	NT[(e)]	Total
All levels of reporting									
Specialist salaried medical officers[(h)]	287,369	438,839	422,733		450,338	226,730	452,519	296,892	377,241
Other salaried medical officers[(h)]	131,642	162,362	169,892	245,360	148,232	281,785	151,606	0	170,163
Salaried medical officers—total[(h)]	180,556	263,099	243,675	245,360	253,987	262,831	242,955	296,892	232,501
Nurses—total[(i)]	104,106	113,016	120,900	103,773	109,170	107,279	114,936	134,335	111,102
Diagnostic and allied health professionals	87,398	104,023	118,665	98,581	106,729	105,876	104,010	115,068	99,827
Administrative and clerical staff[(j)]	81,116	90,837	84,101	89,909	70,913	74,168	97,021	90,450	84,800
Domestic and other personal care staff	56,003	69,031	77,107	69,643	58,249	62,344	73,032	79,843	67,675
Total	**100,358**	**121,611**	**123,454**	**114,474**	**118,571**	**112,028**	**123,561**	**134,613**	**114,413**
Administrative level									
Public hospital	109,084	0	130,671	113,914	119,170	113,102	123,561	137,775	117,665
Local hospital network	106,158	121,675	97,399	119,022	0	106,167	0	124,630	117,634
Jurisdiction	51,663	105,548	117,531	96,664	75,974	0	0	0	55,824
Total	**100,358**	**121,611**	**123,454**	**114,474**	**118,571**	**112,028**	**123,561**	**134,613**	**114,413**

[136] Note that the letters in brackets refer to footnotes for the table that can be viewed in the full table. AIHW, Hospital resources 2020-21 data tables, Table 3.4.
[137] AIHW, Hospital resources 2020-21 data tables, Table 3.4.

The average salaries data for 2023-24 indicates that the ACT has an average total salary for all employee groups combined that is comparable to the average for Australia (ACT $133,825 and Australia $129,852). This comparability holds for salaried medical officers, and nurses.

The average salaries data for the 2020-21 financial year (**Figure 32**) indicates a wider variation between the ACT salaries and those for Australia. In relation to medical officers, the average annual salary for the ACT in 2020-21 was $242,955 compared to the national average of $232,501, a difference of $10,454.

The variation for nurses is smaller in each year but reflects that same pattern as medical officers with a greater variation in 2020-21 than in 2023-24. In 2023-24, the ACT average salary was $1,882 less than the Australian average and in 2020-21, the ACT was $3,834 more than the Australian average.

Figure 32 visualises how average salaries for FTE staff across jurisdictional public hospital services vary. In 2021-22, the lowest average salary was measured in the NT at $101,185 per annum. This significantly increased in the following reporting periods to be the highest in all jurisdictions in 2023-24, with an average total of $155,259. ACT's average salary throughout the three reporting periods was $127,041, $128,802 and $133,825, respectfully. Average salaries in the ACT increased by 1.4% from 2021-22 to 2022-23 and 4% from 2022-23 to 2023-24.[138]

Figure 32: Average salaries for FTE staff across jurisdictional public hospital services[139]

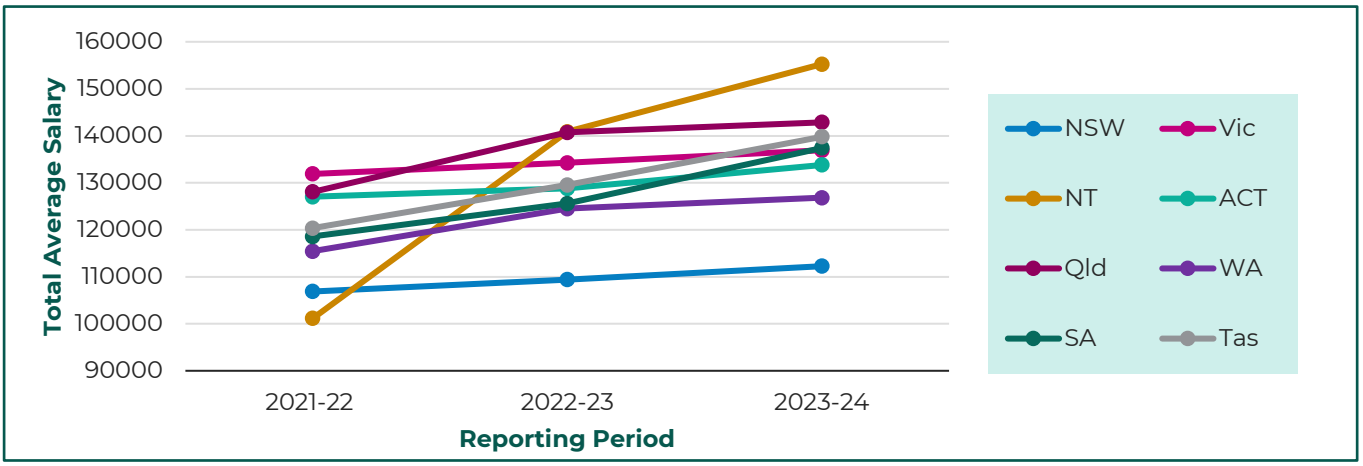
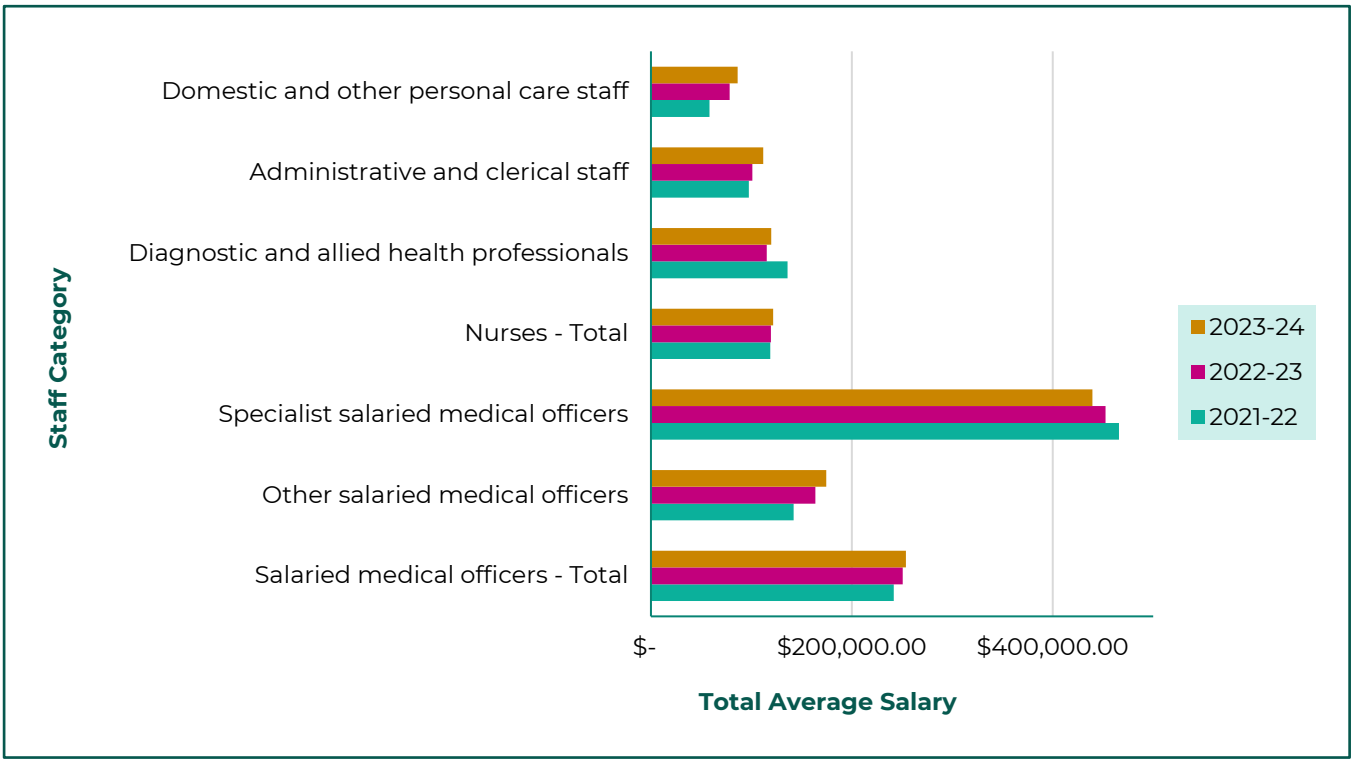


Figure 33 shows how average salaries for FTE staff in ACT public hospital services vary. Whilst average salaries for total specialist and other salaried medical staff increased, this was a result of an increase in salaried medical staff and a decrease in specialist medical staff. The only other staffing category that has a small decrease was diagnostic and allied health professionals.[140]

As mentioned earlier, drawing strong conclusions from this data should be avoided. However, the comparison of ACT average salaries to the average Australian salaries over time indicates that the ACT is not increasing its salaries at a greater rate than the rest of Australia, therefore most likely not contributing to any sustainability issues.

[138] AIHW, Hospital resources 2023-24 data tables, Table 3.2.
[139] AIHW, Hospital resources 2023-24 data tables, Table 3.4.
[140] AIHW, Hospital resources 2023-24 data tables, Table 3.4.

Figure 33: Average salaries for FTE staff in ACT public hospital services[141]



Summary of current state

The ACT Health Services Plan 2022–2030 outlines the strategic direction for health services in the ACT over an eight-year period. The ACT Health Services Plan 2022–2030 was developed through a structured and systematic approach to designing, delivering and optimising services. This included extensive consultation and engagement with health services, consumers and carers, along with detailed research and analysis. An external health planning organisation was contracted to undertake the service plan modelling.

The ACT Health Services Plan 2022–2030 provides activity forecasts for TCH and the NCH out to 2031-32. The actual activity growth covering the first few years of the health services plan have exceeded the forecast growth, except for Emergency Department presentations.

Sustainability has been analysed from a performance and financial perspective. This analysis indicates that activity growth in the ACT is higher than the average growth rate of the other jurisdictions. However, the timeliness, effectiveness and access performance indicators analysed suggest that the ACT is generally maintaining performance as the activity is increasing.

In relation to financial sustainability, the ACT average staff salaries are growing at a rate comparable to other jurisdictions and are also comparable to other jurisdictions.

[141] AIHW, Hospital resources 2023-24 data tables, Table 3.4.

5.3 Future state recommendations

Updating of the ACT Health Service Plan

The current ACT Health Services Plan 2022-30 was published prior to the transition of the NCH into CHS, the commencement of network arrangements across TCH and NCH, the implementation of activity based funding in the ACT, and implementation of the DHR. The ACT Health Services Plan 2022-30 was also developed during the COVID-19 pandemic when health activity was considerably disrupted. These factors have significantly impacted healthcare service planning, prompting changes to demand for healthcare services, and a shift in how care is delivered. The actual activity growth rates in the first few years of the current plan have exceeded the growth rates forecast in the plan, except for the Emergency Department presentations.

To ensure the ACT health system remains responsive and relevant to these changes, HCSD, in collaboration with CHS, should undertake a refresh of the ACT Health Service Plan 2022-30, with an updated timeframe of 2027-35. The plan may not be finalised in the 2027 calendar year. However, basing the activity forecasts from 2027 onwards will provide the closest year to the most recent actual activity in relation to this plan.

The 2027-35 Health Service Plan should be developed using a similar service planning methodology as was used in the 2022-30 plan. Partnering with an external recognised health service planning organisation will allow the most contemporary health planning methodologies to be applied and for the plan to be completed in a reasonable time frame. It is important that the refreshed Services Plan considers:

- Importance of understanding relationships between Southern NSW, including flow of patients across boundaries.
- Importance of agreement on how services and sub-services will be networked across TCH, NCH, University of Canberra Hospital, and other service areas and locations within CHS and partners in the private, primary care and community-based organisation sectors within the ACT.

Recommendation 9

HCSD, in collaboration with CHS, undertake a refresh of the ACT Health Service Plan 2022-30, with an updated timeframe of 2027-35.

Creation of a whole of network Clinical Services Plan (CSP) and refreshed Clinical Services Plans (CSPs) for each major hospital

CHS needs to develop a whole of network CSP, within which there are specific CSPs for TCH, NCH and University of Canberra Hospital.

The overarching CHS network CSP (and nested hospital plans) should be developed while the ACT Health Services Plan is being developed so that all plans are completed and available as soon as possible. The CHS-led process for clinical services planning will need to be undertaken in close collaboration with HCSD. The CHS whole of network CSP should include all services within CHS, including walk-in centres and Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS).

The integration of a whole of network CSP and hospital specific CSPs will support the following:

1. **Seamless integration of services**: A connected system ensures that walk-in centres and other health services operate as part of a cohesive network. This integration allows for better coordination of care, reducing duplication of services and ensuring that patients receive the right care at the right time.
2. **Improved access to care**: Walk-in centres often serve as the first point of contact for many people. By aligning their CSP with the broader health system, these centres can act as gateways to more specialised care, ensuring patients are directed to the appropriate services without unnecessary delays.
3. **Optimised resource allocation**: A connected approach enables the efficient use of resources across the entire health system. By understanding the role of walk-in centres and other services within the broader network, resources can be allocated where they are most needed, reducing inefficiencies and improving service delivery.
4. **Enhanced patient outcomes**: When walk-in centres and other health services are aligned with the CSPs and the whole-of-system CSP, patients benefit from a more streamlined and coordinated care journey. This reduces the risk of fragmented care and improves health outcomes.
5. **Data sharing and insights**: A connected system facilitates the sharing of data across different health services, enabling better decision-making, identification of health trends, and targeted interventions for specific populations.
6. **Equity and standardisation**: By linking walk-in centres and smaller health services with the broader system, health systems can ensure consistent standards of care across all facilities, reducing disparities in healthcare access and outcomes.
7. **System resilience**: A connected network of health services can respond more effectively to public health emergencies or sudden surges in demand, ensuring that all parts of the system work together to provide comprehensive care.

Underneath the CHS whole of network CSP, there needs to be refreshed CSPs for TCH, NCH and the University of Canberra Hospital. The integration of a CHS whole of network CSP with CSPs for individual CHS hospitals will create a robust framework for delivering high-quality, equitable and efficient healthcare services. This includes:

- **Alignment across the system:** Aligning the ACT Health Service Plan 2027-35 with CSPs ensures all facilities work collaboratively towards shared goals, such as patient outcomes and resource efficiency.
- **Optimised resource allocation:** By integrating CSPs with the ACT Health Service Plan 2027-35, TCH, NCH and University of Canberra Hospital can better allocate resources like staff, equipment and funding. This prevents duplication of services and ensures that resources are directed to areas of greatest need.
- **Improved care coordination:** A coordinated approach across the ACT health system, with CHS as a network of services integrating into the broader whole of ACT and surrounds health service ecosystem. This will support continuity of care for patients, and services to be delivered seamlessly across different levels of care, from primary to tertiary, and reduce gaps or overlaps in service delivery.

- **Tailored local solutions:** While the ACT Health Service Plan 2027-35 will provide a broad framework, CSPs for TCH, NCH and University of Canberra Hospital allow for the customisation of services to meet the specific needs of local populations. This ensures that care delivery is both standardised and locally relevant.
- **Enhanced accountability and performance monitoring:** Structured alignment between the ACT Health Service Plan 2027-35 and CSPs enables better tracking of performance metrics at whole-of-system and hospital levels. This transparency fosters accountability and supports continuous improvement.
- **Adaptability to change:** As the ACT health system evolves, having interconnected plans allows for more agile responses to emerging challenges, such as demographic shifts, technological advancements or public health crises.

Recommendation 10

CHS, in collaboration with HCSD, develop a whole of network CSP for all services in CHS, including walk-in-centres, MHJHADS and other CHS services.

Recommendation 11

CHS, in collaboration with HCSD, undertake a refresh of the CSPs for TCH, NCH and University of Canberra Hospital that will be nested into the CHS whole of network Clinical Services Plan.

Analysis of cost variation between ACT cost per Weighted Activity Unit (WAU) compared to the national average

The financial sustainability analysis indicates that the ACT is growing its hospital funding at a similar rate to the other jurisdictions in Australia. The analysis indicates that the ACT's average cost weights for acute separations in public hospitals is above the Australian average.

The NHCDC in Australia is undertaken annually by the IHACPA. It involves the collection, validation, analysis, and reporting of cost data from public hospitals across the country, to allow IHACPA to determine the NEP for funding public hospital services. The NHCDC matches patient-level activity with the costs incurred by hospitals. The costs are collected in streams (e.g. admitted care, Emergency Department, non-admitted care etc) and broken into cost buckets to allow comparability across jurisdictions.

Table 20: Admitted Care Cost per NWAU various years for ACT and the national average ($) and (%) difference[142]

Cost buckets	2018-19				2021-22				2023-24			
	ACT Cost per NWAU18 ($)	National average ($)	Difference ($)	Difference (%)	ACT Cost per NWAU21 ($)	National average ($)	Difference ($)	Difference (%)	ACT Cost per NWAU23 ($)	National average ($)	Difference ($)	Difference (%)
Admitted Care												
Allied health	159	177	-18	-10%	192	218	-26	-12%	301	219	81	37%
Critical care	707	462	245	53%	918	544	374	69%	1,011	560	451	81%
Depreciation	5	182	-177	-97%	24	222	-198	-89%	216	257	-41	-16%
Emergency department	4	16	-12	-75%	4	60	-56	-93%	0	0	0	0%
Hotel costs	203	169	34	20%	215	232	-17	-8%	225	259	-35	-13%
Imaging	148	140	8	6%	280	168	112	67%	164	179	-14	-8%
Non-clinical	310	371	-61	-16%	444	415	29	7%	445	441	3	1%
Oncosts	665	415	250	60%	720	530	189	36%	544	681	-137	-20%
Operating room	1,098	886	212	24%	1,388	937	451	48%	1,351	1,002	349	35%
Pathology	223	211	12	6%	346	238	108	46%	283	251	32	13%
Patient travel	0	32	-32	-100%	0	32	-32	-100%	23	42	-19	-45%
Pharmacy	64	247	-183	-74%	56	309	-253	-82%	164	324	-160	-49%
Prosthesis	93	168	-75	-45%	137	161	-24	-15%	170	189	-19	-10%
Special procedure suite	83	73	10	14%	101	82	19	23%	131	85	46	54%
Ward medical	515	674	-159	-24%	634	799	-165	-21%	616	857	-240	-28%
Ward nursing	1,106	1,059	47	4%	1,282	1,196	86	7%	1,334	1,287	47	4%
Ward supplies	404	415	-11	-3%	718	551	167	30%	906	603	303	50%
TOTAL	**5,787**	**5,697**	**90**	**2%**	**7,458**	**6,695**	**763**	**11%**	**7,883**	**7,236**	**647**	**9%**

[142] Note: In 2023-24, Emergency Department costs are not allocated to Admitted Care. Independent Health and Aged Care Pricing Authority, National Benchmarking Portal IHACPA.
Pink indicates variation >= 35%, yellow indicates variation <= -35%

Table 20 shows the comparison of the cost buckets for the admitted care stream for the ACT and the Australian average over three selected years: 2018-19, 2021-22 and 2023-24. The data for 2018-19 and 2021-22 are available on the IHACPA National Benchmarking Portal.[143] The 2023-24 data is the most recent comparative data available. The 2023-24 s data is not yet available on the IHACPA National Benchmarking Portal but has been provided to the Inquiry by IHACPA. It should be noted that the 2022-23 ACT data is not on the IHACPA portal.

The data shows that for each of the three years, the ACT cost per National Weighted Activity Unit (NWAU) is higher than the Australian average. The table shows that at the cost bucket level of analysis, some of the ACT costs are higher and some are lower. The table identifies the cost buckets where the variation is greater than or equal to 35% in each direction. The analysis shows that the variation between the ACT's costs and the Australian average has become larger since 2018-19 with some cost buckets consistently higher each year but others varying over the years.

There are many factors that could contribute to the variation, including costing methodologies used by States and Territories, differences in the use of capital versus operating expenditure, and the treatment of depreciation. Other factors could relate to differences in the size of the jurisdiction, hospital structures, or the industrial agreements in place in each State and Territory. The variation could also relate to differences in productivity and efficiency between the ACT and other States and Territories.

The ACT needs to undertake a detailed analysis of the variations in cost bucket amounts in all streams within the NHCDC to identify the underlying reasons for the variation and address those matters that are within the control of the ACT health system.

Recommendation 12

HCSD and CHS collaborate to undertake further analysis (and improvement activities) of the cost bucket breakdown of the ACT costs per WAU compared to the Australian average costs.

Supporting GPs in the management of patients to reduce potentially unnecessary Outpatient referrals

During consultations, some GPs raised the challenges of managing complex patients beyond their scope of expertise for prolonged periods, which often occur due to lengthy wait times for specialist Outpatient appointments. Additionally, some highlighted the reliance on informal 'call a friend' networks, where GPs seek second opinions from colleagues or professional contacts for certain cases. While useful in the short term, these informal networks are unsustainable over time, as they require both GPs and specialists to take on extra, unpaid work in addition to their existing responsibilities.

To alleviate these pressures, a virtual, asynchronous consultation service, modelled after the Mater Qld eConsultant, could be explored by the ACT health system. Such a service provides an effective way to address delays in accessing specialist care, while equipping GPs with the critical information and guidance they need to confidently manage patients within the community.

The Mater Queensland eConsultant model operates a 'Request for Advice' (RFA) service that offers GPs timely access to selected specialists. Through this system, GPs can request clinical advice and receive a response within three business days. This guidance often eliminates the need for a

[143] Independent Health and Aged Care Pricing Authority, National Benchmarking Portal IHACPA.

face-to-face specialist appointment, helping to reduce wait times and relieve pressure on the broader healthcare system.

Before rolling out statewide in Qld, the eConsultant service was, yielding promising results. For example, of all RFAs submitted during the pilot, only 14% required a recommendation for a face-to-face Outpatient appointment, indicating the model's potential to significantly improve efficiency and significantly reduce the number of specialist Outpatient referrals.

Under the eConsultant model, there is no cost to the GP to use the service as it is funded by the Qld eConsultant Partnership Program. Specialists providing advice through the service are compensated for their time on a per-advice rate.

Recommendation 13

CHS, in collaboration with HCSD, Capital PHN, RACGP and the AMA, explore initiatives such as the Qld eConsult service to provide access to specialist advice as a way of reducing the number of patients needing to be seen in CHS services.

Establishment of clearer and more connected arrangements between hospitals, Outpatient clinics and walk-in centres

Through consultations, stakeholders reflected that there is an opportunity to establish clearer and more connected arrangements for services provided by hospitals, Outpatient clinics, and walk-in centres across the ACT health system. There are potentially opportunities to utilise walk-in centre facilities to undertake Outpatient appointments or to undertake initial or screening assessments ahead of Outpatient appointment.

To avoid inefficiencies and improve health outcomes, there is an opportunity for CHS to strengthen the operation of hospital, Outpatient clinics and walk-in centres as a network of services. This should assist to help patients and providers navigate the system and support patients to receive the right care, in the right place and the right time. Strengthening the connection between these services may also assist to further reduce Emergency Department presentations, increase the percentage of people treated in time in Outpatients, enhance continuity of care, increase collaboration between clinicians and patients, and optimise the use of clinical resources and reduce system inefficiencies.

Recommendation 14

CHS strengthen the operation of hospital, Outpatient, and walk-in centre services as a network of services that optimises the use of clinical resources and provides more timely access for patients.

Clarity of arrangements for NSW patients to access ACT specialist services

Through consultations, some stakeholders highlighted issues associated with how patients within Southern NSW access ACT health system specialist services. Stakeholders identified a joint local service planning framework and cross-border agreement, which exists between ACT and Southern NSW, and the NSW Ministry of Health. The intent of the local framework is to ensure a standardised and integrated approach to how Southern NSW patients access specialist services closer to where they live in NSW. Notwithstanding this, some stakeholders highlighted that this framework may not be applied consistently and decisions concerning cross-border patient referrals can seem to be made in isolation.

To support a more seamless, consistent and equitable approach, there is an opportunity for CHS and HCSD to continue collaborating with NSW Health (particularly Southern NSW LHD). This collaboration should seek to ensure a streamlined and standardised process for ensuring regional and rural patients receive specialist services close to where they live, in NSW if possible. Documenting and consistently and transparently applying the criteria for the types of referrals from different locations (including a description of the rationale for accepting or not accepting a referral) is essential. In general, if the closest location for a person to access a service is TCH or NCH, then the referral would appear to meet the intent of the NHRA. As with all clinical assessments, there will be exceptions that also need to be described in the cross-border arrangements.

Recommendation 15

CHS and HCSD continue to collaborate with NSW Health, particularly Southern NSW LHD, to progress initiatives to support patients receiving specialist services closer to where they live in NSW.

Enhancing the efficiency and effectiveness of rostering practices

There is an opportunity for CHS to undertake a quality improvement activity to analyse the efficiency and effectiveness of rostering practices across all specialities. The objective of this review should be to analyse current rostering practices and identify areas for improvement including looking at rostered overtime, clinical skill mix, use of locum or contract staff, use of casual staff, and on-call and call-back arrangements.

This activity should support CHS to utilise best-practice rostering techniques and principles and move towards strategic and proactive scheduling. This will support the ACT health system to potentially improve efficiencies in areas such as overtime and the use of locum and agency staff.

Recommendation 16

CHS undertake a quality improvement activity for rostering to identify opportunities to reduce overtime and the use of locum and agency staff and encourage best-practice rostering practices.

Ongoing collaboration with the LHN Assurance Committee to implement sustainability measures

To support the implementation of Inquiry recommendations by CHS and HCSD related to sustainability, CHS and HCSD should continue to work with the LHN Assurance Committee (formally known as the Health System Sustainability Taskforce) on sustainability initiatives. There is the potential for the sustainability recommendations identified in this Inquiry to form part of the work of the LHN Assurance Committee.

Recommendation 17

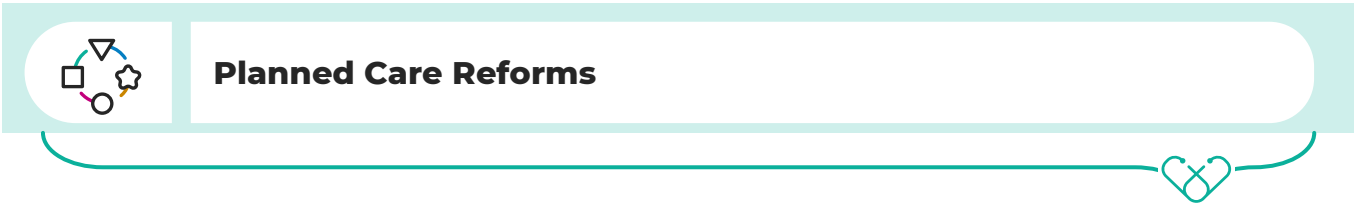
CHS continue to implement sustainability measures in collaboration with the LHN Assurance Committee.

Chapter 6 Planned Care Reforms

Planned Care encompasses Elective Surgery, Outpatient services and specialist appointments. Reform in the Planned Care space seeks to reduce waiting times to improve patient access and equity and ensure the effective utilisation of limited health system resources.

Navigating this chapter

The following visual provides an overview of the structure of this chapter.



Consultations and submissions summary	Thematic findings distilled from stakeholder consultations and written submissions.
Current state analysis	Comprehensive description of current-state arrangements derived from a desktop review of qualitative and quantitative data. This included publicly available information, public health data and reports and documents provided by CHS and HCSD, to provide contextual insights into the functioning of the ACT health system.
Future state recommendations	Considering findings from consultations and submissions, alongside the current state analysis, this section outlines future state recommendations, which serve as opportunities to uplift and enhance the ACT health system.

6.1 Consultations and submissions summary

The Planned Care Program was a key focus during consultations, with stakeholders identifying areas for improvement in its processes and implementation. While some progress has been made in relation to the Planned Care Reforms, such as the introduction of streamlined referral forms and more consistent criteria, stakeholders have communicated that the program's overall purpose could be clearer. Stakeholders expressed a strong desire for clearer communication about the principles and intended outcomes from the Planned Care Reforms, how decisions are made, and how reforms align with clinical priorities and patient needs.

Stakeholders identified a strong opportunity to strengthen clinical engagement in the design and implementation of Planned Care Reforms. They saw value in creating more structured and collaborative processes, particularly around Elective Surgery waitlists, to ensure operational changes are shaped alongside clinical expertise. Consultation feedback also highlighted opportunities to improve transparency and consistency in referral and triage processes.

Stakeholders noted that enhancing partnership between clinicians and management would support greater system efficiency, reinforce continuity of care, and rebuild shared confidence in the Planned Care Reform agenda. Stakeholders expressed interest in clearer referral acknowledgment, more visible triage pathways, and accessible wait-time information to better support safe patient management.

Stakeholders further noted opportunities to enhance operational alignment with clinical judgement. This includes improving pathways so that surgical allocations, emergency prioritisation, and pre-operative requirements, such as imaging and resource preparation, are consistently informed by clinician assessment. Stakeholders emphasised that embedding clinical leadership more deeply in operational decisions would help support patient-centred care, reduce delays, and improve system reliability.

6.2 Current state analysis

Planning for CHS Planned Care Reforms commenced in 2023 and relate to how Outpatient referrals, and referrals for Elective Surgery and Planned Procedures are to be managed.

In March 2024, Canberra Hospital implemented a prototype of an operations centre model to manage the system day to day, assist patient flow and to start to align planning and troubleshooting with the patient journey. The pilot was facilitated by incorporating patient flow resources and building additional functionality around these resources supported by harnessing the capability of the DHR. Planned Care was established as part of the pilot in July 2024, and a decision was made to fully embed the Integrated Operations Centre (IOC) into TCH in November 2024.

The infrastructure for an operations centre has been established at NCH and is currently being used locally within the hospital. The IOC has realigned reporting lines from the General Manager Canberra Hospital to the Chief Operating Officer and CHS plans in the future to implement a service-wide IOC and expand to NCH.

The document titled *'Notes 14: Principles for delivery of Planned Care'*[144] dated 29 December 2023, outlines the basis for the Planned Care Reforms. The reforms have been undertaken to strengthen the clinical quality and safety of the management of referrals, and to provide for a high quality, fair, reliable and timely system. The two foundational principles of the Planned Care Reforms, as stated in this paper, are:

1. CHS is required to make sure that all referrals, to a named clinician, or not, are managed in a reliable and dependable manner
2. People referred to the service must be able to access the service, within reason, on the basis of need, where need is a function of how severe the problem is and how long the person might have to wait relative to others with similar problems of differing severity[145]

The document also points out that:

> These considerations do need to be balanced against the ability of any clinician to get on and do their job without unnecessary obstruction, and where possible to form a personal rapport with a cohort of patients where continuity of care might be important.[146]

The Planned Care Reforms are based on the following seven principles:

1. Responsibility accrues to the respective practitioner
2. System operation occurs in a digital platform
3. Referral intake must be complete, standard, simple and reliable
4. Triage is a clinical interaction that adds value
5. Booking Outpatient first specialist appointments is determined by need and time waited
6. Certainty and transparency are important
7. Booking inpatient care (procedure, diagnostic test etc) is determined by need and time waited

There are three Administrative Instructions (see **Table 21**) that were developed for the Planned Care Reforms and each was valid for 12 months from issue:

1. Administrative Instruction No. 1: Referral Management (Outpatient Non-Admitted Patient Episodes) – 26 April 2023
2. Administrative Instruction No. 2: Wait List Management (Outpatient Non-Admitted Patient Episodes) – 15 September 2023
3. Administrative Instruction No. 3: Management of referrals to CHS for Specialist led services – 23 January 2025

[144] *Notes 14: Principles for delivery of Planned Care,* 29 December 2023 – document supplied by CHS
[145] *Notes 14: Principles for delivery of Planned Care*, 29 December 2023 – document supplied by CHS
[146] *Notes 14: Principles for delivery of Planned Care*, 29 December 2023 – document supplied by CHS

The Inquiry has been informed that all Administrative Instructions have expired as they are all 12 months post being issued, and that whilst worded as administrative instructions, number 1 and 2 were more aligned with principles and strategic intent versus what was implemented or feasible to be implemented within the system at the time of issue.

Table 21: Planned Care Administrative Instructions

Planned Care Administrative Instructions

No. 1: Referral management (Outpatient non-admitted patient episodes) – 26 April 2023
Purpose
To allocate responsibility for management of a referral, at various points in the process of service provision, to the appropriate system management.
Scope
This instruction covers all patient episodes subject to a new referral and booking system. Exemption from this instruction can only be provided by the Chief Operating Officer
Processes
• All patient referrals for a first specialist assessment will be accepted on behalf of CHS through the Central Health Intake (CHI) service.
• CHI will provide processed referrals to a single referral pool for each identified service.
• Each Service Manager (Executive Director or delegate) will assign a suitably experienced clinician to triage patient referrals. An outcome of this process may be:
  • The referral is returned to the referrer with the appropriate advice
  • The referral is assigned to a specific practitioner or preferably subspecialty service
• If the referral is assigned to a secondary referral pool, the service manager will assign a suitably experienced clinician to triage these referrals.
• All patients accepted into a referral pool, once triaged, will be booked to a suitable clinic booking with their approval with respect to date and time.
• All bookings will be allocated on the basis of longest waiting – highest scoring.

No. 2: Wait list management (Outpatient non-admitted patient) - 15 September 2023 **Purpose** To clarify management of wait lists for services provided by CHS, irrespective of the campus or facility this occurs on. **The reasons for Administrative Instructions** Services provided through publicly funded health services should be allocated on the basis of need and length of wait. Processes that support this principle are required to be consistently applied. **Scope** This instruction covers all patient episodes subject to a new referral and booking system1. Exemption from this instruction can only be provided by the Chief Operating Officer. **Processes** • All patients who are referred for an episode of Planned Care, whether an Outpatient consultation, a diagnostic test or procedure, will be placed on the designated public waitlist for that episode • All patients booked to attend an Outpatient consultation, diagnostic test, or procedure will be selected on the basis of the urgency of request (triage category) and length of wait • Selection and booking of referrals will be conducted by operations staff of CHS • Where more than one provider, or a number of providers, are able to provide a service (Outpatient consultation, diagnostic test, or procedure), referrals for this service will be pooled and then selected and booked on the basis of urgency of request (triage) and length of wait

Planned Care Administrative Instructions

No. 3: Management of referrals to Canberra Health Services for specialist led services – 23 January 2025

Purpose

To clarify management of referrals to CHS specialist clinics from 3 February 2025.

The reasons for Administrative Instructions

From Saturday 1 February 2025, Canberra Hospital and NCH will only accept eReferrals for specialist led services. Referrals must meet defined Territory wide referral criteria1. Processes that support this principle are required to be consistently applied.

Scope

This instruction covers all referrals received to Canberra Hospital and NCH for specialist led services. Exemption from this instruction can only be provided by the Chief Operating Officer.

Processes

- All referrals for a specialist Outpatient clinic, will only be accepted if made electronically. External referrals will be via HealthLink online platform and internal referrals via DHR.
- Non-electronic referrals for specialist Outpatient clinics will be returned to referrer with information sheet regarding new eReferral process.
- All eReferrals will be screened by CHI staff to ensure meet territory wide referral criteria.
- eReferrals that do not meet minimum criteria will be considered incomplete therefore not accepted and returned to referrer with reason for non-acceptance.
- Notification of incomplete referrals must include the following information:
    - Patient identifiers
    - Notification as to why referral was screened as incomplete
    - Information or actions required for referral to be deemed complete (when resubmitted)
    - Planned Care Call Centre contact information to obtain further information

The establishment of the Integrated Operations Centre (IOC) in July 2024 was undertaken to assist with the safe and efficient flow of patients through the hospital. This timeline aligned with CHS Planned Care Access and Certainty of Service Policy[147] which was issued in July 2024. The CHS Planned Care Access and Certainty of Service Policy provides the policy framework for Planned Care Reforms that was implemented through Planned Care in the IOC.

This policy outlines:

- Planned care is a service provided by a number of participants and departments (the system) that requires a high degree of coordination for consumers with the greatest need (as determined as objectively as is reasonable) to be seen in an order that reflects that need, and within a period of time that has been determined by expert clinical opinion to be clinically required.
- The coordination required to achieve this requires the system to be managed in a manner consistent with the stated principles of most need and longest waiting.
- Persons requiring a planned episode of care will be seen in order of need (category of urgency) and by the length of time they have waited, across the service. There are two key principles that underpin this arrangement:
    - consistent assessment and categorisation of urgency
    - treat in turn (first on first off) within an urgency category
- Planned care cannot be reliably and safely delivered for all without an equal contribution from clinical staff and operational staff as to how the system is configured, and how clinical professionals work within the system.

[147] Canberra Health Services, Planned Care Access and Certainty of Services, ACT Government.

- At each point of communication, the consumers will be provided with information about access to care to support their decision making.

CHS implemented electronic referrals in February 2025 to support of the Planned Care Reforms.

There is a team within CHS responsible for coordinating the work related to the Planned Care Reforms.

Outpatient and Elective Surgery pathways

Work has been undertaken as part of the Inquiry to map the pathways for Outpatient and Elective Surgery. The Elective Surgery pathways are also applicable for specialist procedures such as endoscopies, some cardiac procedures and some respiratory procedures. The pathways have multiple entry and exit points, and a patient can identify themselves as a public or private patient in the public hospital system at any point in the pathway. A patient can also change their status at any point.

Figure 34 below provides a working-draft summary of different pathways for Outpatients and Elective Surgery/Planned Procedure, including for ACT residents and residents outside of the ACT.

The Inquiry requested data to understand the pathways through which patients are placed on Outpatient, Elective Surgery, and specialist procedure waiting lists. Some of this data has been provided, with some data unable to be extracted from the current systems.

All data for Outpatients, Elective Surgery and Planned Procedures should be aggregated totals and broken down by:

- Urgency category
- Speciality area
- Residential status (ACT and non-ACT)
- Presented over time

The data that is needed to gain a full understanding of the patient pathways and flows through the system includes at least the following:

- The number of patients being placed on an Outpatient waiting list via GP referral, Emergency Department referral, private Specialist referral or another pathway
- The total number of patients on the Outpatient waiting list
- The time to first specialist Outpatient appointment in each urgency category with explanations regarding why some patients are still waiting even though they may have been placed on the list before another patient who has had their first specialist appointment. This data is relevant within each specialty area, not across specialty areas, and should be aggregated and broken down by the referral pathway through which they were placed on the waiting list
- The number of first specialist Outpatient appointments and the number of review appointments
- The number of patients being placed on an Elective Surgery or specialist procedure waiting list via a public Outpatient appointment, private specialist referral, Emergency Department referral or another pathway
- The total number of patients on an Elective Surgery or Planned Procedure waiting list
- The time to treatment for Elective Surgery and Planned Procedure in each urgency category with explanations regarding why some patients are still waiting even though they may have been placed on the list before another patient who has had their treatment. This data is relevant within each specialty area, not across specialty areas, and should be aggregated and broken down by the referral pathway through which they were placed on the waiting list

As noted previously, the consultation and submissions have identified improvements that could be made to the Outpatient and Elective Surgery/Planned Procedure processes. Without the relevant data, it is challenging to understand the pathways through which patients are placed on the waiting lists and the way they flow through the waiting lists.

Central Health Intake

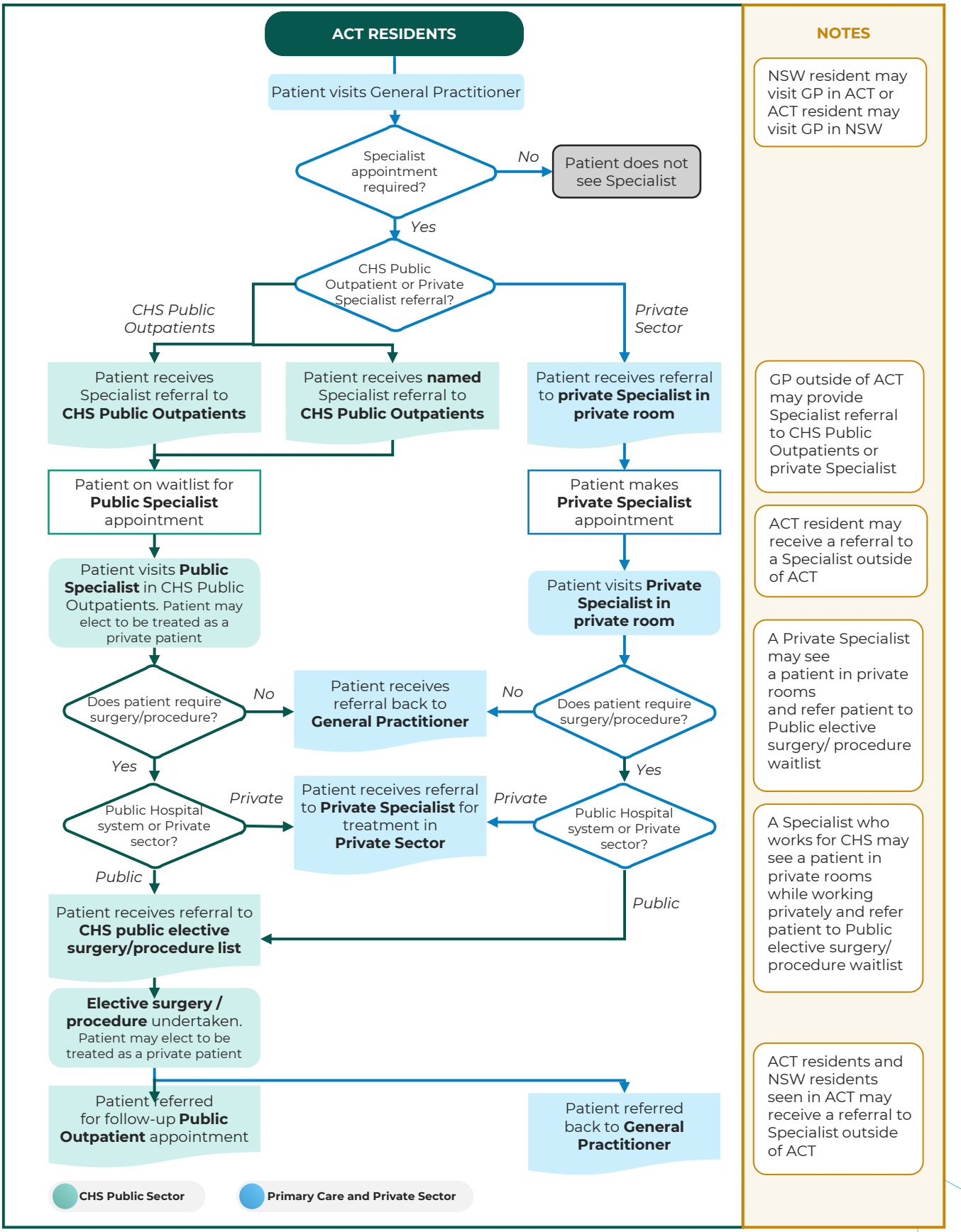
CHS only accepts Outpatient specialist referrals via eReferrals through HealthLink. All eReferrals go to CHI for screening and triage. CHI is available to be contacted by referrers to provide support.

CHI operates across TCH and NCH. CHI assesses referrals for compliance with the criteria for each specialty and noncompliant eReferrals are returned for update. There is a HealthLink website to provide support for referring clinicians to get access to HealthLink. There is a generic eReferral template as well as specific templates for specialist clinics.

Territory-wide referral criteria are available to assist referrers to make a compliant eReferral through HealthLink.

CHI undertakes the administrative activities associated with Outpatient referrals. This includes the initial review of the referral to confirm that it is compliant with the referral guidelines, placing the referral onto the outpatient list for the appropriate specialty, providing it to the speciality area for urgency triage, managing communication with the patient and referrer, and coordinating appointment times.

Figure 34: Example pathways for a patient to enter and exit the ACT public health system



Orthopaedics

Consultation with stakeholders (including Specialists) in and related to the Orthopaedics area of CHS during the Inquiry has been very informative, engaging and productive. In these consultations, concerns were expressed, consistent with other consultations, that the implementation of the Planned Care Reforms had occurred very quickly, without sufficient consultation, and with insufficient planning regarding the impact on patients, clinicians, the orthopaedic workflow, and specialists and other clinicians outside CHS. However, the orthopaedic team has engaged with the Planned Care and CHI teams to work through ways to apply the principles underpinning the Planned Care Reforms within the orthopaedics area and addressing most concerns.

The Orthopaedic Specialists have developed and documented an assessment methodology that is consistently applied to Outpatient referrals to allocate the urgency category. The referral assessment process is part of the CHI process. As described in the summary of the Outpatient pathways section of this report, CHI coordinates the administrative process of receiving Outpatient referrals, undertaking an initial assessment regarding the completeness of the referral, directing them to the relevant clinical area for assessment, coordinating the communication with the referrer and patient, and booking the appointment.

To assist with increasing timely access to orthopaedic appointments, an Orthopaedic Screening Clinic has been established.[148] The Orthopaedic Screening Clinic at CHS provides a specialised assessment service for people referred to orthopaedic Outpatients with bone, joint, muscle, or spine concerns. The clinic is staffed by physiotherapists who have advanced training in musculoskeletal assessment. Their role is to determine the likely cause of a patient's symptoms, evaluate functional movement, and identify the most appropriate treatment pathway. The Orthopaedic Screening Clinic model ensures that patients receive timely, evidence-based care and that referrals to surgeons are made only when surgery is likely to be beneficial.

Following this assessment, conservative management options such as physiotherapy, targeted exercise programs, or other non-surgical interventions may be recommended. If surgery appears to be an appropriate next step, the clinic arranges an appointment with an orthopaedic surgeon. A summary of the assessment and agreed plan is also sent to the referring doctor to support continuity of care.

The Orthopaedic specialists have also supported the establishment of program to support people who do not need surgery, or do not yet need surgery. The GLA:D (Good Life with osteoArthritis: Denmark)[149] program is an evidence-based education and exercise program designed for people experiencing hip or knee pain caused by osteoarthritis. Developed in Denmark, the program is delivered locally through community-based physiotherapists and has been shown to reduce pain, decrease reliance on analgesics, improve physical function, increase activity levels, enhance quality of life, and delay the need for joint replacement surgery.

Appointments to the GLA:D program are managed through Central Health Intake. Before commencing, each participant undergoes an assessment by a physiotherapist to ensure the program is appropriate for their needs. The program runs for six weeks and consists of twelve exercise classes and two structured education sessions. The education components cover the nature of osteoarthritis, risk factors, symptoms, treatment options, and practical strategies for exercise, daily living, coping, and self-management. Exercises use simple, inexpensive equipment and can be tailored to individual capability. Participants complete questionnaires before starting and again at three and twelve months to track progress, with routine follow-up appointments offered after completion.

[148] CHS, Orthopaedic Screening Clinic, ACT Government.
[149] CHS, GLA:D (Good Life with osteoarthritis: Denmark), ACT Government.

Nutritional guidance is also provided, emphasising balanced eating patterns rich in vegetables, fruit, wholegrains, and healthy fats such as omega-3s. ACT residents can access additional support through the Community Care Nutrition Service.

Even though there has been significant effort put into improved Outpatient access and alternative programs to surgery, the waiting times for Elective Surgery remain high. The waiting times for Outpatients are not available. This data needs to be collected and reported and this is addressed elsewhere in the report.

Table 22 shows the admissions and waiting times for admission from Elective Surgery waiting lists for Orthopaedics and all specialties from 2020-21 to 2024-25 for the ACT and Australia. As can be seen in **Table 22**, each year approximately 1,850 admissions to surgery are made from the orthopaedic Elective Surgery waiting list in the ACT. The stability of the number of admissions over time is consistent with the Australian admissions data and for all specialities in the ACT and Australia, although all specialties does have a slight increase in 2024-25 for both the ACT and Australia.

Table 22: Admissions and waiting times for admission from Elective Surgery waiting lists for Orthopaedics and all specialties 2020-21 to 2024-25[150]

	2020-21		2021-22		2022-23		2023-24		2024-25	
	Orthopaedics	All specialties	Orthopaedics	All specialties	Orthopaedics	All specialties	Orthopaedics	All specialties	Orthopaedics	All specialties
ACT										
Admissions	2,028	15,348	1,905	14,033	1,603	12,640	1,853	14,979	1,846	16,565
Days waited at the 50th percentile	140	49	128	43	130	49	145	50	169	54
Days waited at the 90th percentile	497	353	410	281	483	328	530	351	534	352
Percentage waited more than 365 days	23.1%	8.9%	17.3%	5.8%	20.0%	8.1%	20.6%	8.9%	26.8%	9.4%
Australia										
Admissions	108,361	754,600	83,198	622,988	101,442	735,460	105,495	778,466	103,750	790,528
Days waited at the 50th percentile	93	48	84	40	101	49	90	46	86	45
Days waited at the 90th percentile	396	348	391	323	458	361	393	329	371	329
Percentage waited more than 365 days	14.5%	7.6%	12.8%	6.3%	18.2%	9.6%	12.8%	6.4%	10.8%	6.0%

[150]AIHW, Elective surgery waiting times 2024-25 data tables, Table S4.3

The data shows that the number of days waited for 50% of people (and 90% of people) to receive their orthopaedic surgery is much longer than the average for all specialties in the ACT, and for both orthopaedics and all specialties in Australia. The waiting times for all specialties in the ACT are reasonably consistent with those for Australia as a whole.

Further work is required to identify initiatives to address the long waits for orthopaedic surgery. The consultation with the orthopaedic team has confirmed that the team is open to looking at ways to increase access to orthopaedic Elective Surgery.

Cardiology

Consultation with stakeholders (including Specialists) in and connected with the Cardiology area of CHS during the Inquiry has been very informative, engaging and productive. Because separate court proceedings are underway specifically related to this clinical area, and out of an abundance of caution, summarised individual submissions or consultation materials related to this area are not included in this report. This approach avoids the potential to be perceived to have an impact on the legal proceedings. However, the Inquiry has drawn on the broad themes throughout the Inquiry process, and the subsequent analysis, to inform the recommendation in this report relating to Cardiology.

6.3 Future state recommendations

Establishment of updated health service improvements for Planned Care

There is general support for the principles of the Planned Care Reforms, namely:

- There should be a transparent, documented and consistent assessment undertaken by each specialty area to identify the urgency category for referrals to Outpatients, Elective Surgery, and Planned Procedures.
- People should be treated in-turn in each specialty area and urgency category for Outpatients, Elective Surgery and Planned Procedures so that those who have waited longest in each category are treated first within each specialty area.
- In-patient hospital care should flow in a way that ensures clinical quality and safety, and occurs in a timely fashion, and is supported by a whole of hospital view of the best way to achieve this for each patient.

Notwithstanding these overarching principles, as indicated in stakeholder consultations, the implementation of the Planned Care Reforms occurred quickly, with limited clinical engagement and little documentation. There is a genuine willingness of staff to engage in further enhancing the Planned Care Reforms in a way that respects clinical decision making, is collaborative and patient centric, and delivers on the principles. It is critical that CHS undertake significant engagement with clinical areas and health consumers to agree on how the principles will be further operationalised.

Recommendation 18

CHS develop an updated set of documented Health Service Improvements for Planned Care, using a process that is open and transparent, and is undertaken in collaboration with all clinical groups across CHS.

Improvement of processes to ensure transparency for Outpatient, Elective Surgery, and Planned Procedure waiting lists

To streamline access to specialist care and ensure patient safety and equity, it is essential that public specialist Outpatient referrals are coordinated using a whole of CHS approach, assessed based on clinical urgency and patients' waiting time on the list. This ensures that people who have waited longer are seen first in each category. The whole of CHS approach is to streamline the administrative elements of receiving and managing referrals and support each clinical area to undertake urgency assessments and other clinically led activities. A whole of CHS approach also allows for a more transparent understanding of the number of people on the waiting lists and how patients are flowing through these waiting lists.

Elective surgery and Planned Procedures should also be coordinated using a whole of CHS approach that optimises administrative and data transparency aspects and supports each clinical area to make the clinical decisions. There should be visibility of the pathways in which patients are placed on the list, consistent application of urgency criteria for each specialty area, and monitoring of patients being treated in turn. These procedures need to be able to respond to changes in a person's condition, which might result in a change in category and/or a change resulting in a need for them to be treated quickly. However, these circumstances are usually exceptions that need to be accommodated within the general principle of treated in turn.

Within the ACT system, there are strong relationships and communications between the public and private healthcare systems. This can influence how people flow through Elective Surgery and procedure lists; when a person gets referred to a public specialist through the public route, they are triaged, assigned a classification, placed on a public specialist Outpatient waiting lists and then placed on a procedure or surgery list. However, if people attend a private specialist appointment (either bulk-billed or out-of-pocket), this person can get referred directly and placed immediately on the procedure or Elective Surgery list. This pathway means that patients referred from a private specialist could arrive on a procedure or Elective Surgery list faster than a patient referred to a public Outpatient appointment. While this public versus private route for accessing procedures or Elective Surgery occur in other jurisdictions, it is important to understand the volumes of people getting onto the Elective Surgery and Planned Procedures lists from all pathways.

Recommendation 19

The updated Planned Care documentation should include a clear CHS policy and procedures outlining that people on the Outpatient, and Elective Surgery and Planned Procedure waiting lists have been consistently and transparently clinically assessed for urgency and will be seen in order of their waiting time within their specialty area and clinical urgency category so that people who have waited longer are seen first in each category within a specialty area.

Redesign of the Integrated Operations Centre (IOC) operating model

In March 2024, TCH implemented a prototype of an operational centre model to support the efficient flow of patients through TCH. The pilot was facilitated by incorporating patient flow resources and building additional functionality around these resources supported by harnessing the capability of the DHR. Planned Care was established as part of the pilot in July 2024, and a decision was made to fully embed the Integrated Operations Centre (IOC) into TCH in November 2024. While the intent behind the IOC was sound and justifiable, the consultation has indicated that it was implemented without strong clinical engagement and consultation, and mechanisms to ensure the IOC fostered an environment that empowers clinicians and built trust in a respectful and engaging way.

Learning from the challenges encountered, CHS should undertake significant consultation with clinicians and consumer representatives to review the current arrangements. An updated operating model would then be developed and implemented based on these consultations. The fundamental role of the IOC should be supportive of clinical areas, patients and carers, and to foster safe, efficient and patient-centred systems for managing inpatient flow. This must be achieved by adopting a process that is patient centred, clinician-led and coordinated consistently across TCH and NCH and across all clinical groups through a culture of shared responsibility and collaboration.

The IOC must be actively engaged in clinical areas and collaborate with Clinical Directors across the whole system. The IOC should foster a culture of collaboration and transparency, teamwork and shared responsibility for patient outcomes (balancing the outcomes of both current and future patients). This must be done in conjunction with HCSD, to ensure uplift across the whole system. This collaboration is intended to support increased collaboration with the broader health sector, and other related sectors, to facilitate patients being discharged from hospital in a timely and clinically safe manner.

Noting the criticality of this whole-of-system cooperation, the IOC, in collaboration with TCH and NCH, should develop an Operating Framework. This should outline the principles of operation, including details on how it will work collaboratively with the clinical teams and other stakeholders inside and outside the hospital.

Recommendation 20

CHS undertake a refresh of the operating model of the IOC to clearly confirm the centre as a patient-focused team working in collaboration with other hospital staff to assist with patient flow and access to quality and timely care.

Recommendation 21

The refresh of the IOC operating model to be undertaken in close collaboration with clinicians working in all CHS hospitals and health consumers, and the new arrangements to operate in all hospitals within CHS.

Enhancement of the Central Health Intake (CHI) team

As described earlier in this Report, CHS has established a CHI team that is working cooperatively with clinical areas. Although consultation has indicated that this initiative was implemented in a way that did not involve significant clinical engagement, the CHI is focusing on undertaking the administrative aspects of coordinating Outpatient referrals and is working well with the clinical areas within the hospitals.

The clinical and administrative gains that have been achieved for Outpatients can also be applied to Elective Surgery and Planned Procedures. CHI is well placed to provide administrative support to the clinical management of Elective Surgery and Planned Procedure waiting lists. This support will also allow for a transparent view of the waiting lists and support the identification of improvements to how these are managed.

It is worth noting that research consistently demonstrates that Outpatient reforms and redesign are most effective when they are 'focused and led by the clinicians who are delivering it'.[151] According to a conference convened by the Nuffield Trust in the UK, redesign of Outpatient services 'was more effective for having been a team activity, although there was generally a senior clinician driving the process'.[152] As such, process reforms driven by the CHI team should be supported by senior clinical input and allow the exploration of different reform approaches. Further research has described the importance of using data to 'reinforce new ways of working.'[153] As such, the CHI team should use data-driven insights to support cultural change and take a patient-centred, population health approach.

Recommendation 22

CHS further develop the CHI team to strengthen the coordination of all Outpatient referrals and work with each specialist area to operationalise the Planned Care principles of consistent categorisation of urgency and treated in order of being placed on the list within each category.

Recommendation 23

CHS extend the role of the CHI team to administratively support the communication with patients and the administrative coordination of Elective Surgery and Planned Procedures waiting lists to provide a whole of CHS view of the waiting lists and to enhance and streamline communication with patients.

[151] Castle-Clarke, S., Edwards, N, 2018. Rethinking outpatient services: Learning from an interactive workshop, Nuffield Trust.
[152] Castle-Clarke, S., Edwards, N, 2018. Rethinking outpatient services: Learning from an interactive workshop, Nuffield Trust.
[153] Fiona Clay, Corey Joseph & Angela Melder, 2018. Best practice for managing outpatient bookings: Evidence Review. Centre for Clinical Effectiveness, Monash Health, Melbourne, Australia.

Exploration of options to expand the number of Outpatient appointments

There is an opportunity for CHS to explore other models of delivery that can be used to expand the number of Outpatient appointments undertaken.

Harnessing virtual care and technology to deliver Outpatient appointments

In circumstances where it is clinically possible and in line with patient feedback, there is the opportunity to undertake Outpatient appointments through virtual channels, such as video, telephone or email. This would reduce the time and space required for patient interactions within ACT public health facilities while ensuring that care is delivered in a safe, cost-effective way within (or closer to) a patient's home.

This strategy can be effective in supporting the 'flow reversal' of patients, who may travel from Southern NSW to ACT public health facilities. By supporting care to be delivered within, or closer to, home, the ACT health system can reduce the reliance on ACT public health facilities and thus, work to reverse the flow of care back to regional NSW facilities, as the person remains in their residential location and the details of the care provided in the ACT are communicated to the patient and their local healthcare providers.

Patients' preference for being seen virtually is captured by GPs within the ACT Health Referral SmartForm via HealthLink; there is the opportunity for the health system to use this information more proactively and strategically to support Outpatient waitlist management.

Expanding the use of a multi-disciplinary approach to Outpatient appointments

There is also the opportunity for each speciality area to review how patients on the Outpatient waitlist are triaged and consider an alternative, multi-disciplinary model of care that utilises the skills of a wider team of health professionals, such as allied health professionals or nurse practitioners. This model should also consider utilising GPs with special interest (GPSI) to undertaken initial assessments of patients.

By enabling a broader set of health professionals to serve as the first point of contact in the public hospital system for new patients, the clinical capacity of consultants is increased. This model of care provides the opportunity to ensure that the most clinically complex and urgent cases are seen by the most highly trained clinical professions, whilst ensuring all staff are working to the top of their licence.[154] To be effective, this model relies on trust, collaboration and open communication, along with analysis of data retrospectively to ensure clinical quality and safety.

Recommendation 24

CHS explore options to expand the number of Outpatient appointments undertaken including:

- Further use of virtual Outpatient appointments
- Further use of nursing and allied health professionals or GPs with special interests (GPSI) to undertake initial assessments
- Contracting with Private Specialists to undertake Outpatient assessments as part of the CHS Central referral and waitlist management arrangements
- Considering options to expand and/or rearrange the physical space for Outpatients so that more public Outpatient clinics can be operated

[154] Castle-Clarke, S., Edwards, N, 2018. Rethinking outpatient services: Learning from an interactive workshop. nuffieldtrust.

Options to use existing space to undertake more Outpatient appointments or pre-Specialist appointment assessments

Physical space constraints mean that available clinical time may not be fully utilised to undertake Outpatient appointments. TCH has recently undergone expansion through new builds, with more planned, and there is the opportunity to review the current Master Plan to potentially identify existing spaces that could be used to undertake Outpatient appointments or pre-Specialist appointment assessments. This can also occur at NCH, with the new build underway and potentially space becoming available as transfer occurs in the coming years.

Recommendation 25

The Master-Planning for TCH and NCH be revisited to identify opportunities to re-purpose or develop areas to allow for the expansion of the physical space for Outpatients so that more public Outpatient clinics can be operated.

Introduction of quarterly clinical reviews to validate people on the Outpatient waiting list

In supporting the management of Outpatient waiting lists and ensuring equitable, timely and patient-centred care, there is an opportunity for CHS to undertake quarterly administrative audits of people waiting for an Outpatient appointment. Audits ensure the accuracy of the Outpatient waitlist list, removing patients who will not attend and thus, freeing up limited, high-demand resources.

This quarterly review can be conducted through manual or automated formats, including a phone call, email or text message, to ask a series of questions that ascertain whether ongoing clinical care is still required and any unreported changes to health status. Alternatively, administrative audits are increasingly being carried out through automated, digital and AI-driven methods. For example, Metro North Qld partnered with Personify Care to rollout a digital platform that supported the real-time identification of people who needed care versus those who may no longer have needed an appointment. This was delivered across 12 specialities and 5 sites, resulting in significant efficiencies, including a 95% positive patient experience and process that was four times faster than the previously manual and paper-based approach.[155] This digital solution was found to be 53% cheaper than a paper-based audit approach and 67% cheaper than a Health Contact Centre approach.[156]

Recommendation 26

CHS undertake quarterly clinical reviews of people on the Outpatient waitlist to review their circumstances and make adjustments as required.

[155] Personify Care, Metro North Qld, Transforming outpatients waitlist management with digital pathways.
[156] Personify Care, Metro North Qld, Transforming outpatients waitlist management with digital pathways.

Expansion of electronic communication to include Outpatients, Elective Surgery, and Planned Care

Functionality of the DHR should be utilised to support electronic communications with patients in Outpatients and Elective Surgery. Electronic communication should be a component that a patient can elect, to minimise labour and cost associated with production of paper letters. The use of electronic communication must be undertaken with the full knowledge and consent of each health consumer and be compliant with all cyber security and information privacy requirements. The MyDHR app that was rolled out as part of the DHR project, is a very good way of communicating with patients. CHS could consider initiatives to increase the number of patients using the MyDHR app. This uplift would increase the speed of communication and streamline processes, along with improving patient experience.

Recommendation 27

CHS explore the use of electronic communication with patients in Outpatients and Elective Surgery to increase the speed of communication, allow for increased levels of communication with patients and streamline the communication process.

Establishment of clinical protocols concerning the number of Outpatient review appointments

Through consultations, some stakeholders highlighted that there could be improvements to support clear, evidence-based and standardised clinical protocols regarding the number and frequency of Outpatient review appointments that are required before a patient is fully referred back to primary care. Review appointments can occur following Elective Surgery or a Planned Procedure. Stakeholders reflected that the number of review appointments seems to vary across clinicians and specialty areas. Some clinical areas informed the Inquiry that they already have protocol criteria regarding review appointments in place, such as orthopaedics, that has one review appointment post-surgery, unless further surgical or other intervention is required. Increasing the use of agreed clinical protocols for review appointments should lead to more timely access to Outpatient appointments as more appointments would be new appointments.

To support creation of a more consistent and transparent pathway back to primary care, there is an opportunity for CHS to work collaboratively with specialist clinical areas to analyse the current relationships between diagnosis, treatment, and the number and frequency of Outpatient review appointments. This can be achieved by analysing data on existing review appointment volumes, frequencies and durations across specialty groups. Data should be analysed according to diagnosis and speciality, to understand where variation exists and the extent of that variation relative to patient need. Involving clinicians from other jurisdictions to understand what protocols may be in place for Outpatient review appointments will assist this analysis. The CHS clinical analysis and information from clinicians from other jurisdictions will result in clear and documented protocols. This will also assist with clear communication with patients so that they can be informed what is likely to happen prior to and after Elective Surgery or a Planned Procedure.

Recommendation 28

CHS work with specialist clinical groups to analyse the current relationships between diagnosis, treatment, and number and frequency of Outpatient review appointments for Elective Surgery and Planned Procedures. Following this activity, including analysis from other jurisdictions, clinical protocols should be developed for each specialty group regarding the number of Outpatient review appointments before patients are fully referred back to primary care.

Further analysis on the pathways for patients to be placed on Elective Surgery and Planned Procedure lists

Through consultations, a number of stakeholders highlighted the potential for variation between how patients progress through the ACT health system's Elective Surgery and Planned Procedure lists. Currently, patients can be placed on an Elective Surgery or Planned Procedure list through two main entry points: following a public Outpatient appointment or following a specialist appointment within a private setting. A number of stakeholders indicated that patients who enter through the private specialist pathway will have most likely paid an out of pocket fee but will have arrived onto the Elective Surgery or Planned Procedure list faster than a patient who was referred to the public Outpatient list. This is because the time to see a private specialist is shorter than the time for a patient to be seen in public Outpatients. While data was requested from CHS to understand the flow of patients entering through different pathways onto the Outpatient, Elective Surgery and Planned Procedure lists, this data is not available due to the way the e-Referral and DHR systems are configured. Configuring the systems to be able to easily analyse this data will be required to understand how patients are being placed onto, and flowing through, the lists.

With a view to improving the access of patients to Outpatient appointments and subsequently onto the Elective Surgery and Planned Procedure lists, there is an opportunity for CHS to undertake further formal analysis. This should involve a comprehensive mapping exercise to identify pathways in which patients can be placed onto an Elective Surgery and Planned Procedure list, along with points at which decisions are made or administrative steps are required. For example, presence (or absence of) standardised criteria for placement on waiting lists or referral guidelines. This mapping should be supported by data over a defined period, analysed to identify how patient journeys differ depending on referral entry point and clinical need or urgency. This analysis must be undertaken with full engagement with CHS specialists.

Recommendation 29

CHS, in full consultation with specialty clinicians, further develop the e-Referral and DHR systems to allow the analysis of pathways for patients to enter and flow through the public Outpatient, Elective Surgery and Planned Procedure lists. The analysis of these pathways and flows should then lead to agreed arrangements for each specialty area regarding how these pathways are managed.

Ongoing strengthening of Orthopaedic services across TCH and NCH

As captured earlier within the reports, consultation with stakeholders (including Specialists) in and connected with the CHS Orthopaedics area has been very informative, engaging and productive. In these consultations, issues were raised (consistent with other consultations) that the implementation of the Planned Care Reforms had occurred very quickly, without sufficient consultation, and with insufficient planning regarding the impact on patients, clinicians, the orthopaedic workflow, and

specialists and other clinicians outside CHS. However, the orthopaedic team has engaged with the Planned Care and CHI teams to work through ways to apply the principles underpinning the Planned Care Reforms within the orthopaedics area and addressing most concerns. The Orthopaedic Specialists have developed and documented an assessment methodology that is consistently applied to Outpatient referrals to allocate the urgency category. CHS should continue to work with the Orthopaedic services across TCH and NCH to further progress improvements in how services are networked across locations, and equity and timeliness of access.

Recommendation 30

CHS should continue to work with the Orthopaedic services across TCH and NCH, to further progress improvements in how services are networked across locations. This should seek to also continue to improve quality, equity and timeliness of services.

Ongoing strengthening of Cardiology services across TCH and NCH

As referenced earlier in this Report, consultation with stakeholders (including Specialists) in and connected with the Cardiology area of CHS during the Inquiry has been very informative, engaging and productive. As separate court proceedings are underway, specifically related to this clinical area and out of an abundance of caution, summarised individual submissions or consultation materials related to this area are not included in this report. This approach avoids the potential to be perceived to have an impact on the legal proceedings. However, the Inquiry has drawn on the broad themes throughout the process, and the subsequent analysis, to inform the following recommendation in this report relating to Cardiology.

Recommendation 31

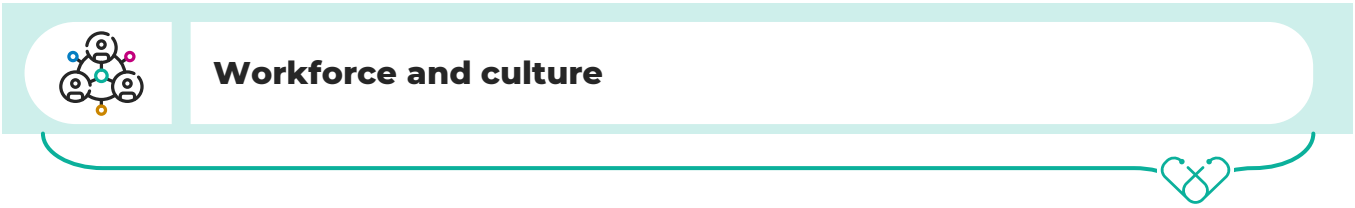
CHS should continue to work with the Cardiology services across TCH and NCH, to further progress improvements in how services are networked across locations. This should seek to also continue to improve quality, equity and timeliness of services.

Chapter 7 Workforce and culture

Workforce and culture are regarded as the critical foundations of any sustainable health system. Workforce encompasses the people within the health system that are employed to deliver care, drive improvement and innovation and ultimately, determine the health outcomes and experience of all patients that flow through the system. Culture describes how these people work together and interact, including collaboration, navigating organisational hierarchies to make decisions, ensuring wellbeing and psychosocial safety, solving complex problems and enacting change or reform. The Inquiry acknowledges the significant effort the ACT health system has made to uplift workforce and culture since 2018.

Navigating this chapter

The following visual provides an overview of the structure of this chapter.



7.1 Consultations and submissions summary

Workforce and culture were common themes raised throughout stakeholder consultations. Stakeholders observed that, while efforts have been made to uplift workforce culture, there continues to be challenges affecting recruitment, retention and workforce morale. Stakeholder also identified opportunities to enhance leadership and training programs, and research capabilities. Stakeholders identified that improvements could be made to strengthen an enterprise-wide approach to a consistent, standardised and automated shared services across HCSD and CHS, including HR/payroll, rostering, learning management and finance.

The following chapter outlines thematic findings that emerged from stakeholder consultations and submissions relevant to workforce and culture. It also contains a comprehensive description and analysis of recent initiatives undertaken to uplift workforce and culture. This includes the Independent Review into Workplace Culture within ACT Public Health Services (2019-2021) and three associated annual reviews, along with key findings that emerged from the 2025 ACT Public Service Employee Survey (ACTPS Employee Survey). Finally, this chapter outlines key recommendations to continue the journey to enhance workforce and culture.

Culture of the ACT public health system

An emerging theme from consultations and submissions was the strong commitment of staff to the ACT public health system, along with significant initiatives undertaken to improve workforce culture, instigated by the Independent Review into Workplace Culture within ACT Public Health Services (2019-2021). Examples provided by stakeholders included staff foregoing private work during COVID-19 and allocating to undertaking and providing education and training.

Notwithstanding this, consultations highlighted persistent cultural challenges within the ACT health system and an ongoing need to assess internal and external factors that continue to impact workforce culture. Many stakeholders identified workplace and cultural concerns stemming from poor change management driven by past administrative or managerial leadership. Despite new initiatives representing better-practice and thus, having the capacity to prompt meaningful, positive change, some reforms have not appropriately engaged or collaborated with expert clinical teams or users from the inception. Approaches to change management have therefore, significantly constrained uptake and the capacity for sustainable reform and innovation.

Some stakeholders also identified opportunities to improve trust and transparency, including clear avenues and mechanisms for clinicians to raise feedback, complaints, concerns and improvement opportunities to leadership. Stakeholders highlighted the importance of feeling confident that their psychosocial safety will be protected by managers and that there will be no consequences. Consistent with other reviews conducted in the past, there were also concerns raised from some stakeholders about cultural safety and racism within the health system, including for First Nations peoples and people from culturally and linguistically diverse backgrounds.

Many clinical stakeholders reflected on the criticality of strong team relationships in high-pressure health settings, where rapid or urgent response is required. Stakeholders emphasised that swift, safe and accurate care relies on a clinical team's ability to rapidly mobilise, communicate effectively and anticipate each other's needs. Stakeholders flagged that shortfalls in workforce culture therefore not only contribute to stress, burnout and enhanced workforce turnover but post a direct risk to patient safety and outcomes.

Recruitment, training and leadership capability

Stakeholders identified initiatives in place to support improving workforce training and culture, including strategies such as a dedicated FTE for supervising trainees. In saying this, stakeholders reflected that training programs are predominantly delivered through self-paced, online modules or short, stand-alone sessions. Stakeholders noted the absence of a clear, organisational leadership development approach to prepare staff transitioning into leadership positions, underpinned by strong executive sponsorship and organisational accountability. This includes a focus on essential skill sets for managers, including change and performance management, communication, financial acumen, governance and risk management, among others. Due to a lack of an organisational approach to leadership and management development, newly appointed leaders are required to learn essential skills on the job to carry out their roles effectively. Stakeholders also identified a need to grow the First Nations workforce and consider the workforce model, including the pathway for recruitment, training, and leadership opportunities.

In addition to this, opportunities were identified during consultations to invest more heavily in innovation and research. Stakeholders reflected on the importance of all staff (from junior doctors in training to well-trained academic supervisors) having the opportunity to undertake research and development activities. In addition to this, stakeholders identified the benefits of affiliation with universities through scholarship programs. Historically, these partnerships have provided student-to-employee pathways that accelerate junior doctor's transition into the workforce. Overall, stakeholders reflected on the importance of a strong research and education culture leading to improved clinical practice and culture.

Systems impacting workforce culture (HR, payroll, rostering and learning management)

Stakeholders interviewed acknowledged the importance of staff mobility and working across different health facilities, to ensure patients receive the best care, while fostering collaboration, professional growth and operational efficiency. In saying this, stakeholders reflected concerns associated with a fragmented approach to shared services across the ACT health system, such as HR/payroll, rostering and the Learning Management System (LMS). While in some locations (such as NCH) staff have access to electronic rostering systems, other locations (such as TCH) carryout rostering through various siloed systems and methods. This includes rostering carried out through manual, paper-based formats, simple spreadsheets or stand-alone local rostering applications.

Through consultations, staff highlighted significant frustration and dissatisfaction with this approach. Most significantly, lack of integration and interoperability at an organisational level has meant that staff who are required to work across multiple locations, must use multiple systems, resulting in duplication of effort and significant manual workarounds. In addition to this, maintenance of multiple, siloed systems has prevented the ability to generate a central repository of workforce information. This is critical, as it allows the ACT health system to obtain a system-wide view of the workforce (including FTE, headcount, skills and experience), to support coordinated workforce planning and forecasting, governance and data-driven policy and decision-making. Collating this information is currently undertaken manually.

Through consultations, stakeholders reflected that, despite some challenges encountered, electronic rostering systems that take a strategic and enterprise-wide approach to simplify, standardise and automate shared services across HCSD and CHS are preferred over other arrangements.

7.2 Current state analysis

An emerging theme from consultations and submissions is the strong commitment of staff to the ACT public health system, along with significant initiatives undertaken to improve workforce culture. Workforce and culture within the ACT public health system was first evaluated by the Independent Review into Workplace Culture within ACT Public Health Services (2019-2021).[157] This provided 20 recommendations to embed values of collaboration, integrity and respect into the ACT public health system. Since the Final Report was published and recommendations formally endorsed by the ACT Government in May 2019, independent and external annual reviews have been performed in 2020, 2021 and 2022 to track implementation of findings and recommendations to ensure ongoing positive change.

The Inquiry acknowledges the importance of past initiatives to uplift workforce and culture. This section of the Inquiry Final Report seeks to compile, review, and summarise key findings and recommendations from past reviews. By doing so, the Inquiry aims to ensure a clear understanding of outstanding issues, avoid duplication of effort, and provide a constructive foundation for meaningful action to address ongoing workplace cultural issues within the ACT public health system.

Independent Review into workplace culture within ACT public health services (2019-2021)

In 2018, the then ACT Minister for Health and Wellbeing, issued a statement on workplace culture within the ACT Public Health System. This statement was in response to persistent allegations and public pressure regarding bullying, harassment, poor governance and a negative environment within ACT's Public Health System.

This statement led to a comprehensive Independent Review into Workplace Culture within ACT Public Health Services (2019-2021) (the 2019 Culture Review). The 2019 Culture Review analysed close to 400 formal submissions from individuals and organisations.[158]

A number of common issues were highlighted, including:

- poor leadership and management at many levels throughout the ACT Public Health System
- inefficient and inappropriate HR practices, including recruitment
- inadequate training in dealing with inappropriate workplace practices
- inefficient procedures and processes including complaints handling
- inappropriate behaviours and bullying and harassment in the workplace
- inability to make timely decisions[159]

[157] Australian Capital Territory 2019, Independent review into the workplace culture within ACT public health services: Final report, ACT Government, Canberra.
[158] Independent review into the workplace culture within ACT public health services: Final report, ACT Government, Canberra.
[159] Independent review into the workplace culture within ACT public health services: Final report, ACT Government, Canberra.

Data was also analysed from 1,953 online survey responses, which were received from the three 'arms' of the ACT Public Health System, comprising CHS, ACT Health Directorate and Calvary Public Hospital (now known as NCH). The survey responses highlighted key trends relating to the ACT Public Health Services' resolving of grievances, workplace conduct, unacceptable conduct and complaints handling. Notably:

- Only 22% of respondents have confidence in the ways the organisation resolves grievances (18% agree, 4% strongly agree)
- 53% of respondents have witnessed misconduct or wrongdoing at work
- 61% have witnessed bullying at work
- 35% have been subjected to bullying at work
- 12% have been subjected to physical harm, sexual harassment or abuse at work within the last 12 months, with 46% of perpetrators being a person at work
- 38% of respondents have submitted a formal complaint regarding the incident/s they were subjected to in the last 12 months, with 49% of respondents saying they were not satisfied with the outcome of the formal complaint process[160]

Findings and recommendations from the 2019 Culture Review were also synthesised from extensive interviews and forums with a broad spectrum of groups and stakeholders, which sought to test findings about problems and issues, discuss areas of best practice and identify practical solutions.

Final conclusions of the 2019 Culture Review

The 2019 Culture Review's Final Report was published in March 2019 and provided 20 recommendations to remediate 'a worrying and pervasive poor culture across the ACT Public Health System.'[161] Recommendations have been categorised in **Table 23** based on primary focus and action.

Table 23: 2019 Culture Review's Final Report recommendations[162]

Primary action	Recommendations mapped from 2019 Culture Review
Establishment of a new forum/group	R4: Convene a summit for clinical service coordination. R18: Establish a Cultural Review Oversight Group. R19: Cultural Review Oversight Group to conduct annual external reviews.
Policy development or enhancement	R2: Develop measures to monitor patient outcomes/experiences. R8: Develop an MoU between ACT and NSW for collaboration. R11: Assess the Choosing Wisely initiative's suitability for safety and governance improvement.
Staff engagement and re-engagement	R1: Re-engage staff with vision and values. R9: Improve clinical engagement throughout the ACT Public Health System. R20: Engage staff in change management and communication strategies.
Leadership and governance	R10: Require senior clinicians' participation in clinical governance. R12: Evolve clinically qualified divisional directors with business manager support. R13: Introduce executive leadership and mentoring programs for current and future leaders.
Cultural and workplace improvements	R3: Promote a healthier workplace culture to reduce inappropriate behaviour. R17: Joint public commitment to implement recommendations for cultural improvement.

[160] Independent review into the workplace culture within ACT public health services: Final report, ACT Government, Canberra.
[161] Independent review into the workplace culture within ACT public health services: Final report, ACT Government, Canberra.
[162] Independent review into the workplace culture within ACT public health services: Final report, ACT Government, Canberra.

Primary action	Recommendations mapped from 2019 Culture Review
HR and recruitment review	R14: Review HR staffing numbers and functions to address concerns. R15: Ensure recruitment processes align with relevant standards and procedures.
Training and development assessment	R16: Review training programs to align with needs identified in the Review.
Improved communication	R6: Re-establish communication with NGOs and stakeholders. R20: Develop a communication strategy for addressing identified issues.
Research and support	R7: Strongly support initiatives underway to develop a coordinated research strategy.
Implement oversight	R18: Establish Cultural Review Oversight Group. R19: Conduct annual independent review of recommendations implementation.

All recommendations were formally endorsed by the ACT Government and leaders that comprise the ACT public health system. This included the then Minister for Health and Wellbeing, Minister for Mental Health, Director-General, ACTHD, Chief Executive Officer (CEO), CHS and Regional CEO and Calvary Public Hospital. These leaders jointly and publicly committed to implementing the 20 recommendations.

This leadership endorsement was further reinforced by a Public Commitment Statement issued on 4 September 2019 by the leaders of the organisations represented in the Culture Reform Oversight Group (Oversight Group). In addition to the Oversight Group, governance and oversight of the culture reform implementation process was supported and enabled by the Culture Review Implementation Steering Group (Steering Group) and Culture Review Implementation team (ACTHD).

Annual Review into Independent Review into workplace culture within ACT public health services

Three annual reviews were completed for 2020, 2021 and 2023 to provide a yearly assessment on progress to implement recommendations that emerged from the Independent Review into Workplace Culture within ACT Public Health Services (2019-2021).

The First Annual Review

In 2020, the *ACT Public Health Services Cultural Review Implementation Inaugural Annual Review* (the first annual review) identified that early progress on implementation was good, however, it was *'too short a timeframe to expect significant improvement'* in workplace culture.[163]

The Second Annual Review

In 2021, the *Culture in the ACT public health system: Second Annual Review* (the second annual review) acknowledged foundational work that had been implemented to enhance workplace culture.[164] This review found that governance arrangements were sufficient with appropriate representation, however acknowledged tensions between some members which hindered their ability to fully participate in a collaborative change process. The second annual report provided recommendations to further enhance governance and oversight. This included slight amendments to the operation, roles and responsibilities, information sharing and learning practices espoused by the Oversight Group and Steering Group. This resulted in the formation of supporting working groups to enhance the exchange of information and learnings between ACT public health organisations.

[163] M Reid & Associates 2020, ACT Public Health Services Cultural Review Implementation-Inaugural annual review, ACT Government, Canberra.
[164] Leon Advisory 2021, Culture in the ACT public health system: Second annual review, ACT Government, Canberra.

The second annual review also acknowledged good foundational work in place to deliver recommendations of the 2019 Culture Review. This included greater focus on defining and disseminating a set of organisational values, which formalise expectations for behaviour and performance. This was delivered through an evidence-based Workplace Cultural Framework, which was delivered in May 2020. The Workplace Cultural Framework identified five workplace change priorities for the ACT health system, along with key prerequisites required to make the change and measure success. While the second annual report acknowledged the importance of this foundational document, it provided commentary that its impact on cultural reform was minimal and there was misalignment between the Framework and staff training programs administered by the ACT public health system. The review also observed that, despite the Cultural Review Implementation Program being underway for two years, there had been no significant management or leadership training due to delays in decision-making and procurement.[165]

In addition to this, the second annual review identified the value of the ACT health system's adoption of an Organisation Culture Improvement Model (OCIM). This OCIM provided a structured framework to better understand and measure the organisational maturity of systems, processes and procedures that support workplace culture. As part of this, five priority areas were assessed against a four-level scale, which were initiating, emerging, engaging and integrated. While the importance of the OCIM model was noted, the second annual report flagged that no change in maturity has been observed across the ACT public health system from 2019 to 2020. In 2019, CHS, ACTHD and Calvary Hospital were assessed as having the lowest level of maturity (initiating) across OCIM priority areas and did not progress to the second level of maturity (emerging) by 2020, although scores improved.

The second annual review also identified the value of the ACT health system's rollout of the Cognitive Institute's Speaking Up for Safety training across CHS and CPHB, which endeavoured to encourage and empower staff to raise workplace concerns. The organisation had also begun efforts to streamline procedures to handle complaints and behavioural issues, with greater involvement of clinicians in management and governance decisions in the health services.

The Third and Final Annual Review

In 2023, the *Workplace culture within the ACT Public Health System: Third and Final Annual Review* (the third and final annual review) was published. This third and final review highlighted that, while evidence of cultural reform initiatives could be seen through enhancements to governance, systems, processes and reporting, momentum was low and system-wide impacts were difficult to measure.[166]

This was demonstrated by OCIM data, which was used to obtain system-wide insights on the maturity of systems, processes and procedures that support workplace culture. Analysis of this data only showed minor improvements in the uplift of systems and processes to manage workplace civility (including the handling of complaints about workplace behaviour) from 2019 to 2021.

Through consultation with employees, there were notable gaps in participant's understanding of the complaints management system or process, and work was still outstanding to support and empower staff members to raise complaints about workplace behaviour, especially junior doctors and student clinicians. In saying this, the review acknowledged that the rollout of the Promoting Professional Accountability program across CHS will support these cohorts with training.

In addition to this, the third and final annual review utilised available datasets (including employee surveys and the Workforce Effective Dashboards) to draw conclusions about staff engagement,

[165] Culture in the ACT public health system: Second annual review, ACT Government, Canberra.
[166] Proximity 2023, Workplace Culture within the ACT Public Health System, Third and Final Annual Review, Canberra, 2023.

bullying and harassment and complaints reporting across the three organisations of the ACT public health system. Data observations include:

Staff engagement

- Staff within ACTHD (now known as HCSD) had improved engagement levels between 2019 and 2021. The 2019 Workplace Climate Survey data indicated 42% of staff were engaged compared to 84% reported in the 2021 Staff Survey Results.
- For CHS, data from the Workplace Culture Survey indicated that staff that were 'openly positive, optimistic and engaged about the organisation's future' had increased from 40% in 2019 to 44% in 2021. Staff that were 'openly negative, pessimistic and disengaged from the organisation's future' remained similar, increasingly slightly from 18% in 2019 to 19% in 2021.
- The lack of consistent survey reporting made it difficult to directly compare between CHS and ACTHD.[167]

Bullying and harassment

- Data from the 2021 Workplace Culture Survey indicated that there was a reduction in the prevalence of bullying and harassment. In 2021, 27% of CHS staff had experienced bullying and harassment compared to 44% in 2019.
- Data from the 2021 Staff Survey did not show chance overtime, however indicated that 12% of ACTHD (now known as HCSD) had personally experienced bullying, with 15% saying they have witnessed it.
- The lack of consistent survey reporting made it difficult to directly compare between CHS and ACTHD (now known as HCSD).[168]

Complaints reporting

- Data on complaints reporting was minimal across the health system and there was no data available for CPHB.
- There was minimal workforce complaint data for ACTHD, however as of April 2022, the number of complaints appeared to be increasing.
- For CHS, as of April 2022, there was the highest number of open workforce complaints over a 16-month period.[169]

Progress against 2019 Culture Review recommendations

The third and final annual review analysed progress to implement the 20 recommendations of the 2019 Culture Review.[170] As of July 2022, all recommendations were endorsed as complete. It identified that only two recommendations had not been implemented, as the original recommendation was no longer fit-for-purpose. For example:

- Recommendation 4, which recommended a summit of senior clinicians be convened to improve clinical services coordination, was not achieved. However, an alternative direction was pursued through the establishment of an executive committee which had a remit to improve cooperation and collaboration across the ACT public health system.
- Recommendation 20, which called for a system-wide change management and communications strategy, had not been delivered. However, the three organisations developed communication

[167] Proximity 2023, Workplace Culture within the ACT Public Health System, Third and Final Annual Review, Canberra, 2023.
[168] Proximity 2023, Workplace Culture within the ACT Public Health System, Third and Final Annual Review, Canberra, 2023.
[169] Proximity 2023, Workplace Culture within the ACT Public Health System, Third and Final Annual Review, Canberra, 2023.
[170] Proximity 2023, Workplace Culture within the ACT Public Health System, Third and Final Annual Review, Canberra, 2023.

action plans consistent with this recommendation. Leaders also committed to cultural improvement initiatives to enhance collaboration and engagement.

While the third and final annual report acknowledges significant progress to enhance workplace culture, continuing areas of focus were outlined. This included enhancing the data and reporting capability required to measure system-wide changes to workplace culture, strengthening staff engagement and communication to improve productivity and workforce culture and governance.

CHS Leadership and management training

Leadership and management programs at CHS provide internal learning opportunities to build core management capability, support compliance and promote respectful, inclusive, and mentally healthy workplaces for leaders at all levels. While a broad range of development offerings are available, programs are generally recommended rather than mandatory and are primarily delivered through self-paced online modules, short virtual sessions or brief face-to-face workshops. Access is typically voluntary or requires manager nomination, with only a small number of programs offered by referral or as external, formal qualifications. As a result, participation and uptake is known to vary across work areas, with engagement often driven by individual or manager initiative rather than in a consistent, and organisationally encouraging and supportive manner. **Table 24** provides a list of leadership programs available to CHS staff members.

Table 24: Leadership programs available to CHS staff members

Course	Detail
Internal courses – recommended learning for managers and leaders	
Internal leadership and management training	
Management fundamentals	Internal program combining online modules and workshops to build core management, coaching, and change leadership.
Stepping Up	Leadership development for Level 1 nurses and midwives preparing for Level 2 roles.
Talk about SED	Short online session supporting effective performance development conversations using the SED framework.
Workplace and team foundations	Online training focused on improving team culture through shared responsibility and everyday practices.
Coaching programs	Supports deeper leadership reflection, decision-making, and professional development.
Respect, safety and wellbeing	
Respect at Work Pre workshop eLearning	Introductory module on respectful workplace principles, legislation, and unreasonable behaviour.
Respect at Work workshop	Interactive workshop building skills to identify and address unreasonable workplace behaviours.
Meridian LGBTIQA+ training	Training to build inclusive practice and improve care for LGBTIQA+ health service users.
From risk to resilience: Building psychologically safe and healthy workplaces	Training for managers on promoting psychologically safe and mentally healthy workplaces.
Operational debriefing	Practical training on facilitating effective debriefs and supporting staff after incidents.

Course	Detail
Psychological first aid	Training in providing immediate support following emergencies or traumatic events.
ACTPS Compassionate foundations	Self-paced eLearning to build suicide prevention, interpersonal, and self-care skills for all ACTPS staff.
Workforce management and compliance	
Champion privacy	Online training on safeguarding health records and responsible DHR use.
Probation and underperformance training for managers	Manager training on probation processes and addressing underperformance appropriately.
Resolving workplace issues – preliminary assessments for managers	Training for managers on responding to workplace complaints and conduct concerns.
Resolving workplace issues – preliminary assessments toolbox	Refresher training reinforcing preliminary assessment skills for workplace issues.
Staff recruitment and selection eLearning	Mandatory training outlining recruitment obligations for selection panel chairs.
Work health safety training for managers	One-day course on WHS legal responsibilities and risk management.
Managers Riskman training	Training supporting consistent reporting and management of workplace incidents.
External courses	
Public sector management program	Postgraduate program developing leadership capability for mid-level public sector managers.
Graduate Certificate in health leadership and management	Formal qualification focused on leadership and management in healthcare settings.

Supporting future enhancement: Payroll Capability and Human Resource Management (PC-HRM) Program

Through the 2023-24 Territory Budget, the ACT Government commenced the Payroll Capability and Human Resource Management (PC-HRM) Program. The purpose of this Program is to take a whole-of-government approach to modernise HR and payroll systems used by the ACT Public Service, along with decommissioning legacy software. Key components of the Program include:

- Closure of the Human Resources (HR) Information Management System (HRIMS) initiative
- Program initiation, and establishment and governance
- Upgrade to Comprehensive Human Resource Information System 21 (Chris 21, where 21 stands for 21st century) – Chris21 is the HR/Payroll component of the system
- Design and implementation of a whole-of-government time and attendance system

The PC-HRM Program is currently underway, with an expected completion date of the end of June 2027.

Chris21 - HR capability

As part of the PC-HRM Program, the ACT Government is upgrading the whole of government instance of the Chris21 HR/Payroll system. When fully upgraded, this system will be used for all ACT Government employees, except for the NCH employees who will remain on their current instance of Chris21.

When the upgrade is complete, at the end of June 2027, CHS will still have two HR/Payroll systems, meaning that manual processes will still need to be used to have a whole of CHS view of their workforce. It will also mean that staff working in NCH and any other location in CHS will need to be in two HR/Payroll systems to ensure accurate role information. The impact on staff will be reduced because of the use of a single rostering system, but staffing, efficiency and planning challenges will remain. It is very important for the ACT to urgently consider moving all health staff (and therefore all ACT Government staff) onto a single HR/Payroll instance to allow for a complete view of the health workforce and more efficient workforce management and planning.

It is important to flag that CHS does not use Chris21 HR/Payroll system to record details of non-employees, including contracted staff such as VMOs. As contracted staff such as VMOs are paid from the finance system. This means that, at the completion of the PC-HRM Program (based on current scope), CHS will still not have a single register of all staff, including contracted staff, within their HR system. Moving forward, it will be important for CHS to explore opportunities to record all staff (including contracted staff) in a single system, such as Chris21. This additional functionality would also allow CHS and HCSD to record information such as qualifications, AHPRA registrations and other data to assist with workforce management and planning.

Rostering capability - UKG Pro

As part of the PC-HRM Program, the ACT Government is moving all rostered ACT Government staff to a single platform called Ultimate Kronos Group Pro (UKG Pro, where Pro is UKG's leading workforce management platform for large organisations with complex workforce management needs). UKG Pro is integrated with Chris21. As of April 2026, 8,300 staff have been transitioned to UKG Pro, with 11,000 remaining and expected to be completed by June 2027. Due to the unique requirements of different business units, transition is occurring incrementally on a cohort-by-cohort basis.

NCH are already using UKG Pro that is integrated to their instance of Chris21. When the rollout of the rostering system is complete, at the end of June 2027, all HCSD and CHS staff will be using UKH Pro but, depending on what role you are undertaking, the rostering system will integrate with either the whole of government version of Chris21 or the NCH version. This is a complexity that will cause challenges for staff working in NCH and any other location in CHS or HCSD.

Moving all CHS and HCSD staff to the same rostering and HR/Payroll system is critically important to improve the morale and culture of staff, as well as the ability for CHS and HCSD to undertake comprehensive workforce management, development and planning. Staff have said that the current arrangements of using paper-based systems, local spreadsheets, and in some instances stand-alone rostering applications is time consuming, confusing and often results in delays in updates to the roster ahead of each pay cycle. The roster system transition is being undertaken with strong consultation with staff, and it is important to maintain the strong engagement and achieve the transition with as minimal disruption as possible and within the current forecast time frame of June 2027.

Learning management system (LMS)

The ACT Government currently has a whole of government LMS system using an SAP platform, which is currently used by all ACT Government employees. The LMS is a contemporary platform that has an ongoing program of improvement work as part of the usual business of maintaining applications. Improvements to the ACT Government LMS is intentionally not part of the PC-HRM Program scope. There is some interfacing of the LMS with the Chris21 system (e.g. names and organisational details). It is a system designed to manage mandatory and voluntary training and is not fully integrated into other HR systems to be a comprehensive Human Capital Management system.

Consideration should be given to moving to a fully integrated Human Capital Management system that fully integrates the LMS into the HR/Payroll system and allows for all activities (including recruitment, payroll, learning and development, qualifications and registrations, workforce planning etc) to be easily accessed, analysed and reported.

Finance systems

Currently, there are different finance systems used across HCSD and CHS. This presents a risk to accurate financial reporting and activity billing. It is also a particular challenge in relation to activity-based funding where the financial allocation methodology is both complex and critically important to receive all available Commonwealth funding.

The Inquiry understands that consideration is being given to move to a contemporary whole of government finance system that will include CHS and HCSD. Progressing such an initiative will be useful in assisting CHS and HCSD to identify funding efficiencies, ensure ABF allocation methodology is accurate, and to capture all own source revenue billing.

2025 ACT public service employee survey (ACTPS employee survey)

Conducted every two years, the ACT Public Service Employee Survey (ACTPS Employee Survey) provides an important opportunity for staff to provide feedback on workforce culture, including the identification of strengths, gaps, limitations and opportunities for improvement. Areas of focus include communication, change, misconduct, supervisor support, leadership and job satisfaction, among others. The Survey is managed by the Office of Industrial Relations and Workforce Strategy (OIRWS) Research, on behalf of the ACT Government. Data and feedback collected from staff through the survey are strictly confidential and no individual is identifiable from any output.[171]

Themes that emerge from the survey are used as the basis for action planning, which is a process that turns feedback into tangible improvements. For example, the identification workforce policy and initiatives across government. For each theme identified, targeted actions and associated responsibility and timelines are set.

For the ACTPS Employee Survey, action planning is performed by leadership at 2 or 3 levels, including:

- **Whole of service** – action planning focuses on identifying themes provided by staff across all participating directorates or sector-wide.
- **Directorate (or sector entity)** – action planning focuses on identifying themes provided by staff across a single directorate or sector entity.
- **Division or branch** – action planning focuses on identifying themes provided by a single division or branch.

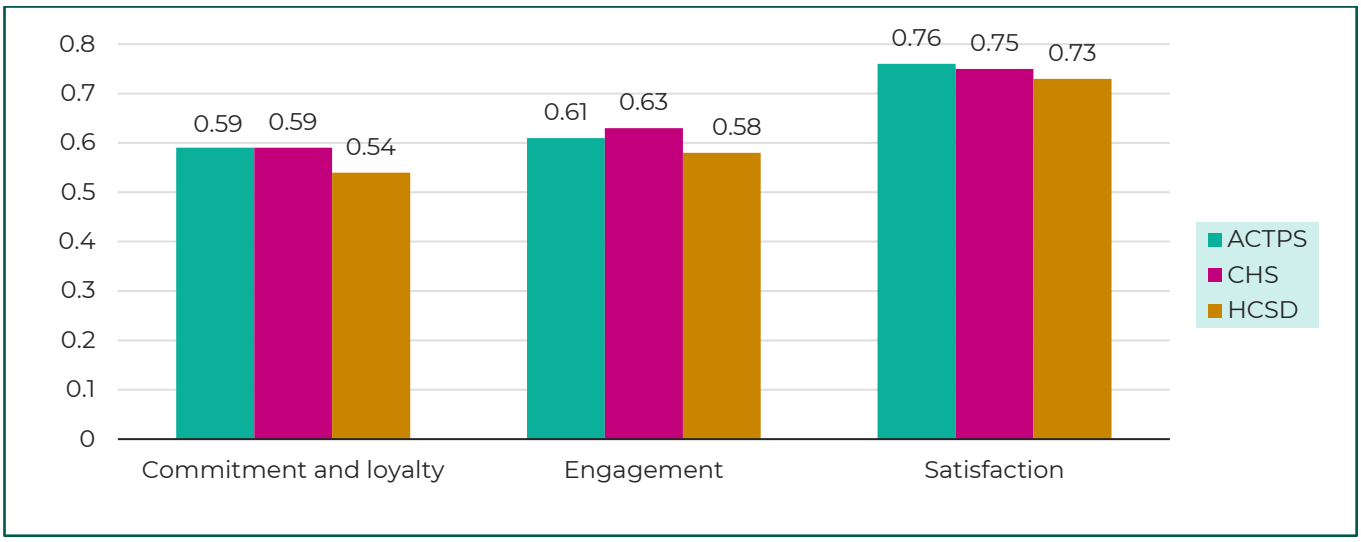
The latest iteration of the ACTPS Employee Survey (2025 ACTPS Employee Survey) was open to staff from 1 – 21 September 2025. Notably, the 2025 survey marked the first time that all eight Directorates and six public sector entities participated, which resulted in a 70% increase in the number of respondents (from 7,889 to 13,506 participants). High level observations and findings from the 2025 ACTPS Employee Survey are outlined below.

[171] Australian Capital Territory 2025, ACT Public Service Employee Survey (ACTPS Survey), ACT Government, Canberra.

Key outcome measures

When examining the key outcome measures of 'commitment and loyalty', 'engagement' and 'satisfaction', the performance of CHS and HCSD is generally aligned with ACTPS-wide results (see **Figure 35**). In saying this, HCSD performed slightly below both the overall ACTPS and CHS across three key measures.

Figure 35: ACTPS employee survey - key outcome measures[172]



Key strengths

Both CHS and HCSD survey respondents identified the following key strengths:

- Customer service culture (CHS: 88%; HCSD: 86%)
- Role clarity (CHS: 86%; HCSD: 79%)

In addition:

- CHS respondents identified job security as a key strength (81%)
- HCSD respondents highlighted team performance (84%) and autonomy (84%) as areas of strength

Opportunities to improve

In terms of opportunities to improve, both CHS and HCSD survey respondents identified key opportunities for improvement:

- Inclusivity (CHS: 60%; HCSD: 62%)
- Support for health and wellbeing (CHS: 49%; HCSD 53%)
- Trust in ACTPS integrity (CHS: 52%; HCSD 54%)

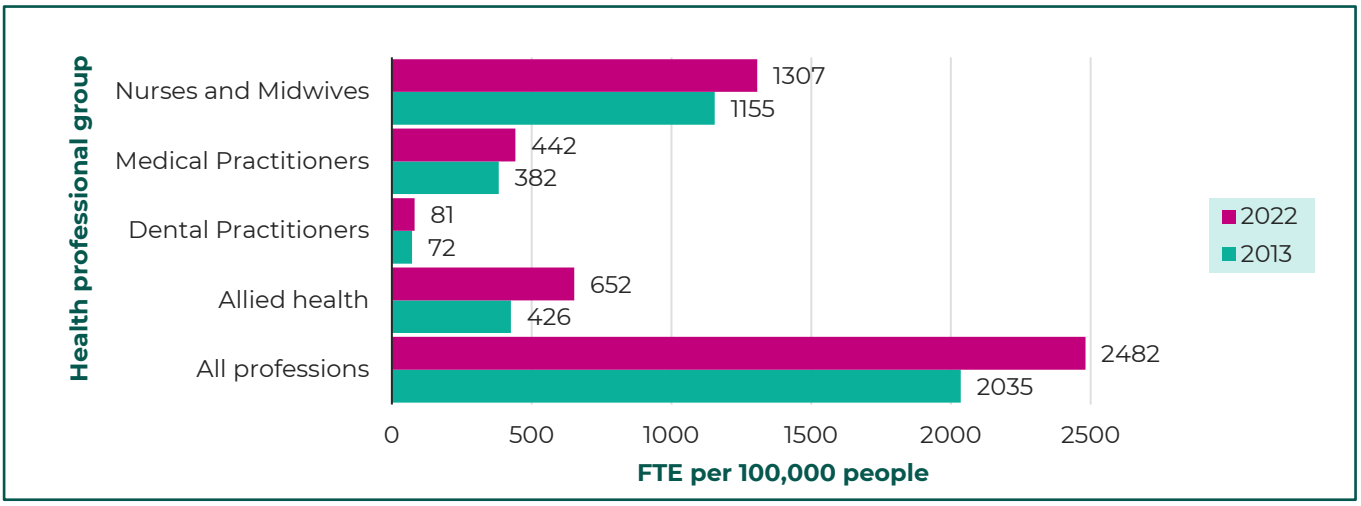
In addition, HCSD also identified goal clarity (71%) as an area for improvement.

[172] Internal data provided to the Inquiry from CHS and HCSD.

Jurisdictional comparison – FTE

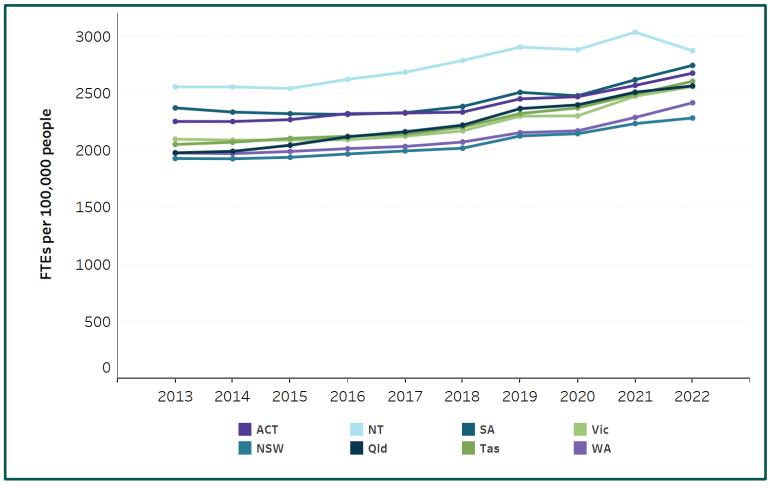
Australia-wide, the number of FTE health professionals per 100,000 population has increased from 2,035 in 2013 to 2,482 in 2022. This equates to a 22% increase in FTE per 100,000 people across all health professional groups. When looking at health professional groups individually, the highest proportion of change was observed in allied health professionals, which increased by 53% from 2013 to 2022 (**Figure 36**).[173]

Figure 36: ACT Full time equivalent rate (per 100,000 people) by profession (from 2013 to 2022)[174]



When looking at how FTE varies by jurisdiction, the highest FTE rate was observed in NT. In 2022, NT had an FTE rate of 2,874 per 100,000 people for all professions. The second highest FTE rate was observed in SA, with an FTE rate of 2,746 per 100,000 people for all professions in 2022. ACT had the third highest FTE rate per 100,000 people for all professions in 2022. This measured 2,678 FTEs per 100,00 people. NSW had the lowest FTE rate across all professions, which was measured at 2,285 FTEs per 100,000 people (**Figure 37**).[175]

Figure 37: Variation of FTE across jurisdictions[176]



[173] Australian Institute of Health and Welfare n.d., Health workforce, AIHW, Canberra.
[174] Australian Institute of Health and Welfare n.d., Health workforce, AIHW, Canberra.
[175] Australian Institute of Health and Welfare n.d., Health workforce, AIHW, Canberra.
[176] Australian Institute of Health and Welfare n.d., Health workforce, AIHW, Canberra.

7.3 Future state recommendations

The Inquiry acknowledges the importance of past initiatives to uplift workforce and culture and sees no benefit in duplicating these. Nonetheless, the consultations highlighted ongoing opportunities to improve culture, especially clinical collaboration and engagement.

The following extract from the letter to Minister for Health at the beginning of this Report describes the importance of the way all recommendations within the report are implemented:

> There are recommendations for each of the Report's organising themes. There are also common threads running through the recommendations that are essential to their successful implementation:
>
> - Open engagement with clinicians, other staff, health consumers, and external stakeholders.
> - Strong collaboration between the Health and Community Services Directorate, Canberra Health Services, Digital Canberra and Infrastructure Canberra.
> - Clarity and transparency in the way things are organised, governed and changed.
>
> The sustainability of the improvements arising from the recommendations will require a strong focus on and shared commitment to these common threads throughout implementation.

Culture and workforce will improve if all recommendations are implemented with the three threads of engagement, collaboration, and clarity and transparency.

Enhancement of leadership development and training programs

Good leaders operating in a supportive culture are essential for an organisation and system to thrive. Whilst policies and programs to improve culture are important, culture is shaped day by day by what leaders do and what they prioritise. Leaders set the tone for how people are treated and whether voices are heard. To this end, building leadership competencies across the health system is central to building a great culture. Leadership is also critical to the successful implementation of all the recommendations in this Report and building a strong and collaborative leadership culture will make implementation easier and the improvements more likely to stick.

While a range of online, self-paced leadership and development training programs are available to cohorts of CHS staff (as captured in **Table 24**), stakeholders highlighted that there is an absence of an organisation-wide and structured leadership training program. This is essential to ensure that CHS adopts a proactive and scalable approach to building core leadership competencies across the ACT health system.

To bridge this gap, there is an opportunity for CHS to develop a formal organisation wide leadership training program to effectively prepare all clinical and non-clinical staff transitioning into leadership positions. This leadership program should be endorsed and championed at an executive level, to ensure a pipeline of skilled leaders that are equipped to support teams, drive reform and deliver high quality, safe, efficient and patient-centred care.

This training program must acknowledge that leaders within the ACT health system require a distinct and expanded capability set beyond technical or frontline expertise. This includes proficiency in areas such as strategic planning and system-wide decision making, financial acumen, governance, risk management, change management, performance management, strategic communication, importance of fostering a culture that embraces multi-disciplinary healthcare teams and 'soft' skills, such as emotional intelligence, mentorship, conflict resolution and cultural competence. This training program should ensure special consideration for the First Nations workforce, including cultural safety and training pathways relevant to the contexts of Aboriginal and Torres Strait Islander staff.

Recommendation 32

CHS reviews its current leadership development programs to enhance the leadership development offerings and opportunities in CHS.

Optimisation of enterprise HR, payroll, rostering and learning management systems (LMS)

The PC-HRM Program is currently underway and adopting a whole of government approach to modernising HR and payroll systems used by the ACT Public Service. As part of this Program, the ACT Government is upgrading the instance of the Chris21 HR/Payroll system, with an estimated completion date of the end of June 2027. Noting the challenges encountered by staff utilising legacy HR/payroll and rostering systems identified above, this Program is likely to significantly improve the morale and culture of staff, as well as the ability for CHS and HCSD to undertake comprehensive workforce management, development and planning.

It is important to flag that CHS does not use Chris21 HR/Payroll system to record details of non-payroll staff, including independent contractors such as VMOs. As contracted staff, VMOs are paid through an alternative route from the finance system. Consequently, despite the positive outcomes likely to be realised through the PC-HRM Program, the current scope will not enable CHS to have a single register of all employed staff, including contracted staff. Without a single system, this will continue to constrain visibility, reporting, planning and monitoring across the workforce and result in additional administrative burden. Moving forward, there is an opportunity for CHS to explore the feasibility of leveraging the Chris21 HR/Payroll system to capture non-payroll staff, including VMOs.

Other jurisdictions have successfully integrated the recording of VMOs in the HR system to allow for a complete picture of the workforce. There are also electronic systems being used in other jurisdictions such as NSW Health's deployment of VMoney Web, which is currently used by approximately 7,000 VMOs across 18 NSW Health organisations to process 6,500 claims per month.[177]

Currently within CHS, collating information about the whole workforce relies on significant manual effort and is reactive in nature. There is an opportunity for CHS to develop a whole of workforce view, including size, distribution, skill mix and demographics of staff across medical, nursing, allied health and other employee streams. Collating information of this kind enables a system wide view of the workforce, to support forecasting, along with a proactive and evidence-based approach to improve the efficiency of health service delivery.

[177] eHealth NSW, VMoney Web, NSW Government.

Recommendation 33

The HR/Payroll and Rostering systems being rolled out within CHS be progressed to cover all staff as soon as possible, so that all staff are using the same systems and that systems are as fully digital as possible.

Recommendation 34

CHS develop a whole of workforce view of medical, nursing, allied health and other employee streams.

Formation of a work effort model that allocates an FTE value to all staff

There is an opportunity for the ACT health system to implement a work effort model that allows an FTE value to be allocated to all staff working within the ACT health system, including contract staff such as VMOs. While VMOs are not salaried employees, assigning an FTE value to these employees creates a standardised and consistent way to compare and aggregate the workforce. The creation of a work effort model that allows an FTE value to be allocated to all staff working within the ACT health system supports the following practices:

- **Workforce planning and optimisation**: By standardising workforce contributions into an FTE model, the ACT health system can better quantify workforce capacity and plan and allocate resources. Instead of relying solely on headcount for some workforce groups a work effort model provides visibility of total hours available. This ensures that staffing levels align with patient care demands and operational needs.
- **Cost management**: An FTE model provides clearer visibility of estimated employee related costs, enabling the ACT health system to manage budgets more effectively.
- **Consistency in service delivery**: Transitioning to an FTE model helps ensure consistent availability of healthcare professionals, reducing variability in service delivery and improving patient care.
- **Enhanced accountability**: An FTE model allows for better tracking of workforce productivity and performance, supporting an improved understanding of workforce pressures and possible solutions.
- **Integration of workforce**: Converting contracted and VMO staff into an FTE model fosters better integration and collaboration within the healthcare team, promoting a more cohesive and efficient work environment.

Recommendation 35

CHS create a work effort model that allows all staff (including VMO and other contract staff) to be allocated an FTE value.

Creation of a First Nations workforce strategy to enhance organisational diversity, innovation and cultural competency

Consultations with stakeholders consistently highlighted the under-representations of Aboriginal and Torres Strait Islander employees in the ACT health system, across all roles, levels and locations. HCSD is in the process of developing a First Nations Workforce Strategy as the overarching framework to attract, develop and retain Aboriginal and Torres Strait Islander employees. Completing the First Nations Workforce Strategy should progress as quickly as possible, in collaboration with First Nations staff and stakeholders outside the ACT health system.

To complement this Strategy, CHS should develop a First Nations Workforce Plan that applies specifically to CHS. The plan should be a comprehensive outline of how CHS will increase its First Nations workforce, provide for career structure and progression, and develop First Nations employees to undertake leadership roles in the organisation. This plan will play an important role in delivering better health outcomes for Aboriginal and Torres Strait Islander people. The development of a First Nations Workforce Strategy and a CHS First Nations Workforce Plan, will support a more culturally safe and inclusive workplace, where First Nations employees feel valued and supported. The Strategy and Plan should consider the following:

- **Tailored recruitment processes**: A tailored application process, including culturally safe interviews and support from dedicated inclusion leads.
- **Clear career pathways**: A structured approach to specific roles, recognising cultural competence as well as professional experience and qualifications, and pathways to senior roles including management and executive roles.
- **Professional growth opportunities**: Opportunities to work on projects that impact Indigenous communities. These initiatives empower First Nations employees to grow professionally and contribute meaningfully.
- **Retention through support and flexibility**: Additional benefits, such as mentorship and training opportunities that allow for increased professional qualifications and preparation for leadership roles.

Recommendation 36

HCSD finalise the development of the First Nations Workforce Strategy for the ACT health system.

Recommendation 37

CHS develop a First Nations Workforce Plan to support recruitment, retention, professional development, and career pathways for First Nations peoples.

Chapter 8 Data collection and reporting

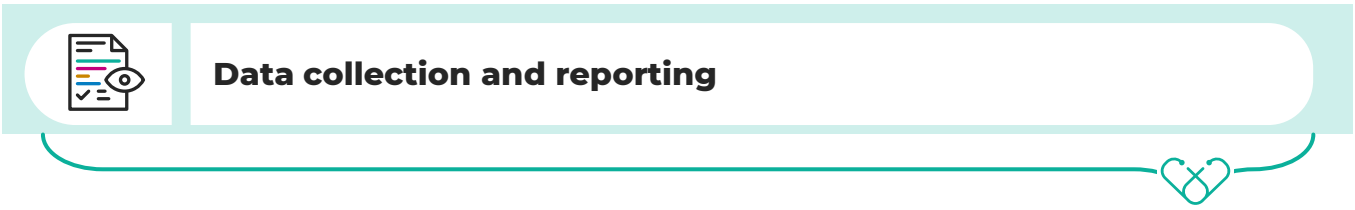
Data collection and reporting are central to the effective governance, planning and performance management of a health system. Robust data infrastructure enables a health system to collect, store, analyse, transform and share high quality data and information. This supports a range of activities, including population health monitoring, strategic planning and performance reporting.

Health-related data activities need to be undertaken within a strong legislative and governance framework that protects the security and privacy of patient data. As the use of digital platforms increases, there is a corresponding increase in the use of data to improve the safety and quality of the care provided, as well as improving the efficiency and sustainability of health services.

Reliable, accurate and timely data is essential for direct clinical care, understanding how a system is operating, reporting performance, and meeting accreditation, funding, legislative, and other accountabilities.

Navigating this chapter

The following visual provides an overview of the structure of this chapter.



8.1 Consultations and submissions summary

Reliable data collection and reporting was recognised during consultations as being fundamental to understanding system performance, planning services and supporting improved patient outcomes. Consultations highlighted that while there have been improvements in data collection and reporting since the introduction of the DHR, challenges with data quality, consistency and accessibility still require dedicated investment to improve.

The following chapter outlines thematic findings that emerged from stakeholder consultations and submissions relevant to data collection and reporting. It also contains a comprehensive description and analysis of current state arrangements, as they relate to data governance and publicly available data across jurisdictions. Finally, this chapter outlines key recommendations to support future uplift.

Data governance

Stakeholders identified that there is a need for more clarity of roles and responsibilities for data governance. Stakeholders reflected on the importance of having a legislative framework in place to underpin data governance, including legal boundaries for ethical and secure data collection, storage, access and utilisation. Stakeholders communicated that there could be clearer and simpler arrangements in place across the system in relation to data governance and work. Such arrangements could reduce the duplication of effort, gaps in data, and inefficiencies. Stakeholders pointed to the public communication of data from different sources that is not calculated using a consistent methodology.

A recurring theme in consultations was the need for a clear data governance framework that defines roles and responsibilities for CHS, HCSD, and Digital Canberra, in alignment with the ACT whole-of-government data frameworks and guidelines. Some community sector stakeholders noted that there is also an opportunity to better share appropriate data with other sectors to support the provision of services and continuity of care, such as NGOs.

The issue of data sovereignty for First Nations peoples was also raised as an important area that needs to be developed in collaboration with First Nations peoples and clearly documented and put into practice.

Data collection and reporting

Stakeholders noted that the implementation of the DHR impacted data quality and the availability of ACT data locally and for national public reports. Issues and inefficiencies associated with data quality were identified by stakeholders to stem from the fact that, during configuration of the DHR system, system flexibility was prioritised, resulting in reduced system consistency. The prioritisation of flexibility means that issues such as the use of mandatory fields, standardised data definitions and set data entry requirements (which ensure data quality, interoperability, safety and operational efficiency) were not areas of strong focus.

Underpinning the development of all DHR systems is the need to develop agreed clinically led models of care and pathways of care. These models form the foundation of the data model required to produce quality clinical, operational and performance reports.

Flexible and varying use of the DHR by clinicians means that the data needs a large amount of quality assurance work to make it meet clinical, operational and performance requirements. High quality data supports meaningful analysis, data-driven insights and reporting requirements. On a clinician level, stakeholders highlighted that data quality issues impact their ability to request meaningful clinical reports, conduct clinical handovers and analysis of local clinical metrics.

Some stakeholders pointed to other jurisdictions as examples of how the data availability for the public could be expanded and improved to increase engagement. Stakeholders also suggested that the data publication arrangements could be more patient focused to provide more data that is relevant to their engagement in the public health system.

Some stakeholders identified additional indicators that could be reported, such as Outpatient wait list numbers and medication-related safety outcomes, that could support transparency and improvements in the health system.

8.2 Current state analysis

Data governance

An emerging theme from consultations and submissions is the critical role of accurate, complete and consistent data to support enhanced decision-making, operational efficiency and improved patient safety and outcomes. Stakeholders also identified the benefit of robust data governance arrangements.

The following sections provide an overview of data collection and reporting within the ACT Health system, as well as other States and Territories.

Robust data governance arrangements

The need for a set of clear data governance arrangements was a matter identified by stakeholders. Data is required to be shared across three ACT health system organisations: CHS, HCSD and Digital Canberra. This requires each organisation to have robust data governance arrangements in place, as well as collectively as a health system. It is also essential that data governance is underpinned by a comprehensive legislative framework that covers the collection, storage, access, and reporting of data across the system.

Health system data involves some of the most sensitive information about people and clear roles and responsibilities are required for those who enter and access data. Data is required for many purposes. For example, data is required to identify staff, to undertake clinical quality and safety activities (including system oversight activities) and for reporting to the public and national bodies. In a complex system like the ACT health system, the data governance framework needs to cover topics such as developing a data catalogue with data stewards, developing a clear map of where data is stored and what data is considered the 'single point of truth', developing common data definitions and calculation methodologies, developing reporting schedules, and incorporating review arrangements to keep the framework up to date.

With the recent MoG changes to create HCSD and to move digital technology implementation and project delivery to Digital Canberra, HCSD has commenced work to develop a data governance framework for the ACT health system. Finalising this work will require collaboration across all three organisations.

The work will be guided by the ACT's whole of government data governance arrangements outlined in the following documents:

- ACT Government Data Governance and Management Policy Framework, 2020
- ACT Government Data Governance and Management Guide, 2020

Data landscape of publicly available data across jurisdictions

The analysis of publicly available health data across State and Territories, focusing on Elective Surgery, Emergency Department and specialist appointments, provides insights into the transparency and reporting landscape. There are no nationally agreed common set of performance indicators to report against, nor agreed calculation methodologies. Therefore, the performance indicators published by different jurisdictions vary in both scope and definition. To make inter-jurisdictional comparisons easier, the performance indicators have been mapped into broader categories to allow for general comparisons. However, although the indicators within each category are related, they do vary in focus and measurement.

Currently, most jurisdictions focus on efficiency and volume-based indicators, such as the number of surgeries performed and wait time length. While this provides clarity on system activity levels, it offers limited visibility into the performance or outcomes of care. Indicators on effectiveness (which are critical indicators of how well the system is performing) are not consistently reported across jurisdictions. Published indicators on effectiveness by each State and Territory focus on wait time in the Emergency Department and Elective Surgery and are reported without a standardised nation-wide approach.

The ACT publishes a comparable level of performance indicators compared to NSW, WA and VIC. Qld publishes the largest number and range of indicators. However, substantial data gaps remain across jurisdictions, particularly pertaining to specialist appointments, waitlists and equity measures for rural/remote populations, First Nations peoples or other priority groups.

Some States and Territories publish real-time data for Emergency Departments, health clinics, and walk-in-centres. Qld publishes this data on a separate website that is accessible using a desktop computer, tablet or smartphone.[178] Similar to Qld, the ACT publishes a website[179] but also provides real-time data via the ACT Health App[180] that is downloadable to a smartphone.

Some States and Territories, provide Ambulance data separate to hospital data, other than measures such as Transfer of Care or Patient off Stretcher time. The data in this section is focusing on what is provided on the public hospitals websites.

As summarised above, inconsistencies in how published indicators are calculated across States and Territories makes comparative performance challenging. **Table 25** provides a high-level summary of the range of data published by States and Territories.

[178] Queensland Health, Open Hospitals, Queensland Government.
[179] CHS, Emergency Department waiting Time, ACT Government.
[180] ACT Government, ACT Health app.

Table 25: Comparison of themes, data domains and metric types across jurisdictions[181]

Effectiveness

Data domain	Metric type	ACT	NSW	Qld	SA	VIC	WA
Elective Surgery	Wait time performance	Yes	Yes	Yes	Nil	Yes	Yes
Emergency Department	Ambulance response performance	Nil	Yes	Nil	Nil	Nil	Nil
Emergency Department	Ambulance transfer time performance	Nil	Yes	Yes	Nil	Yes	Nil
Emergency Department	Daily ambulance transfer performance	Nil	Nil	Nil	Nil	Nil	Yes
Emergency Department	Discharge times performance	Yes	Yes	Nil	Nil	Yes	Yes
Emergency Department	Emergency Department transfer to hospital performance	Nil	Nil	Nil	Nil	Nil	Nil
Emergency Department	Real-time wait time performance	Nil	Nil	Nil	Nil	Yes	Nil
Emergency Department	Treatment time performance	Nil	Nil	Yes	Nil	Nil	Nil
Emergency Department	Wait time performance	Nil	Yes	Yes	Yes	Nil	Yes
Specialist Appointments	Wait time performance	Nil	Nil	Nil	Yes	Nil	Yes

Efficiency

Data domain	Metric type	ACT	NSW	Qld	SA	VIC	WA
Elective Surgery	Surgery activity	Nil	Yes	Yes	Nil	Yes	Yes
Elective Surgery	Surgery referral volumes	Nil	Nil	Yes	Nil	Nil	Nil
Elective Surgery	Wait list patient volumes	Yes	Yes	Yes	Nil	Yes	Yes
Elective Surgery	Wait times	Yes	Yes	Yes	Yes	Yes	Yes
Emergency Department	Ambulance response times	Yes	Yes	Yes	Yes	Nil	Nil
Emergency Department	Ambulance response volumes	Nil	Yes	Nil	Nil	Nil	Nil
Emergency Department	Ambulance transfer times	Nil	Yes	Yes	Yes	Yes	Nil
Emergency Department	Ambulance transfer volumes	Yes	Yes	Yes	Nil	Yes	Nil
Emergency Department	Avoidable presentations	Yes	Nil	Nil	Nil	Nil	Nil
Emergency Department	Daily ambulance transfer times	Nil	Nil	Nil	Nil	Nil	Yes
Emergency Department	Daily attendance volumes	Nil	Nil	Nil	Nil	Nil	Yes
Emergency Department	Daily treatment volumes	Nil	Nil	Nil	Nil	Nil	Yes
Emergency Department	Daily wait times	Nil	Nil	Nil	Nil	Nil	Yes
Emergency Department	Discharge times	Nil	Yes	Yes	Yes	Nil	Nil
Emergency Department	Emergency Department transfer to hospital volumes	Yes	Yes	Yes	Yes	Yes	Nil
Emergency Department	Presentation volumes	Yes	Yes	Yes	Yes	Yes	Nil
Emergency Department	Real-time ambulance transfer times	Nil	Nil	Nil	Yes	Nil	Nil

[181] Yes indicates that data is published on the relevant website. Nil indicates that no information is publicly available on the relevant website. Disclaimer: The comparison is not intended to be complete and comprehensive. The comparisons are presented to show the general landscape of locally presented data in most Australian jurisdictions. The data in the table has been sourced from information that is readily accessible from these sources by a public user.

Data domain	Metric type	ACT	NSW	Qld	SA	VIC	WA
Emergency Department	Real-time ambulance transfer volumes	Nil	Nil	Nil	Yes	Nil	Nil
Emergency Department	Real-time presentation volumes	Nil	Yes	Yes	Yes	Nil	Yes
Emergency Department	Real-time treatment times	Yes	Nil	Nil	Yes	Nil	Nil
Emergency Department	Real-time treatment volumes	Nil	Nil	Nil	Yes	Nil	Nil
Emergency Department	Real-time wait times	Yes	Nil	Yes	Yes	Nil	Yes
Emergency Department	Treatment volumes	Yes	Yes	Nil	Nil	Nil	Nil
Emergency Department	Unexpected departure volumes	Nil	Nil	Yes	Nil	Nil	Nil
Emergency Department	Wait times	Yes	Nil	Yes	Yes	Yes	Nil
Specialist Appointments	Appointment referral volumes	Nil	Nil	Yes	Nil	Nil	Nil
Specialist Appointments	Appointment volumes	Nil	Nil	Yes		Yes	Nil
Specialist Appointments	Appointment wait list volumes	Nil	Nil	Yes	Nil	Nil	Nil
Specialist Appointments	Wait times	Nil	Nil	Yes	Nil	Yes	Nil

Equity

Data domain	Metric type	ACT	NSW	Qld	SA	VIC	WA
Elective Surgery	Surgery activity	Nil	Nil	Yes	Nil	Nil	Nil
Emergency Department	Presentation volumes	Nil	Yes	Yes	Nil	Nil	Nil

The analysis presented is based on publicly available data sourced from the following websites in the preparation of the Final Report:

State	URL
ACT	https://www.act.gov.au/open/act-health-service-data-dashboard https://www.canberrahealthservices.act.gov.au/
NSW	https://www.bhi.nsw.gov.au
Qld	https://www.performance.health.qld.gov.au
Qld	https://openhospitals.health.qld.gov.au
SA	https://www.sahealth.sa.gov.au
VIC	https://vahi.vic.gov.au
WA	https://www.health.wa.gov.au

Publicly reported Elective Surgery data across States and Territories

This section explores in more detail the variation in the calculation and reporting of one area of State and Territory published performance indicators. This analysis is provided as an example of the challenge in comparing the data published by States and Territories. The variation of published performance indicators includes level of detail, frequency of updates, and time lags from the activity occurring and the indicator being updated. The ACT publishes Elective Surgery indicators in both activity related metrics (e.g., additions and removals from Elective Surgery waiting lists) and performance related metrics (e.g., percentage of surgeries performed within recommended timeframes and median wait times). The ACT updates its indicators monthly, which compares to NSW (as an example) which updates its indicators every three months.

Table 26: Summary of data items reports, frequency of updating and time lag across jurisdictions

State	Summary of data items reported	Frequency of updating	Time lag
ACT	Activity Data includes: • Removals from the Elective Surgery waiting list for surgery (by triage category (1-5)) • Removals from the Elective Surgery waiting list for reasons other than surgery • Additions to the Elective Surgery waiting list Performance data includes: • Elective surgeries performed within clinically recommended time-frames • Median waiting time to surgery • Patients waiting for Elective Surgery • Patients overdue for Elective Surgery	Monthly	Time lag of data approx. 3-4 months August data released in December
NSW	NSW Bureau of Health Information (BHI) provides Elective Surgery data on surgeries performed, surgeries performed on time, waiting time, patients on waiting list, and patients waiting longer than recommended. There is the option to look at NSW as a whole or by hospital or LHD.	Quarterly	Quarterly
WA	Monthly elective survey wait list report, available for all public hospitals or for each individual hospital. Includes: • Total cases on waitlist and percentage seen within recommended timeframe • Number of Elective Surgery admissions by category and waiting time by category Elective surgery specialty report, is available for all public hospitals or for each individual hospital. Includes filtered by specialty: • Number of cases and waiting time by specialty and by category, and percent seen within recommended timeframe • Median wait time by specialty • Hospitals with shortest waiting time by specialty	Monthly	Approx. two months

State	Summary of data items reported	Frequency of updating	Time lag
Qld	Planned surgery activity metrics (by urgency category and specialty): 1. Number of people on wait list 2. Number of planned surgery performed 3. Number of referrals for planned surgery Planned surgery performance metrics: • Wait time to access planned surgery by urgency category and specialty (50th percentile, 90th percentile) • Number of patience waiting longer than clinically recommended by urgency category • % of patience waiting within clinically recommended times by urgency category • patients treated in turn cat 2 and 3.	Monthly	Approx. one to two months
Vic	The Victorian Agency for Health Information (VAHI) provides the following data on planned surgery: • Patients treated (overall) • Patients treated by surgical specialty • Patients treated by urgency category (1, 2, 3) • Patients waiting for treatment Planned surgery can be filtered by hospital, surgical specialty and urgency category.	Quarterly	Quarterly
SA	Elective surgery dashboard shows current activity levels (limited ability to identify historical trends). It breaks down data by specialty, general surgery, length of wait of patients on list and general surgery at specific hospitals.	Daily	Approx. one day

Report on Government Services (RoGS) public hospital data reporting

This section focuses on the data provided for the RoGS report and its level of completeness. The most recent RoGS report was released in February 2026.[182]

Over the past five years, most data from ACT public hospitals have been included in the RoGS public hospital data reports, relying on the latest NHCDC datasets. However, the expenditure related data for the 2022-23 period has not been provided, resulting in four expenditure related items not being reported for 2022-23. The four items are:

- Average cost per admitted acute separation (weighted/non-weighted), excluding depreciation, 2022-23 dollars
- Indicative estimates of capital costs per admitted acute weighted separation, 2022-23 dollars
- Average cost per acute Emergency Department presentation in public hospitals, 2022-23 dollars
- Average cost per service event, 2022-23 dollars

As a result of the work undertaken on the Data Remediation and Reporting Project, the ACT is now able to report these expenditure related indicators and the 2026 RoGS report, the data for 2023-24 is presented.

[182] Productivity Commission, Report on Government Services 2026, Australian Government.

The RoGS report data is drawn from the same data sets published by the AIHW. AIHW data has been presented earlier in this report to provide details about Service Planning, Demand and Sustainability.

A unique feature of the RoGS report is the survey data sourced from unpublished Australian Bureau of Statistics patient survey data relating patient experiences of the care they receive. The survey covers the following four areas:

1. People who visited a hospital **Emergency Department** (for their own health) in the last 12 months who reported that the **Emergency Department doctors** or specialists always or often: listened carefully, showed respect, and spent enough time with person
2. People who visited a hospital **Emergency Department** (for their own health) in the last 12 months who reported that the **Emergency Department nurses** always or often: listened carefully, showed respect, and spent enough time with person
3. People who were **admitted to hospital** (for their own health) in the last 12 months who reported that the hospital **doctors or specialists** always or often: listened carefully, showed respect, and spent enough time with person
4. People who were **admitted to hospital** (for their own health) in the last 12 months who reported that the hospital **nurses** always or often: listened carefully, showed respect, and spent enough time with person

Table 27 shows the 2024-25 data from the 2026 RoGS report for responses to the survey for people who were **admitted to hospital** (for their own health) in the last 12 months who reported that the hospital **doctors or specialists** always or often: listened carefully, showed respect, and spent enough time with person. The data is presented with 95% confidence intervals because of the sample size of the survey in each jurisdiction. **Table 28** shows the data relating the same questions as **Table 27** except that it is relation to **nurses.** The confidence intervals for the ACT are wider than most jurisdictions. All responses of satisfaction are higher than 80% indicating a high level of satisfaction from the survey respondents. The data shows that for all questions, the ACT level of satisfaction is similar to Australia as a whole.

Table 27: People who were admitted to hospital in the last 12 months who reported that hospital doctors or specialists:

Hospital doctors or specialists:	ACT	Australia
Always or often listened carefully	89.7%±4.5%	91.0%±1.5%
Always or often showed respect	91.0%±4.9%	92.5%±1.6%
Always of often spent enough time with the person	86.0%±9.2%	87.8%±2.0%

Table 28: People who were admitted to hospital in the last 12 months who reported that hospital nurses:

Hospital nurses:	ACT	Australia
Always or often listened carefully	95.6%±5.3	92.6±1.5%
Always or often showed respect	92.6%±7.0%	93.8%±1.3%
Always of often spent enough time with the person	82.9%±4.4%	89.6±1.2%

RoGS Mental health data reporting

RoGS Mental health data reported over the past five years indicate a notable number of outstanding data points for the ACT, particularly in relation to the three most recent reports in 2024, 2025 and 2026.[183] In these reports, ACT data for 2021–22, 2022–23 and 2023-24 were not available to RoGS at the time of publication due to the implementation of the DHR across ACT public health services. The RoGS data tables contain the following note regarding the data not provided:

> ACT data for 2021-22, 2022-23 and 2023-24 was not available at the time of publication. Following implementation of the Digital Health Record (DHR) across ACT public health services in November 2022, data is undergoing quality assurance work for 2021-22 and subsequent years. Australian totals for 2021-22, 2022-23 and 2023-24 do not include ACT.[184]

It is critical that HCSD and CHS work to collect and report the mental health data for RoGS.

Summary of current state

The way data is collected, stored and used is a matter clearly raised by stakeholders. Data governance for the ACT health system needs to be undertaken within each organisation (CHS, HCSD and Digital Canberra) as well as collectively as a health system. It is also essential that data governance is underpinned by a comprehensive legislative framework that covers the collection, storage, access, and reporting of data across the system.

HCSD has commenced work to develop a data governance framework for the ACT health system. Finalising this work will require collaboration across all three organisations.

Unlike the data reported by the AIHW, there are no nationally agreed common set of performance indicators to report nor agreed calculation methodologies, for data reported by States and Territories directly. The ACT publishes a comparable level of performance indicators compared to NSW, WA and Vic. Qld publishes the largest number and range of indicators. However, substantial gaps remain across jurisdictions, particularly in data pertaining to specialist appointments, waitlists and equity measures for rural/remote populations, First Nations peoples or other priority groups.

The ACT publishes a comparable level of performance indicators compared to NSW, WA and Vic. Qld publishes the largest number and range of indicators. Some States and Territories publish real-time Emergency Department waiting time data. Qld publishes this online while the ACT publishes it both online and via the ACT Health App.

In relation to RoGS, the ACT has provided nearly all hospital-related data except for financial related data for 2021-22 and 2022-23 because of the implementation of the DHR. There are large gaps in the mental health data provided by the ACT for the 2021-22, 2022-23 and 2223-24 RoGS and AIHW returns, which is a result of not having yet implemented activity based funding in this area and the implementation of the DHR.

[183] Productivity Commission, RoGS Mental Health 2026 data tables (released 5/02/2026).
[184] Productivity Commission, RoGS Mental Health 2026 data tables (released 5/02/2026).

8.3 Future state recommendations

Enhancement of the ACT Health performance website

There is an opportunity for the ACT health system to refresh data-driven insights visible on the Health Performance Website, to ensure contemporary and meaningful indicators and reporting arrangements. Data-driven insights should be available across key domains most relevant to residents to build knowledge and drive immediate action. This includes emergency care, Outpatients, Elective Surgery, walk in centres, safety and quality, patient experience and length of stay for older patients. Revising information that is publicly available on the ACT Health Performance Website not only strengthens transparency, accountability and public trust, but enables clinicians, managers and policy makers to identify emerging trends and areas for targeted improvement, to inform evidence-based decision making.

The ACT health system should also consider the value of utilising certain data-driven insights to publicise good news stories or performance improvement spotlights. This recognises and broadcasts areas of the ACT health system that are demonstrating innovation, improvement and impact.

The minimum set of data recommended to be reported on the ACT Health Performance Website is listed below.

Emergency care

- Emergency Department presentations by Triage Category
- Emergency Department presentation by Ambulance
- Percentage of Ambulance to Emergency Department Transfer of Care within 40 minutes
- Median waiting time (mins) to be seen at the Emergency Department by Triage Category
- Percentage of patients seen within clinically recommended time by Triage Category
- Number and percentage of patients whose Emergency Department care was completed within 4 hours by Triage Category, and by all patients, admitted patients and non-admitted patients.

Outpatients

- Total number of people waiting for an Outpatient appointment by category
- Total number of Outpatient appointments undertaken by category, and by medical specialty, and by surgical specialty
- Total number of initial Outpatient appointments undertaken by category, and by medical specialty, and by surgical specialty
- Median waiting time (days) to be seen by category, and by medical specialty, and by surgical specialty
- Number and Percentage of patients waiting to be seen for an initial specialist appointment within clinically recommended times by category, and by medical specialty, and by surgical specialty

Elective surgery

- Total number of people waiting for Elective Surgery by category
- Total number of Elective Surgeries performed by category, and by surgical specialty
- Median waiting time (days) for Elective Surgery by category, and by surgical specialty
- Number and Percentage of patients waiting for Elective Surgery within clinically recommended times by category, and by surgical specialty

Walk in centres

- Total number of presentations at Walk in Centres by Centre
- Median waiting time to be seen at Walk in Centres by Centre

Safety and quality

- Number of Staphylococcus aureus (including MRSA) bacteraemia (SAB) in acute care hospitals
- Estimated percentage hand hygiene rate for public hospitals
- Number and percentage of separations from a public hospital with an adverse event

Patient experience

Most recent annual Report on Government Services Report data for the following performance indicators:

- Proportion of people who visited a hospital Emergency Department in the last 12 months for their own health reporting that the Emergency Department doctors, specialists or nurses 'always' or 'often':
  - listened carefully to them
  - showed respect to them
  - spent enough time with them
- Proportion of people who were admitted to hospital in the last 12 months reporting that the hospital doctors, specialists or nurses 'always' or 'often':
  - listened carefully to them
  - showed respect to them
  - spent enough time with them.

Long-stay older patients

Long-stay for older patients is an important indicator of hospital efficiency or inefficiency, as it highlights how well the ACT health system manages complex care needs and coordinates discharge to appropriate community or aged care supports. The ACT health systems should report on the following:

- Prevalence: Proportion or number of older patients classified as long-stay
- Duration: Average and median length of stay for patients classified as long-stay
- Delayed discharge:
  - Number of older patients who are medically ready for discharge but unable to leave hospital
  - Average days delayed after being declared ready for discharge
  - Reason for delay e.g. home supports, rehabilitation or aged care arrangements not being in place due to inefficiencies, such as poor system integration.

Reporting arrangements

The following specifications should guide the development of the Performance Reporting website:

- Reporting should be released monthly
- The most recent performance data should not be more than two months old
- The performance data should be presented monthly, quarterly, and annually
- The reporting should include a rolling total of three years of data
- The data should be presented in an easy to use and understand format and include graphs and tables for each data set
- The data should be able to be downloaded by users

Recommendation 38

HCSD update its Health Performance Website to include the indicators and arrangements outlined in the Inquiry report.

Expansion of reporting data guided by Performance Framework

It is important that a 'set and forget' mentality isn't adopted when updating the ACT Health Performance Website (as detailed above). As such, to ensure performance indicators remain accurate, useful and strategically aligned to organisational goals and objectives, the ACT health system should develop a forward-looking program of work that aligns with an updated Performance Framework. This should continue to expand and optimise the set of reporting data available, leveraging better practice demonstrated by other jurisdictions and global reference points.

Recommendation 39

HCSD, in collaboration with CHS, develop a forward program of work that expands the set of data reported on the ACT Health Performance website.

Development of a joint Health Data Governance Framework (HDGF)

To further elevate the data capabilities of the ACT health system, it is important that HCSD and CHS develop a joint HDGF, in collaboration with Digital Canberra. This provides the ability to formalise responsibility and accountability for how health data is governed and managed across its lifecycle. This includes how data is captured, stored, used, shared, released and retained or destroyed. The HDGF should be developed in alignment with the ACT Data Governance and Management Policy Framework, which comprises of a Policy Framework and Data Governance and Management Guide.[185] It is important to note that the development of the HDGF should occur in-parallel or following a review of relevant legislation, to ensure all roles can fully undertake their responsibilities.

The ACT Data Governance and Management Policy Framework outlines 12 steps for ACT Directorates to use to develop a Data Governance Framework (see **Figure 40**). These 12 steps represent leading practice in contemporary data governance and will assist HCSD, CHS and Digital Canberra to develop their shared data governance arrangements. This work will also require legislative amendment to ensure that the relevant health legislation supports the operation of the data governance framework.

[185] ACT Government 2020, Data Governance and Management Policy Framework, ACT Government.

Figure 38: Extract from the ACT Data Governance and Management Policy Framework[186]

12 STEPS TO BETTER GOVERN AND MANAGE OUR DATA

The Framework identifies 12 steps to guide all directorates to improve our data governance and management practice. These steps can be implemented in any order to suit their readiness and maturity.

Establish our data vision and purpose

- ☐ Develop and test directorate data vision and purpose based on the ACT data vision and purpose.

Understand the ACT policy, legislation and risk context

- ☐ Understand the relevant legislative and policy frameworks, including privacy and security provisions, and current data governance and management risks.

Know our data governance and management principles

- ☐ Embed the principles in directorate data practice.

Establish data governance

- ☐ Review and re-establish data governance groups at directorate and whole of government levels.
- ☐ Develop a directorate data governance and management implementation strategy.

Identify data roles and responsibilities

- ☐ Support all staff and executives to know their role and responsibilities in working with data.
- ☐ Ensure data custodians and data stewards actively govern and manage datasets assigned to them.
- ☐ Appoint an Executive Data Lead or ensure that the function is assigned to an existing executive role.
- ☐ Support the Executive Data Lead to uplift data practice and build a data culture in the directorate.

Build a culture that values data as an asset

- ☐ Establish and promote our shared data vision, principles and values.
- ☐ Identify barriers to achieving our data vision and embedding principles in daily practice.
- ☐ Identify and foster the desired behaviours of a data driven ACT Government.
- ☐ Measure progress towards data vision and reinforce change, and then continuously improve.

Make data discoverable

- ☐ Set up data roles, responsibilities and governance.
- ☐ Identify directorate datasets.
- ☐ Identify and train data custodians and stewards.
- ☐ Register datasets in a data catalogue.

Make data understood

- ☐ Prepare business glossary for the dataset.
- ☐ Prepare data dictionary for the dataset.
- ☐ Identify primary use of the data.
- ☐ Outline data sharing rules for the dataset.

Improve data sharing

- ☐ Foster a safe data sharing culture.
- ☐ Understand the risks, barriers and challenges to data sharing.
- ☐ Understand the legislative and policy frameworks that govern data sharing.
- ☐ Establish clear, consistent governance and management practice to enable safe data sharing, including by adopting the Five Safes principles.
- ☐ Improve open data by safely releasing more ACT Government datasets on data.act.gov.au.

Ensure quality data

- ☐ Adopt a data quality framework and standard.
- ☐ Identify and document data quality issues.
- ☐ Improve data quality and resolve issues.
- ☐ Communicate quality issues and improvements.
- ☐ Ensure staff have skills and capabilities to use data.

Make data safe and secure

- ☐ Establish safe data practices, technology and controls.
- ☐ Build trust in government through safe data use.
- ☐ Support staff to know their responsibilities to implement privacy and security by design.
- ☐ Establishing directorate-level data protection, including a data breach response plan.

Measure data capabilities

- ☐ Assess our data maturity against five levels: Initiate; Develop; Define; Manage; and Optimise.

[186] ACT Government 2020, Data Governance and Management Policy Framework, ACT Government.

Recommendation 40

HCSD and CHS develop a joint HDGF that is consistent with the ACT Government Data Governance Management Policy Framework and includes the following elements:

- Data Strategy
- Clear roles including: Executive Data Lead (or Chief Data Officer), Data Users, Data Custodians, Data Stewards, System Owners
- A data and system register
- A data delegations register

The HDGF clearly describe the following:

- The enterprise level data sets
- Where the enterprise level data sets are stored
- Where the single point of truth is for each defined data set that is used for performance monitoring and reporting
- The work group responsible for providing reports from the enterprise level data sets

Legislative amendments to ensure staff within HCSD, CHS and Digital Canberra have access to required data within strong privacy and security arrangements

Chapter 4 of the Inquiry (Clinical Quality and Safety) recommends the development of a CQSF, to further support the delivery of high-quality care and ensure safety. To meet new clinical quality and safety arrangements under the CQSF, Chapter 4 of the Inquiry also recommends the need for a formal review of the three key health-related Acts in the ACT (*Health Act 1993, Health Records Act 1997, and Public Health Act 1997*), with amendments implemented as an outcome to ensure clinical quality and safety, and data arrangements are fit-for-purpose.

Following this formal review and the implementation of amendments, there is a need for data teams and governance processes to undergo rapid, structured adjustments, to ensure alignment with the new legislation. This adjustment should involve a gap assessment to determine the difference between traditional practices and new legislated obligations and the subsequent updating of policies and governance and information management practices. This is required to ensure that designated roles within the HDGF can access the data they require to fulfil their roles, along with obligations for confidentiality and sharing, and penalties as appropriate.

Recommendation 41

That legislative changes be undertaken to ensure that designated roles within the HDGF can access the data they require to fulfil their roles, along with obligations for confidentiality and sharing, and penalties as appropriate.

Creation of a joint Performance Framework

There is an opportunity for the ACT health system to develop a Performance Framework, which serves as a structured approach to measuring, evaluating and improving the effectiveness, efficiency and quality of healthcare services. A Performance Framework would provide the ACT health system with a systematic approach to assess how well the health system is achieving its goals, meeting the needs of its population and addressing key challenges such as equity, sustainability and collaboration. The ACT health system's Performance Framework should be developed with reference to the NHRA Mid-Term Review published in October 2023, that proposed an interim Performance Framework using the following structure:

- **Equity:** Ensures fair access to healthcare services for all individuals, regardless of socioeconomic, geographic, or demographic factors.
- **Effectiveness**: Focuses on delivering evidence-based healthcare services that achieve desired health outcomes.
- **Efficiency:** Aims to maximise the value of healthcare resources by optimising time, workforce, and financial investments.
- **Sustainability:** Builds a resilient system capable of adapting to future challenges while maintaining long-term viability.
- **Intersectoral collaboration:** Encourages partnerships across sectors to address complex health challenges and improve population health.
- **Transparency and reporting:** Establishes mechanisms for clear communication, accountability, and performance measurement to build trust among stakeholders.

Recommendation 42

That HCSD and CHS jointly develop a Performance Framework that outlines the health service key performance indicators. This Performance Framework should leverage the following categorisation system for the initial planning but move to align with the national Performance Framework (to be developed as part of the NHRA when it is finalised). This initial categorisation system should include:

- Equity
- Effectiveness
- Efficiency
- Sustainability
- Intersectoral Collaboration
- Transparency and Reporting

Strengthening of Mental Health data reporting in RoGS

Since the implementation of the DHR, significant portions of RoGS data relating to Mental Health has not been reported by the ACT. The Data Remediation and Reporting Project has worked to improve the data reporting required by IHACPA for the purposes of receiving Commonwealth funding. The AIHW also collects Mental Health data and the same issues regarding the ACT not being able to report Mental Health data are prevalent in these data tables.

Further work is required to improve and report the Mental Health data to ensure that complete data sets are provided to the AIHW and for the RoGS report.

Recommendation 43

HCSD and CHS undertake work, in collaboration with Digital Canberra, to collect and report all required Mental Health services activity, performance and expenditure data to the AIHW and for the RoGS report.

Chapter 9 Digital Health Record (DHR)

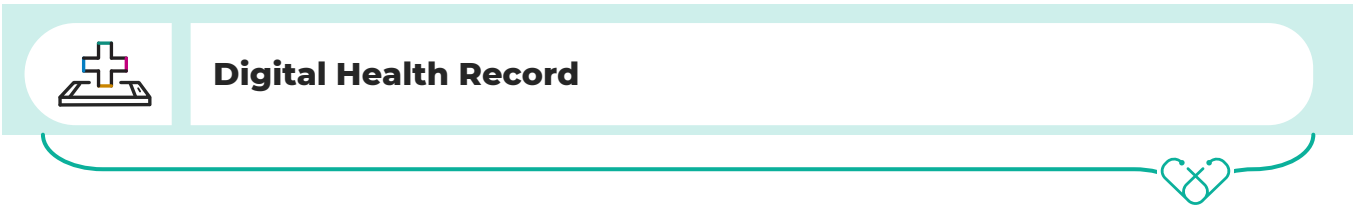
A modern digital health record system is a key enabler of safe, connected and responsive health systems. At a clinical level, digital health record systems enable clinicians to collect and have patient data (including demographics, symptoms, tests and treatment plans) readily accessible. Accessing information of this kind is known to reduce the risk of adverse events, reduce duplication of pathology and imaging tests, and support clinical information sharing and decision-making.

In addition to the benefits for direct patient care, digital health record systems support the analysis of population-level data, extrapolation of patterns and trends, provide real-time insights required to monitor and manage patient outcomes, and support information transfer between services that make up a health system network, such as primary, acute and community settings.

Contemporary health systems are increasingly incorporating digital health functionality into their clinical and operational business. These digital applications also assist the provision of information to health consumers to support greater engagement in their care.

Navigating this chapter

The following visual provides an overview of the structure of this chapter.



Consultations and submissions summary	Thematic findings distilled from stakeholder consultations and written submissions.
Current state analysis	Comprehensive description of current-state arrangements derived from a desktop review of qualitative and quantitative data. This included publicly available information, public health data and reports and documents provided by CHS and HCSD, to provide contextual insights into the functioning of the ACT health system.
Future state recommendations	Considering findings from consultations and submissions, alongside the current state analysis, this section outlines future state recommendations, which serve as opportunities to uplift and enhance the ACT health system.

9.1 Consultations and submissions summary

Inquiry stakeholder consultations highlighted that the DHR is a critical enabler of clinical care in the ACT public health system. While the DHR has delivered important benefits due to its clinical utility, stakeholders also identified key challenges and opportunities for improvement related to DHR governance, data quality and consistent workflows.

Clinical utility

Stakeholders widely acknowledged that the DHR represents a significant improvement on the previous paper-based and fragmented digital systems, particularly in terms of access to information and communication. Clinicians noted that the DHR has enabled faster access to patient histories, improved visibility of results and documentation, and strengthened some safety processes (e.g., improved infection control and reduced medication errors). Electronic referrals and patient portal functions were also identified as valuable enablers of more coordinated care.

The DHR link for General Practitioners (GP) was identified by some stakeholders as a positive development. Some stakeholders emphasised the importance of ensuring there are strong privacy monitoring arrangements in place, while others supported this but balanced with accessible use for both health consumers and clinicians. Some stakeholders also discussed the broader availability of the DHR to clinicians outside of CHS of the DHR GP portal, along with the appropriate privacy and security provisions. Stakeholders noted that CHS is expanding the number of clinicians who can access the DHR.

Stakeholders noted that strengthening the consistency of use of the DHR within CHS will improve continuity of care and patient safety, and support a more cohesive ACT health system. Stakeholders noted the importance of the integration of DHR with the national My Health Record (MHR) system to enhance continuity of care and patient transitions across settings.

Stakeholders highlighted that the DHR link initiative has been welcomed by GPs to whom it has been rolled out. In saying this, some stakeholders reflected that the login process is overly burdensome and time-consuming, resulting in reduced levels of utilisation by GPs. These stakeholders drew comparison to My Health Record, identifying that it was simpler to login to the My Health Record system.

Data quality, workflows, and clinician and patient experience

While the DHR was generally identified throughout consultations as a useful clinical tool, stakeholders noted that data quality (following the transition to the DHR) remains a challenge. Stakeholders highlighted that, post implementation, the focus has predominantly been on the system data reporting requirements, with substantial effort invested into data remediation for external reporting. Stakeholders identified the need to improve the alignment between clinical, operational and system-level reporting needs, with many emphasising that the DHR should be understood first and foremost as a clinical tool, with operational and funding functions as secondary outcomes.

Stakeholders noted that future work needs to be undertaken to standardise the models of care and clinical workflows in the DHR, including a consistent approach to mandatory fields being built into regular clinical practice. This will improve the usability of the DHR, including ability to produce trusted clinical reports, reduce duplication of data entry, and streamline data analysis. Stakeholders emphasised that future improvements for DHR optimisation must involve clinician-led design activities to increase consistency of clinical workflows, models of care, and patient pathways of care.

DHR Governance

Stakeholders identified that there is a need for improved clarity in roles and responsibilities for DHR governance. Stakeholders noted the complexity with the governance arrangements across Digital Canberra, CHS and HCSD, emphasising the need for clear and documented arrangements. Some stakeholders highlighted matters relating to access to DHR records across different work areas. As with the legislative amendments for quality and safety and data, legislative amendments will be required to ensure appropriate user permissions, and legal and privacy considerations, including confidence in safeguards governing who can view, use and share patient information.

Some stakeholders identified opportunities to develop a more structured and transparent approach to optimising the DHR, including clear governance that, embeds clinicians in decision-making, clarifies configuration standards, and ensures prioritisation of changes is aligned with clinical need..

9.2 Current state analysis

DHR Program establishment

The DHR Program was established in 2019 to enhance access to health system data and information, increase the stability of current information and communications technology (ICT) systems and realise the benefits from investment in health infrastructure and equipment.[187] The DHR Program went through a procurement process to select technology vendor Epic to provide the technology solution and deliver this business case. Epic's contract was signed in July 2020, with the DHR system going live in CHS in November 2022.[188]

Since its implementation, the DHR has significantly advanced the modernisation of healthcare delivery in the ACT. The DHR exists as a secure, centralised system that replaced numerous siloed clinical information systems formally utilised across ACT's public health system and many paper-based systems. The DHR provides a single record of a patient's interactions with ACT public health services, including public hospitals, community health centres and walk-in centres. Information consolidated in the DHR includes patient contact details, medication history, allergies, observations, surgical procedures, clinical appointment and hospital administration details, test results and referrals.[189] Centralising information of this kind enables patients and providers to securely and conveniently access comprehensive data, enhancing collaboration among healthcare providers and enabling patients to play a more active role in managing their healthcare.

[187] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra.
[188] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra.
[189] Australian Capital Territory n.d., Digital Health Record, ACT Government, Canberra

The DHR can be conceptualised in more detail by understanding the following access layers:

- **Clinical interface (Epic System)** - DHR provides clinicians with real-time, point of care access to patient interactions with ACT public health services and their medical history. This centralised and comprehensive overview includes important data such as patient medication history, allergies, diagnostic test results, surgical procedures and clinical observations. Having consolidated information of this kind, clinicians can enhance the personalisation, quality and efficiency of care.
- **Historical integration** - Through its interface with the Clinical Patient Folder (CPF), which is a repository of digitised paper clinical records, the DHR provides access to extensive, historical clinical records dating back to 1994. Access to these scanned documents supports continuity of care and informed clinical decisions.
- **Consumer portal (MyDHR)** - Through access to healthcare information through a secure mobile application or the online portal, MyDHR empowers patients to be active participants in their healthcare. Through the portal, patients have access to their medical history, medications and treatment plans. Functionality of MyDHR is planned to be expanded in future.
- **Integration with the National MHR System** - The ACT DHR is a separate system to the national MHR System. ACT's DHR interacts with MHR by updating patient summary information. This enables high-level information to be viewed by people outside the ACT public system.
- **DHR Link project**– The ACT DHR also has the capability to share health records and information with some patients' GP through the DHR Link. A trial project (the DHR Link Project) is currently underway with some Canberra GPs (with patients' consent) to support this information sharing.[190]

DHR Program review

Since its implementation, the DHR has significantly advanced the modernisation of healthcare delivery, removed the need for many paper-based systems, and improved the quality and safety of healthcare in the ACT. Being a complex, large-scale ICT Project, the implementation of the DHR Program has received significant scrutiny. In 2024, KPMG was commissioned to undertake a review of the DHR, to provide independent advice with a focus on financial and performance elements of the DHR Project's delivery. The Digital Health Record Program Review (the Review) stated in the final report that *'the DHR Program provided a successful clinical and technology delivery'*. Despite this, the Report identified a number of risks and challenges associated with governance and program management, financial reporting and offsets and benefits. Findings in relation to these focus areas are elaborated on below.

Governance and program management

The Review identified a number of positive governance practices adopted by the DHR Program. This included the establishment of a Program Board, Functional Steering Committees and organisational governance forums, to support collaboration and communication between leadership and key clinical and delivery stakeholders. In saying this, the Report flagged that the Program's focus on implementation and achieving go-live contributed to deficiencies in the execution of governance mechanisms. The Review identified a number of risks and challenges that compromised the Program's governance over financial outcomes and realisation of benefits. This included under-defined roles and responsibilities, absence of financial advice from Strategic Finance and the Chief Financial Officer (CFO) and no single governance function responsible for the full remit of the DHR Program.

[190] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra.

It was also identified that risk reporting to the Program Board was overly complex and did not provide effective visibility to support management of key risks Based on these lessons learnt, the Report provided four recommendations to guide governance and project management processes in future projects.[191]

These emphasise the importance of the:

- Central provision of financial information to ensure consistency and accuracy (**Recommendation 1**)
- Providing the Program Board with relevant financial information (**Recommendation 2**)
- Direct involvement of the CFO on Project Committees (**Recommendation 3**)
- Appropriately balanced governance and management focus across all critical activities related to the Program and its benefits (**Recommendation 4**)[192]

Financial management

The Review also identified gaps in the Program's financial management processes and reporting. The report identified financial reporting inconsistencies between the Program and ACT Health Directorate. In addition to this, there was not a consistent practice for budget reporting to senior ACT Health Committees and Boards, which increased the risk of gaps and inconsistencies. Finally, the Review identified significant delays and inaccuracies in financial reports provided to the Program Board. Based on these lessons learnt, the Report provided two recommendations to guide financial management processes in future projects.[193] These emphasise the importance of:

- Strengthening cost estimate processes (**Recommendation 5**)
- Strengthening financial oversight and governance to ensure better cost control and accountability (**Recommendation 6**)

Offsets and benefits

The implementation of the DHR Program was planned to deliver a significant proportion of offsets from the decommissioning of existing legacy systems that were to be superseded by the DHR Solution. A key assumption underpinning the Program was that historical data within these legacy systems was to be migrated into a data repository and remain available to end users, to support patient outcomes and meet legislative and regulatory requirements. Despite availability of historical data being a key dependency for DHR go-live, there was a decision to de-couple data migration activities from the DHR implementation timeline. This resulted in the DHR Program Board having limited visibility of offset availability and data migration activities, despite being highly complex and involving sensitive data.[194]

[191] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra.
[192] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra.
[193] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra.
[194] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra.

The Report also identified gaps and challenges in the management of benefits across the DHR Program. Benefits to be realised by the DHR Program were first articulated in the 2018-19 business case, through a comprehensive clinical consultation process. While benefits were refined overtime, management and traceability was ineffective and it did not appear that benefits were quantified or had clear targets. Based on these lessons learnt, the Report provided one recommendation to manage offsets and benefits realisation in future projects. These includes the *formal management of offsets* (**Recommendation 7**).

In addition to this, the Report identified two recommendations for current project. This includes that:

- Ongoing projects should track offsets which can be applied to DHR overspend for 2025-26 and 2026-27 (**Recommendation 8**)
- Ongoing projects should ensure tracking and measuring of benefits realisation (**Recommendation 9**)[195]

DHR Data remediation work

In August 2023, to ensure the ongoing utility of DHR data and information, the Data and Reporting Remediation Project was established. The project's scope of work includes the collection of critical data from the DHR required for IHACPA to fulfil its legislative functions under the *National Health Reform Act 2011*. Specifically, this includes utilising DHR data to provide the evidence base for determining the annual Commonwealth funding contribution to public hospitals in the ACT. The project also undertakes work to collect the performance reporting data required to be provided to the AIHW and RoGS.

The work of the Data and Reporting Remediation Project is nearing the end of its work, with data collection, storage, and reporting arrangements in place for future IHACPA reporting requirements, and most reporting requirements for AIHW and RoGS. However, there is still work to be undertaken to be able to fully report on the ACT Mental Health data. There is a recognition that with the initial focus of work on data reporting, there is a need to undertake work with clinicians to optimise the DHR. This is consistent with the feedback from stakeholders.

The Data and Reporting Remediation Project staff have transitioned to Digital Canberra as a part of the 2025 MoG changes. Stakeholders have identified the need to have clear governance arrangements between CHS, HCSD and Digital Canberra to ensure that the future work of the DHR recognises the foundational clinical purpose of the DHR with additional benefits of local and system reporting.

[195] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra.

Digital Health Record Yearbook 2025

Digital Canberra's DHR Yearbook 2025 presents a collection of case studies and performance measures highlighting the benefits realised in the first three years of DHR implementation across the ACT health system.[196] The overarching findings of this yearbook are that the DHR now serves as a trusted foundation for safer, more connected and increasingly data-driven healthcare in the ACT. While challenges remain, the Yearbook demonstrates clear progress in improving patient experience, clinical safety, workforce capability and system performance.

The Yearbook highlights the clinical utility of the DHR when it functions effectively, including its role as a single, connected source of truth, enabler of timely access to clinical information for both patients and clinicians, and its contribution to improved medication safety, operational efficiency and coordination of care across settings. At the same time, it acknowledges important limitations and areas for improvement. These include an increased administrative burden for clinicians; ongoing reporting and data extraction challenges; and incomplete integration across some care domains, particularly dental services, midwifery and maternity care, and dementia screening visibility across care settings. Together, these findings suggest the DHR has delivered a strong foundational platform, but continued optimisation is required to fully realise its potential.

9.3 Future state recommendations

Implementation of a DHR optimisation project

Acknowledging the nearing completion of the Data and Reporting Remediation Project, there is a need for a follow-on DHR Optimisation Project to be implemented, to support continued improvement of the DHR. This project will allow a renewed effort to identify, prioritise and implement enhancements to the system, with a focus on improving the usability, consistency and value of the DHR system for clinicians, patients, managers and executives. This work should be led by CHS (as the Business Owner of the DHR), in very close collaboration with Digital Canberra and HCSD.

The data in the DHR needs to serve multiple purposes, including:

- Timely and accurate clinical information for clinicians to provide care to individual patients as well as improve clinical practice
- Accessible information for patients
- Operational reporting for senior and executive CHS staff
- Performance reporting to inform the public
- Performance reporting to AIHW, IHACPA and RoGS
- Activity and expenditure reporting to receive funding

The data required to support the key purposes outlined above relies on the following parallel initiatives to be delivered as part of the DHR Optimisation Project. It is important that this initiative to further optimise the DHR receives dedicated focus, including a dedicated multi-disciplinary team that includes clinicians to ensure outcomes are realised and sustainable.

Defining agreed models of care and workflows for each clinical area

The DHR is first and foremost a clinical tool for clinicians. For each clinical area, a process is required, as part of the DHR Optimisation Project, to ensure that the DHR aligns with the requirements of clinicians. This includes models of care, clinical workflows and patient pathways of care, which

[196] Digital Canberra 2026, Digital Health Record Yearbook, ACT Government.

describe the daily operations of clinicians and how care is delivered, underpinned by policies and procedures that incorporate best practice for care delivery. Practical, clinically endorsed models of care, clinical workflows and patient pathways of care should be defined and configured within the DHR, to ensure the system is customised for the existing processes and the requirements within and across clinical areas. Defining agreed models of care, clinical workflows and patient pathways of care for each clinical area should be achieved through a structured, clinically led and co-designed approach. This will support the optimisation of data and documentation captured by the DHR, enhancing clinical decision-making.

Establishing common clinical data definitions and requirements for clinical data items within and across clinical areas to support local patient care and reporting

Within, and across, clinical areas, a process is required to establish standardised clinical data definitions and requirements. Standardised clinical data definitions are essential to support the collection of accurate and consistent data that supports effective clinical decision-making and mitigates the risk of ambiguity or misinterpretation when a patient's record is being analysed or interpretated by other providers within and across clinical areas.

In addition to this, defining common data entry requirements (e.g. mandatory or not, and tight or loose data field specifications) reduces the time and effort required by clinicians to determine what data collection is appropriate for a particular symptom or presentation. This prevents the recording of inconsistent, inaccurate or duplicative data.

Determining common definitions and requirements for data items to be used for operational reporting and external reporting

In addition to this, within and across data sets for models and pathways of care, there is a need to include a small set of additional items required for operational, performance and funding reporting. Most of these data requirements will fall within the data requirements for the models of care and care pathways. This means that only a small number of additional items will need to be identified for the purpose of operational, performance or funding reporting. Undertaking this work as part of the DHR Optimisation Project will ensure information contained within the DHR is reliable, consistent and interpretable across both internal clinical and operational reporting and external regulatory reporting.

Undertaking this work, as part of the DHR Optimisation Project, will ensure the DHR operates as an efficient and effective clinical tool that is trusted, consistently used and configured to improve the efficiency of clinical workflows. This will lead to safer and higher quality of care that is also more efficiently provided. The DHR Optimisation Project will also ensure the DHR meets operational and performance reporting needs and compliance with national reporting obligations.

Recommendation 44

CHS, in collaboration with Digital Canberra and HCSD, lead a DHR Optimisation Project to achieve the following goals:

- Agreed models of care, pathways of care and DHR workflows for each clinical area
- Agreed common definitions and requirements for clinical data items within and across clinical areas
- Agreed common definitions and requirements for data items to be used for operational, performance and other reporting
- Enhanced reporting for clinicians, for hospital and service operations, for internal and external performance reporting, and for external obligatory performance and financial reporting

Formation of a Digital Health Governance Framework (DHGF)

Consultations identified that stakeholders are looking for greater clarity of roles and responsibilities between CHS, HCSD and Digital Canberra, particularly regarding the DHR and how decisions and enhancements are made. Stakeholders identified that whilst Digital Canberra was created to maximise capability and ensure better oversight and consistency, there must be partnership and collaboration mechanisms in place with CHS and HCSD to ensure clinical safety, quality, trust, security and interoperability as the DHR continues to evolve.

To support increased clarity, there is an opportunity for HCSD, in collaboration with CHS and Digital Canberra, to develop a Digital Health Governance Framework (DHGF). This should clearly outline how CHS, HCSD and Digital Canberra work together, their distinct roles and responsibilities, the role of digital health governing committees (established as part of the Framework) that support and enable collaboration and partnership, along with artifacts that support digital health strategy and continuous improvement.

Content of this Framework should acknowledge:

- The role of CHS as the overarching Business Owner of the DHR and other clinical applications
- The role of HCSD as the overarching Business Owner of applications critical to the functions of HCSD
- The role of Digital Canberra as the technology System Owner to support the Business Owner and enable the achievement of the digital objectives of the business. This includes key responsibilities to support the DHR (and other clinical and non-clinical systems) Business Owner in areas such as operation, availability and configuration of changes to the system
- The critical role of CHS, HCSD and Digital Canberra to partner and collaborate to ensure that proposed or implemented changes to the DHR do not result in inadvertent risks or issues. For example, risks associated with clinical quality and safety.

Recommendation 45

HCSD, in collaboration with CHS and Digital Canberra, develop a Digital Health Governance Framework (DHGF) that outlines the roles and responsibilities of all entities, their work units and staff.

Chapter 10 Implementation considerations

To support the translation of the Inquiry recommendations into meaningful and sustainable system-wide improvement, formal endorsement from the ACT Government is required to provide clear authority. Successful implementation of the recommendations will also require deliberate planning, leadership and clear financial investment from the ACT Government. This is required to ensure implementation efforts are supported by clear accountability and resourcing arrangements.

To maintain a clear focus throughout the three-year implementation period, a comprehensive implementation plan should be developed, along with responsibility allocated to a dedicated oversight group, such as the ACT Health System Council. The oversight group should ensure strong governance and accountability arrangements, through regular monitoring and reporting of implementation progress.

10.1 Implementation Plan

Creation of an implementation plan and roadmap

To ensure the Inquiry recommendations are implemented efficiently and effectively, an Implementation Plan should be developed and endorsed. The proposed coverage of the Implementation Plan includes:

- Overall objectives and scope of the plan.
- Detail of recommendations that define scope, including known interdependencies between recommendations and impact on sequencing and integrated work effort.
- Defined workstreams or teams across the ACT health system responsible for undertaking activity to implement each recommendation, including accountable leads.
- Project management mechanisms, including governance, reporting and status meetings (at both team and project levels).
- Stakeholder engagement and co-design principles.
- Delivery timelines and milestones.
- Embedded monitoring and evaluation mechanisms to track progress.
- Governance arrangements including risk and issue management.

The Implementation Plan should be supported by an Implementation Roadmap, which should identify the sequence of implementation according to prioritisation and interdependencies.

The use of an independent oversight group will assist with supporting accountability and transparency during implementation. The ACT Health System Council could play this role, or another group. The oversight group should be independent of those responsible for implementation of the recommendations, and include stakeholders such as health consumers, clinicians and people experienced in governing complex health systems.

Recommendation 46

Develop a comprehensive implementation plan that clearly outlines specific actions, timelines, and assigns accountability by identifying the individuals or teams responsible for leading the activities related to each recommendation.

Broadening role of oversight group to support governance and progress monitoring

Recommendation 47

Allocate responsibility to an oversight group, such as the ACT Health System Council, to undertake regular monitoring of the progress of implementation of the recommendations.

10.2 Implementation progress review

Commissioning of an 18-month implementation progress review

At 18-months post ACT Government endorsement, HCSD and CHS should commission an independent review of implementation progress. The review will serve as an important checkpoint, with a focus on delivery maturity and initial outcomes and benefits delivered. The review should evaluate:

- The extent to which recommendations have been implemented.
- The effectiveness of program governance and project management functions.
- The extent to which staff and relevant stakeholders across the organisations have been engaged and involved through collaborative co-design processes.
- The extent to which improvements have been successfully and sustainably embedded into practice.
- Implementation enablers and barriers which are facilitating or constraining success.

Findings obtained from the 18-month independent review should be formally provided to the Minister for Health, the ACT Health System Council, relevant leadership across the ACT health system, and be released publicly. Findings should be used to recalibrate the Implementation Roadmap and address any risks or barriers to implementation, through collaborative engagement with staff and stakeholders in the ACT health system.

Recommendation 48

Undertake an 18-month implementation progress review with a public report to be completed by 30 June 2028.

Commissioning of a 3-year implementation progress review

At 3-years post ACT Government endorsement, HCSD and CHS should commission a second and final independent review of implementation progress. While this review should focus on implementation progress, there should be greater emphasis placed upon the overall impact, sustainability and value generated through the implementation of recommendations. This includes tangible benefits and outcomes to system performance, clinical quality and safety, patient experience, operational efficiency and data-driven decision making.

Importantly, this final review should evaluate the extent to which the implementation of recommendations has been embedded into governance and organisational structures and business-as-usual operations. Findings from this final implementation progress review should be used to plan further continuous improvement activities, strengthening the ACT health system as learning system focused on continually looking to improve.

Recommendation 49

Undertake a 3-year implementation progress review with a public report to be completed by 31 December 2029.

Appendix A Terms of Reference (ToR)

Inquiry into ACT health system data, demand and processes

Role

The role of the Independent Inquiry is to undertake impartial investigations and provide recommendations for improvement about health data integrity, associated processes and systems, drivers of health system demand and any other related matters as set out in its ToR.

Independent Inquiry

The Minister has appointed the Chair in line with a motion agreed by the ACT Legislative Assembly regarding health system expertise and independence from the ACT's public health system.

Inquiry scope and deliverables

The core deliverables of the Inquiry are to:

1. Make recommendations for any required improvements to the health data made publicly available, including but not limited to wait times for specialist appointments. This will be supported by:
    a. undertaking inter-jurisdictional comparisons of publicly available health data
    b. considering centralisation of the publication of health data
    c. considering improvements in the presentation of data to enable longitudinal comparisons and changes and segmentation to better understand determinants
2. Determine the extent and impact of any interference – administrative, managerial or political – in clinical care decisions at CHS and make recommendations as relevant.
3. Determine the effectiveness, risks, and any unintended consequences of Planned Care Reforms and the DHR implementation, including potential improvements in data, updates to privacy legislation and oversight required to facilitate patients' treatment.
    a. This will include investigating concerns raised publicly regarding the cardiology and orthopaedic surgery groups in the ACT public health system.
4. Investigate current and projected resourcing needs (including workforce, theatres, equipment and beds) relative to demand. To support this analysis, the Inquiry will seek to:
    a. understand drivers of waiting list growth, including referral pathways and any peri-operative capacity constraints
    b. consider inter-jurisdictional comparisons of drivers of waiting-list growth, including referral pathways and peri-operative capacity constraints
5. Investigate factors affecting recruitment, retention and morale of medical, nursing and allied health staff.

6. Make evidence-based recommendations to improve governance, resourcing and data required to facilitate patient, policy and clinical outcomes, and staff wellbeing.

In undertaking this work, the Inquiry will have regard to previous inquiries, reviews and recommendations, and to concurrent reviews and strategic planning work, including that being undertaken by:

- the ACT Auditor Office into the implementation of the Digital Health Record and the Reform of Outpatient Service Delivery (see ACT Audit Office 2025-26 Performance Audit Program), and
- the Health System Sustainability Taskforce comprising senior officials from the Health and Community Services Directorate, CHS and ACT Treasury.

Inquiry process

Consultation

The Inquiry is required to undertake stakeholder consultations and accept written submissions where relevant. Consultation may be public and/or confidential and the Chair will accept confidential submissions and input on request.

Following any public hearings or forums, transcripts and/or summaries may be published on the Health and Community Services Directorate website, subject to privacy considerations.

Reporting

The ACT Health System Council will act as the steering committee for the Inquiry. The Inquiry Chair will provide updates on progress at each Council meeting. The Inquiry may also provide papers for out of session consideration.

The Inquiry Chair will also provide regular reports to the Health System Sustainability Taskforce and attend these meetings at the invitation of its Chair.

The Inquiry will report to the Minister for Health and Mental Health, who will make the final report publicly available, including by tabling it in the ACT Legislative Assembly by 30 June 2026. The Minister will also table a formal response to the final report by the last sitting day of 2026.

Appendix B Stakeholder consultations

The Chair commenced consultations on 25 August 2025 and concluded consultations on 7 May 2026. The Chair conducted 118 consultations with more than 260 participants.[197]

Stakeholders were actively engaged throughout the Inquiry, and consultations were constructive and productive. The Chair met with all individuals and organisations that requested a meeting and proactively sought meetings with relevant key stakeholders. Participants engaged openly with the process, generously offering their time and expertise, and demonstrated strong support for the Inquiry through thoughtful and considered contributions.

All consultations were conducted on the understanding that individuals would not be named or directly identified in this report. Accordingly, the table below provides an overview of the stakeholder organisations and groups with whom the Chair met during the consultation period.

As noted throughout this report, several individuals and groups were consulted more than once. In addition, staff movement, turnover, and acting appointments occurred within some organisations during the consultation period. As a result, the Chair in some instances met with different individuals representing the same role, or with the same individuals in different capacities.

The table below provides a high-level overview of the stakeholder organisations and groups consulted as part of this Inquiry.

Table 29: Overview stakeholder organisations and consulted parties

Stakeholder group	Consulted parties
ACT Audit Office	• Office of the Auditor-General
ACT Government	• Office of the Head of Service and Director-General
Canberra Health Services	• Clinical Director's Advisory Committee • Clinicians • Decision Support Unit • Division of Medicine • Education, Research and Academic Partnerships • North Canberra Hospital, Office of the General Manager • Office of the Chief Executive Officer • Office of the Chief Financial Officer • Office of the Chief Health Officer • People and Culture • Planned Care Unit • Professional Leads • Quality, Safety and Governance • The Canberra Hospital, Office of the Chief Operating Officer • The Canberra Hospital, Office of the General Manager

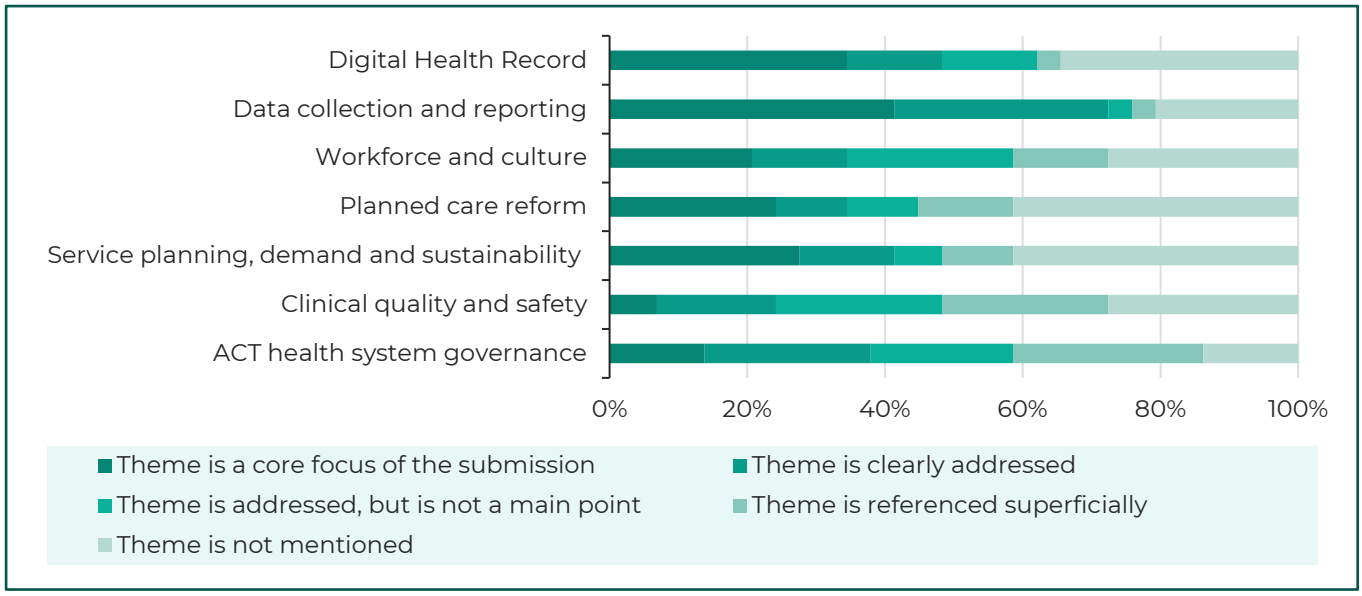
[197] Noting that the 259 participants are not all unique, as some individuals have attended multiple meetings and/or participated in different roles and capacities.

Stakeholder group	Consulted parties
Capital Health Network	• Capital Health Network, Clinical Council • GP Advisory Committee • Office of the Chief Executive Officer
Commonwealth statutory authorities	• Independent Health and Aged Care Pricing Authority (IHACPA) • National Health Funding Body
Community organisations	• ACT Community Peaks Network • ACT Council of Social Service • Carers ACT • Health Care Consumers Association • Indigenous Allied Health Australia • Mental Health Community Coalition • NGO Leadership Group • Southern NSW LHD • Winnunga Nimmityjah Aboriginal Health and Community Services
Digital Canberra	• Office of the Chief Digital Officer • Office of the Chief Information Officer • Office of the Chief Medical Information Officer • Office of the Director-General • Planning, design and digital group
Elected representatives	• Independent members of the Legislative Assembly • Leader of the Greens • Leader of the Opposition • Minister for Health and Mental Health • Office of the Independent Senator for the ACT
Governance	• ACT Health System Council
Health and Community Services Directorate	• Data Analytics Branch • Health System Innovation and Performance • Health System Innovation and Performance • Health Systems Planning and Development • LHN Assurance Committee • Mental Health and Suicide Prevention • Office of the Chief Allied Health Officer • Office of the Chief Health Officer • Office of the Chief Medical Officer • Office of the Director-General • Office of the Deputy-Director-General • Policy, Partnerships and Programs
Members of the community	• Community clinicians • Members of the community
Peak professional body	• Australian Medical Association (AMA) • Royal Australian College of General Practitioners (RACGP)
Treasury and Economic Development Directorate	• Finance and Budget Group
Unions	• Australian Salaried Medical Officers Federation • Community and Public Sector Union
University of Canberra	• Faculty of Health

Appendix C Analysis of submissions

The Inquiry received 29 written submissions, all of which were carefully considered in the preparation of the Final Report. A thematic analysis was undertaken to identify key topics and issues captured by stakeholders through written submission. The output of this comprehensive analysis is provided in **Figure 39**. This illustrates the extent to which each theme was identified across the written submissions received.

Figure 39: Thematic analysis of submissions received



Logic:

- Submissions were first reviewed to identify major and recurring themes, recognising that many contributors addressed multiple themes with varying emphasis.
- A second review was then conducted. Each instance of a theme was coded and weighted according to how it was referenced. For example, whether it was a central focus, clearly addressed, addressed but not a primary point, or mentioned only superficially.

Caveat: The resulting proportions illustrated above do not indicate the relative importance or priority of themes. Rather, they reflect stakeholders' perspectives and the issues most immediate or salient within their respective contexts.

Appendix D Glossary and abbreviations

Acronym/abbreviation	Definition
ACSQHC	Australian Commission on Safety and Quality in Health Care
ACT	Australian Capital Territory
ACTAIM	ACT Acute Inpatient Model
ACCHO	Aboriginal Community Controlled Health Organisation
ACTAIM	ACT Acute Inpatient Model
ACTPS Employee Survey	ACT Public Service Employee Survey
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
CEO	Chief Executive Officer
CHH	Clare Holland House
CHI	Central Health Intake
CHO	Chief Health Officer
CHS	Canberra Health Services
CPF	Clinical Patient Folder
CQSF	Clinical Quality and Safety Framework
CSGC	Clinical System Governance Committee
CSGC	Clinical System Governance Committee
DHR	Digital Health Record
ED Model	Emergency Department Model
FTE	A Full-Time Equivalent
GP/s	General Practitioner/s
HCSD	Health and Community Services Directorate
HDGF	Health Data Governance Framework
HR	Human Resources
ICT	Information and Communication Technology
IHACPA	Independent Health and Aged Care Pricing Authority
KPI/s	Key Performance Indicators
LHN/s	Local Hospital Network/s
LHD	Local Health Districts
M&M	Morbidity and Mortality
MDAAC	Medical and Dental Appointments Advisory Committee
MDAAC	Medical and Dental Appointments Advisory Committee
MHJHADS	Mental Health Justice Health Alcohol and Drug Services
MHR	My Health Record
MoG	Machinery of Government

Acronym/abbreviation	Definition
NCH	North Canberra Hospital
NEC	National Efficient Cost
NEP	National Efficient Price
NGOs	Non-Governmental Organisations
NHCDC	National Hospital Cost Data Collection
NHFPA	National Health Funding Pool Administrator
NHFPB	National Health Funding Pool Body
NHRA	National Health Reform Agreement
NSQHS	National Safety and Quality Health Service
NSW	New South Wales
NT	Northern Territory
NWAU	National Weighted Activity Unit
OCIM	Organisation Culture Improvement Model
OIRWS	Office of Industrial Relations and Workforce Strategy
OV	Occupational Violence
PHN	Primary Health Network/s
QAC	Quality Assurance Committee
QSLN	Quality and Safety Leadership Network
QSLN	Quality and Safety Leadership Network
RACGP	Royal Australian College of General Practitioners
RCA	Root Cause Analysis
RoGS	Report on Government Services
SA	South Australia
SBS	Safety Broadcasting System
SoP	Statements of Priority
TAS	Tasmania
The 2019 Culture Review	Review into Workplace Culture within ACT Public Health Services (2019-2021)
ToR	Terms of Reference
VMOs	Visiting Medical Officers
Vic	Victoria
WA	Western Australia
WAU	Weighted Activity Unit
WHO	World Health Organization

Appendix E Tables and figures

Tables

Figures