2026

THE LEGISLATIVE ASSEMBLY FOR THE

AUSTRALIAN CAPITAL TERRITORY

ELEVENTH ASSEMBLY

Progress Report - Independent inquiry into ACT health system data, demand and processes

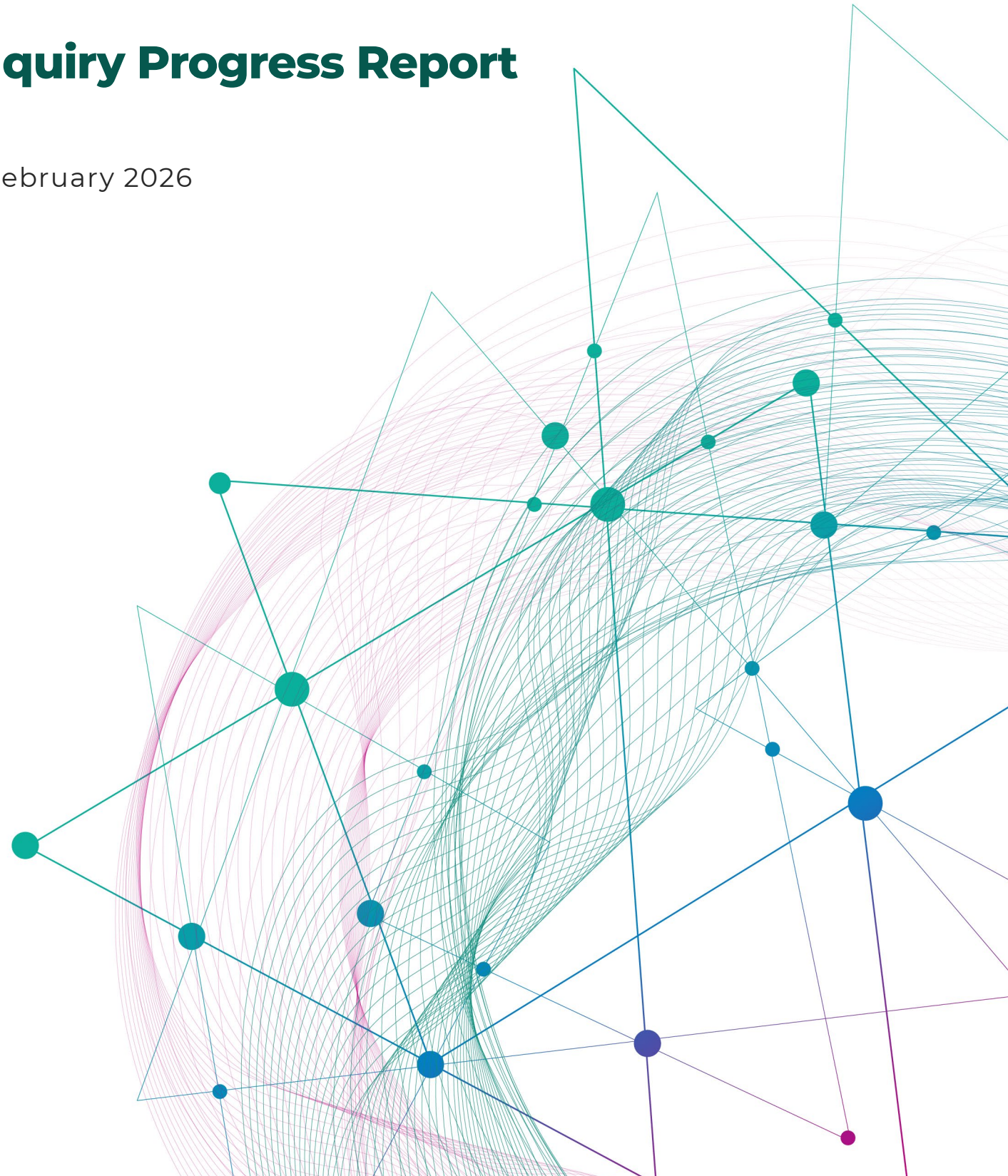
Presented by
Rachel Stephen-Smith MLA
Minister for Health
24-26 February 2026

This page left blank.

Inquiry into ACT health system data, demand and processes

Inquiry Progress Report

4 February 2026

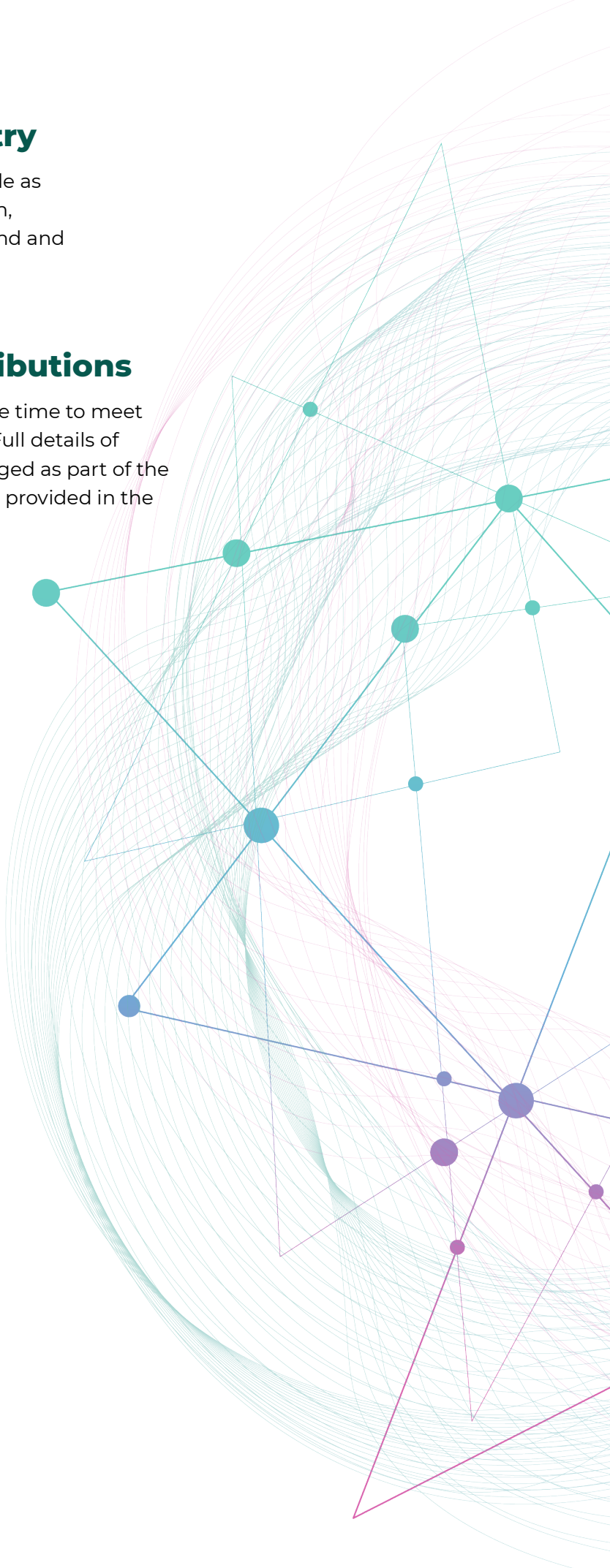


Acknowledgement of Country

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 thank everyone who has taken the time to meet with me and/or provided a submission to date. Full details of categories of stakeholders who have been engaged as part of the Inquiry, along with submissions received, will be provided in the Inquiry Final Report.



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

4 February 2026

Dear Minister

I am pleased to provide you with the Inquiry into ACT health system data, demand and processes - Progress Report: February 2026 (the Inquiry Progress Report).

The report is a requirement of my engagement as Chair of the Inquiry into ACT health system data, demand and process (the Inquiry). The remaining requirement is the provision of the Inquiry Final Report, which will be provided in sufficient time for you to table it in the ACT Legislative Assembly before 30 June 2026, as required in the Terms of Reference (ToR) (**see Appendix A**).

The Inquiry Progress Report provides an initial high-level descriptive and thematic summary of the consultations, received submissions, and data collection and analysis to date. As further consultation will be undertaken, including follow-up discussions with those who have provided submissions, the Inquiry Progress Report describes information that will be used as the Inquiry progresses to arrive at findings and recommendations relevant to the ToR. The Inquiry Final Report will contain more detail from consultations and submissions. The findings and recommendations will be in the Inquiry Final Report.

To date, consultation sessions have been undertaken with more than 170 stakeholders. Some stakeholders have been part of more than one consultation session. A total of 27 submissions have been received to date.

You will note in the Inquiry Progress Report that the consultations and submissions to date have allowed a set of organising themes to be developed, against which the ToR has been mapped. The recommendations in the Inquiry Final Report will be mapped against both the themes and the Inquiry ToR. The themes may change as a result of further consultation and submissions but currently they are:

- System Governance;
- Clinical Quality and Safety;
- Service Planning, Demand, Sustainability and Planned Care Reforms;
- Workforce and Culture;
- Data Collection and Reporting, and
- Digital Health Record.

The Inquiry Progress Report also includes questions that will assist the discussion of the report with the ACT Health System Council, which is the Steering Committee for the Inquiry. The questions will also assist with the follow-up consultations.

Yours sincerely

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

Contents

1. Introduction

This section details the scope of the Independent Inquiry based on the Terms of Reference (ToR), the methodology for conducting the Inquiry to date, and background on the ACT Health System.

About the Independent Inquiry into ACT health system data, demand and processes

Commissioning and Scope of the Inquiry

On 24 June 2025, the 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.[1]

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, and
- 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 has been appointed by HCSD to support the Independent Chair to maintain independence for the Inquiry.

Methodology for the Inquiry

The Inquiry commenced on 25 August 2025 and will be 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 is occurring over four phases (refer **Figure 1**), with the Inquiry Progress Report the conclusion of Phase one.

[1] Legislative Assembly for the Australian Capital Territory 2025, *Notice Paper No. 22: Tuesday, 24 June 2025*, ACT Parliament, Canberra. **https://www.parliament.act.gov.au/__data/assets/pdf_file/0010/2869858/NP-22-24-June-2025.pdf**

The Inquiry Progress Report provides preliminary analysis based on:

- Consultations with more than 170 stakeholders;[2]
- 27 submissions from stakeholders;
- Desktop review of publicly available information and documents provided by CHS and HCSD, and
- Preliminary data analysis, including relating to specialist appointment and elective surgery waiting times and publicly reported public health data.

Phase three of the Inquiry will involve further analysis and consultation to inform the development of the Final Report that will contain findings and recommendations.

Figure 1 Summary of phases and timelines

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

ACT Health System Context

Previous structural changes to the ACT health system and reviews undertaken

The ACT health system has undergone significant changes in 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 globally, 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, Canberra Health Services (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;[3]
- On 12 November 2022, the first Digital Health Record (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;[4]
- 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;*[5]
- 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 the CHS,[6] and
- On 1 July 2025, Machinery of Government (MoG) changes merged the ACT Health Directorate with the Community Services Directorate to form the 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 2 provides an overview of significant changes to the ACT health system, together with previous reviews, investigations, and inquiries. Auditor-General's reports relevant to the ToR are shown separately in **Figure 3**.

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 3** highlighting those that are relevant to the Terms of Reference.

[3] Canberra Health Services 2019, Canberra Health Services Annual Report 2018-19, ACT Government, Canberra. https://www.canberrahealthservices.act.gov.au/__data/assets/file/0010/1933192/CHS-2018-19-AR_Accessible-LR-1.pdf

[4] Stephen-Smith, R 2022, Less than two months until ACT's Digital Health Record goes live, ACT Government, Canberra. https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/rachel-stephen-smith-mla-media-releases/2022/less-than-two-months-until-acts-digital-health-record-goes-live

[5] Australian Capital Territory 2023, Health Infrastructure Enabling Act, Act No. 17 of 2023 (ACT), ACT Government, Canberra. https://www.legislation.act.gov.au/a/2023-17/

[6] Stephen-Smith, R 2025, Settlement reached with Calvary Health Care, ACT Government, Canberra. https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/rachel-stephen-smith-mla-media-releases/2025/settlement-reached-with-calvary-health-care

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 2 Overview significant changes to the ACT health system and previous reviews investigations and inquiries

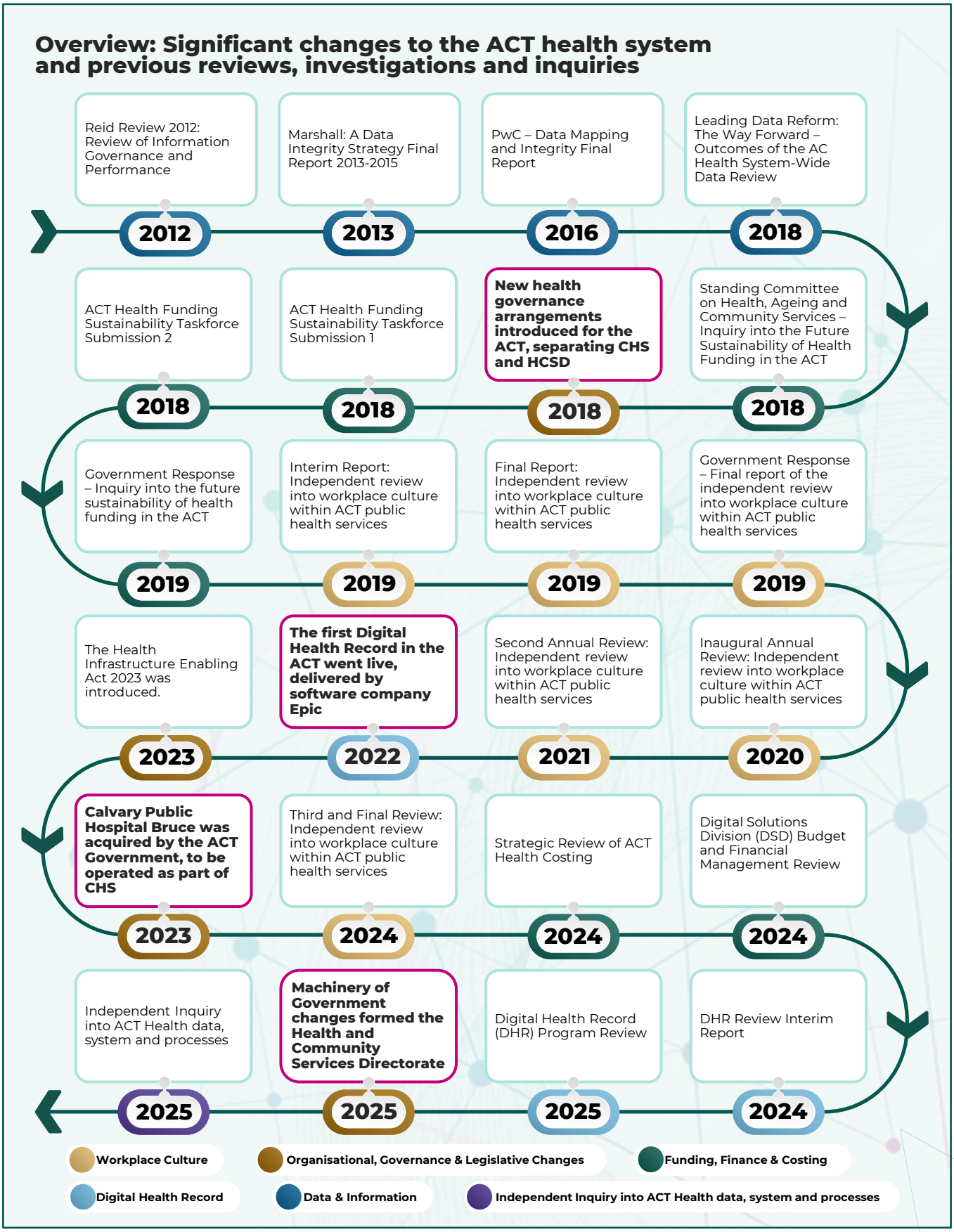
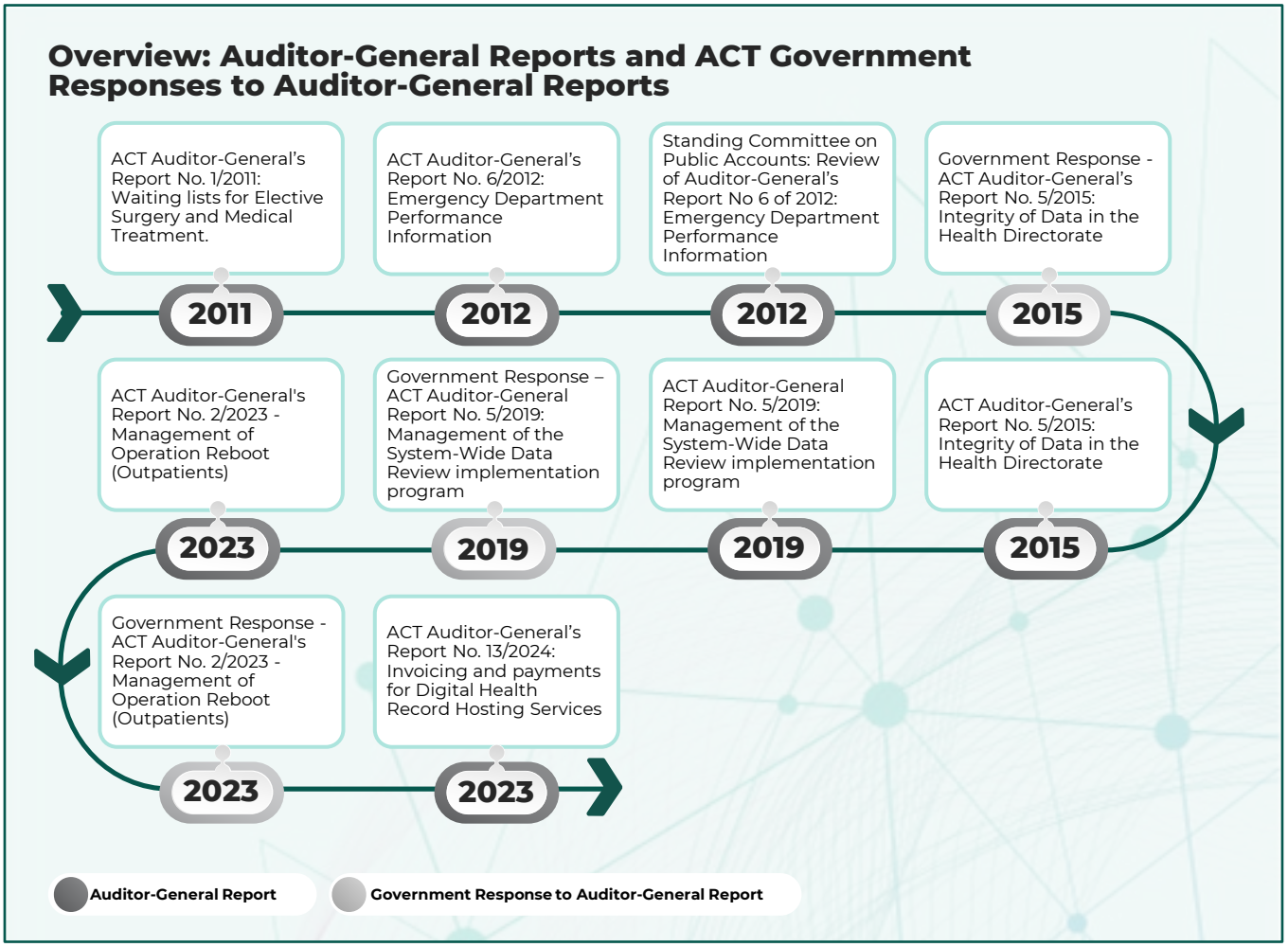


Figure 3 Overview of the Auditor-General reports and ACT Government responses to Auditor-General reports



Current Roles and Responsibilities of CHS and HCSD

The current roles and responsibilities of CHS and HCSD are provided in **Table 1**. 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 System Governance section of this Report (**Section 3.1**).

Table 1 Current roles and responsibilities of CHS and HCSD

	Canberra Health Services	Health and Community Services Directorate
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, and • 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 Canberra Health Services 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, and • 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-government organisations.

2. High-level Stakeholder insights to date

I would like to thank everyone who has taken the time to meet with me and/or provided a submission. Stakeholder's passion and commitment have been evident in all discussions. The information and insights being provided is invaluable to the work of the Inquiry.

This summary section in the Inquiry Progress Report is a brief overview of the consultations and submissions. Further review of the consultations and submissions is occurring and a more detailed summary will be provided in the Final Report.

A summary of stakeholder groups will be provided in the Inquiry Final Report. To maintain confidentiality, no individuals are identified in this report and this will also be the case for the Inquiry Final Report. There will be an opportunity for further consultation to inform the Inquiry ahead of the Inquiry Final Report being delivered.

Stakeholder consultations and submissions have identified several emerging themes. The emerging themes are summarised below, with further detail from the desktop and data analysis and review provided in **Section 3**. It is important to note that this section is a high-level thematic summary, which is not intended to capture all insights from the consultations and the submissions. A more detailed summary will be included in the Inquiry Final Report.

There are six organising themes that are emerging from the consultations and submissions, these are:

1. System Governance;
2. Clinical Quality and Safety;
3. Service Planning, Demand, Sustainability and Planned Care Reforms;
4. Workforce and Culture;
5. Data Collection and Reporting, and
6. Digital Health Record (DHR).

2.1 Thematic summary of high-level stakeholder insights by theme

2.1.1 Health System Governance

Clarity regarding health system governance emerged in consultations as a strong pillar impacting most of the other emerging themes discussed below. 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 emerging themes below.

Stakeholders noted that there is a strong link between clarity in roles and responsibilities and workforce culture. It can lead to inefficiencies as individuals take longer to navigate arrangements to understand responsibilities and authority for decision making. Stakeholders noted it 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.

2.1.2 Clinical Quality and Safety

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 Digital Health Record (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.

2.1.3 Service Planning, Demand, Sustainability and Planned Care Reforms

Service planning, demand and sustainability for public health services

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 North Canberra Hospital. 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 North Canberra Hospital and The Canberra Hospital.

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.

Planned Care Reforms

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 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.

2.1.4 Workforce and Culture

Workforce and culture has been a common theme raised during stakeholder consultations. Consultations indicated that there is a strong commitment of staff to the ACT public health system. However, while efforts have been made to improve workforce culture, consultations identified that there continues to be challenges affecting recruitment, retention and workforce morale.

Culture of the ACT public health system

Consultations highlighted a strong commitment to public health and community service among many clinicians. Examples provided by stakeholders included staff foregoing private work during COVID-19 and allocating to undertaking and providing education and training.

Some stakeholders identified that there have been some improvements coming from the Independent Review into Workplace Culture within ACT Public Health Services (2019-2021) (discussed further in **Section 3.4**), consultations highlighted persistent cultural challenges within the ACT health system. Some stakeholders noted there are opportunities to improve trust and transparency, including feeling confident that there will be no consequences if you raise concerns. Suggestions have been made for ways to develop a better mechanism to provide a feedback loop for clinicians to leadership. Consistent with the review reports, there were concerns raised from some staff about cultural safety and racism within the health system, including for First Nations people and people from culturally and linguistically diverse backgrounds.

Many stakeholders have communicated the stressful demands of working in the health system and the potential impact it can have if it becomes unsustainable and leads to burnout.

Recruitment, training and leadership capability

Some stakeholders discussed initiatives in place to support improving workforce training and culture, including strategies such as a dedicated FTE (Full-Time Equivalent) for supervising trainees. However, consultations identified several barriers to recruitment and training pathways. For example, some stakeholders identified a need to grow the First Nations workforce and consider the workforce model, including the pathway for recruitment, training, and leadership opportunities.

Some stakeholders noted that leadership roles can sometimes be focused on clinical and technical skills, with stakeholders identifying a need for further investment in leadership skill development.

Opportunities were identified during consultations to invest more in innovation and research, and training for staff, to support attracting and retaining staff. This would include increasing access for doctors in training to well-trained academic supervisors to undertake research and development activities. Stakeholders talked about the importance of a strong research and education culture leading to improved clinical practice and culture.

Systems impacting workforce culture

Stakeholders interviewed acknowledged the importance of working across different health facilities, to ensure patients receive the best care, while fostering collaboration, professional growth and operational efficiency. Consultations identified the different HR and payroll systems across TCH and NCH is currently a barrier for this, limiting the flexibility and ease of staff transitioning between locations.

Staff highlighted that, due to system constraints, manual workarounds for HR and payroll activities, and duplication of effort can be required, impacting workload. This includes using different rostering systems and submitting leave forms across the two systems.

Cardiology and Orthopaedic services

As outlined in the ToR, the Inquiry is investigating concerns raised regarding the cardiology and orthopaedic surgery groups in the ACT public health system. Initial consultations have been undertaken with the cardiology and orthopaedic surgery groups, with additional consultations to be scheduled ahead of the Final Inquiry Report being delivered. The Inquiry acknowledges the ongoing matter before the Federal Court in relation to cardiology. Consultation and findings specific to the cardiology and orthopaedic surgery groups will be explored further in the Inquiry Final Report.

2.1.5 Data Collection and Reporting

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 need to be addressed. The data collection and reporting emerging theme is strongly related to the DHR theme, discussed in **Section 2.1.6** below.

Data governance

As noted in **Section 2.1.1**, 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. 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 non-government organisations.

The issue of data sovereignty for First Nations people was also raised as an important area that needs to be developed in collaboration with First Nations people 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 within national public reports.

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.

2.1.6 Digital Health Record (DHR)

The consultations identified that the DHR is a critical enabler to support clinical care in the ACT public health system. While the DHR has delivered important benefit due to its clinical utility, stakeholders have identified some challenges 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., infection control). 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 but that it was important to have strong privacy monitoring arrangements in place. Some stakeholders also talked about the broader availability to clinicians outside of CHS of the DHR GP portal, along with the appropriate privacy and security provisions.

Stakeholders noted that strengthening the consistency of use of the DHR in the ACT will improve continuity of care and patient safety, and a develop 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.

Data quality, workflows, and clinician and patient experience

While the DHR was generally identified during consultations as a useful clinical tool, stakeholders noted that data quality following the transition to DHR remains a challenge. Post implementation the focus has been on the system data reporting requirements, with substantial effort invested in data remediation for external reporting. Stakeholders discussed there being 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 clinical reports, reduce duplication of data entry, and streamline data analysis. Stakeholders emphasised that future improvements for DHR optimisation must involve clinician-led workflow and models of care design.

DHR Governance

As noted in **Section 2.1.1**, 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 indicated that there increased transparency and communication regarding the prioritisation process for undertaking changes in the DHR could improve engagement and understanding across the workforce.

Some stakeholders identified that a more structured and transparent governance model, that embeds clinicians in decision-making, clarifies configuration standards, and ensures prioritisation of changes is aligned with clinical need, should assist with optimising the DHR.

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

The emerging themes from the consultations and submissions are being used to structure the Inquiry Progress Report. A mapping of the ToR against the emerging themes is being used to ensure that all ToR are covered in the final report. The themes may change as further consultations are undertaken and if further submissions are received.

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.

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; and*
    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.*
7. 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; and*
    b. *consider inter-jurisdictional comparisons of drivers of waiting-list growth, including referral pathways and peri-operative capacity constraints.*
8. Investigate factors affecting recruitment, retention and morale of medical, nursing and allied health staff.

9. Make evidence-based recommendations to improve governance, resourcing and data required to facilitate patient, policy and clinical outcomes, and staff wellbeing.

The following table (**Table 2**) provides a mapping of the ToR to the emerging 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 2 Mapping of ToR against emerging themes

Theme	Core Terms of Reference	Ancillary Terms of Reference
System Governance	6	1, 2, 3 and 5
Clinical Quality and Safety	2 and 3	6
Service Planning, Demand, Sustainability and Planned Care Reforms	3 and 4	6
Workforce and Culture	5	4 and 6
Data Collection and Reporting	1	3 and 6
Digital Health Record (DHR)	3	6

3. High-level summary of data gathering and analysis

This section provides a high-level summary of data analysis and desktop review, aligned with the themes identified in **Section 2**. Additional analysis will be undertaken for the Final Report.

3.1 Health System Governance

Key points:

- ACT Government Administrative Arrangements establish the public health entities, assign functions and legislation to entities, and allocate entities to Ministers.
- The National Health Reform Agreement (NHRA) Addendum 2020-25 contains commitments relating to system governance in States and Territories.
- The ACT has developed governance arrangements in response to the NHRA commitments.

An emerging theme from consultations and submissions captured in **Section 2.1.1** is the need for clarity of roles, responsibilities and relationships of organisational entities and positions within the ACT health system. Health system governance is the accountability framework that defines roles and accountabilities, entities and organisational structures, and accountability relationships.

As noted by the World Health Organization (WHO),[7] health system governance ensures that strategic policy frameworks exist with effective oversight, regulations, accountability and system design. It 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.

The following sections describe the current ACT health system governance arrangements, including how they relate to the commitments made by the ACT Government as a signatory to the National Health Reform Agreement (NHRA) Addendum 2020-25.

3.1.1 ACT Administrative Arrangements

To establish the ACT health entities, and allocate functions and legislation to them, the ACT Government publishes Administrative Arrangements under the *Australian Capital Territory (Self-Government) Act 1988 (Cwlth)* and the *Public Sector Management Act 1994*. These Administrative Arrangements also allocate the entities, functions and legislation to Ministers. The current Administrative Arrangements were issued on 19 December 2025.[8]

[7] World Health Organization (WHO) n.d., Health systems governance, World Health Organization, Geneva. https://www.who.int/health-topics/health-systems-governance#tab=tab_1

[8] Australian Capital Territory 2025, Administrative Arrangements 2025 (No 2), ACT Government, Canberra. https://legislation.act.gov.au/ni/2025-686/

provides a graphical representation of the Administrative Arrangements. 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 Administrative Arrangements establish four entities that are allocated health-related functions:

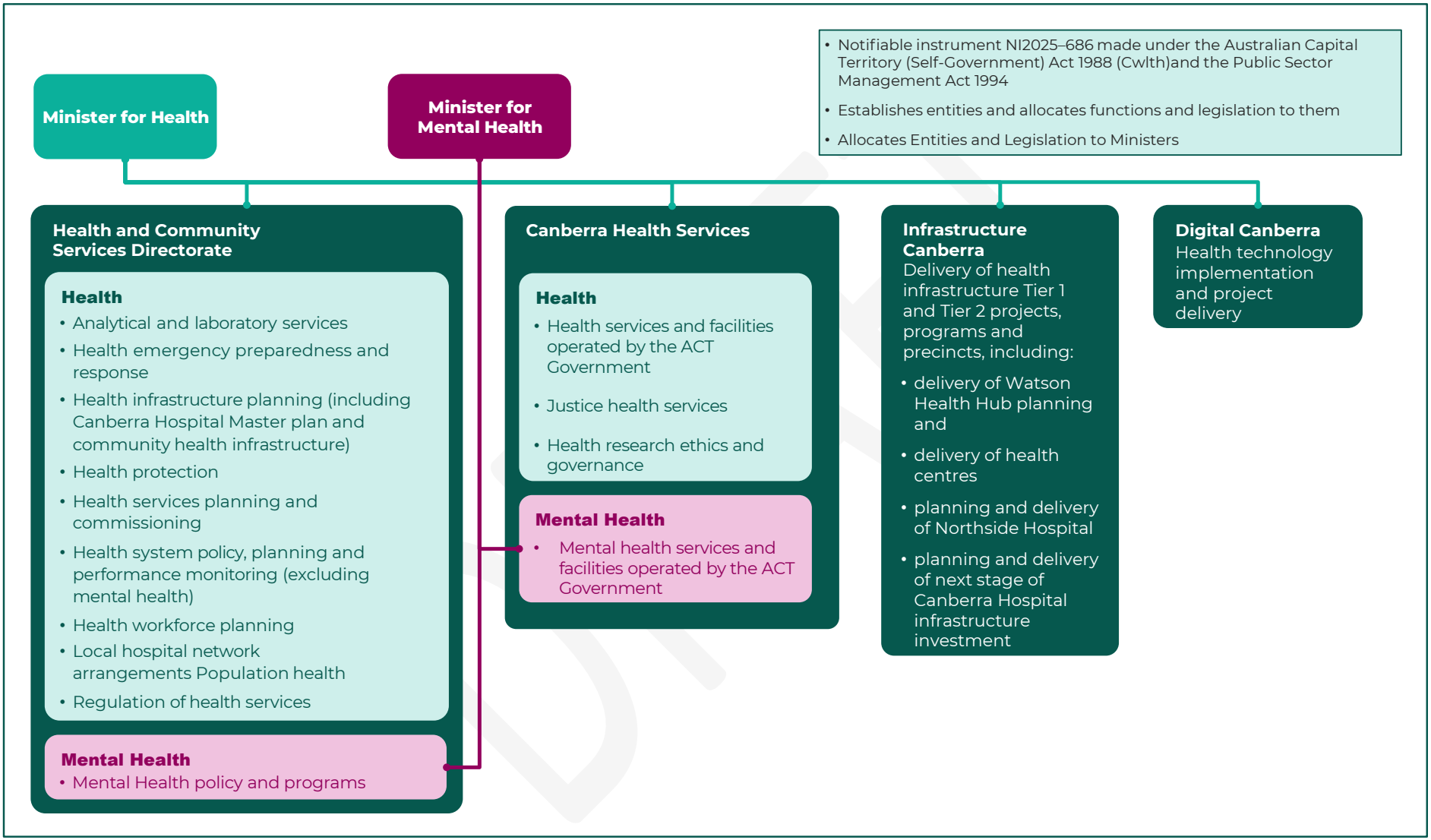
- HCSD;
- CHS;
- Digital Canberra, and
- Infrastructure Canberra.

The functions allocated to each of these entities is described in **Figure 4**. 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. As HCSD and CHS are established through the Administrative Arrangements, they are entities of equal status.

As noted earlier in this report, the arrangement to have two health entities commenced on 1 October 2018 following the review titled *New Health Governance Arrangements for the ACT*.[9] The functions allocated to CHS through the Administrative Arrangements identifies this organisation as the health service provider. The functions allocated to HCSD identifies this organisation as the system planner, service commissioner and system performance monitor.

[9] Nous Group 2018, New health governance arrangements for the ACT, ACT Government, Canberra.<https://nla.gov.au/nla.obj-2863996480/view>

Figure 4 ACT health Administrative Arrangements



Note: the Health and Community Services Directorate is also allocated non-health related functions that are not included in this diagram

3.1.2 Commitments from the National Health Reform Agreement (NHRA)

All State and Territory, and Commonwealth First Ministers have signed the 2020-25 Addendum to the NHRA.[10] The NHRA has been extended for 12 months, by agreement of all signatories, and is currently scheduled to end on 30 June 2026. On 29 January 2026, it was announced that a new 2026-31 NHRA Addendum Agreement had been signed by all States and Territories, and the Commonwealth. The Inquiry Final Report will be updated to reflect any changes contained in the new agreement.

The NHRA is the core agreement for the provision of Commonwealth funding for public health and hospital services to the States and Territories. 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.

Figure 5 provides a graphical summary of the organisational and governance commitments 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 Local Hospital Network/s (LHN/s) 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:[11]

- 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, and
- Independent Health and Aged Care Pricing Authority (IHACPA) – new 2012.

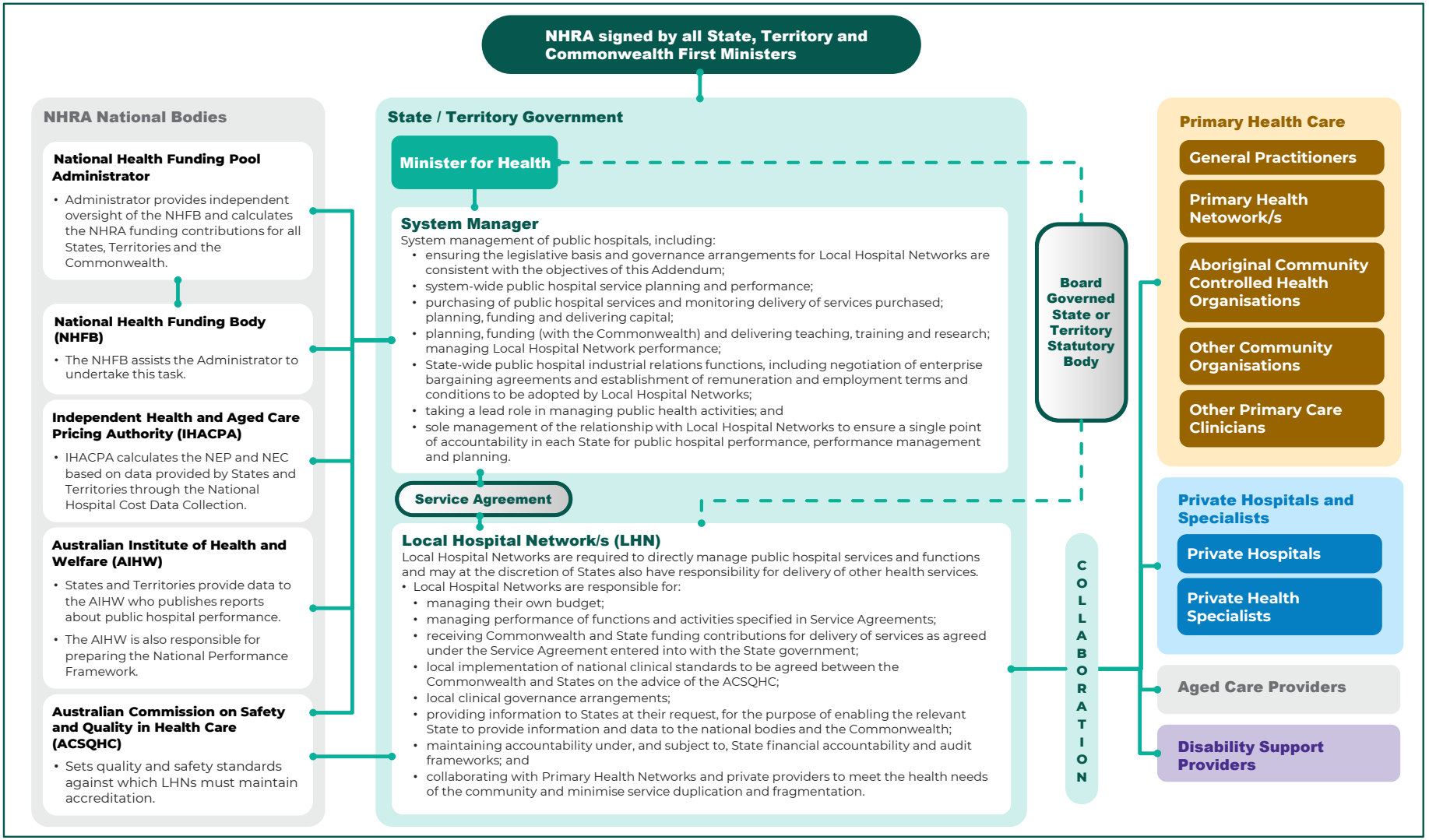
The national bodies provide transparency and independence in relation to the funding, performance and accountability within the national public health and hospital system. The NHRA commitments made by States, Territories and the Commonwealth are complex and the following provides a high-level summary 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 5**. 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 Unity (WAU), and the National Efficient Cost (NEC) for Block Funded Hospitals, and
- The System Manager in each State and Territory to provide past activity reconciliations, and future activity forecasts to the 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.

[10] Australian Government, 2020, National Health Reform Agreement (NHRA), Australian Government, Canberra. https://www.health.gov.au/our-work/national-health-reform-agreement-nhra

[11] These bodies have undergone changes since they were established but the current arrangements are what is relevant to this Inquiry.

Figure 5 Commitments within the National Health Reform Agreement



- 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 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, and
- LHNs to collaborate with other areas within the health ecosystem (e.g. primary health care and private hospitals), and aged care and disability support sectors.

As shown in **Figure 5**, 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).

3.1.3 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.

DRAFT

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 Health and Community Services Directorate, as head of the ACT LHN. 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.	Minister for Health (System Leader) Health and Community Services Directorate (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 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.	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 *Queensland Health Performance and Accountability Framework*.
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*.

Jurisdiction	Service Agreement arrangements	System Manager	LHN arrangements	Performance Monitoring
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 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 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 Minister for Health and Director-General Health and Community Services Directorate, as head of the ACT LHN Directorate, and
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 201312, the ACT has established the ACT Local Hospital Network Directorate, which is part of the Health and Community Services Directorate. The Director-General of the Health and Community Services Directorate manages the ACT health pool account which is established within the ACT local hospital network directorate.

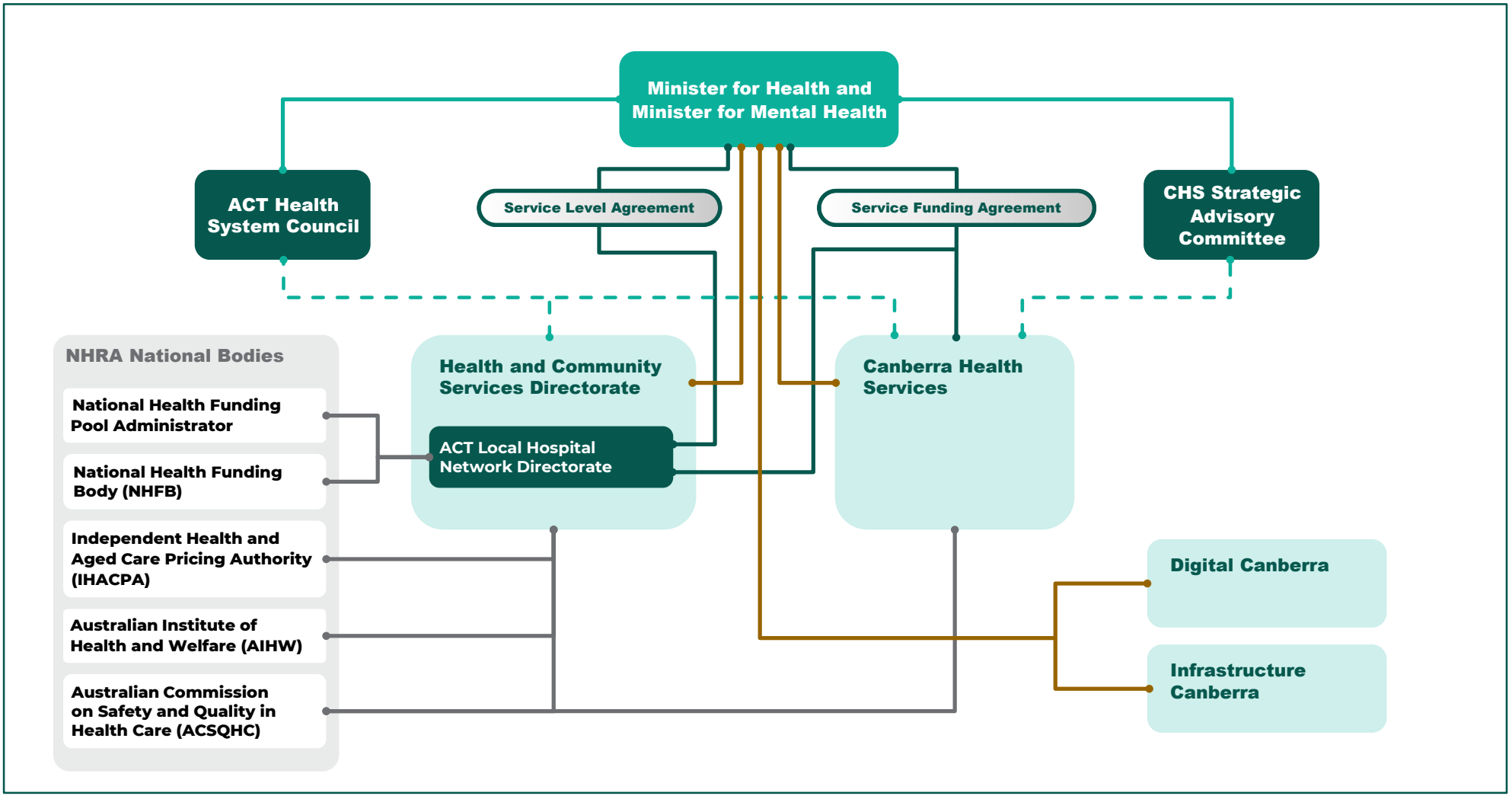
3.1.4 System Governance in the ACT

Figure 6 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 the HCSD and CHS, and the health-related functions in Digital Canberra and Infrastructure Canberra.

[12] Australian Capital Territory 2013, Health (National Health Funding Pool and Administration) Act 2013, ACT no. 2 of 2013, ACT Government, Canberra. https://www.legislation.act.gov.au/a/2013-2/

Figure 6 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 Health and Community Services Directorate as the Head of the ACT LHN Directorate. The purpose of the Service Level Agreement, as stated in the agreement;[13] 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, and*
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*.[14] 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." [15]

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, and
- CHS Strategic Advisory Committee.

The ToR of the ACT Health System Council[16] 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

[13] Australian Capital Territory 2025, 2025–26 ACT Local Hospital Network Service Level Agreement, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0011/2895779/2025-26-ACT-Local-Hospital-Network-Service-Level-Agreement.pdf

[14] Australian Capital Territory 2025, 2025–26 Service Funding Agreement, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0004/2900596/Service-funding-agreement-2025-26.pdf

[15] Australian Capital Territory 2025, 2025–26 Service Funding Agreement (page 3), ACT Government, Canberra.

[16] Australian Capital Territory 2026, ACT Health System Council, ACT Government, Canberra. https://www.act.gov.au/directorates-and-agencies/health-and-community-services-directorate/act-health-system-council

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."[17]

3.1.5 Summary and Questions

The ACT Government Administrative Arrangements establish the public health entities, assign functions and legislation to entities, and allocate entities to Ministers. The HCSD and the CHS are both established under these Administrative Arrangements and are of equal status. The functions allocated to CHS through the Administrative Arrangements identifies this organisation as the health service provider. The functions allocated to HCSD identifies this organisation as the system planner, service commissioner and system performance monitor.

The NHRA Addendum 2020-25 contains commitments relating to system governance in States and Territories. The ACT has developed governance arrangements in response to the NHRA commitments that include a system coordinator role (HCSD) and a service provider role (CHS), along with service agreements and two advisory committees to the Minister.

Questions

The following questions are provided to assist with the further analysis:

1. How can the governance arrangements be presented and described to improve the clarity of these arrangements for staff working in the ACT health system?
2. Are there ways to improve how the current governance arrangements work in the ACT health system?

[17] Canberra Health Services 2026, Governance, ACT Government, Canberra. https://www.canberrahealthservices.act.gov.au/about-us/governance

3.2 Clinical Quality and Safety

Key points:

- The Australian Commission on Safety and Quality in Health Care has developed eight standards against which public hospitals are required to be accredited, and the CHS Executive have formally signed the attestation statement confirming compliance with these standards.
- The Canberra Hospital and North Canberra Hospital are both accredited.
- The Canberra Health Service has clinical incident management arrangements in place.
- There are common features in large State and Territory clinical quality and safety arrangements.
- The Planned Care Reforms have been based on clinical quality and safety principles.

An emerging theme from consultations and submissions captured in **Section 2.1.2** is the criticality of system-wide clinical quality and safety, to support high-quality and safe patient care and a well performing health system.

The following sections provide an overview of clinical quality and safety within the ACT health system, positioned within the broader context of the Australian health system. This section draws on publicly available information, including publicly released reports reviews and inquiries, documented procedures, internal guidelines and performance frameworks. Its purpose is to summarise this publicly available documentation only. The section does not assess the quality, effectiveness, efficiency or appropriateness of any procedures, guidelines or legislation.

3.2.1 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.[18]

The NSQHS Standards (2nd ed.) outline 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, and
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

[18] Australian Commission on Safety and Quality in Health Care 2010, Australian Safety and Quality Framework for Health Care, ACSQHC, Sydney. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-safety-and-quality-framework-health-care

AHSSQA Scheme. This ensures a uniform approach to patient safety and care quality across jurisdictions.[19] 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."[20]

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.

3.2.2 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, that 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, which are discussed further in **Section 3.2.3** of this report. Jurisdictional approaches continue to develop in line with the guidance, standards, and ongoing work of the ACSQHC.

[19] Australian Commission on Safety and Quality in Health Care 2026, About us, ACSQHC, Sydney. https://www.safetyandquality.gov.au/about-us

[20] Australia Commission on Safety and Quality in Health Care 2017, Fact Sheet 2: Accreditation of health services in Australia, ACSQHC, Sydney. https://www.safetyandquality.gov.au/sites/default/files/migrated/Fact-sheet-2-Accreditation-of-health-services-in-Australia.pdf

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.[21]
Legislation	• State/Territory Health Clinical Quality and Safety arrangements are underpinned by legislation, and • 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, and • There is an open and up to date reporting of Quality and Safety and Performance data to support the transparent process to improve services.
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, and • The National Health Reform Agreement contains requirements linking funding to specified clinical performance.

[21] Australian Commission on Safety and Quality in Health Care 2026, Committees, ACSQHC, Sydney. https://www.safetyandquality.gov.au/about-us/our-people/committees

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
	  • 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:
	• Root Cause Analysis: 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	• Quality Assurance Committees 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; • Quality Assurance Committees and their members are usually covered by legislative protections and obligations, and
Reporting	• Reporting of clinical key performance indicators is provided to the AIHW, the Productivity Commission and the ACSQHC.

3.2.3 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 often due to 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.[22] 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.[23] 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 5 summarises the three inquiries and reports, outlining their triggers, identified issues, key recommendations, and resulting outcomes.

[22] Western Australian Department of Health 2017, Review of Safety and Quality in the WA health system, Government of Western Australia, Perth. https://www.health.wa.gov.au/en/Improving-WA-Health/Safety-and-quality-review

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

Table 5 NSW, Vic & Qld Landmark Inquiries Driving Clinical Safety and Quality Reform

	Garling Report (NSW, 2008)[24]	Targeting Zero Report (VIC, 2016)[25]	The Patel Inquiry (QLD, 2005)[26]
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.[27]	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.

[24] Garling, P 2008, Final report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, NSW Government, Sydney. https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0011/258698/Garling-Inquiry.pdf

[25] Duckett, S 2016, Targeting zero: The review of hospital safety and quality assurance in Victoria, Grattan Institute, Melbourne. https://grattan.edu.au/news/targeting-zero-the-review-of-hospital-safety-and-quality-assurance-in-victoria/>

[26] Queensland Public Hospitals Commission of Inquiry 2005, Report of the Queensland Public Hospitals Commission of Inquiry, Queensland Government, Brisbane. http://www.qphci.qld.gov.au/final_report/Final_Report.pdf

[27] Victorian Auditor-General's Office 2021, Clinical governance: Department of Health, Victorian Government, Melbourne. https://www.audit.vic.gov.au/sites/default/files/2021-08/CG2_transcript.pdf?uid=25c6ac46f9

	Garling Report (NSW, 2008)[24]	Targeting Zero Report (VIC, 2016)[25]	The Patel Inquiry (QLD, 2005)[26]
Key Recommendations	The Garling Report presented 139 recommendations with a focus on improving patient safety, clinical practices and workforce culture.[28]	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.[29]	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:[30] • **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;[32] • **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,[33] • **Victorian Agency for Health Information (VAHI)** was established as an independent body to manage health data, publish transparent performance reports, and drive benchmarking, clinical	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;[37;38] • **Strengthened Clinical Governance Frameworks** were introduced, including mandatory. credentialing and privileging systems, outcome monitoring, and public

[28] 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.

[29] Duckett, S 2016, 'Targeting zero: The review of hospital safety and quality assurance in Victoria'.

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

32 Duckett, S 2016, 'Targeting zero: The review of hospital safety and quality assurance in Victoria'.

33 Safer Care Victoria n.d., About the Safer Together program, Victorian Government, Melbourne. <https://www.safercare.vic.gov.au/improvement/safer-together-program/about>

[37] Health Quality and Complaints Commission 2011, Response to request for information from the Health and Disabilities Committee, Queensland Parliament, Brisbane, committee document. https://documents.parliament.qld.gov.au/com/HDC-F5F0/OHQCC-BC04/111123-HQCC-Resptorequest.pdf

[38] Office of the Health Ombudsman 2014, Office of the Health Ombudsman opens, Queensland Government, Brisbane. https://www.oho.qld.gov.au/media-releases/office-of-the-health-ombudsman-opens

	Garling Report (NSW, 2008)[24]	Targeting Zero Report (VIC, 2016)[25]	The Patel Inquiry (QLD, 2005)[26]
	with a strong focus on ongoing training for junior doctors, and • **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.[31]	improvement, and accountability across Victoria's health system;[34] • **The Victorian Clinical Council** was formed to provide strategic, multi-disciplinary advice from clinicians and consumers to the Government, the department and health services, ensuring strong clinical engagement and collaboration across specialties and regions,[35] and • **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.[36]	reporting of clinician performance to improve transparency and patient safety; • **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, and • **Legislative Amendments to the Medical Practitioners Registration Act and Coroners Act,** enhancing investigative powers, mortality reporting, and regulatory oversight of clinical practice.

[31] Bureau of Health Information n.d., Our role, NSW Government, Sydney. https://www.bhi.nsw.gov.au/About_BHI/our-role

[34] Victorian Agency for Health Information 2019, Strategic plan 2019–2022, Victorian Government, Melbourne. https://vahi.vic.gov.au/sites/default/files/2021-12/Strategic%20Plan%202019%E2%80%932022.pdf

[35] Safer Care Victoria 2018, Victorian Clinical Council: Terms of reference, Victorian Government, Melbourne. https://www.safercare.vic.gov.au/sites/default/files/2018-03/VCC%20terms%20of%20reference.pdf

[36] Victorian Government 2025, Boards Ministerial Advisory Committee, Victorian Government, Melbourne. https://www.boards.vic.gov.au/boards-ministerial-advisory-committee

3.2.4 ACT Clinical Governance Arrangements

The *ACT Clinical Governance Arrangements September 2024*[39] (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 Inquiry Final Report will include analysis of how these arrangements may be improved, including scope of work and role of legislation to support data sharing, data privacy, and quality and safety activities.

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, and
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.

[39] Australian Capital Territory 2024, ACT clinical governance arrangements, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0011/2799929/ACT-Clinical-Governance-Arrangements.pdf

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

CHS operates under the Exceptional Care Framework 2024-29, outlining 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 coordinated by the Quality, Safety and Governance team under the Deputy Chief Executive Officer. The CHS clinical quality and safety is 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 sections provide a summary of main policies and guidelines of the CHS Patient Quality and Safety arrangements.

Canberra Health Services (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 *North Canberra Hospital (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 *North Canberra Hospital (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 North Canberra Hospital (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 *North Canberra Hospital (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 North Canberra Hospital (NCH) - Credentialing and Defining the Scope of Clinical Practice for Allied Health Procedure.*

North Canberra Hospital (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.

North Canberra Hospital (NCH) - Incident Management Clinical Procedure

The *North Canberra Hospital (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.

North Canberra Hospital (NCH) – Feedback (Complaints, Compliments) Management Procedure

The *North Canberra Hospital (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

Clinical Variation Assessment for Quality and Safety Performance Data Factsheet

The Factsheet explains how CHS measure and report on performance, including assessing and responding to unwarranted clinical variation.

3.2.6 Summary and Questions

The ACSQHC has developed eight standards against which public hospitals are required to be accredited. The Canberra Hospital 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*[40] (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 CHS has clinical incident management arrangements in place that are widely available. There is a specific organisational entity, under the responsibility of the Deputy Chief Executive Officer that oversees and coordinates the clinical quality and safety arrangements.

[40] Australian Capital Territory 2024, ACT clinical governance arrangements, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0011/2799929/ACT-Clinical-Governance-Arrangements.pdf

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.

Questions

The following questions are provided to assist with the further analysis:

1. What elements of the common jurisdictional components would be beneficial to the ACT health system?
2. What can be learned from the way other jurisdictions have improved their quality and safety arrangements?
3. What other steps can be taken to strengthen quality and safety in the ACT health system?

3.3 Service Planning, Demand and Sustainability and Planned Care Reforms

Key points:

- The ACT health system has a current Health Service Plan 2022-2030 that is based on recognised methodologies that are used by other health systems. This Plan outlines the strategic direction for health services in the ACT over an eight-year period.
- The ACT health system provides data to the AIHW in line with the National Health Performance Framework; ACT performs well in comparison with other States and Territories in relation to some measures but there are others where the ACT's performance is below average. No State or Territory performs above average in all indicators analysed to date.
- Sustainability looks at both performance sustainability and financial sustainability.
- The Planned Care Reforms are currently focusing mainly on Outpatient and Elective Surgery/Procedures across CHS, and patient flow in The Canberra Hospital.

3.3.1 Service Planning

An emerging theme from consultations and submissions captured in **Section 2.1.3** is the importance of service planning in Australia's public health system, to contend with an increasing and ageing population, and increasing burdens of disease. 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.[41]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, and
- encourage innovation and efficient use of resources to maintain long-term viability, including core ACT Government-funded clinical support services.[42]

[41] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0018/2250441/ACT-Health-Services-Plan_2022-to-2030.pdf

[42] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0018/2250441/ACT-Health-Services-Plan_2022-to-2030.pdf

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 (Health Policy Analysis) was contracted to undertake the service plan modelling. In 2024, Nous Group acquired Health Policy Analysis. The service plan modelling and analysis methodology used by HCSD is consistent with methodologies used by other States and Territories.[43] The service planning methodology that underpins the ACT Health Services Plan 2022–2030 is detailed in **Table 6** below.

Table 6 ACT Health Services Plan 2022–2030 Service Planning Methodology[44]

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.

[43] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0018/2250441/ACT-Health-Services-Plan_2022-to-2030.pdf

[44] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0018/2250441/ACT-Health-Services-Plan_2022-to-2030.pdf

Forecasting Public Hospital Demand in the ACT 2021-32

To support needs analysis, Appendix A 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 the HCSD to ensure they are as up to date as possible.[45]

As outlined in Appendix A 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 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[46].

Figure 7 and **Figure 8** are extracts from the ACT Health Service Plan 2022-2030 showing the forecast inpatient and Emergency Department activity for the Canberra Hospital and the NCH (previously the Calvary Public Hospital Bruce). The projections show the forecast annual growth for Multi-day separations is 3.2%, for Same-day separations it is 2.7% and for all Emergency Department triage categories it is 3.0% over the life of the Plan.

Ongoing analysis, to be included in the Inquiry Final Report, is being undertaken to look at the national comparisons of forecast activity growth. This analysis is also looking at the impact of cross-border flow into the ACT from residents living mostly in NSW.

Figure 7 Extract from ACT Health Service Plan 2022-2030 – Inpatient activity projections[47]

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**

[45] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0018/2250441/ACT-Health-Services-Plan_2022-to-2030.pdf

[46] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0018/2250441/ACT-Health-Services-Plan_2022-to-2030.pdf

[47] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0018/2250441/ACT-Health-Services-Plan_2022-to-2030.pdf

Figure 8 Extract from ACT Health Service Plan 2022-2030 – Emergency Department activity projections[48]

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.

Future Service Directions

The Health Service Plan 2022-30 outlines four future service directions that are intended to assist to 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, and
4. Strengthening Core ACT Government-Funded Clinical Support Services.

3.3.2 Demand

The AIHW publishes activity data for all States and Territories. The most recent data activity tables for inpatient data is from 2023-24 and for Emergency Department activity it is from 2024-25.[49] 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 from the following tables (**Table 7-Table 9**), 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 10** and **Table 11**). The impact of the COVID-19 pandemic makes it difficult to use recent activity data to make confident future forecasts. This is affecting all States and Territories.

Ongoing analysis of the data in the following tables, and other activity data, is currently being undertaken and will be included in the Inquiry Final Report.

[48] Australian Capital Territory 2022, ACT Health Services Plan 2022–2030, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0018/2250441/ACT-Health-Services-Plan_2022-to-2030.pdf

[49] AIHW Data Downloads Website. https://www.aihw.gov.au/hospitals

Table 7 Overnight acute separations – public hospitals[50]

	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 8 Same-day acute separations – public hospitals[51]

	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 9 All separations – public hospitals[52]

	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 10 Emergency Department presentations – total – public hospitals[53]

	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 11 Emergency Department presentations – age standardised rate per 1,000 population – total – public hospitals[54]

	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

[50] AIHW Data Downloads Website. 2-admitted patient care 2023-24, Table 2.16, https://www.aihw.gov.au/hospitals
[51] AIHW Data Downloads Website. 2-admitted patient care 2023-24, Table 2.14, https://www.aihw.gov.au/hospitals
[52] AIHW data downloads website, 2-admitted patient care 2023-24, Table 2.2 https://www.aihw.gov.au/hospitals
[53] AIHW data downloads website, Emergency department care 2024-25, Table 2.2, https://www.aihw.gov.au/hospitals
[54] Ibid.

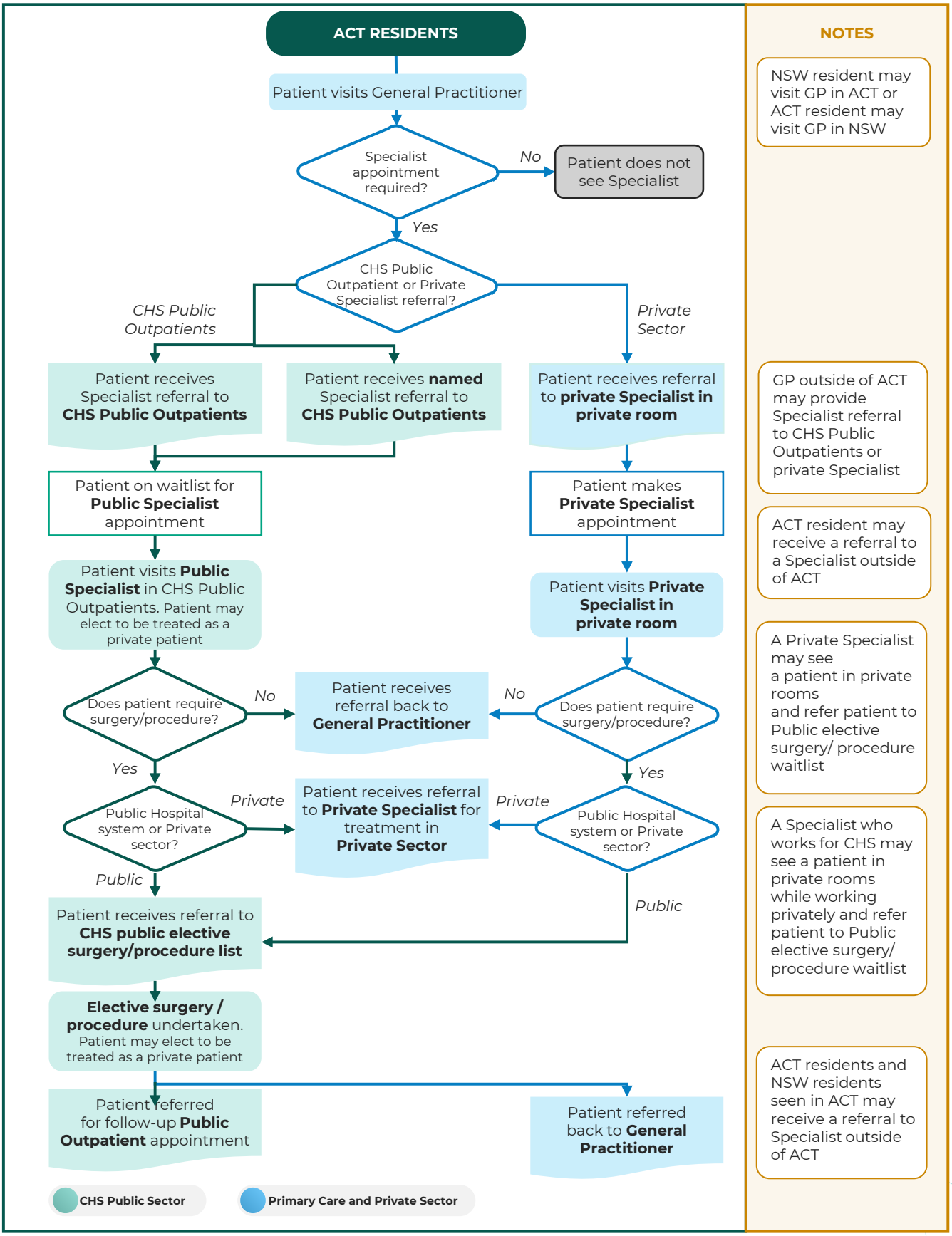
3.3.3 Outpatient and Elective Surgery Pathways

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 and some cardiac 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.

The Inquiry has requested data related to the pathways to map the proportional flows of patients through the Outpatient and Elective Surgery/Specialist Procedure journey. This data is not readily accessible, but work is being undertaken to identify reliable ways to collect the data.

Figure 9 below provides a working draft summary of different pathways for outpatients and elective surgery/procedures, including for ACT residents and residents outside of the ACT.

Figure 9 Example pathways for a patient to enter and exit the ACT public health system



3.3.4 Sustainability

Sustainability for the Inquiry has emerged as having two components. The first is the sustainability of service performance and the second is financial sustainability. These two components are related but also change independently.

Performance sustainability

The ACT health system provides data to the AIHW in line with the National Health Performance Framework.[55] 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 12 below provides a summary of some metrics for emergency care, elective surgery and inpatient care across States and Territories in Australia. The data show that the ACT performs well in comparison with other States and Territories in relation to some measures but there are others where the ACT's performance is below average. No State or Territory performs above average in all indicators analysed to date. Further analysis is currently being undertaken for inclusion in the Inquiry Final Report.

[55] Australian Institute of Health and Welfare 2024, *Australia's Health Performance Framework*, AIHW, Canberra. <https://www.aihw.gov.au/reports-data/ahpf/australias-health-performance-framework>

Table 12 Summary of emergency care, elective surgery and inpatient care data across States and Territories in Australia

Emergency Care Comparisons (2024-25)												Elective Surgery Comparisons (2024-25)				Inpatient care comparisons (2024-25)					
Median wait time to be seen in ED (time in minutes)[56]		Percentage of patients seen within clinically recommended times in the ED[57]		Percentage of Indigenous patients seen within clinically recommended times in the ED[58]		ED Presentation (admission population per 1000 population)[59]		Percentage of patients whose care was completed in the ED within 4 hours[60]		Percentage of patients whose care was completed in the ED and were admitted to hospital within 4 hours[61]		Percentage of patients who waited longer than 365 days for treatment[62]		Percentage of patients who were admitted for public hospital elective surgery within clinically recommended times[63]		Annual grow rate of separations for public hospitals (2022-23 to 2023-24)[64]		Average length of stay in public hospitals (excludes same-day discharges)[65]		Average public cost weights for acute separations in public hospitals[66]	
QLD	15	NSW	73.3%	NSW	73.1%	VIC	278.7	ACT	60.8%	ACT	48.7%	QLD	3.4%	VIC	84.4%	ACT	14.5%	TAS	6.5	NT	0.58
VIC	15	QLD	72.4%	QLD	73.0%	QLD	313.1	NSW	56.3%	VIC	36.8%	VIC	4.2%	NSW	82.6%	VIC	7.3%	SA	6.4	VIC	0.97
NSW	15	VIC	71.5%	VIC	66.7%	TAS	314.2	WA	53.9%	QLD	31.4%	TAS	5.0%	QLD	81.1%	WA	6.0%	NSW	6.3	TAS	1.01
ACT	25	ACT	61.7%	WA	60.7%	SA	323.7	NT	53.6%	NT	29.2%	WA	5.3%	WA	80.0%	TAS	4.5%	VIC	5.8	QLD	1.01
SA	29	SA	53.4%	SA	60.1%	WA	342.8	VIC	52.7%	SA	27.9%	SA	6.0%	SA	71.8%	NSW	3.8%	ACT	5.6	ACT	1.04
TAS	35	NT	48.2%	ACT	59.9%	ACT	350.8	QLD	49.9%	NSW	24.5%	NT	8.2%	NT	68.3%	SA	3.7%	WA	5.5	SA	1.09
NT	37	TAS	46.0%	NT	52.8%	NSW	361.5	SA	49.6%	WA	23.1%	NSW	9.2%	ACT	66.5%	QLD	3.5%	NT	5.4	WA	1.10
WA	44	WA	45.6%	TAS	44.9%	NT	739.5	TAS	47.5%	TAS	20.5%	ACT	9.4%	TAS	65.1%	NT	-1.5%	QLD	5.0	NSW	1.15

[56] AIHW, Emergency department care 2024–25 data tables, Table 5.1. https://www.aihw.gov.au/hospitals/topics/emergency-departments
[57] AIHW, Emergency department care 2024–25 data tables, Table 5.3. https://www.aihw.gov.au/hospitals/topics/emergency-departments
[58] AIHW, Emergency department care 2024–25 data tables, Table 5.5. https://www.aihw.gov.au/hospitals/topics/emergency-departments
[59] AIHW, Emergency department care 2024–25 data tables, Table 2.2. https://www.aihw.gov.au/hospitals/topics/emergency-departments
[60] AIHW, Emergency department care 2024–25 data tables, Table 6.3. https://www.aihw.gov.au/hospitals/topics/emergency-departments
[61] AIHW, Emergency department care 2024–25 data tables, Table 6.3. https://www.aihw.gov.au/hospitals/topics/emergency-departments
[62] AIHW, Elective surgery waiting times 2024-25 data tables, Table 4.2. https://www.aihw.gov.au/hospitals/topics/elective-surgery
[63] AIHW, Elective surgery waiting times 2024-25 data tables, Tables 4.11 to 4.18. https://www.aihw.gov.au/hospitals/topics/elective-surgery
[64] AIHW, Admitted patient care 2023–24 2: How much activity was there?, Table 2.2. https://www.aihw.gov.au/hospitals/topics/admitted-patient-care
[65] AIHW, Admitted patient care 2023–24 2: How much activity was there?, Table S2.8. https://www.aihw.gov.au/hospitals/topics/admitted-patient-care
[66] AIHW, Admitted patient care 2023-24 7: Costs and funding, Table 7.2. https://www.aihw.gov.au/hospitals/topics/admitted-patient-care

Financial Sustainability

As noted in the ToR, the Inquiry is providing 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 Committee is currently working on sustainability activities and the Inquiry will continue working with them in preparation for the Inquiry Final Report.

Table 13 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.

Table 13 Recurrent expenditure on public hospitals ($ million, constant prices) - public hospitals[67]

	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. **Figure 10** is an extract from the AIHW data tables: Hospital Resources 2022–23: Australian hospital statistics.[68] The data in this table 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. However, the data does provide a useful tool to look at where there are significant differences and identifying if these reflect actual variations between States and Territories.

Ongoing analysis, to be included in the Inquiry Final Report, is being undertaken to look at the national comparisons of financial investment and changes over time.

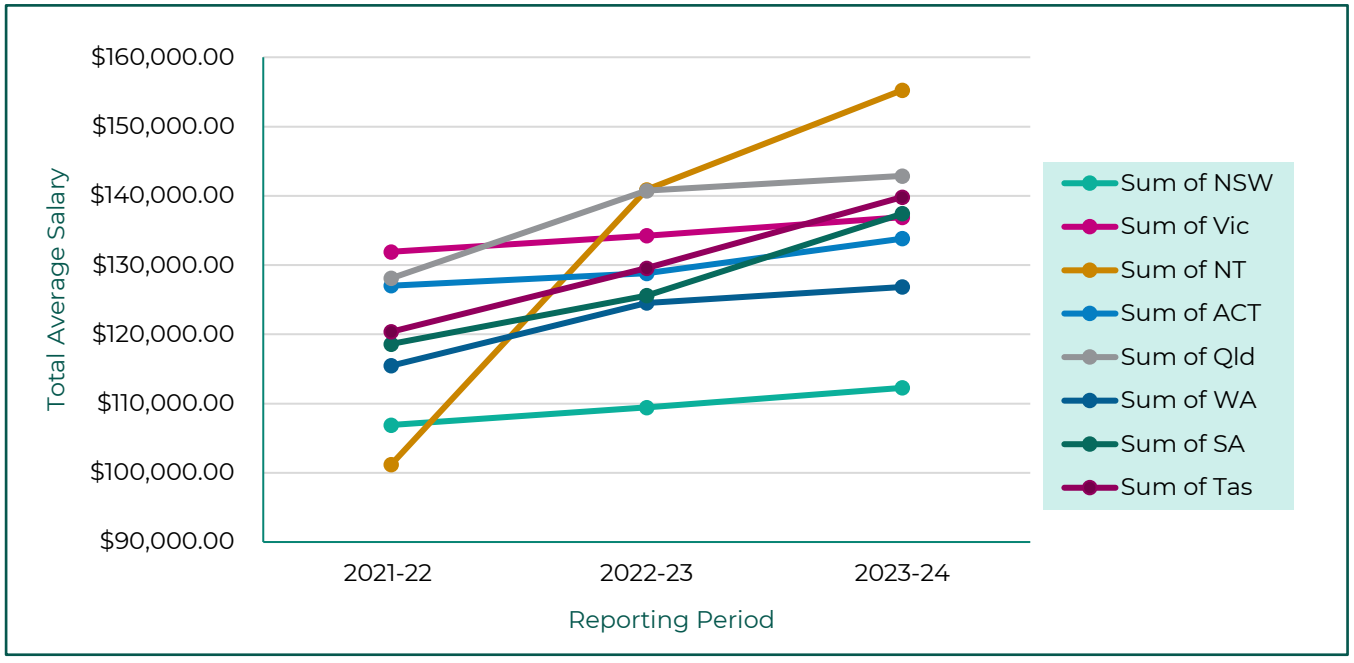
[67] AIHW data downloads website, hospital resources tables 2023-24, Table 2.5, https://www.aihw.gov.au/hospitals
[68] AIHW data downloads website, hospital resources tables 2023-24, Table 3.4, https://www.aihw.gov.au/hospitals

Figure 10 Extract from the AIHW data tables: Hospital Resources 2023–24, Table 3.4 [Extract]: Average salaries(a)(b)[69] ($), full-time equivalent staff, public hospital services, states and territories, 2023–24[70]

	NSW©	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**

Figure 11 visualises how average salaries for FTE staff across jurisdictional public hospital services vary. In 2021-22, the lowest average salary was measured in 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.[71]

Figure 11 Average salaries for full-time equivalent staff across jurisdictional public hospital services[72]



[69] Note that the letters in brackets refer to footnotes for the table that can be viewed in the full table. https://www.aihw.gov.au/hospitals

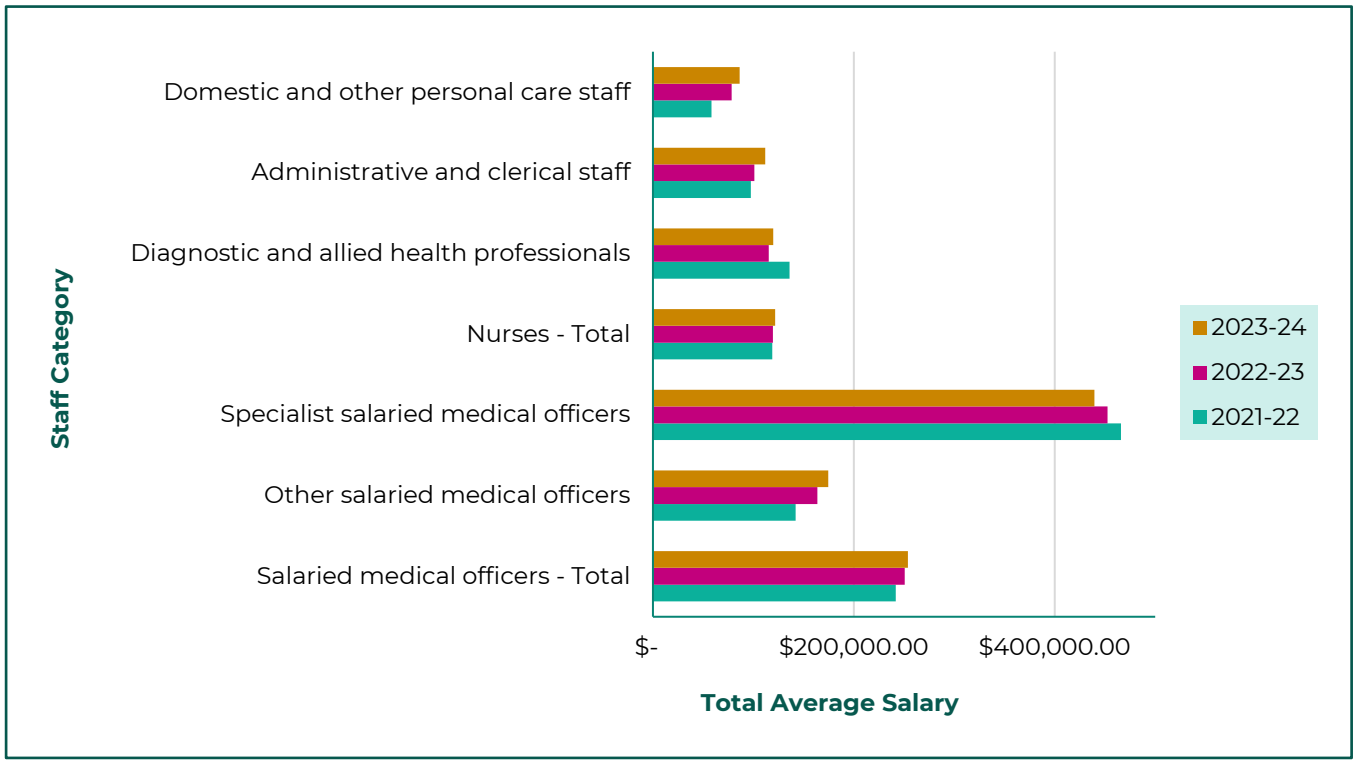
[70] AIHW data downloads website, Hospital Resource Tables 2023-24, Table 3.4. https://www.aihw.gov.au/hospitals

[71] AIHW data downloads website, hospital resources tables 2023-24, Table 3.2, Data - Australian Institute of Health and Welfare

[72] Ibid.

Figure 12 visualises how average salaries for FTE staff in ACT public hospital services vary. Whilst salaries for the majority of FTE staff increased overtime, salaries for specialist salaried medical officers in the ACT have decreased overtime, from $465,930.66 in 2021-22 to $439,493.56 in 2023-24[73].

Figure 12 Average salaries for full-time equivalent staff in ACT public hospital services[74]



3.3.5 Planned Care Reforms

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 operational 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 Digital Health Record (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 the Canberra Hospital in November 2024.

The infrastructure for an operations centre has been established at North Canberra 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 North Canberra Hospital.

[73] AIHW data downloads website, hospital resources tables 2023-24, Table 3.4, Data - Australian Institute of Health and Welfare
[74] Ibid.

The document titled "*Notes 14: Principles for delivery of Planned Care*[75]" 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. *The CHS is required to make sure that all referrals, to a named clinician, or not, are managed in a reliable and dependable manner, and*
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.*[76]

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.*"[77]

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, and
7. Booking inpatient care (procedure, diagnostic test etc) is determined by need and time waited.

There are three Administrative Instructions (see **Table 14**) 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, and
3. Administrative Instruction No. 3: Management of referrals to Canberra Health Services for Specialist led services – 23 January 2025.

The Inquiry has been informed that all administrative instructions have expired as they are 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 implement within the system at the time of issue.

The complexity of referral and waitlist management and planned care more broadly was a contributing factor to Planned Care being established in the Operations Centre in July 2024. This timeline aligned with CHS Planned Care Access and Certainty of Service Policy[78] which was issued in July 2024. This document provides the policy framework for planned care reforms that were implemented through Planned Care in the IOC.

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

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

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

[78] https://canberrahealthservices.act.gov.au/__data/assets/word_doc/0011/2579645/Planned-Care-Access-and-Certainty-of-Service.docx

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, and
    - 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.
- 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. The Inquiry is continuing to review and analyse the Planned Care Reform arrangements and implementation strategy, and a more detailed analysis will be presented in the Inquiry Final Report.

Table 14 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: o The referral is returned to the referrer with the appropriate advice o 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, and • 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, and
- 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.

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 process2
- All eReferrals will be screened by CHI staff to ensure meet territory wide referral criteria 1
- 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); and

Planned Care Call Centre contact information to obtain further information.

3.3.7 Summary and Questions

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 (Health Policy Analysis) was contracted to undertake the service plan modelling.

The ACT Health Services Plan 2022–2030 provides activity forecasts for The Canberra Hospital and the North Canberra Hospital out to 2031-32.

Actual demand data is available for some of the forecast years of the Health Services Plan although, making future data projections is challenging due to the impact of the COVID-19 pandemic on hospital activity.

Sustainability is being analysed from a performance perspective and a financial perspective. Further analysis is being undertaken in these areas which will be included in the Inquiry Final Report.

The Planned Care Reforms have been based on clinical quality and safety principles but there would be benefit in greater clarity regarding how these arrangements are operating in practice across the CHS. Further analysis will be undertaken prior to the completion of the Inquiry Final Report.

Questions

The following questions are provided to assist with the further analysis:

1. Are there improvements that could be made to the ACT Health Service Planning process?
2. What factors may be impacting on ACT Health's performance and financial sustainability?
3. How can the Planned Care Reforms quality and safety principles be improved?
4. What features should be a part of implementing clinical service reforms?

3.4Workforce and Culture

Key points:

- In 2018, the then ACT Minister for Health and Wellbeing, issued a statement on workplace culture within the ACT 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).
- 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 ACTPS Employee Survey (2025 ACTPS Employee Survey) was open to staff from 1 – 21 September 2025. Whole of service results were released week commencing 26 January 2026.

An emerging theme from consultations and submissions captured in **Section 2.1.4** 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).[79] 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 Progress 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.

3.4.1 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.[80]

[79] Australian Capital Territory 2019, *Independent review into the workplace culture within ACT public health services: Final report*, ACT Government, Canberra. Independent-Review-into-the-Workplace-Culture-within-ACT-public-health-services-Final-report-March-2019.pdf

[80] ibid

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, and*
- *inability to make timely decisions.*[81]

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, and
- 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.[82]

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.'[83] Recommendations have been categorised below based on primary focus and action.

Table 15 2019 Culture Review's Final Report recommendations

Primary Action	Recommendations Mapped from 2019 Culture Review[84]
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.

[81] Australian Capital Territory 2019, *Independent review into the workplace culture within ACT public health services: Final report*, ACT Government, Canberra.Independent-Review-into-the-Workplace-Culture-within-ACT-public-health-services-Final-report-March-2019.pdf

[82] ibid

[83] ibid

[84] ibid

Primary Action	Recommendations Mapped from 2019 Culture Review[84]
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.
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).

3.4.2 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.[85]

[85] M Reid & Associates 2020, *ACT Public Health Services Cultural Review Implementation: Inaugural annual review*, ACT Government, Canberra. LIST_-ACT-Public-Health-Services-Cultural-Review-Implementation-Inaugural-Annual-Review.PDF

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.[86] 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.

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.[87]

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.

[86] Leon Advisory 2021, *Culture in the ACT public health system: Second annual review*, ACT Government, Canberra. Culture-in-the-ACT-public-health-system-Second-Annual-Review.pdf

[87] Ibid.

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.[88]

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, 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, and
- The lack of consistent survey reporting made it difficult to directly compare between CHS and ACTHD.[89]

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, and
- The lack of consistent survey reporting made it difficult to directly compare between CHS and ACTHD (now known as HCSD).[90]

[88] Proximity 2023, Workplace Culture within the ACT Public Health System, Third and Final Annual Review, Canberra, 2023, Independent review into the workplace culture within ACT public health services: Final report, ACT Government, Canberra.
[89] ibid
[90] ibid

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, and
- For CHS, as of April 2022, there was the highest number of open workforce complaints over a 16-month period.[91]

Progress against 2019 Culture Review Recommendations

The third and final annual review analysed progress to implement the 20 recommendations of the 2019 Culture Review.[92] 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, and
- Recommendation 20, which called for a system-wide change management and communications strategy, had not been delivered. However, the three organisations developed communication 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.

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.[93]

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.

[91] Proximity 2023, Workplace Culture within the ACT Public Health System, Third and Final Annual Review, Canberra, 2023, Independent review into the workplace culture within ACT public health services: Final report, ACT Government, Canberra.
[92] ibid

[93]Australian Capital Territory 2025, ACT Public Service Employee Survey (ACTPS Survey), ACT Government, Canberra. <https://www.cmtedd.act.gov.au/employment-framework/performance-framework/actps-survey>

For the ACTPS Employee Survey, action planning is performed by leadership at 2 or 3 levels, including:

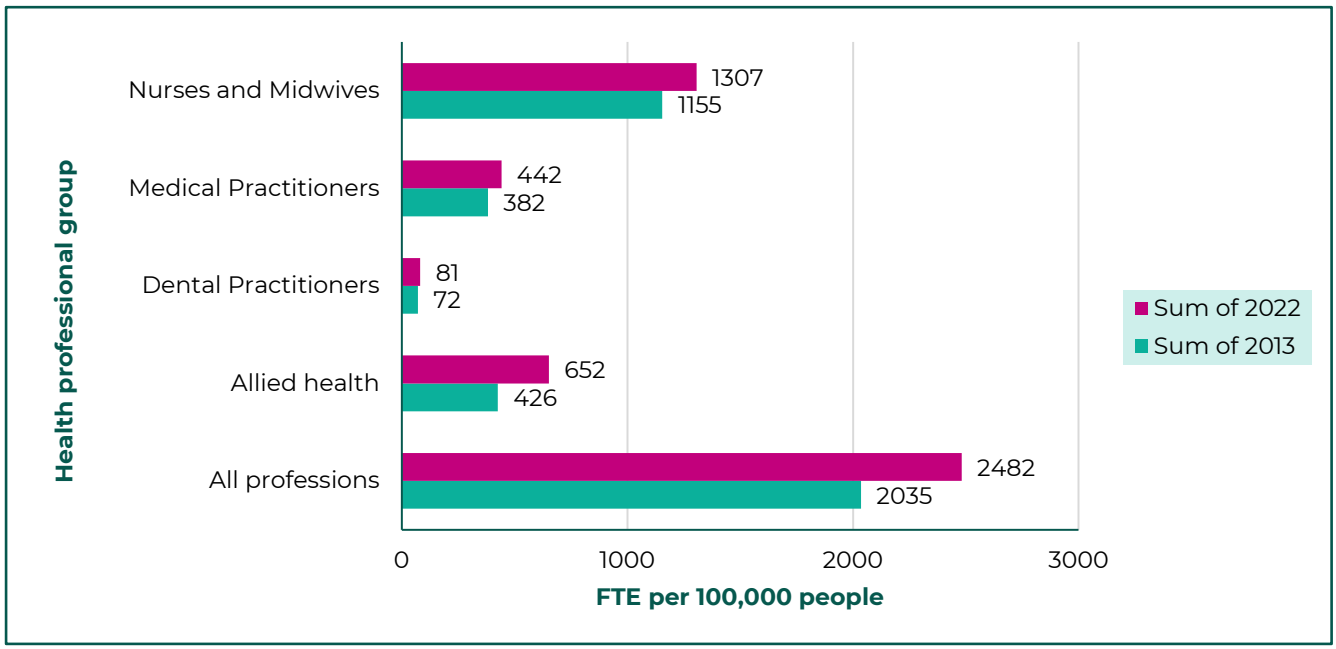
- **Whole of service** – action planning focuses on identifying themes provided by staff across all participating directorates or sector-wide,
- **Directorate (or sector entity)** – action planning focuses on identifying themes provided by staff across a single directorate or sector entity, and
- **Division 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. Presentation of results and potential focus areas by OIRWS Research were planned to occur in November 2025 to the Strategic Board and each Directorate.[94] Publication of the whole of service results were released week commencing 26 January 2026.

3.4.3 Jurisdictional Comparison – FTE

Australia-wide, the number of FTE health professionals per 100,000 population rate 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 2012 to 2022 (**Figure 13**).[95]

Figure 13 Full time equivalent rate (per 100,000 people) by profession (from 2013 to 2022)[96]



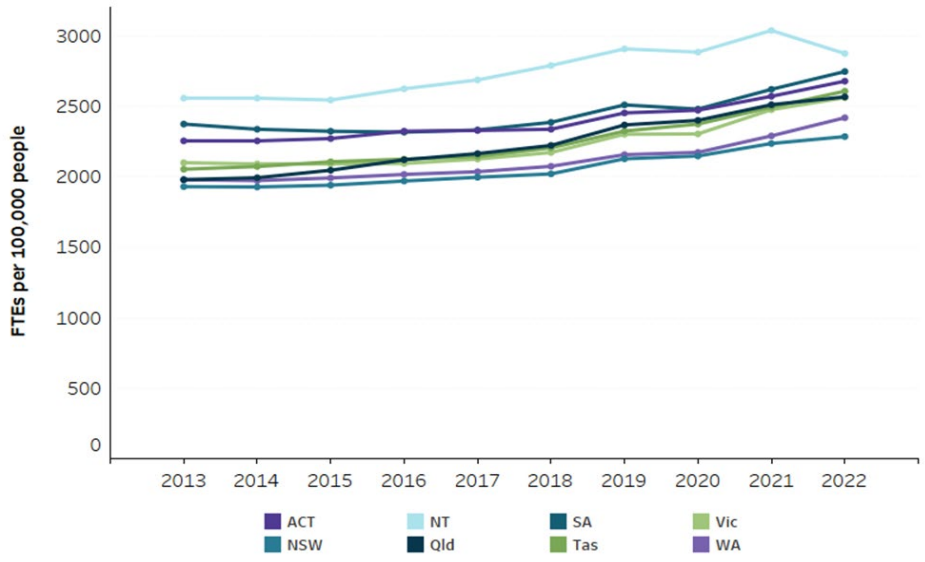
[94] ibid

[95] Australian Institute of Health and Welfare n.d., *Health workforce*, AIHW, Canberra. <https://www.aihw.gov.au/reports/workforce/health-workforce>

[96] ibid

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 14**).[97]

Figure 14 Variation of FTE across jurisdictions[98]



3.4.4 Summary and Questions

The ACT public health system has had a significant focus on workforce culture since 2018. Both CHS and HCSD have undertaken work to progress the recommendations from the initial review, and this work is described in each of the three annual reviews following the release of the Culture Review report in 2019.

The 2019 Culture Review provided 20 recommendations to uplift workforce culture across the ACT public health system. Recommendations included policy development and enactment, staff engagement, establishment of new forums, uplift to leadership and governance, HR and recruitment reviews, along with cultural, workplace and training improvements, among others.

The third of the annual reviews in 2023 concluded that, as of July 2022, all recommendations were endorsed as complete. Notwithstanding this, the final annual review outlined continuing areas of focus, which 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.

[98] Australian Institute of Health and Welfare n.d., Health workforce, AIHW, Canberra. https://www.aihw.gov.au/reports/workforce/health-workforce

Most recently, the ACT public health system conducted the 2025 ACT Public Service Employee Survey, with results released in the week commencing 26 January 2026. Results will be incorporated into the Inquiry's Final Report and are expected to explore staff perceptions on workforce culture. These results will be combined with the feedback from stakeholders collected through this Inquiry.

Questions

The following questions are provided to assist with the further analysis:

1. In addition to stakeholder feedback and information from the 2019 Culture Review Report and three annual progress reviews, what initiatives will be beneficial to continue to improve the workforce culture within the ACT health system?
2. What internal and external factors are having an influence on the ACT health system workforce culture?

3.5 Data Collection and Reporting

Key points:

- Australian health data for public hospitals is collected and reported by the AIHW with some data reported in the Report on Government Services (RoGS) each year by the Productivity Commission. However, even though there are agreed methodologies, there are limitations to the comparability of the data.
- All States and Territories publish some hospital performance indicators on their websites. There is no agreed set of indicators to be published and there are no agreed methods to calculate any of the performance indicators.
- ACT provides a comparable level of data compared to most other States and Territories.
- ACT data has been included in the RoGS reports, except for the cost-related data for 2021-22 and 2022-23, and significant mental health services related data.

An emerging theme from consultations and submissions captured in **Section 2.1.5** 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.

3.5.1 Data governance

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 machinery of government 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

The Inquiry Final Report will include further analysis regarding data governance, along with further progress of the development of the ACT health system data governance arrangements.

3.5.2 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 ED 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 people 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.[99] Similar to Qld, the ACT publishes a website[100] but also provides real-time data via the ACT Health App[101] that is downloadable to a smartphone. Further analysis is being undertaken across States and Territories, and the Inquiry Final Report will provide a more detailed description of the reporting of performance indicators by States and Territories.

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. **Figure 15** provides a high-level summary of the range of data published by States and Territories.

[99] Queensland Government, Open Hospitals. https://openhospitals.health.qld.gov.au/
[100] CHS, Emergency Department waiting Time. https://www.canberrahealthservices.act.gov.au/before,-during-and-after-your-care/coming-to-the-emergency-department/before-you-arrive/emergency-department-waiting-times
[101] ACT Government, ACT Health app. https://www.act.gov.au/health/act-health-app

Figure 15 Comparison of themes, data domains and metric types across jurisdictions

Theme	Data Domain	Metric Type	ACT	NSW	QLD	SA	VIC	WA
Effectiveness	Elective Surgery	Wait time performance	■	■	■		■	■
	Emergency Department	Ambulance response performance		■				
		Ambulance transfer time performance		■	■		■	
		Daily ambulance transfer performance						■
		Discharge times performance	■	■			■	■
		ED transfer to hospital performance		■				
		Real-time wait time performance				■		
		Treatment time performance		■				■
		Wait time performance	■	■	■		■	■
	Specialist Appointments	Wait time performance			■		■	
Efficiency	Elective Surgery	Surgery activity		■	■		■	■
		Surgery referral volumes			■			
		Wait list patient volumes	■	■	■		■	■
		Wait times	■	■	■	■	■	■
	Emergency Department	Ambulance response times	■	■	■	■		
		Ambulance response volumes		■				
		Ambulance transfer times		■	■	■	■	
		Ambulance transfer volumes	■	■	■		■	
		Avoidable presentations	■					
		Daily ambulance transfer times						■
		Daily attendance volumes						■
		Daily treatment volumes						■
		Daily wait times						■
		Discharge times		■	■	■		
		ED transfer to hospital volumes	■	■	■	■	■	
		Presentation volumes	■	■	■	■	■	
		Real-time ambulance transfer times				■		
		Real-time ambulance transfer volumes				■		
		Real-time presentation volumes		■	■	■		■

Theme	Data Domain	Metric Type	ACT	NSW	QLD	SA	VIC	WA
		Real-time treatment times	■			■		
		Real-time treatment volumes				■		
		Real-time wait times	■		■	■		■
		Treatment volumes	■	■				
		Unexpected departure volumes			■			
		Wait times	■		■	■	■	
	Specialist Appointments	Appointment referral volumes			■			
		Appointment volumes			■		■	
		Appointment wait list volumes			■			
		Wait times			■		■	
Equity	Elective Surgery	Surgery activity			■			
	Emergency Department	Presentation volumes		■	■			

Disclaimer: Note that this initial analysis may not be comprehensive of all publicly available data, but rather reflects information that is readily accessible from these sources by a public user. Further analysis will be undertaken for the Inquiry Final Report.

The analysis presented is based on publicly available data sourced from the following websites:

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

3.5.3 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 16 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, and • 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, and • 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 local health district.	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, and • 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, and • Hospitals with shortest waiting time by specialty.	Monthly	Approx. two months
QLD	Planned surgery activity metrics (by urgency category and specialty): 1. Number of people on wait list; 2. Number of planned surgery performed, and 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, and • % of patience waiting within clinically recommended times by urgency category • patients treated in turn cat 2 and 3.	Monthly	Approx. one to two months

State	Summary of data items reported	Frequency of updating	Time lag
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

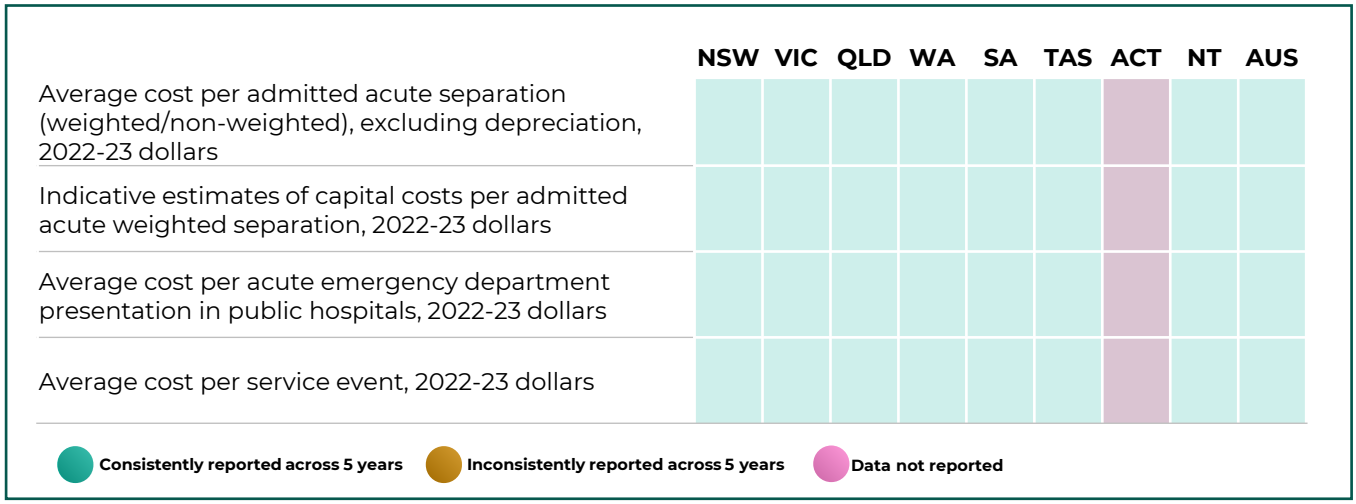
3.5.4 Report on Government Services (RoGS) Public Hospital Data Reporting

AIHW has been described in **Section 3.4**. The final report will include more AIHW data analysis. This section focuses on the data provided for the RoGS report and its level of completeness. The following information is provided in relation to the 2025 RoGS Report. At the time of finalising the Inquiry Progress Report, the Productivity Commission had announced that the 2026 RoGS report for health would be released on Thursday 5 February 2026 at 10.30 pm AEDT[102]. This will include all health reports on the following topics: primary and community health, ambulance services, public hospitals, and services for mental health. The Inquiry Final Report will include an analysis of the data contained in the 2026 RoGS report.

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 National Hospital Cost Data Collection (NHCDC) datasets. However, as of the release of the RoGS report, ACT had not submitted its NHCDC data for the 2022-23 period. As noted previously, ACT has now submitted this data and it is published on the AIHW website. The below provides an overview of RoGS Public Hospital Data Reporting over the last 2 years. **Figure 16** presents only data points that have not been reported by the ACT over the last 2 years.

[102] Productivity Commission, Report on Government Services, Australian Government. https://www.pc.gov.au/ongoing/report-on-government-services/

Figure 16 Comparison of RoGS 2025 public hospitals reporting across jurisdictions[103]



3.5.5 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 two most recent reports in 2024 and 2025.[104] In these reports, ACT data for 2021–22 and 2022–23 were not available to RoGS at the time of publication due to the implementation of the DHR across ACT public health services. The Inquiry is continuing to work with HCSD and CHS in relation to Mental Health data reporting.

3.5.6 Summary and Questions

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 people 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

[103] RoGS Public Hospital Reporting 2025 data tables (released 6/02/2025): 12 Public hospitals - Report on Government Services 2025 | Productivity Commission

[104] RoGS Services for Mental Health 2025 data tables (released 6/02/2025): 13 Services for mental health - Report on Government Services 2025 | Productivity Commission

mental health data provided by the ACT which is a result of not having yet implemented activity based funding in this area.

The 2026 RoGS report is due for release on 5 February 2026, after the finalisation of the Inquiry Progress Report. The Inquiry Final Report will include analysis relating to the 2026 RoGS report as well as further analysis in relation to data governance and State and Territory performance indicator reporting.

Questions

The following questions are provided to assist with the further analysis:

1. What are some of the key features that need to be included in the ACT health system data governance framework?
2. What performance indicators would be most useful to be published to allow residents of the ACT to understand how the health system is performing?

3.6 Digital Health Record (DHR)

Key points:

- Since its implementation in the ACT, 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 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. Recommendations centred on Governance and Program Management, Financial Management and Offsets and Benefits.
- DHR data remediation is in progress, led by the Data Remediation Project, that is now located in Digital Canberra.
- Further analysis is being undertaken, including further consultation, to be included in the Inquiry Final Report.

An emerging theme from consultations and submissions captured in **Section 2.1.6** is the importance of the DHR system, as an enabler of clinical efficiency and safety, patient empowerment, system-wide integration and data-driven decision-making. Stakeholders have identified opportunities to improve DHR governance, clinical utility, data quality, workflows, and clinician and patient experience.

The following sections provide an overview of the DHR system, along with key findings and recommendations from past reviews of the DHR Program.

3.6.1 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.[105] 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 being implemented in November 2022.[106]

Since its implementation, the DHR has significantly advanced the modernisation of healthcare delivery in the ACT. 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 patients' contact details, medication history, allergies, observations, surgical procedures, clinical appointment and hospital administration details, test results and referrals[107]. Centralising information of this kind enables patients and providers to securely and conveniently access comprehensive data, enhancing collaboration among healthcare providers and enabling

[105] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0006/2565141/ACT-Health-Directorate-Digital-Health-Record-Program-Review.pdf

[106] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0006/2565141/ACT-Health-Directorate-Digital-Health-Record-Program-Review.pdf

[107] Australian Capital Territory n.d., Digital Health Record, ACT Government, Canberra https://www.act.gov.au/health/digital-health-record

patients to play a more active role in managing their healthcare. 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 patients' interactions with ACT public health services and their medical history. This centralised and comprehensive overview includes important data such as patient's 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's summary information. This enables high-level information to be viewed by people outside the ACT public system, and
- **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[108].

3.6.2 DHR Program Review

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*".[109] 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. It was also identified that risk reporting to the

[108] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0006/2565141/ACT-Health-Directorate-Digital-Health-Record-Program-Review.pdf
[109] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0006/2565141/ACT-Health-Directorate-Digital-Health-Record-Program-Review.pdf

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.[110]

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**), and
- *Appropriately balanced governance and management focus across all critical activities related to the Program and its benefits* (**Recommendation 4**).[111]

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.[112] These emphasise the importance of:

- *Strengthening cost estimate processes* (**Recommendation 5**), and
- *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.[113]

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:

---

[110] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0006/2565141/ACT-Health-Directorate-Digital-Health-Record-Program-Review.pdf

[111] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0006/2565141/ACT-Health-Directorate-Digital-Health-Record-Program-Review.pdf

[112] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0006/2565141/ACT-Health-Directorate-Digital-Health-Record-Program-Review.pdf

[113] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0006/2565141/ACT-Health-Directorate-Digital-Health-Record-Program-Review.pdf

- *Ongoing projects should track offsets which can be applied to DHR overspend for 2025-26 and 2026-27* (**Recommendation 8**), and
- *Ongoing projects should ensure tracking and measuring of benefits realisation* (**Recommendation 9**).[114]

3.6.3 DHR Data Remediation Work

In August 2023, to ensure the ongoing utility of DHR data and information, the Data Reporting and Remediation Project was established. This project's scope of work includes the collection of critical data from the DHR required for the 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 Commonwealth funding contribution to public hospitals. The project also undertakes work to collect the performance reporting data required to be provided to the AIHW.

The work of the Data Reporting and Remediation Project is nearing the end of its work, with data collection, storage, and reporting arrangements in place for future IHACPA and AIHW reporting requirements. 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 Reporting and Remediation Project staff have transitioned to Digital Canberra as a part of the recent machinery of government 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.

3.6.4 Summary and Questions

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. However, due to the complexity and large-scale nature of the ICT transformation, a number of risk and challenges were encountered by the DHR Program, including governance and program management, financial reporting and offsets and benefits. These were identified by the Digital Health Record Program Review.

The Data Reporting and Remediation Project has had an initial focus on collecting and reporting data to IHACPA and AIHW for national funding and performance requirements. Stakeholders have identified 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 clinical reports, reduce duplication of data entry, and streamline data analysis.

Questions

The following questions are provided to assist with the further analysis:

1. How can the DHR be optimised further to support clinical efficiency and safety, patient empowerment, system-wide integration and data-driven decision-making?
2. What matters need to be considered when finalising the governance arrangements for the DHR that involve CHS, HCSD and Digital Canberra.

[114] KPMG 2024, ACT Health Directorate Digital Health Record Program Review, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0006/2565141/ACT-Health-Directorate-Digital-Health-Record-Program-Review.pdf

4.Next Steps to Support Developing the Final Report

This Inquiry Progress Report has been prepared to provide the ACT Health System Council with an update on progress and includes questions to assist with Council discussion and future consultations.

The Inquiry Progress Report intentionally does not include evaluative judgements, strategic recommendations or detailed stakeholder sentiments relating to the ACT health system data, demand and processes. These elements will be addressed in the Final Report, which will draw on deeper analysis and findings that emerge from final stakeholder consultations and submissions. The Final Report will provide greater depth, clarity and actionable strategic recommendations aligned to the ToR of this review.

The Final Report will be delivered in sufficient time for the Minister to table it in the ACT Legislative Assembly before 30 June 2026, as required in the ToR.

5. Appendices

Appendix A Terms of Reference

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; and*
    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; and*
    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, Canberra Health Services 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 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
ACTPS Employee Survey	ACT Public Service Employee Survey
AIHW	Australian Institute of Health and Welfare
CEO	Chief Executive Officer
CHI	Central Health Intake
CHS	Canberra Health Services
CPF	Clinical Patient Folder
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
HR	Human Resources
ICT	Information and Communication Technology
IHACPA	Independent Health and Aged Care Pricing Authority
LHN/s	Local Hospital Network/s
M&M	Morbidity and Mortality
MDAAC	Medical and Dental Appointments Advisory Committee
MDAAC	Medical and Dental Appointments Advisory Committee
MHR	My Health Record
MoG	Machinery of Government
NCH	North Canberra Hospital
NEC	National Efficient Cost
NEP	National Efficient Price
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
OCIM	Organisation Culture Improvement Model
OIRWS	Office of Industrial Relations and Workforce Strategy
QAC	Quality Assurance Committee
QSLN	Quality and Safety Leadership Network

Acronym/abbreviation	Definition
QSLN	Quality and Safety Leadership Network
ROGS	Report on Government Services
SA	South Australia
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
Vic	Victoria
WA	Western Australia
WHO	World Health Organization

Appendix C Tables and Figures

Appendix D References

Australia Commission on Safety and Quality in Health Care 2017, Fact Sheet 2: Accreditation of health services in Australia, ACSQHC, Sydney. https://www.safetyandquality.gov.au/sites/default/files/migrated/Fact-sheet-2-Accreditation-of-health-services-in-Australia.pdf

Australian Capital Territory 2013, *Health (National Health Funding Pool and Administration) Act 2013, ACT no. 2 of 2013, ACT Government, Canberra.* https://www.legislation.act.gov.au/a/2013-2/

Australian Capital Territory 2019, *Independent review into the workplace culture within ACT public health services: Final report*, ACT Government, Canberra. Independent-Review-into-the-Workplace-Culture-within-ACT-public-health-services-Final-report-March-2019.pdf

Australian Capital Territory 2022, *ACT Health Services Plan 2022–2030*, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0018/2250441/ACT-Health-Services-Plan_2022-to-2030.pdf

Australian Capital Territory 2023, *Health Infrastructure Enabling Act*, Act No. 17 of 2023 (ACT), ACT Government, Canberra. https://www.legislation.act.gov.au/a/2023-17/

Australian Capital Territory 2024, *ACT clinical governance arrangements*, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0011/2799929/ACT-Clinical-Governance-Arrangements.pdf

Australian Capital Territory 2025, *2025–26 ACT Local Hospital Network Service Level Agreement*, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0011/2895779/2025-26-ACT-Local-Hospital-Network-Service-Level-Agreement.pdf

Australian Capital Territory 2025, *2025–26 Service Funding Agreement*, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0004/2900596/Service-funding-agreement-2025-26.pdf

Australian Capital Territory 2025, *ACT Public Service Employee Survey (ACTPS Survey)*, ACT Government, Canberra. https://www.cmtedd.act.gov.au/employment-framework/performance-framework/actps-survey

Australian Capital Territory 2025, *Administrative Arrangements 2025 (No 2)*, ACT Government, Canberra. https://legislation.act.gov.au/ni/2025-686/

Australian Capital Territory 2026, *ACT Health System Council*, ACT Government, Canberra. https://www.act.gov.au/directorates-and-agencies/health-and-community-services-directorate/act-health-system-council

Australian Capital Territory n.d., *ACT Health app*, ACT Government, Canberra. https://www.act.gov.au/health/act-health-app

Australian Capital Territory n.d., *Digital Health Record*, ACT Government, Canberra. https://www.act.gov.au/health/digital-health-record

Australian Commission on Safety and Quality in Health Care 2010, *Australian Safety and Quality Framework for Health Care*, ACSQHC, Sydney. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-safety-and-quality-framework-health-care

Australian Commission on Safety and Quality in Health Care 2026, *About us*, ACSQHC, Sydney. https://www.safetyandquality.gov.au/about-us

Australian Commission on Safety and Quality in Health Care 2026, *Committees*, ACSQHC, Sydney. https://www.safetyandquality.gov.au/about-us/our-people/committees

Australian Government, 2020, *National Health Reform Agreement (NHRA)*, Australian Government, Canberra. https://www.health.gov.au/our-work/national-health-reform-agreement-nhra

Australian Institute of Health and Welfare 2024, *Admitted patient care 2023–24: data tables* (Table 2.16), AIHW, Canberra. https://www.aihw.gov.au/hospitals

Australian Institute of Health and Welfare 2024, *Admitted patient care 2023–24: data tables* (Table 2.14), AIHW, Canberra. https://www.aihw.gov.au/hospitals

Australian Institute of Health and Welfare 2024, *Australia's Health Performance Framework*, AIHW, Canberra. https://www.aihw.gov.au/reports-data/ahpf/australias-health-performance-framework

Australian Institute of Health and Welfare 2024, *Australia's Health Performance Framework*, AIHW, Canberra. https://www.aihw.gov.au/reports-data/ahpf/australias-health-performance-framework

Australian Institute of Health and Welfare 2024, *Hospital resources 2023–24: data tables* (Table 3.4), AIHW, Canberra.

Australian Institute of Health and Welfare 2024, *Hospital resources 2023–24: data tables* (Table 3.2), AIHW, Canberra.

Australian Institute of Health and Welfare 2025, *Admitted patient care 2023-24: data tables* (Table 2.2), AIHW, Canberra. https://www.aihw.gov.au/hospitals

Australian Institute of Health and Welfare 2025, *Elective surgery waiting times 2024-25 data tables*, (Table 4.2), AIHW, Canberra. https://www.aihw.gov.au/hospitals/topics/elective-surgery

Australian Institute of Health and Welfare 2025, *Elective surgery waiting times 2024-25 data tables,* (Tables 4.11 to 4.18), AIHW, Canberra. https://www.aihw.gov.au/hospitals/topics/elective-surgery

Australian Institute of Health and Welfare 2025, *Emergency department care 2024-25: data tables* (Table 2.2), AIHW, Canberra. https://www.aihw.gov.au/hospitals

Australian Institute of Health and Welfare 2025, *Emergency department care 2024–25 data tables*, (Table 5.1), AIHW, Canberra https://www.aihw.gov.au/hospitals/topics/emergency-departments

Australian Institute of Health and Welfare 2025, *Emergency department care 2024–25 data tables*, (Table 5.3), AIHW, Canberra. https://www.aihw.gov.au/hospitals/topics/emergency-departments

Australian Institute of Health and Welfare 2025, *Emergency department care 2024–25 data tables*, (Table 5.5), AIHW, Canberra. https://www.aihw.gov.au/hospitals/topics/emergency-departments

Australian Institute of Health and Welfare 2025, *Emergency department care 2024–25 data tables*, (Table 2.2), AIHW, Canberra. https://www.aihw.gov.au/hospitals/topics/emergency-departments

Australian Institute of Health and Welfare 2025, *Emergency department care 2024–25 data tables*, (Table 6.3), AIHW, Canberra. https://www.aihw.gov.au/hospitals/topics/emergency-departments

Australian Institute of Health and Welfare 2025, *Emergency department care 2024–25 data tables*, (Table 6.3), AIHW, Canberra. https://www.aihw.gov.au/hospitals/topics/emergency-departments

Australian Institute of Health and Welfare n.d., *Health workforce*, AIHW, Canberra. https://www.aihw.gov.au/reports/workforce/health-workforce

Australian Institute of Health and Welfare, *Data Downloads Website*, AIHW, Canberra. https://www.aihw.gov.au/hospitals

Bureau of Health Information n.d., *Our role*, NSW Government, Sydney. https://www.bhi.nsw.gov.au/About_BHI/our-role

Canberra Health Services 2019, *Canberra Health Services Annual Report 2018-19*, ACT Government, Canberra. https://www.canberrahealthservices.act.gov.au/__data/assets/file/0010/1933192/CHS-2018-19-AR_Accessible-LR-1.pdf

Canberra Health Services 2026, *Governance*, ACT Government, Canberra. https://www.canberrahealthservices.act.gov.au/about-us/governance

Canberra Health Services n.d., *Emergency department waiting times*, ACT Government, Canberra. https://www.canberrahealthservices.act.gov.au/before,-during-and-after-your-care/coming-to-the-emergency-department/before-you-arrive/emergency-department-waiting-times

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

Duckett, S 2016, *Targeting zero: The review of hospital safety and quality assurance in Victoria*, Grattan Institute, Melbourne. https://grattan.edu.au/news/targeting-zero-the-review-of-hospital-safety-and-quality-assurance-in-victoria/

Garling, P 2008, *Final report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals*, NSW Government, Sydney. https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0011/258698/Garling-Inquiry.pdf

Health Quality and Complaints Commission 2011, *Response to request for information from the Health and Disabilities Committee*, Queensland Parliament, Brisbane, committee document. https://documents.parliament.qld.gov.au/com/HDC-F5F0/OHQCC-BC04/111123-HQCC-Resptorequest.pdf

KPMG 2024, *ACT Health Directorate Digital Health Record Program Review*, ACT Government, Canberra. https://www.act.gov.au/__data/assets/pdf_file/0006/2565141/ACT-Health-Directorate-Digital-Health-Record-Program-Review.pdf

Legislative Assembly for the Australian Capital Territory 2025, *Notice Paper No. 22: Tuesday, 24 June 2025*, ACT Parliament, Canberra. https://www.parliament.act.gov.au/__data/assets/pdf_file/0010/2869858/NP-22-24-June-2025.pdf

Leon Advisory 2021, *Culture in the ACT public health system: Second annual review*, ACT Government, Canberra. Culture-in-the-ACT-public-health-system-Second-Annual-Review.pdf

M Reid & Associates 2020, *ACT Public Health Services Cultural Review Implementation: Inaugural annual review*, ACT Government, Canberra. LIST_-ACT-Public-Health-Services-Cultural-Review-Implementation-Inaugural-Annual-Review.PDF

Nous Group 2018, *New health governance arrangements for the ACT*, ACT Government, Canberra.https://nla.gov.au/nla.obj-2863996480/view

Office of the Health Ombudsman 2014, *Office of the Health Ombudsman opens*, Queensland Government, Brisbane. https://www.oho.qld.gov.au/media-releases/office-of-the-health-ombudsman-opens

Productivity Commission, Report on Government Services, Australian Government. https://www.pc.gov.au/ongoing/report-on-government-services/

Proximity 2023, Workplace Culture within the ACT Public Health System, Third and Final Annual Review, Canberra, 2023, Independent review into the workplace culture within ACT public health services: Final report, ACT Government, Canberra.

Queensland Government n.d., *Open Hospitals*, Queensland Government, Brisbane. https://openhospitals.health.qld.gov.au/

Queensland Public Hospitals Commission of Inquiry 2005, *Report of the Queensland Public Hospitals Commission of Inquiry*, Queensland Government, Brisbane. http://www.qphci.qld.gov.au/final_report/Final_Report.pdf

ROGS Services for Mental Health 2025 data tables, https://www.pc.gov.au/ongoing/report-on-government-services/2025/data-downloads/

Safer Care Victoria 2018, *Victorian Clinical Council: Terms of reference*, Victorian Government, Melbourne. https://www.safercare.vic.gov.au/sites/default/files/2018-03/VCC%20terms%20of%20reference.pdf

Safer Care Victoria n.d., *About the Safer Together program*, Victorian Government, Melbourne. https://www.safercare.vic.gov.au/improvement/safer-together-program/about

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. https://www.mja.com.au/system/files/issues/190_02_190109/ski11396_fm.pdf

Stephen-Smith, R 2022, *Less than two months until ACT's Digital Health Record goes live*, ACT Government, Canberra. https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/rachel-stephen-smith-mla-media-releases/2022/less-than-two-months-until-acts-digital-health-record-goes-live

Stephen-Smith, R 2025, *Settlement reached with Calvary Health Care*, ACT Government, Canberra. https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/rachel-stephen-smith-mla-media-releases/2025/settlement-reached-with-calvary-health-care

Victorian Agency for Health Information 2019, *Strategic plan 2019–2022*, Victorian Government, Melbourne. https://vahi.vic.gov.au/sites/default/files/2021-12/Strategic%20Plan%202019%E2%80%932022.pdf

Victorian Auditor-General's Office 2021, *Clinical governance: Department of Health*, Victorian Government, Melbourne. https://www.audit.vic.gov.au/sites/default/files/2021-08/CG2_transcript.pdf?uid=25c6ac46f9

Victorian Government 2025, *Boards Ministerial Advisory Committee*, Victorian Government, Melbourne. <https://www.boards.vic.gov.au/boards-ministerial-advisory-committee

Western Australian Department of Health 2017, *Review of Safety and Quality in the WA health system*, Government of Western Australia, Perth. https://www.health.wa.gov.au/en/Improving-WA-Health/Safety-and-quality-review

World Health Organization (WHO) n.d., *Health systems governance*, World Health Organization, Geneva.https://www.who.int/health-topics/health-systems-governance#tab=tab_1