Annual Report 2013–2014

Central Queensland Hospital and Health Service, 2013-2014 Annual Report
Published by Central Queensland Hospital and Health Service, September, 2014
ISSN 2202-5332 (Print)

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An electronic version of this document is available at
http://www.health.qld.gov.au/cq/annual-report-2013-2014/

Information on consultancies expenditure and overseas travel will be published on the Queensland Health Open Data website (qld.gov.au/data)

Interpreter statement:
The Queensland government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on either (07) 4920 5759 or (07) 3115 6999 and we will arrange an interpreter to effectively communicate the report to you.

Message from the Chair

Central Queensland Hospital and Health Service has delivered its second operational surplus, stamping it as a high-performing organisation with a Board resolute in developing efficiencies to drive investment in additional and safer health services for Central Queenslanders.

Guided by the principles in the *Blueprint for better healthcare in Queensland* the Central Queensland Hospital and Health Board (the Board) finished the 2013-2014 financial year with a cash surplus of $8.1 million. This surplus will be invested in quality improvements.

Annual fluctuations in land and building valuations impacted on our financial bottom line. The decline in land value is effectively subtracted from the cash surplus, but it does not impact on the cash operating service.

2013-2014 was punctuated by a serious clinical incident in which the wrong kidney was removed from a patient. The Board took immediate and strong action with a focus on preventing further potential harm to patients. An independent external enquiry is assessing the adequacy of our patient safety systems.

This incident, and the Board's action, has sent a clear message to our staff, clinicians and the community that avoidable patient harm must not just be reduced, but eliminated. The Board wants to ensure the organisation develops and maintains a culture that consistently delivers optimum patient outcomes.

Achieving the best health service, within our fixed budget, is an ongoing challenge and we must do more work to improve our performance to not only meet, but exceed, national funding targets and clinical performance indicators. This includes the continued testing of efficiency and effectiveness through exposure to non-Government providers with the intent of delivering additional and improved services to the community we serve.

I acknowledge the commitment of my Board colleagues and their individual contributions to the collective strength of the Board, their steadfast support of the service, its mission and its journey on the way to achieving its strategic goals.

The 2014-2015 financial year will require more strong decisions, but each will be made with the view to change lives for the better.

Message from the Chief Executive

Patient safety moved to the top of the agenda for the Central Queensland Hospital and Health Service soon after I arrived in Central Queensland in November 2013 with the creation of and appointment to the Executive Director of Quality and Safety position.

That day in May 2014 when it was revealed a doctor had removed the wrong kidney from a patient at Rockhampton Hospital was a defining moment for the Central Queensland Hospital and Health Service. It set in motion a series of initiatives that will establish this health service as a patient safety benchmark in Australia.

Each initiative is designed around a single purpose – to eliminate avoidable patient harm. It is an ambitious aim, but one I ask and expect every one of our 2400 staff to own.

It will simply not be enough to say we have reduced the number incidents of avoidable patient harm or that the number is very low. We are dealing with people – neighbours, friends, family.

Reaching zero harm will require a strong workforce culture. Effective leadership, robust management, dedicated systems and processes and successful recruitment and retention programs, are also essential ingredients.

The 2013-2014 financial year was very much a year of consolidation and preparation. It was a year in which platforms were developed that will foster the development of a service stronger in every way.

The bricks and mortar with the New Ward Block at Rockhampton Hospital that includes Central Queensland Integrated Cancer Service, the Moura Community Hospital, rural rectification work at Biloela and Emerald hospitals, a Community Care Unit for North Rockhampton, a new private practice facility at Theodore, a rooftop helipad and new Intensive Care Unit at Rockhampton, new theatres at Gladstone and many other projects were either completed, continued or initiated.

A new management system and style was initiated, new partnerships formed, staff and community engagement initiatives launched and a new vision for our health service developed.

As we continue to refine and improve the way we deliver health services with the patient journey as the focus for everything we do, it will lead to efficiencies. Any savings will be reinvested into further improving the services we provide to Central Queenslanders.

The 2014-15 financial year will be about change and progress, owning up to weaknesses and seizing opportunities. It will be a year of improving patient care, the patient journey and patient health outcomes and developing a service of which our patients, staff and community can be proud.

We owe it to our patients, to the population of Central Queensland and to our colleagues to ensure we learn from mistakes, to improve our systems and to provide trusted care.

Who we are

The Central Queensland Hospital and Health Board and Central Queensland Hospital and Health Service were established on 1 July 2012.

The CQHHS Annual Report 2013-2014 reflects the CQHHS Strategic Plan 2013-2017 and its Vision, Values and Objectives.

Our Vision
Delivering quality, integrated health services focussed on the patient.

Our Values

- Care - We will care and provide care for our communities, individuals, groups and all of our stakeholders.
- Collaboration -We will work with other providers, educators and researchers, our communities and stakeholders to ensure our collective services are seamlessly delivered across the patient experience.
- Commitment - We will always direct our efforts to delivering the best health care to Central Queenslanders.
- Innovation - We will utilise and contribute to the development of new and effective practices for the delivery of leading edge healthcare.
- Integrity - We will be accountable for everything we do. We will conduct ourselves and our business professionally at all times.
- Respect - We will respect everyone we deal with in all that we do.

The Central Queensland values support those of the Queensland Government: customer first; ideas into action; unleash potential; be courageous; and empower people.

Our Key Objectives

- Striving for better care in Central Queensland (Chapter 2)
- Delivering integrated health services in partnership with other providers (Chapter 3)
- Providing accessible, sustainable, networked services in a quality framework (Chapter 4)
- Providing a great place to work (Chapter 5)
- Underpinning our business through stakeholder, clinician, consumer and community engagement (Chapter 6)
- Living within our means (Chapter 7)

Our key objectives support the *Queensland Government's Statement of objectives for the community*:

- Grow a four pillar economy;
- Lower the cost of living;
- Invest in better infrastructure and use better planning;
- Revitalise front-line services; and
- Restore accountability in Government.

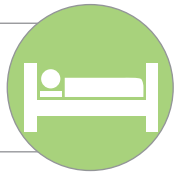
A significantly revised strategic plan has been developed with input from a leadership summit involving 70 of our top personnel.

The CQHHS Strategic Plan 2014-2018 can be viewed at http://www.health.qld.gov.au/cq/cqhhs-board/strategies.asp. This new plan will guide our future.

Organisational snapshots

Cash surplus 8.1 million

Treated 50,000 inpatients



Treated 126,000 in our EDs

Held 168,000 outpatient appointments

Delivered 2349 babies

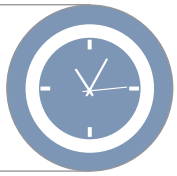
Performed 4541 elective surgeries

Performed 2921 emergency surgeries

Initiated Speaking up for Safety campaign

Introduced monthly **Clinical Governance Half Day**

Almost **87%** of patients were in Gladstone ED less than four hours



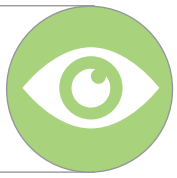
About **72%** of patients were in Rockhampton ED less than four hours

100% of Rockhampton Hospital Category 1 emergency surgery patients treated in time

97% of Gladstone Hospital Category 1 emergency surgery patients were treated in time

2,699 Telehealth sessions up **69%**

Introduced plan to resume public **ophthalmology** service



Letter of compliance

Queensland Government

Central Queensland Hospital and Health Service

The Honourable Lawrence Springborg
Minister for Health
GPO Box 48
BRISBANE Q 4001

Dear Minister Springborg,

I am pleased to present the Annual Report 2013–2014 and financial statements for the Central Queensland Hospital and Health Service (CQHHS).

I certify that this Annual Report complies with:

- The prescribed requirements of the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2009*, and
- The detailed requirements set out in the *Annual report requirements for Queensland Government agencies.*

A checklist outlining the annual reporting requirements can be found at page 105 of this Annual Report or accessed at http://www.health.qld.gov.au/cq/annual-report-2013-2014/

Yours sincerely

Charles Ware
Chair, Central Queensland Hospital and Health Board

5 September 2014

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Chapter 1
Our organisation

Central Queensland's rich cultural, geographic and economic diversities are among its most attractive attributes, and its biggest challenges.

Our organisation is growing in strength and will meet these challenges through its people.

We will change lives for the better.

1.1. Our service

Central Queensland Hospital and Health Service (CQHHS) has 2589 FTE staff focused on patient safety and delivering public hospital and health services from Gladstone in the south, inland to the Southern and Central Highlands and north along the Capricorn Coast, serving a population of around 228,000 people.

In 2013-2014 the organisation treated more than 295,000 patients with services including medical, surgical, emergency, obstetrics, paediatrics, specialist outpatient clinics, mental health, critical care and clinical support.

The geographic footprint of the health service is diverse, ranging from regional cities to remote townships in the west and beach side communities along the coast. Details from the Queensland Government Statisticians Office as at 30 June 2013 revealed the population had grown 2.1% in the five years to 2013 compared with a State average of 2%. The fastest growing Local Government Area in Central Queensland was Gladstone at 2.9% with Banana the lowest at 0.4 %.

Central Queensland has a relatively young population with 21.8% aged 0-14 years compared with 19.9% across the state, and a median age of 35.3, compared with 36.6 in Queensland, as at 30 June 2012.

The Central Queensland population is predicted to grow at 2% per annum to 358,000 at 30 June 2036.

The 2011 census identified Central Queensland as having 5.5% of its population identifying as Aboriginal and Torres Strait Islander where the same figure for all of Australia is 2.5%. The census also revealed 5.1% of the Central Queensland population identify as unemployed, which is comparable to the national figure of 5.6%.

Central Queensland has experienced a slowing of economic development during 2013-2014 as a result of significant downturn in resource sector development in the region.

The health service is responsible for the direct management of facilities within its geographical boundaries including:

- Biloela Hospital
- Capricorn Coast Hospital
- Emerald Hospital
- Gladstone Hospital
- Moura Hospital
- Rockhampton Hospital.

The health service also provides services from a number of Multi-Purpose Health Services (MPHS) and outpatient clinics. MPHS are located in:

- Baralaba
- Blackwater
- Mount Morgan
- Springsure
- Theodore
- Woorabinda.

Outpatient clinics are located at:

- Boyne Valley
- Capella
- Gemfields
- Tieri.

Distance is a challenge to service delivery for the health service. Our large geographic area means we often service rural or remote communities, where it is not possible to have immediate access to 24 hour clinical services. In 2012-2013 the health service introduced and embraced Telehealth, enabling real-time interaction between specialist clinicians and remote communities. Telehealth is used to provide services ranging from core clinical diagnostics to mental health care and antenatal care. Telehealth enables efficiencies in the delivery of quality health care services across the health service.

1.2. Our health

The health service partnered with Central Queensland Medicare Local to complete the Central Queensland Health Needs Assessment 2014 to provide an accurate statement of the future health needs of Central Queenslanders.

The health service will use this information to plan future service delivery, it will develop and initiate programs to address the lifestyle issues that will lead to a significant demand of health resources for the treatment of lifestyle-related chronic disease.

The health service will develop a multi-agency approach to address the key health issues identified. Those issues include:

- Life expectancy at birth for people living in Central Queensland was about 1 year less than the Queensland average, and 1.2 years below the national average (78.5 years for males and 82.9 years for females).
- Indigenous residents of Queensland had a 10.8 year shortfall in life expectancy for males compared with non-Indigenous males, and an 8.6 year shortfall for females.
- The leading causes of avoidable mortality for Central Queensland residents aged 0-74 closely resemble those of Queensland as a whole. Around 40% of all premature deaths are attributed to cancer (with 25% caused by lung and colorectal cancer combined), a further 20% caused by circulatory diseases, and 10% attributed specifically to ischaemic heart disease.
- One in six Central Queensland adults are daily smokers; a higher rate than the Queensland average. Indigenous peoples' smoking rates are particularly high, contributing to the mortality gap. Smoking remains the single largest cause of premature mortality and ill health in Central Queensland, but will soon be overtaken by obesity and nutrition-related conditions.
- The prevalence of obesity in Central Queensland at 29% was significantly higher than the State average of 22.6%. Two-thirds of Central Queensland adults are overweight or obese. Rates have been rising sharply.
- Nearly a quarter of adults (24%) in the Central Queensland population in 2011/12 were estimated to be hazardous drinkers, higher than peer regions and the State average of 21.5%.
- Diabetes rates have been increasing sharply – 9% of the population state they have diabetes or high blood sugar – more than 14,000 people. As obesity rates rise, diabetes prevalence will worsen – high rates of hospitalisation are already evident, particularly for Indigenous residents.
- Central Queensland residents living in Banana and Central Highlands tended to have lower rates of elective surgery – potentially related to access to private facilities.
- With the rate of population growth and ageing, if no change occurred in hospitalisation rates per head there will be a 67% increase in inpatient load to 2031. The increase is particularly driven by those aged 65 and over with a 124% rise in that time. The expected increase in diabetes prevalence will add further pressure.

- Mental health disorders were the third leading cause of total burden of disease (14%) and the largest cause of non-fatal burden of disease for Queensland. Eleven per cent of Central Queenslanders report current mental health and behavioural problems at any one time. Indigenous residents have twice the hospitalisation rate as non-Indigenous - 12/1000 compared with 6/1000 age-standardised rate. Within Central Queensland high mental health service use is apparent for Rockhampton residents, but this may relate mainly to the residential location of the more severe mentally ill patients. There are relatively high suicide rates compared with the Queensland average.

1.3. Our diversity

CQHHS serves a culturally diverse population, with Australian Bureau of Statistics data reporting languages spoken at home in Rockhampton as including Vietnamese, Portuguese, Afrikaans, Tagalog and German, as well as English. In Rockhampton 5.1% of households speak two or more languages. Our staffing profile is changing too, as we recruit more graduate doctors from outside Australia in order to meet the demand for qualified clinical staff in rural and remote Queensland.

It is our responsibility to tailor our services and their delivery to meet the needs of all members of our communities. We utilise translator services where necessary and have specialised programs to assist with the delivery of health services to our multicultural population.

Our community is supported through Queensland Health Multicultural Services which takes the lead role in the coordination of our state wide interpreter and refugee health service, implementation of dedicated strategies aimed at addressing the health issues of our special needs population and the development of health initiatives to promote better health within our multicultural communities.

Resources and initiatives have been implemented to ensure a fair and equitable workplace for all our employees including:

- Aboriginal and Torres Strait Islander Cultural Respect Strategies Policy G12
- Anti-Discrimination Policy E2
- Diversity Policy G1
- Equal Employment Opportunity Policy G2
- Aboriginal and Torres Strait Islander Health Worker Career Structure
- Aboriginal and Torres Strait Islander Workforce Advisory Group
- Aboriginal and Torres Strait Islander Staff Recognition Awards
- Workplace Equity and Harassment Officer Network.

The health service complies with the Queensland Health Cultural Competency Framework. This Framework identifies the four foundation areas which are necessary to achieve organisational cultural competency including:

- Management commitment - a commitment to developing organisational cultural competency;
- National quality standards - a commitment to improve the quality of health services to people from culturally and linguistically diverse backgrounds;
- Culturally inclusive systems and services - a commitment to making all systems and services culturally inclusive;
- Cross-cultural capabilities - a definition of the cross cultural knowledge and skills that are expected.

We all have a shared responsibility to respect and value the contribution diversity brings to our community and our workforce. The strategies that have been implemented within our health service will promote mutual respect and understanding regardless of our cultural, religious, ethnic and linguistic backgrounds.

1.4. Our role

1.4.1. Our Board of Directors

The Central Queensland Hospital and Health Board has oversight of the strategic management of the health service and is responsible for compliance, governance and the setting and pursuit of strategic goals and objectives. The composition of the Board is revised annually through a process of nomination and Ministerial approval. The Board membership for the 2013-2014 period is displayed below.

Chair: Mr Charles Ware

person with legal expertise
term of appointment 18 May 2013 to 17 May 2016

Mr Charles Ware is a Central Queensland lawyer. He is admitted as a solicitor and practises as a legal consultant with a Yeppoon legal firm.

Charles has completed terms as Deputy Chancellor of Central Queensland University and Deputy Chair of Gladstone Ports Corporation Limited. He previously held positions in the Queensland electricity supply industry as Chair of Capricornia Electricity and a Director of Ergon Energy. He was also a director of the Residential Tenancy Authority.

Charles is a former Chair of the Rockhampton Art Gallery Trust and a Director of Queensland Biennial Festival of Music Pty Ltd. He also has served on the board of the Rockhampton Regional Development Ltd and continues to support Capricorn Enterprise as an honorary legal advisor.

Charles has a Masters of Law and Masters of Business (Public Management) from Queensland University of Technology. He has undergraduate degrees in Arts and Law and is a Fellow of the Australian Institute of Company Directors.

Deputy Chair: Dr David Austin

person with clinical expertise
term of appointment: 18 May 2013 to 17 May 2016

Dr David Austin is an Intensive Care and Anaesthetics specialist whose medical career has extended across Australia and New Zealand. David brings with him a wealth of committee experience and expertise in outdoor and sports medicine.

David is currently Director of Intensive Care at Rockhampton Hospital, Discipline Academic Coordinator (Intensive Care) - Rural Clinical School and a member of a number of medical steering groups and committees. He is also author of numerous publications, conference presenter and college examiner for the College of Intensive Care Medicine and the College of Anaesthesia.

David has worked in anaesthesia and intensive care medicine within rural and metropolitan hospitals across New Zealand and Australia.

David has combined his love of sport with his medical knowledge and has been the medical director for Mount Everest treks since 1990, medical advisor and doctor for diving expeditions, ski patrols, yacht races and other mountaineering adventures.

David is currently a Manuscript Reviewer for: The Lancet (1998 - present), Anaesthesia and Intensive Care (2010 - present), Wilderness and Environmental Medicine (1998 - present) and the College of Intensive Care Medicine (2009 - present) and a member of the Primary Exam Committee - CICM (2010 - present). David is also a member of the Steering Group for the Statewide Intensive Care

Network Queensland (2011 - present) and Deputy Chair of the ICU Primary exam. David was also an Examiner for the Australian and New Zealand College of Anaesthesia (2005 – 2014).
David also holds membership for the following:

- Surgical Taskforce Group Rockhampton (2009 - present),
- Responsible Investigation Ordering (RIO) Project Working Group Rockhampton (2010 - present),
- Rockhampton Hospital Simulation Committee (2010 - present),
- Rockhampton Hospital Trauma Committee (2001 - present),
- Rockhampton Hospital Disaster Management Group (2007 - present) and
- Rockhampton Hospital Directors' Group (2007 - present).

David is a Clinical Champion for Central Queensland District for the Deteriorating Patient Project (2009 - present).

David is a Fellow of the Australian and New Zealand College of Anaesthesia and Fellow of the College of Intensive Care Medicine.

Member: Mr Frances (Frank) Houlihan

person with expertise in business management, financial management and human resource management
term of appointment: 18 May 2013 to 17 May 2016

Mr Frank Houlihan is a Partner and Managing Director in HHH Partners a chartered accountancy firm he established in Emerald in 1986.

With more than 30 years experience, Frank graduated with a Bachelor of Commerce from James Cook University and has been in public practice since 1979.

Frank is also a Director of the Central Queensland Rural Division of General Practice, Director of Central Queensland Primary Health Care Pty Ltd and a director of Central Highlands Health Care the operator of the not-for profit GP Super Clinic being developed in Emerald.

His current professional affiliations are: Fellow, Institute of Chartered Accountants, Fellow, Australian Society of Certified Practising Accountants and Associate Member, Institute of Arbitrators and Mediators Australia.

Member: Mr Graeme Kanofski

person with expertise in business management, financial management and human resource management
term of appointment: 18 May 2013 – 17 May 2014; 18 May 2014 – 17 May 2017

Mr Graeme Kanofski has 36 years of experience in local government in Queensland, including three years as Chief Executive Officer of the Gladstone Regional Council and 17 years as Chief Executive Officer of the former Calliope Shire Council. He recently undertook the role of Transfer Manager overseeing the de-amalgamation of Livingstone Shire Council from Rockhampton Regional Council.

Graeme holds a Bachelor of Business degree and has served as President of Local Government Managers Australia, Queensland Division. He is a well-respected local who has an extensive career history in local government and associated organisations in Queensland.

He has studied local government management in El Segundo City in the USA and in the United Kingdom and has a wealth of experience in local government

associated activities including disaster response management. Graeme has experience as a Board Director having served in that role on the Gladstone Economic and Industry Development Board, the Australian Airport Owners Association and other community associations. Graeme has received a Public Service Medal in 2002 for his service to local government. He has owned and operated small businesses in the Gladstone Region. Graeme resides in Calliope.

Member: Ms Elizabeth Baker

person with expertise in health management, business management, financial management and human resource management
term of appointment: 18 May 2013 – 17 May 2014; 18 May 2014 – 17 May 2017

Ms Elizabeth Baker is an experienced commercial/corporate lawyer with experience in Australian and international business environments and has a Bachelor of Laws, Master of Laws, and a Graduate Certificate of Employment Relations.

Elizabeth has served on a number of community boards, including the Gladstone District Health Council and is currently a Director of the Gladstone Airport Corporation. Her professional memberships include:

- Queensland Law Society
- Queensland Industrial Relations Society
- Australian Corporate Lawyers Association
- Resources and Energy Law Association

Elizabeth is currently employed as General Counsel for Queensland Alumina Limited at Gladstone and is an active member of the Gladstone community.

Member: Ms Sandra Corfield

person with knowledge of health consumer and community issues relevant to the operations of the service
term of appointment: 18 May 2013 to 17 May 2014

Ms Sandra Corfield is the Chief Executive Officer of the Central Queensland Rural Division of General Practice and has an extensive nursing career history which has taken her from rural Queensland to international posts including Scotland.

Sandra is a registered nurse and midwife and has practised as a community nurse, accident and emergency nurse and neonatal special care nurse in her diverse nursing career. She holds a postgraduate Midwifery Certificate, was a finalist in the Australian Institute of Management Rural Manager Awards Program in 2012 and winner of the 2013 RDAQ Memorial Medal for services to Rural Medicine.

An affiliate member of the Australian Institute of Company Directors, Sandra has owned a small business and was previously engaged as company secretary for Central Queensland Primary Health Care Pty Ltd.

Sandra and her family run a successful primary production venture at their property “Vandeena”, outside Biloela.

Member: Ms Karen Smith

person with clinical expertise
term of appointment: 18 May 2013 – 17 May 2014; 18 May 2014 – 17 May 2017

Ms Karen Smith is the Nurse Unit Manager for the Intensive Care Unit at Rockhampton Hospital and has held that position since 1993. She has an extensive career in Intensive Care units across Australia and is an active member of the Rockhampton community.

Karen began her nursing career as a student nurse at Rockhampton Hospital and chose to specialise in Intensive Care nursing soon thereafter. She has worked at Royal Melbourne Hospital, various Brisbane hospitals and at Rockhampton Hospital.

She is a member of a number of specialist groups, including: the Australian College of Critical Care Nurses, the Central ICU Clinical Network and the Paediatric Intensive Care Advisory Group.

Karen is a Registered Nurse and has a postgraduate Certificate in Critical Care Nursing from the Royal Melbourne Hospital. She is an active member of the local equestrian community.

Member: Mr Kurt Heidecker

person with other areas of expertise the Minister considers relevant to a service performing its functions
term of appointment: 18 May 2013 – 17 May 2014; 18 May 2014 – 17 May 2017

Mr Kurt Heidecker is the inaugural Chief Executive Officer of the Gladstone Industry Leadership Group which addresses issues of regional concern for six of Australia's largest industrial sites.

Kurt brings with him a wealth of business and industry experience. In his current role, Kurt is responsible for overseeing a virtual team aimed at building an open and trusting relationship between industry and the community.

Some of his achievements include forming strong relationships with industry, activist, government and community and the development of successful Board Advisory Committees. From 2006 to 2008, Kurt led a team of implementation, network and support training specialists in the software company.

Kurt holds various board positions including:

- Director – Fitzroy Basin Association, and
- Member – Central Queensland Institute of TAFE Advisory Council.

Kurt's qualifications include:

- Bachelor of Engineering (Civil),
- Masters of Design Science (Building),
- Graduate Diploma of Management and
- Master Practitioner of Neuro- Linguistic Programming

Member: Ms Bronwyn Christensen

person with knowledge of health consumer and community issues relevant to the operations of the service
18 May 2013 – 17 May 2014, 18 May 2014 – 17 May 2017

Ms Bronwyn Christensen is a successful local farmer and grazier, Cotton Australia's Dawson Valley Regional Manager, Secretary to the Board for the community owned Hotel Theodore Cooperative Association and Principal of Green Cow Communications.

Bronwyn currently highlights the lighter side of farm life with her regular newspaper column and blog 'The Farmer's Wife'.

Bronwyn is a well-respected local who has had significant involvement in local business and community organisations in Central Queensland over many years. She is currently the President of the Theodore Hospital Auxiliary. Bronwyn is a previous Board member of the Hotel Theodore Cooperative Association and she has previously held executive positions on the Theodore District Health Council, Theodore Meals on Wheels, Theodore Show Society and Theodore School of Ballet.

From 2001 to 2005, Bronwyn played a key role in setting up the Theodore District Health Council Inc office, Youth Centre, and in the development of the council's primary health care project plan. She was also instrumental in the submission for and awarding of Queensland's Healthiest Town to Theodore in 2003. In the same year, Bronwyn was awarded the Australian Institute of Management's Rural and Remote Manager of the Year. Bronwyn has recently been awarded a place and is participating in the iconic Australian Rural Leadership Program.

Member: Professor Leone Hinton

person from universities, clinical schools or research centres with expertise relevant to the operations of the service
19 May 2013 – 17 May 2016

Professor Leone Hinton was recently appointed to the position of Dean of School, Nursing and Midwifery, Central Queensland University. Previously she was the Director, Corporate Strategy and Planning. Leone's expertise in this area was recognised when in 2010 she was awarded the Australian Institute of Management Central Queensland Professional Manager of the Year. Her interests are in organisational culture, evaluation, strategic planning and risk management.

Leone began her career as a Registered Nurse working at the Mater Children's and Rockhampton hospitals before changing career paths to nursing training, education and research at CQUniversity.

Leone is a Fellow of the Australian Institute of Management and Member of the Australasian Institute of Public Administrators.

Leone is a Doctor of Professional Studies (Transdisciplinary) and has a Masters of Education (Education Administration).

The CQHH Board has met 12 times since July 2013 and meets monthly. Committees meet either quarterly or bi-monthly, with provision for extraordinary meetings as required.

Costs associated with committee members' fees and incidental expenses totalled $239,000 for the 2013-2014 financial year.

1.4.2. The Board has three Committees:

Finance and Resource Committee

Chaired by Mr Kurt Heidecker, the Finance and Resource Committee is responsible for monitoring and assessing the financial management and reporting obligations of the health service. It oversees resource utilisation strategies including monitoring the service's cash flow and its financial and operating performance. The committee is also responsible for bringing the attention of the Board to any unusual financial practices. The Finance and Resource Committee works in close cooperation with the Health Service Chief Executive, Executive Director Workforce and the Chief Finance Officer receiving quarterly reports from these areas.

Quality and Safety Committee

Chaired by Professor Leone Hinton, the Quality and Safety Committee is responsible for advising the Board on matters relating to the safety and quality of health services provided by the service, including the service's strategies to address the maintenance of high quality, safe, contemporary health services to patients. The committee works in close cooperation with the Health Service Chief Executive, Executive Director Quality and Safety, Executive Director Accreditation, Executive Director of Medical Services and the Executive Director Workforce, receiving monthly reports from these areas.

Audit and Risk Committee

Membership of the Audit and Risk Committee as at 30 June 2014 comprised:

- Chair: Frank Houlihan
- Charles Ware
- Daniel Nolan (External nominee with relevant experience)
- Nik Fokas (standing rights of attendance as CFO)
- Len Richards (standing rights of attendance as HSCE)
- Nichole Bunning (standing rights of attendance as Executive Director Workforce)
- Lee Peters (standing rights of attendance as internal audit)
- Richard Wanstall (standing rights of attendance as external audit Deloitte Touche Tohmatsu)
- Josh Langdon (standing rights of attendance as external audit Deloitte Touche Tohmatsu)
- Karen Forest (invitee as contract accountant)

As members of the CQHHB Mr Houlihan and Mr Ware are remunerated for their services to the committee.

The Audit and Risk Committee has observed the terms of its charter and had due regard to Treasury's Audit Committee Guidelines.

The Audit and Risk Committee met five times during the 2013-2014 period adopting a new charter and work plan in March 2014.

The role of the committee is to provide independent assurance and assistance to the Board in the areas of:

- risk, control and compliance frameworks
- external accountability responsibilities as prescribed in the Financial Accountability Act 2009, the Hospital and Health Boards Act 2011, the Hospital and Health Boards Regulation 2012 and the Statutory Bodies Financial Arrangements Act 1982; and
- integrity framework.

The functions and responsibilities of the Audit and Risk Committee as contained in its charter and linked to the committee's work plan cover the areas of:

Financial Statements

- Reviewing the appropriateness of the accounting policies adopted by the health service and ensure they are relevant to the health service and its specific circumstances.
- Reviewing the appropriateness of significant assumptions and critical judgements made by management, particularly around estimations which impact on reported amounts of assets, liabilities, income and expenses in the financial statements.
- Reviewing the financial statements for compliance with prescribed accounting and other requirements.
- Reviewing, with management and the external auditors, the results of the external audit and any significant issues identified.
- Exercising scepticism by questioning and seeking full and adequate explanations for any unusual transactions and their presentation in the financial statements.
- Analysing the financial performance and financial position and seek explanation for significant trends or variations from budget or forecasts.
- Ensuring that assurance with respect to the accuracy and completeness of the financial statements is given by management.

Integrity Oversight and Misconduct Prevention

- Providing oversight, direction and guidance on the health service's integrity framework to ensure it is functioning appropriately.
- Overseeing the health service's Lobbyists Contact Register reporting and any significant integrity issues arising.
- Monitoring the effectiveness of the health service's Public Interest Disclosure process.
- Ensuring the health service complies with relevant integrity legislation (e.g. Crime and Misconduct Act 2001, Public Sector Ethics Act 1994, Public Interest Disclosure Act 2010, Integrity Act 2009) and whole of government policies, principles and guidelines (including the Code of Conduct for the Queensland Public Service).
- Providing advice and recommendations on integrity issues to the Board and Executive Management, as necessary.
- Monitoring health service misconduct trends and prevention approaches and address any gaps in dealing with integrity issues in relation to misconduct (including fraud and corruption).
- Ensuring the health service complies with any Crime and Misconduct Commission requirements and recommendations to improve misconduct prevention and response.

Risk Management

- Reviewing the risk management framework for identifying, monitoring and managing significant risks, including fraud.
- Satisfying itself that insurance arrangements are appropriate for the risk management framework, where appropriate.
- Liaising with management to ensure there is a common understanding of the key risks to the health service. These risks will be clearly documented in a risk register which will be regularly Reviewinged to ensure it remains up-to-date.
- Assessing and contribute to the audit planning processes relating to the risks and threats to the health service.
- Reviewing effectiveness of the health service's processes for identifying and escalating risks, particularly strategic risks.

Internal Control

- Reviewing, through the internal and external audit functions, the adequacy of the internal control structure and systems, including information technology security and control.
- Reviewing, through the internal and external audit functions, whether relevant policies and procedures are in place and up to date, including those for the management and exercise of delegations, and whether they are complied with.
- Reviewing, through the Chief Finance Officer and the System Manager assurance certifications, whether the financial internal controls are operating efficiently, effectively and economically.

Performance Management

- Reviewing the health service's compliance with the performance management and reporting requirements of the Financial Accountability Act 2009, the Financial and Performance Management Standard 2009 and the 'Annual Report Requirements for Queensland Government Agencies'.
- Reviewing whether performance management systems in place reflect the health service's role/purpose and objectives (as stated in its strategic plan).
- Identifying that the performance reporting and information uses appropriate benchmarks, targets and trend analysis.

Internal Audit

- Reviewing the budget, staffing and skills of the internal audit function.
- Reviewing and approve the internal audit plan, its scope and progress, and any significant changes to it, including any difficulties or restrictions on scope of activities, or significant disagreements with management.
- Reviewing the proposed internal audit strategic plan and annual plan to ensure they cover key risks and that there is appropriate co-ordination with the external auditor.
- Reviewing the findings and recommendations of internal audit and the response to them by management.
- Reviewing the implementation of internal audit recommendations accepted by management.
- Ensuring there is no material overlap between the internal and external audit functions.

External Audit

- Consulting with external audit on the service's proposed audit strategy, audit plan and audit fees for the year.
- Reviewing the findings and recommendations of external audit (including from performance audits) and the response to them by management.
- Reviewing responses provided by management to ensure they are in line with the health service's risk management framework.
- Reviewing the implementation of external audit recommendations accepted by management and where issues remain unresolved ensure that satisfactory progression is being made to mitigate the risk associated with audit's findings.

Compliance

- Determining whether management has considered legal and compliance risks as part of the health service's risk assessment and management arrangements.
- Reviewing the effectiveness of the system for monitoring the health service's compliance with relevant laws, regulations and government policies.
- Reviewing the findings of any examinations by regulatory agencies, and any auditor observations.

Reporting

- Submitting quarterly reports to the Board outlining relevant matters that have been considered by it as well as the committee's opinions, decisions and recommendations.
- Circulating minutes of the committee meetings to the Board, committee members and standing invitees as appropriate.
- Preparing an annual report to the Board summarising the performance and achievements for the previous year.
- Submitting a summary of its activities for inclusion in the health service Annual Report.

1.4.3. Internal audit

For the period July 2013 to February 2014, internal audits were commissioned as required through the Executive Management Team of the Hospital and Health Service. From 1 March 2014, the Sunshine Coast, Wide Bay and Central Queensland Hospital and Health Services approved the Internal Audit Charter to establish an internal audit function under a hub and spoke, co-sourced model. This model ensures the effective, efficient and economical operation of the function.

The service's internal audit function provides independent assurance and advice to the Board Audit and Risk Committee, the Health Service Chief Executive and senior management. It enhances the service's corporate governance environment through an objective, systematic approach to evaluating the effectiveness and efficiency of corporate governance processes, internal controls and risk assessment. This is in keeping with the role and responsibilities detailed in Part 2, Division 5 of the *Financial and Performance Management Standard 2009*.

The role, the operating environment and reporting arrangements of the function are established in an internal audit charter that has due regard to the professional standards and the Audit Committee Guidelines: Improving Accountability and Performance issued by Queensland Treasury and Trade.

Since March 2014, the internal audit function has operated in accordance with a strategic and annual plan approved by the Board's Audit and Risk Committee. The internal audit function is independent of management and the external auditors. The function has:

- discharged the responsibilities established in the charter by executing the annual audit plan prepared as a result of risk assessments, materiality, and contractual and statutory obligations;
- provided reports on the results of audits undertaken to the Health Service Chief Executive and the Audit and Risk Committee;
- monitored and reported on the status of the implementation of audit recommendations to the Audit and Risk Committee. Management is responsible for the implementation of audit recommendations;
- liaised with the Queensland Audit Office to ensure there was no duplication of 'audit effort';
- supported management by providing advice on corporate governance and related issues including fraud and corruption prevention programs and risk management;
- allocated audit resources to those areas considered to present the greatest risk and where the work of internal audit can be valuable in providing positive assurance or identifying opportunities for positive change; and
- reviewed the service's annual financial statements prior to presenting them to the Audit and Risk Committee.

The audit team are members of professional bodies including the Institute of Internal Auditors and CPA Australia. The service continues to support their ongoing professional development.

CQHHS was included in Queensland Audit Office Report 8: 2013-2014 Results of audit: Hospital and Health Services entities 2012-2013. The report is accessible on the QAO website at www.qao.qld.gov.au. The Audit and Risk Committee monitors the implementation of any recommendations associated with these audits.

1.4.4. Our Management Team

Central Queensland Hospital and Health Service Executive Management Team
At 30 June 2014, the Executive Management Team comprised 12 members. See CQHHS Organisational Structure in chapter nine.

Chief Executive
Len Richards
Overall accountability for the strategic development and operational delivery of services.

Executive Director Medical Services
Dr Tony Austin
Responsible for professional oversight for medical recruitment and scope of practice.

District Director of Nursing
Sandy Munro
Responsibility for nursing practice, strategic nursing workforce, nursing standards of practice, workload processes and education.

Executive Director Quality and Safety
Karen Wade
Responsibility for the quality and safety systems, and clinical governance, across the health service.

Chief Finance Officer
Nik Fokas
Responsibility for the provision of strategic advice on budget allocations, auditing and performance monitoring against the Service Level Agreement.

Executive Director Workforce

Nicole Bunning

Responsibility for human resources, organisational development and workplace health and safety.

Executive Director Infrastructure

Janelle Diamond

Responsibility for capital development program, asset management and maintenance programs of equipment and buildings, fleet and accommodation management.

Executive Director Rural Health Services

Rod Hutcheon

Responsible for health service delivery in rural areas of Central Queensland - all facilities and services outside Rockhampton and Gladstone.

Executive Director Rockhampton Hospital

Jennifer Gale

Responsible for health service delivery at Rockhampton Hospital.

Executive Director/Director Medical Services Gladstone Hospital

Dr Nicki Murdock

Responsible for health service delivery at Gladstone Hospital.

Executive Director Subacute and Community Services

Michele Gardner

Responsible for the delivery of health services in the community, Rockhampton Correctional Centre and Residential Aged Care facilities.

Executive Director Mental Health Services

Lindsay Farley

Responsible for the delivery of mental health services and alcohol and other drug programs across Central Queensland.

The operations of the health service are the subject of routine scrutiny from external agencies including but not limited to coronial inquests, Ombudsman's Office reports and the Crime and Misconduct Commission (CMC).

There were no formal investigations involving the health service completed during 2013-2014. An independent investigation involving safety systems was incomplete at the time of this report.

All health service clinical and business applications operate on a secure network and are password protected. A key strategy in the information systems development space is to increase the information available to healthcare providers by implementing an integrated electronic medical record in alignment with the national Personally Controlled Electronic Health Record. The health service has taken the first steps in this direction implementing key building blocks such as "The Viewer" which is available to authorised users and provides a single point of access where clinicians can view a range of important summary patient information across the health service. Regular access audits are undertaken to monitor appropriate use and management of information.

The health service is committed to upholding the Department of Health's strong commitment to improving record keeping practices and complying with the *Public Records Act 2002*, Information Standard 40: Record keeping and Information Standard 31: Retention and Disposal of Public records.

The Machinery of Government network Group has assisted with the transfer of records from the Department of Health to the health service.

The health service manages its administrative records in accordance with the requirements of the Public Records Act 2002 and relevant Information Standards (IS); IS 40 (Record keeping); IS 34 (Metadata); IS 31 (Retention and Disposal of Public Records) and IS 18 (Information Security).

The health service utilises an electronic system to manage all of the communications of its executive office.

All staff involved in the management of records are conversant with their obligations under the relevant acts including the *Information Privacy Act 2009*.

Records are securely stored to ensure that privacy and confidentiality requirements are met. The security is enhanced by electronic proximity security systems limiting access to the facilities that house records.

1.4.5. Medical Records

All patients and clients are registered on a patient administration system, with a unique identifier and medical Records are stored, managed and accessed in accordance with relevant legislation and standards.

Routine quality monitoring is undertaken, via a number of mechanisms, including manual and electronic audits. In accordance with the *Public Records Act 2002*, the intellectual control of approximately 850,000 clinical records was transferred from the Queensland Department of Health to the Chief Executive of CQHHS. Once transferred, the Chief Executive became responsible for the management and safe custody of these clinical records in accordance with s.8 of the *Public Records Act 2002* and Queensland Government Information Standard: 40 Record keeping and Queensland Government Information Standard: 31 Retention and Disposal of Public Records. The safety and security of these records are monitored via the Quality Management Framework and regularly reported to the Chief Executive.

Queensland legislation which ensures privacy and confidentiality protections for personal information and which is applied at CQHHS include:

- *Information Privacy Act 2009*
- *Information Privacy Regulation 2009*
- *Hospital and Health Boards Act 2011*
- *Hospital and Health Boards Regulation 2012*.

1.4.6. Risk management

CQHHS continually monitors and improves risk management practices across the region, enabling the delivery of effective, appropriate and efficient risk management across the clinical, corporate and governance environments. Within those environments, the health service undertakes to assess risk in alignment with the Risk Management - Principles and Guidelines Standard AS/NZS ISO 31000: 2009, which includes strategic risk, departmental, divisional, program and operational risk.

The health service Risk Management policy was established to ensure all staff will have knowledge of their level of accountability and responsibility in risk identification, assessment, reporting, treatment / control of risks as well as participate in management of risks across the organisation. Aligning with AS/NZS ISO 31000: 2009 Australian/New Zealand Standard - Risk Management and the Queensland Health Policy on Integrated Risk Management, the procedure describes risk escalation and reporting procedures to ensure risk is appropriately managed at all health service sites.

The Audit and Risk Committee is responsible for establishment and maintenance of a single Risk Register to capture all high level risk and reports and escalates risks to the health service Board.

In accordance with the health service Risk Management Policy, CQHHS risks are systematically raised, concluded or escalated as required.

Procedurally, all risks are reported through to the Health Service Management Board. Clinical risks are then reported through to the Board's Safety and Quality Committee. Human Resource related risks are reported through to the Board's Finance and Resource Committee and corporate and financial risks are reported to the Audit and Risk Committee.

Chapter 2
Better care

Objective: **Striving for better care in Central Queensland**

Our patients are the focus of everything we do.

We owe it to our patients and community to focus on continually improving our standard of care and eliminate avoidable patient harm.

Safe care is the best care.

Eliminating avoidable patient harm is the clear goal of the health service and its employees.

A significant clinical incident in early 2014 was a defining moment for the organisation and has hardened the resolve to become, and be recognised as, a patient safety leader in Queensland and across the country.

Quality, safety and the management of risks across the health service is reaffirmed as the highest priority for the health service. The initial focus was to ensure sustainable systems around the quality, safety and risk management agenda are established to ensure patients are safe.

Integrated into the work around patient safety is preparation for the Australian Council of Healthcare Standards EQuIP national accreditation to be held on 3 to 7 November 2014.

Vanguard Health was contracted to review all outstanding recommendations in a document known as the Vanguard Report. This report became a key focus to ensure quality and safety initiatives were implemented across the health service.

It was identified that a large number of recommendations from internal reviews and coronial inquiries, each with the aim of improving patient safety and reducing patient risk, had not been implemented. The 123 recommendations from the 2012 ACHS EQuIP survey had also not been implemented. At 30 June 2014, 98% of the recommendations had been implemented.

This work has identified opportunities to improve patient safety and the review of safety systems was prioritised to ensure the building blocks were in place to maximise quality and safety.

From this work, the health service:

- Developed and implemented a risk framework.
- Established a quality framework which sets direction for the implementation of quality initiatives across the organisation. This includes a quality improvement operational plan for all business units outlining new initiatives, safety initiatives and an audit program.
- Implemented project teams to maximise opportunities for a multidisciplinary approach to the implementation of innovation.
- Provided extensive training in the management of a Root Cause Analysis (RCA – an internal review resulting from avoidable or unavoidable patient death or serious harm) to create a greater awareness of the management of Severity Assessment Code 1 (SAC1) incidents and RCAs and create greater awareness of the safety systems required to limit the number of SAC1 incidents.
- Initiated a Speaking up for Safety campaign. This campaign included confidential forums with designated groups of clinical staff regarding safety and risk with the intent of gaining insight into safety risks identified by front-line staff. These discussions informed a wider strategy to identify organisation changes that would make it safer for patients and staff. This campaign included staff engagement on safety and safety initiatives with the shared aim of eliminating avoidable patient harm.
- Introduced a monthly Clinical Governance Half Day as a direct result of the Speaking up for Safety meetings. The protected time allows clinical staff to focus on the safety and effectiveness of services across the health service. It also provides a teaching opportunity in a multi-disciplinary setting.
- Developed a communication flow sheet to centralise and formalise quality information from across the health service. A Quality and Safety Operational Governance meeting was implemented to develop a comprehensive and quality system across the health service.

- The Quality and Safety Unit developed an intranet site incorporating alerts and preparedness for accreditation. This site will hold all information relevant to the quality and safety program allowing staff access to information relevant to their application of quality and safety.

The continual monitoring of Nurse Sensitive indicators,including reported incidents on falls, pressure ulcers, medication administration, blood transfusion,nursing skill mix and nursing agency utilisation was introduced to allow the timely development of strategies with the aim of reducing the number of incidents.

A software system called TrendCare, a nursing tool measuring patient acuity, was implemented in all acute services allowing a review of nursing procedures to ensure they are evidence-based and contemporary in their practice.

Clinical governance structures were established for each hospital. The clinical governance framework at Rockhampton Hospital includes a global audit schedule and monthly discussion and oversight of the hospital's clinical care.

Chapter 3
Integrated health services

Objective: Delivering integrated health services in partnership with other providers

Together we achieve great things.

CQHHS develops partnerships to achieve better outcomes for our community, staff and patients, such as the link with CQUniversity.

This partnership improves care, develops students' career pathways and aids recruitment and retention.

There are many health service providers in Central Queensland and across Australia who have the expertise and processes to enhance the delivery of health services to out patients.

The health service continues to identify partnership opportunities to enhance patient care and during 2013-2014 there was considerable progress in the strengthening of existing partnerships and development of effective new relationships.

Health Needs Assessment

CQHHS partnered with Central Queensland Medicare Local to produce the *Central Queensland Health Needs Assessment 2014*.

The Health Needs Assessment identifies the burden of ill health that will face Central Queensland communities if there is not a significant behaviour change at an individual level.

There are many warning signs in the Health Needs Assessment that suggest a significant growing burden of disease and ill health that may lead to premature and avoidable death is facing our region. They include:

- the impact of the aging population;
- smoking remains the single largest cause of premature mortality and ill health in Central Queensland, but will soon be overtaken by obesity and nutrition-related conditions;
- current levels of obesity (1 in 3 for our adults);
- only 1 in 2 adults participate in the minimum level of physical activity;
- 1 in 4 consume risky levels of alcohol; and
- 9 out of 10 adults in Central Queensland do not eat the recommended daily intake of fruit and vegetables.

This is on top of a growing population and the significant inequity between the health of the Indigenous and the non-Indigenous populations. Life expectancy for the Indigenous population is approximately 10 years less than the non-Indigenous population. Differences in terms of accessibility to services is also an important factor.

If behavioural change is not encouraged it is conceivable that the burden of ill health and disease will far exceed the ability of health agencies to develop the required capacity and capability to respond effectively.

Findings from the HNA highlight the need for a multi-agency approach. The health service has developed a strategy to establish a Coalition for Health - a partnership of health providers, community and statutory organisations - to explore the development of a Social Movement for Change.

CQUniversity

The Sub-Acute Chronic Care Rehabilitation Interdisciplinary Student Clinic at CQUniversity is the result of an effective partnership between CQUniversity and the health service.

The clinic integrates and coordinates clinical placements for more than 150 pre-entry students each year. It creates a functional workforce that provides sub-acute care to clients with a range of complex chronic diseases.

The clinic provides interdisciplinary, goal-oriented, time-limited intervention to clients with disabling conditions. After assessing a client's condition, those who have the potential to improve their independence and quality of life are managed through a rehabilitation program.

Preliminary research data has demonstrated that the clinic has achieved a significant reduction in hospitalisations and average length of stay for clients who have multi-morbidity and a significant improvement of quality of life.

While addressing gaps in service delivery, the clinic also improves health workforce recruitment and retention.

The clinic was Australia's first interdisciplinary student-assisted clinic based in a health service and currently supports clinical placements from more than 10 universities across Australia.

The students are from the disciplines of occupational therapy, podiatry, physiotherapy, speech pathology, exercise physiology, nutrition and dietetics, social work, pharmacy, nursing and medical science.

Ophthalmology

The public ophthalmology service within the health service ceased in 2007. Ongoing recruitment attempts to re-establish the service were unsuccessful and ophthalmology patients were being put on waiting lists outside the health service. In late 2013, a partnership with Vanguard Health led to the implementation of a three phase plan for the reintroduction of an ophthalmic service to treat patients locally so as to reduce the need for patients to travel to South East Queensland for treatment.

The first phase was designed to re-establish a public service utilising private service providers. This phase was completed by mid 2014 and about 200 public patients received their surgery closer to home.

The second phase is starting towards the end of the financial year and is designed to introduce more ophthalmologists to Central Queensland with an agreed contract for the provision of 623 ophthalmic procedures to Central Queenslanders in Central Queensland.

Phase 3 is the consolidation of full consultative and surgical services at Rockhampton Hospital. Phase 3 is service vision for the future.

Gladstone Hospital

Gladstone Hospital is part of the Rio Tinto One Gladstone Health Plan Executive Group which is focussing on working together to improve services for the whole population of Gladstone and its greater area.

This group has spent the past 18 months identifying barriers to working together and working to remove them. It is intended over the coming 6 months to define health care priorities for Gladstone and to conduct a community consultation through a citizens' jury.

Gladstone Hospital is working in partnership with the Gladstone Mater to create more sustainable services moving away from the single practitioner model. The collaboration includes working together for out-of-hours emergency care and working towards the appointment of two paediatricians, an extra surgeon, an extra physician, an anaesthetist and an orthopaedic surgeon across the two hospitals.

The reduction in services which has resulted from some tertiary providers in Brisbane reviewing their outreach services are being addressed through the new paediatrics, endocrinology and diabetics service. Telehealth endocrinology, paediatrics and diabetes services are to be developed during the coming year.

With the arrival of permanent specialists it will be possible to apply for accreditation for specialist registrar training across the campus. Until now this has not been possible because the colleges need two specialists available for training registrars. The hope is that trainees will be encouraged to enter rural and remote practice once qualified.

Work started on the rebuild of Gladstone Hospital's operating theatre and high dependency unit in a partnership with local industry with the work funded through generous industry donations by QGC ($1.5 million for operating theatre work) and Santos GLNG ($1.45 million for high dependency unit work).

The operating theatre upgrade includes modern air filtration which will mean joint replacements can be done locally by Gladstone's new orthopaedic surgeon.

The high dependency unit will include new clinical measurement facilities, a redesigned nurses' station with the latest monitoring equipment and toilet and showering facilities.

Capricorn Coast Hospital

To address the historic recruitment and retention difficulties at Capricorn Coast Hospital, the health service partnered with Vanguard Health for the attracting, contracting, payroll and retention of 6 full-time medical practitioners over a three year agreement at the Capricorn Coast Hospital.

The instability of the medical workforce was affecting the service's ability to deliver and develop sustainable health services to the coastal community.

Vanguard Health was contracted to create stability in the workforce to allow the health service to concentrate on the design and implementation of a sustainable and attractive service model.

Contestability

CQHHS continues to test the efficiency and effectiveness of its service delivery in the open market to ensure Central Queenslanders are receiving the maximum health returns.

Aged Care

A revised Aged Care Facility Divestment Strategy was developed in consultation with the Department of Health Contestability Branch for the sale of aged care facilities in Rockhampton to a non-government provider. The strategy put to the open market was for:

- Both facilities to a single purchaser;
- Each facility "as is" to independent purchasers;
- Separate divestment negotiations to ensure maximum value for the health service including the possible transition of residents to an alternate aged care provider and the closure of the facility/facilities as an aged care centre.

The strategy is expected to be finalised by August 2014.

Radiology

An Expression of Interest for the provision of medical imaging services across the health service attracted considerable market interest and highlighted potentially significant improvements for patient access to critical imaging solutions for our patients.

The health service's intention was to present an Invitation to Offer to the open market early in the 2014-2015 financial year. Additional services that will be invited as part of this process would include:

- 24-hour on-site general / computed tomography (CT) radiographer service in Rockhampton Hospital and increased services at Gladstone Hospital;
- 24-hour coverage (through on-call) at Emerald and Biloela;
- Expanded on-site coverage for ultrasound and MRI at Rockhampton Hospital;
- New CT service on-site for Gladstone (128 slice) and Emerald (16 slice);

- Ultrasound service for Emerald and a roving rural ultrasound for Biloela, Moura, Mt Morgan and Blackwater;
- Radiology registrar position in addition to onsite radiologist at Rockhampton Hospital;
- On-site radiologist at Gladstone Hospital for a minimum of 15 hours per week; and
- Improvement in interventional radiology services including nuclear medicine at Rockhampton Hospital.

A contract with a private provider would also ensure:

- Capacity for Positron Emission Tomography/CT services for cancer care;
- Capacity for services to a cardiac catheter laboratory at Rockhampton Hospital;
- Commitment to participate in our training and development strategies; and
- Improved training for radiographers and sonographers.

Radiation Oncology

A radiation oncology market sounding questionnaire was developed to assess private radiation oncology practice interest in providing services at CQHHS.

Chapter 4
Accessible, sustainable services

Objective: **Provide accessible, sustainable, networked services in a quality setting**

Providing treatment options close to where people live improves health outcomes and quality of life.

Innovation, such as our Telehealth service, provides a vital lifeline for regional and rural communities to connect with health professionals without the need for travel.

In 2013-2014 we linked patients to clinicians via Telehealth 2,699 times.

Central Queensland benefits from having a diverse geography that is home to a culturally diverse population with equally diverse needs.

CQHHS aims to accurately identify those needs through a range of measures such as the Central Queensland Health Needs Assessment, and respond to those needs regardless of how challenging they might be.

To meet the challenge of distance and isolation head-on, CQHHS uses innovative techniques and strategies to deliver quality health care services.

We continue to develop new and contemporary ways for the people of Central Queensland to access health care services equal to, or better than, those available elsewhere in Queensland.

The health service is determined that patients should only travel as part of planned service delivery.

Innovation is encouraged and an environment that rewards new processes, procedures and approaches is fostered to meet the diversity of needs.

Utilising technology is key to providing improved access in rural and regional areas.

CQHHS has also developed partnerships to improve accessibility and sustainability of services, such as partnering with Vanguard Health in a program to reintroduce an ophthalmology service to Central Queensland.

The funding, development and upgrade of brick-and-mortar resources play a necessary role in the development of new, improved and innovative services. There has been extensive investment in CQHHS facilities.

Cancer Centre

One of the greatest improvements to the delivery of safe and sustainable services to Central Queenslanders will be delivered through the development of the Regional Cancer Centre at Rockhampton Hospital.

It is well established that people with cancer who live in rural areas have poorer survival rates than Australians with cancer who live in the major metropolitan centres. Several factors are thought to contribute to lower survival rates including:

- Rural patients' cancers are often diagnosed at a later stage, meaning their conditions are more advanced and more difficult to successfully treat
- Poorer access to specialised treatment
- Relative shortage of health care providers in rural and regional areas
- Higher proportion of disadvantaged groups such as Aboriginal and Torres Strait Islander people.

There are currently no comprehensive cancer services between the Sunshine Coast and Townsville. This covers a distance of more than 1,257km, a population of 700,000 people, and about 4,300 new cancer incidences each year - or 15% of Queensland in total.

It is estimated the cancer centre will deliver radiotherapy to about 500 patients in the first year alone, reducing the need for patients to travel and increasing their quality of life and health outcomes.

As the centre is developed, the services it delivers are strengthened, new services developed, and as staffing and expertise allows the development of outreach centres, it will change the lives of many Central Queenslanders for the better.

Telehealth

The use of Telehealth technology has saved thousands of Central Queenslanders from the need to travel for a specialist appointment.

During 2013-2014 there were 2,699 Telehealth sessions, an increase of 69% from the 1,598 from the previous calendar year. This means almost 2700 appointments that would usually have required face-to-face consultation were provided by real-time television links from a hospital closer to where the patient lives.

The largest Telehealth clinic in the health service was for orthopaedic fractures. There were 534 Telehealth appointments for patients in Emerald alone. The service is also provided to Gladstone, Blackwater, Springsure and Central West districts.

Other Telehealth clinics provided from Rockhampton Hospital include blood-borne viruses and liver clinic and pre-admission clinic.

Rockhampton also has patients attend clinics provided from other Hospital and Health Services including irritable bowel disease, burns and paediatrics with a proposed persistent pain clinic for the coming year.

Moura started a pilot for a *Blueprint for better health care in Queensland* initiative called Telehealth Emergency Management Support Unit in December 2013 with five patients receiving clinical assessment and treatment through a local nurse videoconferencing to a senior medical officer.

Biloela, Emerald Blackwater and Moura have been funded through the Rural Revitalisation program for additional staffing to support Telehealth service delivery from sites.

Expanded paediatric development to Biloela, antenatal services for women birthing in Rockhampton and a urology service are Telehealth initiatives planned for the 2014-2015 financial year.

Rural Health

A major workforce initiative was approved to stabilise the medical officer positions in the Rural Health Services Division to benefit our patients, doctors and the community. This initiative will decrease locum dependency and remove pressure from Gladstone and Rockhampton hospitals.

The plan will also bring to an end to sole-doctor towns which will improve fatigue and clinical safety in small rural communities. As part of this plan, recruitment for a medical educator position will ensure quality of training and education for our rural generalist trainees based in Emerald.

The Rural Generalist Training Program (24 month program) commenced in February 2013 with accreditation for six rural generalists. Two rural generalists commenced in February 2013 and four in February 2014. The plan incorporates an expansion in rural generalist numbers to eight in 2015.

Further development of an after-hours model with the Telehealth Emergency Management Support Unit resulted in Emerald supporting Moura and the roll out of services into Springsure to allow support for rural medical officers.

This model has also been used to provide support to the Capricorn Correction Centre from Emerald Hospital when medical officers have been unavailable.

Partnering with CQUniversity to recruit seven midwifery students to enable sustainable midwifery workforce has also been a positive boost for rural health.

This has resulted in the employment of 14 graduate nurses in rural areas and places newly graduated nurses with either a nursing or nursing/midwifery (dual) degree into vacant positions.

These nurses will participate in further tertiary studies to facilitate employment in rural areas (e.g. midwifery, rural and isolated practice).

Another boost in the midwifery field was the establishment of the caseload midwifery model at Emerald with midwives providing a total care for a defined caseload of women – the roll-out of a similar model is now being extended into Rockhampton in the coming financial year.

The continuation of the Beach to Bush Program for registered and enrolled nurses has allowed these nurses to rotate through rural facilities and, on completion, a permanent registered nurse position may be negotiated in one of those sites.

The implementation of the Vanguard Health consultancy solution at the Capricorn Coast Hospital aims to provide delivery of a health service program that will remove delays to health services and reduce the healthcare inequality caused by service availability.

Consultation with the Moura community has reached agreement for a smaller, smarter model of health care that will serve the community into the future. A contemporary design has been agreed upon in conjunction with the community and the new Community Hospital is due for construction by early 2015.

Emerald's after-hours General Practitioner Clinic partnership between Emerald Hospital and Central Queensland Medicare Local commenced in May 2013 finishing in June 2014. Though it was not continued, the exercise was a success in terms of developing working arrangements between the two organisations.

Flying surgeon services and flying obstetrician services expanded in Emerald with procedure numbers increasing from 500 in 2012 to approximately 800 in 2013. These services also started in Biloela during April 2014 with the intention of expanding the services to residents of the Banana Hub.

A Memorandum of Understanding with Check Up funded visiting specialists for endocrinology; gastroenterology; hearing; ophthalmology; obstetrics, women's health and diabetes. Provision of the services was arranged through consultation rooms at Emerald Hospital while the Emerald General Practitioner Super Clinic is being built.

Funding ($8 million) was approved through the Rural and Remote Infrastructure Rectification Works Project for the Emerald Hospital. The scope of the project included redesign of the emergency department with an update to the department's security plan to ensure staff safety as well as security and upgrades to the operating theatre complex. The works project commenced in July 2013 with the opening by the Minister scheduled August 2014.

Funding ($7 million) was also allocated at Biloela Hospital under the Rural and Remote Infrastructure Rectification Works Projects for a new emergency department. The project included refurbishment to accommodate community health (which will be moving to the hospital and will be collocated in August 2014), and offices for the management team and clinical governance support unit.

In September 2013 construction was completed for the private medical clinic in Theodore for the Medical Superintendent with Right of Private Practice. The facility was officially opened by the Minister for Health in October 2013.

Mental Health

Central Queensland Mental Health Alcohol and Other Drugs Division concluded an extensive review of its operations which was provided to the Chief Executive in early 2013.

The outcome of the review provided a redesign for the division leading into the future and recognised the need for additional leadership support for community teams as well as the provision of leadership for growth in inpatient and residential mental health services.

A major capital project to enhance services for mental health consumers was progressed with the identification and purchase of a site for the construction of a new 20-unit community rehabilitation centre (Community Care Unit) in North Rockhampton.

Enhancement to the treatment and assessment options for older people with a mental illness has also progressed with the identification of a site and allocation of capital funds to construct a four bed Acute Older Persons Mental Health Inpatient Assessment Unit within Rockhampton's Quarry Street Mental Health facility.

Subacute, Ambulatory and Community Services

The division aims to support integrated models of care across the range of health services and focuses on alternatives to hospital care, pre and post discharge planning and to ensure integration with community-based partner organisations and acute services.

All current services provided are being reviewed to ensure they are innovative and integrated with our partners to provide patient-centred, safe and efficient care focused on the transition between community and acute health services.

The division delivers services in a number of community settings, including: Capricornia Offender Health Services; Hospital in the Home; Hospital Avoidance Risk Program (HARP) Acute Aged Care; HARP Community Interface Program; HARP Post Acute Care; Community Palliative Care (non-cancer); Chronic Disease / Subacute, and Chronic Care; Rehabilitation Services (joint CQHHS and CQUniversity health clinic); Blood-Borne Virus and Sexual Health Service (HIV, Hep B and C); Aged Care Assessment Team; Transition Care Program; Public Health Services; Environmental Health Services; Geriatric Services ; Rehabilitation Services including outreach services Gladstone and Yeppoon; Residential Aged Care Facilities and Oral Health Services.

An effective review and reform of clinical and administration practices in Oral Health Services achieved an 83% reduction in public dental waiting lists in 10 months. In that time the seven-year waiting list was reduced to a little more than a year.

A 27-bed Geriatric Evaluation Management Step-Down Unit is being developed in the New Ward Block at Rockhampton Hospital and will allow the implementation of a "Geriatric Flying Squad" model of care.

A new service and staffing model was implemented in Geriatric and Rehabilitation Services after an external culture review.

The Hospital in the Home program effectively decreased admissions in CQHHS hospitals. At the start of the reporting period the program was diverting 1.5% of admissions from hospitals and by the end of the reporting period 3.5% of overall admissions were receiving care in their own home.

The division works with the Rural Health Services Division to ensure integrated models of service are delivered, with a focus on diverting patients from unnecessary admissions to hospital in the safest and most efficient model of health care delivery.

In February 2013, 3569 people had waited more than two years for an oral health appointment.

In February 2014 there was not a single person who had waited more than two years.

Rockhampton Hospital

The external work on the Rockhampton Hospital Ward Block development neared completion allowing the internal fit out to start. This development includes the new regional cancer service and general wards. The project is expected to be completed in October 2014.

Planning continued for the development of the new intensive care unit and construction of the roof-top helipad funded from the 2012-2013 CQHHS budget surplus. The helicopter landing site is expected to be completed mid-2015 and completion of the intensive care unit is expected by the end of first quarter, 2015.

Expansion of the peri-operative suite was completed, upgrading of the air conditioning system in the kitchen neared completion at the end of the financial year and tenders for the expansion and refurbishment of the central sterilising department had closed and were being evaluated.

Gladstone Hospital

Planning for the upgrade of the Operating Theatres and High Dependency Unit continued and the project is expected to be completed in early 2015.

With the arrival of permanent specialists it will be possible to apply for accreditation for specialist registrar training across the campus. This would encourage trainees to enter rural and remote practice once qualified (as detailed in Chapter 3).

2014 is the first year a rural generalist obstetric trainee has been working in Gladstone. Intern accreditation was undertaken and provisionally approved for a number of units in Gladstone. Interns will be able to start working in Gladstone from 2015. This will increase the likelihood of getting good quality junior doctors in Gladstone.

Tier 1 Key Performance Indicators

	2013-14 Target/Estimate	2013-14 Estimated Actual	2013-14 Actual
Performance measure as published in the 2012-13 SDS	*(published target in 2012-13 Service Delivery Statement)*	*(published estimated actual data in 2013-14 Service Delivery Statement)*	*(Actual data as at 30 June 2014)*
E4: National Emergency Access Target (NEAT) % of Emergency Department attendances who depart within 4 hours of their arrival in the Emergency Department	80.00%	79.00%	77.71%
Variance Reporting: CQHHS has not met the NEAT Target for attendances who depart within 4 hours of their arrival in the Emergency Department.			
E5:Emergency Department: % seen within recommended time frame			
E5.1: Category 1 (within 2 minutes)	100.00%	100.00%	100.00%
Variance Reporting: All Category 1 patients are being seen immediately upon arrival in the Emergency Department.			
E5.2: Category 2 (within 10 minutes)	80.00%	84.00%	84.51%
Variance Reporting: CQHHS has met and exceeded the target for Category 2 patients seen in time.			
E5.3: Category 3 (within 30 minutes)	75.00%	82.00%	78.43%
Variance Reporting: CQHHS has met and exceeded the target for Category 3 patients seen in time.			

	2013-14 Target/Estimate	2013-14 Estimated Actual	2013-14 Actual
Performance measure as published in the 2012-13 SDS	*(published target in 2012-13 Service Delivery Statement)*	*(published estimated actual data in 2013-14 Service Delivery Statement)*	*(Actual data as at 30 June 2014)*
E5.4 Category 4 (within 60 minutes)	70.00%	78.00%	78.43%
Variance Reporting: CQHHS has met and exceeded the target for Category 4 patients seen in time.			
E5.5 Category 5 (within 120 minutes)	70.00%	93.00%	93.02%
Variance Reporting: CQHHS has met and exceeded the target for Category 5 patients seen in time.			
E6: Patient Off Stretcher Time (POST): < 30minutes (%)	90.00%	90.00%	96.68%
Variance Reporting: CQHHS has met and exceeded the target for Patient Off Stretcher Time.			
E7: Elective Surgery: % treated within clinically recommended time frames			
E7.1: Category 1: within 30 days	100.00%	98.00%	99.41%
Variance Reporting: CQHHS has achieved 100% throughout the majority of the 2013-14Financial Year.			
E7.2: Category 2: within 90 days	91.00%	97.00%	89.32%
Variance Reporting: CQHHS has not met the target for Category patients being seen in time.			
E7.3: Category 3: within 365 days	96.00%	100.00%	98.80%
Variance Reporting: CQHHS has met and exceeded the target for Category 3 patients being seen in time.			
E8 Elective Surgery: Number of patients waiting more than the clinically recommended time frame:			
E8.1: Category 1: within 30 days	0	0	1
Variance Reporting: CQHHS has again performed soundly in achieving only 1 Category 1 patient waiting more than the clinically recommended time frame.			
E8.2: Category 2: within 90 days	0	0	42
Variance Reporting: CQHHS experienced challenges in provision of some Category 2 surgical services during 2013/14, but overall perfromance remains strong.			
E8.3: Category 3: within 365 days	0	0	2
Variance Reporting: CQHHS has again performed soundly in achieving only 2 Category 3 patients waiting more than the clinically recommended time frame.			
E9: Activity: variance between Purchased activity and Year to Date activity:			
E9.1: Inpatients			114.08
E9.2: Outpatients			-24.35
E9.3: Emergency Department			15.8
E9.4: Mental Health			73.26
E9.5: Critical Care			33.58
E9.6: Sub and Non-Acute Patients			-170.28

Chapter 5
Great place to work

Objective: **Providing a great place to work**

A great place to work starts with strong, committed leaders engaging staff in service improvements.

The journey to implement the robust management system called Lean – driven by staff and supported by management – has started.

We will continually improve.

Strong, ambitious and effective leadership is the essential ingredient to success for the health service.

With the right leadership style and management program the health service will be efficient and effective in the delivery of safe and sustainable health services and it will also lead to the development of a culture, brand and reputation that will establish our organisation as a great place to work.

The organisation's leaders have been identified and the first Leadership Summit was held to identify the strategic direction and the leadership required for success.

The Leadership Summit led to the development of the new CQHHS Strategic Plan 2014-2018 (see Chapter 8), and it identified the need to implement a robust management system.

As one component of the path to implementing improved management systems, Rona Consulting was engaged to start the health service on the journey to implement powerful and robust system that has proven results in health care – Lean.

Lean is a system of continual improvement based on the Toyota Production System that uses the knowledge, skills and ability of staff to drive effectiveness and efficiency.

Strong and appropriate leadership, investment in leadership and enhancement of leadership capability are integral for the continued success of Lean and to ensure the health service achieves its vision of changing lives for the better.

Learning and development needs are identified through performance conversations and a suite of leadership and management development programs are offered.

Recruiting and retaining quality employees is a challenge in regional centres because the advantages of working in Queensland's metropolitan areas are perceived as outweighing those afforded for professionals in regional areas.

The health service acknowledges that recruiting quality medical officers to the region remains particularly difficult. The CQHHS website includes employee and community profiles and narrative from employees who love where they live.

Potential employees can access information about the services and the community to assist with their decision to join the health service. We are committed to employing high performing employees.

The health service undertakes workforce planning at the business unit and whole of health service levels. There are a number of considerations in developing the workforce plan such as the health needs of the community and future health service provision; what the future workforce profile needs to look like; the current workforce profile; and the most effective strategies to align the workforce with the business strategy and the subsequent transition plan to achieve the desired future workforce state.

The health service collaborates with the general practice and tertiary education sectors to identify opportunities for developing service models, clinical research and clinical skills enhancement.

Integral to this process is the need to assess and review workforce requirements so that team-based interdisciplinary care becomes central to the planning and development of health services.

CQHHS Workforce on 30 June 2014

Stream	FTE
Medical including VMOs	237
Nursing	1146.89
Health Practitioners and Technical	282.23
Managerial and Clerical	449.54
Operational	461.89
Trade, Artisans and General	12
Total	2589.55

Key strategies to attract and retain a skilled and capable workforce are captured under the objective of "Providing a great place to work". There are a variety of strategies including:

- Strong and visible leadership – a culture of leadership at all levels and high levels of leadership capability are key drivers for creating a great place to work
- Competitive employment conditions and family-friendly working environments
- Enhancing a culture of high performance and innovation, particularly exploring new service delivery models and ways of working
- Employee recognition, including an awards program for exceptional service and achievements
- Employee engagement initiatives so that employees at all levels have a voice in how we operate our business and our workplace
- A strong commitment to safety
- A suite of employee support programs
- Targeted recruitment strategies for critical roles
- A suite of education, learning and development programs that focus on building both clinical and non-clinical capability

During the year there were 592 separations including 563 (95%) permanent employees.

The health service employee permanent retention rate is 81.44% indicating that efforts to recruit and retain quality staff are effective. During this period, 367 appointments were made, of which 94 (26%) were temporary.

In 2013-2014, there was a significant decrease in WorkCover expenses and an 11% decrease in new claims. This will have a positive impact on our 2014-15 WorkCover premium with an expected reduction of more than $1 million.

In 2013-2014, there was a 20% decrease in average days in return to work and a decrease in average monthly payments to staff on WorkCover, saving $692,862.

The health service successfully completed an audit against AS/NZ 4801:2001 in March 2014 addressing a set of 25 audit criteria. The health service passed with no non-conformance, 5 conformance, 14 conformance with minor improvement and 6 conformance with major improvement.

A total of 61 recommendations were made for continual improvement, which are progressively being implemented.

The performance of all employees, including volunteers, is critical to the overall success and outcomes of the health service. The performance management framework supports all mangers to provide regular and constructive feedback to their employees, and hold at least two formal conversations with their employees every year. This ensures that there is alignment with the health service Strategic Plan, we continue to improve performance and productivity and we have a performance culture.

New employees attend an orientation program that provides general information about the health service and mandatory non-clinical training modules. A new Learning Management System has been under development for launch in 2014-15, which includes an online learning platform allowing employees to undertake self-paced learning. Local level inductions are also provided to new employees to orient them to their workplace and work procedures.

The health service offers employees a wide range of in-service and external learning and development opportunities that enhance their capability and support career development.

Our core principles:

Integrity and impartiality

Promoting the public good

Commitment to the system of government

Accountability and transparency

The extended skill sets achieved by employees are highly valued by the health service. Supervisors and managers play key roles in reinforcing employee commitment and sense of belonging within the health service.

It is our intention to enable our employees to enjoy the benefits of being part of a flexible workforce.

The health service promotes flexible working arrangements and work-life balance using a range of policies including:

- HR Policy B59 - Job Sharing
- HR Policy C4 – Work Life Balance
- Central Queensland Hospital and Health Service Procedure – Transition to Retirement Program for Nurses
- HR Policy C9 – Carers Leave
- HR Policy C21 – Purchased Leave
- HR Policy C26 – Parental Leave
- Public Service Commission Directive 26/2010 Paid Parental Leave
- HR Policy G2 – Equity and Diversity
- Public Sector Ethics Act 1994 - Code of Conduct for the Queensland Public Sector

The health service's industrial and employee relations are conducted under the provisions of the Service Agreement with the Department of Health.

Employment terms and conditions are in accordance with the relevant industrial awards and agreements. Grievances or disputes are managed in accordance with the Award grievance resolution provisions and Queensland Health Human Resources Policies.

The health service is committed to meeting the requirements of the relevant industrial awards and is cognisant of the benefits of maintaining a robust relationship with relevant unions. To achieve this, regular consultative forums are conducted including the CQHHS Consultative Forum; Local Consultative Forums; and Nursing and Midwifery Consultative Forum.

During the financial year 74 employees received redundancy packages at a cost of $4,306,338.80. Employees who did not accept an offer of a redundancy were offered case management for a set period of time, where reasonable attempts were made to find alternative employment placements. There is currently one employee being case managed.

The health service is committed to upholding the values and standards of conduct outlined in the Code of Conduct for the Queensland Public Service. The code of conduct applies to all employees of the health service and was developed under the *Public Sector Ethics Act 1994*, consisting of our core principles:

- Integrity and impartiality
- Promoting the public good
- Commitment to the system of government
- Accountability and transparency

All CQHHS employees are required to undertake training in the Code of Conduct for the Queensland Public Service. New employees attend the New Starter Orientation program, which contains the Code of Conduct training, within three months of the date of commencement. Employees are required to repeat the Code of Conduct training every two years. Code of Conduct face-to-face training sessions are also available to health service units on request.

A newly revised Department of Health eLearning package, Ethics, Integrity and Accountability has also been sourced by the health service for hosting on our own eLearning platform enabling staff to access the training on a 24/7 basis via the CQHHS intranet. Plans are also in place to introduce a web-based Learning Management System in 2014-2015 which will enable employees to access this training from any internet connected device.

In 2013-2014, 1939 staff completed training including:

- Applying the code
- The code and your obligations
- Five step ethical decision making model
- Queensland Health zero tolerance to violence
- Assault in the workplace
- Workplace harassment and ethical standard of behaviour
- Equity and diversity
- *Public Sector Ethics Act 1994* ethical obligations.

Chapter 6
Business through engagement

Objective: **Underpinning our business through stakeholder, clinician, consumer and community engagement**

We ask Central Queenslanders what they want, and listen to their answers.

Community, consumer, clinician and stakeholder engagement influences the planning, design and implementation of our services.

Through engagement we will meet our community needs.

The health service has a focus on engagement at all levels to inform, consult, involve, collaborate and empower consumers and the community, staff, clinicians and stakeholders.

The development and strengthening of internal and external engagement activities continued as widespread input was sought on issues ranging from the design of the Moura Community Hospital to staff input on improving patient safety.

The Central Queensland Hospital and Health Board and its members provide a strong engagement link for the community and professional organisations. The Board continues to use its grass-roots links to measure and shape the delivery of health services.

Consumer and Community Engagement

The health service uses consumer and community engagement to gather the knowledge, ideas, issues and praise of those who have used our services and those who may use them in the future to plan, deliver and improve the delivery of health services to the community.

Ongoing consultation with the Moura community about the design and layout of the new Moura Community Hospital continued.A community meeting in Moura on 22 April 2014 showed strong support for and provided official in-principle approval for the design of the new Moura Community Hospital. There was strong support for the design and the community is now looking forward to work starting on the site.

Engagement in rural areas continues through the five active Community Advisory Networks established to support each of the Multi-Purpose Health Services in Central Queensland.

Participation in the development of the One Gladstone Health Plan with industry, community and stakeholder representation has led to the establishment of strong links between members.

Education and awareness programs continue to inform and engage targeted groups. BreastScreen, bowel screen, cervical screening and Donate Life remain visible in the community.

Consultation with maternity consumers occurs through the Maternity Advisory Committee.

The health service actively invites patient and consumer feedback through compliments and complaints. During 2013-2014 the organisation received 1305 compliments and 2021 complaints. Information gathered from compliments and complaints is analysed to identify trends and issues are addressed.

The Consumer and Community Engagement strategy describes how the health service will engage with our communities and individual consumers, with the continued use of Community Advisory Networks and establishment of new strategies including use of internet, newsletters and social media.

Staff engagement

Increasing staff engagement was identified as a key objective to ensure staff are not only aware of issues and the direction of the health service, but also to provide them opportunities to have their say, ask questions or share ideas.

Initiatives launched during the year included the introduction of:

- Speaking up for Safety campaign includes confidential forums with front-line clinical staff to gain insight into safety risks. This campaign includes staff engagement on safety and safety initiatives with the shared aim of eliminating avoidable patient harm.

- Clinical Friday. Members of the Executive Management Team spend one afternoon a month working on the "coal face" at a facility or unit across the health service. This includes working alongside those in the facility or unit, understanding their job and allowing face-to-face interaction, hosting an open staff forum and, where appropriate, meeting with senior clinicians.
- Regular CQHHS-wide or facility-specific open staff forums on an as-needed basis.
- "Ask the Executive" and "Feedback" email addresses that allow engagement in a more protected manner.
- Regular, sponsored barbecues for staff to allow direct contact with executives.

A major staff engagement program will be implemented in 2014-2015.

Clinician engagement

Increasing clinician engagement and clinician involvement in the decision-making processes of the health service were key targets in the second half of the financial year.

The peak decision-making body for the operational arm of the organisation, the Health Service Management Board, was established and its membership is weighted to capture increased clinical input.

Increased medical officer engagement was essential during the finalisation of medical contracts and the established communication pathways have contributed to improved input from senior medical staff.

Clinician engagement helped develop the structure for the Speaking up for Safety campaign. Feedback gathered from meetings and forums with clinicians contributed to the initiation of a Clinical Governance Half Day across the organisation. Under this program, on one afternoon each month all clinicians and other staff not required to provide emergency treatment have protected time to discuss and improve patient safety across the organisation.

The health service works with Central Queensland Medicare Local to engage general practitioners and a dedicated General Practitioner Liaison Officer has been employed to increase engagement in that area.

Service delivery relies significantly on the cooperation and commitment of clinical staff. The Clinician Engagement Strategy has been developed to describe a transparent and effective means of ensuring clinicians across the health service are consulted in the decision making processes.

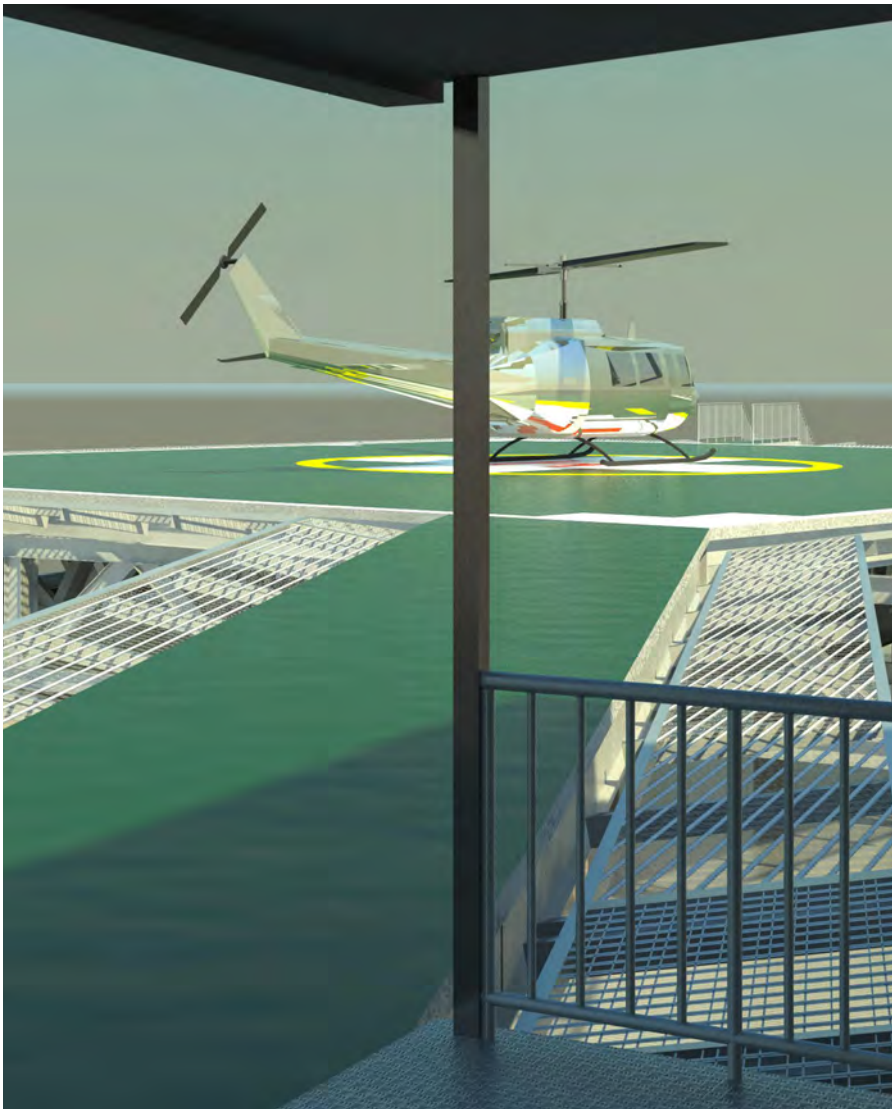
Stakeholder engagement

As the primary provider of health care services, CQHHS works closely with external agencies and expends considerable energy to ensure those external relationships are meaningful and enduring.

Our relationship with Central Queensland Medicare Local is guided by an engagement protocol, which is a legislative requirement. The protocol identifies shared objectives for the two agencies and outlines activities in which we will collaborate for the benefit of our communities, patients and other stakeholders.

Subacute, Ambulatory and Community Services developed and maintained effective relationships with community advisory groups, non-government organisations and other government agencies to advance primary health care and general community wellness in Central Queensland. The division leads and develops co-ordination of partnership agreements with acute care providers, Central Queensland Medicare Local and key community agencies with a focus on priority areas such as avoidable admissions and hospital alternatives as well as chronic disease management.

Chapter 7
Living within our means



We save to invest and invest to save.

Developing efficiency delivers improved access to strengthened and additional services.

Through improvement and innovation we will continue to deliver more.

7.1. Our performance overview

Central Queensland Hospital and Health Service (CQHHS) is an independent statutory body overseen by a local Hospital and Health Board. The health service reported an operating deficit of $1.9 million in 2013-2014 primarily due to the impact of land revaluations undertaken during the financial year. Decreases in land values resulted in an $11.2 million impact on the health service's operating position due to an insufficient Land Revaluation Reserve generated since the inception of the health service in July 2012.

Queensland Treasury and Trade's policy requires all land and buildings to be reported annually at fair value. Movements in individual asset's fair value such as land tends to rise and fall cyclically depending on the economy and market conditions (external to the operations of the health service). During 2014, building valuations have demonstrated increases, whereas individual properties within the class of land have experienced significant declines.

The land revaluation decrement in 2014 was caused by a decline in land values across the Central Queensland region secondary to the slowing of investment in the mining sector, infrastructure development and an overall tightening in financing activities.

It is noted that without the impact of this non-cash loss, the operating result for the health service would have been a surplus of $9.185 million.

Comprehensive revaluations of 25 Buildings (82% of value) and land improvements at Rockhampton Hospital and Capricorn Coast Hospital sites were undertaken. The outcome of this is an increase of $42 million in the net value of these assets. The impact of this is seen in the increase in the Buildings Revaluation Reserve. The revaluation process also supported that componentisation of these buildings would have a material impact on the depreciation rates of CQHHS buildings.

In 2013-2014 CQHHS total Assets administered grew to $397.2 million, up from $358.7 million in 2012-2013. This is primarily due to an increase of $36.4 million in Property, Plant and Equipment (PPE) relating to the commissioning of new buildings, purchases of clinical and non-clinical equipment and revaluation program for land and buildings. The reclassification of aged care facilities from Assets Held for Sale to PPE and their subsequent valuation (based on value in use rather than market value) resulted in further increases of $5.3 million.

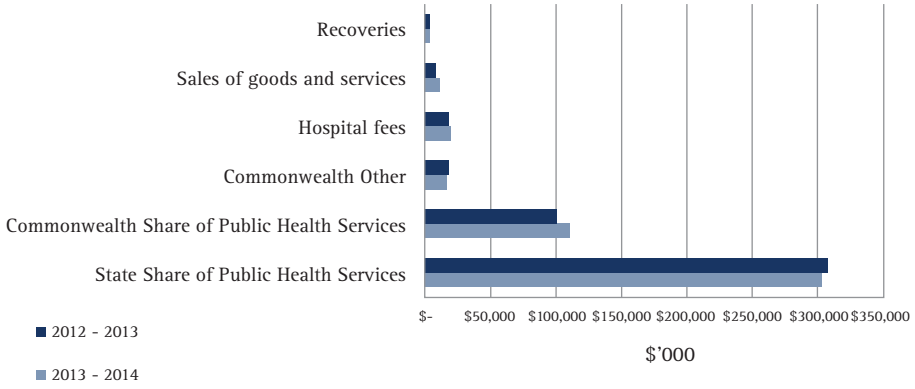
Key financial highlights are outlined in Table 1 below:

Key Financial Results	*2013-14 Actuals $'000*	*2012-13 Actuals $'000*	*2013-14 Target $'000*
Income	462,045	454,283	447,142
Expenses	464,036	435,548	447,142
Operating surplus/(deficit) after land decrement	**(1,991)**	**18,735**	**-**
Operating surplus/(deficit) before land decrement	**9,185**	**18,735**	**-**
Net revaluation movement on land and buildings	34,617	18,021	16,316
Cash and cash equivalents	48,429	39,645	32,439
Total Assets	397,202	358,708	383,905
Total Liabilities	31,231	28,168	33,978
Total Equity	**365,972**	**330,540**	**349,927**
Current Ratio	1.96	2.10	>=1.5
Quick Ratio	1.86	1.75	>1.0

7.1.1. Sources of funding

In providing services to the public, CQHHS's predominate source of revenue is public health service funding from both the State and Commonwealth Governments as well as own source revenues such as private patient fees. Chart 1 indicates all sources of funding and their contribution to total income for 2013-2014 in comparison to 2012-2013.

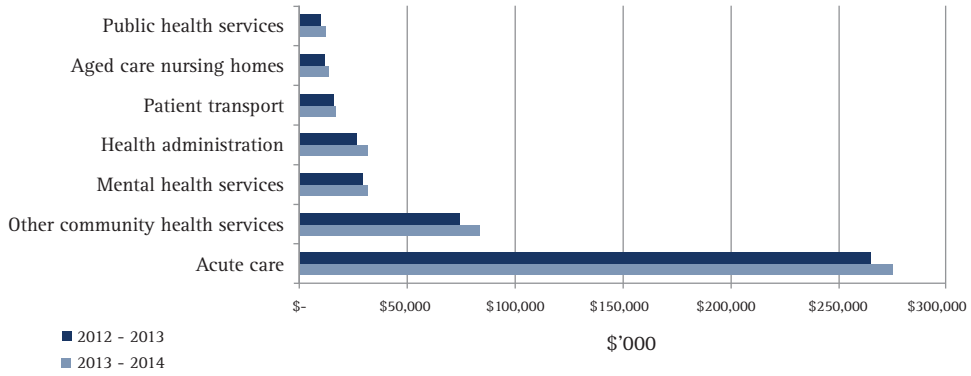
Chart 1: Sources of Funding Comparison



7.1.2. How the money was spent

The health service is responsible for the delivery of public hospital and health services in line with government priorities. The cost of these services for 2013-2014 are outlined in Chart 2 below. The health service is actively pursuing partnerships with the Central Queensland Medicare Local and GPs, as well as the private and non-government health sectors, to clarify its role in primary healthcare service delivery and to better configure its hospital and hospital-related services to improve health outcomes within the community.

Chart 2: Expenditure Program Comparison



7.1.3. Comparison of actual financial results with budget

CQHHS's actual performance in comparison to the previous year and its budget as published in the State Budget Papers 2013-2014 Service Delivery Statements are presented in the following tables with accompanying notes. *# Note where separate categories are not disclosed in financial statements due to materiality, budget has been reclassified to assist in comparative analysis.*

Table 2: Statement of comprehensive income for the year ended 30 June 2014

	Notes	2013-14 Actual	2012-13 Actual	2013-14 Budget	Actuals Variance	Actual v Budget Variance
		$'000	$'000	$'000	%	%
Income from Operations						
User Charges	1	29,647	24,227	22,193	22%	34%
Funding public health services*	8	409,841	405,772	-	1%	100%
Grants and other contributions	9	18,979	19,890	424,349	(4.6%)	(95.5%)
Other revenue	2, 10	3,578	4,394	600	(18.6%)	496%
Total income		462,045	454,283	447,142	2%	3%
Expenses from Operations						
Employee expenses	3, 11	1,947	1,403	523	39%	272%
Health service employee expenses		282,666	277,352	283,222	2%	0%
Supplies and services	4	140,819	132,920	142,905	6%	(1.5%)
Depreciation and amortisation	5	20,015	17,124	18,857	17%	6%
Other expenses	6, 12	7,413	6,750	1,635	10%	353%
Total Expenses pre valuation adjustment		452,860	435,548	447,142	4%	1%
Revaluation Decrement	7	11,176			100%	100%
Total Operating Results		(1,991)	18,735	-	(110.6%)	100%

Notes:

Major variations between 2013-2014 Actual and 2012-2013 Actual

1 Sales of goods and services increased primarily as a result of changes to funding arrangements between the Commonwealth and the State for high cost drugs. In 2012-2013 these funds were directly received by the Department of Health, and provided to CQHHS through public health service funding. Private billing by medical officers with right of private practice (ROPP) (Option A) were up 30% in 2013-2014 resulting in increased hospital fees.

2 2012-2013 other revenue was higher due to a one off adjustment on initial establishment of the health service's impairment policy. This resulted in a write back to the provision.

3 Higher employee expenses primarily reflects a termination payment to the Chief Operation Officer in 2013-2014 and the direct employment of a staff member previously employed by the Department (part of Health service employee expenses) .

4 Supplies and services in 2013-2014 were higher reflecting increased costs for electricity (tariff rates and usage) and patient travel (allowance rates doubled combined with a noticeable increase in the volume of patient claims). CQHHS increased outsourced services, particularly for oral health and medical services in the Capricorn Coast region to meet growing demand across the region. Overall drug and clinical supply costs increased commensaturate with higher levels of services/activity (WAU increased 2%) in 2013-2014.

5 Depreciation charges in 2013-2014 rose as a result of the introduction of building componentisation and additional depreciation on new medical equipment purchases.

6 2013-2014 was the first full year of internal audit function. This resulted in higher audit fees. In addition in 2013-2014 the health service wrote off obsolete equipment (high volume, low value items in storage and not used or not found at stocktake for two years) from the asset register.

7 2014 has seen a significant decline in land values representing the slowing of investment in the mining sector, infrastructure development and overall tightening in financing activities. This is the first year that comprehensive revaluations have been undertaken by the health service. Land was last comprehensively valued by the Department in 2010-11. Since then indicies have been applied.

8 & 9 At time of presentation of budget, public health funding was included in Grants. A separate category has now been established as this is a major source of funds for the health service.

10 Recoveries of health service employee expenses are disclosed as Other revenue for Actuals reporting. The 2013-2014 Budget had treated these transaction as a contra-expenditure.

11 The original budget included an allowance for the Chief Executive Officer and the Chief Finance Officer (2 FTE's) and was estimated before the formal structure of the Executive team had been established. There are currently 4 FTEs employed directly by the health service. This is essentially a reclassification between the categories of Employee expenses and Health service employee expense.

12 Reclassification of QGIF insurance premium from supplies and services to other expenses.

Table 3: Statement of financial position as at 30 June 2014

	Notes	2013-14 Actual	2012-13 Actual	2013-14 Budget	Actuals Variance	Actual v Budget Variance
		$'000	$'000	$'000	%	%
Current Assets						
Cash and cash equivalents	13	48,429	39,645	32,439	22%	49%
Receivables	14	8,343	9,080	3,125	(8.1%)	167%
Inventories	15	3,108	2,901	2,424	7%	28%
Other	16	1,434	610	590	135%	143%
		61,313	52,237	38,578	17%	59%
Assets classified as held for sale	17	-	6,959	-	(100.0%)	0%
Total Current Assets		61,313	59,195	38,578	4%	59%
Non-Current Assets						
Property, plant and equipment	18	335,889	299,513	345,327	12%	(2.7%)
Total Non-Current Assets		335,889	299,513	345,327	12%	(2.7%)
Total Assets		397,202	358,708	383,905	11%	3%
Current Liabilities						
Payables	19	31,231	28,168	33,978	11%	(8.1%)
Total Current Liabilities		31,231	28,168	33,978	11%	(8.1%)
Net Assets		365,972	330,540	349,927	11%	5%
Equity						
Contributed equity		285,412	293,784	333,611	(2.8%)	(14.4%)
Accumulated surplus/(deficit)		16,745	18,735	-	(10.6%)	100%
Asset revaluation surplus	20	63,814	18,021	16,316	254%	291%
Total Equity		365,972	330,540	349,927	11%	5%

Notes:

Major variations between 2013-2014 and 2012-2013 Actuals, and 2013-14 Actuals and Budget

13 Cash balances have increased reflecting cash generated from operating activities less outflows for capital purchases funded by the health service e.g. construction of Helipad and ICU beds at Rockhampton Campus. The 2013-2014 budget forecast minimal movements in cash from operating activities and all capital purchases were funded by the Department.

14 Private Patient billings (RoPP Option A) have increased significantly in 2014 reflecting a catchup in processing of backlog billings plus additional participation in the scheme by Senior Medical Officers. 2014 also includes accruals for reimbursement from the Queensland Government Insurance Scheme for the reconstruction of Woorabinda staff accomodation (destroyed by fire) and donations for the refurbishment of Gladstone theatre. Offsetting these increases was a decline in the amount of funding receivable from the Department for public health services. 2012-2013 funding included a one off payment for voluntary redundancies. Due to the timing of the 2013-2014 budget, the forecast did not include any of increases noted above. Funding receivables were not included in the Budget forecast.

15 Actual overall inventory stock levels remained constant in 2013-2014 except for clinical supplies which increased 20%, representing higher stock levels held by Rockhampton Hospital Operating Theatre, Rockhampton Emergency Dept and Gladstone Emergency Dept. Consistent with expenditure, clinical supplies increased in both price and items stocked reflecting current clinical practices at the hospitals. The 2013-2014 Budget assumed no growth in inventory levels and was based on 2012-2013 estimates (budget was 25% below actuals in 2012-2013)

16 Other current assets increased in 2013-2014 primarily as a result of the prepayment of a new medical services contract for Capricorn Coast Hospital. The 2013-2014 budget did not forecast growth in other current assets and was based on the 2012-2013 forecast position.

17 In 2012-2013, the health service announced its intention to divest of Aged Care facilities. These assets were classified as held for sale under AASB 5 at 30 June 2013. Subsequently DoH issued a policy clarifying where a HHS doesn't hold legal title, assets can not be classified as held for sale. The Aged Care facilities were reclassified back to PPE and inventory on 1 July 2013.

18 Revaluations in 30 June 2014 resulted in higher values for buildings partially offset by declines in land values. Impairments previously applied to aged care facilities were reversed in 2013-2014. In addition capital purchases in 2013-2014 included the commencement of construction on the Rockhampton hospital helipad/ICU ward, a rebuild of Woorabinda

staff accommodation and a significant replacement program for medical equipment. The Department transferred land and buildings to the health service including the newly completed Theodore Private Practice Clinic during 2013-2014. Partially offsetting these increases in capital were depreciation charges. A delay in commissioning of buildings has resulted in lower than forecast transfers (budget) from the Department of Health to the health service.

19 Payables increased reflecting higher volumes, outsourcing of services and higher prices experienced throughout the year. Invoices processed but not paid at 30 June 2014 increased 46% reflecting a large increase in the value of payments towards the end of the financial year (2013 payments were more evenly distributed throughout the year). Accruals for health service employee expenses increased reflecting the impact of EB increases 3% and an additional day accrued due to the timing of pay cutoffs at 30 June.

20 Revaluations at 30 June 2014 resulted in a decrease in land (47%) and increase in building (28%) values. For further information on land decrements see item 7 above. Increases in building values represent a change in the model applied when valuing these assets rather than real growth in costs. The budget revalued land and buildings using an index supplied by Treasury based on CPI.

7.1.4. Future outlook

Central Queensland Hospital and Health Service is committed to the provision of safe, quality, and cost effective care. A prime objective is to re-invest funds generated from efficiencies into key service initiatives. This is reflected in the decision to re-invest funds from the 2012 -13 operating surplus into the construction of a new Intensive Care Unit with additional bed capacity and a helipad on top of the New Ward Block building at Rockhampton Hospital. These will come on line during 2014-15 in conjunction with the commissioning of the Cancer Services Building.

The Health Service is committed to strengthening its performance framework through improved peer comparisons of service delivery. There is a strong drive for relevant dashboard reporting from "Ward to Board' that will enhance appropriate business decisions at all levels. Furthermore this stronger reporting will assist with highlighting potential issues early to allow prompt attention and management. These improvements will further drive efficiencies within the organisation with savings reinvested in improving service delivery and the creation of new services. Investment will be driven by the priorities identified in the Strategic Plan 2014-2018.

7.2. Financial review

General Information

These financial statements cover the Central Queensland Hospital and Health Service (CQHHS, Central Queensland HHS or Hospital and Health Service).

CQHHS was established on 1 July 2012 as a statutory body under the *Hospital and Health Boards Act 2011*.

The Hospital and Health Service is controlled by the State of Queensland which is the ultimate parent.

The head office and principal place of business of CQHHS is:
Rockhampton Hospital Campus
Canning Street
Rockhampton QLD 4700

A description of the nature of the Hospital and Health Service's operations and its principal activities is included in the notes to the financial statements.

For information in relation to the Hospital and Health Service's financial statement please visit the website www.health.qld.gov.au/cq.

Amounts shown in these financial statements may not add to the correct sub-totals or totals due to rounding.

7.2.1. Statement of Comprehensive Income for the year ended 30 June 2014

	Notes	2014 $'000	2013 $'000
Income from Continuing Operations			
User charges and fees	3	29,647	24,227
Funding public health services*	4	409,841	405,772
Grants and other contributions	5	18,979	19,890
Other revenue	6	3,578	4,394
Total revenue		462,045	454,283
Total Income from Continuing Operations		462,045	454,283
Expenses from Continuing Operations			
Employee expenses	7	1,947	1,403
Health service employee expenses	8	282,666	277,352
Supplies and services	9	141,350	132,920
Depreciation and amortisation	10	20,015	17,124
Other expenses	11	7,413	6,750
Revaluation decrement	12	11,176	-
Total Expenses from Continuing Operations		464,036	435,548
Operating Results from Continuing Operations		(1,991)	18,735
Other Comprehensive Income			
Items that will not be reclassified subsequently to Operating Result			
Increase/(decrease) in Asset Revaluation Surplus	20	45,793	18,021
Total items that will not be reclassified subsequently to Operating Result		45,793	18,021
Total Other Comprehensive Income		45,793	18,021
Total Comprehensive Income		43,803	36,755

**Comparatives have been adjusted to enhance disclosures of funding of public health services previously included in receipt of grants and other contributions. Refer Note 2 (ae).*

7.2.2. Statement of Financial Position as at 30 June 2014

	Notes	2014 $'000	2013 $'000
Current Assets			
Cash and cash equivalents	13	48,429	39,645
Receivables	14	8,343	9,080
Inventories	15	3,108	2,901
Other	16	1,434	610
		61,313	52,237
Assets classified as held for sale	17	-	6,959
Total Current Assets		61,313	59,195
Non-Current Assets			
Property, plant and equipment	18	335,889	299,513
Total Non-Current Assets		335,889	299,513
Total Assets		397202	358,708
Current Liabilities			
Payables	19	31,231	28,168
Total Current Liabilities		31,231	28,168
Total Liabilities		31,231	28,168
Net Assets		365,972	330,540
Equity			
Contributed equity*		285,412	293,784
Accumulated surplus/(deficit)*		16,745	18,735
Asset revaluation surplus	20	63,814	18,021
Total Equity		365,972	330,540

**Refer to Statement of Changes in Net Assets for further information.*

7.2.3. Statement of Changes in Equity for the year ended 30 June 2014

	Accumulated Surplus	Asset Revaluation Surplus (Note 22)	Contributed Equity	TOTAL
	$'000	$'000	$'000	$'000
Balance as at 1 July 2012	-	-	-	-
Operating Result from Continuing Operations	18,735	-	-	18,735
Other Comprehensive Income				
Increase in Asset Revaluation Surplus	-	18,021	-	18,021
Total Comprehensive Income for the year	18,735	18,021	-	36,756
Transactions with Owners as Owners:				
Net assets received (transferred during year via machinery-of-Government change) Note 2 (h)			12,513	12,513
Net assets received (transferred under Administrative Arrangement Note 2 (h) at 1 July 2012)	-	-	293,132	293,132
Equity injections (Minor Capital works) Note 2 (e)			5,123	5,123
Equity withdrawals (Depreciation funding) Note 2 (e)	-	-	(16,982)	(16,982)
Total changes to contributed equity	-	-	293,786	293,786
Balance as at 30 June 2013	18,735	18,021	293,786	330,540
Balance as at 1 July 2013	18,735	18,021	293,786	330,540
Operating Result from Continuing Operations	(1,991)	-	-	(1,991)
Other Comprehensive Income				
Increase in Asset Revaluation Surplus	-	45,793	-	45,793
Total Comprehensive Income for the Year	(1,991)	45,793	-	43,803
Transactions with Owners as Owners:				
Net assets received (transferred during year via machinery-of-Government change) Note 2 (h)	-	-	6,129	6,129
Equity injections (Minor Capital works) Note 2 (e)	-	-	5,508	5,508
Equity withdrawals (Depreciation funding) Note 2 (e)	-	-	(20,009)	(20,009)
Net Transactions with Owners as Owners	-	-	(8,372)	(8,372)
Balance as at 30 June 2014	16,745	63,814	285,412	365,972

7.2.4. Statement of Cash Flows for the year ended 30 June 2014

	Notes	2014 $'000	2013 $'000
Cash flows from operating activities			
Inflows:			
User charges and fees		27,468	34,403
Funding public health services*		392,718	384,627
Grants and other contributions		18,979	19,890
GST input tax credits from ATO		8,603	7,516
GST collected from customers		320	293
Other receipts		3,463	3,479
		451,550	450,208
Outflows:			
Employee expenses		(2,012)	(1,328)
Health service employee expenses		(281,143)	(267,814)
Supplies and services		(140,270)	(131,482)
GST paid to suppliers		(8,798)	(8,307)
GST remitted to ATO		(297)	(238)
Other		(6,918)	(6,478)
		(439,439)	(415,647)
Net cash provided by (used in) operating activities	21	12,111	34,561
Cash flows from investing activities			
Inflows:			
Sales of property, plant and equipment		23	15
Outflows:			
Payments for property, plant and equipment		(8,858)	(4,664)
Net cash provided by (used in) investing activities		(8,835)	(4,649)
Cash flows from financing activities			
Inflows:			
Cash transferred in under administrative arrangement		-	4,610
Equity Injections		5,508	5,123
Net cash provided by (used in) financing activities		5,508	9,733
Net increase/(decreased) in cash and cash equivalents		8,784	39,645
Cash and cash equivalents at the beginning of the financial year		39,645	-
Cash and cash equivalents at the end of the financial year		48,428	39,645

** Comparatives have been adjusted to enhance disclosures of funding of public health services previously included in receipt of grants and other contributions.*

7.2.5. Notes to and Forming Part of the Financial Statements 2013-2014

1. Objectives and Principal Activities of the Hospital and Health Service

Central Queensland Hospital and Health Service (CQHHS) was established on 1 July 2012, as a not-for-profit statutory body under the *Hospital and Health Boards Act 2011*.

The HHS is responsible for providing primary health, community and public health services in the area assigned under the H*ospital and Health Boards Regulation 2012*. The Central Queensland HHS covers an area of 114,000 square kilometres in regional Queensland, extending from Miriam Vale in the south, inland to the Central Highlands and north along the Capricorn Coast and services a resident population of approximately 230,000 which is culturally diverse and dispersed over a wide and largely rural geographical area.

This includes responsibility for the direct management of six hospital facilities, six multi-purpose health centres and five outpatient/primary health care clinics and two aged care facilities. Rockhampton Hospital is the main referral hospital, providing secondary level care, with referral to Brisbane for tertiary services.

Funding is obtained predominately through the purchase of health services by the Department of Health on behalf of both the State and Australian Governments. In addition, health services are provided on a fee for service basis mainly for private patient care.

CQHHS provides services and outcomes as defined in a publicly available service agreement with the Department of Health (as manager of the public hospital system).

2. Summary of Significant Accounting Policies

(a) Statement of Compliance

The Hospital and Health Service has prepared these financial statements in compliance with section 62 (1) of the *Financial Accountability Act 2009* and section 43 of the *Financial and Performance Management Standard 2009*.

These financial statements are general purpose financial statements, and have been prepared on an accrual basis in accordance with Australian Accounting Standards and Interpretations. In addition, the financial statements comply with Queensland Treasury and Trade's *Minimum Reporting Requirements* for the year ending 30 June 2014, and other authoritative pronouncements.

With respect to compliance with Australian Accounting Standards and Interpretations, as the Hospital and Health Service is a not-for-profit statutory body it has applied those requirements applicable to not-for-profit entities. Except where stated, the historical cost convention is used.

(b) The Reporting Entity

The financial statements include the value of all revenues, expenses, assets, liabilities and equity of Central Queensland Hospital and Health Service.

(c) Trust Transactions and Balances

The Hospital and Health Service acts in a fiduciary trust capacity in relation to patient trust accounts. Consequently, these transactions and balances are not recognised in the financial statements. Although patient funds are not controlled by CQHHS, trust activities are included in the audit performed annually by the Auditor-General of Queensland. Note 26 provides additional information on the balances held in patient trust accounts.

(d) User Charges and Fees

User charges and fees are recognised as revenues when earned and can be measured reliably with a sufficient degree of certainty. This involves either invoicing for related goods/services and/or the recognition of accrued revenue.

Revenue in this category primarily consists of hospital fees (private patients), reimbursements of pharmaceutical benefits, and sales of goods and services.

(e) Funding for Provision of Public Health Services

Funding revenue is received in accordance with Service Agreements with the Department of Health. The Department purchases delivery of health services based on nationally set funding and efficient pricing models determined by the Independent Hospital Pricing Authority (IHPA). The majority of services are funded on an activity unit basis. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by CQHHS.

Funding is received fortnightly in advance. At the end of the financial year, a financial adjustment may be required where the level of services provided is above or below the agreed level. State funding is also provided for depreciation and minor capital works. There has been a change in the recognition of Department of Health funding from Grants and Other contributions in 2012-2013 to Funding of Public Health Services this year, refer Note 2 (ae) for details.

IHPA was established to develop and specify national classifications for activity in public hospitals for the purposes of Activity Based Funding. It determines the national efficient price for services provided, on an activity basis, in public hospitals and develops data and coding standards to support uniform provision of data. In addition to this, IHPA determines block funded criteria and what other public hospital services are eligible for Commonwealth funding.

The Australian and State government contributions for activity based funding is pooled and allocated transparently via a National Health Funding Pool. The Australian and State government contributions for block funding and training, teaching and research funds is pooled and allocated transparently via a State Managed Fund. Block funding is provided for services which are outside the scope of Activity Based Funding Model. Public Health funding from the Australian government is managed by the Department of Health. The National Health Funding Body and National Health Funding Pool have complete transparency in reporting and accounting for contributions into and out of pool accounts. The Administrator is an independent statutory office holder, distinct from Federal and State departments.

Depreciation funding

CQHHS received $20 million funding in 2014 (2013: $17 million) from the Department of Health to cover depreciation costs. However as depreciation is a non-cash expenditure item, the Health Minister has approved a withdrawal of equity by the State for the same amount, resulting in a non-cash revenue and non-cash equity withdrawal.

Minor capital works

Purchases of equipment, furniture and fittings associated with capital works projects are managed by CQHHS. In 2014 CQHHS received $5.5 million (2013: $5.1 million) funding from the State as equity injections throughout the year. These funds are paid by the Department of Health on behalf of the State.

A review of the nature of service payments made to third parties and their subsequent disclosure was undertaken during 2013-2014. As a consequence of this review, and to ensure consistency in classification between the Department of Health and CQHHS, funding received from the Department has been reclassified from grant revenue to government funding revenue. Comparatives have been restated to improve transparency across the years.

(f) Grants and Other Contributions

Grants, contributions, donations and gifts that are non-reciprocal in nature are recognised as revenue in the year in which the Hospital and Health Service obtains control over them. Where grants are received that are reciprocal in nature, revenue is progressively recognised as it is earned, according to the terms of the funding arrangements.

Contributed assets are recognised at their fair value. Contributions of services are recognised only if the services would have been purchased if they had not been donated and their fair value can be measured reliably. Where this is the case, an equal amount is recognised as revenue and an expense.

CQHHS receives corporate services support from the Department of Health for no cost. Corporate services received include payroll services, accounts payable services, accounts receivable services, finance transactional services, taxation services, supply services and information technology services. As the fair value of these services is unable to be estimated reliably, no associated revenue and expense is recognised in the Statement of Comprehensive Income.

(g) Other Revenue

Other revenue primarily reflects recoveries of payments for contracted staff from third parties such as universities and other government agencies as well as recoveries of insurance claims from the Queensland Government Insurance Scheme.

(h) Administrative Arrangements

In 2012-2013, certain balances were transferred from the Department of Health to Hospital and Health Services. This was effected via a transfer notice signed by the Minister for Health, designating that the transfer be recognised as a contribution by owners through equity. The transfer notices were approved by the Director-General of the Department of Health and the Chairman and Chief Executive Officer of each Hospital and Health Board.

The value of assets and liabilities transferred to the Central Queensland Hospital and Health Service were as follows:

	2013
	$'000
Cash and cash equivalents	4,610
Receivables	13,644
Inventories	2,361
Other	482
Property, plant and equipment	288,533
Payables	(16,497)
Other financial liabilities	(1)
Contributed equity	293,132

CQHHS has the full right of use, managerial control of land and building assets and is responsible for maintenance. The Department generates no economic benefits from these assets. In accordance with the definition of control under Australian Accounting Standards, each Hospital and Health Service must recognise the value of these assets on their Statement of Financial Position.

Transfer of assets between Hospital and Health Services and the Department of Health

In 2014, the Minister for Health signed an enduring designation of transfer for property, plant and equipment between Hospital & Health Services (HHS) and the Department of Health. This transfer is recognised through equity when the Chief Finance Officers of both entities agree in writing to the transfer. During this year a number of assets have been transferred under this arrangement.

	2014	*2013*
	$'000	*$'000*
Transfer in - practical completion of projects from the Department *	4,998	12,497
Net transfer of property plant and equipment to/from the Department	1,067	-
Net transfers equipment between HHSs	64	-
	6,129	12,497

**Construction of major health infrastructure continues to be managed and funded by the Department of Health. Upon practical completion of a project, assets are transferred from the Department to the health service.*

(i) Special payments

Special payments include ex gratia expenditure and other expenditure that the HHS is not contractually or legally obligated to make to other parties. In compliance with the *Financial and Performance Management Standard 2009*, the HHS maintains a register setting out details of all special payments exceeding $5,000. The total of all special payments (including those of $5,000 or less) is disclosed separately within Other expenses (Note 11). However, descriptions of the nature of special payments are only provided for special payments greater than $5,000.

(j) Cash and Cash Equivalents

For the purposes of the Statement of Financial Position and the Statement of Cash Flows, cash assets include all cash and cheques receipted but not banked at 30 June as well as deposits at call with financial institutions and cash debit facility. CQHHS operational bank accounts form part of the Whole-of-Government banking arrangement with the Commonwealth Bank of Australia.

Debit facility
Hospital and Health Service has access to the Whole-of-Government debit facility with limits approved by Queensland Treasury and Trade.

(k) Receivables

Trade debtors are recognised at their carrying value less any impairment. The recoverability of trade debtors is reviewed on an ongoing basis at an operating unit level. Trade receivables are generally settled within 120 days, while other receivables may take longer than twelve months.

Impairment of financial assets

Throughout the year, CQHHS assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. Objective evidence includes financial difficulties of the debtor, changes in debtor credit ratings and current outstanding accounts over 120 days. The allowance for impairment reflects CQHHS's assessment of the credit risk associated with receivables balances and is determined based on historical rates of bad debts (by category) over the past three years and management judgement. Increases in the allowance for impairment are based on loss events as disclosed in Note 27 (c). All known bad debts are written off when identified.

(l) Inventories

Inventories consist mainly of medical supplies held for distribution in hospitals and are provided to public admitted patients free of charge except for pharmaceuticals which are provided at a subsidised rate. Inventories are valued at the lower of cost and net realisable value. Cost is assigned on a weighted average cost adjusted, where applicable, for any loss of service potential.

(m) Other non-financial assets

Other non-financial assets primarily represent prepayments by CQHHS. These include payments for rental and maintenance agreements, deposits and other payments of a general nature made in advance.

(n) Assets classified as held for sale

Assets held for sale consist of those assets that management has determined are available for immediate sale (highly probable within the next twelve months) in their present condition rather than through continuing use.

In accordance with *AASB 5 Non-current Assets Held for Sale and Discontinued Operations*, when an asset is classified as held for sale, its value is measured at the lower of the asset's carrying amount and fair value less costs to sell. Any restatement of the asset's value to fair value less costs to sell (in compliance with AASB 5) is a non-recurring valuation. Such assets are no longer amortised or depreciated upon being classified as held for sale.

As outlined in Note 2 (h), land and buildings under the operational control of CQHHS were transferred from the Department of Health under a Deed of Lease. As the Department continues to be the registered owner, CQHHS has a legal impediment to selling these assets. Where land and buildings are identified as held for sale by CQHHS, the Deed of Lease is partially surrendered and the assets are returned to the Department for sale. CQHHS, under the partial leasing arrangement is required to effectively maintain and operate these assets until their disposal.

(o) Property, Plant and Equipment

Acquisition

Actual cost is used for the initial recording of all non-current physical and intangible asset acquisitions. Cost is determined as the value given as consideration plus costs incidental to the acquisition, including all other costs incurred in getting the assets ready for use, including architects' fees and engineering design fees. However, any training costs are expensed as incurred. Items or components that form an integral part of an asset are recognised as a single (functional) asset.

Where assets are received free of charge from another Queensland Government entity (whether as a result of a machinery-of-Government change or other involuntary transfer), the acquisition cost is recognised as the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation. Assets acquired at no cost or for nominal consideration, other than from an involuntary transfer from another Queensland Government entity, are recognised at their fair value at the date of acquisition in accordance with AASB 116 *Property, Plant and Equipment*.

Central Queensland Hospital and Health Service holds property, plant and equipment in order to meet its core objective of providing quality healthcare that Queenslanders value.

Items of property, plant and equipment with a cost or other value equal to more than the following thresholds and with a useful life of more than one year are recognised at acquisition.

Items below these values are expensed on acquisition.

Class	Threshold
Buildings and Land Improvements	$10,000
Land	$1
Plant and Equipment	$5,000

Land improvements undertaken by the health service are included with buildings.

On 1 July 2012, the Minister for Health approved the transfer of land and buildings via a three year concurrent lease (representing its right to use the assets) to the HHS from the Department of Health. Under the terms of the lease no consideration in the form of a lease or residual payment by the HHS is required.

While the Department of Health retains legal ownership, effective control of these assets was transferred to the CQHHS. Under the terms of the lease the HHS has full exposure to the risks and rewards of asset ownership however proceeds from the sale of major infrastructure assets cannot be retained by CQHHS, with funds to be returned to Consolidated Fund (the State).

CQHHS has the full right of use, managerial control of land and building assets and is responsible for maintenance. The Department generates no economic benefits from these assets. In accordance with the definition of control under Australian Accounting Standards, each Hospital and Health Service must recognise the value of these assets on their Statement of Financial Position.

AASB 117 *Leased Assets* is not applicable to land and buildings, as no consideration in the form of lease payments are required under the agreement and accordingly fails to meet the criteria in section 4 of this standard for recognition.

(p) Revaluations of non-current physical assets

Land and buildings are measured at fair value in accordance with AASB 116 *Property, Plant and Equipment*, AASB 13 *Fair Value Measurement* and Queensland Treasury and Trade's *Non-Current Asset Policies for the Queensland Public Sector.* These assets are reported at their revalued amounts, being the fair value at the date of valuation, less any subsequent accumulated depreciation and impairment losses where applicable.

In respect of the above mentioned asset classes, the cost of items acquired during the financial year has been judged by management to materially represent their fair value at the end of the reporting period.

Plant and equipment, is measured at cost in accordance with the *Non-Current Asset Policies*. The carrying amounts for plant and equipment at cost should not materially differ from their fair value.

Land and building classes measured at fair value, are revalued on an annual basis either by comprehensive valuations or by the use of appropriate and relevant indices undertaken by independent professional valuers/quantity surveyors.

Comprehensive revaluations are undertaken at least once every five years. However if a particular asset class experiences significant and volatile changes in fair value (i.e. where indicators suggest that the value of the class has changed by 20% or more since the previous reporting period), that class is subject to specific appraisal in the reporting period, where practical, regardless of the timing of the last specific appraisal.

Assets under construction are not revalued until they are ready for use.

For financial reporting purposes, the revaluation process is jointly managed by the Financial Services Division and the Infrastructure and Support Services Division, who determine the specific revaluation practices and procedures. In 2013-2014 CQHHS established an Asset Valuation Steering Committee (chaired by the Chief Finance Officer) including external representatives from construction and property management services to oversee the revaluation processes.

The committee reviews revaluation practices and outcomes for 2013-2014, and reports to the Audit Committee regarding the outcomes of, and recommendations arising from, its review.

The fair values reported by CQHHS are based on appropriate valuation techniques that maximises the use of available and relevant observable inputs and minimise the use of unobservable inputs (refer to Note (q)).

Land is measured at fair value each year using either independent revaluations, desktop market revaluations or indexation by the State Valuation Service (SVS) within the Department of Natural Resources and Mines. Reflecting the specialised nature of health service buildings and on hospital-site residential facilities, fair value is determined using depreciated replacement cost methodology. Depreciated replacement cost is calculated by determining the cost to replicate the future service potential of the asset, adjusted for it's age and condition. Buildings are measured at fair value by applying either, a revised estimate of individual asset's depreciated replacement cost, or an interim index which approximates movement in market prices for labour and other key resource inputs. These estimates are developed by independent quantity surveyors.

Where assets have not been specifically appraised in the reporting period, their previous valuations are materially kept up-to-date via the application of an interim index which approximates fair value at reporting date.

Land Indices are based on actual market movements for each local government area issued by the Valuer-General. An individual factor change per property has been developed from review of market transactions, and has been endorsed by the Queensland Audit Office. The State Valuation Service undertakes investigation and research into each factor provided for the interim land indexation. All local government property market movements are reviewed annually by market surveys to determine any material change in values. Ongoing market investigations undertaken by SVS assists in providing an accurate assessment of the prevailing market conditions and detail the specific market movement applicable to each property.

The independent valuers/quantity surveyors provide assurance of their robustness, validity and appropriateness for application to the relevant assets.

Indices are reviewed for reasonableness by CQHHS. Where indices were based on observable market data, review of market sales and overall regional trends for similar properties was performed. Comparison of results with similar assets valued by an independent professional valuer or quantity surveyor, as well as analysing the trend of changes in values over time was undertaken. Through this annual process, management assesses and confirms the relevance and suitability of indices provided based on CQHHS's own particular circumstances.

In accordance with Queensland Treasury and Trade's *Non Current Asset Policies*, management has discretion in the application of interim indicies where the cumulative change impact is below 5%. In 2013 -14, interim indicies were not applied to buildings. For further details refer to Note 18.

Early in the reporting period, the HHS reviewed all fair value methodologies in light of the new principles in AASB 13. Some minor adjustments were made to methodologies to take into account the more exit-oriented approach to fair value under AASB 13, as well as the availability of more observable data for certain assets (e.g. Land and general purpose buildings). Such adjustments did not result in a material impact on the values for the affected property, plant and equipment classes.

Any revaluation increment arising on the revaluation of an asset is credited to the asset revaluation surplus of the appropriate class, except to the extent it reverses a revaluation decrement for the class previously recognised as an expense.

A decrease in the carrying amount on revaluation is charged as an expense, to the extent it exceeds the balance, if any, in the revaluation surplus relating to that asset class.

On revaluation, accumulated depreciation is restated proportionately with the change in the carrying amount of the asset and any change in the estimate of remaining useful life.

Materiality concepts under AASB 1031 *Materiality* are considered in determining whether the difference between the carrying amount and the fair value of an asset is material.

Separately identified components of assets are measured on the same basis as the assets to which they relate.

(q) Fair value measurement

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date under current market conditions (i.e. an exit price) regardless of whether that price is directly derived from observable inputs or estimated using another valuation technique.

Observable inputs are publicly available data that are relevant to the characteristics of the assets/ liabilities being valued, and include, but are not limited to, published sales data for land and residual dwellings.

Unobservable inputs are data, assumptions and judgements that are not available publicly, but are relevant to the characteristics of the assets/liabilities being valued. Significant unobservable inputs used by CQHHS include, but are not limited to, subjective adjustments made to observable data to take account of the specialised nature of health service buildings and on hospital-site residential facilities, including historical and current construction contracts (and/or estimates of such costs), and assessments of physical condition and remaining useful life. Unobservable inputs are used to the extent that sufficient relevant and reliable observable inputs are not available for similar assets/liabilities. Subjective adjustments are also made to observable data for land classified as reserve (by the Minister for a community purpose). Reserve land parcels are not sold and therefore there are no directly observable inputs. This land can only be sold when un-gazetted and converted to freehold by the State.

A fair value measurement of a non-financial asset takes into account a market participant's ability to generate economic benefit by using the asset in its highest and best use or by selling it to another market participant that would use the asset in its highest and best use.

All assets and liabilities of the HHS for which fair value is measured or disclosed in the financial statements are categorised within the following fair value hierarchy, based on the data and assumptions used in the most recent specific appraisals:

* level 1 - represents fair value measurements that reflect unadjusted quoted market prices in active markets for identical assets and liabilities;
* level 2 - represents fair value measurements that are substantially derived from inputs (other than quoted prices included in level 1) that are observable, either directly or indirectly; and
* level 3 - represents fair value measurements that are substantially derived from unobservable inputs.

None of CQHHS's valuations of assets or liabilities are eligible for categorisation into level 1 of the fair value hierarchy. As 2013-2014 is the first year of application of AASB 13 by CQHHS, there were no transfers of assets between fair value hierarchy levels during the period. More specific fair value information about the HHS's property, plant and equipment is outlined in Note 18.

(r) Depreciation

Property, plant and equipment are depreciated on a straight-line basis. Annual depreciation is based on fair values and CQHHS's assessments of the useful remaining life of individual assets. Land is not depreciated as it has an unlimited useful life.

Assets under construction (work-in-progress) are not depreciated until they reach service delivery capacity. Service delivery capacity relates to when construction is complete and the asset is first put to use or is installed ready for use in accordance with its intended application. These assets are then reclassified to the relevant classes within property plant and equipment.

Where assets have separately identifiable components, subject to regular replacement, components are assigned useful lives distinct from the asset to which they relate and depreciated accordingly. In accordance with Queensland Treasury and Trade's *Non-current Asset Policy Guideline 2*, CQHHS has determined all specialised health service buildings (material by value) are complex in nature and warrant componentisation (separate useful lives assigned to component parts). These building comprise three components:

- Structural shell
- Fitout
- Services including plant

Useful lives are disclosed as part of depreciation table below and are amended progressively as part of the asset revaluation process (when inspected by the valuer) or when sigificant elements within a component are replaced. Any expenditure that increases the originally assessed capacity or service potential of an asset is capitalised and the new depreciable amount is depreciated over the remaining useful life of the asset. The written down value of the replaced element/s (original value) is deducted from the asset value. Where the replacement forms part of a planned refurbishment program, accelerated depreciation is applied to approximate remaining useful life. Major spares purchased specifically for particular assets are capitalised and depreciated on the same basis as the asset to which they relate. The depreciable amount of improvements to or on leasehold land is allocated progressively over the shorter of the estimated useful lives of the improvements or the unexpired period of the lease. The unexpired period of leases includes any option period where exercise of the option is probable.

For each class of depreciable assets, the following range of depreciation rates were used:

Class	Depreciation rates
Buildings and Improvements	
- Shell	1-3%
- Fitout	2-5%
- Services	2-4%
- Land improvements	1-4%
- Other buildings including residential	1-5%
Plant and equipment	1-20%

Leased property, plant and equipment

Operating lease payments, being representative of benefits derived from the leased assets, are recognised as an expense of the period in which they are incurred. AASB 117 *Leased Assets* is not applicable to land and buildings, currently under a Deed of Lease with the Department of Health, as no consideration in the form of lease payments are required under the agreement. CQHHS has no other assets subject to finance lease.

(s) Impairment of non-current assets

All non-current and intangible assets are assessed for indicators of impairment on an annual basis in accordance with AASB 136 *Impairment of Assets*. If an indicator of possible impairment exists, CQHHS determines the asset's recoverable amount (higher of value in use and fair value less costs to sell). Any amount by which the asset's carrying amount exceeds the recoverable amount is considered an impairment loss. An impairment loss is recognised immediately in the Statement of Comprehensive Income, unless the asset is carried at a revalued amount, in which case the impairment loss is offset against the asset revaluation surplus of the relevant class to the extent available.

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of its recoverable amount, but so that the increased carrying amount does not exceed the carrying amount that would have been determined had no impairment loss been recognised for the asset in prior years. A reversal of an impairment loss is recognised as income, unless the asset is carried at a revalued amount, in which case the reversal of the impairment loss is treated as a revaluation increase. Refer also Note 2 (p).

(t) Payables

Payables are recognised for amounts to be paid in the future for goods and services received. Trade creditors are measured at the agreed purchase/contract price, gross of applicable trade and other discounts. The amounts are unsecured and normally settled within 30 - 60 days.

(u) Financial instruments

Recognition

Financial assets and financial liabilities are recognised in the Statement of Financial Position when CQHHS becomes party to the contractual provisions of the financial instrument.

Classification

Financial instruments are classified and measured as follows:

- Cash and cash equivalents - held at fair value through profit or loss
- Receivables - held at amortised cost
- Payables - held at amortised cost

Central Queensland Hospital and Health Service does not enter into transactions for speculative purposes, nor for hedging. Apart from cash and cash equivalents, the HHS holds no financial assets classified at fair value through profit and loss. All other disclosures relating to the measurement and financial risk management of financial instruments held by CQHHS are include in Note 27.

(v) Employee benefits and Health service employee expenses

Under section 20 of the *Hospital and Health Boards Act 2011* (HHB Act) - a Hospital and Health Services can employ health executives, and (where regulation has been passed for the HHS to become a prescribed service) a person employed previously in the department, as a health service employee. Where a HHS has not received the status of a "prescribed service", non executive staff working in a HHS legally remain employees of the Department of Health.

(i) Health service employee expenses

In 2013-2014 the Central Queensland Hospital and Health Service was not a prescribed service and accordingly all non-executive staff were employed by the department. Provisions in the HHB Act enable HHS to perform functions and exercise powers to ensure the delivery of its operational plan.

Under this arrangement: - The department provides employees to perform work for the HHS, and acknowledges and accepts its obligations as the employer of these employees.

- The HHS is responsible for the day to day management of these departmental employees.
- The HHS reimburses the department for the salaries and on-costs of these employees.

As a result of this arrangement, the Hospital and Health Service treats the reimbursements to the Department of Health for departmental employees in these financial statements as health service labour expenses and detailed in Note 8.

In addition to the employees contracted from the Department of Health, the Hospital and Health Service has engaged employees directly. The information detailed below relates specifically to the directly engaged employees.

(ii) Hospital and Health Service's directly engaged employees

CQHHS classifies salaries and wages, rostered days-off, sick leave, annual leave and long service leave levies and employer superannuation contributions as employee benefits in accordance with AASB 119 *Employee Benefits* (Note 7). Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at current salary rates. As CQHHS expects such liabilities to be wholly settled within 12 months of reporting date, the liabilities are recognised at undiscounted amounts.

Prior history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised. As sick leave is non-vesting, an expense is recognised for this leave as it is taken.

Payroll tax and workers' compensation insurance are a consequence of employing employees, but are not counted in an employee's total remuneration package. They are not employee benefits and are recognised separately as employee related expenses.

(v) Employee benefits and Health service employee continued

Annual leave

The Queensland Government's Annual Leave Central Scheme (ALCS) became operational on 30 June 2008 for departments, commercial business units, shared service providers and selected not for profit statutory bodies. CQHHS was admitted into this arrangement effective 1 July 2012. Under this scheme, a levy is made on CQHHS to cover the cost of employee's annual leave (including leave loading and on-costs).

The levies are expensed in the period in which they are payable. Amounts paid to employees for annual leave are claimed from the scheme quarterly in arrears. The Department of Health centrally manages the levy and reimbursement process on behalf of all HHS. No provision for annual leave is recognised in CQHHS' financial statements as the liability is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting.*

Long Service Leave

Under the Queensland Government's Long Service Leave Scheme, a levy is made on CQHHS to cover the cost of employees' long service leave. The levies are expensed in the period in which they are payable. Amounts paid to employees for long service leave are claimed from the scheme quarterly in arrears. The Department of Health centrally manages the levy and reimbursement process on behalf of the HHS. No provision for long service leave is recognised in the HHS' financial statements as the liability is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting.*

Superannuation

Employer superannuation contributions are paid to QSuper, the superannuation scheme for Queensland Government employees, at rates determined by the Treasurer on the advice of the State Actuary. Contributions are expensed in the period in which they are paid or payable and CQHHS's obligation is limited to its contribution to QSuper. The QSuper scheme has defined benefit and defined contribution categories. The liability for defined benefits is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting.*

Board members and Visiting Medical Officers are offered a choice of superannuation funds and CQHHS pays superannuation contributions into a complying superannuation fund. Contributions are expensed in the period in which they are paid or payable. CQHHS's obligation is limited to its contribution to the superannuation fund. Therefore no liability is recognised for accruing superannuation benefits in the Hospital and Health Service's financial statements.

Key management personnel and remuneration

Key management personnel and remuneration disclosures are made in accordance with *section 5* of the *Financial Reporting Requirements* for Queensland Government Agencies issued by Queensland Treasury and Trade. Refer to Note 28 for the disclosures on key executive management personnel and remuneration.

(w) Unearned revenue

Monies received in advance primarily for rental income and fees for services yet to be provided are represented as unearned revenue.

(x) Insurance

The Department of Health insures property and general losses above a $10,000 threshold through the Queensland Government Insurance Fund (QGIF). Health litigation payments above a $20,000 threshold and associated legal fees are also insured through QGIF. QGIF collects from insured agencies an annual premium intended to cover the cost of claims occurring in the premium year.

The Insurance Arrangements for Public Health Entities Health Service Directive (directive number QH-HSD-011:2012) enables Hospital and Health Services to be named insured parties under the department's policy. For the 2013-2014 policy year, the premium was allocated to each HHS according to the underlying risk of an individual insured party. The Hospital and Health Service premiums cover claims from 1 July 2012, pre 1 July 2012 claims remain the responsibility of the department, however CQHHS must pay the $20,000 excess payment on these claims.

Queensland Health pays premiums to WorkCover Queensland on behalf of all Hospital and Health Services in respect of its obligations for employee compensation. These costs are reimbursed to the department.

(y) Contributed equity

Non-reciprocal transfers of assets and liabilities between wholly-owned Queensland Government entities as a result of machinery-of-Government changes are adjusted to Contributed Equity in accordance with Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities.*

(z) Federal taxation charges

CQHHS is a State body as defined under the *Income Tax Assessment Act 1936* and is exempt from Commonwealth taxation with the exception of Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). The Australian Taxation Office has recognised the Department of Health and the seventeen Hospital and Health Services as a single taxation entity for reporting purposes.

All FBT and GST reporting to the Commonwealth is managed centrally by the department, with payments/ receipts made on behalf of the CQHHS reimbursed to/from the department on a monthly basis. GST credits receivable from, and GST payable to the ATO, are recognised on this basis. Refer to Note 14.

(aa) Issuance of Financial Statements

The financial statements are authorised for issue by the Chairman of the Hospital and Health Service, the Chief Executive and the Chief Financial Officer at the date of signing the Management Certificate.

(ab) Critical accounting judgements and key sources of estimation uncertainty

The preparation of financial statements necessarily requires the determination and use of certain critical accounting estimates, assumptions and management judgements that have the potential to cause a material adjustment to the carrying amounts of assets and liabilities within the next financial year . Such estimates, judgements and underlying assumptions are reviewed on an ongoing basis, historical experience and other factors that are considered to be relevant. Revisions to accounting estimates are recognised in the period in which the estimate is revised and future periods as relevant.

Estimates and assumptions that have a potential significant effect are outlined in the following financial statement notes:

- Property, plant and equipment – Note 18
- Contingencies – Note 24

The Australian government passed its *Clean Energy Act* in November 2011 which resulted in the introduction of a price on carbon emissions made by Australian businesses from 1 July 2012.

The withdrawal of the carbon pricing mechanism by the government in July is not expected to have a significant impact on CQHHS's critical accounting estimates, assumptions and management judgements.

(ac) Rounding and comparatives

Amounts included in the financial statements are in Australian dollars and have been rounded to the nearest $1,000 or, where that amount is $500 or less, to zero, unless disclosure of the full amount is specifically required.

Comparative information has been restated where necessary to be consistent with disclosures in the current reporting period. In particular, separate disclosure of funding for public health services (Note 4), previously part of Note 5 Grants and other contributions has resulted in comparative figures being restated.

(ad) New and revised accounting standards

Central Queensland Hospital and Health Service did not voluntarily change any of its accounting policies during 2013-2014 except as outlined in Note 2 (ae). The only Australian Accounting Standard changes applicable for the first time as from 2013-2014 that have had a significant impact on the HHS's financial statements are those arising from AASB 13 *Fair Value Measurement*, as explained below.

AASB 13 *Fair Value Measurement* became effective from reporting periods beginning on or after 1 January 2013. AASB 13 sets out a new definition of 'fair value' as well as new principles to be applied when determining the fair value of assets and liabilities. The new requirements apply to all of the HHS's assets and liabilities (excluding leases) that are measured and/or disclosed at fair value or another measurement based on fair value. The impact of AASB 13 relate to the fair value measurement methodologies used and financial statement disclosures made in respect of such assets and liabilities.

CQHHS reviewed its fair value methodologies (including instructions to valuers, data used and assumptions made) for land and buildings measured as fair value to assess whether those methodologies comply with AASB13. To the extent that the methodologies didn't comply, changes were made and applied to the valuations. None of the changes to valuation methodologies resulted in material differences from the previous methodologies.

AASB13 has required an increased amount of information to be disclosed in relation to fair value measurements for both assets and liabilities. For those fair value measurements of assets or liabilities that substantially are based on data that is not 'observable' (i.e. accessible outside the HHS), the amount of information disclosed has significantly increased. Note 2 (q) explains some of the principles underpinning the additional fair value information disclosed. Most of this additional information is set out in Note 18 Property Plant and Equipment.

A revised version of AASB 119 *Employee Benefits* became effective for reporting periods beginning on or after 1 January 2013 with the majority of changes to be applied retrospectively. Given CQHHS's circumstances, the only implication for the HHS were the revised concept of 'termination benefits' and the revised recognition criteria for termination benefit liabilities. If termination benefits meet the timeframe criterion for 'short-term employee benefits' they will be measured according to the AASB119 requirements for "short-term employee benefits'. Otherwise, termination benefits need to be measured according to the AASB 119 requirements for 'other long-term employee benefits'. Under the revised standard, the recognition and measurement of employer obligations for 'other long-term employee benefits' will need to be accounted for according to most of the requirements for defined benefit plans.

The revised AASB 119 includes changed criteria for accounting for employee benefits as 'short-term employee benefits'. However, as the HHS is a member of the Queensland Government central schemes for annual leave and long service leave this change in criteria has no impact on the HHS's financial statements as the employer liability is held by the central scheme. The revised standard also includes changed requirements for the measurement of employer liabilities/assets arising from defined benefit plans, and the measurement and presentation of changes in such liabilities and assets. CQHHS makes employer superannuation contributions only to the QSuper defined benefit plan, and the corresponding QSuper employer benefit obligation is held by the State. Therefore, those changes to AASB119 will have no impact on the HHS.

AASB 1053 *Application of Tiers of Australian Accounting Standards* became effective for reporting periods beginning on or after 1 July 2013. AASB 1053 establishes a differential reporting framework for those entities that prepare general purpose financial statements, consisting of two Tiers of reporting requirements - Australian Accounting Standards (commonly referred to as 'Tier 1'), and Australian Accounting Standards - Reduced Disclosure Requirements (commonly referred to as 'Tier 2'). Tier 1 requirements comprise the full range of AASB recognition, measurement, presentation and disclosure requirements that are currently applicable to reporting entities in Australia. The only difference between the Tier 1 and Tier 2 requirements is that Tier 2 requires fewer disclosures than Tier 1.

Pursuant to AASB 1053, public sector entities like CQHHS may adopt Tier 2 requirements for their general purpose financial statements. However, AASB 1053 acknowledges the power of a regulator to require application of the Tier 1 requirements. In the case of CQHHS, Queensland Treasury and Trade is the regulator. Queensland Treasury and Trade has advised that it is its policy decision to require adoption of Tier 1 reporting by all Queensland government departments and statutory bodies (including CQHHS) that are consolidated into the whole-of-Government financial statements. Therefore, the release of AASB 1053 and associated amending standards has had no impact on CQHHS.

Central Queensland Hospital and Health Service is not permitted to early adopt a new or amended accounting standard ahead of the specified commencement date unless approval is obtained from Queensland Treasury and Trade. Consequently, the CQHHS has not applied any Australian Accounting Standards and Interpretations that have been issued but are not yet effective. CQHHS applies standards and interpretations in accordance with their respective commencement dates.

At the date of authorisation of the financial report, the following new or amended Australian Accounting Standards are expected to impact on the Central Queensland Hospital and Health Service in future periods. The potential effect of the revised Standards and Interpretations on the Hospital and Health Service's financial statements is not expected to be significant but a full review has not yet been completed.

Standards effective for annual periods beginning on or after 1 July 2014:

- AASB *1055 Budgetary Reporting* applies to reporting periods beginning on or after 1 July 2014. CQHHS will need to include in its 2014-15 financial statements the original budgeted figures from the Income Statement, Balance Sheet, Statement of Changes in Equity, and Cash Flow Statement as published in the 2014-15 Queensland Government's Service Delivery Statements. The budgeted figures will need to be presented consistently with the corresponding (actual) financial statements, and will be accompanied by explanations of major variances between the actual amounts and the corresponding original budgeted figures.

The following new and revised standards apply as from reporting periods beginning on or after 1 January 2014:

- *AASB 10 Consolidated Financial Statements;*
- *AASB 11 Joint Arrangements;*
- *AASB 12 Disclosure of Interests in Other Entities;*
- *AASB 127 (revised) Separate Financial Statements;*
- *AASB 128 (revised) Investments in Associates and Joint Ventures;*
- *AASB 2011-7 Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards [AASB 1, 2, 3, 5, 7, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 1023 & 1038 and Interpretations 5, 9, 16 & 17]; and*
- *AASB 2013-8 Amendments to Australian Accounting Standards - Australian Implementation Guidance for Not-for-Profit Entities - Control and Structured Entities.*

AASB 10 redefines and clarifies the concept of control of another entity, and is the basis for determining which entities should be consolidated into an entity's financial statements. AASB 2013-8 applies the various principles in AASB 10 for determining whether a not-for-profit entity controls another entity. On the basis on those accounting standards, CQHHS has reviewed the nature of its relationships with entities that the HHS is connected with to determine the impact of AASB 2013-8. Currently CQHHS does not have control over any other entities.

AASB 11 deals with the concept of joint control and sets out new principles for determining the type of joint arrangement that exist, which in turn dictates the accounting treatment. The new categories of joint arrangements under AASB 11 are more aligned to the actual rights and obligations of the parties to the arrangement. CQHHS has assessed its arrangements with other entities to determine whether a joint arrangement exists in terms of AASB 11. Based on present arrangements, no joint arrangements exist. However, if a joint arrangement does arise in the future, CQHHS will need to follow the relevant accounting treatment specified in either AASB 11 or the revised AASB 128, depending on the nature of the joint arrangement.

AASB 9 *Financial Instruments* and AASB 2010-7 *Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Interpretations 2, 5, 10, 12,19 & 127]* will become effective for reporting periods beginning on or after 1 January 2017.

The main impacts of these standards on CQHHS are that they will change the requirements for the classification, measurement and disclosures associated with CQHHS's financial assets. Under the new requirements, financial assets will be more simply classified according to whether they are measured at amortised cost or fair value. Pursuant to AASB 9, financial assets can only be measured at amortised cost if two conditions are met. One of these conditions is that the asset must be held within a business model whose objective is to hold assets in order to collect contractual cash flows. The other condition is that the contractual terms of the asset give rise to cash flows that are solely payments of principal and interest on the principal amount outstanding. The only financial asset currently disclosed at amortised cost is receivables and as they are short term in nature, the carrying amount is expected to be a reasonable approximation of fair value so the impact of this standard is minimal. For financial liabilities which are designated as at fair value through profit or loss, the amount of change in fair value that is attributable to changes in the liability's credit risk will be recognised in other comprehensive income.

All other Australian accounting standards and interpretations with new or future commencement dates are either not applicable to CQHHS's activities, or have no material impact on CQHHS.

(ae) Voluntary change in accounting policy

CQHHS has made a voluntary change in accounting policy for the recognition of funding provided by the Department of Health under a service agreement. The service agreement specifies those public health services purchased by the Department from CQHHS.

In 2012-2013 the Department of Health provided this funding as grant payments but for 2013-2014 has determined that the payment is not of a grants nature but rather is procurement of public health services. Specific public health services are received by the Department under a service agreement and the Department has determined that it receives approximately equal value for the payment provided, and directly receives an intended benefit.

To align with this basis of funding provided by the Department of Health, CQHHS now recognises $409 million as Government funding revenue for 2013-2014 rather than as grants revenue which occurred in 2012-2013. The main effect is that the revenue is now recognised under the criteria detailed in AASB118 *Revenue* for 2013-2014, rather than under AASB 1004 *Contributions* in 2012-2013. The revenue recognition criteria is described in Note 2 (e) Funding Public Health Services and Note 2 (f) Grants and Other Contributions.

This change in accounting policy has been applied retrospectively with the effect that grants and other contributions revenue for 2012-2013 has reduced by $405 million and funding public health services has increased by the same amount.

A review of the balance of funding revenue (5%) currently classified as Grants and Other Contributions will be undertaken in 2014-15.

(af) Other Events

Payroll system

Whilst employees are currently paid under a service arrangement using the Department of Health's payroll system, the responsibility for the efficiency and effectiveness of this system remains with the department.

(ag) Subsequent events

Hospital and Health Services to be prescribed as employers

Currently, all staff, except Health Service Chief Executives and health executive service (HES) employees (working in an HHS), are employed by the Director-General, Department of Health. In June 2012, amendments were made to the Hospital and Health Boards Act 2011, giving Hospital and Health Boards more autonomy by allowing them to become the employer of staff working for their HHS. HHSs are prescribed as employers by regulation.

Once an HHS becomes prescribed to be the employer, all existing and future staff working for the HHS become its employees. The HHS, not the Department of Health, will recognise employee expenses in respect of these staff. The Director-General, Department of Health, will continue to be responsible for setting terms and conditions of employment, including remuneration and classification structures, and for negotiating enterprise agreements.

CQHHS is expected to be prescribed on 1 July 2015.

Senior Medical Officer and Visiting Medical Officer Contracts

Effective 4 August 2014, Senior Medical Officers and Visiting Medical Officers will transition to individual employment contracts. Individual contracts mean senior doctors will have a direct employment relationship with their HHS and employment terms and conditions tailored to individual or medical specialty circumstances (within a consistent state-wide framework).

As a direct employment relationship will be established between contracted medical officers and their HHS, employee-related costs for contracted Senior Medical Officers and Visiting Medical Officers will be recognised by the employing HHS (not the Department) from the date the contracts are effective. Non-contracted Senior Medical Officers and Visiting Medical Officers will remain employed under current award arrangements. Whilst CCHHS is not a prescribed employer, they will continue to be employed by the Department of Health.

Transfer of legal ownership of health service land and buildings to HHSs

Commencing 1 July 2014, the legal title of health service land and buildings will progressively transfer from the department to HHSs. Refer to Note 2 (o). As CQHHS currently control these assets, through Deed of Lease arrangements, there will be no material impact to the accounts of CQHHS upon transfer. Buildings which are currently used by the Department which reside on CQHHS land will be leased back to the Department. Legal title transfer is currently expected to occur on 1 July 2015, allowing sufficient time for the development of capacity and capability as effective asset managers within CQHHS.

Transfer of general purpose housing to the Department of Housing and Public Works

As part of a whole-of-Government initiative, management of all non-operational housing transitioned to the Department of Housing and Public Works (DHPW) on 1 January 2014. Legal ownership of housing assets will transfer to the DHPW on 1 July 2014.

At 30 June 2014, CQHHS held non-operational housing assets with a total net book value of $10 million under a Deed of Lease arrangement with the Department of Health. Effective 1 July 2014, the Deed of Lease arrangement in respect of these assets will cease, and the assets will be transferred to the Department of Heath at their net book value, prior to their subsequent transfer to the DHPW. This transfer will be designated as a Contribution by Owners and will be undertaken through CQHHS's equity account. It will not impact on the Statement of Comprehensive Income in the 2014-15 financial year.

Other matters

No other matter or circumstance has arisen since 30 June 2014 that has significantly affected, or may significantly affect CQHHS's operations, the results of those operations, or the HHS's state of affairs in future financial years.

3. User charges and fees

	2014	*2013*
	$'000	*$'000*
Sales of goods and services	10,247	6,237
Hospital fees	19,112	17,761
Rental income	288	230
	29,647	24,227

4. Funding public health services

	Share of funding		*2014*	*2013*
	State	Australian Government	*$'000*	*$'000*
*National Health Reform**				
Activity based funding	162,125	83,752	245,877	200,236
Block funding	43,100	25,192	68,292	91,716
Teacher Training funding	1,646	980	2,625	14,331
General purpose funding	93,047	-	93,047	99,488
Total National Health Reform funding			409,841	405,772

* - refer Note 2 (e). The Australian Government pays its share of National Health funding directly to the Department of Health, for on forwarding to the Hospital and Health Service.

5. Grants and other contributions

	2014	*2013*
	$'000	*$'000*
Australian Government grants		
Nursing home grants*	9,747	9,881
Home and community care grants*	443	2,394
Specific purpose - Multipurpose centre^	3,535	3,461
Specific purpose payments	2,420	2,495
Total Australian Government grants	16,145	18,232
Other		
Other grants	2,835	1,658
	18,979	19,890

*As an approved provider of aged care services, CQHHS received funding from the Australian Government under the *Aged Care Act 1997*. This funding is dependent on the number of approved places and clients, with subsidies determined in accordance with Aged Care Funding Instruments (ACFI) administered by Medicare.

^CQHHS received subsidies for a number of rural community multipurpose health centres under a jointly funded program between the State and Commonwealth government. The Australian Government's contribution is paid in the form of a flexible care subsidy as determined under section *52-1* of the *Aged Care Act 1997* and is paid in accordance with the *Flexible Care Subsidy Principles 1997*.

6. Other revenue

	2014	2013
	$'000	$'000
Sale proceeds for assets	22	10
Licences and registration charges	30	29
Recoveries	2,244	3,097
Insurance compensation from loss of property	960	73
Reversal impairment loss*	-	873
Other	322	313
	3,578	4,394

*The approach adopted by CQHHS for impairment allowance on receivable balances differed from that previously applied by the Department of Health (balances transferred in on 1 July 2012) which provided for all outstanding accounts over 60 days. This resulted in a one off reversal of impairment loss of $873,117 in 2012-2013.

7. Employee expenses

		2014	2013
		$'000	$'000
Employee benefits			
Wages and Salaries		1,264	1,030
Annual leave levy*		97	141
Employer superannuation contributions*		138	108
Long service leave levy*		21	17
Termination benefits		228	2
Employee related expenses			
Workers compensation premium		36	6
Payroll tax		67	52
Other employee related expense		96	47
	*	1,947	1,403

Employee expenses represent the cost of engaging board members and the employment of Health Executives who are employed directly by the HHS.

The number of employees including both full-time employees and part-time employees measured on a full-time equivalent basis (reflecting Minimum Obligatory Human Resource Information (MOHRI)) is:

Number of Employees*	4	5

* Refer to Note 2(v).

Key executive management and personnel are reported in Note 28.

8. Health service employee expenses

	2014	2013
	$'000	$'000
Department of Health - health service employees*	282,666	277,352

The Hospital and Health Service through service arrangements with the Department of Health has engaged 2,585 (2013: 2,548) full-time equivalent persons. Refer to Note 2 (v) (i) for further details on the contractual arrangements.

9. Supplies and services

	2014 $'000	2013 $'000
Consultants and contractors	36,880	36,650
Electricity and other energy	5,570	4,279
Patient travel#	23,439	21,213
Other travel	1,106	1,194
Building services	1,905	1,704
Computer services	1,874	1,511
Motor vehicles	412	520
Communications	2,858	2,817
Repairs and maintenance	6,347	6,504
Minor works including plant and equipment	872	1,065
Operating lease rentals	3,957	4,187
Inventories held for distribution		
Drugs	13,080	12,259
Clinical supplies and services	20,565	17,480
Catering and domestic supplies	5,034	4,916
Pathology, blood and parts	10,885	11,465
Other	6,036	5,157
	140,819	132,920

Includes payments for aeromedical services provided by Royal Flying Doctors and ambulance fees.

10. Depreciation and amortisation

		2014 $'000	2013 $'000
Depreciation and amortisation expenses for the financial year were charged in respect of:			
Buildings and land improvements		14,609	12,365
Plant and equipment		5,406	4,759
	*	20,015	17,124

Queensland Treasury and Trade's *Non Current Asset Policy (No 2)* requires where significant components of a building are replaced at varying intervals i.e. different useful lives, and the impact is material to depreciation expense, componentisation is to be applied.

An assessment of the actual replacement cycle for components within special purpose buildings (representing 82% of buildings controlled by CQHHS) and the impact on depreciation expense was undertaken in 2013-2014 with material differences in depreciation noted. Accordingly in 2014, twenty five complex buildings were comprehensively revalued. Useful lives were reassessed by the valuer (based on physical inspection and review of replacement history) replacing a single useful life for the entire building with three useful lives (one per major component) reflecting the consumption and replacement patterns within CQHHS. The impact of this resulted in depreciation expense increasing $1.9 million. Refer Note 2 subsection r.

Depreciation expense on buildings and land improvements increased by $0.8 million as a result of revaluations as at the end of the previous reporting period.
* Refer Note 18

11. Other expenses

	2014	*2013*
	$'000	*$'000*
External audit fees*	446	89
Insurance**	5,206	5,163
Insurance premiums - Other#	38	63
Losses from the disposal of non-current assets	239	79
Special payments - ex-gratia payments		
Ex-gratia payments	-	11
Out-of-court settlements***	140	-
Other legal costs	485	395
Advertising	87	107
Grants	375	461
Interpreter fees	47	33
Impairment losses plant and equipment	-	53
Impairment losses on trade receivables^	204	167
Other	145	129
	7,413	6,750

*Total audit fees paid to the Queensland Audit Office relating to the 2013-2014 financial year are estimated to be $184,000 (2013: $195,000) including out of pocket expenses. There are no non-audit services included in this amount.
** Includes payments to Department of Health representing CQHHS's share of the departments QGIF premium. Certain losses of public property and health litigation costs are insured with the Queensland Government Insurance Fund refer Note 2 (x). Upon notification by QGIF of the acceptance of claims, revenue is recognised for the agreed settlement amount and disclosed as "Other Revenues - Insurance compensation from loss of property". Refer Note 3.
# Under Treasurer's approval has been obtained for entering into the insurance contracts.
*** Two out-of-court settlements were paid to private individuals involved in patient disputes.
^Refer Note 14.

12. Revaluation decrement

	2014	*2013*
	$'000	*$'000*
Land	11,176	-

Queensland Treasury and Trade's policy requires all land and buildings to be reported annually at fair value. Movements in individual asset's fair value such as land tends to rise and fall cyclically depending on the economy and market conditions (external to the operations of CQHHS). During 2014, building valuations have demonstrated modest increases, whereas individual properties with the class of land have experienced significant declines.

Land values within CQHHS's region experienced significant increases during the period 2006 to 2012 as demand for residential development grew in line with strong growth in the mining sector, and infrastructure development within the Gladstone region. The majority of hospital site valuations increased 100% or more during this time, with the Department of Health engaging the State Valuation Service in 2011 to appraise all land holdings on a individual basis. Since this time, an index has been applied to approximate movement in market growth. This index is generic in nature, based on overall sales data for properties within each local government region. While the index distinquishes between land with dwellings versus hospital sites, specific conditions/ restrictions applicable to individual land parcels are not considered.

On 1 July 2012, the Department of Health transferred control of these properties (land) to CQHHS (associated asset revaluation reserves remained with the Department). 2014 has seen a decline in land values representing the slowing of investment in the mining sector, infrastructure development and overall tightening in financing activities.

The asset revaluation surplus represents the net effect of upward and downward revaluations of assets to fair value. Within the asset revaluation surplus are reserves for each class subject to revaluation (land and buildings). Under AASB 116, each reserve is limited to its respective class, ie only asset movements in land can be offset against the land reserve. Where the net movement exceeds the reserve for that class, a decrement is recorded in the Statement of Comprehensive Income. The decrement, not being the reversal of a previous revaluation increment in respect of the same class of assets, has been recognised as an expense in the Statement of Comprehensive Income.

13. Cash and cash equivalents

	2014	*2013*
	$'000	*$'000*
Imprest accounts	8	10
Cash at bank*	44,838	35,516
QTC cash funds*	3,583	4,119
	48,429	39,645

CQHHS's operating bank accounts are grouped as part of a Whole-of-Government (WoG) banking arrangement between Queensland Treasury and Trade and the Commonwealth Bank, and does not earn interest on surplus funds nor is it charged interest or fees for accessing its approved cash debit facility. Any interest earned on the WoG fund accrues to the Consolidated Fund.

*CQHHS receives cash contributions primarily from private practice clinicians and external entities to provide for education, study and research in clinical areas. Contributions are also received from benefactors in the form of gifts, donations and bequests for stipulated purposes. At 30 June 2014, amounts of $4.0 million ($4.3 million 2012-2013) in General Trust including $442 thousand ($362 thousand 2012-2013) for excess earnings under Right of Private Practice option B. A further $6.3 thousand ($6.3 thousand 2012-2013) for Clinical Drug Trials, were set aside for the specified purposes underlying the contribution.

General trust bank and term deposits do not form part of the WoG banking arrangement and incur fees as well as earn interest. Cash deposited with Queensland Treasury Corporation earns interest, calculated on a daily basis reflecting market movements in cash funds. Rates achieved throughout the year range between 3.3% to 4.2% (2013: 3.5% to 5%).

14. Receivables

	2014	*2013*
	$'000	*$'000*
Trade debtors	6,454	4,438
Payroll receivables	8	8
Less: Allowance for impairment	(305)	(264)
Sub total	6,157	4,182
GST receivable	987	792
GST payable	(78)	(55)
Sub total	909	736
Funding public health services receivable	1,277	4,162
Total	8,343	9,080
Movements in the allowance for impairment loss		
Balance at beginning of the year	264	-
Balance transferred in on establishment of HHS	-	1,137
Amounts written off during the year	(163)	(167)
Amount recovered during the year	-	-
Increase/(decrease) in allowance recognised in operating result	204	(706)
Balance at the end of the year	305	264

Trade debtors includes receivables of $3.1 million (2013: $3.1 million) from health funds (reimbursement of patient fees) , $914 thousand insurance claim recoveries from Queensland Government Insurance Scheme, $410 thousand residential fees for aged care and $174 thousand (2013: $562 thousand) from the Australian Government for Pharmacy Pharmaceutical Benefits Scheme claims.

15. Inventories

	2014	*2013*
	$'000	*$'000*
Inventories held for distribution - at cost	3,080	2,879
Medical supplies and equipment*	10	4
Catering and domestic	18	18
Other	3,108	2,901

16. Other

	2014	*2013*
	$'000	*$'000*
Prepayments	1,434	610
	1,434	610

17. Assets classified as held for sale

	2014	*2013*
	$'000	*$'000*
Inventory	-	13
Land	-	2,855
Buildings	-	3,602
Plant and equipment	-	488
Assets held for sale*	-	6,959

*In January 2013, CQHHS announced its intention to withdraw from the provision of Aged Care services and divest its share of residential aged care facilities (Eventide Rockhampton and North Rockhampton Nursing Centre) as a going concern to a private provider.

Subsequent to the completion of the financial statements, the Department issued a policy on the treatment of land and buildings under lease agreement and identified as held for sale. Where land and buildings are identified as held for sale by CQHHS, the Deed of Lease is partially surrendered and the assets are returned to the Department for sale. Accordingly these assets were reclassified on 1 July 2013 as inventory held for distribution, and property plant and equipment and valued based on depreciated replacement cost. At the time of preparation of 2013 financial statements, classification of aged care facilities as held for sale was appropriate based on the information available at that time. The change in treatment in 2014 reflects a change in estimate and not an error. Accordingly no restatement of comparative figures for 2013 is warranted. For further information on these assets refer to Note 2 (ag)

	2014	*2013*
	$'000	*$'000*
Land*		
At fair value	23,954	34,383
Buildings*		
At fair value	533,503	440,922
Less: Accumulated depreciation	(251,595)	(201,345)
	281,908	239,577
Plant and equipment		
At cost	57,480	50,603
Less: Accumulated depreciation	(31,139)	(27,066)
	26,341	23,537
Capital works in progress		
At cost	3,686	2,015
Total property, plant and equipment	335,889	299,513

* Refer Note 2 (o).

Land

Land is measured at fair value using independent revaluations, desktop market revaluations or indexation by the State Valuation Service (SVS) within the Department of Natural Resources and Mines. Independent revaluations are performed with sufficient regularity to ensure assets are carried at fair value.

In 2014, CQHHS engaged the State Valuation Service (SVS) to undertake a comprehensive revaluation program over the next four years (with indices applied in the intervening periods) for all land holdings at February 2014 excluding properties which do not have a liquid market, for example properties under Deed of grant (recorded at a nominal value of $1.5). SVS was also engaged to provide indices for land parcels not comprehensively revalued during the year.

SVS revalued 21 land lots (61% by value) at 30 June 2014. On I July 2014 land valued at $5.1 million will effectively transfer to DHPW as part of a Whole-of-government initiative to centrally manage non-operational housing (refer Note 2 (ag)). These properties were not included in the

comprehensive revaluation program for 2014. After adjustment for general purpose housing, 2014 revalued land lots account for 77% (by value) of all properties at 1 July 2014.

In 2011, the Department of Health engaged SVS to comprehensively revalue land holdings. Indices provided by SVS have been subsequently applied each year to approximate market movement and are based on actual market movements for each local government area issued by the Valuer-General.

The fair value of land was based on publicly available data on sales of similar land in nearby localities. In determining the values, adjustments were made to the sales data to take into account the location of CQHHS's land, its size, street/road frontage and access, and any significant restrictions. The extent of the adjustments made varies in significance for each parcel of land - refer to the reconciliation table later in this note for information about the fair value classification of the HHS's land.

The revaluation program resulted in a decrement of $12.8 million (increment 2013: $1.6 million) to the carrying amount of land. For further details on the decrement in land values refer to Note 12.

Buildings

Reflecting the specialised nature of health service buildings and on hospital-site residential facilities, fair value is determined using depreciated replacement cost methodology, due to there not being an active market for such facilities.

Depreciated replacement cost is calculated by determining the cost to replicate the future service potential of the asset, adjusted for it's age and condition. Buildings are measured at fair value by applying either, an estimate of individual asset's depreciated replacement cost (valuation), or an interim index (that approximates movement in price) as at reporting date. These estimates are developed by independent quantity surveyors.

Rider Levett Bucknall Qld Pty (RLB), independent quantity surveyors, were engaged in 2014 by CQHHS to comprehensively revalue twenty five buildings and two land improvement hospital sites (82% by class). This was necessitated by the introduction of componentisation of special purpose buildings. Refer Note 10 for further details.

The replacement cost of each building is based on replicating the existing facility as currently designed (assuming the service potential of the asset is fully utilised) and makes no allowance for upgrading to current standards or technology. This is achieved by measuring each asset, determining a bill of quantities and applying current market rates at reporting date.

Architectural floor drawings and physical site inspections by a senior quantity surveyor were used to determine quantities. The site inspection also identified the condition and deterioration of components comprising the asset (impacts remaining useful life assessments and written down value).

The valuation was prepared on an elemental basis with rates applied based on current market rates used on comparable building types in Queensland, taking into account the type of material, size, quality and complexity of the asset. All rates are based on Brisbane rates at 30 June 2014 and adjusted for regional locality based on judgement and experience. Elements such as substructure, columns, upper floor, roof, facade, internal partitions, doors walls, floor and ceiling finishes and sanitary fixtures were based on current market rates. For elements such as joinery fittings, hydraulic reticulation, mechanical services, medical gases, electrical services, communications, fire protection and lifts pricing was based on RLB's health database and analysis of recent projects were used for pricing.

Valuations assume a nil residual value. Significant capital works, such as a refurbishment across multiple floors of a building, will result in an improved condition assessment and higher depreciated replacement values. This increase is typically less than the original capitalised cost of the refurbishment, resulting in a small write down. Presently all major refurbishments are funded by the Department of Health.

RLB was engaged to provide an interim index for 2014 movements in tender construction prices for specialised buildings. The rate derived by RLB demonstrated only minor fluctuations in construction costs (3.78%). In accordance with Queensland Treasury and Trade's *Non Current Asset Policies*, management has discretion in the application of interim indicies where the cumulative change impact is below 5%. The fair values for buildings (not subject to comprehensive revaluation) were assessed by management as reasonable without application of the index. If indexation had been applied, the buildings class would have been higher by $1.2 million or 0.04%

Significant judgement is also used to assess the remaining service potential of the facility, given local climatic and environmental conditions and records of the current condition of the facility.

The revaluation program resulted in an increment of $42 million (increment 2013: $22 million) to the carrying amount of buildings. Refer Note 2 (p) & (q) for further details on the revaluation methodology applied.

Plant and equipment

CQHHS has plant and equipment with an original cost of $1.1 million (2013: $1.4 million) or 2% (2013: 3%) of total plant and equipment gross value and a written down value of zero still being used in the provision of services. 10% (2013: 35%) of these assets with a gross cost of $118 thousand (2013: $209 thousand) are expected to be replaced in 2015.

	Land	*Buildings*	*Plant & equipment*	*Work in progress*	*Total*
	$'000	*$'000*	*$'000*	*$'000*	*$'000*
Property, Plant and Equipment Reconciliation					
Carrying amount at 1 July 2012	-	-	-	-	-
Acquisitions through restructuring (Note 2 h)	34,744	227,300	25,002	1,486	288,533
Acquisition major infrastructure transfers	-	12,497	-	-	12,497
Acquisitions	-	229	3,905	529	4,664
Disposals	-	-	(94)	-	(94)
Assets reclassified as held for sale	(2,855)	(3,602)	(488)	-	(6,945)
Transfer between classes	-	(8)	8	-	-
Transfers in from Public Health	-	-	15	-	15
Impairment losses recognised in operating	-	-	(53)	-	(53)
Net revaluation Increments/(decrements)	1,642	21,719	-	-	23,361
Impairment gains/(loss) recognised in equity	852	(6,192)	-	-	(5,340)
Depreciation charge	-	(12,366)	(4,759)	-	(17,125)
Carrying amount at 30 June 2013	34,383	239,578	23,537	2,015	299,513

	Land	*Buildings*	*Plant & equipment*	*Work in progress*	*Total*
	$'000	*$'000*	*$'000*	*$'000*	*$'000*
Property, Plant and Equipment Reconciliation					
Carrying amount at 1 July 2013	34,383	239,578	23,537	2,015	299,513
Assets reclassified from held for sale	2,855	3,602	488	-	6,945
Acquisition major infrastructure transfers	548	4,451	-	-	4,998
Transfers in from other Queensland Government entities	-	-	2,030	-	2,030
Acquisitions	-	1,507	4,855	2,496	8,858
Disposals	-	(22)	(218)	-	(240)
Transfers out to other Queensland Government entities	(162)	(618)	(10)	(108)	(899)
Transfer between classes	-	(308)	1,024	(716)	-
Impairment gains recognised in operating surplus/(deficit)*	-	40	41	-	81
Net revaluation Increments/(decrements)	(12,818)	42,096	-	-	29,278
Reversals of Impairment gains/(loss) in equity*	(852)	6,192	-	-	5,340
Depreciation		(14,609)	(5,406)	-	(20,015)
Carrying amount at 30 June 2014	23,953	281,908	26,341	3,686	335,889

* Impairment losses and reversals of impairment losses are shown as separate line items in the Statement of Comprehensive Income.

Categorisation of fair values recognised as at 30 June 2014 (refer to note 2 (q))	Level 2 *$'000*	*Level 3 $'000*	*Total $'000*
Land	23,373	580	23,953
Buildings		281,908	281,908

CQHHS has seven land lots classified as reserve in nature. Reserved land is land dedicated by the Minister for a community purpose. Reserves are not sold and therefore there are no directly observable inputs. This land can only be sold when un-gazettted and converted to freehold by the state. The Queensland property market is deemed the most advantageous market. Property sales and values derived from this market assist the determination of values for reserves. To derive a value for reserved land considering current restrictions and classifications, valuations reference sales of land of a restricted nature, preferably not sales of land reflecting a highest and best use which is unrestricted. Where sales of land with a potential alternate use are used, appropriate allowance is included to reflect the nature of the restrictions on the land. Reserved land has been classified as a level 3 hierarchy for fair value determinations. categorised within the following fair value hierarchy, based on the data and assumptions used in the most recent Reserved lands current use is generally considered to already be used at highest and best use, taking into consideration the tests of physically possible, financially feasible and legally permissible.

All buildings (and land improvements) have historically been valued using depreciated replacement cost methodology and accordingly are assigned a level 3 fair value hierarchy. The majority of buildings controlled by CQHHS reflect the specialised nature of health service buildings and on hospital-site residential facilities. These facilities are considered to already be used at highest and best use, taking into consideration the tests of physically possible, financially feasible and legally permissible. A number of general purpose employee housing controlled by CQHHS at 30 June 2014, would meet the criteria for level 2 in future valuations (ie using observable market data) however as these properties will be transferring to DHPW on 1 July 2014 no valuations were sought in 2014.

Level 3 fair value reconciliation (Refer Note 2 (q))	Land *$'000*	Buildings *$'000*	Total *$'000*
Carrying amount at 1 July 2013	648	239,578	240,225
Assets reclassified from held for sale	-	3,602	3,602
Acquisition major infrastructure transfers	-	4,451	4,451
Acquisitions	-	1,507	1,507
Disposals	-	(22)	(22)
Transfers out to other Queensland Government entities	-	(618)	(618)
Transfer between classes	-	(308)	(308)
Net revaluation Increments/(decrements)	(68)	42,096	42,028
Reversals of impairment gains/(loss) in equity	-	6,192	6,192
Depreciation	-	(14,609)	(14,609)
Carrying amount at 30 June 2014	580	281,868	282,448

Level 3 significant valuation inputs and relationship to fair value

As the measurement of quantities is finite for buildings the major variables in determining the valuation are the rates applied to each quantity, locality index and on-costs.

In regard to the sensitivity of valuations to variances in rates, locality index and pricing of preliminaries and builder's margin the following factors may affect the valuation:

-local industry construction volumes/market conditions;
-material supply prices (steel, raw metals, etc);
-exchanges rate fluctuations; and
-enterprise bargaining agreements.

Over the next twelve months RLB do not reasonable foresee any subtantial movements in price as construction volumes remain relatively low with no indication of a significantly increased pipeline of new projects. The current RLB tender level index forecasts a modest 2 to 3% increase in construction prices.

19. Payables

	2014	*2013*
	$'000	*$'000*
Trade creditors	14,473	12,847
Accrued health service labour - Department of Health*	16,719	15,196
Other	39	125
	31,231	28,168

* Refer Note 2 (v)

20. Asset revaluation surplus by class

	2014	*2013*
	$'000	*$'000*
Land		
Balance at the beginning of the financial year	2,494	-
Revaluation increment/(decrement)	(1,642)	1,642
Impairment gain (loss) through equity*	(852)	852
*Impairment gain (loss) through equity**	-	2,494
Buildings		
Balance at the beginning of the financial year	15,527	-
Revaluation increment/(decrement)	42,095	21,719
Impairment gains (losses) through equity*	6,192	(6,192)
Balance at the end of the financial year	63,814	15,527
Total	63,814	18,021

The asset revaluation surplus represents the net effect of revaluation movements in assets.

* CQHHS policy decision to dispose of current aged care facilities resulted in a change in the valuation method applied from depreciated replacement cost to fair value less cost to sell. Subsequent to the signing of the financial statements for 2012-2013 policy advice from the Department of Health, clarified that as the assets are still legally owned by the department, any resultant gains or losses on disposal are borne by the Department. As such, previous losses recorded by CQHHS relating to these assets were reversed in 2013-2014.

21. Cash flows

	2014	*2013*
	$'000	*$'000*
Reconciliation of operating result to net cash flows from operating activities		
Operating Result	(1,991)	18,735
Non-cash movements :		
Depreciation and amortisation	20,015	17,124
Depreciation grant funding	(20,009)	(16,982)
Net (gain)/loss on disposal/revaluation of non-current assets	218	78
Impairment (gain)/loss on plant and equipment	(81)	53
Impairment on receivables	41	
Decrement on land	11,176	
Reversal of impairment loss receivables	-	(873)
Change in assets and liabilities after adjustment for transfers in from restructure:*		
(Increase)/decrease in receivables	(2,017)	10,335
(Increase)/decrease in funding receivables	2,885	(4,162)
(Increase)/decrease in GST receivables	(195)	(792)
(Increase)/decrease in inventories	(192)	(553)
(Increase)/decrease in prepayments	(824)	(128)
Increase/(decrease) in accounts payable	1,603	2,052
Increase/(decrease) in accrued contract labour	1,523	9,538
Increase/(decrease) in accrued employee benefits	(63)	79
Increase/(decrease) in GST payable	22	55
Increase/(decrease) in unearned funding revenue	-	2.472
Total non-cash movements	14,101	15,826
Cash flows from operating activities	12,111	34,561

* Refer Note 2 (g).

22. Non-cash financing and investing activities

Assets and liabilities received or transferred by the Hospital and Health Service are set out in the Statement of Changes in Equity and Note 2 (h).

23. Expenditure commitments

	2014	*2013*
	$'000	*$'000*
(a) Non-cancellable operating leases		
Commitments under operating leases at reporting date are inclusive of anticipated GST and are payable as follows:		
Not later than one year	45	45
Later than one year and not later than five years	92	136
Total	137	181

CQHHS has non-cancellable operating leases relating predominantly to office and residential accommodation. Lease payments are generally fixed, but with escalation clauses on which contingent rentals are determined. No lease arrangements contain restrictions on financing or other leasing activities.

(b) Capital expenditure commitments

Material classes of capital expenditure commitments inclusive of anticipated GST, contracted for at reporting date but not recognised in the accounts are payable as follows: 2014 2014 2013

	2014	*2014*	*2013*
	$'000	*$'000*	*$'000*
	Buildings*	Plant and Equipment	Plant and Equipment
Not later than 1 year	4,957	597	1,424
	4,957	597	1,424

* Includes $4.8 million contract commitments for the construction of the helipad and ICU beds at the Rockhampton hospital site.

24. Contingent assets and liabilities

(a) Litigation in progress

As at 30 June 2014, the following cases were filed in the courts naming the State of Queensland acting through the Central Queensland Hospital and Health Service as defendant:

	2014	*2013*
	Number of cases	*Number of cases*
Supreme Court	0	1
Magistrates Court	1	1
Tribunals, commissions and boards	0	1
	1	3

Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). CQHHS's liability in this area is limited to an excess per insurance event of $20,000 - refer Note 2(x). As at 30 June 2014, CQHHS has 12 claims (2013: 18) currently managed by QGIF, some of which may never be litigated or result in payments to claims (excluding initial notices under Personal Injuries Proceedings Act). Tribunals, commissions and board figures represent the matters that have been referred to QGIF for management. CQHHS's legal advisers and management believe it would be misleading to estimate the final amounts payable (if any) in respect of the litigation before the courts at this time.

b) Native Title

As at 30 June 2014, the Central Queensland Hospital and Health Services does not have legal title to properties under its control, refer Note 2 (o). The Department of Health remains the legal owner of health service properties. Currently two of these properties are subject to a Deed of Grant in Trust (land is held by traditional owners) and recorded at nominal value.

25. Right of private practice

Under the right of private practice scheme, Senior Medical Officers (SMOs) employed in the public health system are permitted to treat individuals who elect to be treated as private patients. In order to do so, the SMOs receive a private practice allowance and in return assign any private practice revenue to the Hospital (Option A). A variation of this model allows the SMOs to pay a facility charge and administration fee to the Hospital and to retain a proportion of the private practice revenue (Option B). The remaining revenue is deposited into a trust account to fund research and education of all staff. Receipts and payments relating to right of private practice (Option A & B) during the financial year were as follows:

	2014	*2013*
	$'000	*$'000*
*Receipts**		
Billings - (Doctors and Visiting Medical Officers)	4,176	2,786
Total receipts	4,176	2,786
*Payments**		
Payments to Doctors	7,589	6,577
Hospital and Health Service recoverable administrative costs	129	90
Hospital and Health Service education/ travel fund	68	54
Total payments	7,786	6,721
Closing balance of bank account, under a trust fund arrangement not yet 17 37 disbursed, and not restricted cash.	17	37

26. Fiduciary trust transactions and balances

CQHHS acts in a custodial role in respect of these transactions and balances. As such, they are not recognised in the financial statements, but are disclosed below for information purposes. The activities of trust accounts are audited by the Queensland Audit Office (QAO) on an annual basis. The fee for this service is incorporated in the total fee charged by QAO for the full audit of the Annual Financial Report.

	2014	*2013*
	$'000	*$'000*
Patient Trust receipts and payments		
Receipts		
Patient trust receipts	4,400	4,338
Total receipts	4,400	4,338
Payments		
Patient trust related payments	4,311	4,435
Total payments	4,311	4,435
Increase/ in net patient trust assets	89	(97)
Patient trust assets opening balance 1 July 2013	910	1,007
	999	910
Patient trust assets		
Current assets		
Cash at bank and on hand	625	537
Patient trust and refundable deposits	374	373
Total current assets	999	910

27. Financial Instruments

a) Categorisation of financial instruments

CQHHS has the following categories of financial assets and financial liabilities:

Category	Note	*2014*	*2013*
		$'000	*$'000*
Financial assets			
Cash and cash equivalents	13	48,429	39,645
Receivables	14	8,343	9,080
Total		56,771	48,725
Financial liabilities			
Financial liabilities measured at amortised cost:			
Payables	19	31,231	28,047
Total		31,231	28,047

(b) Financial risk management

CQHHS's activities expose it to a variety of financial risks - credit risk, liquidity risk and market risk. Financial risk management is implemented pursuant to Government and CQHHS's policy. These policies focus on the unpredictability of financial markets and seek to minimise potential adverse effects on the financial performance of CQHHS.

CQHHS measures risk exposure using a variety of methods as follows:

Risk Exposure	**Measurement method**
Credit risk	Ageing analysis, cash inflows at risk
Liquidity risk	Monitoring of cash flows by active management of accrual accounts
Market risk	Interest rate sensitivity analysis

(c) Credit risk exposure

Credit risk is the potential for financial loss arising from a counterparty defaulting on its obligations. The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the financial asset, inclusive of any allowance for impairment. The carrying amount of receivables represents the maximum exposure to credit risk. As such, receivables are not included in the disclosure below. Refer Note 13 for further information.

Credit risk is considered minimal given all CQHHS deposits are held by the State through Queensland Treasury Corporation.

Maximum exposure to credit risk	Note	*2014*	*2013*
		$'000	*$'000*
Cash	13	48,429	39,645

No collateral is held as security and no credit enhancements relate to financial assets held by CQHHS. No financial assets and financial liabilities have been offset and presented net in the Statement of Financial Position.

CQHHS manages credit risk through the use of a credit management strategy. This strategy aims to reduce the exposure to credit default by ensuring that the CQHHS invests in secure assets and monitors all funds owed on a timely Throughout the year, CQHHS assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. Objective evidence includes financial difficulties of the debtor, changes in debtor credit ratings and current outstanding accounts over 120 days. The allowance for impairment reflects CQHHS's assessment of the credit risk associated with receivables balances and is determined based on historical rates of bad debts (by category) over the past three years and management judgement.

The allowance for impairment reflects the occurrence of loss events. If no loss events have arisen in respect of a particular debtor, or group of debtors, no allowance for impairment is made in respect of that debt/group of debtors. If CQHHS determines that an amount owing by such a debtor does become uncollectible (after appropriate range of debt recovery actions), that amount is recognised as a bad debt expense and written-off directly against receivables. In other cases where a debt becomes uncollectible but the uncollectible amounts exceeds the amount already allowed for impairment of that debt, the excess is recognised directly as a bad debt expense and written-off directly against receivables. Impairment loss expense for the current year regarding receivables is $163 thousand (2013: $167 thousand).

Ageing of past due but not impaired as well as impaired financial assets are disclosed in the following tables:

Financial assets past due but not impaired 2013

		Overdue $'000				
	Not overdue $'000	*Less than 30 days*	*30-60 days*	*61-90 days*	*More than 90 days*	*Total*
Receivables	6,531	905	648	379	616	9,080
Total	6,531	905	648	379	616	9,080

Financial assets past due but not impaired 2014

		Overdue $'000				
	Not overdue $'000	*Less than 30 days*	*30-60 days*	*61-90 days*	*More than 90 days*	*Total*
Receivables	4,714	1,736	1,019	346	528	8,343
Total	4,714	1,736	1,019	346	528	8,343

*Individually impaired financial assets 2013**

	Overdue $'000				
	Less than 30 days	*30-60 days*	*61-90 days*	*More than 90 days*	*Total*
Receivables (gross)	9	6	1	68	84
Allowance for impairment	(9)	(6)	(1)	(68)	(84)
Carrying amount	-	-	-	-	-

*Individually impaired financial assets 2014**

	Overdue $'000				
	Less than 30 days	*30-60 days*	*61-90 days*	*More than 90 days*	*Total*
Receivables (gross)	27	9	2	95	133
Allowance for impairment	(27)	(9)	(2)	(95)	(133)
Carrying amount	-	-	-	-	-

* This represents individual debts impaired. In addition, patient debtors are impaired on a historical percentage basis. These general impairments are not included in the figures above.

(d) Liquidity risk

Liquidity risk is the risk that CQHHS will not have the resources required at a particular time to meet its obligations to settle its financial liabilities.

CQHHS is exposed to liquidity risk through its trading in the normal course of business and aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations at all times. An approved debt facility of $4.5 million under Whole-of-Government banking arrangements to manage any short term cash shortfalls has been established. No funds had been withdrawn against this debt facility as at 30 June 2014.

All financial liabilities are current in nature and will be due and payable within twelve months. As such no discounting of cashflows has been made to these liabilities in the Statement of Financial Position.

(e) Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises: foreign exchange risk, interest rate risk, and other price risk.

CQHHS does not trade in foreign currency and is not materially exposed to commodity price changes.

CQHHS has interest rate exposure on the 24 hour call deposits, however there is no risk on its cash deposits. The HHS does not undertake any hedging in relation to interest rate risk.

(f) Interest rate sensitivity analysis

Changes in interest rate have a minimal effect on the operating result of CQHHS. This is demonstrated in the interest rate sensitivity analysis below:

		2014 Interest rate risk			
	Carrying amount	*-1%*		*1%*	
Financial instrument		*Profit*	*Equity*	*Profit*	*Equity*
	$'000	*$'000*	*$'000*	*$'000*	*$'000*
Cash and cash equivalents	3,583	(36)	(36)	36	36
Potential impact		(36)	(36)	36	36

		2013 Interest rate risk			
	Carrying amount	*-1%*		*1%*	
Financial instrument		*Profit*	*Equity*	*Profit*	*Equity*
	$'000	*$'000*	*$'000*	*$'000*	*$'000*
Cash and cash equivalents	4,119	(41)	(41)	41	41
Potential impact		(41)	(41)	41	41

With all other variables held constant, CQHHS would have a surplus and equity increase/(decrease) of $36,000 (2013: $41,000).

(g) Fair value

CQHHS does not recognise any financial assets or liabilities at fair value. The fair value of trade receivables and payables is assumed to approximate the value of the original transaction, less any allowance for impairment.

28. Key executive management personnel and remuneration

(a) Key executive management personnel

The following details for key executive management personnel include those positions that had authority and responsibility for planning, directing and controlling the activities of the health service during 2013-2014. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management.

Position	Responsibilities	Current Incumbents	
		Contract classification and appointment authority	*Date appointed to position (date resigned from position)*
Health Service Chief Executive	Responsible for the overall leadership and management of the Central Queensland Hospital and Health Service to ensure that the health service meets its strategic and operational objectives.	s24 Appointed by Board under Hospital and Health Board Act 2011 (Section 7 (3)).	18 November 2013
Acting Health Service Chief Executive			1 July to 24 November 2013
Chief Operations Officer	Responsible for strategic direction, and operational functions for CQHHS clinical operations.	HES 2 Appointed by Chief Executive (CE) under Hospital and Health Board (HHB) Act 2011	Resigned 4 April 2014
Acting Chief Operations Officer			1 July to 28 November 2013 (Temporary Assignment)
Chief Finance Officer	Responsible for management and oversight of the CQHHS finance framework including financial accounting processes, budget and revenue systems, activity measurement and reporting, performance management frameworks and financial-corporate governance systems.	HES 2 Appointed by CE under HHB Act 2011	1 July 2012
Acting Chief Finance Officer			1 July to 25 November 2013 (Temporary Assignment)
Executive Director, Medical Services	Responsible for strategic and professional responsibility for CQHHS medical workforce, and clinical governance.	MMOI1-MMOI2 Appointed by CE under HHB Act 2011	27 May 2013
Acting Executive Director, Medical Services			1 July to 16 May 2014 (Temporary Assignment)
			5 May to 1 August 2014 (Temporary Assignment)
District Director, Nursing	Responsible for strategic and professional leadership of nursing workforce .	NRG11 Appointed by CE under HHB Act 2011	Resigned 13 October 2013
District Director, Nursing and Midwifery			21 October 2013
Executive Director, People and Culture	Responsible for provision of leadership and oversight of human resource, occupational health and safety functions, Indigenous training and development, and cultural awareness programs for the Health Service.	HES 2 Appointed by CE under HHB Act 2011 - temporary agency contract	Resigned 20 January 2014
Acting Executive Director, People and Culture			1 July to 17 November 2014 (Temporary Assignment)
Acting Director, Workforce			18 November to 30 March 2014 (Temporary Assignment)
Acting Executive Director, Workforce			31 March to 30 June 2014 (Temporary Assignment)

Position	Responsibilities	Current Incumbents	
		Contract classification and appointment authority	*Date appointed to position (date resigned from position)*
Acting Director, Infrastructure & Support.	Responsible for management of corporate service functions including capital works projects, asset management, legal issues, contract management and nonfinancial-corporate governance systems.	DSO1 Appointed by CE under HHB Act 2011	Resigned 24 August 2013
			25 August to 17 November 2014 (Temporary Assignment)
			24 November to 30 June 2014 (Temporary Assignment)
Acting Executive Director, Quality & Safety	Responsible for the leadership, management and coordination of the CQHHS Quality and Safety Division.	HES 2 Appointed by CE under HHB Act 2011	13 January to 30 June 2014 (Temporary Assignment)
Acting Executive Director, Rockhampton Hospital	Responsible for the leadership, management and coordination of the Rockhampton Hospital business unit.	HES 2 Appointed by CE under HHB Act 2011 - temporary agency contract	31 March to 30 June 2014 (Temporary Assignment)
Director Mental Health, Alcohol and Other Drug Services	Responsible for the leadership, management and coordination of the Mental Health Services business unit.	DSO2 Appointed by CE under HHB Act 2011	1 July 2012
Executive Director Rural Health Services	Responsible for the leadership, management and coordination of the Rural Health Services business unit.	HES 2 Appointed by CE under HHB Act 2011	20 September 2012
Executive Director Sub-Acute and Community	Responsible for the leadership, management and coordination of the Sub-Acute and Community Services business unit.	HES 2 Appointed by CE under HHB Act 2011	1 July 2013

(b) Remuneration

Section 74 of the *Hospital and Health Board Act 2011* provides the contract of employment for health executive staff must state the term of employment, the person's functions and any performance criteria as well as the person's classification level and remuneration package. Section 76 of the Act provides the Chief Executive authority to fix the remuneration packages for health executives, classification levels and terms and conditions having regard to remuneration packages for public sector employees in Queensland or other States and remuneration arrangements for employees employed privately in Queensland.

Remuneration policy for the Service's key executive management personnel is set by direct engagement common law employment contracts. The remuneration and other terms of employment for the key executive management personnel are also addressed by these common law employment contracts. The contracts provide for other benefits including motor vehicles and expense payments such as rental or loan repayments.

Remuneration packages for key executive management personnel comprise the following components:

- Short-term employee expenses include:
  - salaries, allowances and leave entitlements earned and expensed for the entire year or for that part of the year during which the employee occupied the specified position.
  - Non-monetary benefits – consisting of provision of vehicle and expense payments together with fringe benefits tax applicable to the benefit.
- Long term employee expenses include long service leave earned.
- Post employment expenses includes expensed in respect of employer superannuation obligations.
- Termination benefits are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu on termination, regardless of the reason for termination.
- Performance bonuses are not paid under the contracts in place.

Total fixed remuneration is calculated on a 'total cost' basis and includes the base and non-monetary benefits, long term employee benefits and post employment benefits.

1 July 2013 - 30 June 2014

Position (date resigned if applicable)	*Short Term Employee Expenses*		*Long Term Employee Expenses*	*Post Emp. Expenses*	*Termination Benefits*	*Total Expenses*
	Monetary Expenses	*Non-Monetary Benefits*				
	$'000	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*
Health Service Chief Executive (18 Nov to 30 June 14)	237	22	5	17	0	281
Acting Health Service Chief Executive (1 July to 24 Nov 2013)	79	7	2	9	0	97
Chief Operations Officer (25 Nov resigned 4 April 2014)	244	6	1	8	227	486
Acting Chief Operations Officer (1 July to 28 Nov 2013)	83	16	2	7	0	108
Chief Finance Officer - (26 Nov to 30 June 2014)	105	23	2	10	0	140
Acting Chief Finance Officer (1 July to 25 Nov 2013)	79	0	1	7	0	87
Acting Executive Director, Medical Services (1 July to 16 May 2014)	365	36	0	0	0	401
Acting Executive Director, Medical Services (5 May to 30 June 2014)	57	17	1	4	0	79
Executive Director/Director Medical Services Gladstone Hospital	462	4	5	32	0	503
Acting Executive Director Quality and Safety (13 Jan to 30 June 2014)	89	32	4	9	0	134
District Director of Nursing and Midwifery (21 Oct to 30 June 2014)	145	0	3	11	0	159
District Director of Nursing (1 July resigned 13 Oct 2013)	48	22	1	6	7	84
Executive Director People and Culture (1 July resigned 20 Jan 2014)	115	0	2	10	20	147
A/Executive Director People and Culture (1 July to 17 Nov 2013)	56	0	1	6	0	63
Acting Director Workforce (18 Nov to 30 Mar 2014)	50	0	1	5	0	56
Acting Executive Director Workforce (31 Mar to 30 June 2014)	71	18	0	0	0	89
Acting Director Infrastructure and Support resigned 24 Aug 2013	36	0	0	3	181	220
Acting Director Infrastructure and Support (25 Aug to 17 Nov 2013)	37	22	1	3	0	63
Acting Director Infrastructure and Support (24 Nov to 30 Jun 2014)	82	0	2	9	0	93
Acting Executive Director, Rockhampton Hospital (31 Mar to 30 June 2014)	58	17	0	0	0	75
Director Mental Health, Alcohol and Other Drug Services	141	0	3	15	0	159
Executive Director Rural Health Services	189	0	4	18	0	211
Executive Director Sub-Acute and Community	168	10	4	18	0	200

1 July 2012 - 30 June 2013

Position (date resigned if applicable)	*Short Term Employee Expenses*		*Long Term Employee Expenses*	*Post Emp. Expenses*	*Termination Benefits*	*Total Expenses*
	Monetary Expenses	*Non-Monetary Benefits*				
	$'000	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*
Health Service Chief Executive - resigned 30 June 2013	207	24	5	20	127	382
Chief Operations Officer	158	22	3	18	-	200
Chief Finance Officer	146	18	3	15	-	182
Executive Director, Medical Services resigned 2 June 2013	554	-	-	-	-	554
District Director, Nursing (29 Apr - 30 June 2013)	18	-	-	2	-	21
District Director, Nursing (26 Nov - 28 April 2013)	70	17	2	7	-	96
District Director, Nursing (I July - 25 Nov 2012)	78	-	2	8	-	87
Executive Director, People and Culture	109	17	3	13	-	141
A/Executive Director, People and Culture (6 Mar - 30 June 2013)	40	16	1	4	-	61
A/Executive Director, Corporate Services	114	17	3	15	-	148

(c) Board remuneration

The Central Queensland Hospital and Health Service is independently and locally controlled by the Hospital and Health Board (Board). The Board appoints the Health Service Chief Executive and exercises significant responsibilities at a local level, including controlling (a) the financial management of the Service and the management of the Service's land and buildings (section 7 Hospital and Health Board Act 2011).

Board member	Position	Date of appointment
Roy (Charles) Ware	Board member/Chairperson	29 June 2012 - 17 May 2016
Bronwyn Christensen	Board member	29 June 2012 - 17 May 2017
Kurt Heidecker	Board member	29 June 2012 - 17 May 2017
Leone Hinton	Board member	29 June 2012 - 17 May 2016
Francis Houlihan	Board member	9 November 2012 - 17 May 2016
Dr David Austin*	Deputy Chair	29 June 2012 - 17 May 2016
Sandra Corfield	Board member	18 May 2013 - 17 May 2014
Elizabeth Baker	Board member	18 May 2013 - 17 May 2017
Karen Smith*	Board member	18 May 2013 - 17 May 2017
Graeme Kanofski	Board member	18 May 2013 - 17 May 2017

Remuneration paid or owing to board members during 2012-2013 was as follows:

Board Member	*Short Term Employee Expenses*		*Post Emp. Expenses*	*Total Expenses*
	Monetary Expenses	*Non-Monetary Benefits*		
	$'000	*$'000*	*$'000*	*$'000*
Roy (Charles) Ware	55	-	4	59
Robert Miles	50	-	4	54
Bronwyn Christensen	32	-	2	34
Kurt Heidecker	31	-	1	32
Leone Hinton	29	-	3	32
Francis Houlihan	18	-	2	20
Sandra Corfield	3	-	-	3
Elizabeth Baker	2	-	-	2
Graeme Kanofski	3	-	-	3

Remuneration paid or owing to board members during 2013-2014 was as follows:

Board Member	*Short Term Employee Expenses*		*Post Emp. Expenses*	*Total Expenses*
	Monetary Expenses	*Non-Monetary Benefits*		
	$'000	*$'000*	*$'000*	*$'000*
Roy (Charles) Ware	72	-	6	78
Bronwyn Christensen	33	-	3	36
Kurt Heidecker	36	-	3	38
Leone Hinton	32	-	3	35
Francis Houlihan	33	-	3	36
Sandra Corfield	27	-	3	30
Elizabeth Baker	34	-	3	37
Graeme Kanofski	32	-	3	35

*Board members who are employed by either the HHS or the Department of Health are not paid board fees.

7.2.6. Certificate of Central Queensland Hospital and Health Service

These general purpose financial statements have been prepared pursuant to section 62(1) of the *Financial Accountability Act 2009* (the Act), relevant sections of the *Financial and Performance Management Standard 2009* and other prescribed requirements. In accordance with section 62(1)(b) of the Act we certify that in our opinion:

a. the prescribed requirements for establishing and keeping the accounts have been complied with in all material respects; and
b. the statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Central Queensland Hospital and Health Service for the financial year ended 30 June 2014 and of the financial position of the Hospital and Health Service at the end of that year.
c. these assertions are based on an appropriate system of internal controls and risk management processes being effective, in all material respects, with respect to financial reporting throughout the reporting period.

Charles Ware	Len Richards	Nik Fokas
Chairperson, BA, LLB (Hons) MBus, LLM		Member of Institute of Public Accountants
Chair, CQHH Board	Chief Executive Officer	Chief Finance Officer
22/8/14	22/8/14	22/8/14

7.2.7. Independent Auditor's Report

INDEPENDENT AUDITOR'S REPORT

To the Board of Central Queensland Hospital and Health Service

Report on the Financial Report

I have audited the accompanying financial report of Central Queensland Hospital and Health Service, which comprises the statement of financial position as at 30 June 2014, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and certificates given by the Chairperson, Chief Executive Officer and Chief Finance Officer.

The Board's Responsibility for the Financial Report

The Board is responsible for the preparation of the financial report that gives a true and fair view in accordance with prescribed accounting requirements identified in the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2009*, including compliance with Australian Accounting Standards. The Board's responsibility also includes such internal control as the Board determines is necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial report based on the audit. The audit was conducted in accordance with the *Auditor-General of Queensland Auditing Standards*, which incorporate the Australian Auditing Standards. Those standards require compliance with relevant ethical requirements relating to audit engagements and that the audit is planned and performed to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation of the financial report that gives a true and fair view in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control, other than in expressing an opinion on compliance with prescribed requirements. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Board, as well as evaluating the overall presentation of the financial report including any mandatory financial reporting requirements approved by the Treasurer for application in Queensland.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

Independence

The *Auditor-General Act 2009* promotes the independence of the Auditor-General and all authorised auditors. The Auditor-General is the auditor of all Queensland public sector entities and can be removed only by Parliament.

The Auditor-General may conduct an audit in any way considered appropriate and is not subject to direction by any person about the way in which audit powers are to be exercised. The Auditor-General has for the purposes of conducting an audit, access to all documents and property and can report to Parliament matters which in the Auditor-General's opinion are significant.

Opinion

In accordance with s.40 of the *Auditor-General Act 2009* –

(a) I have received all the information and explanations which I have required; and

(b) in my opinion –

(i) the prescribed requirements in relation to the establishment and keeping of accounts have been complied with in all material respects; and

(ii) the financial report presents a true and fair view, in accordance with the prescribed accounting standards, of the transactions of the Central Queensland Hospital and Health Service for the financial year 1 July 2013 to 30 June 2014 and of the financial position as at the end of that year.

Other Matters - Electronic Presentation of the Audited Financial Report

Those viewing an electronic presentation of these financial statements should note that audit does not provide assurance on the integrity of the information presented electronically and does not provide an opinion on any information which may be hyperlinked to or from the financial statements. If users of the financial statements are concerned with the inherent risks arising from electronic presentation of information, they are advised to refer to the printed copy of the audited financial statements to confirm the accuracy of this electronically presented information.

QUEENSLAND
31 AUG 2014
AUDIT OFFICE

B R Steel CPA
(as Delegate of the Auditor-General of Queensland)

Queensland Audit Office
Brisbane

Chapter 8
Our direction

The patient will always be the centre of everything we do.

Safety, patient satisfaction, staff satisfaction and health service performance will measure our success.

We have mapped our future.

Our future effectiveness will be measured by four precise and measurable indicators:

- Safety
- Patient satisfaction
- Staff satisfaction, and
- Health service performance

It is with those four indicators in mind that the CQHHS Strategic Plan 2014-2018 was designed. They will guide its implementation and measure its success.

To achieve success, the Strategic Plan has established six objectives and dedicated clear actions to achieve the objectives. They are:

Safe, reliable services

- Implement comprehensive service improvement approach
- Strengthen safety governance system
- Increase the use of technology
- Implement Speaking up for Safety strategy

Sustainable, cost effective services

- Deliver a surplus for reinvestment in health care services
- Move away from sole practitioners
- Meet Statewide access standards

Excellent patient experience and healthcare outcomes

- Actively engage our community on service planning and delivery
- Maximise use of rural facilities to ensure local access
- Develop cancer centre

Great place to work

- Introduce a zero harm strategy
- Deliver high performance culture through strong visible leadership
- Reduce reliance on temporary medical workforce

Strong reputation

- Introduce clear and accurate consultation methods
- Greater transparency in reporting of our performance
- Put in place a media strategy
- Increase community visibility through positive presentation

Effective partner relationships

- Implement One Gladstone Health Plan
- Develop cardiac catheter laboratory
- Develop radiation oncology

The health service has many strengths and changes many lives for the better every day. Developing and capitalising on the opportunities, with a focus on patient safety and improving the patient journey, is vital to success.

In Central Queensland, a Cancer Strategy will be developed to ensure the new Cancer Centre reaches its full potential, reduces the need for cancer patients to travel to the south-east for treatment and increases life expectancy of Central Queenslanders. Our aim is to develop services to treat the top five cancers: Colorectal (colon cancer); Urology (prostate cancer); Breast (breast cancer); Dermatology (skin cancer); and Upper GI (lung cancer).

The development of a cardiac catheter laboratory is a crucial link in the development of service delivery to Central Queensland and it will play an important part with its supportive link to cancer services.

The expansion of Clinical Support Services and increasing the ability for Rockhampton to provide support to Gladstone, Biloela and Emerald will maximise the services offered in those regional centres.

The development of a cardiac catheter laboratory is a crucial link in the cardiac service plan that will enable people to be treated locally rather than in Brisbane.

Add to this the development of a new 14-bed Intensive Care Unit, providing increased capacity from the existing six bed unit, and the rooftop helipad – both funded from efficiency improvements from the 2012-2013 financial year – and Rockhampton Hospital will become a strong regional centre for Central Queensland.

The strength of partnerships in Gladstone will drive the implementation of the One Gladstone Health Plan and create a critical mass that will support the development of improved health services for that community.

It is the strong relationship with the co-located Mercy Health and the Mater Hospital that will foster the success in the Harbour City.

To strengthen our service delivery in rural and remote areas CQHHS will introduce clinical support and bring and end to sole-doctor towns. This is not only vital for the delivery of safe services but will be a valuable recruitment and retention tool as it improves the quality of life for the clinicians.

Partnering with universities, the use rural generalists, Rural and Isolated Practice Endorsed Registered Nurses and allied health services will be maximised to take services closer to the community.

Mental Health services will develop a 20-unit Community Care facility in North Rockhampton to help patients to re-enter the community. A four-bed Older Person Mental Health Inpatient Unit will provide additional support to the community and partnership with community organisations will be strengthened to better meet the needs of residents in a community setting.

The most effective form of health care is prevention. It is with that in mind that work will continue to establish a Coalition for Health which aims to create a social movement to change lifestyle habits and reduce the impact of chronic disease on the health system.

The Subacute, Ambulatory and Rehabilitation unit will work with Central Queensland Medicare Local to determine the pattern of community services for Central Queensland. It will provide and, where necessary, work with partners to create alternative services to hospital admission and to aid early discharge.

By focusing on systems, strategies and a philosophy of continuous improvement,

By developing strong leadership through consistency and courage,

By eliminating waste and utilising available resources,

By delivering cultural change through action,

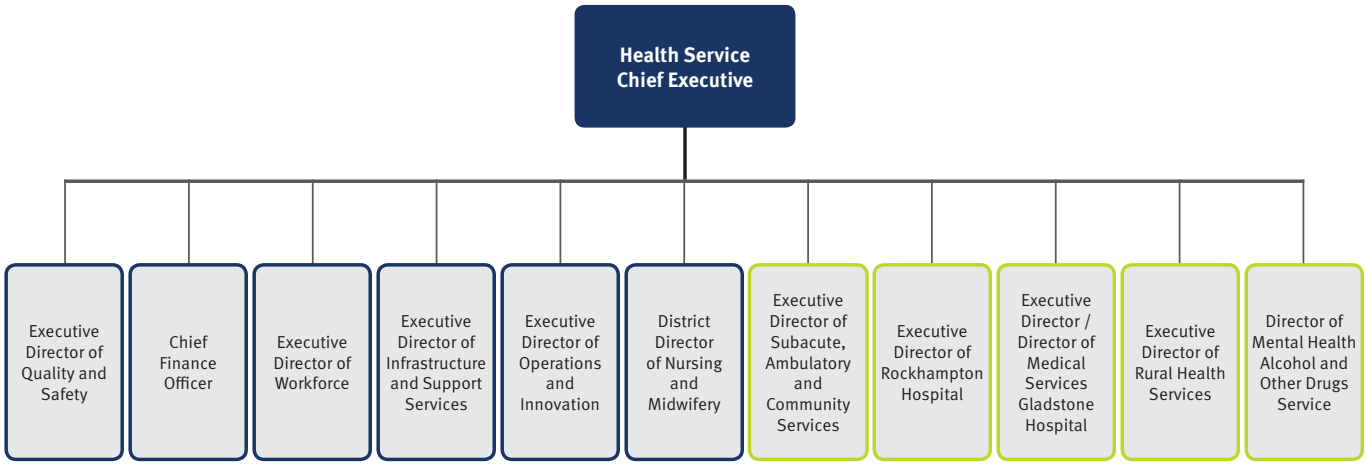
By implementing quality as a strategy,

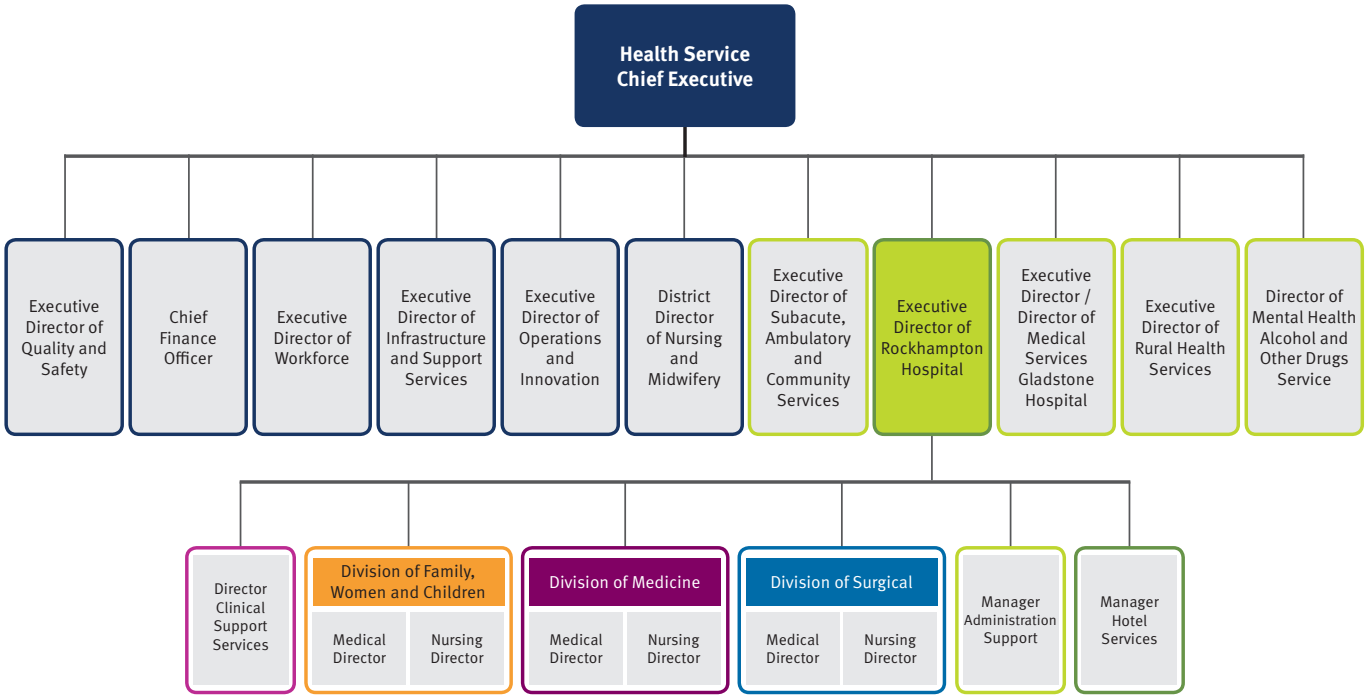
We will deliver

- Safety
- Patient satisfaction
- Staff satisfaction, and
- Health service performance

Chapter 9
Appendices

9.1. Executive Management Structure





9.2. Compliance Checklist

Summary of Requirement		Basis for Requirement	Annual Report Reference
Letter of Compliance	A letter of compliance from the accountable officer or statutory body to the relevant Minister	ARRs – section 8	page vi
Accessibility	Table of Contents Glossary	ARRs – section 10.1	page vii page 109
	Public Availability	ARRs – section 10.2	inside front cover
	Interpreter Service Statement	*Queensland Government Language Services Policy* ARRs – section 10.3	inside front cover
	Copyright Notice	*Copyright Act 1968* ARRs – section 10.4	inside front cover
	Information Licensing	*QGEA – Information Licensing* ARRs – section 10.5	inside front cover
General Information	Introductory Information	ARRs – section 11.1	page iii
	Agency role and main functions	ARRs – section 11.2	page iii
	Operating Environment	ARRs – section 11.3	pages iv-v
	Machinery of Government Changes	ARRs – section 11.4	page 17
Non-Financial Performance	Government's objectives for the community	ARRs – section 12.1	page iii
	Other whole-of-government plans/specific initiatives	ARRs – section 12.2	pages i, iii, 33
	Agency objectives and performance indicators	ARRs – section 12.3	pages 36-37, each chapter
	Agency service areas as service standards	ARRs – section 12.4	pages 36-37
Financial Performance	Summary of financial performance	ARRs – section 13.1	pages 50-54
Governance – Management and Structure	Organisational Structure	ARRs – section 14.1	page 104
	Executive Management	ARRs – section 14.2	pages 15-16
	Related Entities	ARRs – section 14.3	Not Applicable
	Government Bodies	ARRs – section 14.4	Not Applicable
	Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* (section 23 and Schedule) ARRs – section 14.5	pages 42-43
Governance – risk management and accountability	Risk management	ARRs – section 15.1	page 18
	External scrutiny	ARRs – section 15.2	page 17
	Audit committee	ARRs – section 15.3	pages 10-13
	Internal audit	ARRs – section 15.4	pages 13-14
	Public Sector Renewal	ARRs – section 15.5	pp ii-iii
	Information systems and recordkeeping	ARRs – section 15.6	page 17
Governance – human resources	Workforce planning, attraction and retention and performance	ARRs – section 16.1	pages 40-43
	Early retirement, redundancy and retrenchment	Directive No. 11/12 *Early Retirement, Redundancy and Retrenchment* ARRs – section 16.2	page 42
Open Data	Open Data	ARRs – section 17	inside front cover
Financial Statements	Certification of Financial Statements	FAA – section 62 FPMS – sections 42,43 and 50 ARRs – section 18.1	page 95
	Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 18.2	page 96-97
	Remuneration disclosures	*Financial Reporting Requirements for Queensland Government Agencies* ARRs – section 18.3	page 90-94

FAA *Financial Accountability Act 2009*
FPMS *Financial and Performance Management Standard 2009*
ARRs *Annual Report Requirements for Queensland Government Agencies*

Chapter 10
Abbreviations

Abbreviation	Full Name
AASB	Australian Accounting Standards Board
CE	Chief Executive
CMC	Crime and Misconduct Commission
CQHHS	Central Queensland Hospital and Health Service
CT	computed tomography
DHPW	Department of Housing and Public Works
EQuIP	edition of the ACHS Evaluation and Quality Improvement Program
FBT	Fringe Benefit Tax
FTE	Full time equivalent
GP	General Practice
GST	Goods and Services Tax
HARP	Hospital Avoidance Risk Program
HES	health executive service
HHS	Hospital and Health Service
HR	Human Resources
ICU	Intensive Care Unit
IS	Information Standards
MPHS	Multi-Purpose Health Service
MRI	Magnetic resonance imaging
PPE	Property, Plant and Equipment
QAO	Queensland Audit Office
QGIF	Queensland Government Insurance Fund
RCA	Root Cause Analyses
ROPP	Right of Private Practice
SAC1	Severity Assessment Code 1
SVS	State Valuation Service

Chapter 11
Glossary

Word	Definition
Accessible	Accessible healthcare is characterised by the ability of people to obtain appropriate healthcare at the right place and right time, irrespective of income, cultural background or geography.
Activity Based Funding (ABF)	A management tool with the potential to enhance public accountability and drive technical efficiency in the delivery of health services by: • capturing consistent and detailed information on hospital sector activity and accurately measuring the costs of delivery • creating an explicit relationship between funds allocated and services provided • strengthening management's focus on outputs, outcomes and quality • encouraging clinicians and managers to identify variations in costs and practices so they can be managed at a local level in the context of improving efficiency and effectiveness • providing mechanisms to reward good practice and support quality initiatives.
Acute	Having a short and relatively severe course.
Acute care	Care in which the clinical intent or treatment goal is to: • manage labour (obstetric) • cure illness or provide definitive treatment of injury • perform surgery • relieve symptoms of illness or injury (excluding palliative care) • reduce severity of an illness or injury • protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function • perform diagnostic or therapeutic procedures.
Admission	The process whereby a hospital accepts responsibility for a patient's care and/or treatment. It follows a clinical decision, based on specified criteria, that a patient requires same-day or overnight care or treatment, which can occur in hospital and/or in the patient's home (for hospital-in-the-home patients).
Allied Health staff	Professional staff who meet mandatory qualifications and regulatory requirements in the following areas: audiology; clinical measurement sciences; dietetics and nutrition; exercise physiology; leisure therapy; medical imaging; music therapy; nuclear medicine technology; occupational therapy; orthoptics; pharmacy; physiotherapy; podiatry; prosthetics and orthotics; psychology; radiation therapy; sonography; speech pathology and social work.
Benchmarking	Involves collecting performance information to undertake comparisons of performance with similar organisations.
Best practice	Cooperative way in which organisations and their employees undertake business activities in all key processes, and use benchmarking that can be expected to lead to sustainable world class positive outcomes.

Word	Definition
Clinical governance	A framework by which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Clinical practice	Professional activity undertaken by health professionals to investigate patient symptoms and prevent and/ or manage illness, together with associated professional activities for patient care.
Clinical workforce	Staff who are or who support health professionals working in clinical practice, have healthcare specific knowledge/ experience, and provide clinical services to health consumers, either directly and/or indirectly, through services that have a direct impact on clinical outcomes.
e-Health	Since 2007 Queensland Health has been working on an e-Health agenda that aims to create a single shared electronic medical record (eMR) which will be delivered through the use of information and communication technology. The vision of the e-Health Program is to enable a patient-centric focus to healthcare delivery across a networked model of care.
e-Learning	QH Online Training Environments. ELMO http://elmolearning.com.au/ and iLearn
e-plan	Computerised plan storage room.
Emergency department waiting time	Time elapsed for each patient from presentation to the emergency department to start of services by the treating clinician. It is calculated by deducting the date and time the patient presents from the date and time of the service event.
Full time equivalent (FTE)	Refers to full-time equivalent staff currently working in a position.
Health outcome	Change in the health of an individual, group of people or population attributable to an intervention or series of interventions.
Health reform	Response to the National Health and Hospitals Reform Commission Report (2009) that outlined recommendations for transforming the Australian health system, the National Health and Hospitals Network Agreement (NHHNA) signed by the Commonwealth and states and territories, other than Western Australia, in April 2010 and the National Health Reform Heads of Agreement (HoA) signed in February 2010 by the Commonwealth and all states and territories amending the NHHNA.
Hospital	Healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.
Hospital and Health Board	The Hospital and Health Boards are made up of a mix of members with expert skills and knowledge relevant to managing a complex health care organisation.
Hospital and Health Service	Hospital and Health Service (HHS) is a separate legal entity established by Queensland Government to deliver public hospital services.
Hospital in the home (HITH)	Provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation.
Incidence	Number of new cases of a condition occurring within a given population, over a certain period of time.
Indigenous health worker	An Aboriginal and/or Torres Strait Islander person who holds the specified qualification and works within a primary healthcare framework to improve health outcomes for Indigenous Australians.
Long wait	A 'long wait' elective surgery patient is one who has waited longer than the clinically recommended time for their surgery, according to the clinical urgency category assigned. That is, more than 30 days for a category 1 patient, more than 90 days for a category 2 patient and more than 365 days for a category 3 patient.
Medicare Local	Established by the Commonwealth to coordinate primary health care services across all providers in a geographic area. Works closely with HHSs to identify and address local health needs.
Medical practitioner	A person who is registered with the Medical Board of Australia to practice medicine in Australia, including general and specialist practitioners.
Nurse practitioner	A registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessing and managing clients using nursing knowledge and skills and may include, but is not limited to, direct referral of clients to other healthcare professionals, prescribing medications, and ordering diagnostic investigations.
Outpatient	Non-admitted health service provided or accessed by an individual at a hospital or health service facility.
Outpatient service	Examination, consultation, treatment or other service provided to non-admitted non-emergency patients in a speciality unit or under an organisational arrangement administered by a hospital.
Overnight stay patient	A patient who is admitted to, and separated from, the hospital on different dates (not same-day patients).

Word	Definition
Patient flow	Optimal patient flow means the patient's journey through the hospital system, be it planned or unplanned, happens in the safest, most streamlined and timely way to deliver good patient care.
Performance indicator	A measure that provides an 'indication' of progress towards achieving the organisation's objectives. Usually has targets that define the level of performance expected against the performance indicator.
Private hospital	A private hospital or free-standing day hospital, and either a hospital owned by a for-profit company or a non-profit organisation and privately funded through payment for medical services by patients or insurers. Patients admitted to private hospitals are treated by a doctor of their choice.
Public patient	A public patient is one who elects to be treated as a public patient, so cannot choose the doctor who treats them, or is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.
Public hospital	Public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.
Registered nurse	An individual registered under national law to practice in the nursing profession as a nurse, other than as a student.
Statutory bodies / authorities	A non-departmental government body, established under an Act of Parliament. Statutory bodies can include corporations, regulatory authorities and advisory committees/councils.
Sustainable	A health system that provides infrastructure, such as workforce, facilities and equipment, and is innovative and responsive to emerging needs, for example, research and monitoring within available resources.
Telehealth	Delivery of health-related services and information via telecommunication technologies, including: • live, audio and/or video inter-active links for clinical consultations and educational purposes • store-and-forward Telehealth, including digital images, video, audio and clinical (stored) on a client computer, then transmitted securely (forwarded) to a clinic at another location where they are studied by relevant specialists • teleradiology for remote reporting and clinical advice for diagnostic images • Telehealth services and equipment to monitor people's health in their home.
The Viewer	The Viewer is a read-only web-based application that displays consolidated clinical information sourced from a number of existing Queensland Health enterprise clinical and administrative systems.
Triage category	Urgency of a patient's need for medical and nursing care.
Wayfinding	Signs, maps and other graphic or audible methods used to convey locations and directions.