Annual Report 2013–2014

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Queensland Government

Darling Downs Hospital and Health Service
Annual Report 2013-14

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Interpreter Service Statement

Darling Downs Hospital and Health Service 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 (07) 4699 8412 and we will arrange an interpreter to effectively communicate the report to you.

Letter of compliance

The Honourable Lawrence Springborg MP
Minister for Health
Member for Southern Downs
Level 19, 147-163 Charlotte Street
Brisbane Qld 4000

Dear Minister

I am pleased to present the Annual Report 2013-14 and financial statements for the Darling Downs Hospital and Health Service.

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 on page 60 of this annual report or accessed at http://www.health.qld.gov.au/darlingdowns/pdf/ddhhs-annualreport-2014.pdf.

Yours sincerely

Mr Mike Horan AM
Chair
Darling Downs Hospital and Health Board

05/09/2014

Mission statement

Our vision

To be trusted to deliver excellence in rural and regional healthcare.

Our purpose

Delivering quality healthcare in partnership with our communities.

Our values

Our values guide how we work and support us to achieve our goals. They are:

- **Caring** – We deliver care, we care for each other and we care about the service we provide.
- **Doing the right thing** – We respect the people we serve and try our best. We treat each other respectfully and we respect the law and standards.
- **Openness to learning and change** – We continually review practice and the services we provide.
- **Being safe, effective and efficient** – We will measure and own our performance and use this information to inform ways to improve our services. We will manage public resources effectively, efficiently and economically.
- **Being open and transparent** – We work for the public and we will inform and consult with our patients, clients, staff, stakeholders and community.

Acknowledgement of Traditional Owners

Darling Downs Hospital and Health Service respectfully acknowledges the traditional owners of the land on which its sites stand.

Contents

Letter of compliance i

Mission statement ii
Our vision ii
Our purpose ii
Our values ii
Acknowledgement of Traditional Owners ii

Contents 1

Board Chair 2

Chief Executive 3

About us 4
Our role 4
Our services 4
Our facilities 4
DDHHS catchment map 5

Strategic directions 6

Our year at a glance 7

Our performance 8
Delivering quality healthcare 11
Ensuring resources are sustainable 13
Ensuring processes are clear 15

Our people 16
Ensuring dedicated trained staff 16

Our organisation 19
Organisational structure 20

Our divisions 21
Toowoomba Hospital 21
Rural Health 22
Mental Health 24
Medical Services 27
Nursing and Midwifery 29
Allied Health 30
Finance and Corporate 32

Service Delivery Statements 35
Service standards 36
Comparison of actual financial results with budget 37

Governing our organisation 39

Our Board 40
Board meeting 46
Board committees 46
Board activities 49

Our Executives 51

Glossary of terms 55

Compliance checklist 60

Appendix 1
Annual Financial statements 01
Independent auditor's report 52

Board Chair

It is with great pride, that on behalf of the Darling Downs Hospital and Health Board, I present the second annual report for the Darling Downs Hospital and Health Service (DDHHS). While there are always challenges to be dealt with, it is encouraging to reflect on the many achievements across the health service. They are evidence of how our vision – to be trusted to deliver excellence in rural and regional healthcare – has been realised during the year.

I strongly believe the establishment of local Boards and Hospital and Health Services as independent statutory authorities two years ago, has made a real difference to how healthcare is delivered in each of the communities we serve.

Our Board is comprised of representatives from all geographical areas within the DDHHS who have worked hard to ensure they are aware of relevant local issues that impact on health services. I thank all Board members for their professionalism, willingness to consider all options, and governance of the DDHHS over the past year.

Key to this success has been the Board's community engagement program. Every second Board meeting was held at a rural location where we took the opportunity to meet with community representatives, different levels of government, others in the healthcare industry and our staff to gain a picture of what's important locally. Our meetings in Toowoomba have also provided valuable information about the depth and variety of services offered and community needs. These interactions, together with individual Board member's community insights, have been a valuable part of our decision-making process. I thank all who have taken such a keen interest in the operations of the DDHHS.

One example of the Board using its local knowledge was the decision to keep residential aged care facilities under DDHHS ownership and management. Under state contestability guidelines to ensure tax payer funds were used effectively, we carefully considered both the financial and community implications of potentially having a private provider operate five facilities. The Board remains confident our staff can deliver the required efficiency improvements while maintaining quality aged care in local communities.

On behalf of the Board, I sincerely thank Chief Executive Dr Peter Bristow for his strong leadership and expertise. Under his professional guidance, the dedication of the executive team, and the tireless efforts of staff, the Health Service has continued to provide excellent services to our patients and communities.

The Board certainly appreciates the extraordinary talents of our staff and the care and compassion they provide our patients.

A budget surplus of $14 million from the 2012-13 financial year was returned to patients and staff through increased surgery and endoscopies, new equipment, and upgraded facilities. I am pleased to report a second surplus in a row, this year being $17.7 million, was achieved and will also be used for more services and equipment while maintaining a modest reserve.

It is important to note this strong financial position that enables the delivery of more and better local healthcare services has been achieved whilst the HHS has delivered four per cent more services than contracted for by the Department of Health. It has also been done with a strong focus on safety and quality, so it is indeed a commendable result.

It is rewarding for our staff that surplus funds can be retained and used for more patient care, equipment and facilities.

We are confident the health service will continue to meet future challenges in delivering core health services, as well as an ambitious infrastructure program covering maintenance, rehabilitation projects and new facilities.

Mr Mike Horan AM
Chair
Darling Downs Hospital and Health Board

Chief Executive

I would like to pay tribute to the hard work and dedication of staff throughout the DDHHS in 2013-14. The staff and executives of the service delivered significantly on our purpose: To deliver quality healthcare in partnership with our communities.

The service delivered 104 per cent of activity contracted with the Department of Health. At the same time, significant improvements in access to services were also achieved—with increased numbers being treated in a timely manner in emergency departments, increased elective surgery and reduced waiting lists for elective surgery, reduced numbers waiting for an outpatient appointment, and abolition of long waits for general dental appointments. Some of these goals were achieved by partnering with the private sector to increase capacity. The net result was increased services to our residents and patients.

The service was more productive and this enabled investments in increased capacity and facilities. The Board was actively involved in these decisions through the community dividend program.

As part of the journey to our vision to be trusted to deliver excellence in rural and regional healthcare, we have improved the sustainability of some local maternity services, increased local access to dialysis, performed more surgical procedures in rural towns, improved facilities in rural towns and increased telehealth consultations. The rural generalist program run by DDHHS has been recognised nationally as a model for rural medical workforce capacity and capability and has attracted increased government funding.

This year we focussed extensively on the National Standards on Safety and Quality in Healthcare to ensure our improvements in timely access did not compromise care. There has been a momentum to improve the quality of care we provide and a number of innovations. During the year, the Board authorised expansion of quality and clinical governance services to ensure the quality of our care. Patient satisfaction surveys were conducted by external organisations to enable us to learn from our patients' experiences and improve our care.

Staff have adapted to and embraced DDHHS with significant improvements in a number of markers in the annual staff opinion survey, Working for Queensland. Throughout the year the service continued its clinical leaders' forums highlighting innovations throughout the service. The service continues to train the healthcare professionals of the future and employ new graduates to meet future healthcare needs.

The service also undertook the development of a Health Service Plan to identify future needs until 2023 across DDHHS. At the end of 2013-14, planning for the infrastructure requirements identified in the Health Service Plan was underway. This will enable us long term to deliver for our communities and keep us on track to deliver on our vision.

In 2013-14 work commenced on undertaking backlog maintenance of facilities, after DDHHS received additional funding provided by the Queensland Government. This work is vital to ensure we can continue to deliver services at our 20 hospitals and other sites.

The Executive worked throughout the year cohesively to achieve these results for which I thank them.

Finally, I would like to thank the Board for their unflagging support of our patients, the staff, and me personally in my role.

Dr Peter Bristow FRACP FCICM FRACMA GCM GAICD
Chief Executive
Darling Downs Hospital and Health Service

About us

On 1 July 2012, in accordance with the National Health Reform Agreement and Queensland's *Hospital and Health Boards Act 2011* (the Act), the Darling Downs Hospoital and Health Service (DDHHS) was established as an independent statutory body, overseen by a local hospital and health board (the Board), which reports to the Minister for Health, The Honourable Lawrence Springborg MP. The functions of the Board are outlined in the Act and include establishing, maintaining and monitoring the performance of systems to ensure the Health Service meets community needs.

Our role

DDHHS provides public hospital and healthcare services as defined in the service agreement with the Department of Health as the manager of the public health system. We deliver clinical services to approximately 300,000 people from 26 locations.

We are one of the largest employers in the Darling Downs, employing more than 4,800 people, and manage a budget with revenues of more than $600 million annually.

Geographically our service is located across 90,000 square kilometers. We cover the local government areas of the Toowoomba Regional Council, Western Downs Regional Council, Southern Downs Regional Council, South Burnett Regional Council, Goondiwindi Regional Council, Cherbourg Aboriginal Shire Council and part of the Banana Shire Council (community of Taroom).

Our services

DDHHS provides a comprehensive range of hospital services including inpatient and outpatient services, surgical sub-specialties, medical sub-specialties, and diagnostic services.

We also offer community and primary health services including: aged care assessment, Aboriginal and Torres Strait Islander health programs, child and maternal health services, alcohol and other drug services, home care services, community health, sexual health service, allied health services, oral health, and public health programs.

DDHHS also operates an integrated mental health service which provides specialist services across a number of clinical programs through Toowoomba Hospital, Baillie Henderson Hospital and rural communities.

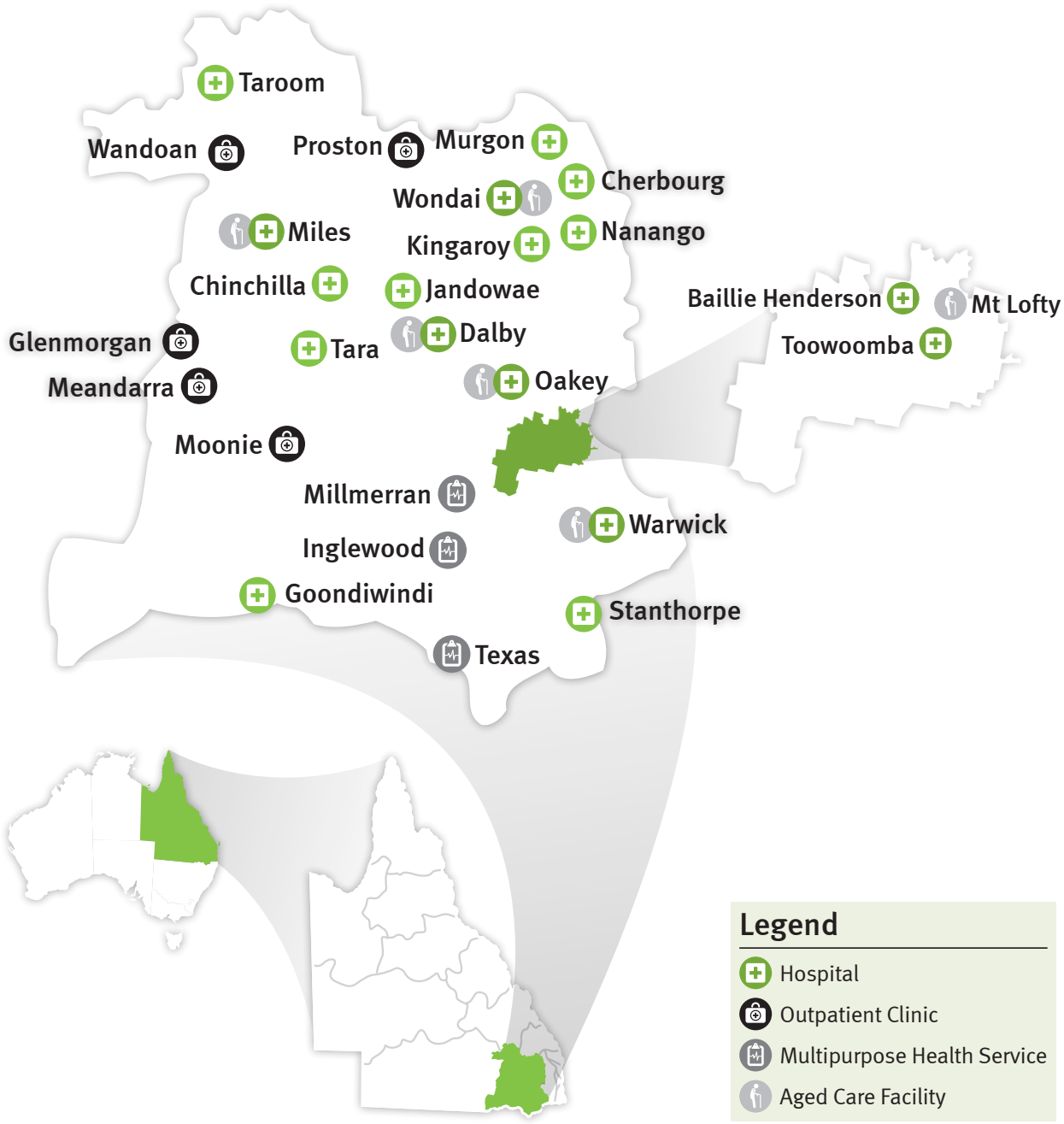
DDHHS operates six residential aged care services located at Dalby - Karingal Nursing Home, Miles - Milton House, Toowoomba - Mt Lofty Heights, Oakey - Dr EAF McDonald Nursing Home, Warwick - The Oaks Nursing Home and Wondai - Forest View Aged Care Facility.

The majority of the residents in our region receive public hospital inpatient care at our facilities, either at their local hospital or at Toowoomba Hospital. Patients are at times required to travel to Brisbane to access some types of specialist services only offered at tertiary facilities. To support such travel, the DDHHS administers locally the Queensland Government's Patient Travel Subsidy Scheme.

Our facilities

The facilities within DDHHS's physical boundaries include the regional hospital in Toowoomba, district hospitals in Kingaroy, Dalby and Warwick, as well as rural community hospitals, residential aged care facilities, multipurpose health services, community health and primary care facilities.

DDHHS catchment



Strategic directions

The Darling Downs Hospital and Health Board's vision is to be trusted to deliver excellence in rural and regional healthcare. The strategic plan identifies the key initiatives to achieve this goal, and the organisational values that underpin its success.

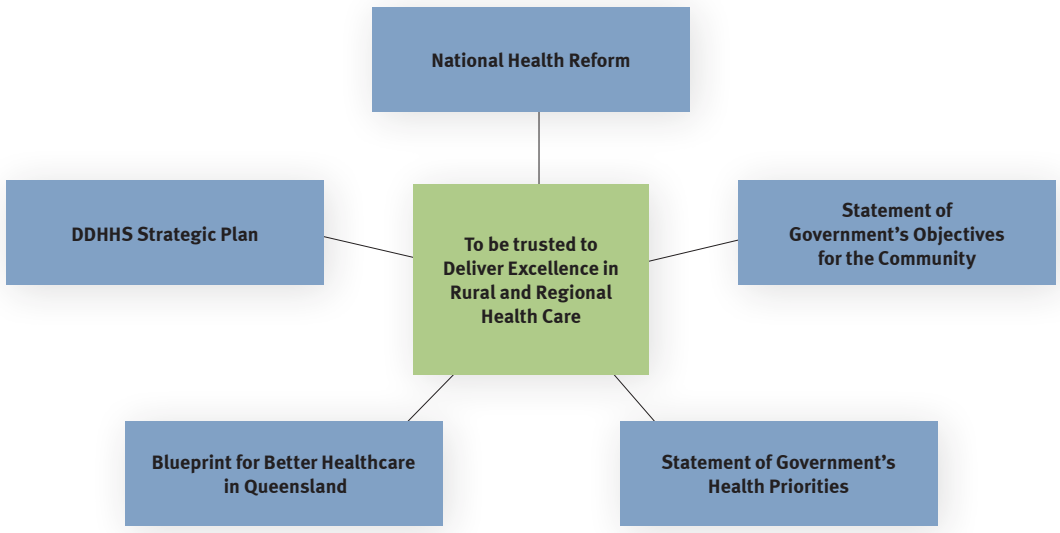
The Darling Downs Hospital and Health Service Strategic Plan has four key strategic directions:

- Deliver quality healthcare (delivering core health services; improving access to services; reducing the impact of chronic disease; ensuring safe and quality health outcomes; and increasing confidence in the health system)
- Ensure resources are sustainable (balanced operating position; ensuring appropriate costs; maximising revenue; leveraging other providers; and optimising asset usage)
- Ensure processes are clear (collaboration with primary health care and other service providers; deliver more care locally; effective operational planning; review and improve care; increase use of clinical evidence-based decision making; and engage the community and health care consumers)
- Ensure dedicated trained staff (embed a values-based culture; develop, educate and train our workforce; plan, recruit and retain an appropriately skilled workforce; engage clinicians to improve the service; and promote and support the health and wellbeing of our staff).

Our strategic plan supports the commitments outlined in the Queensland Government's "Getting Queensland Back on Track – statement of objectives for the community" and is aligned with National Health Reform, Statement of Government Health priorities, and the Blueprint for better healthcare in Queensland.

During 2013-14 DDHHS has had a strong focus on:

- Achieving the National Emergency Access Target (NEAT) of 77 per cent of patients who present to emergency departments admitted, discharged or transferred within four hours
- Meeting the National Elective Surgery Target (NEST) of no patients waiting longer than clinically recommended for urgent, semi-urgent and routine elective surgery at Toowoomba Hospital
- Engaging with local communities to ensure health services planning and delivery meet stakeholders' needs
- Cutting waiting times for general (non-urgent) dental treatment
- Improving local services through infrastructure investments funded through budget efficiencies.



Our year at a glance

Surgeries performed
7,965
+925 from 2012-13

Mums and Bubs visits
4,210

Separations (discharges)
65,628
+4,791 from 2012-13

Telehealth consultations
3,201
+1,670 from 2012-13

Bed days
276,014
+12,241 from 2012-13

Mental health consultations
242,691
+2,275 from 2012-13

Same day admissions
26,911
+1,107 from 2012-13

Adult dental treatments
33,515
+9,896 from 2012-13

Emergency department presentations
174,870
+29,797 from 2012-13

Child/school-based dental treatments
21,204

Babies born
3,136
+28 from 2012-13

Breastscreens
17,888
+206 from 2012-13

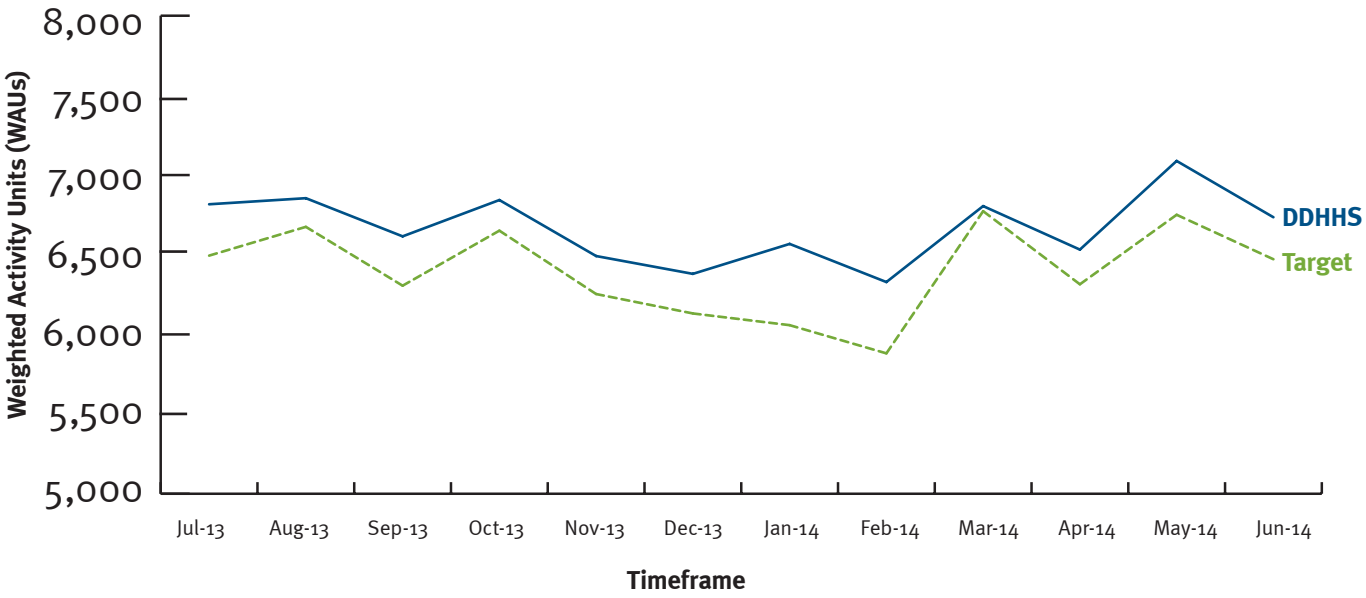
All outpatient attendances
191,363
+9,859 from 2012-13

Pharmacy attendances
46,681
+1,670 from 2012-13

Our performance

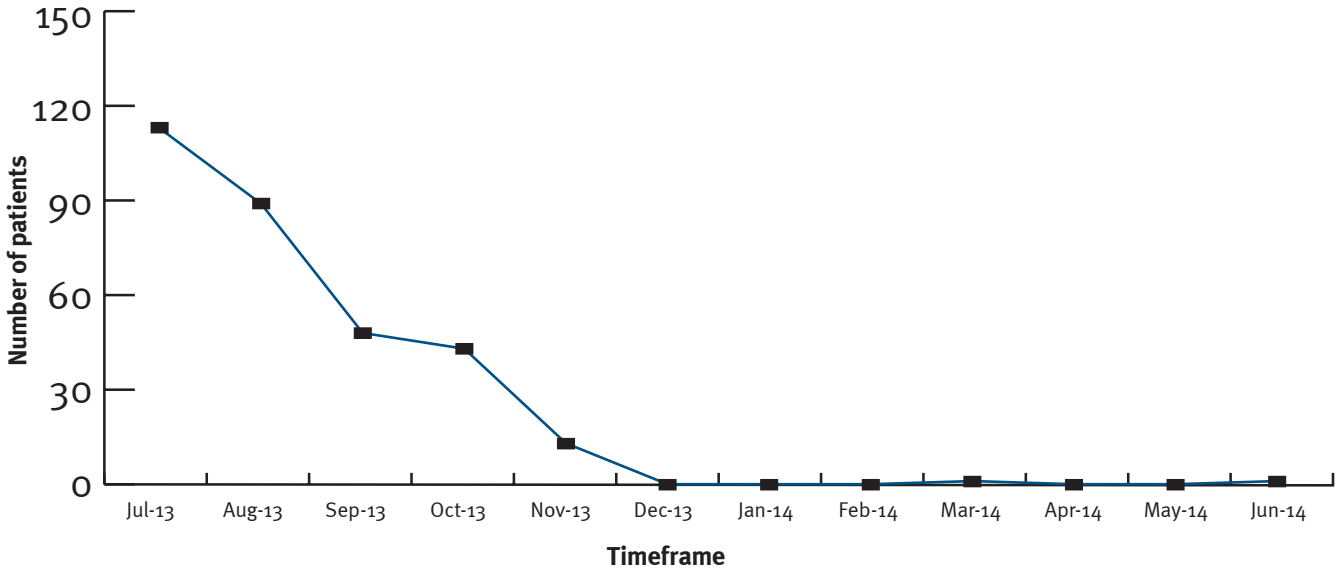
DDHHS delivers more health care than contracted

DDHHS has consistently delivered more health care than contracted to under the service agreement with the Department of Health. The top line shows what the DDHHS provided (as measured in weighted activity units which provide a common unit of comparison) while the bottom line is the contracted level of service.



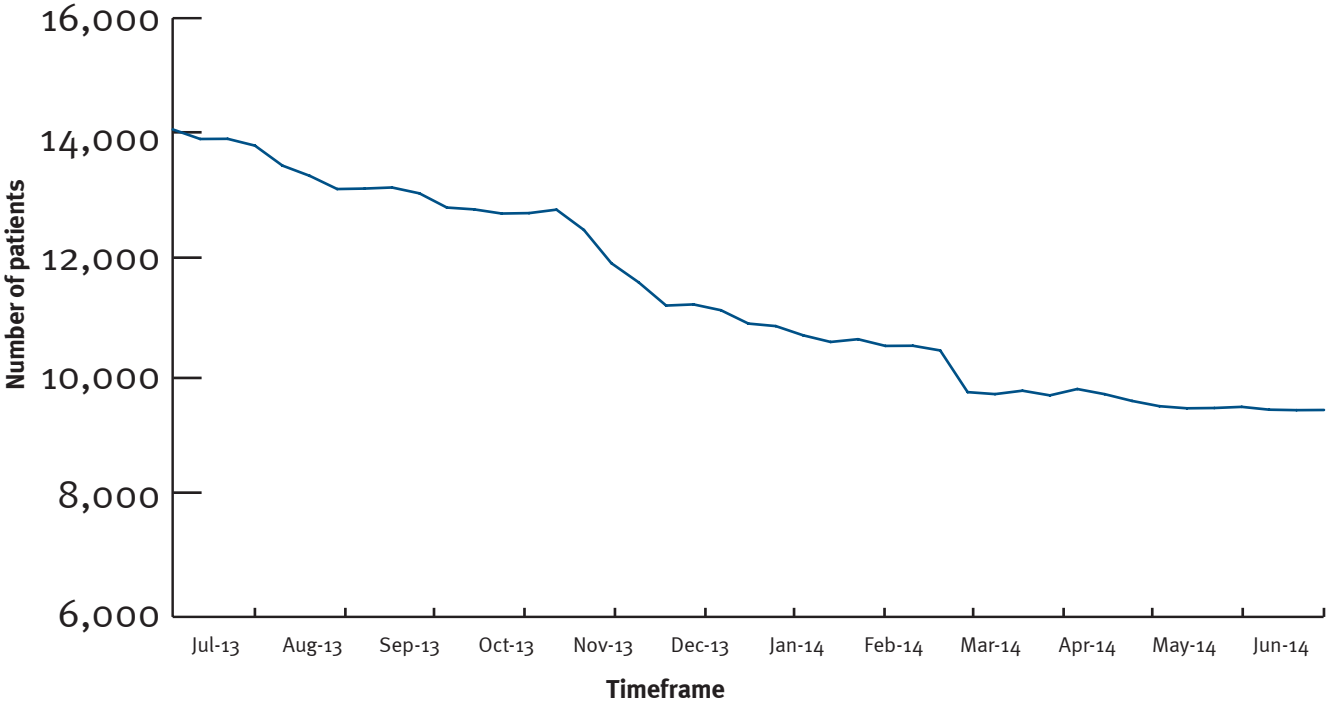
Number of long waits for routine elective surgery reduced

The numbers of people waiting longer than clinically recommended for routine (Category 3) elective surgery was significantly reduced as shown in graph below.



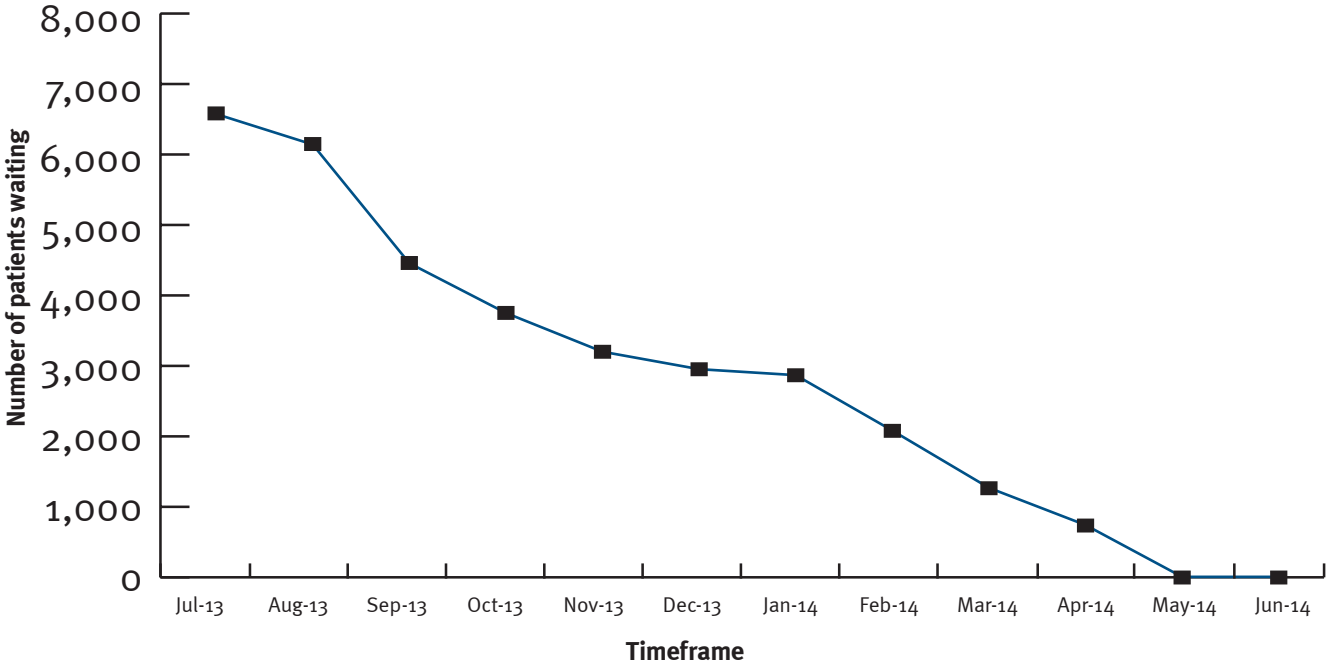
Numbers waiting for Specialist Outpatients' appointment improves

People waiting for an outpatient appointment dropped by 34 per cent between July 2013 and June 2014. Reducing the waiting list further will continue to be a focus in 2014-15.



Oral Health long waits improve

DDHHS had a strong focus on reducing waiting times for oral health care. By the end of June 2014, no one was waiting longer than clinically recommended for a routine dental check-up.



Our performance

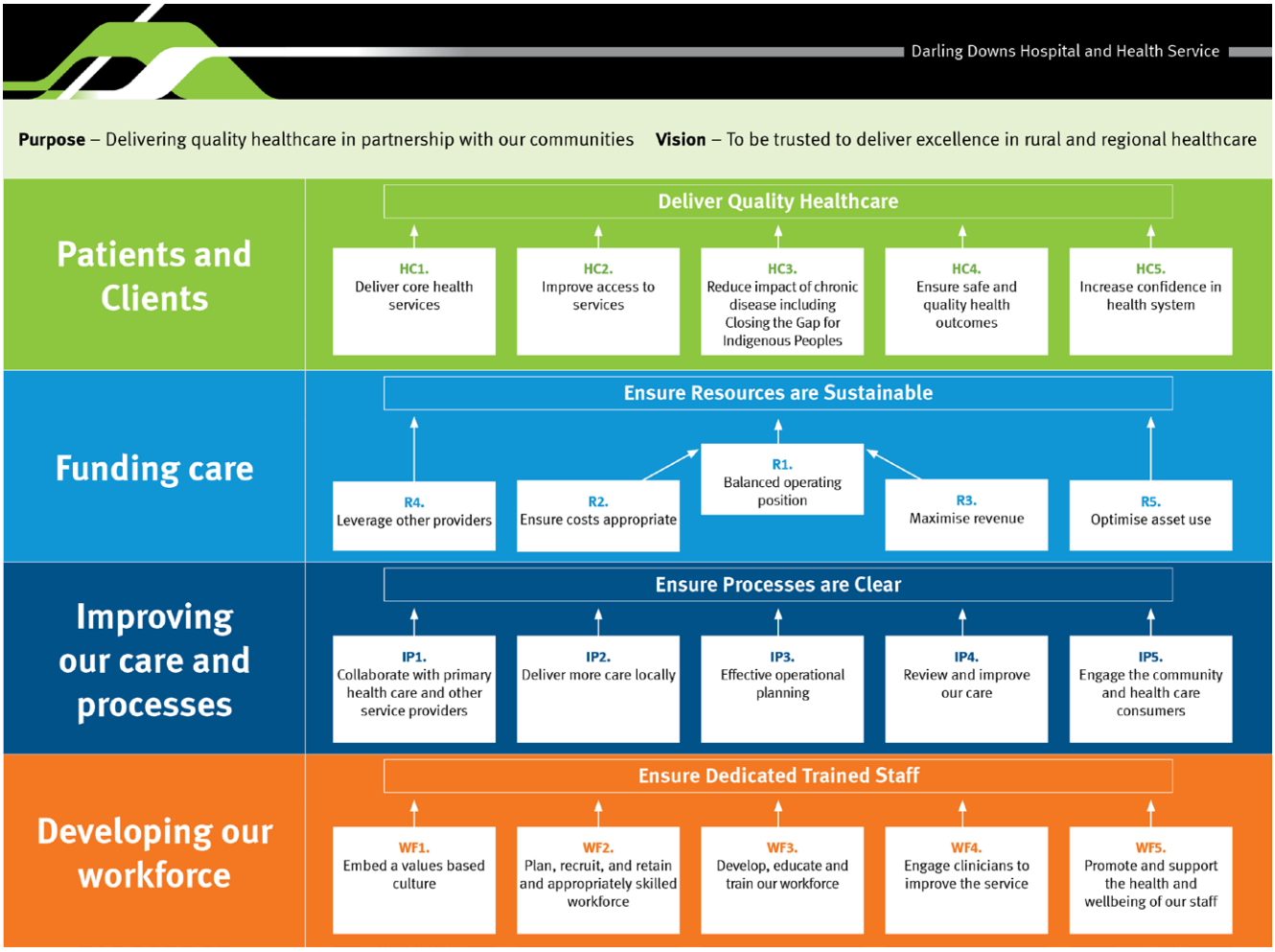
DDHHS Strategic Plan 2013-17 (below) sets out the priorities for how the service will meet our vision: to be trusted to deliver excellence in rural and regional healthcare.

It is a living document which guides planning, implementation and review of all aspects of our operations.

It focuses on our need to have dedicated trained staff who are supported with clear processes and sustainable resources so they are best placed to deliver quality healthcare.

This section of the annual report details our performance in four key areas covered in the strategic plan:

- delivering quality healthcare
- ensuring resources are sustainable
- ensuring processes are clear
- ensuring dedicated trained staff.



Delivering quality healthcare

DDHHS operates under a service agreement with the Department of Health to deliver agreed core health services. During the year we delivered above the contracted amount with 104 per cent of services provided to patients and communities.

For 2013-14, the Board had a strong focus on delivering core health services that would improve patient care on several fronts.

In 2013, the Toowoomba Emergency Department admitted to a ward, transferred or discharged within four hours, 79 per cent of the more than 46,000 presentations during the year. This was above the National Emergency Access Target (NEAT) of 77 per cent. Several rural facilities exceeded the target: Stanthorpe (97.6 per cent), Cherbourg Hospital (97 per cent), Warwick (94.5 per cent) and Kingaroy Hospital (89.5 per cent).

By the end of 2013, no patients waited longer than clinically recommended for urgent, semi-urgent or routine elective surgery at Toowoomba Hospital. In 2013-14, 4,796 elective surgical procedures were performed, 934 (24 per cent) more than in 2012-13. Surgery activity also increased in Kingaroy, Warwick and Dalby.

In July 2013 urology services were reinstated at Toowoomba Hospital. Many patients no longer have to travel for treatment. In the first year, 447 urology outpatients were seen with 301 elective surgical procedures and 51 emergency procedures performed.

In January 2014 increased ophthalmology services started at Toowoomba Hospital. In 2012-13, 327 cataract patients were treated, while in 2013-14 there were 469 patients treated.

There were 3,441 endoscopies performed, an increase of 480 on the previous year.

In June 2013, there were 6,826 people waiting longer than clinically recommended for a general dental appointment. By June 2014, there were no patients waiting outside the clinically recommended timeframes. This was achieved through recruitment of more staff, use of a voucher system to see a private dentist, a public-private partnership at Inglewood, and staff working overtime and after hours to offer more appointments.

Maternity services delivered 3,136 babies across DDHHS, 28 more than in 2012-13. This included 412 babies in Kingaroy, one of the busiest non-specialist birthing facilities in the state.

DDHHS operates seven designated birthing facilities. In 2013-14 the distribution of births at these facilities was:

Toowoomba	1,994
Kingaroy	412
Dalby	272
Warwick	195
Stanthorpe	128
Goondiwindi	95
Chinchilla	33

In addition seven babies were delivered at other facilities in DDHHS.

During the year, there were 4,210 visits to new parents under the "Mums and Bubs" program where midwives and child health nurses provide in-home support services through two visits in the first four

Allied Health Clinical Leader role example of innovation

Physiotherapist Doug Murtagh and Occupational Therapist Sue McLevie (pictured) helped host the visit.

A program developed by DDHHS allied health staff to streamline and better coordinate patient care caught the attention of allied health professionals from one of Australia's leading tertiary hospitals. Members of Melbourne's Alfred Hospital's allied health team visited Toowoomba Hospital in May to learn more about a Clinical Leader role that has been implemented in the Acute Medical Unit to improve patient flow and enhance patient care.

The visit was organised after the Toowoomba team presented at a national Allied Health conference in September 2013.

weeks after giving birth. The program gives information on immunisation, breastfeeding and nutrition, providing a safe environment and the importance of reading to children.

Toowoomba Hospital's Stroke Unit was the only facility offering stroke lysis treatment, 24/7, on the Darling Downs. The unit has had remarkable success with patients who have been able to receive treatment within hours of stroke symptoms developing. Patient feedback on the unit and rehabilitation facilities has been outstanding.

The delivery of these core health services was achieved in an environment of strong clinical governance and focus on safety and quality.

A Senior Medical Officer was appointed as the Director Clinical Governance and other senior staff were recruited to lead the safety and quality functions across the Health Service.

The Patient Safety and Quality Unit continued to play a vital function in the operation of the DDHHS. The team included quality officers and facilitators, patient safety officers, and the consumer liaison service who all had a role in maximising patient safety in line with the National Safety and Quality Health Service Standards.

DDHHS has maintained accreditation across all components of the service.

DDHHS is committed to providing safe and quality healthcare. To supplement existing processes, in 2014 the DDHHS implemented the statewide initiative "Ryan's Rule". Ryan was a child elsewhere in Queensland whose parents could see he was deteriorating. They had no way of alerting clinicians to this problem and Ryan died. As a consequence, 'Ryan's Rule' was introduced and promoted so that if families become concerned about a relative's care they can escalate their concern to a senior medical manager.

Several promotional opportunities focused on raising awareness of key safety issues. These included "April No Falls" month, a national and international initiative to raise awareness of falls and minimise preventable fall injuries. The "Be a Hand Hygiene Angel" campaign at Toowoomba Hospital won a state-wide competition for its creativity in raising awareness, joining many other initiatives across the Health Service to improve hand hygiene rates.

DDHHS launched a new clinical newsletter, *The Clinical Standard*, as part of an open communication and continuous education program to improve patient care. The publication seeks to provide valuable lessons, and includes some real-life case studies, links to relevant literature, and other useful information.

The DDHHS has a strong Patient Safety and Quality team who work across all parts of the Hospital and Health Service.

General Manager Toowoomba Hospital Dr Peter Gillies was one of more than 30 staff members who were happy to champion the infection control cause by becoming a "hand hygiene angel". The Toowoomba team took out the State award for best hand hygiene promotion campaign.

Ensuring resources are sustainable

Financial Summary

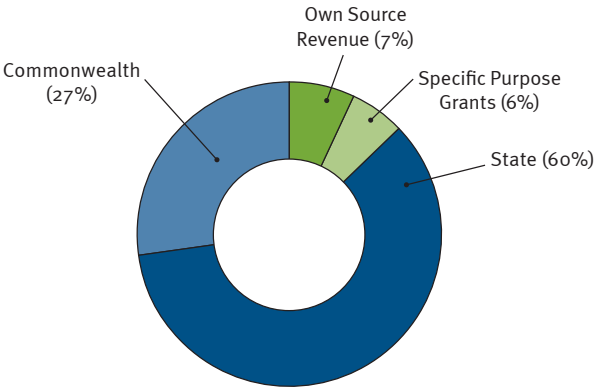
DDHHS has finished its second financial year as a statutory body with an operating surplus of $17.7 million, on revenue of $607.4 million, while still delivering on agreed major services and meeting and improving key safety and quality performance indicators. This occurred largely as a result of continued productivity improvements as well as increasing own source revenue.

Where the Money Comes From

DDHHS income is predominantly from government funding comprising:

- State Government contribution for activity based and block funded services
- Commonwealth Government contribution paid through Queensland Treasury for activity based and block funded services
- Other State and Commonwealth specific purpose grants such as Home and Community Care and Nursing Home revenue
- Own Source Revenue generated from user charges and recoveries from other agencies.

Revenue by funding source



DDHHS total income from continuing operations for 2013-14 was $607.4 million. Of this the State contribution was $366 million (60 per cent), Commonwealth contribution was $163 million (27 per cent), Specific Purpose Grants were $35 million (6 per cent) and own source and other revenue was $43 million (7 per cent).

Where the Money Goes

DDHHS operates a complex group of services. The table below shows the proportion of the budget spent on services within DDHHS.

Toowoomba Hospital	37%
Rural Health (incl. Aged Care and Public Health)	32%
Mental Health (incl. Alcohol and Other Drugs)	13%
Allied Health (incl. Commonwealth Programs)	5%
Oral Health	2%
Infrastructure Costs	4%
Other Professional and Support Services	7%

73 per cent of expenditure in the service is on employee expenses both internal and external. 23 per cent of expenditure is on non labour expenses such as clinical supplies, drugs, prosthetics, pathology, catering, repairs and maintenance, communication and energy. Four per cent of expenditure is related to depreciation of our fixed asset base.

2013-14 in review

DDHHS produced a surplus of $17.7 million (2.9 per cent of revenue) in its second year as a statutory authority, while delivering activity purchased by the Department of Health. This was achieved mainly as a result of:

1. Productivity Improvements – given 73 per cent of DDHHS expenditure is labour related it is not surprising that the most significant contribution to the surplus has been through increased productivity. In 2013-14 the DDHHS managed to deliver 6.8 per cent additional activity compared to 2012-13, with only a corresponding 5 per cent increase in expenditure including enterprise bargaining increases and additional expenditure on backlog maintenance
2. Own Source Revenue – another significant contributor to improved performance has been an increased focus on maximising all sources of revenue, including maximising revenue from patients electing to be treated privately, bulk billing for Medicare eligible services and improvements in aged care revenue. Through improvements over the last two financial years this has added $8.5 million each year to the operating income for DDHHS.

Fulltime medical imaging service set for Goondiwindi and Warwick

A contestability process ensured local access to a CT scanner at Goondiwindi Hospital for the first time.

At its April 2014 meeting, the Board accepted a recommendation for medical imaging services such as x-rays, ultrasounds and CT scans to be provided by a private company at Goondiwindi and Warwick hospitals (pictured above).

This partnership approach with the private sector is a sustainable way of providing a full time medical imaging service in the two regional centres. It is expected to be in place by late 2014.

An Outlook

In spite of the result achieved by DDHHS, the financial sustainability of services in DDHHS remains a close focus given the expected increase in demand for services over the next 5-10 years and budgetary pressures on both Commonwealth and State Governments. The Board and Management of DDHHS remain vigilant in ensuring maximum services are achieved within the finite resources of the DDHHS and continue to develop strategies to strengthen the financial sustainability of DDHHS, including the retention of a modest contingency reserve from the generated surplus.

Community dividend

The 2012-13 surplus was reinvested, as a community dividend, to deliver improved local services including a $1.2 million refurbishment of the Stanthorpe Hospital maternity unit. Warwick company FBC Constructions Pty was awarded the tender to refurbish two birthing suites and install a birthing pool. The project was the culmination of extensive consultation with local stakeholders including Mothers United Maternity Services Stanthorpe (MUMSS) and the Stanthorpe Birthing Suite User Group. Work is set to be completed in late 2014.

The surplus was also used to fund a $360,000 project to build a dedicated palliative care room at Goondiwindi Hospital. Local company RJ Hanna Constructions were awarded the tender to build the facility which will help terminally ill patients stay closer to their families and friends for their end-of-life care. The palliative care room will include an upgraded private ensuite to offer home-like facilities. It will be opened in late 2014.

Also as part of the 'community dividend', the Board announced a $2 million expansion of the endoscopy unit at Toowoomba Hospital which will double existing capacity in the unit and free up other operating theatres so more complex surgery can be performed. The expansion means patients won't wait as long for procedures to investigate bowel conditions and will also help meet an expected increase in demand for endoscopies.

The Board allocated an extra $3 million for extra elective surgery in order to meet the national target of no patients waiting longer than clinically recommended for surgery. This funding facilitated extra surgery sessions, including on weekends, to cut through the lists. By the end of 2013, the target was achieved.

Backlog Maintenance Program

Work started on a $50.6 million program of maintenance and rehabilitation works to rejuvenate buildings and other facilities across DDHHS over the next four years. The State Government provided this funding to fix the backlog of maintenance work. This is in addition to the service's regular repairs and maintenance expenditure of around $13 million each year. Some of the common works include internal and external painting, plumbing, air conditioning upgrades, fencing repairs, improved security and electrical switchboard upgrades or replacements across the whole Health Service. The program includes $10 million for painting and refurbishments at Toowoomba and Baillie Henderson hospitals which started this year.

Ensuring processes are clear

Improving our care and processes means we look for opportunities to deliver more care locally, as well as review and improve our services through engaging the community and health care consumers.

DDHHS leads the State in the most number of telehealth consultations with 3,201 'occasions of service' provided, more than double the 1,531 consultations in 2012-13. A new unit was established to provide more support to this mode of health care delivery.

Patients who presented to our rural Emergency units needing Mental Health services were able to access specialist support through the Mental Health Consistent Assessment in Rural Emergency (MH CAiRE) project. It involved the use of telehealth to increase access to after-hours specialist Mental Health assessment services located in Toowoomba.

Some patients however do need to travel. The Patient Travel Subsidy Scheme (PTSS) supported more patients than ever before to access specialist medical services.

- Number of patients 9,792
- Number of claims 29,671
- Number of nights 48,415
- Total reimbursement $6,006,678.

DDHHS established a Commercial Management Unit to identify and explore business improvement opportunities and see them through to implementation. The unit's focus was to review DDHHS's models of service provision, identify options for service improvement, procure goods and services as required and manage contracts for goods and services to ensure that DDHHS receives value from its contracts.

More than twenty community service sector and government support agencies from across the region gathered together at the Toowoomba Hospital's inaugural Big Day Out in October. The day gave hospital staff the opportunity to find out more about the services available in the community for patients and their families. A community network meeting identified that there was a need for more information sharing between the hospital and local agencies.

The day included information stalls from a wide range of local and state government services and non-government organisations, as well as presentations on topics such as homelessness and housing, refugee support services domestic violence, and refugee support.

Another example of care process improvement during the year was the establishment of the Safe Haven unit at Toowoomba Hospital. It was created especially for patients experiencing delirium (a state of acute confusion). The unit features around-the-clock, continuous nursing care, a homely atmosphere and four beds specifically designed for patients experiencing delirium. Delirium commonly occurs in elderly patients, particularly those who have undergone surgery or have experienced an infection, electrolyte imbalance, depression or dementia. Up to 80 per cent of patients in intensive care will experience delirium. The new unit provides a space for families and friends of the patients to be accommodated, as well as security provisions, diversional therapies like craft and music, and specialised beds.

Outpatients' list improves

Toowoomba Hospital's specialist outpatient waiting list (excluding endoscopy) was reduced from 11,664 at the end of June 2013 to 7,745 in June 2013, a decrease of almost 34 per cent.

This was thanks to a special project which looked at ways to reduce the list so patients were waiting within clinically appropriate times.

General Practice Liaison Officer (GPLO) Dr Debra Carroll (pictured), whose position was co-funded by Darling Downs South West Queensland Medicare Local, has been an important part of the project's success as she has worked with GPs to streamline referrals to specialists.

The GPLO position arose through the Queensland Government's commitment to improving communications between GP Practices and the Health and Hospital Service.

The Board has confirmed continued improvements in waiting lists are a priority for 2014-15.

Our people

Ensuring dedicated trained staff

Our workforce comprises over 4,800 employees. The clinical workforce (65 per cent) includes doctors, nurses, and a wide range of allied health and other professional and technical staff. Effective and efficient service delivery also requires non-clinical staff, including administrative officers in clinical and corporate support (14 per cent), and operational and trades staff in hotel services, infrastructure, and other supports (21 per cent).

About one in 60 people in the Darling Downs work for us. These individuals add to our collective story. A summary of the statistics describing our employees is below.

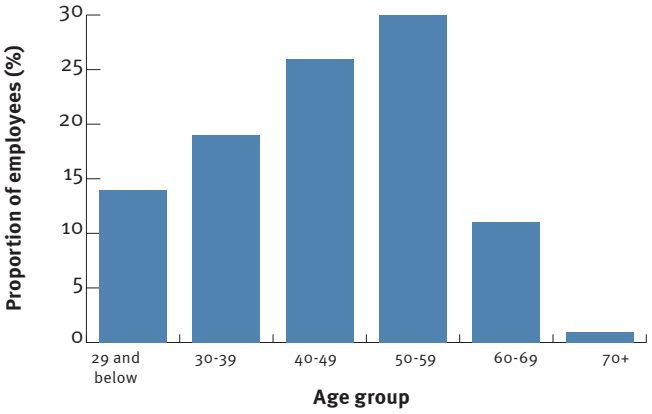
Employees by service area, 30 June 2014	MOHRI Occupied FTE	MOHRI Occupied Headcount
Toowoomba Hospital	1,353	1,715
Rural and Aged Care	1,392	1,895
Mental Health	576	655
Allied Health	205	313
Finance & Corporate Support	190	200
Professional Governance	47	48
Health Service Chief Executive	18	19
Other	24	26
DDHHS Total	**3,805**	**4,871**

The retention rate for permanent staff within the DDHHS for 2013-14 was 93.4 per cent, with a separation rate of 6.6 per cent.

Key staff appointments were made over the past year. These included Infectious Diseases Specialists, an Orthopaedic Consultant and a Gastroenterologist.

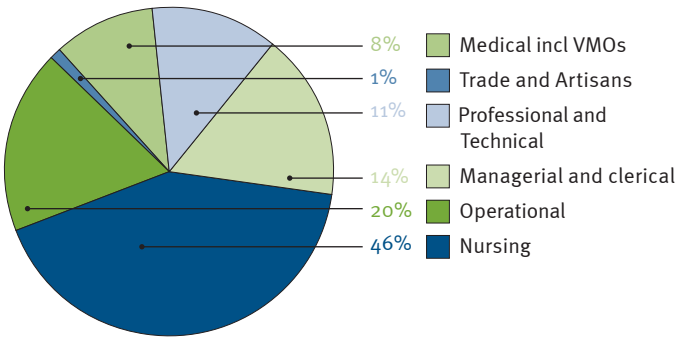
In 2014 Toowoomba Hospital took on a record number of interns when 35 new doctors started the next phase of their careers. Kingaroy Hospital welcomed two medical interns for the first time.

DDHHS staff age by percentage



DDHHS staff occupation by percentage

The following graph shows the occupational stream as a proportion for the 2013-14 financial year:



We employed more than 20 graduate nurses across all divisions.

Toowoomba Hospital's Building Engineering and Maintenance Services (BEMS) department bolstered its ranks with the appointment of two new electrical trades apprentices, which meant the experienced electricians could pass their knowledge onto the next generation, and enhance the effectiveness of the BEMS department.

Integrity and ethical behaviour

DDHHS is committed to ensuring the highest level of ethical behaviour through all aspects of our activities.

Employees at all levels within DDHHS are required by the Queensland Government to follow the standards of behaviour and conduct set out in the Code of Conduct for the Queensland Public Service (available at www.premiers.qld.gov.au/publications/categories/policies-and-codes/code-of-conduct.aspx).

The values contained in the DDHHS Strategic Plan 2013-2017 were mapped to the 'Code of Conduct for the Queensland Public Service' (the code):

- Caring - 1.3 & 1.5 in the code
- Doing the right thing - 1.1, 1.2, 2.2, 3.1, 4 in the code
- Openness to learning and change - 2.1 & 4.5 in the code
- Being safe, effective and efficient - 4.3 & 4.5 in the code
- Being open and transparent - 1.3, 1.4, 2.2, 2.3, 3.1, 4.1, 4.2, 4.4 in the code

To address the strategic objective WF1 'Embed a values-based culture', a new framework, 'Our Values in Action', has been developed. 'Our Values in Action' describes how our values and behaviours lead to outcomes. It encourages staff to reflect on their behaviours and actions in terms of the DDHHS values to ensure we deliver on our purpose and can achieve the vision of being trusted to deliver excellence in rural and remote healthcare.

Messages that establish and reinforce the DDHHS values are now delivered to employees throughout their employment journey, from recruitment and orientation to performance appraisal and regular communications, including:

- News items
- All-staff email alerts
- Intranet spotlights
- Screensavers
- Staff Newsletter (available in electronic and hard copy).

A comprehensive review of the employee performance management system was undertaken, which included a survey of staff views and trial of a new, electronic employee performance appraisal tool. A package including a procedure, guides, and other support materials for performance support, assessment and improvement is in preparation for roll-out in 2014-15. The new approach will emphasize values-based behaviour and the importance of an effective, ongoing relationship between managers and their staff.

Staff opinion survey

Thirty per cent of DDHHS staff took the opportunity to have their say in the Working for Queensland survey in May 2014. In line with our commitment to openness and transparency, the survey results were made available on our intranet and Executive Directors were presented with their portfolio results. Overall it showed improvements in 101 out of the 103 items surveyed and compared with the previous year, the greatest improvements were shown in the following:

Nurse achieves credentialing

Toowoomba Hospital's gastroenterology nurse coordinator Wendy Irwin (pictured) joined an elite group after being awarded Credentialing from the Gastroenterology Nursing College of Australia.

Nurse Unit Manager for Perioperative Services Denise Iseppi said since 2004, five nurses from Toowoomba Hospital had sat and passed this exam and, of those, three had attained the highest mark in Australia, including Wendy.

The road to achieving credentialing is an arduous one, as Wendy explained.

"First of all you have to have at least two years or 3,500 hours employment experience in gastroenterological nursing, then you need to be able to provide three professional references, and once you've fulfilled those criteria you can sit the exam during Australian Gastroenterology Week."

- Agree with the way my organisation tries to achieve its goal ↑ 14 per cent
- My organisation motivates me to achieve its objectives ↑ 14 per cent
- Leadership operates with high level of integrity ↑ 13 per cent
- My organisation inspires me to do the best in my job ↑ 13 per cent
- My senior manager demonstrates honesty and integrity ↑ 12 per cent

These results seemed to validate the values approach taken. A focus for improvement from the survey will be red tape reduction.

Supporting and acknowledging our staff

Eighty-nine employees were recognised for their length of service at an award ceremony held to mark Queensland Day, June 6 2014. It was an opportunity to acknowledge the outstanding dedication of our staff members who had achieved the milestones of 30, 35, and 40 years of service. Staff members, with a combined 3,000 years of service, came from locations all across the DDHHS, and represented different professions and occupations including nursing, medical, allied health, administration and operational streams. A total of 942 staff were recognised for reaching five-year milestones across the Hospital and Health Service.

Years of Service	Number Awarded
5	345
10	177
15	149
20	96
25	86
30	44
35	25
40	20
TOTAL	**942**

Individuals and teams were recognised for their outstanding service to healthcare delivery at an Australia Day awards ceremony. They included:

- Principal Dentist of the Toowoomba Oral Health Service, Dr Helen Linneman, for her work in leading the oral health service reforms in the Darling Downs and for her many years of outstanding service.
- Dr Anthony (Tony) Balston for his long service as Jandowae Hospital's Medical Superintendent since 1982. He has held executive positions with the Australian College of Rural and Remote Medicine, the Australian Medical Association, the Darling Downs Local Medicare Association and the Southern Queensland Rural Division of GPs.
- The Emergency Department and Medical Unit 1 at Toowoomba Hospital received a team award for their outstanding efforts in achieving the National Emergency Access Target (NEAT) by the end of 2013. Under the target, Queensland public hospitals aimed to have 77 per cent of patients who present to emergency departments admitted, discharged or transferred within four hours.
- The Mobile Women's Health Service was awarded for its role in delivering healthcare to women in rural and remote areas. Kathryn Anning, Marcia Hunt and Barbara Milne operate as sole practitioners to provide services such as cervical screening, sexual health testing and information, family planning information, continence advice, breast health awareness, and information and support relating to domestic and sexual abuse.
- Surgical Services at Toowoomba Hospital was nominated for achieving its goal of having all elective surgery patients seen within the clinical recommended timeframes set down in the National Elective Surgery Target (NEST).

Many of our staff lead varied and interesting research projects into their fields of interest or expertise. During the year there were around 200 research projects overseen by the DDHHS Human Research Ethics Committee. Research topics ranged from delirium to occupational therapy, palliative care to mindfulness training.

We hosted several leading national health experts through the Clinical Leaders' Forums held as a way of linking and inspiring the Service's top clinicians. Gordon Gregory, Executive Director of the National Rural Health Alliance (NRHA) shared his views on the benefits and challenges of the rural and remote health movement for the people in the Darling Downs. Professor Christine Bennett, previous Chair National Health and Hospitals Reform Commission, provided her insights on health reform in Australia.

Our organisation

The establishment of the Darling Downs Hospital and Health Service as an independent statutory body has been a major change in how we run the business of delivering healthcare services to local communities.

The organisational structure is configured as follows:

Clinical divisions

There are three 'clinical' operating Divisions. These Divisions lead in the delivery of high quality, evidence-based, safe patient care. The Divisions work in a collaborative manner to provide integrated patient care across the continuum and geography of DDHHS:

- **Toowoomba Hospital** operates with four clinical services groups - Surgical, Medical, Ambulatory Care Support Services Women's and Children's Services. In addition Facility Services for Toowoomba Hospital and Baillie Henderson Hospital are operationally aligned to this Division.
- **Rural Health** operates 18 hospitals (three of which are multi-purpose heath services) and six residential aged care facilities. The Division is managed via a Cluster Model with three geographic clusters (Southern, Western and South Burnett) and a cluster for residential aged care services. In addition Oral Health Services for DDHHS are operationally aligned to this Division.
- **Mental Health** includes child & youth, adult and older persons, acute inpatient services at Toowoomba Hospital, and community services in Toowoomba and a range of rural centres. Mental Health services for consumers who require extended treatment and rehabilitation, extended secure rehabilitation, who have acquired brain injury and dual diagnosis involving mental illness and intellectual disability or are older people requiring extended treatment are provided at Baillie Henderson Hospital, Toowoomba. In addition the Alcohol and Other Drugs Service for DDHHS is operationally aligned to this division.

Professional divisions

The operating divisions are supported by three professional divisions. The professional divisions lead DDHHS in promoting clinical service improvement, consumer satisfaction, clinician engagement, clinical governance, professional and clinical standards and clinical workforce planning and education:

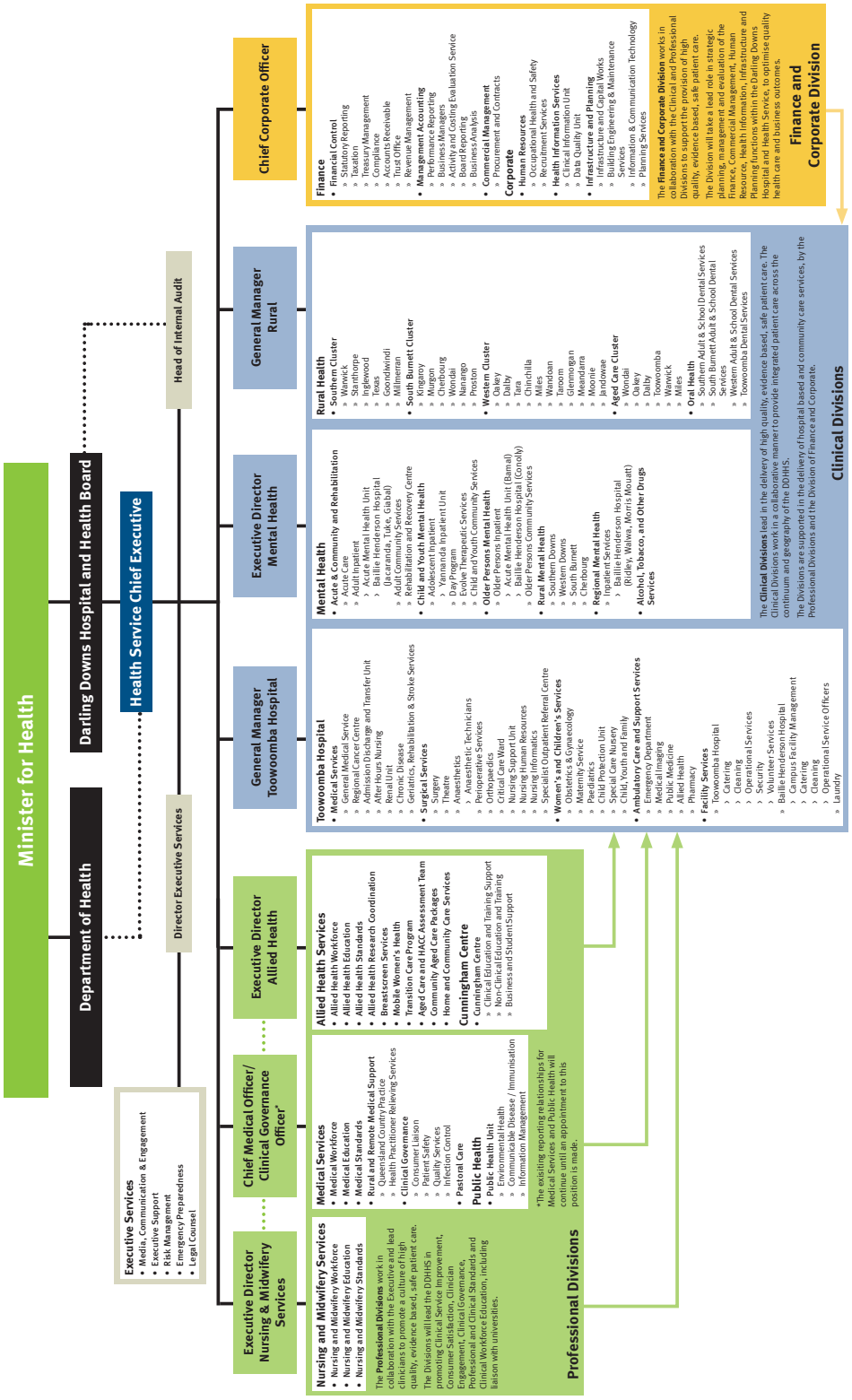
- **Medical Services** includes Medical Workforce, Medical Education, Clinical Governance, Rural and Remote Medical Support and Public Health.
- **Allied Health** provides professional lead for Allied Health Services (including workforce planning, education and standards). This Division also includes the Cunningham Centre (Registered Training Organisation), Breastscreen, mobile womens health services, Aged Care and Home and Community Care (HACC) Assessment Team and Transition Care Program.
- **Nursing and Midwifery** provides professional lead for Nursing and Midwifery Services (including workforce planning, education and standards).

Finance and Corporate division

The **Finance and Corporate** division provides a range of DDHHS-wide support functions across all divisions, comprising Financial Control, Management Accounting, Commercial Management, Human Resources, Health Information Services, and Infrastructure and Planning.

Each division is lead by an Executive who, as part of the DDHHS Executive Team, supports the Chief Executive (HSCE) to fulfill the accountabilities and responsibilities for the delivery of health services. The Divisional Executive is the single point of accountability for the division exercising delegation from the Health Service Chief Executive (*Hospitals and Health Boards Act 2011*, Section 34). The Executives report to the HSCE who in turn reports to the Darling Downs Hospital and Health Board.

Organisation structure



Our divisions

Toowoomba Hospital

Achievement highlights

- National elective surgery target reached
- More patients get seen in emergency faster
- Infrastructure improvement program started

Toowoomba Hospital was able to achieve a high level of healthcare delivery in 2013-14. This included:

- 47,966 emergency department occasions of service
- 93,259 admitted patient bed days
- 111,306 outpatient department occasions of service (including 19,970 Allied Health service provisions)
- 1,997 births.

Toowoomba Hospital achieved the National Emergency Access Target (NEAT) by the end of 2013. Under NEAT, Queensland public hospitals aimed to have 77 per cent of patients who present to emergency departments admitted, discharged or transferred within four hours. For the period 1 January to 31 December 2013, Toowoomba Hospital achieved a 78 per cent rating overall with over 48,000 presentations. This great result was due to a number of factors – the extraordinary effort of the staff across the hospital but particularly in the Emergency Department and Medical Unit 1, an improved bed booking process and multi-disciplinary meetings within the wards to improve patient flow. From 1 January 2014 the NEAT target increased to 83 per cent and despite a very busy January and February, progress towards reaching this new target was good. For the period from 1 January to 30 June 2014 Toowoomba Hospital achieved 81.1 per cent, which again, was a testament to how hard staff across the hospital worked to ensure patients were treated efficiently.

In 2013, the surgical service achieved its goal of having all patients awaiting elective surgery treated within the clinical recommended timeframes set down in the National Elective Surgery Target (NEST). Improving our NEST was a key focus of the Hospital and Health Service and by the end of December 2013 the hospital reached its target of having no elective surgery long wait patients. In 2013-14, 4,796 elective surgical procedures were performed, which was 934 (24 per cent) more than in 2012-13.

Significant progress was made in addressing the outpatients waiting list. A dedicated GP Liaison Officer, jointly funded with the Darling Downs South West Queensland Medicare Local, led a project to identify where improvements could be made. This included consistent processes and the provision of relevant information to local GPs to assist with providing good quality referrals. Within the past 12 months, the waiting list, excluding endoscopy, has reduced from 11,664 to 7,745, a reduction of almost 34 per cent.

Toowoomba's Jenni Price named as Queensland Midwife of the Year

For the second successive year a midwife from Toowoomba Hospital was named Queensland Midwife of the Year. Jenni Price (pictured), a midwife for more than 26 years, was delighted to be named as this year's winner during celebrations for International Day of the Midwife at Toowoomba Hospital's Harbison Maternity Unit in May.

"It is a privilege and an honour to receive this award," she said.

"I have the opportunity to work within a large team of health professionals who support me in what I do and it means so much to me to work in a town where women have choices in their care and birth."

The Board committed $2 million in funding to expand the endoscopy suite at Toowoomba Hospital, doubling existing capacity. The second endoscopy suite will free up general operating theatres for more complex surgery and will allow increased numbers of endoscopy procedures to be undertaken to detect health issues such as bowel cancer.

From 1 July 2013, when urology services were re-commenced at Toowoomba Hospital, until 30 June 2014, 447 urology outpatients were seen with 301 elective surgical procedures and 51 emergency procedures performed.

Design work on a new $9.76 million kitchen at Toowoomba Hospital commenced to replace the current kitchen which produces around 1,000 meals per day but was built in 1963 and no longer meets modern standards. Construction is scheduled to start in late 2014 with completion expected by mid-2015.

Work started to rejuvenate 24 buildings at Toowoomba Hospital as part of a $2.2 million project. The external façade of the hospital will be extensively revamped, with repairs made as necessary to restore the infrastructure to a good condition. It was part of a $50.6 million backlog maintenance program across the Hospital and Health Service funded by the Queensland Government over four years.

The Stroke Unit celebrated its first birthday and one year of success. The service has delivered excellent outcomes to a number of stroke patients over the past 18 months since offering stroke lysis treatment, which involves administering a clot-busting injection within hours of the first symptom of stroke.

A unit, especially created for patients experiencing delirium, was launched at the Toowoomba Hospital. The four-bed Safe Haven Unit features around-the-clock, continuous nursing care in a homely atmosphere.

Toowoomba Hospital's pastoral care team celebrated 20 years of service to patients, families and staff in 2013. Around 200 hours of pastoral care is provided at hospital bedsides each week.

Rural Health

Achievement highlights

- Oral health care delivered in clinically recommended timeframes
- Large increase in telehealth services provided greater local access to care
- Surgery activity increased at Kingaroy, Warwick and Dalby

During the past year the Rural Health Division provided:

- 99,103 emergency unit occasions of service
- 67,827 admitted patient bed days
- 56,924 outpatient department occasions of service
- 53,391 community-based occasions of service
- 1,142 births

More care locally was achieved through:

- Telehealth services providing access to specialist medical services for many rural patients meant that the Darling Downs is leading the State in the frequency and numbers of telehealth consultations. Telehealth services providing a geriatrician into our residential aged care facilities has also improved care and avoided costly travel.
- Surgical activity has been increased in Kingaroy, Warwick and Dalby.
- In February 2014, the Chinchilla Hospital implemented a new medical model which enabled improved service provision to the community through a primary health clinic as well as increased anaesthetic coverage following employment of a rural generalist doctor with anaesthetics qualifications. This also means more consistent availability of birth services.
- The Birthing on Country Project has started to explore culturally sensitive and safe birthing services for women in the South Burnett.

Other highlights included:

Health Minister and Member for Southern Downs, The Honourable Lawrence Springborg MP, officiated at an event to celebrate 100 years of health service delivery in Texas on 2 November 2013. A high level of community involvement in establishing the hospital on 3 December 1913 — and in its operations since then — has been proof of the extraordinary role the local health service had

played in everyday life. Staff, past and present, were praised for their work in caring for the Texas community. The facility's oldest resident, Mrs Eva Beard who turned 100 on 3 March 2014, was guest of honour at the event.

DDHHS partnered with resources company Glencore to establish the Wandoan Primary Health Care Centre. The $950,000 primary health care centre was operational at the end of September 2013. The clinic is staffed by a full-time nurse practitioner who is able to prescribe medication and diagnose conditions. The clinic also has facilities to accommodate regular visits from other health professionals including General Practitioners from Miles, a social worker, occupational therapist, podiatrist and physiotherapist, as well as equipment for telehealth. The new primary health care clinic replaced an ageing outpatient clinic which was located on the same site.

The health of Indigenous men living in the South Burnett was given a shot in the arm with the arrival of Liaison Officer Barry Fisher in December 2013. Barry helps men from the Cherbourg community while they access health services at Kingaroy Hospital. He works alongside fellow Indigenous Liaison Officer Jocelyn Clancy who started in her role in 2012. Both officers help patients understand their treatment or other parts of the healthcare process, as well as liaise with all stakeholders.

Oral health care

Better access to high quality oral health services has been a focus across the Darling Downs Hospital and Health Service over the past year, with significant investment in achieving the nationally recommended time for a dental assessment for eligible clients.

At the beginning of June 2014, no eligible public patient across the Darling Downs was waiting longer than clinically recommended for a routine dental check-up. This was achieved through a range of measures to see more patients including:

- Establishing relationships with private dentists
- Implementing a voucher scheme for some long-wait patients to access private dentists
- Staff undertaking overtime and working away from home in areas of need
- Supporting a private dentist to see public patients at Inglewood Multipurpose Health Service
- Appointing a range of professional staff including new principal dentists in the Southern Downs, South Burnett and Western Downs, and
- Offering after-hours appointments to patients in some areas.

There were 252,376 oral health occasions of service provided during the year. Of these, 168,037 were adult dental treatments (20.6 per cent over target) and 84,229 were child or school-based treatments (12 per cent more than targeted).

More renal dialysis offered at Kingaroy Hospital

Renal dialysis services in the South Burnett were increased as resources were moved from Toowoomba Hospital to avoid lengthy travel for South Burnett patients and their families. There are now 18 patients who receive haemodialysis at Kingaroy Hospital, an increase from the 12 places that were previously available.

The expanded service also includes telehealth services for patients in Cherbourg to help manage chronic kidney disease. Patients receiving care closer to home say their quality of life has improved. Cherbourg resident Erica Duncan (pictured with Kingaroy Hospital Indigenous Liaison officer Barry Fisher and Renal Unit Nurse Unit Manager Karen Quealy) no longer needs to travel to Toowoomba three times a week.

Aged care

The Darling Downs Hospital and Health Board considered the *Queensland Commission of Audit Report 2013* specifically recommendation 78, to examine options for transfer of ownership and operation of residential aged care facilities. The Board carefully considered over a period of time information regarding the six residential aged care facilities operated by the Darling Downs Hospital and Health Service.

The Hospital and Health Service management reviewed the aged care facilities in accordance with the State contestability guidelines to ensure tax payer funds are used in the best way. These investigations concluded the Health Service subsidises the operations of the aged care facilities, but the Board decided that the improvements staff had already achieved demonstrated, they could deliver the required improvements. The Board reflected that these facilities are important to our local communities and are co-located with the local hospitals in many instances. The Darling Downs Hospital and Health Board provided advice to the minister of their decision that the Health Service would continue to own and operate each of its six residential aged care facilities.

All DDHHS aged care facilities are accredited under the National Aged Care Standards. We cared for more than 300 people a day in our residential care facilities or multipurpose health services. This equated to a total of 99,355 bed days in our aged care facilities and 10,902 bed days at multipurpose health services.

Mental Health

Achievement highlights

- The Mental Health Division has conducted 11 Mental Health First Aid Courses to 151 participants – four courses in rural areas and seven in Toowoomba.
- Enhanced services and streamlined processes were provided for rural clinics using telehealth assessments and reviews.
- Appointed a Carer Consultant to provide advice to the service and work with carers of clients of the service

Over the year the Mental Health Community Ambulatory Service provided 242,691 occasions of service across the catchment area. This equated to 665 services of all types provided on any day.

The adult acute inpatient unit at Toowoomba Hospital had 1,151 admissions compared with 1,209 last year. This represents 16,216 occupied bed days.

The Yannanda Adolescent Unit, which admitted its first patient in August 2012, had 207 admissions representing 1,816 occupied bed days. These were days young people were able to receive appropriate care locally within the context of their family and important networks.

Baillie Henderson Hospital had 50,682 occupied bed days, a reduction from 59,038 occupied bed days last year.

Every month throughout the year the Mental Health Service has performed well on two Statewide performance indicators of note:

- The Mental Health Service has exceeded the target of 60 per cent of clients discharged from an acute inpatient unit being followed up within seven days of discharge.
- In terms of readmissions to acute Mental Health units within 28 days of discharge - for seven months of the 2013-14 financial year, our performance exceeded the target by being below 12 per cent.

Community Care Unit

Construction started in March 2014 on a new Community Care Unit (CCU) in Kearney Springs, Toowoomba. A Community Care Unit (CCU) is a residential facility for adult mental health consumers who are in recovery but require additional support and life skills rehabilitation to successfully transition to independent community living.

The CCU will comprise 24 one-bedroom villas with some common rooms and parking areas. Construction is funded by the Commonwealth Government with a project cost of $11.6 million and is expected to be completed in late September 2014 with the transition of consumers to start from January 2015.

The Toowoomba facility is one of four CCUs being built as part of this project, with construction of others underway at Rockhampton, Bundaberg and the Sunshine Coast. The majority of places at all CCUs will be offered to consumers currently receiving rehabilitation services at Baillie Henderson Hospital (BHH). It is anticipated that the transition of consumers from BHH will be completed by June 2015. Working parties to transfer appropriate consumers to all sites have been set up.

A Human Resources working party, to assist in minimising the impact on staff of the downsizing of BHH, was established. In particular, an expression of interest process was put in place whereby positions elsewhere in DDHHS were offered to permanent staff at BHH before they are advertised more widely. By the end of the 2013-14 financial year, ten employees from a variety of streams had been placed into alternative permanent positions through this process.

Ridley Incident

In January 2014, DDHHS released a report on a review of a serious incident on 19 January 2013 in which a number of staff were injured at the Ridley Unit at BHH. The independent review was commissioned by the DDHHS Chief Executive and made 62 recommendations, mainly relating to clinical processes and carer and consumer engagement, all of which the DDHHS agreed to implement. Thirty-four of the recommendations have been implemented to date, with the appointment of a Carer Consultant and the implementation of gender-sensitive protocol, already in place before the report was released. Work is ongoing to implement the remainder of the recommendations.

Peer Support Workforce

The Mental Health Service employed two Peer Support Workers who will be working from the Services Rehabilitation and Recovery Centre. The workers are people who have lived through the challenges of mental health and can use their life experiences to walk alongside others, supporting them in their recovery journey. Peer support workers and clinical staff offer programs covering a range of topics including mental health treatments and options, life skills, physical health, wellbeing, and community involvement. This initiative complements the consumer companion program

Access to specialist Mental Health services improves

More patients who presented to Emergency Departments at rural hospitals were able to access specialist Mental Health care after hours.

The Mental Health Consistent Assessment in Rural Emergency (MH CAiRE) has been implemented across the DDHHS. It involves telehealth being used to increase access to after-hours specialist Mental Health assessment services in rural and remote communities, access to on-call psychiatrists, and mental health education outreach.

Project Manager Greg Neilson (pictured) said the use of telehealth services avoided more than 10,000km of unnecessary travel within the first three months of the project as patients were able to be treated at their local hospitals where clinically appropriate.

which has been operating at the Acute Mental Health Unit at Toowoomba Hospital for four years.

Carer Support

A Carer Consultant worked closely with families of mental health consumers to promote positive family involvement in the recovery process. Strong relationships with carer-focused community organisations continued to be forged through the Carer Advisory Group which looked at increasing efficiency and reducing duplication of services across the DDHHS. Carer involvement has been an important part of planning for consumers' transition to Community Care Units.

Rehabilitation and Recovery Centre

The Rehabilitation and Recovery Centre (RRC) provided a wide range of recovery-oriented programs which supported both inpatient and community consumers to build mastery in self management. The centre provided 19 programs a week and achieved many positive outcomes for consumers, including a dramatic reduction in the number of admitted days to the Acute Mental Health Unit.

School LinQ Project

The School LinQ pilot project promoted leveraging partnerships between the Child and Youth Mental Health Service (CYMHS), schools and other external services provided to current and potential CYMHS consumers. The project recognised teachers and school support staff were often the first to notice when a young person is at risk of developing mental illness. The CYMHS team educated school staff on referral pathways to various clinical support options, and provided clinical advice on issues such as identifying risk factors and potential impacts of mental illness on learning. The trial at five schools was a success and the project is expected to be rolled out more broadly in 2014-15.

Alcohol and Other Drugs

The Alcohol and Other Drugs service health promotion staff were involved with several projects across DDHHS, including some in partnership with community agencies. They included Mental Health First Aid, Men's Shed, It's a Bloke Thing, as well as healthy lifestyle and wellness programs.

Underpinning this work was the acknowledgment of the strong link between mental health, general physical health, and substance use.

Repositioning

The division has undertaken a restructuring process which aims to align the service with the current future plan for mental health and to create a more responsive and effective service, targeted at specific contemporary workforce and practice roles. This also builds on the amalgamation and integration of the Alcohol and Other Drugs service into the Mental Health division that was undertaken last financial year.

Specialist Registrar Training Program

For the fourth consecutive year the DDHHS Mental Health Service employed a registrar under the Specialist Training Program (STP). The program is designed to work with GPs in their practices to provide collaborative care to GP clients who require specialist psychiatry input. This program is, in the major part, funded by the Commonwealth Government and has proved highly successful and beneficial to clients and to the training registrars who are supervised by the Mental Health Service psychiatrists.

Medical Services

Achievement highlights

- More specialist doctors join ranks
- Outreach medical services provide local care in rural facilities
- Doctor relieving service offers state-wide coverage

From late 2013 until April 2014 extensive consultation was undertaken with the Senior Medical Officers across the Health Service in relation to the transition to individual employment contracts. This was a major change for senior doctors involving a move from being an employee of Department of Health under a collective agreement and an Industrial Award to becoming an employee of the Health Service on a contract. Despite being challenging at times we are very pleased that 219 of our senior doctors signed new contracts and will migrate to being DDHHS employees from 4 August 2014.

Several new specialists have joined the DDHHS Medical team including an anaesthetist, infectious diseases specialists, an orthopaedic surgeon, a general surgeon, an obstetrician and gynaecologist, and a new Director of Clinical Governance. The new urology services are also supported by three new part-time surgeons.

These new doctors have assisted the health service to expand services in several ways, including outreach general surgical, and gynaecology services to DDHHS rural facilities in Kingaroy, Stanthorpe, Warwick and Dalby.

Our close partnerships with the private hospital sector continue with the ongoing appointment of several medical specialists and specialist medical training positions. The federal government has also assisted in funding these training positions, allowing an expansion of learning and experience opportunities for training doctors.

Further recruitment is ongoing with a focus to extend the cardiology and palliative care services. Toowoomba Hospital continues to support the Rural Generalist Pathway with advanced skills training positions in general surgery, anaesthetics and obstetrics.

DDHHS was celebrated as the gold sponsor again this year at the 25th annual Rural Doctors Association of Queensland conference held in Brisbane in June. A large group of representatives from the DDHHS participated throughout the three-day conference, including presenting individual talks, sitting on panel discussions, moderating discussions and staffing a trade display.

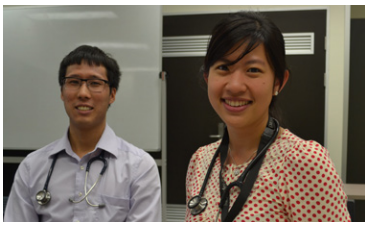
Rural and Remote Medical Support

Consolidation and development best categorises 2013-14 for the Rural and Remote Medical Support (RRMS) team and programs. The second year of being a part of DDHHS has been focussed on maintaining the relief program capacity while improving our program and service capability and efficiency. This work has positioned the team and services to springboard into an exciting year ahead.

Next year the RRMS will examine opportunities and build on its effectiveness in delivering programs that contribute to rural communities' health and access to services across Queensland.

RRMS which incorporates Queensland Country Practice (QCP) has continued to work with Hospital and Health Services across the state this year and has undergone a development phase of the governance requirements for its programs, in particular how the medical employment

Kingaroy host interns for first time



Intern Dr Tran Nguyen and second-year doctor Dr Michael Tam were part of the rotation program.

Kingaroy Hospital welcomed two medical interns on rotation from the Greenslopes Private Hospital for the first time.

Taking part in the federally-funded, Prevocational General Practice Placements Program (PGPPP), the interns spent 12 weeks in the rural hospital to gain more experience and skills.

In addition to the two interns, Kingaroy also hosted two second-year medical officers on rotation.

Kingaroy Hospital went through an accreditation process to be able to offer placements which give opportunity for doctors to participate in a continuum of training in a rural setting.

framework and prescribed employer structures needed the service to respond to change.

The service has approached the further development and expansion of the Rural Generalist Program with excitement as the prospect of workforce capability and rural generalist capacity is being realised, ensuring services are available where people live. The Queensland Country Relieving Doctors program has also been undertaking a project which is seeking to leverage the emerging rural medical workforce design to establish a contemporary rural generalist prevocational training program.

The goal is to further strengthen the options available to rural communities to attract and grow their own medical workforce, as well as participating in the broader medical training opportunities across the State.

Relieving services and programs have continued to perform strongly delivering:

- 186 weeks of relief by 30 senior vocational relieving doctors
- 1,179 weeks of relief by the 350 junior doctors that rotated through our program
- 818 weeks of relief by 25 health practitioners which include radiographers, pharmacists, physiotherapists and social workers
- 15 x-ray operator training courses, training 68 new x-ray operators to enable x-rays to be taken in small towns throughout rural Queensland
- management of the Queensland Health Bonded Medical Scholarship Scheme which will provide 229 doctors into communities in areas of need, of which only 12 are still at university with the rest already working in areas of priority across Queensland.

DDHHS sponsored the World Summit on Rural Generalist Medicine Australia 2013 conference in October where Health Minister The Honourable Lawrence Springborg MP announced a $1.8 million boost and a redirection of scholarship funding to double the number of rural generalist training places in Queensland by 2016. The expansion will continue to address Queensland's rural workforce shortage to ensure rural and regional communities have better access to high quality medical services. The intake will increase from 37 in 2013 to 80 in 2016.

Public Health

The 'Tackle Flu Before It Tackles You' campaign was a great success this year with 1,068 people vaccinated – triple the number of people vaccinated the previous year. The annual campaign targets Indigenous people aged over 15 years to increase the uptake of the seasonal flu vaccination. While the campaign was driven by the Darling Downs Public Health Unit (DDPHU), support is also provided by staff members from Toowoomba Hospital's Kobi House and health workers in each of the communities. Two DDPHU staff members showcased the successes of the locally co-ordinated Indigenous vaccination campaign at a national immunisation conference.

In response to a report by the Chief Health Officer on Legionella in water, all health services were required to ensure facility water supplies were monitored and managed appropriately. The DDPHU worked closely with Infrastructure and Planning and Building, Engineering and Maintenance Services to develop a sampling and water management plan for the DDHHS.

After the Toowoomba Regional Council (TRC) decision to continue water fluoridation the DDHHS assisted with the development of an education program on oral health. The DDPHU collaborated with Oral Health, the TRC, Darling Downs South West Queensland Medicare Local and the Toowoomba Hospital Foundation to coordinate a healthy teeth competition which provided an opportunity for local primary school children to create a video focussing on oral care messages.

An investigation into complaints from a member of the public, lead to the successful conviction of a company selling food past it's 'use by' date. The company was fined $10,000 and ordered to pay court costs. Several foods were also being sold that were past the 'best before' date. These foods had significantly deteriorated and were unsuitable for sale.

As part of its regulatory role to protect the public's health, Environmental Health Officers continued to monitor the sale of tobacco products in particular targeting those retailers that have previously been found to sell tobacco products to minors. It was pleasing to see that in 2013-14 no retailers were found selling smoking products to children.

Nursing and Midwifery

Achievement highlights

- More than 2,700 nurses employed across DDHHS
- Private Practice Midwifery Model receives Premier's Award
- DDHHS nurses score well in statewide comparisons

DDHHS employs more than 1,650 Full Time Equivalent (FTE) nurses and midwives. As many nurses work part time this number equates to more than 2,700 nurses across the service.

Of these nurses approximately 71 per cent are employed as Registered Nurses (RNs) or Midwives. The DDHHS employs first-year Registered Nurses each year through the Graduate Nurse program. In January 2014, more than 20 graduate nurses were employed across all divisions.

DDHHS is performing well on its Nurse Sensitive Indicators (NSI), a monthly scorecard which provides a comparison against other hospitals in the state. NSI data enables comparison and benchmarking of nursing indicators across 10 categories including falls, pressure injuries, medication administration, blood transfusion, hand hygiene, nursing sick leave, overtime and agency usage. In 2013-14, the DDHHS was tracking at or better than the state average on most indicators, with the greatest improvements in reduced agency and casual usage as well as overtime rates.

Thirty-five nurses working across the DDHHS Mental Health Service have gained credentialing as a Mental Health Nurse under a program offered through the College of Mental health Nurses.

Toowoomba Hospital's gastroenterology nurse Wendy Irwin joined an elite group of nurses, after being awarded credentialing from the Gastroenterology Nursing College of Australia. Since 2004 five nurses from Toowoomba Hospital have sat and passed this exam and, of those, three have attained the highest mark in Australia, including Wendy.

Toowoomba Hospital's Maternity Service was highly commended in the 2013 Premier's Awards. The Private Practice Midwifery Model of Care is a public private partnership between Toowoomba Hospital and midwives in private practice. This model provides access for women who, with their own midwife, use the Toowoomba Hospital Birth Centre.

The successes of a Toowoomba Hospital program that provides midwifery care to local Indigenous women were highlighted at an international conference in June 2014. Midwife Linda Evans travelled to Prague in the Czech Republic to present a talk about the Boomagam Caring Outreach Midwifery Service which provides culturally appropriate antenatal and postnatal care to local Aboriginal and Torres Strait Islander women in their homes. The service started in 2010 as a way of improving the health outcomes for pregnant Indigenous women, with 100 per cent of Indigenous women who come to the Toowoomba Hospital completing the recommended five antenatal health checks.

Toowoomba's first direct-entry midwife graduates

Susara Kitching was the Toowoomba Hospital Maternity Unit's first graduate from the direct-entry midwifery program at Griffith University.

"I've been so lucky to be in Toowoomba, because people training in big tertiary hospitals don't have what I have in terms of one-on-one training and support," Susara said.

"She's special, and we are very proud of what she's done," said Lisa Gierke, clinical midwife and Susara's training supervisor (pictured with Susara). "Susara has become an excellent midwife."

After graduating, Susara secured a midwifery position at Charleville Hospital.

Goondiwindi Hospital Director of Nursing, Lorraine McMurtrie had results of her research project published in an international nursing journal. The article, entitled "Keeping our nursing and midwifery workforce: Factors that support non-practising clinicians to return to practice" was published in the May 2014 edition of *Nurse Education Today*.

The Darling Downs Hospital and Health Service was the first Australian health service to undertake the Frontline Leadership Training offered by The Advisory Board Company based in America. The DDHHS has supported more than 30 frontline nursing staff to undertake this program. The program enables these staff to develop their leadership skills to enable them to effectively manage change, drive innovation, and lead improvement initiatives. Each of the participants is leading a project in their work unit under the guidance of leadership coaches and the Advisory Board.

Appointment of an experienced senior nurse Jill Richardson to a new position as Resource, Management and Productivity Nurse Manager, reinforces DDHHS's commitment to nursing and midwifery resource management and future workforce planning.

Following the retirement of two long-serving Directors of Nursing (DON) and the resignation of three other DONs, a recruitment process was instigated and new Directors of Nursing were appointed at Goondiwindi, Inglewood, Millmerran, Tara, and Warwick.

Allied Health

Achievement highlights

- Highest number ever of breast screens performed
- New Allied Health service models implemented
- More than 9,000 training activities delivered

Allied Health professions represented in the division include: occupational therapy, physiotherapy, nutrition and dietetics, speech pathology, podiatry, social work and psychology.

The Allied Health workforce is employed across the DDHHS. In Toowoomba Hospital alone a total of 68,179 occasions of service were delivered to 8,986 patients by the allied health professionals.

A report '*Ministerial Taskforce on Expanded Scope of Practice*' was released in May 2014 of which a number of models of care from DDHHS were included. These were:

- Allied Health Acute Medical Clinical Leader
- Rural Generalist Allied Health Clinical Leader (Warwick Emergency Department)
- Advanced Allied Health Assistant Rural Outreach Model of Care (South Burnett)

The DDHHS had its strongest representation yet at the 10th National Allied Health Conference held in Brisbane. A wide range of allied health employees from the DDHHS were involved in delivering a pre-conference workshop, three oral presentations and four posters at the event. The Cunningham Centre also held a trade display where staff fielded many enquiries from conference attendees. The conference provided a forum for the allied health workforce, educators and researchers to showcase innovations, share their latest research findings, hear from national and international speakers, and network with colleagues from around the country.

BreastScreen and Mobile Women's Health Services

BreastScreen Queensland Toowoomba Service continued to demonstrate its commitment to providing women in the Darling Downs and South West Hospital and Health Services, and parts of West Moreton and Central West Hospital and Health Services, with a professional, sensitive and accessible breast cancer screening service.

During the year, the Toowoomba Service and associated mobile services screened 17,888 women, the highest number of screens since the inception of the service in 1992.

In 2013, the BreastScreen Mobile Service also expanded its list of sites in Toowoomba to include an extra two locations not previously visited. The van spent two to three weeks each, at two new sites in Wilsonton and Kearney Springs in order to meet the growing demand for the service.

A new mobile screening service commenced at Kingaroy during the year. New mobile services to Drayton and Pittsworth are planned for 2014-15, along with the introduction of an annual visit to Warwick.

The commencement of mobile services to additional sites has been made possible through the sharing of mobile units between other BreastScreen Queensland Services and the Toowoomba Service. Toowoomba BreastScreen is continually reviewing program participation rates and changes in population demographics in order to improve access to the screening service.

In May and June 2014, the BreastScreen Queensland Toowoomba Service ran a successful awareness raising campaign encouraging women to have 'the coffee conversation'. Selected coffee shops in Toowoomba were stocked with limited edition pink cups emblazoned with "Keep Calm and Have a Breast Screen".

DDHHS manages three mobile women's health nursing services that operate across the Darling Downs and South Burnett, as well as some communities in the West Moreton, Wide Bay and Sunshine Coast regions. The three nurses operate as sole practitioners and use an outreach model to provide services to women. In 2013-14 the three nurses delivered services to 3,457 women, and travelled a total of 74,000km. Consumer feedback overwhelmingly indicated that the services offered are highly valued by women and service providers in the rural communities they visit.

Home and Community Care (HACC) Services

Members of DDHHS's HACC Continence Advisory Service were praised for their efforts during a consumer-based forum. As part of its federal funding commitment, the service is required to host a forum where clients can provide feedback. Eight clients, some with their carers, took part in the face-to-face forum in late March. The feedback provided was overwhelming positive, with clients praising staff members' discretion, sensitivity and helpfulness. The free service is located at the Toowoomba Hospital and provides education, health promotion and group programs for people in the community who experience bladder and bowel weakness.

Aged Care and HACC Assessment Team (ACHAT)

During the year, 100 per cent of priority one clients, 98.5 per cent of priority 2 clients and 93.1 per cent of priority 3 clients were seen on time. There were 625 assessments conducted for clients as inpatients in either acute or other inpatient settings. The average timeframe for an ACHAT assessment to be conducted for clients who were inpatients was: 1 day for 7 priority 1 clients, 3-4 days for 601 priority 2 clients and 20 days for 17 priority 3 clients.

Transition Care Program

The Transition Care Program (TCP) continued to help older people recover from illness or injury that had initially needed hospital treatment. It offered community-based rehabilitation support to help get older people back on their feet after an acute episode. The TCP provides a holistic approach to care with physiotherapists, occupational therapists, dieticians, social workers, pharmacists and nurses as part of the skill mix. Although mostly a Toowoomba-based service, there are case managers in Warwick and Kingaroy, and the team travelled to most parts of the DDHHS.

The Cunningham Centre

The Cunningham Centre, DDHHS's registered training organisation provides allied health, medical, nursing, and vocational training to the DDHHS and statewide role-specific required training, as well as administering mandatory training for DDHHS employees.

Accreditation

The Rural and Isolated Practice (Scheduled Medicines) Registered Nurse (RIPRN) course obtained National Accreditation with the Australian Nursing and Midwifery Accreditation Council (ANMAC). This course enables Registered Nurses working in rural and isolated areas to initiate the administration and supply of certain medications that normally require a doctor's order.

In the previous year, the Cunningham Centre's new Immunisation Program

curriculum was re-accredited. As a result, student numbers doubled which subsequently presented the nursing team with considerable challenges in providing suitable clinical placements. In response, the Cunningham Centre set up an Immunisation Simulation Clinic in Freshney House to create a learning environment that facilitated practice and supplements training.

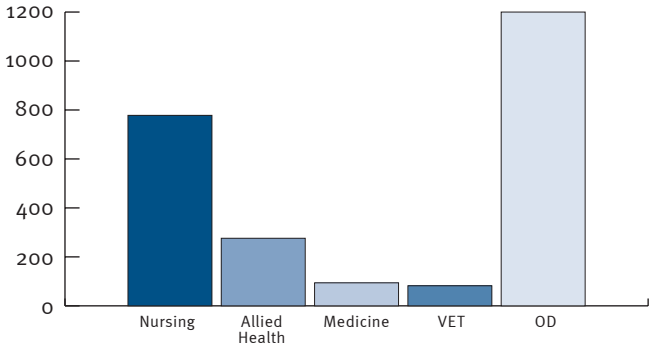
Clinical Education
Evaluation of the Rural Generalist Pathway program by Ernst & Young demonstrated the success of the Rural Generalist Program.

Workshops to support and prepare Rural Generalists include introductory workshops for Obstetrics and Gynaecology and Anaesthetic trainees and the Towards Excellence in Rural Generalist Practice program.

Education and Research
A Research paper on the quality and effectiveness of clinical supervision of occupational therapists in Queensland was presented by Ms Priya Martin at the 16th International Congress of the World Federation of Occupational Therapists in Yokohama Japan.

Training Activities
During the financial year, the Cunningham Centre provided a total of 9,103 training activities to clients (2,430 were provided to DDHHS, 5,931 to other HHS's and 646 to non Queensland Health).

Activities provided to DDHHS clients 2013-14



VET - Vocational Education Training
OD - Organisational Development

Finance and Corporate Division

Achievement highlights

- Several infrastructure projects improve local services
- Commercial management unit delivers value for money
- Occupational Health and Safety performance better than state average

Financial Control

Assisting the operating divisions to maximise revenue remained a key focus during 2013-14. There were significant increases in the percentage of patients with private health insurance electing to be treated as private patients within DDHHS thereby providing an alternative funding source to the DDHHS.

Management Accounting

Finance has continued to support the operating divisions to meet their objectives. One of the key support functions to the operating divisions is providing meaningful information that reinforces commercial decision making. This has been achieved through focusing on capturing the true cost of clinical service provision within the operating divisions, ensuring reporting structures are appropriate, and that corporate reporting is completed accurately and is timely.

During the year the performance management framework was further refined including the introduction of key performance indicator dashboard reports at a divisional level. This ensures that the focus of performance reporting is not limited to financial performance but also considers other factors such as service provision.

Commercial Management

DDHHS established a Commercial Management Unit to identify and explore business improvement opportunities and see them through to implementation. The unit's focus was to review DDHHS's models of service provision, identify options for service improvement, procure goods and services as required and manage contracts for goods and services to ensure DDHHS receives value from its contracts.

The Commercial Management Unit conducted expressions of interest to engage an operator for the Baillie Henderson Pool and Recreation Facility,

outsource endoscopies at Toowoomba Hospital while a new extra endoscopy theatre is being planned to address demand, and find a private provider for medical imaging services at Goondiwindi and Warwick hospitals.

Human Resources

Human Resources completed a trial of an electronic rather than paper-based Employee Performance and Development (e-PAD) system. A trial evaluation survey indicated 80 per cent positive feedback, and accordingly it will need to be implemented to support managers and staff to identify and implement performance improvements and professional development opportunities.

During the period, 101 employees received redundancy packages at a cost of $6.6 million. 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.

Occupational Health and Safety

Occupational Health and Safety service performs well against its peers in metrics. The service has consistently achieved KPI target since 1 July 2012 for Workcover Absenteeism, and is one of only four HHS's to achieve this.

The OHS service continues to establish and improve the OHS safety management system in readiness for the move from the Queensland Health safety management system to DDHHS becoming a prescribed employer with their own OHS safety management system.

Occupational health, safety and injury management performance average for Quarters 1,2,3 (July 2013 –June 2014) *	KPI target	DDHHS
KPI 2.22 Workcover absenteeism Hours lost (Workcover hours) versus Occupied FTE (staff currently working in a position)	≤ 0.40	0.33
KPI 4.1.2 Average paid days per accepted Workcover claim (Average paid days, full and partial per claim per financial year)	≤ 23.21	18.7
KPI 4.1.3 Average days to first return to work (Average days to secure any form of return to work – time lost claims only)	≤ 21.44	13.94
KPI 4.1.4 Average monthly payments per accepted Workcover claim	≤ $2,360	$2,150

*Information from Occupational Health Safety and Injury management Safety Assurance Report including Key Performance Indicators Quarters 1,2 & 3, 2013/14

Infrastructure and Planning

The Infrastructure and Planning Unit oversees DDHHS service planning and physical infrastructure and buildings management requirements including capital works projects.

Projects across 2013-14 included:

- Toowoomba Hospital kitchen replacement
- Goondiwindi Palliative Care Suite
- Stanthorpe Maternity refurbishment
- Chinchilla Hospital roof replacement
- Stanthorpe Hospital water upgrades
- Baillie Henderson Hospital pool roof replacement
- Kingaroy Hospital ramp upgrade
- Dalby Hospital air conditioning upgrade
- Wondai generator replacement
- Millmerran Emergency unit extension

Infrastructure and Planning managed the development of the 2013-23 Darling Downs Health Service Plan. The plan articulates the future needs of the population and services required for their delivery. Public meetings throughout DDHHS were held to gain community input.

Building, Engineering and Maintenance Services completed approximately 19,300 work orders during the year to help maintain buildings and other infrastructure.

DDHHS has a large asset base of land and buildings with a replacement value of $1 billion comprising 475 buildings spread across 90,000 square kilometres. We also manage over 6,000 individual pieces of medical equipment.

A Capital infrastructure planning study started for Kingaroy Hospital. The study takes into account the future demand for local health services.

Our Hospital and Health Board nominated a new Kingaroy Hospital as the most urgent infrastructure need across the health service. It recommended to the State Health Minister at the June 2014 Board meeting that a completely new hospital should be considered for State Government funding. Kingaroy Hospital staff worked closely with the Capital Infrastructure Planning Study (CIPS) team on planning for a potential new hospital. The CIPS team was commissioned by the Department of Health. Implementation of the study is subject to State Government approval and funding.

Health Information Services

Health Information Services has the primary responsibility for:

- the management, maintenance and security of health information
- the implementation, maintenance and management of patient and clinical data systems
- management and control of patient health care records for use in continuing patient care, teaching and research
- clinical coding services; overseeing information access and clinical information analysis
- public access to records under Right to Information (RTI) and other related legislation
- the collection, extraction and provision of statistics relating to facility and individual departmental activity.

During the year DDHHS used the services of a Standing Offer Arrangement-approved company to extend its ability to store records in an offsite location, ensuring optimal security and environmental conditions were maintained.

Records Management

The *Right to Information Act* (2009) and *Information Privacy Act* (2009) grants the public a legally enforceable right to access documents in the possession of government agencies, including clinical and non-clinical records. DDHHS processes all requests for access to documents in accordance with the provisions of the Acts and Administrative Access protocols using staff with advanced health information management skills.

DDHHS ensures records are maintained through application of the State Archives approved retention schedule.

The service has assigned formal responsibility for administrative records and clinical records to senior staff. This includes training for staff in records management.

Information system security is considered in collaboration with the Health Services Information Agency of the Department of Health.

In line with the government's commitment to open data, the DDHHS has published consultancies and overseas travel information through the Queensland Government Open Data website https://data.qld.gov.au/.

Service Delivery Statements

Service standards

DDHHS actual results in comparison to its performance, standards and targets/estimated as published in the Service Delivery Statements 2013-14 are presented below.

Darling Downs Hospital and Health Service - Service Standards	Notes*	2013-14 Target/est.	2013-14 Est. Actual	2013-14 Actual
Percentage of patients attending emergency departments seen within recommended timeframes				
Category 1 (within 2 minutes)		100%	100%	100%
Category 2 (within 10 minutes)		80%	94%	94%
Category 3 (within 30 minutes)		75%	75%	75%
Category 4 (within 60 minutes)		70%	71%	70%
Category 5 (within 120 minutes)		70%	85%	84%
All categories	1		76%	75%
Percentage of emergency department attendances who depart within four hours of their arrival in the department	2	80%	80%	80%
Median wait time for treatment in emergency departments (minutes)	3	20	18	18
Median wait time for elective surgery (days)	3	25	30	29
Percentage of elective surgery patients treated within clinically recommended times:				
Category 1 (30 days)		100%	100%	100%
Category 2 (90 days)		91%	100%	98%
Category 3 (365 days)	2	96%	76%	86%
Percentage of specialist outpatients waiting within clinically recommended timeframes:				
Category 1 (within 30 days)		64%	66%	71%
Category 2 (within 90 days)		20%	32%	30%
Category 3 (within 365 days)	4	90%	40%	43%
Total weighted activity units:				
Acute Inpatients	5	40,170	42,649	42,072
Outpatients		8,474	9,763	10,127
Sub-acute		7,333	4,230	4,977
Emergency Department		14,251	16,226	16,027
Mental Health	6	15,636	15,636	24,334
Interventions and Procedures		3,066	3,753	3,670
Average cost per weighted activity unit for Activity Based Funding facilities	7	$4,395	$4,104	$4,142
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days	8	0.9	1.0	1.0
Number of in-home visits, families with newborns		3,742	4,235	4,370
Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit		>60%	74.3%	72%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	9	<12%	14.4%	13%
Ambulatory mental health service contact duration	10	56,491 – 69,330	59,701	59,225

*See over for notes

Notes:

1 A target is not included as there is no national benchmark for all triage categories, however the service standard has been included (without a target) as it is a nationally recognised standard measure. The 2013-14 estimated actual figures are based on data from July to December 2013.

2. The 2013-14 targets were set as the midway point between the 2013 and 2014 calendar year National Elective Surgery Target (NEST) and National Emergency Access Target (NEAT), as per the National Partnership Agreement on Improving Public Hospital Services. The 2013-14 estimated actual figures are based on data from July 2013 to February 2014.

3. There is no nationally agreed target for median waiting time for treatment in emergency departments or in elective surgery. The 2013-14 estimated actual figures are based on data from July 2013 to February 2014. The large number of category 3 patients treated impacts on the 2013-14 estimated actual figure.

4. The 2013-14 targets for Category 1 and 2 were based on actual 2012-13 performance, and the target for Category 3 aligns with the *Blueprint for better healthcare in Queensland*.

5. The 2013-14 Target/Est. has been amended to reflect Phase 17 ABF model QWAUs to enable comparison with 2014-15 Service Delivery Statements.

6. Actual Mental Health QWAU data fluctuates at the Baillie Henderson Hospital mental health facility based on discharges. As such 2013-14 Estimated Actual has been set to equal the 2013-14 Budget.

7. Estimates of average cost per QWAU are affected by the parameters of the ABF model and are specific to the ABF model under which they are calculated. The 2013-14 Target/Est. that was published in the 2013-14 Service Delivery Statements and the 2013-14 Est. Actuals have been recalculated based on the Phase 17 ABF model to enable comparison with 2014-15 Target/Est. figures. The 2013-14 Target/Est. has been calculated as per Value for Money indicator methodology, excluding Site Specific Grants and Clinical Education and Training.

8. *Staphylococcus aureus* are bacteria commonly found on around 30% of people's skin and noses and often cause no adverse effects. Infections with this organism can be serious, particularly so when they infect the bloodstream. The data reported for this service standard are for bloodstream infections with *Staphylococcus aureus* (including MRSA) and are reported as a rate of infection per 10,000 patient days aggregated to HHS level. The target/estimate for 2014-15 has been revised to align with the national benchmark of 2.0 cases per 10,000 acute public hospital patient days. For further information on this benchmark, see **www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129545750**

9. The target for mental health readmissions is the nationally indicative target identified in the *Fourth National Mental Health Plan Measurement Strategy*. As such, it represents a stretch target of good practice for HHSs to attain rather than an incremental improvement from prior year performance. This HHS has made improvements on this measure over the past five years and a range of initiatives continue to be progressed to achieve targets on this measure.

10. For 2013-14, a standard methodology was adopted based on previous investment in mental health services, with adjustments for variation expected due to geographic locality.

Comparison of actual financial results with budget

DDHHS actual results in comparison to its budget as published in the State Budget Papers 2013-14 are presented in the following tables with accompanying notes. These do not form part of the annual financial statements of the DDHHS which are presented in Appendix 1.

Income Statement for the year ended 30 June 2014

Darling Downs Hospital and Health Service	Notes	2013-14 Budget $'000	2013-14 Act. $'000
Income			
User charges and fees	1,2	536,885	569,261
Grants and other contributions	1,3	30,921	34,003
Other revenue	4	541	4,124
Total income		568,347	607,388
Expenses			
Employee expenses		2,142	1,938
Supplies and services	5	540,204	562,006
including employees still employed by Department of Health		*420,682*	*418,197*
Grants and subsidies		2,404	1,582
Depreciation and amortisation		21,083	21,516
Other expenses		959	1,569
Losses on sale/revaluation of assets/impairment		1,555	1,088
Total expenses		568,347	589,699
OPERATING SURPLUS/(DEFICIT)	6	..	17,689

Notes:

1. ABF and Block Funding received under service level agreements were classified as Grants and other contributions for the 2013-14 Service Delivery Statements. This has been reclassified as User charges and fees in line with change in accounting treatment for better comparison.
2. Increase in user charges largely reflects additional funding from amendments to the Service Agreement between Darling Downs Hospital and Health Service (DDHHS) and the Department of Health (DoH). In 2013-14 the largest amendments were the provision of funding for Backlog Maintenance Remediation Program ($50.6m over 4 years) and National Partnership Agreement on improving Dental services funding. The amendments also reflect costs previously being held centrally being devolved to the HHS.
3. Increase reflects additional revenue from Nursing Homes following review of processes together with donations received during the year.
4. Increase reflects change in accounting for salary recoveries from other agencies. Offset in labour.
5. Additional expenditure reflects the amendments in the Service Agreement between DDHHS and the DoH partly offset by efficiency savings in DoH contract labour. Increases in other supplies and services mainly represent expenditure on backlog maintenance remediation program.
6. Expected surplus for 2013-14 delivered through efficiency savings and increased own source revenue together with some one-off benefits. Surplus will be reinvested in additional facility improvements and services for DDHHS.

Balance sheet

Darling Downs Hospital and Health Service	Notes	2013-14 Budget $'000	2013-14 Act. $'000
CURRENT ASSETS			
Cash assets	7	33,646	60,937
Receivables	8	4,226	9,385
Inventories		4,806	5,535
Other		209	234
Total current assets		42,887	79,091
NON-CURRENT ASSETS			
Property, plant and equipment	9	329,637	305,469
Other		..	..
Total non-current assets		329,637	305,469
TOTAL ASSETS		372,524	381,560
CURRENT LIABILITIES			
Payables		40,467	41,551
Accrued employee benefits		..	25
Other		3	30
Total current liabilities		40,470	41,606
TOTAL LIABILITIES		40,470	41,606
NET ASSETS/(LIABILITIES)		332,054	339,954
EQUITY			
Capital/contributed equity	10	309,585	288,219
Accumulated surplus/(accumulated deficit)	11	..	31,938
Asset revaluation surplus	12	22,469	19,797
TOTAL EQUITY		332,054	339,954

Notes:

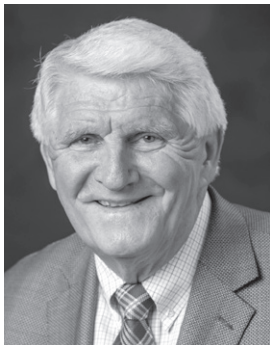
7. Increase in cash reflects surpluses achieved in 2012-13 and 2013-14.
8. Increase reflects year end accruals, mainly service agreement amendments not settled by end of year
9. Decrease reflects lower commissioning of building assets than incorporated in 2013-14 budget, together with lower than expected revaluation increment.
10. Decrease in Contributed Equity due to lower than budget commissioning of building assets.
11. Reflects accumulated surplus in 2012-13 and 2013-14. Surplus will be re-invested in additional facility improvements and services for DDHHS.
12. Lower than expected revaluation increment on buildings.

Governing our organisation

The Darling Downs Hospital and Health Board is comprised of 10 non-executive members appointed by the Governor in Council on the recommendation of the Minister for Health, and in accordance with *the Act*.

Back (left to right): Dr Jeffrey Prebble OAM, Dr Dennis Campbell, Dr Ross Hetherington, Dr Ian Keys, Mr Terry Fleischfresser.
Middle: Mr Mike Horan AM, Ms Megan O'Shannessy, Ms Cheryl Dalton, Ms Patricia (Trish) Leddington-Hill.
Front: Ms Marie Pietsch, Dr Peter Bristow Health Service Chief Executive.

Our Board



Mr Mike Horan AM

Board Chair, Darling Downs Hospital and Health Board

Mike was the Member for Toowoomba South in the Queensland Parliament from 1991 to 2012.

During his political career Mike served as the leader of the National Party, the leader of the Opposition, Shadow Attorney-General and Shadow Minister for Police, Health and Primary Industries respectively. Mike regards his time as Minister for Health (1996-1998) as a highlight of his political career.

Mike has considerable experience in the development and construction of small and large health facilities. More than 100 health construction projects varying from rural Hospitals to major metropolitan Hospitals occurred under his Health Ministry.

During his time as Health Minister the Surgery on Time System was established, a ten year Mental Health Plan introduced and targets for BreastScreening and Children's Immunisation were set and achieved. Thirty-eight District Health Councils were put in place and the Rural Health Council was established at Roma.

Mike held the position of General Manager of The Royal Agricultural Society of Queensland (Toowoomba Showgrounds) from 1978 to 1991 and was a driving force in the sale of the old inner city Toowoomba Showgrounds and the development of the new Toowoomba Showgrounds on a 98 hectare site. Mike also served as secretary of the Darling Downs sub-chamber of Agricultural Societies, a number of Breed Societies and of the Downs Harness Racing and the Toowoomba Greyhound Racing Club.

Mike is currently a board member of Downs Rugby Ltd, covering rugby union from Gatton to St George and a board member of the Toowoomba Police Citizens Youth Club.

In June 2013 Mike was awarded a Member (AM) in the General Division of the Order of Australia for significant service to the Parliament of Queensland and to the community of the Darling Downs.

He is a great believer in working with the community to achieve results.

Dr Dennis Campbell PhD, MBA, FCHSM, CHE, FAIM

Deputy Chair, Darling Downs Hospital and Health Board

Dr Dennis Campbell has been a Chief Executive Officer in the public and private sectors and served on numerous boards and advisory committees. He has legal and health qualifications and in 2007 was awarded an Australia Day Medallion for services to the Australian College of Health Service Executives.

Dennis has held the positions of Assistant and Acting Regional Director, in the public sector, as well as Chief Executive Officer at St Vincent's Hospital, Toowoomba.

Dennis served as Corporate Director with Legal Aid, Queensland for ten years as well as in other executive positions within the Department of Education and Department of Aboriginal and Islander Advancement.

Dennis joined the Heritage Board in 2000. He is currently the Deputy Chairman of the Heritage Bank Board and Chair of the Finance Committee. He also served as a trustee of the Queensland Museum Foundation and as Chairperson on the Management Advisory Committee of the Cobb & Co Museum, Toowoomba.

In 2008, Dennis was awarded the Gold Medal for Leadership and Achievement in Health Services Management, recognising his contribution and professional achievements in shaping healthcare policy at institutional, state and national levels.

Ms Cheryl Dalton

Board Member, Darling Downs Hospital and Health Board

Ms Cheryl Dalton is currently the Chief Executive Officer of SBcare a South Burnett provider of aged and disability care services. Previous to this she was a Councillor for the South Burnett Regional Council and former Kingaroy Shire Council with 17 years local government experience as well as being a long-standing member of the Queensland Resource Operating Plan and Moratorium Panels, a Department of Natural Resources and Mines water management and planning entity.

Community involvement includes her executive position on the Links Community Services Board (JobMatch Kingaroy and Gympie), a Disability Employment Service, Chairman of the South Burnett Mayors Community Benefit Fund, as well as the Voluntary Auditor for the Wooroolin Scout Group.

Her business experience includes agribusiness, being a Managing Director of a stockfeed manufacturing business, Goldmix Stockfeeds, from 1993 to 2005 and subsequently working in a consultative role in quality assurance. She is a Managing Director of Dalton Agribusiness, which has interests in agriculture (cattle and pigs), a tractor and dozer parts wholesaling business, and property development.

Dr Jeffrey Prebble OAM

Board Member, Darling Downs Hospital and Health Board

Dr Jeff Prebble is a respected Paediatrician with extensive medical experience in public and private hospitals across Toowoomba and Brisbane. Jeff is a member of several health-related committees and professional organisations, and has published numerous papers.

Jeff currently holds a number of key positions in the medical community. He is a consultant Paediatrician in private practice in Toowoomba and Visiting Paediatrician at Toowoomba Hospital. Previously Jeff has held positions as Senior Visiting Consultant in Department of Paediatrics, Head of Department of Paediatrics and Chairman of Division of Infants, Children and Youth at Toowoomba Base Hospital.

Jeff has held various committee membership positions at:

- Queensland Health
- Toowoomba Hospital
- St. Vincent's Hospital, Toowoomba
- Royal Australasian College of Physicians
- Queensland State Committee of Australian College of Paediatrics
- The Sovereign Order of St. John of Jerusalem Knights Hospitaller.

Jeff is a member of the committee for preparation of examinations conducted by the Australian Medical Council for overseas doctors, Examiner for the Australian Medical Council and Associate Professor (Paediatrics), University of Queensland, Rural Clinical School at Toowoomba. Jeff is also a Member of the Ethics Committee, Toowoomba and District Local Medical Association and Patron of the Down Syndrome Association, Darling Downs. Jeffrey's professional memberships include Member of Faculty of Community Child Heath, Member of the Australian Perinatology Society and Member of the Australian Medical Association.

Jeff graduated from the University of Queensland with an M.B.B.S (Honours) and is a Fellow of the Royal Australasian College of Physicians (Paediatrics).

Jeff has been awarded a number of awards including the Order of Australia Medal in 2002 for services to paediatric medicine as a practitioner, educator and advocate for clinical care and practice standards for paediatrics. He was awarded the Australian Centenary Medal in 2003 for distinguished service to the medical profession.

Dr Ian Keys

Board Member, Darling Downs Hospital and Health Board

Dr Ian Keys is a retired medical practitioner with experience at the Princess Alexandra Hospital, Barcaldine Hospital and Private Rural Medical Practice in Dalby.

Ian is a well known identity in Dalby and operated a private rural medical practice in the area for close to 40 years, before retiring in 2008. Ian now breeds thoroughbred horses.

Ian was Medical Superintendent with Right of Private Practice at Barcaldine in 1969 and returned to Dalby in 1970 to commence Rural General Practice. During his time in Dalby he has been associated with many community and sporting bodies including a term as an Alderman on the Dalby Town Council and was also a member of the Committee which constructed the Dalby Great Hall at Dalby High School.

After his early years in Dalby, Ian attended Anglican Church Grammar School Brisbane and graduated with an M.B.B.S in 1966 from the University of Queensland.

While at University Ian was the inaugural President of the Students Club at International House and was the first student to be on the controlling body of that College's Board of Governors.

Ms Marie Pietsch

Board Member, Darling Downs Hospital and Health Board

Marie Pietsch has extensive healthcare experience throughout Queensland and has held positions on numerous councils and committees, including Chair of the Minister's Rural Health Advisory Council and Chair Southern Downs Health Community Council.

Marie has a professional background working in the Darling Downs region and her work on agricultural and health-related committees has given her strong exposure to local community issues.

Marie is a member of various health committees and panels including:

- Member of Inglewood Multipurpose Health Service Management Committee
- Chair of Inglewood Community Advisory Network.

Marie's work in representing health consumers in her region earned her a 2003 Centenary Medal for distinguished service to the community as Chair of the Southern Downs District Health Council. Marie also received an Australia Day Achievement Medallion for outstanding service to Queensland Health in 2005. In 2014, Marie was awarded the Australia Day Citizen of the Year by the Goondiwindi Regional Council for her tireless efforts volunteering for many organisations, including health, in the community.

Dr Ross Hetherington

Board Member, Darling Downs Hospital and Health Board

Dr Ross Hetherington is a medical practitioner and a Designated Aviation Medical Examiner (DAME). Ross also co-founded the Central Queensland Rural Division of General Practitioners and holds a number of aviation and medical memberships.

Ross has been in private practice as a GP in Warwick since 1996 and has extensive experience in rural medicine. He is Board Chair of Health Workforce Queensland which supports the regional, rural and remote health workforce in Queensland. Ross is Board Chair of RHealth and was a Foundation Member of Regional Health Board, Longreach. He has held previous Directorships with Australian General Practice Network (AGPN) and the Australian Rural and Remote Workforce Agency Group.

Ross is a Member of the Aviation Medicine Society of Australia and New Zealand and a Foundation Member of the Menopause Society of Australasia.

Ross has an MBBS from the University of Queensland and has a Post Graduate Diploma in Palliative Care.

Ms Trish Leddington-Hill

Board Member, Darling Downs Hospital and Health Board

Ms Patricia (Trish) Leddington-Hill worked for more than 10 years with RHealth, a primary health care organisation servicing the Darling Downs and South West Queensland.

Trish grew up on a rural property near Millmerran, Queensland, and was educated in Millmerran, Toowoomba and Brisbane. She completed a Bachelor of Science and Bachelor of Laws at the University of Queensland in 2000.

Trish worked in the rural sector in a number of roles, before joining RHealth (then known as Southern Queensland Rural Division of General Practice) in 2002 where she coordinated and managed projects across the areas of allied health, mental health, aged care, quality use of medicines, health promotion and integration.

More recently, Trish's work has focused on promoting improvements to the health and community services sectors through partnerships and workforce planning and development. She has completed studies in the internationally recognised Partnership Brokering Accreditation Scheme (PBAS) and is an internationally accredited Partnership Broker.

A keen supporter of her local community, Trish's committee memberships have included:

- Secretary, Chinchilla Family Support Centre
- Member, Chinchilla Melon Festival
- Member, Chinchilla Community Unity Committee
- Member, Smoked Fish Junior Fishing Competition Committee.

Mr Terry Fleischfresser

Board Member, Darling Downs Hospital and Health Board

Terry Fleischfresser has represented a number of local and state government committees since 2000 in the Kingaroy Shire Council and South Burnett Regional Council. Terry is the past Chairman for South Burnett Jobmatch.

Terry is a local business owner and operator in the Kingaroy and South Burnett Region. He has a strong background in the public sector and in community engagement in the Darling Downs region over the past 37 years.

In 2000, Terry was elected to Local Government in the Kingaroy Shire Council in the portfolio of Environment and Health. He went on to a ministerial appointment for the South Burnett Regional Health Council and was re-elected in 2004 to the Kingaroy Shire Council Environment and Health Portfolio. He currently holds the appointment of Local Government Association of Queensland (LGAQ) Representative to Health Workforce Ltd. Queensland.

Terry has long been committed to community service. For his dedication he has been awarded the:

- Melvin Jones Fellow Award (International Association of Lions Clubs)—for dedication to community, and the International Association of Lions Clubs
- James D Richardson Fellow Award (International Association of Lions Clubs)—for dedication to Lions International District Convention.
- Lions International Presidents Award—for humanitarian services performed in solidarity with the civic ideals exemplified by the International Association of Lions Clubs.

Terry is a Member of the Australian Institute of Company Directors and holds Diploma of Business and Painter and Decorator Apprenticeship.

Ms Megan O'Shannessy

Board Member, Darling Downs Hospital and Health Board

Megan is a Registered Nurse and Midwife. Over a 25 year rural nursing career she has been the Director of Nursing at Thargomindah, Cunnamulla, Dirranbandi, St George and Warwick hospitals.

Megan was a member of the Queensland Nursing Council from 1998 to 2000. She completed a Bachelor of Nursing at the University of Southern Queensland in 1996 and is at present completing her Masters in Public Health at the James Cook University.

She is now the Director of Prevocational General Practice Program at Queensland Rural Medical Education (QRME), Deputy Chief Executive Officer QRME, and Senior Lecturer Griffith University.

Our Board

Board Meetings

The full Board meets monthly, with every second meeting being held in a rural area. The Health Service Chief Executive and Director Executive Services attend as standing invitees at each Board meeting. During 2013-14 Board meetings were held in Stanthorpe, Murgon, Miles, Goondiwindi and Nanango, as well as in Toowoomba. While meeting in the rural areas the Board routinely took the opportunity to visit all of the local hospitals and community health centres, as well as meet with staff and key stakeholders including GPs within the local communities.

The members of the DDHHS Board have experience in governance, management, healthcare delivery and most importantly, strong local knowledge.

There are two Board directors representing each of the four different regions of the hospital and health service area - Southern Downs, Western Downs, South Burnett and Toowoomba and a director with nursing experience.

In 2013-14 collectively the Board travelled in excess of 33,000 km throughout the 90,000 sq km of the DDHHS to attend Board meetings and undertake site visits. A summary of Board activities for 2013-14 is provided on page 49.

Board committees

To support the Board in its functions the Board has established the following committees:

- Executive Committee
- Finance Committee
- Quality and Safety Committee
- Audit and Risk Committee.

Executive Committee: supports the Board in its role, working with the Chief Executive to progress strategic issues and ensure accountability in the delivery of health services by the service.

In 2014 the Board Executive Committee charter was updated to include the functions of a performance appraisal, development and remuneration committee in relation to the Health Service Chief Executive position. The committee will undertake a formal assessment and make recommendations to the Board in July each year.

During the 2013-14 financial year executive committee meetings were held monthly. The membership of the committee comprised Mr Mike Horan AM (Chair), Dr Dennis Campbell and Dr Jeff Prebble. The HSCE attends all executive committee meetings.

Finance Committee: provides assurance and assistance to the Board, through oversight of the financial position, integrity and policies of the DDHHS.

During the 2013-14 financial year, finance committee meetings were held monthly. The membership of the committee comprised Dr Dennis Campbell (Chair), Dr Ross Hetherington, Ms Cheryl Dalton and Mr Terry Fleischfresser. Also attending meetings in advisory capacities were the Health Service Chief Executive and Chief Finance Officer.

Safety and Quality Committee: provides assurance and assistance to the Board on safety, quality, clinical governance frameworks and strategies of the service. The committee routinely reviews a range of reports and data in relation to planning, outcomes, feedback and external review of the safety and quality of care provided by the Darling Downs Hospital and Health Service.

During the 2013-14 financial year, safety and quality committee meetings were held bi-monthly. The membership of the committee comprised Dr Jeff Prebble (Chair), Dr Ian Keys, Ms Marie Pietsch, Ms Trish Leddington-Hill and Ms Megan O'Shannessey. Also attending in an advisory capacity were the Health Service Chief Executive, Executive Director Nursing and Midwifery Services, General Manager Toowoomba Hospital, and Director Clinical Governance.

Audit and Risk Committee: operates with due regard for the Treasury's *Audit Committee Guidelines*, and provides assurance and assistance to the Board on:

- the service's risk, control and compliance frameworks, and
- the service's external accountability responsibilities as prescribed in the *Financial Accountability Act 2009*, the *Auditor-General Act 2009*, the *Financial*

Accountability Regulation 2009 and the *Financial and Performance Management Standard 2009*.

This committee has an oversight role and does not replace management's primary responsibilities for the management of risks including fraud risk, the operations of the internal audit and risk management functions, the follow up of internal and external audit findings or governance of the DDHHS generally.

During the 2013-14 financial year, audit and risk committee meetings were held quarterly. The membership of the committee comprised Dr Dennis Campbell (Chair), Dr Ross Hetherington, Ms Cheryl Dalton and Mr Terry Fleischfresser. Also attending meetings in advisory capacities were the Health Service Chief Executive, Chief Finance Officer, Head Internal Audit and representatives of Queensland Audit Office.

The committee oversaw:

- endorsement of the annual risk-based audit plan
- completion of fieldwork in line with the audit plan, and
- the preparation of the Annual Financial Statements.

Internal Audit

DDHHS has established an Internal Audit function that operates under a Board-approved charter in accordance with the requirements of *Financial and Performance Management Standard 2009*, and consistent with relevant audit and ethical standards.

The role of the Internal Audit function is to conduct independent assessment and evaluation of the effectiveness and efficiency of organisational systems, processes and activities, thereby providing assurance and value to the Board and Management. In the development of its charter and reporting requirements, due regard has been given to the Queensland Government Treasury Audit Committee Guidelines. Internal Audit works in accordance with strategic and annual audit plans which are approved by the Board. The plans are developed using a risk-based approach that considers both strategic and operational risks. The Internal Audit function is independent of management, and its work is carried out by both in-house resources and co-sourced providers of internal audit services. Internal audit works independently, but collaboratively with the external auditors.

The Head of Internal Audit reports functionally to the Audit and Risk Committee of the Board, and administratively to the Chief Executive, and is required to attend all meetings of the Executive and Board Audit and Risk Committees to report on Internal Audit activities, direct the unit's activities and provide a framework for it to operate effectively.

Risk Management

The DDHHS is committed to effectively managing risks through compliance with legislation, alignment with best practice and through a practical approach that carefully plans for and prioritises risks and balances the costs and benefits of action.

The DDHHS Risk and Assurance Framework and Risk Reporting and Management Procedure uses an integrated risk management approach to describe how risks are identified, managed and monitored within the DDHHS.

Chief Finance Officer statement

Section 77(2)(b) of the Financial Accountability Act 2009 requires the Chief Finance Officer (CFO) of departments to provide the accountable officer with a statement as to whether the financial internal controls are operating efficiently, effectively and economically.

The DDHHS is not specifically required to comply with this provision as a statutory authority, however, as per best practice, for the year ending 30 June 2014, a statement assessing DDHHS's financial internal controls has been provided by the CFO to the Chair of the Board and the Board Audit and Risk Committee. This included reliance on representations from the Department of Health in relation to shared systems such as general ledger, accounts payable and payroll.

Board and Board Committee meetings 2013-14

The table shows the number of meetings of the Board and Board Committees attended by Board members during 2013-14

Name	Term of Office	Board Meeting		Executive Committee		Finance Committee		Audit and Risk		Quality and Safety	
		Held	*Attended*	*Held*	*Attended*	*Held*	*Attended*	*Held*	*Attended*	*Held*	*Attended*
Mr Mike Horan AM – *Chair*	18 May 2012 – 17 May 2016	11	10	11	10	-	-	-	-	-	-
Dr Dennis Campbell – *Deputy Chair*	29 June 2012 – 17 May 2016	11	9	11	10	10	10	4	4	-	-
Dr Jeff Prebble	29 June 2012 – 17 May 2016	11	9	11	11	-	-	-	-	6	6
Ms Cheryl Dalton	29 June 2012 – 17 May 2018	11	10	-	-	10	9	4	4	-	-
Mr Terry Fleischfresser	29 June 2012 – 17 May 2016	11	9	-	-	10	9	4	4	-	-
Dr Ross Hetherington	29 June 2012 – 17 May 2018	11	10	-	-	10	8	4	4	-	-
Ms Marie Pietsch	29 June 2012 – 17 May 2016	11	11	-	-	-	-	-	-	6	3
Dr Ian Keys	29 June 2012 – 17 May 2015	11	11	-	-	-	-	-	-	6	6
Ms Trish Leddington – Hill	9 November 2013 – 17 May 2018	11	11	-	-	-	-	-	-	6	6
Ms Megan O'Shannessy	18 May 2013 – 17 May 2016	11	10	-	-	-	-	-	-	6	5

General Meetings & Consultations
Alcohol & Drug Foundation of QLD
Australian Medical Council
Axion Biomedical
Barambah Health Centre
Blackbutt Medical Centre
Blue Care (Goondiwindi)
Blue Care (Stanthorpe)
Blue Care (South Burnett)
Carbal Medical Centre
Carinya Hostel
Carramar Home for Senior Citizens Association
Chamber of Commerce & Industry (Stanthorpe)
Chemmart Chemist (Goondiwindi)
Chief Operating Officer and Deputy Director-General, Public Sector Renewal - Department of Premier and Cabinet
Clubouse Toowoomba
Community Consultative Advisory Committee (Goondiwindi)
Community Consultative Committee (Stanthorpe)
Community Development Services (Stanthorpe)
Darling Downs South West Queensland Medicare Local
General Practitioners (Goondiwindi)
General Practitioners (Stanthorpe)
General Practitioners (Toowoomba)
Goondir Health Services
Goondiwindi Hospital Auxiliary
Goondiwindi State High School
Graham House Community Transport
Granite Belt Diagnostic Imaging
Heads of Churches Meeting (Toowoomba)
Health Service Planning Consultations (Toowoomba, Warwick, Goondiwindi, Dalby, Miles, Kingaroy, Murgon)
Home Instead
Italian Australian Welfare Association (Stanthorpe)
Kaloma Home for the Aged
Laing O'Rourke
Local Medical Association - Darling Downs
Meals on Wheels (Nanango)
MEDEX
Mental Health Commissioner
Miles State High School
Mothers United Maternity Stanthorpe (MUMSS)
Murgon Dental
Murilla Community Centre
My Midwives
Nanango Hospital Auxiliary
Nanango Physiotherapy
Nanango State High School
Nanango State School
Object Consulting
Origin Energy
Partners In Recovery
Pastoral Care (Goondiwindi)
Qld College of Wine Tourism, TAFE (Stanthorpe)
QML Pathology (Goondiwindi)
Queensland Airports Limited (Miles)
Queensland Ambulance Service (Miles)
Queensland Ambulance Service (Stanthorpe)
Queensland Audit Office
Queensland Gas Corporation
Queensland Police Service (Miles)
Red Cross (Goondiwindi)
Southern Cross Care Karinya (Nanango)
St Mary's Primary School (Goondiwindi)
St Vincent de Paul Society (Goondiwindi)
Stanthorpe Art Gallery Society
Stanthorpe Nursing Home
Stanthorpe State High School
Surat Basin Property Group
Toowoomba Hospital Foundation
Toowoomba Surat Basin Enterprises
University of Queensland
University of Southern Queensland
Wondai Chamber of Commerce
Young Leos (Nanango)

Forums and Events
15th National ASAPO Conference and Scientific Exhibition
Accelerating Vision - Concrete Steps to a Leading Region - USQ
ACHSM College Breakfast Forum
April No Falls Month displays
BreastScreen DDHHS 21st Celebration
Centenary Heights State School Senior Graduation Ceremony
Child Protection Week Breakfast
Collaboration Towards Better Outcomes: Health Care, Research & Education - USQ
Community Cabinet Meeting - Toowoomba
DDHHS Child Youth and Family Health Conference
DDHHS Clinical Leaders Forums
e-REGIONS Health Launch
Give Me Five for Kids - Toowoomba Hospital Foundation
Griffith University - Stanthorpe Clinical Education Facility Opening
Griffith University, Darling Downs Clinical Training Centre Opening
Health Renewal Portfolio Board Workshops
Improving Aboriginal and Torres Strait Islander Health - Study Tour
Launch of the Toowoomba Hospital Children's Appeal
Maintaining Momentum Forum - Clinical Redesign Unit
Midwife of the Year - DDHHS
Official Opening of the new Training Facility, SWQ Training and Assessing, Toowoomba
Official Opening of the Toowoomba Blue Care Community Care Centre
Opening of the Mental Illness Fellowship QLD Toowoomba
Opening of the Oakey Hospital Grand Gardens
Opening of Toowoomba 7 Springs Medical and Dental Centre
Partners in Recovery Official Launch - Toowoomba
QLD Ministerial Roundtable on Rural and Remote Mental Health
QLD Police "Leading Change" Workshop
Quality in Trauma Care Workshop - Qld Statewide Trauma Network
Queensland Clinical Senate
South West Regional Disability Council
St Vincent's Hospital Christmas Event
Statewide Stroke Clinical Network Forum
Toowoomba Hospital Volunteer's Luncheon
Toowoomba Launch of the I.D.E.A.S Van, Carbal Medical Centre
Workplace Health and Safety Workshop

Members of Parliament
Member for Nanango
Member for Southern Downs - Minister for Health
Member for Toowoomba North

Local Government
Goondiwindi Regional Council
South Burnett Regional Council

Hospital Visits
Baillie Henderson Hospital
Cherbourg
Goondiwindi
Inglewood
Jandowae
Miles
Millmerran
Murgon
Nanango
Stanthorpe
Tara
Texas
Toowoomba

Staff Awards
Australia Day Awards Ceremony
Length of Service Awards - Baillie Henderson Hospital
Length of Service Awards - Chinchilla
Length of Service Awards - Nanango
Length of Service Awards - Toowoomba
Length of Service Awards - Warwick

Our Executives

Dr Peter Bristow FRACP FCICM FRACMAGCM GAICD

Health Service Chief Executive

Dr Bristow was appointed as Chief Executive of the Darling Downs Hospital and Health Service in August 2012. Dr Bristow had been Acting Chief Executive Officer of the Darling Downs Health Service District from June 2011 and had previously worked in the role of Executive Director of Medical Services (EDMS) from November 2004, and then subsequently Director Toowoomba Hospital and EDMS.

Dr Bristow has a strong background in hospital medicine and is an Intensive Care specialist, previously working as the Intensive Care Unit Director in Toowoomba. He has been a doctor for 30 years and worked in New South Wales and Victoria before coming to Queensland, in 2000.

He has presented and published in medical literature with his main research interests being severity of illness scoring systems and in Intensive Care.

Mr Scott McConnel

Chief Finance Officer

Mr McConnel is an accountant with extensive management and finance experience and perspective from a diverse range of industries including mining, information technology, education and banking and finance, including seven years in financial services in London.

With experience across both the public and private sectors he has a track record of leading continuous improvement and in engendering a more commercial focus in not-for-profit settings.

Mr McConnel holds a Bachelor of Commerce degree with first class honours from the University of Queensland and is a member of the Australian Society of Certified Practising Accountants Australia and Graduate of the Australian Institute of Company Directors.

Dr Peter Gillies

General Manager Toowoomba Hospital

Dr Gillies came to Toowoomba in 2009 to take up the role of Director Medical Services following his employment as the Director of Medical Services for Hunter New England Health in Armidale, New South Wales.

Dr Gillies is a Fellow of the Royal Australasian College of Medical Administrators and has a Masters of Business Administration from Otago University. He is also a Graduate of the Australian Institute of Company Directors.

He has a background in general management, previously working as the general manager of a health software company and as the regional manager for a not-for-profit private hospital group in Auckland, New Zealand.

He has been a doctor for 19 years and worked in South Africa and the UK in both hospital and general practice roles prior to emigrating to New Zealand in 1995.

Ms Shirley Wigan

Executive Director Mental Health

Ms Wigan has extensive experience in the delivery of mental healthcare services, having worked at Mackay Hospital, West Moreton, Princess Alexander Hospital, Royal Brisbane Women's Hospital and Bayside as the Executive Director of Mental Health Services for seven years.

Ms Wigan has a social work background and graduated from the University of Queensland in 1970 with a Bachelor of Social Work. She went on to complete a Graduate Diploma in Public Health and Masters of Business Administration in 1995.

Ms Wigan was appointed Executive Director Mental Health for the Darling Downs in 2008. She has a strong background in community development, consumer and community engagement and innovative service delivery models in line with national and international imperatives and trends.

She is a member of the International Mental Health Leadership Network and is committed to a safe and quality consumer-focused service within a recovery framework.

Mr Michael Bishop

General Manager Rural

Mr Bishop is a founding member of the Mental Health Council of Australia, and a member of the National Rural Health Alliance, the Australian National Art Therapy Association, Mackay Centre for Research On Children and Community Services, The Australian College for Child and Family Protection Practitioners and Services for Australian Rural and Remote Allied Health (SARRAH).

Mr Bishop graduated with a Bachelor of Occupational Therapy degree from the University of Queensland in 1983 and a Masters degree in Health Services Management from the University of New South Wales in 1996. He has undertaken postgraduate study in both profession-specific areas as well as social economics.

He has worked nationally and internationally with health services aimed at improving both the scope and quality of allied health professional services. As a result of this development and review work, he is acknowledged as an allied health professional leader by peers (the Queensland SARRAH Network Coordinator, and Australian Chair, AHLANZ).

He has a Human Rights Commendation for work in destigmatising mental illness. Michael was chair of the Editorial Boards of the Australian Journal of Rural Health, Communities, and Families and Children Australia and convened several Australian Rural and Remote Scientific Health Conferences. Michael is the Deputy Chair of the Darling Downs and South West Queensland Medicare Local.

Ms Judy March

Executive Director Nursing and Midwifery

Ms March has worked for the Queensland public hospital system for over 40 years.

Ms March was appointed as the Director of Nursing (DON) Toowoomba Hospital and the Executive Director of Nursing from 2000 to 2008. Judy was then appointed to the role of Clinical Operations Manager for the Rural Division during the time of the amalgamation of Darling Downs and West Moreton, Health Service Districts.

Prior to moving to Toowoomba Judy was employed at the Gold Coast Health Service for 19 years, in positions from Midwifery Student, Registered Nurse, Nurse Manager and Nursing Director (ND) for Surgical Services.

In her current role she is the professional head of nursing and midwifery for the DDHHS – and works closely with the DONs and NDs across the service.

Ms March has a Nursing Degree and Masters in Health Administration.

Ms March has been awarded two Queensland Health Australia Day Awards, the first in 1997 for Services to the Surgical Services at the Gold Coast Hospital and in 2010 for Nursing Leadership. She was also the recipient of the inaugural Outstanding Leadership in Nursing Award from the Association of Queensland Nurse Leaders in 2008.

Ms Annette Scott

A/Executive Director Allied Health

Ms Scott commenced her career in health as a physiotherapist, graduating from the University of Queensland in 1983. After spending her earlier career as a private practitioner in solo practice in Central Queensland, she joined the public health system in Queensland in 1993. She has subsequently fulfilled a number of clinical, quality improvement and management roles, and has worked across a range of service settings including acute inpatient, outpatient, community and rural outreach.

Prior to taking on the role of A/Executive Director Allied Health, Ms Scott fulfilled the role of Allied Health Workforce Development officer in the Darling Downs. In this role she was responsible for implementing a range of innovative redesign initiatives across the Health Practitioner workforce. These initiatives have attracted national and state-wide attention for their ability to impact positively on patient flow and health service delivery. To support the validity and effectiveness of the redesign agenda Ms Scott has undertaken training in the Calderdale Framework, a transformational workforce redesign program developed in the United Kingdom. She is now one of only three Calderdale Practitioners in Australia who is endorsed to train in the framework.

In her role as A/Executive Director Allied Health, Ms Scott is the professional lead for Allied Health for the Darling Downs HHS as well as the Operational Lead for a range of Commonwealth and State-funded programs.

Mr Stewart Gordon

Executive Director People and Corporate until 24 March 2014

Mr Gordon has worked for the public health system in Queensland for approximately 20 years. He has a Business Degree (Human Resources and Marketing) and a background in rural health service delivery. He has worked in a number of locations, including in Roma as District Manager of the South West Health Service District and also spent time working in the Department of Health head office.

Having grown up in rural south west Queensland, Mr Gordon is passionate about rural health and advocates access to an appropriate range of services for people in rural areas.

Mr Gordon took up the post of Executive Director Rural Services for the former Toowoomba and Darling Downs Health Service District in October 2007 before moving into the role of Executive Director Rural Health & Aged Care during the time of the amalgamation of Darling Downs and West Moreton, Health Service Districts.

After a period of long service leave he returned to the Darling Downs Health Service District in February 2012 to take up the newly created position of Executive Director People & Corporate Services.

Glossary of terms

Term	Meaning
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.
Acute Hospital	Is generally a recognised hospital that provides acute care and excludes dental and psychiatric hospitals.
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).
Advance Allied Health Assistant	An advanced level of clinical practice which requires a high-level of clinical skill, knowledge and practice, closely integrated with clinical leadership skills, applied research and evidence-based practice capacities, and competence in facilitating education and learning of others.
Aged Care and HACC Assessment Team (ACHAT)	ACHAT provides comprehensive assessments for the needs of frail older people and facilitates access to available care services appropriate to their needs.
Allied Health Clinical Leader - Acute Medical	This role provides clinical leadership on behalf of allied health within the Acute Medical Services. It is undertaken by an advanced practice Occupational Therapist or Physiotherapist, who can also operate within an extended scope framework to deliver allied health services to patients which previously would have been delivered by another professional group eg. Speech Pathology, Nutrition and Dietetics.
Allied Health Clinical Leader - Rural Generalist	This role provides clinical leadership on behalf of allied health within the Emergency Department. It is undertaken by an advanced practice Physiotherapist, who can also operate within an extended scope framework to deliver allied health services to patients which previously would have been delivered by another professional group eg. Occupational Therapy, Speech Pathology, Nutrition and Dietetics.
Allied Health staff (Health Practitioners)	Professional staff who meet mandatory qualifications and regulatory requirements in the following areas: audiology; clinical measurement sciences; dietetics and nutrition; exercise physiology; medical imaging; nuclear medicine technology; occupational therapy; orthoptics; pharmacy; physiotherapy; podiatry; prosthetics and orthotics; psychology; radiation therapy; sonography; speech pathology and social work.
Ambulatory	Care provided to patients who are not admitted to the hospital, such as patients of emergency departments, outpatient clinics and community based (non-hospital) healthcare services.
Backlog Maintenance Remediation Program	A State Government Program providing capital expenditure and maintenance funding to address high priority and critical operational maintenance, life cycle replacements and upgrades.
Balanced Scorecard	A tool to align metrics with the strategic plan.
Benchmarking	Involves collecting performance information to undertake comparisons of performance with similar organisations.
Block Funded	Block funding is typically applied for small public hospitals where there is an absence of economies of scale that mean some hospitals would not be financially viable under Activity Based Funding (ABF), and for community based services not within the scope of Activity Based Funding.

Term	Meaning
Cardiology	Management, assessment and treatment of cardiac (heart related) conditions. Includes monitoring of long-term patients with cardiac conditions, maintenance of pacemakers and investigative treatments.
Chronic Disease	Chronic disease: Diseases which have one or more of the following characteristics: (1) is permanent, leaves residual disability; (2) is caused by non-reversible pathological alteration; (3) requires special training of the individual for rehabilitation, and/or may be expected to require a long period of supervision, observation or care.
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 Redesign	Clinical process redesign is concerned with improving patient journeys by making them simpler and better coordinated. The redesign process is patient focused, led by clinical staff, systematic and methodical and quick with tight timeframes.
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.
Community Care Unit	A Community Care Unit (CCU) is a residential facility for adult mental health consumers who are in recovery but require additional support and life skills rehabilitation to successfully transition to independent community living.
Community Health	Community health provides a range of services to people closer to their home. Some of these services include children's therapy services, pregnancy and postnatal care, rehabilitation and intervention services, and programs that focus on the long-term management of chronic disease.
Compensable Patient	One who receives care and/or treatment for an injury, illness or disease and receives, or is entitled to receive, compensation that covers the cost of hospital treatment.
Computerised Tomography (CT)	CT is diagnostic imaging technique which uses Xrays that are rotated around a patient to demonstrate the anatomy and structure of the organs and tissues.
Consumer Advisory Networks	Groups that represents people who use health services. Consumer Advisory Networks act as a bridge between health consumers and the health service.
Consumer Companion	Consumer Companions are people with lived experience of mental illness who have undergone specific training to undertake their role as a companion to people experiencing an acute hospital admission.
Delirium	An acute disorder characterised by confusion, disorientation, restlessness and clouding of the consciousness.
Department of Health	The Department of Health is responsible for the overall management of the public sector health system, and works in partnership with Hospital and Health Services to ensure the public health system delivers high quality hospital and other health services.
Direct Entry Midwife	Registered midwives who have completed a Bachelor of Midwifery and work in maternity settings such as hospitals, birth centres and other community agencies.
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.
Endoscopy	Internal examination of either the upper or lower gastro intestinal tract.
Environmental Health	Environmental Health programs are related human health issues that are affected by the physical, chemical, biological and social factors that are present in the environment.
Full-time equivalent (FTE)	Refers to full-time equivalent staff currently working in a position.
Gastroenterology	Consultation, diagnosis, treatment and follow-up of patients suffering diseases and disorders of the digestive system
Governance	Governance is aimed at achieving organisational goals and objectives, and can be described as the set of responsibilities and practices, policies and procedures used to provide strategic direction, ensure objectives are achieved, manage risks, and use resources responsibly and with accountability.
GP (General Practitioner)	A general practitioner is a registered medical practitioner who is qualified and competent for general practice in Australia. General practioners operate predominantly through private medical practices.
General Practice Liaison Officer	The General Practice Liaison Officer program strengthens the partnership between primary, community and secondary care by understanding the working health care environment/concerns between primary, community and tertiary care and together strive to improve health outcomes for the community. This includes improving access to services; providing information regarding alternative services; continuity of care (discharge and ongoing care pathways); resources, technology and shared care models.

Term	Meaning
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, including the National Health and Hospitals Network Agreement (NHHNA), the National Health Reform Heads of Agreement (HoA),and the National Healthcare Agreement 2012. This last agreement was signed by the Commonwealth and then all states and territories and sets out future directions on prevention, primary and community care, hospital and related care, and aged care.
Home and Community Care (HACC)	The Commonwealth funded HACC Program provides services which support frail older people and their carers, who live in the community and whose capacity for independent living are at risk of premature or inappropriate admission to long term residential care.
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	Provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation.
Indigenous health worker	An Aboriginal and/or Torres Strait Islander person who works to improve health outcomes for Indigenous Australians.
Inpatient	A patient who is admitted to a hospital or health service for treatment that requires at least one overnight stay.
Internal Audit	Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.
Interns	A medical practitioner in the first postgraduate year, learning medical practice under supervision.
Key Performance Indicators	Key performance indicators are metrics used to help a business define and measure progress towards achieving its objectives or critical success factors.
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 an urgent (category 1) operation, more than 90 days for a semi-urgent (category 2) operation and more than 365 days for a routine (category 3) operation.
Medical practitioner	A person who is registered with the Medical Board of Australia to practice medicine in Australia, including general and specialist practitioners.
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.
MH CAiRE	Mental Health Consistent Assessment in Rural Emergency. MH CAiRE is a project that aims to examine and improve the journey for people who present to rural emergency departments with a mental health problem. The solution involves the use of telehealth to increase access to after-hours specialist mental health assessment services in rural and remote communities. Staff are also supported by on-site and video-conference education around mental health assessment
Minimum Obligatory Human Resource Information (MOHRI)	MOHRI is a whole of Government (WoG) methodology for producing an Occupied Full Time Equivalent (FTE) and headcount value sourced from the Queensland Health payroll system data for reporting and monitoring.
Mobile Womens Health	The Mobile Womens Health service, aims to improve the health and well-being of women in rural and remote areas of Queensland. Mobile Women's Health Nurses work as sole practitioners and provide a range of preventative health services for women, including pap smears, education, information, counselling and support on a range of women's health issues.
Models of Care	Model of Care and Models of Service Delivery broadly defines the way that clinical and non-clinical services will be delivered.
Multidisciplinary team	Health professionals employed by a public health service who work together to provide treatment and care for patients. They include nurses, doctors, allied health and other health professionals.
Multipurpose Health Service (MPHS)	Provide a flexible and integrated approach to health and aged care service delivery for small rural communities. They are funded through pooling of funds from Hospital and Health Services (HHS) and the Australian Government Department of Health and Ageing.
Mums and Bubs	Postnatal In-Home Visiting program provides families with newborns with home visits from qualified and experienced Community Family Health midwives and/or child health nurses.

Term	Meaning
National Safety and Quality Healthcare Standards	The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in consultation and collaboration with jurisdictions, technical experts and a wide range of other organisations and individuals, including health professionals and patients. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of care provided by health service organisations.
NEAT	National Emergency Access Target. NEAT is a National Performance Benchmark for public hospitals. NEAT commenced in January 2012, with annual increment targets over the next four years for all patients presenting to a public hospital Emergency Department (ED) to either physically leave the ED for admission to hospital, be transferred to another hospital for treatment, or be discharged, within four hours.
NEST	National Elective Surgery Target. NEST is a National Performance Benchmart for public hospitals. The objectives of NEST are to improve patient care by: Increasing the percentage of elective surgery patients seen within the clinically recommende time, and reducing the number of patients who have waited longer than the clinically recommended time.
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.
Nurse Sensitive Indicators	The statewide Nurse Sensitive Indicator (NSI) reporting tool delivers a series of useful and relevant reports to help adult health facilities to analyse, trend, monitor, compare and/or benchmark the care delivered by nurses. These reports can be used to develop quality improvement initiatives which support the delivery of patient safety and care.
Occupied Bed Days	Is the occupancy of a bed or bed alternative by an admitted patient as measured at midnight of each day, for any period of up to 24 hours prior to that midnight.
Opthamology	Consultation, assessment, review, treatment and management of conditions relating to eye disorders and vision, and services associated with surgery to the eye.
Orthopaedics	Consultation, diagnosis, treatment and follow-up of patients suffering diseases and disorders of the musculoskeletal system and connective tissue.
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.
Outreach	Services delivered to sites outside of the service's base to meet or complement local service needs.
Overnight stay patient	A patient who is admitted to, and separated from, the hospital on different dates (not same-day patients).
Own Source Revenue	Own Source Revenue (OSR) is revenue generated by the agency, generally through the sale of goods and services. Examples of OSR include revenue generated through privately insured inpatients, private outpatients, and Medicare ineligible patients (overseas visitors).
Palliative Care	Palliative care is an approach that improves quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychological and spiritual.
Pastoral Care	Pastoral Care Services exist within a holistic approach to health, to enable patients, families and staff to respond to spiritual and emotional needs, and to the experiences of life and death, illness and injury, in the context of a faith or belief system.
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.
Patient Travel Subsidy Scheme (PTSS)	The Patient Travel Subsidy Scheme (PTSS) provides assistance to patients, and in some cases their carers, to enable them to access specialist medical services that are not available locally.
Peer Support Worker	In Mental Health, peer support has been defined as: a system of giving and receiving help founded on key principles of respect, shared responsibility , and mutual agreement about what is helpful.
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.
Primary Health Care	Primary health care services include health promotion and disease prevention, acute episodic care not requiring hospitalisation, continuing care of chronic diseases, education and advocacy.
Private Practice Midwife	Qualified midwives who practise privately, providing continuity of care in primary maternity services for women and their families.
Public hospital	Public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.
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.

Term	Meaning
Queensland Weighted Activity Unit (QWAU)	QWAU is a standardised unit to measure healthcare services (activities) within the Queensland Activity Based Funding (ABF) model.
Registered nurse (RN)	An individual registered under national law to practice in the nursing profession as a nurse, other than as a student.
Registered Training Organisation (RTO)	A Registered Training Organisation, is a vocational education organisation that provides students with training that results in qualifications and statements of attainment that are recognised and accepted by industry and other educational institutions throughout Australia.
Renal Dialysis	Renal dialysis is a medical process of filtering the blood with a machine outside of the body.
Risk management	A process of systematically identifying hazards, assessing and controlling risks, and monitoring and reviewing activities to make sure that risks are effectively managed.
Rural Generalist	A Rural Generalist is defined as a rural medical practitioner who is credentialed to serve in: • Hospital-based and community-based primary medical practice; and • Hospital-based secondary medical practice in at least one specialist medical discipline (commonly but not limited to obstetrics, anaesthetics and surgery); and without supervision by a specialist medical practitioner in the relevant disciplines.
Ryan's Rule	Ryan's Rule offers patients, their family and/or carer an opportunity to 'escalate' their concerns independently when they believe the patient in hospital is getting worse, is not doing as well as expected or who shows behaviour that is not normal for them.
Senior Medical Officer	A medical officer registered with the Medical Board of Australia under the provisions of the *Health Practitioners National Law Act 2009*.
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.
Stroke Lysis	Treatment to dissolve blood clots in blood vessels, improve blood flow, and prevent damage to tissues and organs.
Sub-acute	Sub-acute care focuses on continuation of care and optimisation of health and functionality.
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 • Telehealth services and equipment to monitor people's health in their home.
Tertiary Hospitals	Tertiary Hospitals provide care which requires highly specialized equipment and expertise.
Thrombolysis	The pharmacological process of breaking up and dissolving blood clots.
Transition Care Program (TCP)	The Transition Care Program (TCP) aims to provide time limited and therapy focussed support and active management for older people at the interface of the acute/sub-acute and residential aged care sectors, in a residential or community setting.
Triage category	Urgency of a patient's need for medical and nursing care.
Urology	Consultation, diagnosis, treatment and follow-up of patients suffering from diseases patients suffering from diseases and disorders of the kidney and urinary tract.
Visiting Medical Officer	A medical practitioner who is employed as an independent contractor or an employee to provide services on a part time, sessional basis.
Weighted activity Unit	A single standard unit used to measure all activity consistently. Phase 16 is the current version of the Queensland Health Activity Based Funding Model.
Weighted Occasions Of Service (WOOS)	A WOOS is a unit of measure of oral health services activity based on the oral health care delivered to a client as indicated by treatment items.

Compliance checklist

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	i
Accessibility	Table of contents	ARRs – section 10.1	1
	Glossary	ARRs – section 10.1	55
	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	*Queensland Government Enterprise Architecture – Information licensing* ARRs – section 10.5	Inside front cover
General information	Introductory Information	ARRs – section 11.1	ii, 4-5
	Agency role and main functions	ARRs – section 11.2	4-5, Appendix 1 (2, 8)
	Operating environment	ARRs – section 11.3	6-38, 48-50
	Machinery of Government changes	ARRs – section 11.4	N/A
Non-financial performance	Government objectives for the community	ARRs – section 12.1	6-18
	Other whole-of-government plans / specific initiatives	ARRs – section 12.2	N/A
	Agency objectives and performance indicators	ARRs – section 12.3	6-18
	Agency service areas, service standards and other measures	ARRs – section 12.4	35-38
Financial performance	Summary of financial performance	ARRs – section 13.1	13-14, 37-38

Compliance Checklist cont.

Compliance Checklist			
Summary of Requirement		Basis for requirement	Annual report reference
Governance – management and structure	Organisational structure	ARRs – section 14.1	19-20, 40-45, 48, Appendix 1 (42)
	Executive management	ARRs – section 14.2	46-48, 51-54, Appendix 1 (43,44)
	Related entities	ARRs – section 14.3	N/A
	Government bodies	ARRs – section 14.4	N/A
	Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* (section 23 and Schedule) ARRs – section 14.5	17
Governance – risk management and accountability	Risk management	ARRs – section 15.1	46, 47
	External Scrutiny	ARRs – section 15.2	12, 25
	Audit committee	ARRs – section 15.3	46, 47
	Internal Audit	ARRs – section 15.4	47
	Public Sector Renewal	ARRs – section 15.5	24
	Information systems and recordkeeping	ARRs – section 15.7	34
Governance – human resources	Workforce planning, attraction and retention and performance	ARRs – section 16.1	16-18, 27, 32
	Early retirement, redundancy and retrenchment	*Directive No.11/12 Early Retirement, Redundancy and Retrenchment* ARRs – section 16.2	33
Open Data	Open Data	ARRs – section 17	34
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 18.1	Appendix 1 (51)
	Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 18.2	Appendix 1 (52)
	Remuneration disclosures	*Financial Reporting Requirements for Queensland Government Agencies* ARRs – section 18.3	Appendix 1 (42-48)

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

Darling Downs Hospital and Health Service

ABN 64 109 516 141

Financial Statements - 30 June 2014

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Financial Statements 2013-14

Contents

	Page
Statement of Comprehensive Income	3
Statement of Financial Position	4
Statement of Changes in Equity	5
Statement of Cash Flows	6
Notes To and Forming Part of the Financial Statements	8
Management Certificate	51
Independent Audit Report	52

General Information

Darling Downs Hospital and Health Service is a Queensland Government statutory body established under the *Hospital and Health Boards Act 2011* and its registered trading name is Darling Downs Hospital and Health Service.

Darling Downs Hospital and Health Service is controlled by the State of Queensland which is the ultimate parent entity.

The principal address of the Hospital and Health Service is:

Jofre
Baillie Henderson Hospital
Cnr Hogg & Tor Streets
Toowoomba QLD 4350

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

For information in relation to the financial statements of the Darling Downs Hospital and Health Service, email DDHHS@health.qld.gov.au or visit the Darling Downs Hospital and Health Service website at: http://www.health.qld.gov.au/darlingdowns/default.asp

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

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
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	569,261	541,169
Grants and other contributions	4	34,003	30,337
Other revenue	5	4,109	4,293
Total Revenue		607,373	575,799
Gains on disposal/remeasurement of assets	6	15	53
Total Income from Continuing Operations		**607,388**	**575,852**
Expenses from Continuing Operations			
Employee expenses	7	(1,938)	(2,068)
Supplies and services	8	(562,006)	(537,636)
Grants and subsidies	9	(1,582)	(1,339)
Depreciation	10	(21,516)	(18,688)
Impairment losses	11	(1,088)	(333)
Other expenses	12	(1,569)	(1,539)
Total Expenses from Continuing Operations		**(589,699)**	**(561,603)**
Operating Result from Continuing Operations		**17,689**	**14,249**
Other Comprehensive Income			
Items that will not be reclassified subsequently to Operating Result			
Increase in Asset Revaluation Surplus	21	2,393	17,404
Total items that will not be reclassified subsequently to Operating Result		2,393	17,404
Total Other Comprehensive Income		2,393	17,404
Total Comprehensive Income		**20,082**	**31,653**

The accompanying notes form part of these statements

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Statement of Financial Position
as at 30 June 2014

	Notes	2014 $'000	2013 $'000
Current Assets			
Cash and cash equivalents	13	60,937	38,852
Receivables	14	9,385	12,430
Inventories	15	5,535	4,764
Other current assets	16	234	168
Total Current Assets		**76,091**	**56,214**
Non-Current Assets			
Property, plant and equipment	17	305,469	310,467
Total Non-Current Assets		**305,469**	**310,467**
Total Assets		**381,560**	**366,681**
Current Liabilities			
Payables	18	41,551	38,523
Accrued employee benefits	19	25	73
Unearned revenue	20	30	5
Total Current Liabilities		**41,606**	**38,601**
Total Liabilities		**41,606**	**38,601**
Net Assets		**339,954**	**328,080**
Equity			
Contributed equity		288,219	296,427
Accumulated surplus/(deficit)		31,938	14,249
Asset revaluation surplus	21	19,797	17,404
Total Equity		**339,954**	**328,080**

The accompanying notes form part of these statements

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Statement of Changes in Equity
for the year ended 30 June 2014

	Notes	*Accumulated Surplus/ Deficit*	*Asset Revaluation Surplus (Note 21)*	*Contributed Equity*	*TOTAL*
		$'000	*$'000*	*$'000*	*$'000*
Balance as at 1 July 2012					
Operating result from continuing operations		14,249			14,249
Other Comprehensive Income					
Increase in asset revaluation surplus	21 2(o)		17,404		17,404
Total Comprehensive Income for the year		14,249	17,404		31,653
Transactions with Owners as Owners:					
Net assets received (transferred under Administrative Arrangement at 1 July 2012)				303,518	303,518
Net assets received during year	2(g)			4,566	4,566
Non appropriated equity injections (Minor Capital works)	2(y)			6,999	6,999
Non appropriated equity withdrawals (Depreciation funding)	2(y)			(18,656)	(18,656)
Net Transactions with Owners as Owners				296,427	296,427
Balance as at 30 June 2013		**14,249**	**17,404**	**296,427**	**328,080**

	Notes	*$'000*	*$'000*	*$'000*	*$'000*
Balance as at 1 July 2013		14,249	17,404	296,427	328,080
Operating result from continuing operations		17,689			17,689
Other Comprehensive Income					
Increase in asset revaluation surplus	21 2(o)		2,393		2,393
Total Comprehensive Income for the Year		17,689	2,393		20,082
Transactions with Owners as Owners:					
Net assets received during year	2(g)			7,752	7,752
Non appropriated equity injections (Minor Capital works)	2(y)			5,487	5,487
Non appropriated equity withdrawals (Depreciation funding)	2(y)			(21,447)	(21,447)
Net Transactions with Owners as Owners				(8,208)	(8,208)
Balance as at 30 June 2014		**31,938**	**19,797**	**288,219**	**339,954**

The accompanying notes form part of these statements

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
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		549,885	521,916
Grants and other contributions		34,025	30,270
Interest receipts		159	154
GST input tax credits from ATO		7,634	5,663
GST collected from customers		557	568
Other		3,947	4,188
		596,207	**562,759**
Outflows:			
Employee expenses		(1,987)	(2,006)
Supplies and services		(559,830)	(514,989)
Grants and subsidies		(1,587)	(1,339)
GST paid to suppliers		(7,693)	(6,429)
GST remitted to ATO		(616)	(521)
Other		(1,364)	(1,531)
		(573,077)	**(526,815)**
Net cash provided by operating activities	22	**23,130**	**35,944**
Cash flows from investing activities			
Inflows:			
Sales of property, plant and equipment		32	53
Outflows:			
Payments for property, plant and equipment		(14,317)	(11,142)
Net cash used in investing activities		**(14,285)**	**(11,089)**
Cash flows from financing activities			
Inflows:			
Proceeds from machinery-of-Government change (1 July 2012)			2,432
Proceeds from equity injections		5,488	6,999
Movements in equity - other		7,752	4,566
Outflows:			
Equity withdrawals			
Net cash provided by financing activities		**13,240**	**13,997**
Net increase in cash and cash equivalents		**22,085**	**38,852**
Cash and cash equivalents at beginning of financial year		38,852	
Cash and cash equivalents at end of financial year	13	**60,937**	**38,852**

The accompanying notes form part of these statements

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Notes to and Forming Part of the Financial Statements 2013-14

Index of Notes

Note	Title
1.	Objectives and Strategic Priorities of the Darling Downs Hospital and Health Service
2.	Summary of Significant Accounting Policies
3.	User charges and fees
4.	Grants and other contributions
5.	Other revenue
6.	Gains on disposal/remeasurement of assets
7.	Employee expenses
8.	Supplies and services
9.	Grants and subsidies
10.	Depreciation
11.	Impairment losses
12.	Other expenses
13.	Cash and cash equivalents
14.	Receivables
15.	Inventories
16.	Other current assets
17.	Property, plant and equipment
18.	Payables
19.	Accrued employee benefits
20.	Unearned revenue
21.	Asset revaluation surplus
22.	Reconciliation of Operating Surplus to Net Cash From Operating Activities
23.	Non-cash financing and investing activities
24.	Commitments for Expenditure
25.	Contingencies
26.	Restricted assets
27.	Fiduciary Trust Transactions and Balances
28.	Financial Instruments
29.	Key Management Personnel and Remuneration
30.	Events occurring after balance date
	Certificate of Darling Downs Hospital and Health Service
	INDEPENDENT AUDITOR'S REPORT

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Notes to and Forming Part of the Financial Statements 2013-14

1. Objectives and Strategic Priorities of the Darling Downs Hospital and Health Service

The Darling Downs Hospital and Health Service is an independent statutory body, overseen by a local Hospital and Health Board. The Darling Downs Hospital and Health Service provides public hospital and healthcare services as defined in the service agreement with the Department of Health.

These services reflect Darling Downs Hospital and Health Service's planning priorities as articulated in Darling Downs Hospital and Health Service Strategic Plan and support investment decision-making based on the health continuum. These strategic directions are set by the Darling Downs Hospital and Health Board and the Darling Downs Hospital and Health Service implements and develops initiatives in accordance with these strategic directions.

Geographically, the Darling Downs Hospital and Health Service provides services across an area of approximately 90,000 square kilometres, covering the local government areas of the Toowoomba Regional Council, Western Downs Regional Council, Southern Downs Regional Council, South Burnett Regional Council, Goondiwindi Regional Council, Cherbourg Aboriginal Shire Council and part of the Banana Shire Council (community of Taroom).

The Darling Downs Hospital and Health Service delivers clinical services to approximately 300,000 people from 26 locations. The majority of the Darling Downs Hospital and Health Service residents receive inpatient care either at their local hospital or at the Toowoomba Hospital. Patients are at times required to travel to Brisbane to access some types of specialist services only offered at tertiary facilities.

The Darling Downs Hospital and Health Service has four strategic themes:

* delivering quality healthcare;
* ensuring resources are sustainable;
* ensuring processes are clear; and
* ensuring dedicated trained staff.

These align with the *Blueprint for better healthcare in Queensland* and support the Government's objectives for the community to deliver better infrastructure and planning and revitalise frontline services for families.

2. Summary of Significant Accounting Policies

(a) Statement of Compliance

The Darling Downs Hospital and Health Service has prepared these financial statements in compliance with Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board ('AASB') and 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 Darling Downs 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

Darling Downs Hospital and Health Service was established as a separate reporting entity on 1 July 2012. The services undertaken by Darling Downs Hospital and Health Service are disclosed at note 1. The financial statements include the value of all revenues, expenses, assets, liabilities and equity of Darling Downs Hospital and Health Service.

2. Summary of Significant Accounting Policies continued

(c) Fiduciary Trust Transactions and Balances

Darling Downs Hospital and Health Service acts in a fiduciary trust capacity in relation to patient fiduciary funds (formerly known as patient trust accounts) and Right of Private Practice trust accounts. Consequently, these transactions and balances are not recognised in the financial statements. Although patient funds are not controlled by Darling Downs Hospital and Health Service, trust activities are included in the audit performed annually by the Auditor-General of Queensland. Note 27 provides additional information on the balances held in patient fiduciary funds and Right of Private Practice trust accounts.

(d) User Charges and Fees

User charges and fees primarily comprises Department of Health funding, hospital fees, reimbursement of pharmaceutical benefits and sales of goods and services. There has been a change in the recognition of Department of Health funding from grants and other contributions in 2012-13 to user charges and fees this year, refer note 2(ad) for details.

User charges and fees controlled by Darling Downs Hospital and Health Service are recognised as revenues when the revenue has been earned and can be measured reliably with sufficient degree of certainty. User charges and fees are controlled by the Darling Downs Hospital and Health Service where they can be deployed for the achievement of Darling Downs Hospital and Health Service's objectives.

The funding from Department of Health is provided predominantly for specific public health services purchased by the Department from Darling Downs Hospital and Health Service in accordance with a service agreement between the Department and Darling Downs Hospital and Health Service. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by Darling Downs Hospital and Health Service.

The funding from Department of Health 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.

Revenue recognition for other user charges and fees is based on either invoicing for related goods, services and/or the recognition of accrued revenue.

(e) 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 Darling Downs 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.

(f) Other Revenue

Other revenue primarily reflects recoveries of payments for contracted staff from third parties such as universities and other government agencies.

(g) Administrative Arrangements

Darling Downs Hospital and Health Service has the full right of use, managerial control of land and building assets and is responsible for maintenance. The Department of Health 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.

2. Summary of Significant Accounting Policies continued

(g) Administrative Arrangements continued

Transfer of assets on practical completion

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 Darling Downs Hospital and Health Service by the Minister for Health as a contribution by the State through equity. In 2013-14 the value of assets transferred was $7.752 million ($4.566 million in 2012-13) by the Department of Health to Darling Downs Hospital and Health Service.

(h) Special Payments

Special payments include ex gratia expenditure and other expenditure that the Darling Downs Hospital and Health Service is not contractually or legally obligated to make to other parties. In compliance with the *Financial and Performance Management Standard 2009* , the Darling Downs Hospital and Health Service maintains a register setting out details of all special payments approved by Darling Downs Hospital and Health Service delegates in accordance with approved financial delegations. The total of all special payments (including those of $5,000 or less) is disclosed separately within Other expenses (note 12). However, descriptions of the nature of special payments are only provided for special payments greater than $5,000.

(i) 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.

Overdraft Facility

Darling Downs Hospital and Health Service operational bank accounts form part of the whole-of-Government banking arrangement with the Commonwealth Bank of Australia.

Under this arrangement, Hospital and Health Services have access to the whole-of-Government debit facility with limits assigned to Department of Health and individual Hospital and Health Services which are approved by Queensland Treasury and Trade.

Darling Downs Hospital and Health Service has an approved debt facility of $6 million under whole-of-Government banking arrangements to manage any short term cash shortfalls.

(j) Receivables

Trade debtors are recognised at the amounts due at the time of sale or service delivery i.e. the agreed purchase/contract price. Settlement of these amounts is generally required within 30 days from invoice date. The collectability of receivables is assessed periodically with provision being made for impairment. All known bad debts were written-off as at 30 June.

Impairment of receivables

Throughout the year, Darling Downs Hospital and Health Service 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 Darling Downs Hospital and Health Service's assessment of the credit risk associated with receivables balances and is determined based on historical rates of bad debts (by category) and management judgement. Increases in the allowance for impairment are based on loss events as disclosed in Note 28 (c).

2. Summary of Significant Accounting Policies continued

(k) Inventories

Unless material, inventories do not include supplies held ready for use in the wards throughout the hospital facilities. These are expensed on issue from the Darling Downs Hospital and Health Service's central store. Items held on consignment are not treated as inventory, but are expensed when utilised in the normal course of business.

Stock on hand is stated at the lower of cost and net realisable value. Cost comprises purchase and delivery costs, net of rebates and discounts received or receivable. Inventories are measured at weighted average cost, adjusted for obsolescence.

Inventories consist mainly of medical supplies and drugs held for distribution to hospitals or residential aged care facilities within Darling Downs Hospital and Health Service and other Hospital and Health Services. These inventories are provided to the facilities at cost. Darling Downs Hospital and Health Service provides a central store enabling the distribution of supplies to other Hospital and Health Services.

(l) Other Non-Financial Assets

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

(m) Acquisitions of Assets

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.

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*.

(n) Property, Plant and Equipment

Darling Downs Hospital and Health Service holds property, plant and equipment in order to meet its core objective of providing quality healthcare.

Items of property, plant and equipment with a cost or other value equal to or in excess of 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 Darling Downs Hospital and 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 Darling Downs Hospital and Health Service from the Department of Health. Under the terms of the lease, no consideration in the form of a lease or residual payment by the Darling Downs Hospital and Health Service is required.

2. Summary of Significant Accounting Policies continued

(n) Property, Plant and Equipment continued

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

Darling Downs Hospital and Health Service has the full right of use, managerial control of land and building assets and is responsible for their maintenance. The Department of Health 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.

Legislation to enable the transfer of ownership of land and buildings was passed by State Parliament on 20 June 2012. A sub committee with representatives from the Hospital and Health Services and the Department of Health has been established to develop protocols to enable this transfer to occur. It is anticipated that the transfer for Darling Downs Hospital and Health Service will be completed by December 2014.

(o) 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 abovementioned 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 experts. 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 managed by a team in Darling Downs Hospital and Health Service, who determine the specific revaluation practices and procedures. The Darling Downs Hospital and Health Service Board Audit & Risk Committee oversees the revaluation processes managed by the Finance team.

The fair values reported by Darling Downs Hospital and Health Service 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 2 (p)).

Where assets have not been specifically appraised in the reporting period, their previous valuations are materially kept up-to-date via the application of relevant indices. The Darling Downs Hospital and Health Service ensures that the application of such indices results in a valid estimation of the assets' fair values at reporting date.

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 determined as the replacement cost less the cost to bring an asset to current standards.

2. Summary of Significant Accounting Policies continued

(o) Revaluations of Non-Current Physical Assets continued

Buildings are measured at fair value by applying either, a revised estimate of individual asset's depreciated replacement cost, or interim indices which approximate movement in market prices for labour and other key resource inputs, as well as changes in design standards as at the reporting date. These estimates are developed by independent quantity surveyors.

Land is measured at fair value each year using indexation by the State Valuation Service (SVS) within the Department of Natural Resources and Mines.

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, having regard to the review of land values undertaken for each local government area.

The independent experts provide assurance of their robustness, validity and appropriateness for application to the relevant assets. Indices used are also tested for reasonableness by applying the indices to a sample of assets, comparing the results to similar assets that have been valued by an independent professional valuer or quantity surveyor, and analysing the trend of changes in values over time. Through this process, which is undertaken annually, management assesses and confirms the relevance and suitability of indices provided based on Darling Downs Hospital and Health Service's own particular circumstances.

Early in the reporting period, the Darling Downs Hospital and Health Service 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 - in themselves - 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. 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.

(p) 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, general office buildings and residential 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 Darling Downs Hospital and Health Service 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.

2. Summary of Significant Accounting Policies continued

(p) Fair Value Measurement continued

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 Darling Downs Hospital and Health Service 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 Darling Downs Hospital and Health Service's valuations of assets or liabilities are eligible for categorisation into level 1 of the fair value hierarchy. As 2013-14 is the first year of application of AASB 13 by Darling Downs Hospital and Health Service, there were no transfers of assets between fair value hierarchy levels during the period.

More specific fair value information about property, plant and equipment is outlined in note 17.

(q) Depreciation

Property, plant and equipment are depreciated on a straight-line basis. Annual depreciation is based on fair values and Darling Downs Hospital and Health Service's assessments of the useful remaining life of individual assets.
All asset useful lives were reviewed to ensure that the remaining service potential of the assets was reflected in the accounts. 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.

Any expenditure that increases the capacity or service potential of an asset is capitalised and depreciated over the remaining useful life of the asset. Major components purchased specifically for particular assets are capitalised and depreciated on the same basis as the asset to which they relate. A review of major components was undertaken and whilst components are not separately accounted for, there is no material effect on depreciation expense reported. 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.

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

Class	Depreciation rates
Buildings and Improvements	0.76% - 3.85%
Plant and equipment	2.0% - 20.0%

2. Summary of Significant Accounting Policies continued

(r) 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. Darling Downs Hospital and Health Service has no finance lease assets as at the reporting date.

Darling Downs Hospital and Health Service has a Deed of Lease arrangement with the Department of Health for assets transferred to the Hospital and Health Service in the Transfer Notice effective 1 July 2012. For recognition under AASB 117 *Leases* , there must be consideration paid under the lease for assets to be recognised as leased assets, and this is not the case in the current arrangements. Therefore assets transferred are recognised as property, plant and equipment rather than leased assets.

(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, Darling Downs Hospital and Health Service 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 (o).

(t) Payables

Trade creditors are recognised upon receipt of the goods or services ordered and are measured at the nominal amount i.e. agreed purchase/contract price, net of applicable trade and other discounts. Amounts owing are unsecured and generally settled in accordance with the vendors' terms and conditions but within 60 days.

(u) Financial Instruments

Recognition

Financial assets and financial liabilities are recognised in the Statement of Financial Position when Darling Downs Hospital and Health Service 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

Darling Downs Hospital and Health Service does not enter into transactions for speculative purposes, nor for hedging. Apart from cash and cash equivalents, the Darling Downs Hospital and Health Service 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 Darling Downs Hospital and Health Service are include in note 28.

2. Summary of Significant Accounting Policies continued

(u) Financial Instruments continued

For financial assets carried at amortised cost, the amount of the impairment loss recognised is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the financial asset's original effective interest rate. When a trade receivable is considered uncollectible, it is written off against the allowance account. Subsequent recoveries of amounts previously written off are credited against the allowance account. Changes in the carrying amount of the allowance account are recognised in Statement of Comprehensive Income.

(v) Employee Benefits and Health Service Employee Costs

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

(i) Health Service Employees

In 2013-14 the Darling Downs Hospital and Health Service was not a prescribed service and accordingly all non-executive staff were employed by the Department of Health. Provisions in the *Hospital and Health Boards Act 2011* enable Darling Downs Hospital and Health Service 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 Hospital and Health Service, and acknowledges and accepts its obligations as the employer of these employees;
- The Darling Downs Hospital and Health Service is responsible for the day to day management of these employees; and
- The Darling Downs Hospital and Health Service reimburses the Department for the salaries and on-costs of these employees.

(ii) Darling Downs Hospital and Health Service's Executives

In addition to the Health Service employees 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.

Darling Downs Hospital and Health Service 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 Darling Downs Hospital and Health Service 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 Costs 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. Darling Downs Hospital and Health Service was admitted into this arrangement effective 1 July 2012. Under this scheme, a levy is made on Darling Downs Hospital and Health Service 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 paid or 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 Darling Downs Hospital and Health Service. No provision for annual leave is recognised in Darling Downs Hospital and Health Service's 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 Darling Downs Hospital and Health Service 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 Darling Downs Hospital and Health Service. No provision for long service leave is recognised in the Darling Downs Hospital and Health Service's 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 Darling Downs Hospital and Health Service'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 Darling Downs Hospital and Health Service pays superannuation contributions into a complying superannuation fund.

Darling Downs Hospital and Health Service complies with *The Superannuation Guarantee (Administration) Act 1992* (Superannuation Guarantee) which requires the Hospital and Health Service to provide a minimum superannuation cover for all eligible employees. The minimum level of superannuation cover under the Superannuation Guarantee was 9.25 per cent of each eligible employee's earnings base as at 30 June 2014.

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 (see note 29). These may include both Health Service Executives and Health Service Employees.

(w) Unearned Revenue

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

2. Summary of Significant Accounting Policies continued

(x) Insurance

Darling Downs Hospital and Health Service is covered by Department of Health insurance policies with Queensland Government Insurance Fund (QGIF) and WorkCover Queensland, and pays a fee to the Department of Health as a fee for service arrangement. This is included in supplies and services (refer note 8).

QGIF covers property and general losses above a $10,000 threshold and health litigation payments above a $20,000 threshold and associated legal fees. QGIF collects from insured agencies an annual premium intended to cover the cost of claims occurring in the premium year, calculated on a risk assessment basis.

(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*. Appropriations for equity adjustments are similarly designated.

Transactions with owners as owners include equity injections for non-current asset acquisitions and non-cash equity withdrawals to offset non-cash depreciation funding received under the Service Agreement with the Department of Health.

(z) Taxation

Darling Downs Hospital and Health Service 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.

Both the Darling Downs Hospital and Health Service and the Department of Health satisfy section 149-25(e) of the *A New Tax System (Goods and Services) Act 1999* (Commonwealth) (the GST Act) and were able, with other Hospital and Health Services, to form a “group” for GST purposes under Division 149 of the GST Act. This means that any transactions between the members of the "group" do not attract GST. However, all entities are responsible for the payment or receipt of any GST for their own transactions. As such, GST credits receivable from and payable to the Australian Taxation Office (ATO) are recognised and accrued. Refer note 14 (Receivables).

All FBT and GST reporting to the Commonwealth is managed centrally by the Department, with payments/receipts made on behalf of the Darling Downs Hospital and Health Service reimbursed to/from the Department on a monthly basis. GST credits receivable from, and GST payable to the ATO, are recognised on this basis.

(aa) Issuance of Financial Statements

The financial statements are authorised for issue by the Chair of the Board and the Chief Finance Officer at the date of signing the Management Certificate.

(ab) Critical Accounting Judgements and Key Sources of Estimation Uncertainty

The preparation of the financial statements requires management to make judgements, estimates and assumptions that affect the reported amounts in the financial statements. Management continually evaluates its judgements and estimates in relation to assets, liabilities, contingent liabilities, revenue and expenses. Management bases its judgements, estimates and assumptions on historical experience and on other various factors, including expectations of future events. The resulting accounting judgements and estimates will seldom equal the related actual results. The judgements, estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities (refer to the respective notes) within the next financial year are:

2. Summary of Significant Accounting Policies continued

(ab) Critical Accounting Judgements and Key Sources of Estimation Uncertainty continued

Provision for impairment of receivables
The provision for impairment of receivables assessment requires a degree of estimation and judgement. The level of provision is assessed by taking into account the recent revenue transaction experience, the ageing of receivables, historical collection rates and specific knowledge of the individual debtor's financial position.

Fair value and hierarchy of financial instruments
The Darling Downs Hospital and Health Service is required to classify financial instruments, measured at fair value, using a three level hierarchy, being:

Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities;
Level 2: Inputs other than quoted prices included within level 1 that are observable for the asset or liability, either directly (as prices) or indirectly (derived from prices); and
Level 3: Inputs for the asset or liability that is not based on observable market data (unobservable inputs).
An instrument is required to be classified in its entirety on the basis of the lowest level of valuation inputs that is significant to fair value.

Considerable judgement is required when determining fair value and the relevant reportable category.

Estimation of useful lives of assets
The Darling Downs Hospital and Health Service determines the estimated useful lives and related depreciation on charges for its property, plant and equipment. The useful lives could change significantly as a result of technical innovations or some other event. The depreciation charge will increase where the useful lives are less than previously estimated lives, or technically obsolete or non-strategic assets that have been abandoned or sold will be written off or written down.

(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.

(ad) Voluntary change in accounting policy

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

In 2012-13 the Department of Health provided this funding as grant payments but for 2013-14 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 under a service agreement, Darling Downs Hospital and Health Service now recognises the 2013-14 funding of $529.4 million as user charges and fees revenue for 2013-14 rather than as grants revenue which occurred in 2012-13. The main effect is that the revenue is now recognised under the criteria detailed in AASB 118 *Revenue* for 2013-14, rather than under AASB 1004 *Contributions* in 2012-13. The revenue recognition criteria is described in note 2(d) user charges and fees and note 2(e) grants and other contributions.

This change in accounting policy has been applied retrospectively with the affect that grants and other contributions revenue for 2012-13 has reduced by $512.6 million and user charges and fees revenue has increased by the same amount.

2. Summary of Significant Accounting Policies continued

(ae) New and Revised Accounting Standards

Other than the voluntary change in accounting policy for revenue received from the Department of Health detailed in note 2(ad), Darling Downs Hospital and Health Service did not voluntarily change any of its accounting policies during 2013-14. The only Australian Accounting Standard changes applicable for the first time as from 2013-14 that have had a significant impact on the Darling Downs Hospital and Health Service's financial statements are those arising from AASB 13 *Fair Value Measurement.*

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 Hospital and Health Service'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 relates to the fair value measurement methodologies used and financial statement disclosures made in respect of such assets and liabilities.

Darling Downs Hospital and Health Service reviewed its fair value methodologies (including instructions to valuers, data used and assumptions made) for land and buildings measured at 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 Hospital and Health Service), the amount of information disclosed has significantly increased. Note 2 (p) explains some of the principles underpinning the additional fair value information disclosed. Most of this additional information is set out in note 17 - 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 Darling Downs Hospital and Health Service's circumstances, the only implication for the Darling Downs Hospital and Health Service was 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 Darling Downs Hospital and Health Service 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 Darling Downs Hospital and Health Services 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. Darling Downs Hospital and Health Service 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 Darling Downs Hospital and Health Service.

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.

2. Summary of Significant Accounting Policies continued

(ae) New and Revised Accounting Standards continued

Pursuant to AASB 1053, public sector entities like Darling Downs Hospital and Health Service 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 Darling Downs Hospital and Health Service, 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 Darling Downs Hospital and Health Service) 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 Darling Downs Hospital and Health Service.

Darling Downs 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 Darling Downs Hospital and Health Service has not applied any Australian Accounting Standards and Interpretations that have been issued but are not yet effective. Darling Downs Hospital and Health Service 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 Darling Downs 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. Darling Downs Hospital and Health Service 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 of those accounting standards, Darling Downs Hospital and Health Service has reviewed the nature of its relationships with entities that the Darling Downs Hospital and Health Service is connected with to determine the impact of AASB 2013-8. Currently Darling Downs Hospital and Health Service does not have control over any other entities.

2. Summary of Significant Accounting Policies continued

(ae) New and Revised Accounting Standards continued

AASB 11 deals with the concept of joint control and sets out new principles for determining the type of joint arrangements 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. Darling Downs Hospital and Health Service 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, Darling Downs Hospital and Health Service 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 Instrument* s and AASB 2010-7 A*mendments 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 Darling Downs Hospital and Health Service are that they will change the requirements for the classification, measurement and disclosures associated with Darling Downs Hospital and Health Service'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 approximate 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 Darling Downs Hospital and Health Service's activities, or have no material impact on the Darling Downs Hospital and Health Service.

(af) Other

Voluntary Redundancies

In 2013-14 Darling Downs Hospital and Health Service, in line with whole of Government initiatives, conducted a Voluntary Redundancy program offering bona-fide redundancy packages to selected Department of Health staff. 101 voluntary redundancies were accepted in accordance with the terms of the Queensland Public Service Commission's Directive 11/12 *Early Retirement, Redundancy and Retrenchment* .

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.

Corporate Services Received for No Cost

Darling Downs Hospital and Health Service receives corporate services support from the Department of Health for no cost. Corporate services received include payroll services, accounts payable services, some taxation services, some supply services and some 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 Profit or Loss and Other Comprehensive Income.

2. Summary of Significant Accounting Policies continued

(af) Other continued

Property Maintenance Backlog

This represents the total cost of repairs, maintenance and assets due for replacement, with these activities to occur over future years. It is estimated that expenditure for the next 12 months will be approximately $19.6 million. The current estimate of all property maintenance backlog costs is $44.2 million as at the reporting date.

The Department of Health has provided $16.1 million of additional funding in the 2014-15 budget allocation to address the property maintenance backlog of the Darling Downs Hospital and Health Service.

3. User charges and fees

	2014 *$'000*	*2013* *$'000*
Government Funding		
Activity Based Funding		
State Share	161,308	126,314
Commonwealth share	104,233	65,137
	265,541	191,451
Block Funding		
State share	98,844	130,706
Commonwealth share	57,791	56,851
	156,635	187,557
Training, teaching and research		
State share	2,166	13,876
Commonwealth share	1,289	6,036
	3,455	19,912
Other government funding	103,812	112,071
Total Government Funding	**529,443**	**510,991**
Sales of goods and services	2,475	3,086
Hospital fees	24,366	21,069
Pharmaceutical Benefits Scheme Reimbursement	12,954	5,987
Other user charges - Rental income	23	36
	569,261	**541,169**

4. Grants and other contributions

Commonwealth and State Government grants		
Nursing home grants	16,380	15,849
Home and community care grants	7,678	7,637
Other specific purpose grants	7,905	6,667
Total Australian Government grants	**31,963**	**30,153**
Other		
Donations non-current physical assets	8	18
Donations other	1,359	166
Other grants	673	
	34,003	**30,337**

5. Other revenue

	2014 $'000	2013 $'000
Health Service Employee Cost Recoveries		
Queensland Government Departments	15	239
External	1,950	2,583
Workcover	734	695
Total Health Service Employee Cost Recoveries	**2,699**	**3,517**
Interest	159	154
Licences and registration charges	25	29
Non-labour recoveries	913	281
Other	313	312
	4,109	**4,293**

6. Gains on disposal/remeasurement of assets

Gains on sale of property, plant and equipment	15	53
	15	**53**

7. Employee expenses

Employee benefits		
Wages and Salaries	1,465	1,422
Annual leave levy	96	150
Employer superannuation contributions	152	163
Long service leave levy	23	25
Employee related expenses		
Redundancies	159	189
Workers compensation premium	20	21
Payroll tax	21	37
Other employee related expense	2	61
	1,938	**2,068**

The number of employees including both full-time employees and part-time employees measured on a full-time equivalent basis is:

Number of Employees (Full time Equivalents) as at 30 June	**4**	**4.8**

Refer to Note 2 (v).

Key management personnel and remuneration is reported in Note 29.

8. Supplies and services

	2014 *$'000*	*2013* *$'000*
Health Service Employee Costs	418,197	411,117
Consultants and Contractors	12,901	12,868
Water and utility costs	7,090	6,701
Patient travel	8,148	4,875
Other travel	1,786	1,374
Building services	1,052	996
Insurance Premiums (paid to Department of Health)	6,619	6,604
Motor vehicles	655	640
Inter-entity supplies (paid to Department of Health)	9,045	9,519
Computer Services and Communications	7,182	6,752
Repairs and maintenance	16,262	9,860
Minor works, including plant and equipment	2,102	888
Operating lease rentals	2,339	3,039
Drugs	19,180	16,633
Clinical supplies and services	20,450	18,105
Outsourced service delivery contracts (clinical services)	7,846	3,686
Catering and domestic supplies	8,768	8,487
Pathology and laboratory supplies	10,940	11,292
Other	1,444	4,200
	562,006	**537,636**

Health Service Employee Costs

The Hospital and Health Service through service arrangements with the Department of Health, has engaged a further 3,801 full-time equivalent persons (2013: 3,763 FTE's), as calculated by reference to the minimum obligatory human resources information (MOHRI). Refer to Note 2 (v) (i) for further details on the arrangements.

9. Grants and subsidies

Grants to other Hospital and Health Services for Rural Generalist Pathway	1,490	1,163
Medical research programs	92	131
Other		45
	1,582	**1,339**

10. Depreciation

Buildings	15,837	13,509
Plant and equipment	5,679	5,179
	21,516	**18,688**

Refer Note 17 and Note 2 (q).

11. Impairment losses

Impairment losses on trade receivables	579	(74)
Bad debts written off	509	407
	1,088	**333**

Refer Note 14.

12. Other expenses

	2014 *$'000*	*2013* *$'000*
External audit fees	205	205
Bank fees	15	14
Insurance	200	149
Inventory written off	46	91
Losses from the disposal of non-current assets	184	422
Special payments - ex-gratia payments	41	56
Other legal costs	349	246
Journals and subscriptions	131	116
Advertising	97	84
Interpreter fees	178	137
Sponsorships	55	
Other	68	19
	1,569	**1,539**

Total audit fees recognised as payable to the Queensland Audit Office relating to the 2013-14 financial year are estimated to be $200,000 (2013: $205,000). There are no non-audit services included in this amount.

Insurance costs represent excess amounts under motor vehicle insurance claims and costs of insurance for motor vehicle fleet managed by the Darling Downs Hospital and Health Service. Certain losses of public property and health litigation costs are insured with the Queensland Government Insurance Fund. Insurance premiums are paid via fee for service arrangements to the Department of Health (refer Note 2 (x) Insurance) and disclosed at Note 8 (Supplies and Services).

Special payments (ex-gratia payments) greater than $5,000 include: a compensation payment of $18,245 to a member of the public; a compensation payment to a member of the public for $5,350 in relation to a matter referred to the Queensland Civil and Administrative Tribunal; and a payment of $5,000 to a Regional Council for a health infrastructure initiative.

13. Cash and cash equivalents

General trust cash at bank	1,239	501
Operating cash on hand and at bank	56,697	35,448
General trust at call deposits	3,001	2,903
	60,937	**38,852**

Refer Note 26 Restricted Assets

Darling Downs Hospital and Health Service's operating bank accounts are grouped as part of a whole-of-Government (WoG) banking arrangement with Queensland Treasury Corporation, 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.

General trust bank and term deposits do not form part of the WoG banking arrangement and incur fees as well as earn interest. Interest earned from general trust accounts is used in accordance with the terms of the trust.

Cash deposited with Queensland Treasury Corporation earns interest, calculated on a daily basis reflecting market movements in cash funds. Annual effective interest rates (payable monthly) achieved throughout the year range between 3.22% to 4.17% (2013: 3.61% to 4.68%).

14. Receivables

	2014 $'000	*2013 $'000*
Trade receivables	5,477	4,191
Payroll receivables	6	11
Less: Provision for impairment of receivables	(1,142)	(564)
	4,341	3,638
GST input tax credits receivable	826	766
GST payable/(receivable)	12	(47)
	838	719
Accrued revenue from Department of Health	2,732	6,528
Other accrued revenue	1,474	1,495
Other		50
Total	**9,385**	**12,430**

Payroll receivables represent interim cash payments and salary overpayments for executive staff.

Impairment of receivables
Darling Downs Hospital and Health Service has recognised a loss of $1.09M (2013: $0.3M) in respect of impairment of receivables.

Refer Note 28 for details of the ageing of impaired receivables.

Movements in the allowance for impairment loss

Balance at beginning of the year	564	
Balance transferred in on establishment of Hospital and Health Service		638
Amounts written off during the year	(509)	(407)
Amount recovered during the year		
Increase/(decrease) in allowance recognised in operating result	1,088	333
Balance at the end of the year	**1,143**	**564**

15. Inventories

Medical supplies and equipment	2,866	2,308
Drugs	2,275	2,072
Catering and domestic	129	98
Other	265	286
	5,535	**4,764**

16. Other current assets

Prepayments	234	168
	234	**168**

17. Property, plant and equipment

	2014 *$'000*	*2013* *$'000*
Land		
At fair value	44,563	42,169
Buildings		
At fair value	628,667	619,284
Less: Accumulated depreciation	(395,505)	(379,709)
	233,162	239,575
Plant and equipment		
At cost	63,778	60,135
Less: Accumulated depreciation	(36,634)	(32,649)
	27,144	27,486
Capital works in progress		
At cost	600	1,237
Total property, plant and equipment	**305,469**	**310,467**

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, Darling Downs Hospital and Health Service engaged the State Valuation Service (SVS) to undertake land indexation with a comprehensive revaluation program to occur over the next four years (with indices applied in the intervening periods) for all land holdings, excluding properties which do not have a liquid market, for example properties under Deed of Grant (recorded at a nominal value of $1).

Indices are based on actual market movements for the relevant location and asset category and were applied to the fair value of land transferred from the Department of Health on 1 July 2012.

The fair value of land was based on publicly available data on sales of similar land in nearby localities prior to the date of the indexation. In determining the values, adjustments were made to the sales data to take into account the location of the 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 Darling Downs Hospital and Health Service's land.

The revaluation program resulted in an increment of $2.393 million (2013: $0) to the carrying amount of land.

17. Property, plant and equipment continued

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 determined as the replacement cost less the cost to bring an asset to current standards. Buildings are measured at fair value by applying either, a revised estimate of individual asset's depreciated replacement cost, or interim indices which approximates movement in price and design standards as at reporting date. These estimates are developed by independent quantity surveyors.

In determining the replacement cost of each building, the estimated replacement cost of the asset, or the likely cost of construction including fees and on costs if tendered on the valuation date, is assessed. This is based on internal records of the original cost, adjusted for more contemporary design/construction approaches and current construction contracts. Assets are priced using Brisbane rates with published industry benchmark location indices applied. Revaluations are then compared and assessed against current construction contracts for reasonableness. The valuation assumes a replacement building will provide the same service function and form (shape and size) as the original building but built consistent with current building standards. Area estimates were compiled by measuring floor areas of Project Services e-plan room or drawings obtained from Darling Downs Hospital and Health Service. Refurbishment costs were derived from specific projects and are therefore indicative of actual costs.

In determining the asset to be revalued the measurement of key quantities includes:
- Gross floor area
- Number of floors
- Girth of the building
- Height of the building
- Number of lifts and staircases.

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 'cost to bring to current standards' is the estimated cost of refurbishing the asset to bring it to current design standards and in an "as new" condition. This estimated cost is linked to the condition factor of the building assessed by the quantity surveyor. It is also representative of the deemed remaining useful life of the building. The condition of the building is based on visual inspection, asset condition data, guidance from asset managers and previous reports.

In assessing the condition of a building the following ratings (International Infrastructure Management Manual) were applied:

Category	Condition
1	Very good condition - only normal maintenance required. Generally newly constructed assets that have no backlog maintenance issues.
2	Minor defects only - minor maintenance required or the asset is not built to the same standard as equivalent new assets (such as IT cabling, complying with new regulation's such as the *Disability Discrimination Act 1992*). Refurbishment is approximately 5% of replacement cost.
3	Largely still in good operational state however maintenance required to return to acceptable level of service. Significant maintenance required up to 50% of capital replacement cost.
4	Requires renewal - complete renewal of internal fitout and engineering services required (up to 70% of capital replacement cost).
5	Asset unserviceable - complete asset replacement required. Asset's value is nil.

Valuations assume a nil residual value. Significant capital works, such as a refurbishment across multiple floors of a building, may 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.

17. Property, plant and equipment continued

In 2014, Darling Downs Hospital and Health Service engaged independent experts, Davis Langdon Australia Pty Ltd (Davis Langdon) to provide indices for asset revaluations. All building and land improvement assets were assessed for indexation in 2014, and due to low market levels of construction activity, coupled with considerable slowing in the engineering and mining sectors , price escalation is at low levels. With the lack of new building project commencements, prices in the building industry are very competitive. On this basis, the application of a nil change was adopted for current asset values for 2013-14. Refer Notes 2 (o) & (p) for further details on the revaluation methodology applied.

Darling Downs Hospital and Health Service has plant and equipment with an original cost of $1.656 million (2013: $1.753 million), or 2.6% of total plant and equipment gross value, with a written down value of zero still being used in the provision of services. 5% of these assets, with a gross cost of $0.08 million, are expected to be replaced in 2015.

Reconciliations (including fair value levels refer Note 2 (p)) of the carrying amount for each class of property, plant and equipment are set out below:

	Land*	Buildings**		Total
	Level 2	Level 2	Level 3	
	$'000	$'000	$'000	$'000
As at 1 July 2013	42,169	6,204	233,371	281,744
Acquisitions			5,462	5,462
Donations received				-
Disposals			-	-
Transfer between classes			3,963	3,963
Revaluation Increments/ (decrements)	2,393			2,393
Depreciation			(15,837)	(15,837)
As at 30 June 2014	**44,562**	**6,204**	**226,959**	**277,725**

* Land level 2 assets represent vacant land in an active market whereas level 3 assets are land parcels with no active market and/or significant restrictions.

** Buildings level 2 assets represent offsite residential dwellings in an active market whereas level 3 are special purpose built buildings with no active market.

Reconciliations of the carrying amount for each class of property, plant and equipment are set out below:

	Land	Buildings	Plant & equipment	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000
Carrying amount at 1 July 2013	42,169	239,575	27,486	1,237	310,467
Acquisitions		5,462	5,411	3,444	14,317
Donations received			8		8
Disposals			(200)		(200)
Transfers between asset classes		3,963	118	(4,081)	
Net revaluation increments/(decrements)	2,393				2,393
Depreciation		(15,837)	(5,679)		(21,516)
Carrying amount at 30 June 2014	**44,562**	**233,163**	**27,144**	**600**	**305,469**

	Land	Buildings	Plant & equipment	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000
Carrying amount at 1 July 2012					
Assets transferred in 1 July 2012	41,467	229,581	28,166	1,887	301,101
Acquisitions	702	3,404	4,990	2,046	11,142
Donations received			18		18
Disposals		(1)	(509)		(510)
Transfers between asset classes		2,696		(2,696)	
Net revaluation increments/(decrements)		17,404			17,404
Depreciation		(13,509)	(5,179)		(18,688)
Carrying amount at 30 June 2013	**42,169**	**239,575**	**27,486**	**1,237**	**310,467**

17. Property, plant and equipment continued

Categorisation of fair values recognised at 30 June 2014 (refer to note 2(p))

	Level 2 $'000	Level 3 $'000	Total $'000
Land	44,562		44,562
Buildings	6,204	226,959	233,163
Total	**50,766**	**226,959**	**277,725**

Level 3 significant valuation inputs and relationship to fair value

Description	Fair value at 30 June 2014	Types of Level 3 input	Possible alternative outcomes for level 3 inputs	Impact of alternative outcomes for level 3 inputs
Buildings - health service hospital facilities	$227M	Replacement cost estimates	Increase or decrease	An increase in the estimated replacement costs would increase the fair value of the assets. A decrease in the estimated replacement costs would reduce the fair value of the assets.
		Remaining useful lives estimates	Increase or decrease	An increase in the estimated remaining useful lives would increase the fair value of the assets. A decrease in the estimated remaining useful lives would reduce the fair value of the assets.
		Cost to bring to current standards	Increase or decrease	An increase in the estimated costs to bring to current standards would reduce the fair value of the assets. A decrease in the estimated costs to bring to current standards would increase the fair value of the assets.
		Condition rating	Improvement or decline	An improvement in the condition rating would increase the fair value of the assets. A decline in the condition rating would reduce the fair value of the assets.

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 Davis Langdon do not reasonably foresee any substantial movements in price as construction volumes remain relatively low with no indication of a significantly increased pipeline of new projects. The current cost escalation estimate from Davis Langdon utiliising the cost modelling method, the Davis Langdon Tender Price Index, and DPW's Building Price Index (discontinued in December 2013) was in the range of 0.5% to 1% over the 2013-14 financial year.

There are no significant inter-relationships between unobservable inputs that materially impact fair value.

18. Payables

	2014 *$'000*	*2013* *$'000*
Trade creditors	4,265	3,505
Payable to Department of Health	26,889	26,468
Accrued expenses	10,397	8,519
Other		31
	41,551	**38,523**

19. Accrued employee benefits

Salaries and wages accrued	25	73
	25	**73**

Refer Note 2 (v) (i)

20. Unearned revenue

Revenue in advance	30	5
	30	**5**

21. Asset revaluation surplus

	Land *$'000*	*Buildings* *$'000*	*Total* *$'000*
Balance at 1 July 2012			
Revaluation increment/(decrement)		17,404	17,404
Balance at 30 June 2013		**17,404**	**17,404**
Balance at 1 July 2013		17,404	17,404
Revaluation increment/(decrement)	2,393		2,393
Balance at 30 June 2014	**2,393**	**17,404**	**19,797**

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

22. Reconciliation of Operating Surplus to Net Cash From Operating Activities

	2014 *$'000*	*2013* *$'000*
Operating surplus	17,689	14,249
Non-cash movements :		
Depreciation and amortisation	21,516	18,688
Write-off of assets		510
Depreciation grant funding (non-cash)	(21,447)	(18,656)
Net (gain)/loss on disposal/revaluation of non-current assets	170	(53)
Assets donated revenue - non-cash	(8)	(18)
Change in assets and liabilities:		
(Increase)/decrease in receivables	5,875	(1,577)
(Increase)/decrease in GST receivables	(59)	(766)
(Increase)/decrease in inventories	(772)	(79)
(Increase)/decrease in prepayments	(66)	3
(Increase)/decrease in accrued revenue	(2,713)	1,300
Increase/(decrease) in trade and other payables	1,092	16,546
Increase/(decrease) in accrued employee benefits	(49)	73
Increase/(decrease) in unearned funding revenue	25	3
Increase in other operating liabilities	1,877	5,721
Net cash from operating activities	**23,130**	**35,944**

23. Non-cash financing and investing activities

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

24. Commitments for Expenditure

(a) Non-Cancellable Operating Leases

Committed at the reporting date but not recognised as liabilities, payable:		
Within one year	74	90
One to five years	220	269
More than five years	679	660
Total	**973**	**1,019**

Commitments under operating leases at reporting date are inclusive of anticipated GST. Darling Downs Hospital and Health Service has non-cancellable operating leases relating predominantly to offices. 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.

24. Commitments for Expenditure continued

(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 included. Capital projects are included as commitments for the remaining project amounts. Each of these projects is currently at a different stage of the contractual cycle.

	2014 $'000	*2013* $'000
Committed at the reporting date but not recognised as liabilities:		
Repairs & maintenance	11,775	552
Supplies & services	357	17
Capital works	7,906	1,941
Other	350	103
	20,388	**2,613**
Committed at the reporting date but not recognised as liabilities, payable:		
Within one year	20,388	2,613
	20,388	**2,613**

25. Contingencies

(a) Litigation in Progress

Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). Darling Downs Hospital and Health Service's liability in this area is limited to an excess per insurance event (Refer Note 2 (x) "Insurance"). Darling Downs Hospital and Health Service'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.

The introduction of the Personal Injuries Proceedings Act 2002 (PIPA) has resulted in fewer cases appearing before the courts. These matters are usually resolved at the pre-proceedings stage.

As at 30 June 2014 there were 14 claims managed by QGIF(2013: 13 claims), some of which may never be litigated or result in payments to claims (note that this figure excludes Initial Notices under PIPA). The maximum exposure to Darling Downs Hospital and Health Service under this policy is up to $20,000 for each insurable event.

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

	2014 **Number of cases**	***2013*** **Number of cases**
Supreme Court	4	2
Tribunals, commissions and boards	1	1
	5	**3**

b) Native Title

The Queensland Government Native Title Work Procedures were designed to ensure that native title issues are considered in all of Darling Downs Hospital and Health Service's land and natural resource management activities.

All business pertaining to land held by or on behalf of Darling Downs Hospital and Health Service must therefore take native title into account before proceeding. Such activities include disposal, acquisition, development, redevelopment, clearing, fencing of real property including the granting of leases, licences or permits.

25. Contingencies continued

b) Native Title continued

Real Property Dealings may proceed on Darling Downs Hospital and Health Service owned land where native title continues to exist, provided native title holders or claimants receive the necessary procedural rights.

Darling Downs Hospital and Health Service undertakes native title assessments over real property when required and will negotiate Indigenous Land Use Agreements (ILUA) with native title holders as necessary. These ILUAs will provide trustee leases to validate the tenure of current and future health facilities. The National Native Title Tribunal has reported no native title claims for Darling Downs Hospital and Health Service as at the reporting date.

26. Restricted assets

Darling Downs Hospital and Health Service receives cash contributions primarily from private practice clinicians and from 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.

As at 30 June 2014, amounts are set aside for clinical trials $203,098 (2013: $185,640); clinical research $14,301 (2013: $32,206); health research $30,861 (2013: $23,845) and other purposes $53,208 (2013: $87,144) for the specific purposes underlying the contribution.

27. Fiduciary Trust Transactions and Balances

(a) Patient Fiduciary Funds

Darling Downs Hospital and Health Service acts in a custodial role in respect of patient fiduciary fund (formerly known as patient trust accounts) transactions and balances (refer Note 2(c)). As such, they are not recognised in the financial statements, but are disclosed below for information purposes.

	2014	*2013*
Patient Trust receipts and payments	$'000	$'000
Receipts		
Patient fiduciary fund receipts	7,796	7,901
Total receipts	**7,796**	**7,901**
Payments		
Patient fiduciary fund payments	7,670	8,001
Total payments	**7,670**	**8,001**
Increase/(decrease) in net patient fiduciary fund assets	126	(100)
Patient fiduciary fund assets opening balance 1 July	584	684
Patient fiduciary fund assets closing balance 30 June	**710**	**584**
Fiduciary Fund assets		
Current assets		
Cash at bank and on hand	710	584
Total current assets	**710**	**584**

27. Fiduciary Trust Transactions and Balances continued

(b) Right of Private Practice (RoPP) scheme

Under the Australian Government's National Health Reform Agreement with the states and territories, patient choice is facilitated by the Right of Private Practice (RoPP) scheme, which provides for senior medical officers (SMOs) who are employed in the public health system to also treat those patients who come into the public system and elect to be treated as private patients.

The Queensland RoPP scheme was approved to capture privately insured patients receiving treatment as public patients, and to assist in the recruitment and retention of full time specialist staff in the public hospital system. Public patients were not to be affected adversely by the introduction of scheme options.

Under the scheme, SMO's receive a private practice allowance as well as a base salary. In exchange for being paid this allowance, these SMOs assign all the private practice revenue they generate to the Hospital and Health Service facility where they are working. In turn, the Hospital and Health Service fully absorbs the direct and indirect costs (facility, administrative and other overheads) associated with these services including, for example, the cost of billing and collection of revenue. Today, this scheme is called Option A. It is also referred to as the 'assignment' model.

The other major scheme variant allows SMOs to retain a proportion of the private fees they earn, with the balance being paid into a trust account for the Hospital and Health Service facility to apply to research by, and education of, all staff at the facility referred to as SERTA funds. The Hospital and Health Service recovers a facility charge and administration fee from each participating SMO to defray the overhead costs of service provision. Today, this scheme is called Option B, and there is a variant called Option R which is available only for radiologists. It is also referred to as the 'retention and revenue sharing' model.

A third model, available only to pathologists, is a combination of the assignment and revenue sharing models, known as Option P.

Darling Downs Hospital and Health Service acts in an agency role in respect of the transactions and balances of the accounts. As such, the Right of Private Practice funds are not controlled by Darling Downs Hospital and Health Service but the activities are included in the annual audit performed by the Auditor-General of Queensland.

	2014	*2013*
Right of Private Practice (ROPP) receipts and payments	$'000	$'000
Receipts		
Medical Practice receipts	6,569	5,237
Bank interest	8	8
Total receipts	**6,577**	**5,245**
Payments		
Payments to Medical Officers	922	785
Payments to Hospital and Health Service	4,779	3,612
Payments to Hospital and Health Service General Trust	876	749
Total payments	**6,577**	**5,146**
Increase in net private practice assets		**99**
Current Assets		
Cash - RoPP	652	507
Total Current Assets	**652**	**507**
Current Liabilities		
Payments to Medical Officers	49	49
Payments to Hospital and Health Service	504	371
Payments to Hospital and Health Service General Trust	99	87
Total current liabilities	**652**	**507**

28. Financial Instruments

(a) Categorisation of Financial Instruments

Darling Downs Hospital and Health Service has the following categories of financial assets and financial liabilities:

Category	*Note*	*2014 $'000*	*2013 $'000*
Financial assets			
Cash and cash equivalents	13	60,937	38,852
Receivables	14	9,385	12,430
Total		**70,322**	**51,282**
Financial liabilities			
Financial liabilities measured at amortised cost:			
Payables	18	41,551	38,523
Total		**41,551**	**38,523**

(b) Financial Risk Management Objectives

The Hospital and Health Service's activities expose it to a variety of financial risks: market risk (including foreign currency risk, price risk and interest rate risk), credit risk and liquidity risk.

Darling Downs Hospital and Health Service measures risk exposure using a variety of methods as follows:

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

Financial risk is managed in accordance with Queensland Government and Darling Downs Hospital and Health Service policy. These policies provide written principles for overall risk management, as well as policies covering specific areas, and aim to minimise potential adverse effects of risk events on the financial performance of Darling Downs Hospital and Health Service.

(c) Credit Risk Exposure

Credit risk exposure refers to the situation where the Darling Downs Hospital and Health Service may incur financial loss as a result of another party to a financial instrument failing to discharge their obligation.

Credit risk on receivables is considered minimal given that $3.4 million (37%) (2013: $7.5 million or 61%) of total receivables is receivable from the Department of Health. Refer Note 14 for further information.

Credit risk on cash and cash equivalents is considered minimal given all Darling Downs Hospital and Health Service deposits are held through the Commonwealth Bank of Australia and by the State through Queensland Treasury Corporation. No financial assets have had their terms renegotiated as to prevent them from being past due or impaired and are stated at the carrying amounts as indicated.

Maximum exposure to credit risk	*Note*	*2014 $'000*	*2013 $'000*
Cash and cash equivalents	13	60,937	38,852

No collateral is held as security and no credit enhancements relate to financial assets held by Darling Downs Hospital and Health Service.

28. Financial Instruments continued

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 Darling Downs Hospital and Health Service 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 $579K (2013: $-74K).

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 2014

		Overdue $'000				
	Not overdue $'000	*Less than 30 days*	*30-60 days*	*61-90 days*	*More than 90 days*	*Total*
Receivables	7,668	944	265	70	432	9,379
Payroll Receivables			(2)		8	6
Total	**7,668**	**944**	**263**	**70**	**440**	**9,385**

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	10,068	1,092	317	228	714	12,419
Payroll Receivables	4		-		7	11
Total	**10,072**	**1,092**	**317**	**228**	**721**	**12,430**

Unimpaired debts are represented by amounts for hospital admissions that have been referred to health insurers for settlement. These unimpaired debts are expected to be fully recoverable upon completion of health insurer's processing requirements, in line with industry experience.

Individually impaired financial assets 2014

	Overdue $'000				
	Less than 30 days	*30-60 days*	*61-90 days*	*More than 90 days*	*Total*
Receivables (gross)	28	30	29	74	161
Allowance for impairment	(28)	(30)	(29)	(74)	(161)
Carrying amount					

Individually impaired financial assets 2013

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

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

28. Financial Instruments continued

(d) Liquidity Risk

Liquidity risk refers to the situation where Darling Downs Hospital and Health Service may encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivering cash or another financial asset.

Darling Downs Hospital and Health Service is exposed to liquidity risk through its trading in the normal course of business, and manages liquidity risk through the use of a liquidity management strategy. This strategy aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations as they fall due. This is achieved by ensuring that minimum levels of cash are held within the various bank accounts so as to match the expected duration of the various employee and supplier liabilities.

Darling Downs Hospital and Health Service has an approved debt facility of $6 million under Whole-of-Government banking arrangements to manage any short term cash shortfalls (See Note 2 (i)).

The following table sets out the liquidity risk of financial liabilities held by the Darling Downs Hospital and Health Service. It represents the contractual maturity of financial liabilities, calculated based on undiscounted cash flows relating to the liabilities at reporting date. The undiscounted cash flows in these tables differ from the amounts included in the Statement of Financial Position that are based on discounted cash flows.

		2014 Payable in			
	Note	*1 year $'000*	*1-5 years $'000*	*> 5 years $'000*	*Total $'000*
Financial Liabilities					
Payables	18	41,551			41,551
Total		**41,551**			**41,551**

		2013 Payable in			
	Note	*1 year $'000*	*1-5 years $'000*	*> 5 years $'000*	*Total $'000*
Financial Liabilities					
Payables	18	38,523			38,523
Total		**38,523**			**38,523**

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

The Darling Downs Hospital and Health Service does not trade in foreign currency and is not materially exposed to commodity price changes. Darling Downs Hospital and Health Service is exposed to interest rate changes on the 24 hour at call deposits and there is no interest rate exposure on its cash and fixed rate deposits.

Darling Downs Hospital and Health Service does not undertake any hedging in relation to interest rate risk and manages its risk as per the Darling Downs Hospital and Health Service liquidity risk management strategy articulated in the Darling Downs Hospital and Health Service's Financial Management Practice Manual. Changes in interest rates have a minimal effect on the operating result of the Hospital and Health Service.

28. Financial Instruments continued

(f) Interest Rate Sensitivity Analysis

The following interest rate sensitivity analysis depicts the outcome on net income if interest rates would change by +/- 1% from the year end rates applicable to the Darling Downs Hospital and Health Service's financial assets.

		2014 Interest rate risk			
	Carrying amount	*-1%*		*1%*	
Financial Assets		*Profit*	*Equity*	*Profit*	*Equity*
	$'000	*$'000*	*$'000*	*$'000*	*$'000*
Cash and cash equivalents					
General trust cash at bank	1,239				
Operating cash on hand and at bank	56,697				
General trust at call deposits	3,001	(30)	(30)	30	30
Potential impact		(30)	(30)	30	30

		2013 Interest rate risk			
	Carrying amount	*-1%*		*1%*	
Financial Assets		*Profit*	*Equity*	*Profit*	*Equity*
	$'000	*$'000*	*$'000*	*$'000*	*$'000*
Cash and cash equivalents					
General trust cash at bank	501				
Operating cash on hand and at bank	35,448				
General trust at call deposits	2,903	(29)	(29)	29	29
Potential impact		(29)	(29)	29	29

Operating cash at bank is not subject to interest due to existing Whole-of-Government banking arrangements. Refer to Note 13 Cash and cash equivalents for details.

(g) Fair Value

Darling Downs Hospital and Health Service 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.

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Notes to and Forming Part of the Financial Statements 2013-14

29. Key Management Personnel and Remuneration

(a) Board members

The following details for Board members include those positions that had authority and responsibility for planning, directing and controlling the activities of Darling Downs Hospital and Health Service during 2013-14.
Further information on these positions can be found in the body of the Annual Report under the section relating to Governing our Organisation.

Name and position of current incumbents	Responsibilities	Contract classification and appointment authority	Appointment date
Mike Horan *AM*	Chair	Government Board B1	18 May 2012
Dr Dennis Campbell	Deputy Chair	Government Board B1	29 June 2012
Cheryl Dalton	Board member	Government Board B1	29 June 2012
Terry Fleischfresser	Board member	Government Board B1	29 June 2012
Dr Ross Hetherington	Board member	Government Board B1	29 June 2012
Dr Ian Keys	Board member	Government Board B1	29 June 2012
Patricia Leddington-Hill	Board member	Government Board B1	9 November 2012
Marie Pietsch	Board member	Government Board B1	29 June 2012
Dr Jeffrey Prebble *OAM*	Board member	Government Board B1	29 June 2012
Megan O'Shannessy	Board member	Government Board B1	18 May 2013

The date of appointment shown for Board members is the original date of appointment. From time to time, Board members are re-appointed in accordance with *Hospital and Health Boards Act 2011* .

29. Key Management Personnel and Remuneration continued

(b) Executive

The following details for key executive management personnel include those positions that had authority and responsibility for planning, directing and controlling the activities of Darling Downs Hospital and Health Service during 2013-14. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management.

Darling Downs Hospital and Health Service Executives (employed under contract by the Darling Downs Hospital and Health Service)

Name and position of current incumbents	Responsibilities	Contract classification and appointment authority	Date appointed to position (date resigned from position)
Dr Peter Bristow Health Service Chief Executive	Responsible for the overall management of Darling Downs Hospital and Health Service through major functional areas to ensure the delivery of key government objectives in improving the health and well-being of all Darling Downs residents.	s24 & s70 Appointed by Board under *Hospital and Health Boards Act 2011* (Section 7 (3)).	6 August 2012
Scott McConnel Chief Finance Officer	Provides single point accountability and leadership for the Finance Division and coordinates the Health Service's financial management consistent with relevant legislation and policy directions to support high quality health care delivery within the Darling Downs Hospital and Health Service.	HES 2-3 Appointed by Chief Executive (CE) under *Hospital and Health Boards Act 2011*	12 December 2011
Harold Shelton A/Chief Finance Officer		HES 2-3 Appointed by Chief Executive (CE) under *Hospital and Health Boards Act 2011*	22 October 2013 to 23 February 2014
Stewart Gordon Executive Director People and Corporate Services *	Provides single point accountability and leadership for the Division of People and Corporate Services within the Darling Downs Hospital and Health Service. This includes the functions of human resources management, occupational health & safety, workforce planning and development, infrastructure and planning (including service planning, capital works planning and delivery, facility engineering and maintenance), operational and administrative support services in Toowoomba and the provision of oversight of these support services in rural areas of the Health Service.	HES 2-3 Appointed by Chief Executive (CE) under *Hospital and Health Boards Act 2011*	27 January 2012 Ceased 24 March 2014
Michael Bishop General Manager Rural *	Provides single point accountability and leadership for the Division of Rural Health and Aged Care within the Darling Downs Hospital and Health Service. This Division includes 19 hospitals and health care services, including co-located residential aged care services, and Mt Lofty Heights Residential Aged Care Facility.	HES 2-3 Appointed by Chief Executive (CE) under *Hospital and Health Boards Act 2011*	28 May 2012
Shirley Wigan Executive Director Mental Health	Provides single point accountability and leadership for the Darling Downs Hospital and Health Service Mental Health, Alcohol and Other Drugs services, including acute in-patient services at Toowoomba Hospital, extended in-patient services at Baillie Henderson Hospital and ambulatory care services located throughout the Health Service.	HES 2-3 Appointed by Chief Executive (CE) under *Hospital and Health Boards Act 2011*	22 November 2012

* Following an Executive restructure effective 31 March 2014, the position of Executive Director People and Corporate Services was abolished. The functions of this role were distributed to remaining Executive Officers. The Hospital and Health Service is in the process of creating the position of Chief Corporate Officer which will have a single point of accountability for Finance, Commercial Management, Human Resource, Health Information, Infrastructure and Planning functions. The position of Executive Director, Rural Health and Aged Care has had it's position title changed to General Manager Rural.

29. Key Management Personnel and Remuneration continued

(b) Executive continued

As part of the Executive restructure, some position titles were amended although responsibilities of these positions remained substantially the same.

Darling Downs Hospital and Health Service Executives employed by the Department of Health under Award

Name and position of current incumbents	Responsibilities	Contract classification and appointment authority	Date appointed to position (date resigned from position)
Dr Peter Gillies General Manager Toowoomba Hospital * **	Provides single point of accountability and leadership for the Division of Toowoomba Hospital. Also provides professional leadership for the medical services of the Darling Downs Hospital and Health Service and Toowoomba Hospital. Leads the development and implementation of strategies that will ensure the medical workforce is aligned with identified service delivery needs, and appropriately qualified, competent and credentialled workforce is maintained. In addition, the position oversights Medical Research and clinical governance including patient safety and quality.	Medical - MMOI2	Appointed 8 July 2013. (Acting from 1 July 2012 to 7 July 2013)
Judith March Executive Director of Nursing and Midwifery Services	Provides professional leadership for the nursing services of the Darling Downs Hospital and Health Service. The position leads the development and implementation of strategies that will ensure the nursing and midwifery workforce is aligned with identified service delivery needs.	Nursing and Midwifery – NRG12-1	22 May 2012
Megan Morse Executive Director Allied Health	Provides single point accountability and leadership, strategic planning, management, delivery and evaluation of the Allied Health Professional functions, Commonwealth Programs, and Staff Education and Training programs within the Darling Downs Hospital and Health Service, to optimise quality health care and business outcomes.	Health Practitioner - HP7-1	4 July 2012 Ceased 9 August 2013
Annette Scott A/Executive Director Allied Health **			12 August 2013 (Acting)

* Following an Executive restructure effective 31 March 2014, a decision was made to transfer professional leadership for medical services from the Executive Director Toowoomba Hospital and Medical Services to a new position of Chief Medical Officer. Medical leadership within the Hospital and Health Service continues to be provided by the General Manager, Toowoomba Hospital, until the Chief Medical Officer position is filled. The position of Executive Director of Toowoomba Hospital has had it's position title changed to General Manager Toowoomba Hospital.

** Following the abolishment of the position of Executive Director People and Corporate Services, some responsibilities were transferred to the positions of Executive Director Allied Health and General Manager Toowoomba Hospital.

(c) Remuneration - Board Members

The Governor in Council approves the remuneration arrangements for Hospital and Health Board Chair, Deputy Chairs and Members.

Chairs, Deputy Chairs and Members are paid an annual salary consistent with the Government policy titled: *Remuneration of Part-time Chairs and Members of Government Boards, Committees and Statutory Authorities* .

29. Key Management Personnel and Remuneration continued

(c) Remuneration - Board Members continued

1 July 2013 - 30 June 2014

Name and position (date resigned if applicable)	Short-Term Benefits	Post-employment benefits	Total
	Directors Fees and Allowances $'000	$'000	$'000
Mike Horan *AM* Chair	69	5	74
Dr Dennis Campbell Deputy Chair	34	3	37
Cheryl Dalton Board member	34	3	37
Terry Fleischfresser Board member	34	3	37
Dr Ross Hetherington Board member	35	3	38
Dr Ian Keys Board member	35	3	38
Patricia Leddington-Hill Board member	39	3	42
Marie Pietsch Board member	38	3	41
Dr Jeffrey Prebble *OAM* Board member	34	3	37
Megan O'Shannessy Board member	32	3	35

(d) Remuneration - Executive

Remuneration policy for Darling Downs Hospital and Health Service's key Health Executive personnel is set by the Director-General, Department of Health, as provided for under the *Hospital and Health Boards Act 2011* . The remuneration and other terms of employment for the key executive management personnel are specified in employment contracts. For the 2013-14 year, the remuneration of key executive management personnel (with the exception of the Health Service Chief Executive) increased by 2.2% in accordance with government policy.

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

- Short-term employee benefits which include:
  - Base – consisting of base salary, allowances and leave entitlements paid and provided for the entire year or for that part of the year during which the employee occupied the specified position. Amounts disclosed equal the amount expensed in the Statement of Comprehensive Income.
  - Non-monetary benefits – consisting of provision of vehicle and expense payments together with fringe benefits tax applicable to the benefit. Non-monetary benefits includes the notional value of motor vehicles provided to key management personnel.
- Long term employee benefits include long service leave accrued.
- Post employment benefits include amounts expensed in respect of superannuation obligations.
- Redundancy payments 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.
- There were no performance bonuses paid in the 2013-14 financial year.

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.

29. Key Management Personnel and Remuneration continued

(d) Remuneration - Executive continued

Darling Downs Hospital and Health Service Executives (employed under contract by the Darling Downs Hospital and Health Service)
1 July 2013 - 30 June 2014

Name and position (date resigned if applicable)	Short-term Employee Expenses		Long-Term Employee Expenses	Post-Employment Expenses	Termination Benefits	Total Expenses
	Monetary Expenses $'000	Non-Monetary Benefits $'000	$'000	$'000	$'000	$'000
Dr Peter Bristow Health Service Chief Executive	448	28	9	49		534
Scott McConnel Chief Finance Officer	182		4	19		205
Harold Shelton A/Chief Finance Officer 22 October 2013 to 23 February 2014	53		1	5		59
Stewart Gordon Executive Director People and Corporate Services Ceased 24 March 2014	106		2	12	159	279
Michael Bishop General Manager Rural	169	12	4	19		204
Shirley Wigan Executive Director Mental Health	182		4	21		207

29. Key Management Personnel and Remuneration continued

(d) Remuneration - Executive continued

Darling Downs Hospital and Health Service Executives employed by the Department of Health under Award
1 July 2013 - 30 June 2014

Name and position (date resigned if applicable)	Short-term Employee Expenses		Long-Term Employee Expenses	Post-Employment Expenses	Termination Benefits	Total Expenses
	Monetary Expenses $'000	Non-Monetary Benefits $'000	$'000	$'000	$'000	$'000
Dr Peter Gillies General Manager Toowoomba Hospital	486	9	10	33		538
Judith March Executive Director of Nursing and Midwifery Services	185		4	34		223
Megan Morse Executive Director Allied Health Ceased 9 August 2014	18			1	5	24
Annette Scott A/Executive Director Allied Health Commenced 12 August 2013	144		3	15		162

(d) Remuneration - Board Members 1 July 2012 - 30 June 2013

Name and position (date resigned if applicable)	Short-Term Benefits	Post-employment benefits	Total
	Directors Fees and Allowances $'000	$'000	$'000
Mike Horan *AM* Chair	74	6	80
Dr Dennis Campbell Deputy Chair	33	3	36
Danielle Causer Board member Ceased 31 December 2012	19	1	20
Cheryl Dalton Board member	31	3	34
Terry Fleischfresser Board member	32	3	35
Dr Ross Hetherington Board member	35	3	38
Dr Ian Keys Board member	32	3	35
Patricia Leddington-Hill Board member	22	2	24
Megan O'Shannessy Board member	4	1	5
Marie Pietsch Board member	37	3	40
Dr Jeffrey Prebble *OAM* Board member	31	3	34

29. Key Management Personnel and Remuneration continued

(e) Remuneration - Executive 1 July 2012 - 30 June 2013 (employed under contract by the Darling Downs Hospital and Health Service)

Name and position (date resigned if applicable)	Short-term Employee Expenses		Long-Term Employee Expenses	Post-Employment Expenses	Termination Benefits	Total Expenses
	Monetary Expenses $'000	Non-Monetary Benefits $'000	$'000	$'000	$'000	$'000
Dr Peter Bristow Health Service Chief Executive	466	28	10	50		554
Scott McConnel Chief Finance Officer	180		4	20		204
Stewart Gordon Executive Director People and Corporate Services Ceased 24 March 2014	144		3	17		164
Michael Bishop Executive Director Rural Health and Aged Care	155	25	3	20		203
Shirley Wigan Executive Director Mental Health	161	3	3	20		187
Brigid Loughnane Executive Director Toowoomba Hospital Ceased 11 January 2013	93		10	2	189	293

(e) Remuneration - Executive 1 July 2012 - 30 June 2013 (employed by the Department of Health under Award)

Name and position (date resigned if applicable)	Short-term Employee Expenses		Long-Term Employee Expenses	Post-Employment Expenses	Termination Benefits	Total Expenses
	Monetary Expenses $'000	Non-Monetary Benefits $'000	$'000	$'000	$'000	$'000
Dr Peter Gillies Executive Director Medical Services & Toowoomba Hospital	454	23	10	34		521
Judith March Executive Director of Nursing and Midwifery Services	179		4	25		208
Megan Morse Executive Director Allied Health Ceased 9 August 2013.	145		3	18		166

30. Events occurring after balance date

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.

As at 30 June 2014, Darling Downs Hospital and Health Service held non-operational housing assets with a total net book value of $10.2 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 Health at their net book value, prior to their transfer to the DHPW.

As this transfer will be designated as a Contribution by Owners, the transfer will be undertaken through the Darling Downs Hospital and Health Service's Equity account. Therefore, this transaction will have no impact on the Statement of Profit or Loss and Other Comprehensive Income in the 2014-15 Financial Year.

Transfer of legal ownership of health service land and buildings to Hospital and Health Services

Commencing 1 July 2014, the legal title of health service land and buildings will progressively transfer from the Department of Health to Hospital and Health Services. As Darling Downs Hospital and Health Service currently controls these assets through a Deed of Lease arrangement, there will be no material impact to the accounts of the Hospital and Health Service upon transfer. Buildings which are currently used by the Department which reside on Hospital and Health Service land will be leased back to the Department by Hospital and Health Services.

Legal title transfer is currently expected to occur within three tranches, according to when both entities have mutual confidence that the respective Hospital and Health Service has the capacity and capability to be effective asset managers. The proposed transfer for Darling Downs Hospital and Health Service is expected to occur in December 2014.

Hospital and Health Services to be prescribed as employers

Currently, all staff, except Board members, Health Service Chief Executives and health executive service (HES) employees (working in an Hospital and Health Service), 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 Hospital and Health Service. Hospital and Health Services will become prescribed employers by regulation.

Once a Hospital and Health Service becomes prescribed to be the employer, all existing and future staff working for the Hospital and Health Service become its employees. The Hospital and Health Service, 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.

Darling Downs Hospital and Health Service is expected to be a prescribed employer on 1 July 2015.

Senior Medical Officer and Visiting Medical Officer Contracts

Effective 4 August 2014, Senior Medical Officers and Visiting Medical Officers have transitioned to individual employment contracts.

Individual contracts mean senior doctors will have a direct employment relationship with their Hospital and Health Service 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 the Darling Downs Hospital and Health Service, employee-related costs for contracted Senior Medical Officers and Visiting Medical Officers will be recognised by Darling Downs Hospital and Health Service (not the Department of Health) from the date the contracts are effective.

30. Events occurring after balance date continued

Senior Medical Officer and Visiting Medical Officer Contracts continued

Non-contracted Senior Medical Officers and Visiting Medical Officers will remain employed under current award arrangements. As the Darling Downs Hospital and Health Service is not yet a prescribed employer, they will continue to be employed by the Department of Health.

Queensland Payroll Tax Exemption

Following the announcement in the 2014-15 State Budget regarding Queensland payroll tax exemption, Darling Downs Hospital and Health Service will be exempt from paying payroll tax from 1 July 2014.

Based on this announcement, Queensland Treasury and Trade will no longer be providing funding to the Department of Health for payroll tax, and therefore the Department will subsequently reduce its funding to the Darling Downs Hospital and Health Service by $1.7 million dollars.

Other Matters

No other matter or circumstance has arisen since 30 June 2014 that has significantly affected, or may significantly affect Darling Downs Hospital and Health Service's operations, the results of those operations, or the Darling Downs Hospital and Health Service's state of affairs in future financial years.

DARLING DOWNS HOSPITAL AND HEALTH SERVICE

Certificate of Darling Downs 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 financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Darling Downs Hospital and Health Service for the financial year ended 30 June 2014 and of the financial position of the Darling Downs Hospital and Health Service at the end of that year; and

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.

Mike Horan ***AM***

Chair
Darling Downs Hospital and Health Board
26/8/14

Scott McConnel (CPA)

Chief Finance Officer
Darling Downs Hospital and Health Service
26/8/2014

INDEPENDENT AUDITOR'S REPORT

To the Board of Darling Downs Hospital and Health Service

Report on the Financial Report

I have audited the accompanying financial report of Darling Downs 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 Chair 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

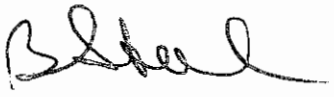
(b) in my opinion –

  (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 Darling Downs 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.



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

Queensland Audit Office
Brisbane