Department of Health

2012–13 **Annual Report**

Great state. Great opportunity.

Queensland Government

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ISSN: 1838–4110

For more information

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An electronic version of this document is available at www.health.qld.gov.au/about_qhealth/annual-report

Additional information on consultancies, overseas travel and the Queensland Multicultural Policy has been published on the Queensland Government Open Data website (qld.gov.au/data)

Interpreter service statement

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on (07) 3234 0111 and we will arrange an interpreter to effectively communicate the report to you.

Letter of compliance

17 September 2013

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 2012–13 and financial statements for the Department of Health.

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
- 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 147 of this annual report or accessed at www.premiers.qld.gov.au/publications/categories/guides/annual-report-guidelines.aspx.

Yours sincerely

Dr Michael Cleary
Acting Director-General

Contents

Every day in Queensland Health...

Non-admitted patient services in public hospitals

4735 emergency services are provided for non-admitted patients in acute public hospitals.

30,007 non-admitted patient services are provided in acute public hospitals.

Admitted patient services in public hospitals

1403 people receive same day admitted care in acute public hospitals.

8554 people receive admitted care in acute public hospitals.

Maternity services

123 babies are born in acute public hospitals.

13 HEALTH (13 43 25 84)

859 callers receive information and clinical advice from qualified nurses.

Breast cancer screening

638 women are screened for breast cancer.

Dental

1819 adult dental appointments are provided.

1640 child and adolescent dental appointments are provided.

676 children and adolescents complete dental treatment.

Year in review

From 1 July 2012, Queensland's public healthcare sector underwent the most significant structural change in its 112 year history. In recent years, it had become increasingly large and centralised. Post health reform, Queensland Health comprises a smaller Department of Health and 17 independent Hospital and Health Services (HHSs). Each HHS is managed by a Hospital and Health Board (HHB) responsible for the delivery of healthcare to their local community.

The *Blueprint for better healthcare in Queensland* was published in February 2013 and outlines structural and cultural improvements to establish Queensland as the leader in Australian healthcare. It marks a significant step towards ensuring Queensland is the pace-setter for value-for-money, performance and delivery. The Queensland Health Renewal Taskforce assisted the Minister for Health in the development of the blueprint.

This reorganisation, and the blueprint's focus on health outcomes rather than inputs, has resulted in significant improvements to health service delivery and a more efficient and cost-effective system overall. Frontline health services are now managed at a local level and are more responsive to the needs of the local community.

Placing the control of health service delivery in the hands of boards has allowed health services to be delivered within budget—a surplus was recorded in 2012–13 for the second year in a row. These budget surpluses are being reinvested to ensure health services are responsive to the needs of the community. These surpluses have been delivered in an environment of rising demand for health services and increased need for financial responsibility across the Queensland Government.

To accommodate an increasing demand for services, a significant investment has been made by the department to support HHSs to implement a range of clinical redesign projects. This has enabled hospital services to become more efficient and better armed to meet the standards set under the national health reform agenda for emergency department access and elective surgery waiting lists. Queensland has delivered its best-ever performance for emergency departments—a reduction of around two hours per patient—and the shortest median waiting times for elective surgery in Australia. Due to the increased efficiencies of our hospitals, we are able to deliver more services to more patients with the same, or reduced, resources.

In addition, in cooperation with the Queensland Ambulance Service (QAS), the practice of placing hospital emergency departments on bypass has been eliminated. In March 2013, 88 per cent of all patients taken to hospital by an ambulance were transferred to a bed inside the emergency department within 30 minutes of arrival—an improvement of nine per cent since March 2012. This has been achieved, in part, because our emergency departments are operating far more efficiently. By transferring patients into a ward sooner, we are able to improve patient safety and free up emergency beds for new patients arriving by ambulance.

This year also saw the introduction of a more open system of reporting hospital performance. Hospital performance data on the Queensland Health website (www.health.qld.gov.au) was expanded to cover detailed statistics from 40 reporting hospitals. In addition, the first quarterly performance reports were published in local newspapers. These reports compare the performance of HHSs against six key statewide measures:

1. Shorter stays in emergency departments.
2. Shorter waits for elective surgery.
3. Shorter waits for specialist outpatient clinics.
4. Increased support for families with newborns.
5. Fewer hospital acquired infections.
6. Better value-for-money.

Publishing this data in a form that can be easily accessed and understood has helped Queenslanders to better understand and compare the performance of their local health services.

This financial year has also seen continued investment in capital works projects ensuring the public healthcare sector remains capable of providing the high level of care expected by Queenslanders—even in the face of the major challenges of an expanding and ageing population and an increasing demand for health services.

Some of the major projects completed in 2012–13 include:

- Robina Hospital Expansion (July 2012)
- Croydon Primary Health Care Centre and Staff Accommodation (August 2012)
- Redland Hospital Emergency Department (September 2012)
- Townsville Hospital Neo-natal Intensive Care Unit (October 2012)
- Mackay Base Hospital Redevelopment—Stage 2 (November 2012)
- The Prince Charles Hospital Paediatric Emergency Services (November 2012)
- Maryborough Hospital Rehabilitation Services (December 2012)
- Bayside Mental Health Community Care Unit (January 2013)
- Caboolture Hospital Paediatric Emergency Services (February 2013)
- Mount Isa Regional Cancer Centre (March 2013)
- Caloundra Hospital Department of Emergency Medicine Upgrade (March 2013)
- Rockhampton Hospital Expansion—Stage 1 (March 2013)
- Injune and Surat Longer Stay Older Persons Multipurpose Health Centre Upgrades (March 2013)
- Logan Hospital Paediatric and Medical Outpatient Upgrade (May 2013)
- Mount Isa Health Campus Redevelopment—Stage 2 (June 2013).

Meanwhile, the establishment of the department's Contestability Branch has seen an increased emphasis on developing partnerships with the private and not-for-profit sectors for investigation of alternative service delivery models that deliver value-for-money, innovation and improved services. The Department of Health is regarded across government and industry as a leader in implementing contestability reforms. As a result, the Public Service Commission has asked the department to lead the implementation of contestability reforms for whole-of-government corporate services.

There have also been major improvements to the Queensland Health Payroll System during the last 12 months, including a significant reduction in the instances of incorrect payments to staff. A change to the pay date in October 2012 means there is now more time to submit, approve and process payroll forms for each roster period. Progress was also made on recovering outstanding overpayments and preparations were put in place for the introduction of automated recovery of new overpayments (commencing July 2013). The department also commenced the implementation of an online payroll information system to allow staff to access payslips, payment summaries and overpayment records as well as lodge and track payroll enquiries electronically.

In 2012–13, Queensland was again significantly impacted by natural disasters. Severe flooding caused by Ex-Tropical Cyclone Oswald required the evacuation of 125 patients from Bundaberg Hospital to seven hospitals around the state. As part of the coordinated Queensland Government response, the department activated the State Health Emergency Coordination Centre to tackle the immediate health issues, and collaborated with HHSs on the subsequent recovery efforts, including expanded mental health support for those adversely impacted by flooding.

While the establishment of HHSs and HHBs has significantly increased the level of engagement health services have with their local communities, increased efforts have also been made to explore innovative new ways of engaging with Queenslanders. Expanded use of social media has enabled greater direct interaction with healthcare consumers on a range of health topics. The development of smart phone applications, such as the *Sun Effects Booth,* has opened new channels of communication to allow important messages about sun safety to reach younger people. Taking advantage of these new and exciting ways of delivering health messages to Queenslanders is going to take on greater significance in the future and we are working hard to make sure we deliver those messages in a way that is relevant and engaging to all people.

After a period of significant change, the department is emerging as an efficient, accountable, responsive and innovative organisation that is ready to meet the healthcare needs of the community. While the change process has, at times, been difficult, the dedication of our staff to providing a world-class health service has never been in question. I am confident the reforms we have implemented will provide the kind of public healthcare sector that Queenslanders expect and deserve.

Dr Michael Cleary
Acting Director-General
Queensland Health

Mandate

The Department of Health was established in 1901 and, until 1 July 2012, was responsible for management, administration and delivery of public health services in Queensland.

Enactment of the *Hospital and Health Boards Act 2011* from 1 July 2012 resulted in the establishment of 17 HHSs—independent statutory bodies, each governed by its own professional HHB and managed by a Health Service Chief Executive (HSCE) with responsibility for the delivery of public health services in their local area.

This change to the health system strengthens local decision-making and accountability, consumer and community engagement, and clinician engagement.

The role of the department is to:

- manage, guide and coordinate the healthcare system through policy and regulation
- manage statewide planning, industrial relations and major capital works
- purchase health services
- monitor the performance of individual HHSs and the system as a whole
- collate and validate statewide performance data and provide performance and other data to the Australian Government
- issue binding health service directives
- employ departmental staff and non-prescribed HHS staff
- own land and buildings and enter into occupancy agreements with the HHSs, prior to proposed devolution to HHSs.

The functions of the department have been realigned under three divisions (Health Service and Clinical Innovation, System and Policy Performance, and System Support Services) and two commercialised business units (Health Services Information Agency and Health Services Support Agency)—all overseen by the Office of the Director-General.

Significant staff changes occurred as part of this realignment. During 2012–13, there was a reduction of 1432 full-time employees through voluntary redundancies, retrenchments, end of temporary contracts and natural attrition. A further 639 full-time employees transferred to HHSs.

The new departmental structure has resulted in a leaner organisation compared to the former corporate office, consistent with returning the management and delivery of health services to local communities.

Our vision

Quality healthcare that Queenslanders value.

Our purpose

To provide leadership and direction for the public healthcare sector, and create an environment that encourages innovation and improvement in the delivery of health services.

Our values

The Department of Health aligns to the Queensland public service values outlined in the code of conduct:

- integrity and impartiality
- promoting the public good
- commitment to the system of government
- accountability and transparency.

Strategic direction

The *Blueprint for better healthcare in Queensland* has four principal themes:

1. **Health services focused on patients and people.**

   Our healthcare system provides the best services, at the best time and in the best place, and patients and people are at the centre of all we do. We are committed to making the healthcare system less complicated and more accessible for all Queenslanders including those in rural and remote communities.

2. **Empowering the community and our health workforce.**

   We are committed to empowering local communities and healthcare professionals to make decisions about local healthcare needs. By improving collaboration with non-government providers, we will maximise the value of our health investment. Through greater transparency in the reporting of hospital performance, we promote public confidence in the health system. A more flexible workforce supports local healthcare decision-making, improved patient access and quality service delivery.

3. **Providing Queenslanders with value in health services.**

   Queenslanders expect that money provided for healthcare is spent wisely. By investing in public, private and not-for-profit partnerships, we will improve the healthcare system to meet the needs and choices of all Queenslanders. A focus on outcomes rather than inputs will provide a more accurate measure of performance. Exposing public sector health services to contestability will drive innovation and new measures for financial accountability will improve performance and reduce waste.

4. **Investing, innovating and planning for the future.**

   A lasting commitment to collaborative effort and improvement will provide Queenslanders with a world-class healthcare system. By simplifying the employment and industrial relations environment and providing access to flexible opportunities for employment, we can build a highly-skilled, capable and sustainable workforce for the future. By exploring new opportunities to promote and review infrastructure investment, we can ensure we have the facilities to support the future delivery of innovative clinical services for Queenslanders.

Highlights for 2012–13

The road ahead—continuing the reform process

In 2012–13, the major reform process that was started in 2011–12 continued with the establishment of 17 HHSs as statutory bodies on 1 July 2012 and the launch of the *Blueprint for better healthcare in Queensland* in February 2013. The blueprint outlines the government's direction to ensure Queensland is a pace-setter for value-for-money, performance and delivery.

Other major reform activities included:

- establishment of robust governance and compliance systems for HHSs as statutory bodies
- establishment of a Contestability Branch to lead and coordinate contestability reforms
- restructure of corporate office to support HHSs in the delivery of health services
- planning for the transfer of the employer function to HHSs
- planning for the transfer of ownership of land and buildings to HHSs
- renewal of the membership of HHBs
- implementation of the National Activity Based Funding (ABF) Model for 2013–14, service agreements and successful negotiation and execution of service agreements between the department and the HHSs.

Fraud risk management

The department has continued to strengthen and improve its fraud and risk control measures, including implementing all of the recommendations of the Auditor-General's *Report to Parliament 9—Fraud risk management.*

During 2012–13, a Fraud risk and control improvement project educated staff about the department's zero tolerance approach to fraud, misconduct and corruption. The project delivered a:

- Fraud Control Policy
- Implementation Standard for Fraud Control Governance, Prevention, Detection and Response
- Guide to Fraud and Corruption Control
- centralised fraud risk register
- comprehensive fraud risk assessment
- fraud awareness training program
- integrated fraud control education program
- increased employee fraud awareness during February–March 2013 with the fraud awareness month activities.

To continue a focus on fraud control, a Fraud and Corruption Working Group chaired by the chief governance officer, was established with membership from across the department.

Payroll and Rostering System

Ongoing improvement of the payroll and rostering system continued to impact budget allocation in 2012—13. The department continued to operate, maintain and enhance the rostering and payroll environment to improve the pay outcomes for Queensland Health staff, reduce the level of fortnightly overpayments and reduce recurrent operational payroll costs.

Key initiatives commenced to address the recommendations from the independent review of the payroll system which was tabled in Parliament on 6 June 2012 include:

- moving the staff pay date by one week to enable more time to submit, approve and process payroll forms
- progressive rollout of the online Payroll Self Service since October 2012
- Payroll Program Board established to oversee payroll and workforce management projects
- a workforce transformation project focused on identifying potential future payroll operating and service delivery models
- payroll forms lodgement campaign to encourage timely submission
- recovery of overpayments
- progressive introduction of automated recovery of any new overpayments from July 2013.

More than 630 payroll system information sessions kept staff informed about progress with improvements to the Queensland Health Payroll System and to resolve any disputes or issues with overpayments experienced by staff.

The department also assisted the Commission of Inquiry into the implementation of the Queensland Health Payroll System, which commenced on 1 February 2013. Both current and former staff provided evidence.

Finding efficiencies

The department initiated a number of strategies to reduce costs and increase efficiency, including:

- implementing a series of clinical service redesign projects in hospitals around the state to streamline processes in emergency departments
- continuing the Health Practitioner Models of Care project to explore how allied health professionals can decrease patient waiting time and improve patient satisfaction and outcomes
- implementing the Surgery Connect Program to reduce pressure on elective surgery waiting lists
- partnering with private dental providers to reduce public dental waiting lists

- expanding Hospital in the Home to increase the delivery of hospital services to people in their own homes
- implementing a series of waste cutting initiatives, including realising around $169 million in cost savings on the purchase of clinical products by Queensland public hospitals.

Better healthcare

The department implemented a number of initiatives to improve the health of Queenslanders, including:

- commencement of the Enhanced Maternal and Child Health Service Initiative
- development of statewide health service strategies for diabetes and intensive care services and rural and remote health services
- completing the Queensland Bedside Audit to support HHSs improve patient safety and care
- investments in health infrastructure totalling more than $1.6 billion
- expansion of the Telehealth network to provide better care to people in rural and remote communities
- eliminating hospital bypass and improving patient-off-stretcher-time
- implementing the Healthy Hearing Program to screen more than 99 per cent of all children
- developing health campaigns to help Queenslanders make healthy choices:
  - *E.N.D. H.I.V.*
  - *Young women and smoking*
  - *Get healthy*
  - *Defend against Dengue*
  - Workplace Quit Smoking Program.
- improving engagement with clinicians through the Queensland Clinical Senate and 18 clinical advisory networks
- implementing a range of eHealth solutions to support the increasingly sophisticated demands of a modern healthcare system
- preparations for the establishment of the Queensland Mental Health Commission on 1 July 2013.

Closing the Gap

The department implemented a number of strategies and initiatives to help close the gap in health outcomes for Indigenous Queenslanders, including:

- publishing the Indigenous Health Policy and associated plans

- opening the Southern Queensland Centre of Excellence for Indigenous Primary Health Care in Inala to provide best practice health services, training of health professionals and service delivery research
- implementing the *Young women and smoking* campaign aimed at young Indigenous women living in rural and remote locations
- implementing the Indigenous Respiratory Outreach Care Program
- implementing an Indigenous Cardiac Outreach Program to service 28 rural and remote sites across northern Queensland
- implementing expanded respiratory services for rural and remote communities and a statewide spirometry training program for Indigenous health workers
- establishing 17 new multidisciplinary care teams in Aboriginal and Torres Strait Islander Community Controlled Health Services in high demand locations
- establishing the Regional Indigenous Youth Alcohol and Other Drugs Treatment Network in Brisbane, Gold Coast, Cherbourg, Rockhampton, Mount Isa, Townsville and Cairns
- implementing programs under the National Partnership Agreement on Indigenous Early Childhood Development
- implementing programs under the Project Agreement for Improving Ear Health Services for Indigenous Australian Children
- implementing programs under the Project Agreement on Improving Trachoma Control Services for Indigenous Australians
- providing three Drover Mobile Dental Clinics and mobile dental equipment to deliver improved dental services to Indigenous Australians in Cherbourg, the Torres Strait and Cape York, and surrounding communities in Queensland
- implementing an *Aboriginal and Torres Strait Islander Workforce Strategy* to position Queensland Health as a responsive employer of Aboriginal and Torres Strait Islander people
- launching a proactive Quitline quit smoking support program for Aboriginal and Torres Strait Islander clients.

Enabling technologies

The department received the 2012 Queensland iAwards merit award for its statewide patient information viewing solution (The Viewer/Clinical Data Repository). The application, which gives Queensland Health clinicians faster access to patient information in one place, received the award for developing an innovative information and communications technology (ICT) solution that supports a broad spectrum of services and activities delivered by healthcare professionals.

The department also implemented a number of eHealth, and ICT projects to support the increasingly sophisticated demands of a modern healthcare system, including:

- an emergency department information system to record patient treatment details
- a teleradiology network providing specialised digital radiology services

- an operating room management system to assist with effective theatre management
- an automated anaesthetic record keeping solution to capture vital signs data for patients in operating theatres
- an endoscopy information solution that reports diagnostic treatment and follow-up information
- a statewide patient discharge summary system that delivers discharge information to general practitioners (GPs) to support the continuity of care
- a digital breast screening solution that has resulted in a reduction of technical recall rates due to the replacement of chemical film processing
- a schools oral health information system
- a mental health application that provides detailed patient mental health information to authorised clinicians and administration staff
- a testing phase for an integrated electronic medical record (ieMR)
- expansion of the Telehealth network
- expansion of the number of medical imaging facilities with access to teleradiology reporting
- exploring the use of mobile technology solutions.

In addition, the Queensland Government Chief Information Office undertook a whole-of-government ICT audit, with a focus on identifying savings and waste, risks and issues, and performance and accountability. A review of the Health Services Information Agency was completed in April 2013 and the agency is working to implement the six recommendations.

Department of Health structure

Health Service and Clinical Innovation

Health Service and Clinical Innovation (HSCI) delivers statewide clinical support and coordination functions to assist HHSs. HSCI has three branches and four professional offices:

- Office of the Deputy Director-General
- Chief Health Officer Branch
- Mental Health, Alcohol and Other Drugs Branch
- Health Systems Innovation Branch
- Nursing and Midwifery Office
- Office of the Chief Dental Officer
- Office of the Chief Allied Health Officer
- Office of the Principal Medical Officer.

HSCI is responsible for:

- statutory functions related to public health, private health licensing and mental health, as required under relevant legislation
- statewide coordination of regulatory and other interventions to address potential harm or illness caused by exposure to environmental hazards, diseases or harmful practices, including disease surveillance, prevention and control
- statewide coordination and monitoring of interventions and oversight of service quality in relation to alcohol and other drugs as well as mental health
- advice and support services to maximise patient safety outcomes, and clinical process improvement to help resolve and improve patient access to care across Queensland and improve the efficiency and performance of the health system
- provision of statistical information to enable decision-making, clinical improvement, monitoring and evaluation of health services, and for reporting against national agreements and other requirements
- development of strategies to meet future clinician workforce challenges
- provision of advice and coordination, workforce development and support—including education and training—and performance and productivity monitoring, for nursing, medical, allied health and dental professions
- setting system-wide preventive health program objectives and targets in line with government policy direction, epidemiological information for statewide planning and public health data management, cancer screening strategies, policies and standards, and leadership and direction for health and medical research.

HSCI also delivers the following statewide services:

- aeromedical coordination and retrieval capability
- clinical and operational leadership and governance for specialised and contracted retrieval services and aeromedical transport providers
- counter disaster and mass events coordination and response
- statewide management of organ and tissue donation, and blood supply.

Health Services Information Agency

The Health Services Information Agency (HSIA) coordinates the operation of information systems and technologies for the department and HHSs.

HSIA is responsible for:

- ICT strategies, policy, governance and architecture, including standards
- access to major information systems, such as desktop computers, laptops, personal computing devices, mobile devices and telephones
- shared (enterprise) infrastructure, applications and services
- ICT procurement and strategic sourcing
- information management policy and standards
- eHealth strategy and solution delivery, including compliance with the national eHealth agenda and whole-of-government direction.

Health Services Support Agency

The Health Services Support Agency (HSSA) provides forensic, scientific, diagnostic and therapeutic services to support HHSs in achieving efficiency, improved patient flow, access and patient safety. HSSA manages 13 HEALTH (13 43 25 84), which provides Queenslanders access to health advice 24 hours a day, seven days a week.

HSSA is progressively commercialising its operations, establishing fully costed charges for the goods and services it provides, and is adopting other features of the commercial environment. The introduction of contestability is a key strategy for HSSA to improve health service delivery outcomes. Contestability is a process of conducting business reviews to compare current HSSA service delivery to alternative operational models and to recommend future service delivery models. Contestability assessments of HSSA services are progressing with a preliminary business case completed for Central Pharmacy.

HSSA is responsible for:

- Diagnostic and Scientific Services: Pathology Queensland, Forensic and Scientific Services (FSS), and Laboratory Information Systems and Solutions
- Procurement Logistics and Health Technology: Biomedical Technology Services, Group Linen Services, and Procurement Logistics and Contracts

- Clinical Support Services: Radiology Support, Healthy Hearing Program, Health Contact Centre and Medication Services Queensland
- Business and Commercial Support Portfolio: Finance, ICT Portfolio, and Human Resources (HR) and Business Support.

Office of the Director-General

The Office of the Director-General (ODG) provides support and advice to the Director-General and Minister for Health through the strategic coordination of departmental activities. ODG facilitates intra- and inter-governmental partnerships and communication, and delivery of statewide marketing and media campaigns.

ODG contains the following units:

- Cabinet and Parliamentary Services Unit. This unit manages the provision of strategic services to the Office of the Minister for Health, provides high-level strategic policy advice on Cabinet and executive government issues, and coordinates whole-of-government reporting.
- Departmental Liaison and Executive Support Unit (comprising Senior Departmental Liaison Office, Departmental Liaison Office, and Executive Support Services). This unit manages the flow of information to and from other government departments and statutory bodies, and manages incoming patient and customer feedback on behalf of the department and the Minister.
- Marketing and Online Communication Unit. This unit develops and manages statewide marketing and communication campaigns and strategies, manages the department's brand, develops and manages online services and provides graphic design services.
- Media and Communication Unit. This unit develops standards, guidelines and plans, and delivers media and communication strategies. It manages enquiries, provides strategic advice to the Minister, Director-General and other agency leads and provides stakeholder engagement and communication services.
- Secretariat Services (providing secretariat services to the department's Executive Management Team (EMT), Australian Health Ministers' Advisory Council, Australian Health Workforce Ministerial Council, Standing Council on Health, Community Care and Population Health Principal Committee and Estimates Committee). This unit provides secretariat services to key decision-making bodies within the health system, represents the department's interest on a state and national level, and manages engagement and relationships to facilitate inter- and intra-governmental relations.

System Policy and Performance

System Policy and Performance (SPP) leads high-level strategic and policy development, plans and forecasts health services for the Queensland population, acts as purchaser of health services on behalf of the state, and monitors and manages performance according to the purchasing model and service agreements.

SPP also provides leadership and strategic advice on Aboriginal and Torres Strait Islander health and supports the statutory agencies within the health portfolio.

SPP is responsible for:

- development, review and updating of portfolio legislation and regulations
- data analysis and research to support health service planning
- statewide health service planning and support HHS with local service planning
- strategic planning and policy development
- integrated planning frameworks
- introduction of an activity based funding model and national efficient price for services
- healthcare purchasing and development/execution of service agreements between the department and HHSs
- performance monitoring and management of HHSs
- development of the department's state budget submissions and contribution to the state budget papers
- support of statutory agencies within the health portfolio
- coordination of policy, planning, investment and monitoring of Aboriginal and Torres Strait Islander health initiatives.

System Support Services

System Support Services (SSS) is responsible for major corporate functions, including financial, legal and HR services. It administers the infrastructure program and has oversight of key governance functions, such as risk, audit, right to information, privacy ethical standards, and service procurement and contract management. Additionally, through the Contestability Branch, the division provides strategic oversight and coordination on contestability reforms which are the basis for improving operational efficiencies across Queensland Health.

SSS is responsible for:

- Finance Branch—supports Queensland Health in the delivery of efficient and quality health services. This is achieved through effective partnering with the HHSs, enabling compliance, financial service delivery and reporting, and strategic financial policy, strong governance frameworks and business advice.
- Legal Branch—provides legal services to the Minister, Director-General, deputy directors-generals and other senior officers.

- Human Resource Services Branch—provides statewide support, including enterprise bargaining and industrial relations functions.
- Health Infrastructure Branch—leads and coordinates statewide health service infrastructure and ensures the life of built assets is maximised. The branch works with HHSs, other government agencies and key stakeholders on service and infrastructure planning and delivery.
- Governance Branch—develops and implements risk mitigation strategies and frameworks, internal audit, right to information, privacy, ethical standards, and service procurement and contract management.
- Contestability Branch—provides strategic oversight and coordination of contestability reforms which are the basis for improving operational efficiencies and ensuring value-for-money in the delivery of healthcare services. It provides assistance to the department and HHSs through the development of policy and operational frameworks, as well as high-level expertise in the engagement of industry in innovative and sustainable contracting models.

Overview of organisational changes

Health Service and Clinical Innovation

HSCI's role in the following services discontinued in 2012–13 when they were transitioned to HHSs:

- public health units
- dental workshop
- organ and tissue donation
- Queensland Tuberculosis Control Centre
- victim support services
- BreastScreen vans and radiography relief pool.

Health Services Support Agency

HSSA's role in the following services discontinued in 2012–13 when they were transferred to HSCI and HHSs:

- the management of blood and blood products
- Telehealth
- pharmacist continuing education program
- provision of pharmacist and radiography relievers.

Of the notable appointments, Helen Little became General Manager, Michael Kelly became Chief Finance Officer, Malcolm Burchett became Chief Operating Officer and Matt Mazotta became Chief Procurement Officer. The role of Senior Director, Business Services has been replaced with an Executive Director, People, Change and Communications. The HSSA Advisory Board, chaired by Professor Gary Sturgess, was established to provide advice to Kathy Byrne, Chief Executive, HSSA. Membership includes five HHB members, three HHS executive members and one independent member.

Office of the Director-General

In mid-2012, ODG implemented an organisational restructure, in line with the department's commitment to drive cost efficiency. The restructure resulted in the transfer of the Ethical Standards Unit, and Assurance and Risk Advisory Services to SSS.

System Policy and Performance

SPP was created from work units, or parts thereof, that were previously located across three divisions: Policy, Strategy and Resourcing; Performance and Accountability and Health Planning; and Infrastructure Division. Philip Davies was appointed Deputy Director-General on 27 May 2013.

System Support Services

SSS brought together three previous divisions: Human Resource Services (including Payroll Portfolio Office); Finance, Procurement and Legal Services; and elements of Health Planning and Infrastructure Division. It also incorporated units from the former ODG, Performance and Accountability Division and Policy, Strategy and Resourcing Division. The former Health Services Purchasing and Logistics Branch, excluding Community Services Unit and Strategic Procurement Unit, was transferred to HSSA.

Following the initial establishment of SSS, the division underwent further structural changes with the transitioning of the shared services to other divisions. Supply Services was transferred from SSS to HSSA and some areas of Recruitment Services and Finance Transactional Services were transferred to the HHSs. In addition, the Strategic Procurement team transitioned to HSSA in December 2012. The former Community Services Unit transitioned from the Finance Branch to the Governance Branch and was renamed the Funding and Contract Management Unit from 1 January 2013.

Machinery-of-government change

The Queensland Health Shared Service Partner ceased existence on 27 July 2012 after the following changes: Supply Services and Linen Services transitioned to the HSSA from 1 July 2012; Finance Transactional Services transitioned to the Finance Branch within SSS from 27 July 2012 and Payroll and Establishment Services and Statewide Recruitment Services transitioned to Human Resource Services Branch within SSS from 27 July 2012.

Financial highlights

Queensland Health is committed to creating dependable healthcare and better health for all Queenslanders. To achieve this, six major services are utilised to reflect the department's planning priorities. These services are: Prevention, promotion and protection; Primary health care; Ambulatory care; Acute care; Rehabilitation and extended care; and Integrated mental health services.

How the money was spent

The department's major services and their relative share are shown in Figure 1.

Queensland Health achieved an operating surplus of $14.1 million in 2012-13 while still delivering on agreed major services.

Queensland Health, through its risk management framework and financial management policies, is committed to minimising operational expenses and related liabilities. In addition, the department's risk of contingent liabilities resulting from health litigations is mitigated by its insurance with the Queensland Government Insurance Fund.

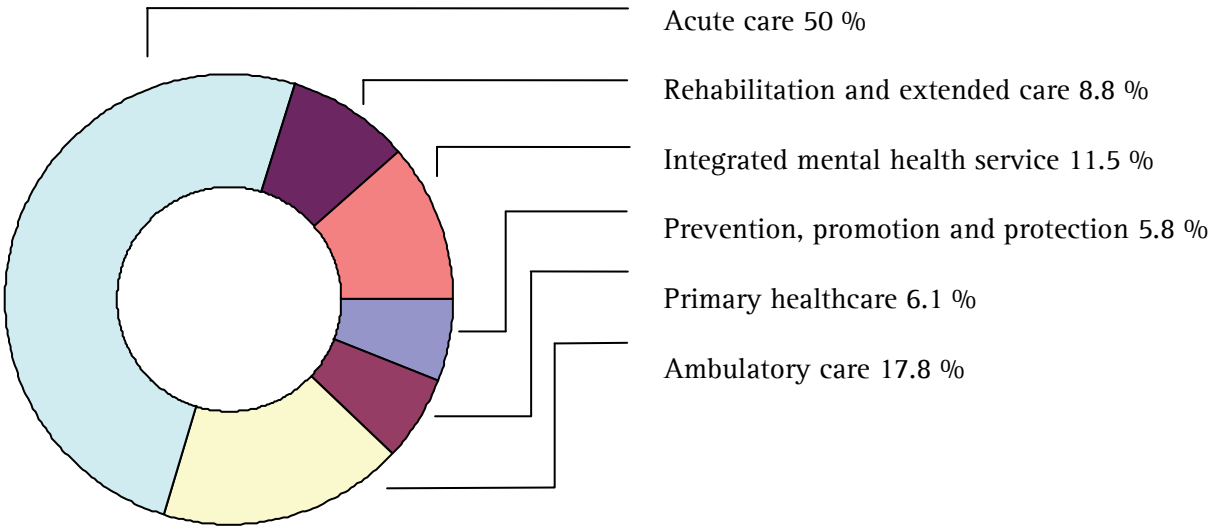


Figure 1: Expense by major services

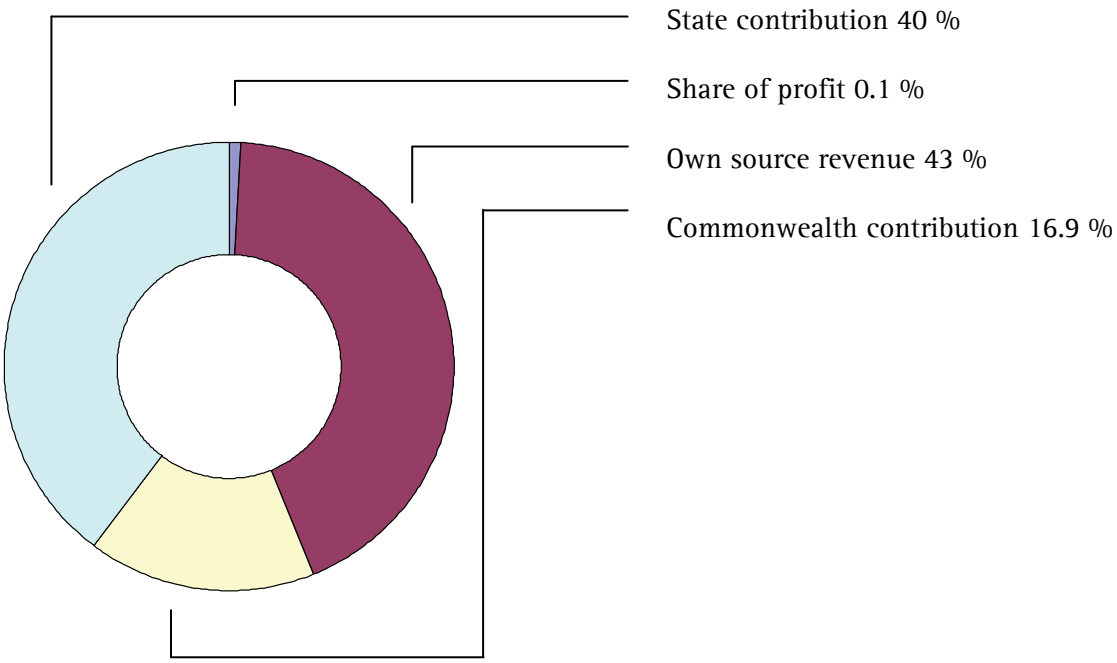


Figure 2: Revenue by funding source

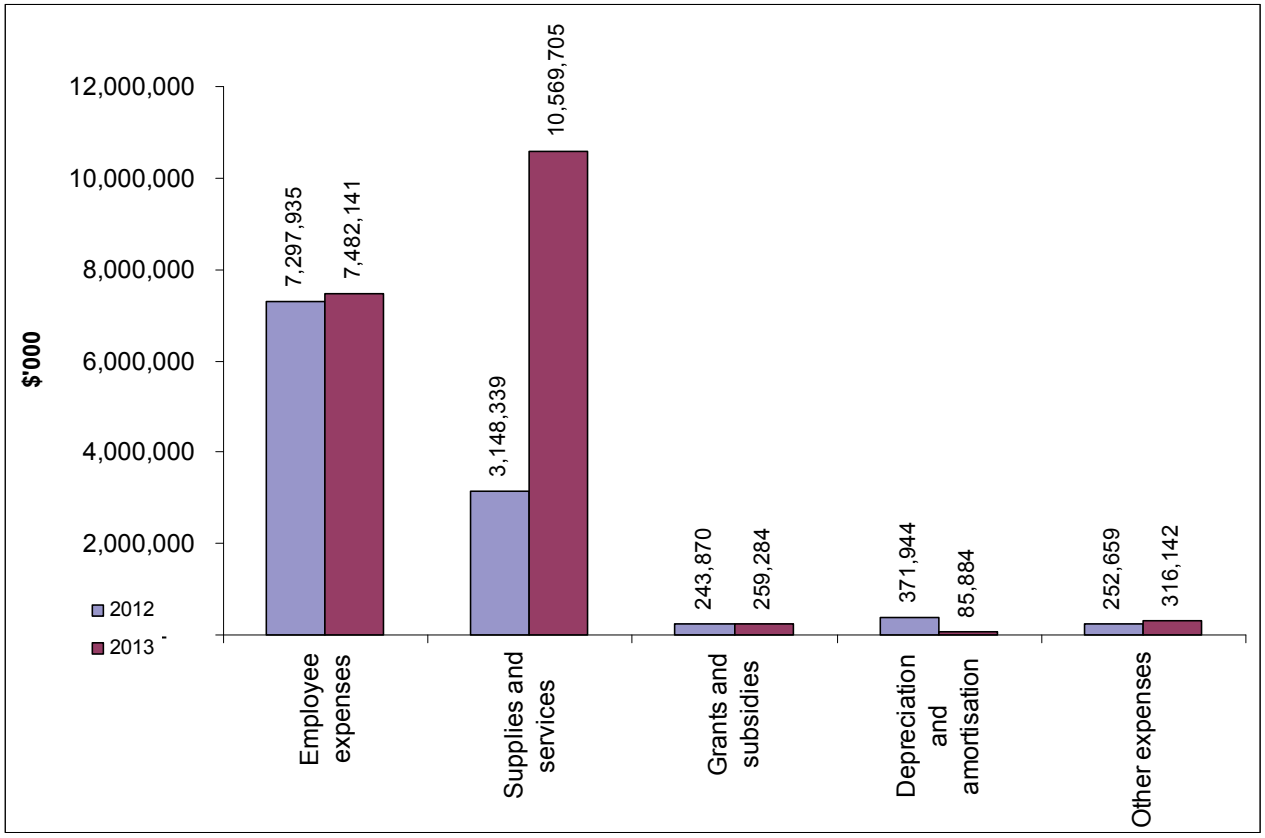


Figure 3: Expense two-year comparison

Income

Queensland Health's income includes operating revenue and its share of profit in associates. The operating revenue is sourced from three areas:

- State contributions
- Commonwealth contributions and grants
- Own sourced revenue generated from user charges (including Right of Private Practice arrangements), grants and other revenue (including recoveries from Health and Hospital Services).

Figure 2 details the extent of these funding sources for 2012-2013.

Queensland Health's total gross income from continuing operations and share of profit in associates for 2012-13 was $18.727 billion. This is inclusive of $6.693 billion for labour recoveries from the HHSs. The $18.727 billion includes a state contribution of $7.495 billion (40 per cent), Australian Government contribution of $3.157 billion (16.9 per cent), other revenue of $8.062 billion (43 per cent) and share of profit in associates of $0.014 billion (0.1 per cent).

Queensland Health's underlying revenue exclusive of labour recoveries and profits from associates was $12.005 billion when compared to the 2012–13 budget of $11.049 billion. The difference relates to a greater receipt of user charges and recoveries from HHSs for items such as drugs, pathology and blood products.

Expenses

Total expenses for 2012–13 were $18.713 billion. These are inclusive of HHS labour costs of $6.693 billion. The underlying expenses of $12.012 billion represent an increase of 6.2 per cent in comparison to the previous financial year. Figure 3 provides a comparison of expenses in 2011–12 and 2012–13.

The increase in expenses incurred includes:

- supplies and services—which reflects the revision of service procurement expenditure in 2012-13
- employee expenses—salary increases under the current enterprise bargaining agreement
- depreciation and amortisation—following trends over previous years
- other expenses—reflecting increase in insurance premiums.

Supplies and services for 2012-13 include labour recoveries revenue from HHSs. The increase in labour recoveries revenue largely relates to the change in accounting treatment from prior year upon the creation of HHSs. The department continues to be the employer of all health service employees (excluding persons appointed as a health executive). Employees are provided by the department to perform work for HHSs under a fee-for-service agreement. Under this agreement the department recovers all employee expenses and associated costs

from the HHSs. This arrangement has resulted in an increase in revenue and a corresponding increase in employee expenses.

Comparison of actual financial results with budget

Queensland Health actual result in comparison to its budget as published in the State Budget Papers 2012-13 Service Delivery Statements are presented in Table 1 and Table 2 with accompanying notes.

Table 1: Statement of comprehensive income for the year ended 30 June 2013

	Notes	2012-13 actual	2012-13 budget	Variance
		$000	$000	%
Income				
Departmental services revenue	1	7,853,570	7,792,873	1%
User charges	2	1,396,834	473,357	195%
Labour recoveries	3	6,693,409	-	n/a
Grants and contributions		2,734,388	2,771,610	(1)%
Other revenue		32,815	11,194	193%
Gains		2,093	-	n/a
Total income		**18,713,109**	**11,049,034**	**69%**
Expenses				
Employee expenses	4	7,482,141	1,224,465	511%
Supplies and services	5	906,879	410,313	121%
Health Services	6	9,662,826	-	n/a
Grants and subsidies	7	259,284	9,197,675	(97)%
Depreciation and amortisation		85,884	95,102	(10)%
Impairment loss		13,487	-	n/a
Appropriation returned		120,453	-	n/a
Other expenses		182,202	121,479	50%
Total expenses		**18,713,156**	**11,049,034**	**69%**
Share of profit of associates	8	14,147	-	n/a
Operating result from continuing operations		**14,100**	**-**	**n/a**

Notes:

1. The increase in service revenue to budget is due to funding related to the public sector voluntary separation program, offset by a deferral of Commonwealth National Healthcare specific purpose payments operating funds as a result of a delay in the associated Capital Build.

2. Variance to budget predominately relates to recoveries from HHSs for items such as drugs, pathology, ambulance and fixed wing, biotechnology services and blood and blood products. The variance can also be attributed to an increase greater than forecast revenue received from the Department of Veteran's Affairs, QComp and Motor Accident Insurance Commission and other reimbursements.

3. The increase in labour recoveries revenue largely relates to the change in accounting treatment from prior years upon the creation of HHSs. The Department of Health continues to be the employer of all health service employees (excluding persons appointed as a Health Executive). Employees are provided by the department to perform work for the HHSs under a fee for service agreement. Under this agreement the

department recovers all employee expenses and associated costs from the HHSs. This arrangement has resulted in an increase in revenue and a corresponding increase in employee expenses. This change in accounting treatment has not been reflected in the 2012–13 budget.

4. Refer to point 3 above. The increase in employee expenses above budget predominately relates to salaries associated with employees contracted to HHSs and the cost associated with the government's voluntary separation process.

5. The increase in supplies and services expenses compared to budget is due to a change in accounting treatment for payments to HHSs. Refer to point 2 above

6. The increase in actuals compared to budget is a result of a change in accounting treatment for funding payments to HHSs reclassified from grants to supplies and services.

7. Refer point 6 above. The decrease in actuals compared to budget is a result of a change in accounting treatment for funding payments to HHSs reclassified from grants to supplies and services.

8. The increase in actuals above budget is due to the recognition of share of profit in associates. As at the 30th June 2013, the department has two associates: the Translational Research Institute (TRI) Trust and the Queensland Children's Medical Research Institute (QCMRI). Dividends receivable from associates are recognised in the Statement of Profit or Loss and Other Comprehensive Income as a component of Other Income. The share of profit in associates for 2012–13 relates to TRI. The department has reinvested all distributions from TRI in accordance with the TRI Trust Deed. These amounts have not been reflected in the 2012/13 Budget.

Table 2. Statement of Financial Position as at 30 June 2013

	Notes	2012-13 Actual $000	2012-13 Budget $000	Variance %
Current assets				
Cash and cash equivalents		(181,785)	(231,090)	(21)%
Loans and Receivables	9	974,024	713,384	37%
Inventories		48,747	60,295	(19)%
Assets held for sale		-	-	n/a
Other		137,521	125,080	10%
Total current assets		**978,507**	**667,669**	**47%**
Non-current assets				
Loans and Receivables	10	424,464	20,191	2,002%
Property, plant & equipment	11	3,532,114	2,019,426	75%
Intangibles		229,861	157,037	46%
Other financial assets		20,000	90,769	(78)%
Investments in Associates		83,339	-	n/a
Other		3,394	(2,217)	(253)%
Total non-current assets		**4,293,172**	**2,285,206**	**88%**
Total assets		**5,271,679**	**2,952,875**	**79%**
Current liabilities				
Payables	12	551,815	318,314	73%
Accrued employee benefits	13	611,207	463,095	32%
Interest-bearing liabilities	14	-	179,857	n/a
Other liabilities		9,113	2,068	341%
Total current liabilities		**1,172,135**	**963,334**	**22%**

Non-current liabilities				
Other financial liabilities	15	263,665	59,977	340%
Other liabilities payable		4,953	1,775	179%
Total non-current liabilities		**268,618**	**61,752**	**335%**
Total liabilities		**1,440,753**	**1,025,086**	**41%**
Net assets		**3,830,926**	**1,927,789**	**99%**
Equity				
Contributed equity		335,593	(1,523,276)	(122)%
Retained surpluses		3,417,084	2,417,194	41%
Asset revaluation surplus	16	78,249	1,033,871	(92)%
Total equity		**3,830,926**	**1,927,789**	**99%**

Notes:

9. Increase in actuals to budget predominately relates to Appropriation receivable from Queensland Treasury and Trade and an increase in operating receivables.
10. Increase in actuals to budget relates to the finance lease for the TRI and payroll overpayments.
11. Increase in actuals to budget is due to a change in commissioning date for Gold Coast University Hospital.
12. Increase in actuals to budget reflects an increase in payables primarily as a result for final payment for 2012–13 to HHSs
13. Increase in actuals to budget is due to additional 14 days accrual for salaries and wages as a result of the change in pay date.
14. Decrease in actuals to budget is due to the re-classification of pre-paid lease payments by the TRI from current to non-current.
15. Refer 14 above. Increase in actuals to budget is due to the re-classification of pre-paid lease payments by the TRI from current to non-current.
16. Decrease in actuals to budget is a result of the reduction in revaluation surplus as a result of land and buildings being controlled by HHSs.

Chief Finance Officer statement

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

For the financial year ended 30 June 2013, a statement assessing the Department of Health's financial internal controls has been provided by the A/Chief Finance Officer to the A/Director-General.

The statement was prepared in accordance with Section 57 of the *Financial Performance Management Standard 2009*. The statement was also provided to the Department's Audit and Risk Committee.

Future outlook

In 2013-14, Queensland Health's overall budget (including The Department of Health and 17 Hospital and Health Services) will grow to $12.326 billion, an increase of 3.9 per cent on the 2012-13 budget.

Queensland Health will also invest $1.752 billion in 2013-14 in a range of health infrastructure priorities including hospitals, health technology, research and scientific services, mental health services, residential care, staff accommodation, and ICT.

2013–14 infrastructure program highlights include:

- scheduled opening of the Gold Coast University Hospital in September 2013
- continued development of the Queensland Children's Hospital and the Sunshine Coast Public University Hospital
- continued redevelopments at Cairns, Mackay, Mount Isa (construction forecast to be completed in June 2014), Rockhampton (construction forecast to be completed in mid 2014), Townsville, Logan, QEII (construction forecast to be completed in January 2014) and Ipswich (construction forecast to be completed in February 2014) Hospitals
- continued rectification works at rural and remote facilities
- completion of the Medical Research Centre at the Queensland Institute of Medical Research.

Queensland Mental Health Commission

From 1 July 2013, $7.147 million has been allocated to establish and run the new Queensland Mental Health Commission. This funding was made up of $2 million for operational management of the commission's functions and $5.147 million for strategic programs now managed through the commission which were previously managed through Queensland Health.

The commission will drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health, drug and alcohol system and will be responsible for leading a cultural change in the way mental health, drug and alcohol services are planned and delivered in Queensland.

Cochlear Implant Waiting Lists

In 2013–14, $5.8 million has been allocated to provide cochlear implants to patients with moderate to profound hearing loss. It is expected that this additional funding will mean all people currently on the cochlear implants waiting list will receive their implant during the 2013-14 financial year.

Hospital in the Home

An additional $28.3 million has been allocated over the next four years for additional hospital in the home (HITH) services to be provided by the private sector and non-

government organisations. HITH provides acute care by health care professionals at a patient's usual place of residence as a substitute for inpatient care received in a hospital.

Backlog maintenance

Increased funding of $147 million over four years has been allocated to address the backlog of maintenance. This brings the total contribution from the department and HHSs for the backlog maintenance program to $327 million.

Revitalisation of regional, rural and remote services

To address the specific service delivery challenges for the health sector in non-metropolitan areas, the government has approved funding of $51.9 million over four years to support and enable better access to health care services for Queenslanders in regional, rural and remote communities.

Rural Telehealth Service

To support enhanced models of care and outreach services, the government has approved funding of $30.9 million over four years to establish a Rural Telehealth Service. For Queenslanders from rural areas, this will improve access to health services and reduce extended waiting times for treatment.

Rural Mental Health

In 2013-14, the department will provide $0.2 million to facilitate the provision of mental health first aid and psychological first aid workshops by non-government organisations in rural communities declared in drought. These workshops will assist communities to identify mental health related issues, promote normal recovery pathways, increase resilience and facilitate access to physical, emotional and social supports.

In addition, the department will provide $0.7 million in funding in 2013–14 to the non-government sector to provide mental health information, advice and personal support through individual and group counselling services for patients in the North Burnett and Bundaberg regions affected by Ex-Tropical Cyclone Oswald.

Payroll system enhancements

Additional funding of $384.3 million over four years, including $124.3 million in 2013-14, will enable the department to operate, maintain and enhance the Queensland public health system rostering and payroll environment. This will be used to improve the pay outcomes for Queensland public health system employees, reduce the level of fortnightly overpayments and reduce recurrent operational payroll costs.

Service Agreements

In 2013-14, $10.319 billion (or 83.7 per cent of the total budget) will be allocated through service agreements to purchase public healthcare services from Hospital and Health Services and other organisations, including Mater Health Services, St Vincent's Hospital, Noosa Hospital, and from December 2013, the Sunshine Coast University Private Hospital.

Activity based funding

In 2012-13, Queensland transitioned to the national activity based funding model developed by the Independent Hospital Pricing Authority. The national model will be adopted as far as practicable in 2013-14. The remaining Queensland Health hospitals and some specialised services and non-hospital services such as primary and community care are funded by block grants. These arrangements are subject to agreed adjustments in the service agreements between the system manager and HHSs.

The Commonwealth has also committed to fund 45 per cent of the efficient growth in public hospital activity from 1 July 2014, increasing to 50 per cent from 1 July 2017.

1. Health services focused on patients and people

Objectives

- Patients are at the centre of all we do.
- Our healthcare system provides the best services, at the best time and in the best place.
- Collaboration and partnerships allow the healthcare system to be less complicated and more accessible for Queenslanders.
- Remote communities gain a wide range of new services, delivered at-call through a revised statewide Telehealth network.

Key performance indicators

- Statewide percentage of unplanned hospital readmissions.
- Improvements in vaccination rates.
- Age standardised rate of potentially preventable admitted patient episodes of care.
- Improvements in population statistics for priority health areas (e.g. obesity, smoking).
- Change in the percentage of sites participating in multi-site projects designed to improve access (especially in rural and regional hospitals).
- Publication of the *Patient Safety Learning to Action Report* presenting clinical incidents and sentinel events in the Queensland public healthcare sector 2010–11.
- Percentage of formal reviews undertaken on HHS responses to significant negative variance in key safety and quality indicators.
- The impact of funding provided through the Closing the Gap schedule on the access to and/or quality of services for Aboriginal and Torres Strait Islander people.
- Changes in the total weighted activity units (WAUs) per capita for all key service areas.
- Establish Queensland's first Mental Health Commission to coordinate our strategic focus in this key area.
- HHS performance: Shorter stays in emergency departments, shorter waits for elective surgery, shorter waits for specialist outpatient clinics, increased support for families with newborns, fewer hospital acquired infections, better value-for-money.

Patients at the centre of all we do

Patients and their healthcare needs are the central consideration of health planning, practice and accountability. The department aims to provide Queenslanders with a healthcare system that encourages choice and self-management.

Queensland Bedside Audit

The 2012 Queensland Bedside Audit was the second annual statewide bedside patient safety audit for Queensland. In November 2012, the audit was carried out across 119 inpatient and 22 residential aged care facilities. The audit collected data for reporting on elements of the National Safety and Quality Health Service Standards and other key safety and quality areas.

Data was collected for known highest risks for patient safety and quality, which is not usually systematically collected, such as:

- falls prevention
- malnutrition prevention
- pressure injury prevention
- medication safety
- patient identification
- recognition and management of the deteriorating patient.

As well as reviewing clinical documentation, the audit involved a physical examination of all eligible patients, subject to consent.

Figure 4 provides an indication of the change in statewide inpatient results from 2011 to 2012. Indicators displayed are those where performance aims to reach 100 per cent. The blue bar represents the percentage change in the statewide inpatient result of those indicators that can be compared between years.

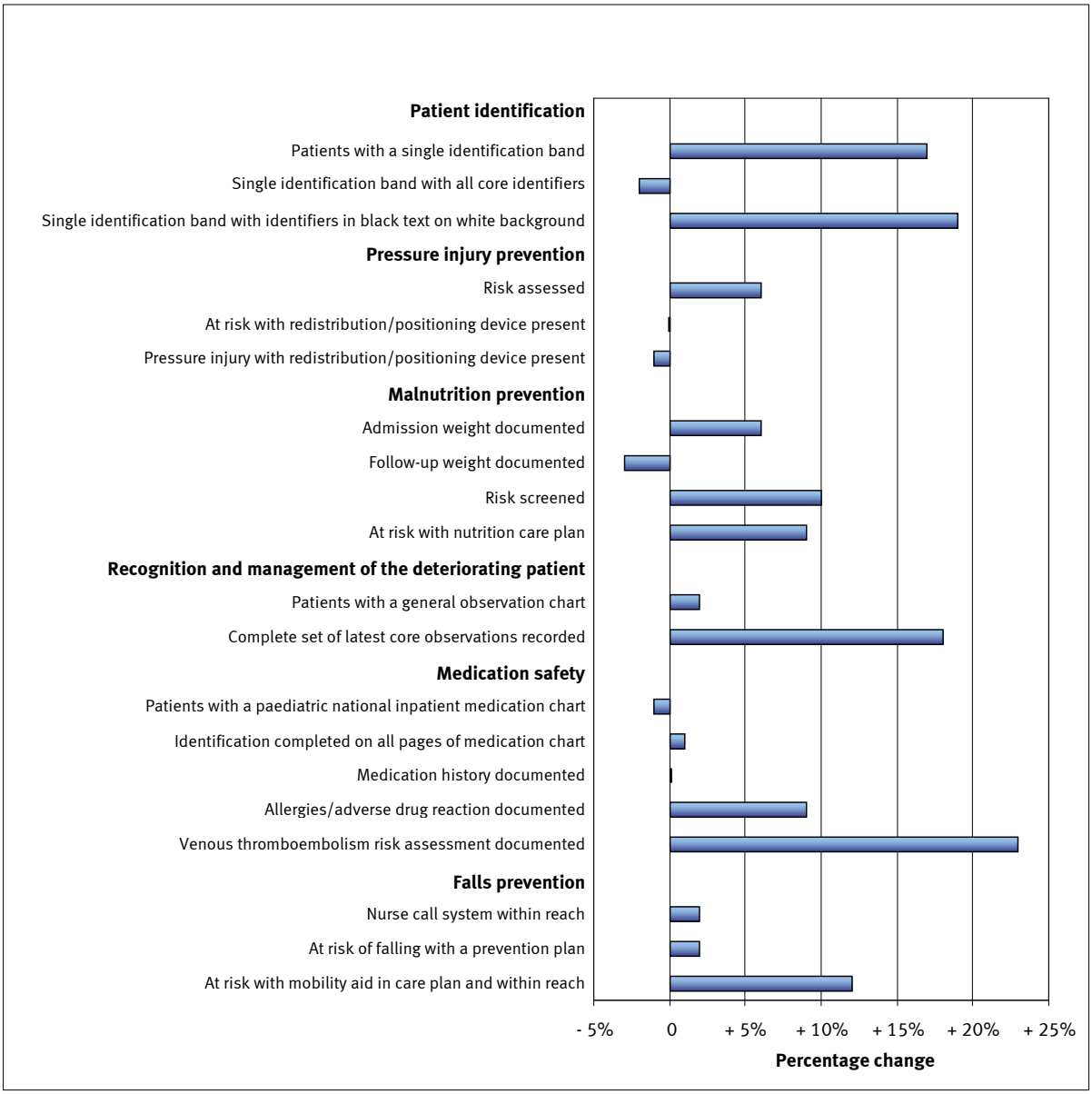


Figure 4: Queensland Bedside Audit change in statewide inpatient indicator results 2011 to 2012

Patient safety notices

Patient safety notices provide information on known or potential quality and safety issues and recommend actions for risk assessment and management at the local area. In 2012–13, the department issued 14 patient safety notices on a range of topics to support HHSs in providing the safest care possible.

Early Warning and Response System

The department has continued its development of Early Warning and Response System tools to assist clinicians to recognise and respond to clinical deterioration in a timely manner.

The tools have been designed for use by clinicians caring for general medical and surgical patients in paediatric and adult inpatient settings and have been customised to support tertiary, secondary, and rural and remote facilities. The department's Patient Safety Unit has developed education materials for each tool and provides implementation support. A series

of user-testing trials are being conducted in 2013 to examine the use of the tools in emergency, maternity and Hospital in the Home settings.

Accreditation

In July 2012, the department launched an online toolkit on the Queensland Health intranet to support HHSs in achieving accreditation against the 10 National Safety and Quality Health Service Standards.

This toolkit includes resources to assist HHSs to meet each of the actions required under the 10 standards. It also includes audit tools to assist in the collection of data.

The department also developed policies, implementation standards and guidelines for falls, pressure injury, recognising and responding to clinical deterioration, and for clinical handover to support HHSs in meeting the standards.

Online Interactive Education System

The department has maintained and supported an Online Interactive Education System that enables clinicians across the state to have access to:

- clinical education on falls prevention
- pressure injury prevention
- malnutrition prevention
- clinical handover
- the deteriorating patient
- open disclosure
- junior doctor orientation
- professional development for rural and remote medical staff
- mandatory training.

Variable Life Adjusted Display

Variable Life Adjusted Display charts provide an easily understood graphical overview of clinical outcomes over time and plot the cumulative difference between expected and actual patient outcomes. The charts use a logistic regression model to predict the expected outcome for each patient, which is then compared to the actual outcome. This helps clinicians to monitor the quality of services provided.

Between March 2012 and February 2013, an average of 675 Variable Life Adjusted Display charts were distributed each month across 69 public hospitals and 317 were distributed to 38 private hospitals. In that period, 41 significant negative variances in key safety and quality indicators were recorded and reviewed by the Variable Life Adjusted Display Committee.

Planning health services

The Health of Queenslanders 2012: Advancing good health is the fourth report on the health of the Queensland population from the Chief Health Officer. The report is published every

two years and informs Queenslanders about the performance of the health system by reporting on the health status and burden of disease of the state's population. Information from these reports is used to inform and guide the department, HHSs and other key stakeholders in planning health services.

Best services, at the best time and in the best place

The department is committed to providing Queenslanders with quality services where and when they need them.

Accessing and assessing patient information

The introduction of the statewide patient summary viewing solution, The Viewer, has changed the way clinicians are able to access and assess patient information.

The availability of computer-based patient summary information in any Queensland Health facility means authorised clinicians and their support staff are able to reduce the time spent on managing paper-based medical records.

The system has also improved the way information is shared between facilities enabling a more seamless transfer of patient information between healthcare professionals resulting in higher quality patient services.

Improving public hospital services

The National Emergency Access Target (NEAT) and the National Elective Surgery Target (NEST) measure the performance of hospital emergency departments and hospital elective surgery services against national standards.

National Emergency Access Target

Queensland implemented a number of strategies throughout 2012–13 aimed at improving performance against the NEAT. The Macro NEAT project targeted emergency department performance in 15 sites and aimed to spread successful improvement strategies to other emergency departments.

Other statewide strategies aimed at improving emergency department performance include:

- standardisation of emergency department short stay unit processes and operation
- engagement of key clinical networks, such as the Queensland Emergency Department Advisory Panel and the Statewide General Medicine Clinical Network
- implementation of an agreed statewide Admission Facilitation Policy and Implementation Standard
- implementation of recommendations from the Metropolitan Emergency Department Access Initiative (MEDAI)
- development of an agreed statewide standardised pathology palette
- inclusion of NEAT performance in HHSs executive performance agreements.

Queensland's performance against the NEAT as at June 2013 was 75 per cent—just short of the 77 per cent target required as at December 2013. This represents a significant improvement on the 67 per cent achieved in 2012.

National Elective Surgery Target

Queensland implemented a number of strategies throughout 2012–13 aimed at improving performance against the NEST, including the 'Scalpel' clinical services redesign program, which is currently being undertaken at nine facilities identified as having significant challenges in meeting elective surgery targets.

The Scalpel program examines and improves processes across the entire patient journey, from referral to surgical outpatients review, categorisation and subsequent treatment, and through to hospital discharge. The program builds on the foundations already in place to continue to provide the best possible care to patients, reduce waiting time for elective surgery and effectively progress towards achievement of the NEST.

Queensland's 2013 NEST performance for the year to June shows:

- 92 per cent category 1 patients treated within the clinically recommended timeframe (target 100 per cent)
- 76 per cent category 2 patients treated within the clinically recommended timeframe (target 87 per cent)
- 88 per cent category 3 patients treated within the clinically recommended timeframe (target 94 per cent).

Metropolitan Emergency Department Access Initiative, bypass and patient off-stretcher time

The department, in collaboration with the QAS, identified 15 recommendations to reduce ambulance ramping and improve consumer access to emergency care through MEDAI.

The final MEDAI report was tabled by the Minister for Health in Queensland Parliament on 2 August 2012. The government has pledged full support for the implementation of all recommendations, which were implemented on 1 January 2013.

As recommended by MEDAI, no facilities have initiated bypass since January 2013. In addition, statewide 'patient off-stretcher time' performance has improved, with 88 per cent of patients transferred off-stretchers within 30 minutes during June 2013 compared with 79 per cent in June 2012.

Specialist outpatient services

In 2012–13, $16.02 million was allocated as part of the better access to specialist care initiative to deliver an additional 40,000 specialist outpatient services. To date, an additional 68,802 specialist outpatient services have been delivered statewide.

The initiative also included the introduction of general practice liaison officers into 20 of Queensland's largest hospitals. These officers work towards improving the interface between

GPs in primary care and hospital-based specialist care. To date, 14 out of 15 HHSs have recruited general practice liaison officers, covering 19 of the 20 largest hospitals.

Clinical services redesign

A number of successful clinical services redesign projects were carried out in Queensland hospitals in 2012–13 at:

- Royal Brisbane and Women's Hospital (emergency department, general medicine, the use of Hospital in the Home and other hospital admission avoidance strategies, outpatients, inpatient admissions and inpatient length of stay, long stay medical patients, and patient flow and bed management practices)
- Toowoomba Hospital (emergency department, general medicine, long stay patients, and patient flow and bed management practices)
- Wide Bay HHS—Bundaberg, Hervey Bay and Maryborough Hospitals (emergency department, elective surgery, general medicine, and patient flow and bed management practices)
- Central Queensland HHS—Rockhampton and Gladstone Hospitals (emergency department, general medicine, outpatients, and patient flow and bed management practices)
- Princess Alexandra Hospital (emergency department, outpatients, and patient flow and bed management practices)
- Redcliffe Hospital (emergency department, general medicine, long-stay medical patients, referral of patients to alternative hospital care services, and patient flow and bed management practices)
- Caboolture Hospital (emergency department, patient admissions, hospital services—pharmacy, pathology, radiology, discharge planning, and patient flow and bed management practices).

In addition, the Queensland Institute of Clinical Redesign Program commenced in November 2012 with more than 50 clinical services redesign projects being conducted in four cohorts covering surgical, medical, integrated care, oral health and mental health domains.

Participating staff use the project as a vehicle to learn and apply the department's clinical services redesign methodology to their everyday work. In this way, HHSs will improve and develop their capability to independently conduct such projects in the future.

Better care for Queensland kids

The Healthy Hearing Program screens all babies born in both public and private hospitals in Queensland for hearing loss. In 2012–13, 62,359 newborns were screened (greater than 99 per cent coverage) to detect the 1 per 1000 children born with a permanent bilateral hearing loss of moderate degree or greater.

Teleaudiology was used to reduce the burden and cost of travel for families and their infants. In 2012–13, Queensland Health tested 74 infants and toddlers from the Mackay, Nambour and Hervey Bay regions using a combination of videoconferencing and remote control testing audiology equipment to diagnose hearing problems in newborn babies and toddlers.

Childhood Hearing Clinics are conducted at the Mater, Royal Children's and Townsville hospitals. Children with a newly diagnosed hearing loss can be referred to these clinics for medical investigations, developmental assessments, amplification options, counselling and early intervention counselling in one location. Around 150 children were assessed at these clinics in 2012–13.

The new QChild Early Hearing Detection Management and Information System was implemented in March 2013 by the Healthy Hearing Program. QChild is a data collection and clinical information system which is accessed by frontline staff to ensure that children with hearing loss, or risk of hearing loss, receive timely intervention and care.

QChild contains all data relating to births in Queensland and matches newborn hearing screening results to birth data to ensure a capture rate of more than 99 per cent. Diagnostic audiology results, family support, medical assessment and early intervention information is also collected and children diagnosed with a hearing loss, or at risk of developing a hearing loss, can be tracked using the system.

Assisting Queenslanders to make healthy choices

Campaigns

In 2012–13, Queensland Health ran a number of advertising campaigns to help Queenslanders make healthy choices.

E.N.D. H.I.V.

In the last 10 years, HIV cases in Queensland have doubled. The Minister for Health established the Ministerial Advisory Committee on HIV/AIDS (MAC) in September 2012 to provide independent advice on HIV prevention and awareness strategies. The *Let's End HIV* campaign was first introduced in August 2012 and aimed to raise awareness of the rise in HIV rates in Queensland. In June 2013, the campaign launched the brand *E.N.D. H.I.V.* which focuses on putting a full stop to HIV transmission and shows that all Queenslanders have a role to play in ending HIV by addressing topics, such as stigma, prevention, testing and treatment. The campaign comprises television, online, outdoor and press advertising and is supported by a website (www.endhiv.qld.gov.au).

Young women and smoking

During June 2013, the *Young women and smoking* campaign ran to encourage young women, aged 18–24, to consider their smoking habit and how it impacts on their health. The campaign website (www.mysmoking.qld.gov.au) features videos of real people with real stories and links to support on how to quit smoking. The campaign also included radio advertisements to reach young Indigenous women living in rural and remote locations.

Defend against Dengue

The *Defend against Dengue* campaign ran in Far North Queensland to promote prevention and outbreak messages. The campaign included television, radio, print and online advertising.

Health and Wellbeing franchise

As part of the government's one-stop-shop strategy, the *Health and Wellbeing* franchise site (www.qld.gov.au/health) was launched. It contains 109 topic areas and is supported by strong customer research, enabling Queenslanders to easily find health information on a broad range of health topics.

Workplace Quit Smoking Program

Queensland blue-collar workers are receiving best practice quit smoking services through their workplace at a time of their choosing. During 2012-13, 1700 people joined the Workplace Quit Smoking Program, of which 68 per cent were men with an average age of 40 years. Quit smoking success rates are very high, with 37 per cent of participants not smoking at six months after program graduation.

The program provides six telephone counselling contacts with Quitline, 13QUIT (13 7848), and 16 weeks supply of quit smoking medication. The program is also offered to family members who reside with a participant, as research shows this supports successful quitting.

13 HEALTH (13 43 25 84)

In 2012–13, the department's 13 HEALTH (13 43 25 84) service—the 24 hours a day, seven days a week phone service for Queenslanders with health concerns—received 313,651 calls. This was an increase of 2.8 per cent on the previous year. The majority of these calls were answered within 20 seconds.

The services offered via 13 HEALTH (13 43 25 84), including 13QUIT (13 7848), were used by 8.8 per cent of Queenslanders over the year and more than 400 compliments were received from consumers. The number of Queenslanders participating in Quitline programs exceeded the target by 19 per cent.

Sun Effects Booth smartphone application

The *Sun Effects Booth* smartphone application was launched in August 2012 and allows young people to see how their current behaviour in the sun can damage their face in the future. The application targets Queenslanders aged 16–24, who are the group with the highest rates of sunburn in the community. The application has been downloaded more than 12,800 times.

Collaboration and partnerships allow the healthcare system to be less complicated and more accessible for Queenslanders

Get Healthy

In partnership with the Health Contact Centre and Medibank Health Solutions, the Queensland *Get Healthy* information and coaching service started in February 2013. *Get Healthy* is a free telephone and online service that aims to support adults who are at risk of developing chronic disease to make healthy lifestyle changes regarding physical activity, healthy eating and reaching and maintaining a healthy weight. The service provides participants with up to 10 telephone calls over a period of six to nine months. To date, 615

participants enrolled in the *Get Healthy* service. The launch of the *Get Healthy* service was supported by an advertising campaign which included press, radio and online advertising to promote the service across Queensland.

Clinician engagement

Clinician engagement is essential to ensuring care is patient-focused. The Queensland Clinical Senate provides a multi-disciplinary forum for clinicians to share their collective knowledge in the deliberation of strategic clinical issues and to make recommendations to the department and HHSs on how to deliver the best care to Queenslanders.

Queensland has 18 key clinical advisory networks which review current procedures and help inform the department on strategic clinical issues. Strong links between the networks, local clinicians and HHSs encourage the spread of innovative models of care and service delivery across the healthcare system. The clinical networks and advisory groups work with Queensland Health and with external health services to support improved patient flow through the healthcare system.

Highlights of clinical network achievements in 2012–13:

Statewide Rural and Remote Clinical Network

The network has progressed a number of collaborative planning and engagement initiatives associated with the design and adoption of safe and applicable models of care, the cost-effective use and reinvigoration of rural and remote health services, workforce improvements, and strategies to deliver services closer to home, including Telehealth service delivery models.

Statewide Stroke Clinical Network

The Queensland public healthcare sector has invested $5 million to support the expansion of a best practice model for stroke management. As a result, the 10 existing stroke units have been enhanced, 11 new dedicated stroke services have been established and all services have been endorsed in line with best practice requirements.

Statewide Cardiac Clinical Network

The AGFA Impax CV Cardiac Catheter Laboratory Program was implemented in six of the seven Queensland Health cardiac laboratories. The program is the first of its type in Australia and allows live images and reports to be shared across the state, along with the collation of clinical and service data. The program offers opportunities for improved patient safety, remote professional support, and clinical and service improvements.

The network also collaborated with the National Heart Foundation to launch *Heart Online* (www.heartonline.org.au) in May 2013, which is a national website providing tools, and professional support resources for health professionals working in primary and secondary cardiac prevention.

Statewide Renal Clinical Network

The Statewide Renal Clinical Network developed a *Statewide Renal Disaster Project Plan* to ensure safe delivery of dialysis during disaster events. This plan assists hospitals to adequately prepare patients, staff and renal units in the event of a natural disaster.

Statewide Maternity and Neonatal Clinical Network

The Statewide Maternity and Neonatal Clinical Network developed the Perinatal Social and Emotional Wellbeing Project in partnership with the Northern Maternity and Neonatal Clinical Network. The project strengthens the knowledge, skills and understanding of Aboriginal and Torres Strait Islander health workers so that they may better support the social and emotional wellbeing of Aboriginal and Torres Strait Islander women and their families during the perinatal period.

In July 2012, the network completed the implementation of neoResus, a neonatal resuscitation education program administered by the Victorian Newborn Resuscitation Project, into Queensland Health maternity services.

The network, in partnership with the Clinical Pathways and Systems Redesign team and colleagues from the Queensland Institute of Medical Research, conducted an evaluation of the use, acceptability and impact that the pregnancy health record has had on clinical practice for providers of maternity care in Queensland. The outcomes of the evaluation were presented at the second international Network to Network Conference in November 2012.

The network also carried out a Neonatal Intensive Care Nursery and Special Care Nursery Workforce Survey and commenced exploring practice and admission criteria to state special care nurseries with a view to providing recommendations that will improve efficiencies in neonatal cot use.

Statewide Respiratory Clinical Network

The Statewide Respiratory Clinical Network implemented the Indigenous Respiratory Outreach Care Program which provides outreach respiratory care to Aboriginal and Torres Strait Islander people (adults and children) with a respiratory condition in regional, rural and remote locations. The program also developed training and education resources to make care more understandable, culturally appropriate and accessible.

The program recruited multidisciplinary teams to provide outreach clinics in consultation with local communities and in liaison with local health staff at Doomadgee, Mornington Island, Thursday Island, Bamaga, Horn Island, Cherbourg, Woorabinda, Mount Isa, Palm Island, Roma, Charleville and Rockhampton. Clinics are planned for Palm Island.

A number of resources were also developed, including culturally appropriate resources for Aboriginal and Torres Strait Islander people and a Living Well with Chronic Obstructive Pulmonary Disease Patient Guide DVD, which is now available from the Australian Lung Foundation.

Statewide Diabetes Clinical Network

The Statewide Diabetes Clinical Network worked collaboratively with Diabetes Queensland to update and print a collection of patient resources for gestational diabetes specifically designed for Aboriginal and Torres Strait Islander people.

The network has also developed a 10-year plan for diabetes services which includes the mapping of current diabetes services, development of a plan for the future and proposals for an implementation and evaluation strategy.

Remote communities gain a wide range of new services

eHealth solutions

Since 2007, Queensland's public hospitals have received eHealth solutions to support the increasingly sophisticated demands of a modern healthcare system. Delivery of these solutions has occurred in a staged approach, primarily based on immediate need in key specialty areas, with progress also being made towards the introduction of ieMR.

The first phase of Queensland's eHealth journey has seen solutions implemented in specialty and high priority areas, linking rural and remote areas with metropolitan services. This has seen a reduction in inefficient paper-based processes and an increase in integrated, enterprise systems that provide immediate access to vital patient information regardless of location. A reduction in waste, improved efficiencies and access to information for clinicians means they can now treat more patients in their own communities rather than transporting them to metropolitan facilities for assessment and diagnosis.

With the BreastScreen Queensland Digital, Wave One and Intensive Care Unit Clinical Information System (phase one) projects all successfully completed in the past year, the first phase of Queensland's eHealth journey has seen major improvements in a number of areas:

- critical specialist systems integrated in areas of clinical need—cardiology, anaesthesiology, radiology, digital breast screening, endoscopy, intensive care, patient discharge and referral, oral and mental health
- statewide patient information viewing solution (Viewer/Clinical Data Repository) which shares key patient information with authorised clinicians on one screen in any place resulting in:
  - a reduction in the time spent on managing paper-based medical records
  - improvements in the way information is shared between facilities enabling a more seamless transfer of patient information between healthcare professionals
- emergency department information system to record patient treatment details
- teleradiology network which provides specialised digital radiology services to Queenslanders, no matter where they are located
- operating room management system to assist with effective theatre management
- automated anaesthetic record keeping solution to capture vital signs data for patients in operating theatres

- endoscopy information solution that reports diagnostic treatment and follow-up information
- statewide patient discharge summary system that delivers discharge information to GPs to support the continuity of care
- digital breast screening solution that has resulted in a reduction of technical recall rates due to the replacement of chemical film processing
- schools oral health information system for Queensland's state, independent and catholic schools
- mental health application that provides detailed patient mental health information to authorised clinicians and administration staff.

Delivery of these specialist solutions has assisted the department and HHSs in preparing for the next major step in the state's eHealth journey—implementation of an ieMR. An ieMR will leverage existing eHealth and infrastructure investment and capability, and will see Queensland's public hospitals take their most significant step away from paper-based medical records. An ieMR will allow authorised clinicians to create and access a patient's electronic medical record, reducing the amount of time spent on administrative paperwork, and allowing for more time with patients.

Following a major showcase event in February 2013, where more than 800 clinicians and supporting staff viewed and endorsed the functionality of the first release of the application, the ieMR solution is now in the testing stage with the first hospital scheduled to receive 'release one' in late 2013. Future releases will build on the foundations delivered in release one and will eventually see the ieMR available in a total of nine public hospitals across Queensland.

These ICT solutions are all contributing to ensuring Queensland patients are receiving the best possible care and information, regardless of their location.

Telehealth solutions

Queensland has one of the largest managed Telehealth networks in Australia with 1579 videoconferencing systems deployed in more than 200 hospitals and community facilities supporting more than 40 clinical specialities and sub-specialties across the state. Implementation of Telehealth service delivery models has enabled health system redesign and transformed how some clinical services are delivered and accessed by rural and remote communities in Queensland.

As outlined in the *Blueprint for better healthcare in Queensland*, Telehealth services will provide unprecedented access to a new generation of safe and sustainable healthcare services for residents in small, rural or remote communities. To improve health equity and support for rural and remote Queenslanders, the department is working towards the implementation of a new rural Telehealth service across six pilot sites in 2013–14.

Telehealth is used to deliver:

- services to admitted and non-admitted patients
- statewide medical emergency management advice
- aeromedical retrieval coordination across the state.

In 2012–13, Telehealth delivered:

- 11,699 mental health consumer provisions of service
- 15,748 non-admitted patient occasions of service
- 147 trauma management and aeromedical retrieval services
- 623 admitted patient Telehealth events.

The most frequent non-admitted specialist services delivered using Telehealth were diabetes, oncology, gastroenterology, mental health, paediatrics, general medicine, orthopaedics, pre-admission services and cardiology. The most frequent admitted patient Telehealth services were predominantly to deliver remote intensive care management advice and support.

A number of initiatives to improve access to and the quality of specialist services have been implemented in 2012–13, including the:

- Heart Health Project to improve cardiac rehabilitation services
- Telestroke initiative which made Telehealth laptops or cameras available to 15 stroke specialists around Queensland.

Teleradiology

In 2012–13, the number of medical imaging facilities with access to radiology reporting increased to 100 per cent, an increase from 59 per cent in 2008–09. A total of 103 facilities now access specialist radiology reporting services via teleradiology enabling remote specialist interpretation of X-ray images taken at remote locations.

Aboriginal and Torres Strait Islander Public Health Program

The Aboriginal and Torres Strait Islander Public Health Program seeks to reduce the incidence and severity of acute and chronic diseases in Aboriginal and Torres Strait Island communities.

A key success in 2012–13 was the availability of employment opportunities for 34 local workers across the 16 Aboriginal and Torres Strait Islander local governments.

Patient Travel Subsidy Scheme

From 1 January 2013, the commercial accommodation and vehicle mileage subsidies were doubled, making it more affordable for Queenslanders in regional areas to travel to access specialist medical services.

The changes were supported by a press and radio advertising campaign which informed Queenslanders about the increased financial assistance available for patients and carers who need to travel more than 50 kilometres from their local health facility.

Right person, right information

Connecting to the national Healthcare Identifiers Service

With health information often distributed nationally to a wide range of locations—including general practices, hospitals, imaging centres, specialists, and allied health practices—ensuring the right information is available at the point-of-care has presented challenges across the Australian health system.

In January 2013, Queensland Health took a step toward resolving this by working with the National E-Health Transition Authority (NEHTA) to connect to the National Healthcare Identifiers Service (NHIS) and add Individual Healthcare Identifiers (IHI) to patient discharge summaries. NHIS uniquely identifies healthcare providers and patients.

The ability to assign IHI to Queensland clinical documents, such as discharge summaries, is an important step in being able to send these documents to the national Personally Controlled Electronic Health Record (PCEHR) in the future. PCEHR, launched in June 2012, is an electronic record for a patient that contains a summary of their health information from a range of distributed locations. The use of healthcare identifiers is essential in ensuring that the PCEHR has the right information associated with the right patient.

Health services focussed on community needs

Working collaboratively with other service providers and community partners in the development of strategic policy and planning of health services is a critical factor in sustaining health services that meet the needs of the community.

In 2012–13, the department, in collaboration with health service partners, developed the following:

- *Guide to health service planning*
- Health service planning health service directive
- Integrated planning
- *Diabetes services statewide health service strategy 2013*
- *Adult intensive care services statewide health service strategy 2013*
- *Guidelines for rural outreach needs-based planning*
- *Remote health project guidelines for planning health services in remote communities*
- Health service needs assessment for 2013–14 service agreements.

SPP also commenced the Enhanced Maternal and Child Health Service Initiative.

Forensic and Scientific Services

The department's Forensic and Scientific Services (FSS) supports the coroner and police, and protects public health.

In 2012–13, FSS:

- expanded testing of new synthetic, designer drugs and performance enhancing substances and increased testing of clandestine drug laboratories to meet increased demand
- expanded and enhanced the use of molecular techniques to assist in the investigation of outbreaks of foodborne-related illness. These techniques identify clusters faster to enable a faster public health response
- responded to the imminent threat of H7N9 avian flu in China by developing Australia's first assay to detect and confirm the identity of this virus
- commissioned a new world-class facility to measure the stable, isotopic composition of samples enabling the detection of counterfeit foodstuffs by accurately distinguishing between samples that previously would have been deemed identical
- cooperated with the Office of the State Coroner to increase the proportion of non-suspicious deaths receiving a death certificate to 60 per cent, significantly reducing unnecessary autopsies and distress for families
- was instrumental in creating a single, centralised location in South East Queensland for the care of victims of sexual assault to avoid patients attending multiple locations to receive their care
- was the first to successfully implement the new national standard in DNA testing and the only Australian unit to meet the national target for introducing this new methodology.

National partnership agreements

National Partnership Agreement on Improving Public Hospital Services

The *National Partnership Agreement on Improving Public Hospital Services* is designed to provide:

- a flexible funding pool to support and drive improvements and public patient access to emergency departments, elective surgery and subacute care services by improving efficiency and capacity in public hospitals
- capital funding to enhance emergency department capacity and patient management in public hospitals to help achieve the NEAT
- capital funding to boost elective surgery capacity in public hospitals to help achieve the NEST
- facilitation funding to prepare for implementation of the NEST
- capital and recurrent funding for the delivery and operation of more than 1300 new subacute care beds nationally, in hospital and community settings.

Some of the key projects related to this agreement are:

Emergency departments—MacroNEAT Project

The MacroNEAT project aimed to improve the performance of 15 emergency departments through the implementation of the department's clinical services redesign methodology. The project ended on 30 June 2013 and improved the flow of patients out of admitted patient beds to free up capacity for patients admitted from the emergency department, as well as streamlining emergency department processes.

Elective surgery—Surgery Connect Program

ThSurgery Connect Program aims to provide alternative treatment options for 'long wait' elective surgery patients, either in the private sector or by making use of available capacity in the public sector outside of normal operating hours.

Elective surgery—Scalpel Program

The Scalpel Program aims to improve elective surgery performance in nine facilities by examining and improving processes across the entire patient journey through the implementation of the department's clinical services redesign methodology.

Elective surgery surgical equipment

This project facilitates the purchase of additional surgical equipment and capital developments to improve surgical throughput in public hospitals. Additional equipment will contribute to increasing internal capacity, improving operating room efficiency and contribute to reductions in waiting times for elective surgery.

Elective surgery and emergency department infrastructure

Table 3: Elective surgery and emergency department infrastructure projects completed or initiated under the National Partnership Agreement on Improving Public Hospital Services

Site	Construction completed
Caboolture emergency department	Construction completed—February 2013
Logan: • expanded emergency department services • day surgery and 23-hour ward.	 • Forecast practical completion—June 2014 • Forecast practical completion—February 2015
Redcliffe: • six paediatric short stay beds • emergency department refurbishment • paediatric outpatient rooms.	 • Construction completed—March 2012 • Construction completed—November 2012 • Forecast construction completion—January 2014
Queen Elizabeth II—emergency department	Forecast construction completion—September 2013
Queen Elizabeth II—endoscopy unit	Forecast construction completion—August 2013

Schedule E—Sub-acute	
Cairns—16 subacute rehab beds	Forecast construction completion—April 2014
Logan—24 rehabilitation beds	Forecast construction completion—August 2014
Maryborough—22 additional beds and rehabilitation space	Construction completed—December 2012
Queen Elizabeth II—new reception and support services Stage 2	Forecast construction completion—December 2013
Rockhampton—16 subacute rehabilitation beds	Forecast construction completion—February 2014
Townsville—subacute 15 bed rehabilitation/sub-acute facility. (Delivered in conjunction with Taking the Pressure off Public Hospitals—Townsville Parklands 30 bed subacute facility)	Forecast construction completion—July 2014

National Partnership Agreement on Financial Assistance for Long Stay Older People

The *National Partnership Agreement for Financial Assistance for Long Stay Older People* provides funding to Queensland Health in recognition of the costs incurred in providing care for people in public hospitals who are not able to access nursing home care. In 2012–13, Queensland received $16.8 million under this agreement.

The agreement also provided funding to engage an independent consultant to liaise with a reference committee of Australian and State Government representatives to coordinate national censuses of long stay older people in public hospitals covering 2011–12 and 2012–13. The consultant developed the methodology and an instrument for data collection, coordinated censuses of long stay older people across the states and territories and reported on the results of each census to the Australian Government. In March 2013, a further census of long stay older people was conducted in Queensland as part of the national census as required under this agreement.

Memorandum of Understanding in relation to Developing an Effective National E-Health Capability (replacing the National Partnership Agreement on E-Health)

In December 2012, the Minister for Health signed the *Memorandum of Understanding in relation to Developing an Effective National E-Health Capability* to replace the expired *National Partnership Agreement on E-Health*. The memorandum of understanding is a directional framework that seeks agreement from all jurisdictions to work collaboratively on national eHealth and formalises a commitment to fund the NEHTA until June 2014. The memorandum of understanding does not commit parties to any additional funding, but seeks to guide future investment towards the cohesive national strategy.

Specifications and standards

Queensland received funding from NEHTA from March 2011 to January 2013 as part of the Wave One eHealth Site Support Project to implement standards, such as Clinical Document Architecture for eReferrals and eDischarge summaries and undertake a planning study for secure messaging standards.

Authentication for service providers

As part of the PCEHR Integration project, the department will be using National Authentication Service for Health organisational certificates to view patient electronic health records and send eDischarge summaries to the PCEHR.

Individual Healthcare Identifiers

Queensland received funding from NEHTA to implement IHI as part of the Wave One eHealth Site Support Project. Currently, the use of IHI is limited to eDischarge summaries. The department is currently applying for Healthcare Provider Identifiers–Organisation for HHSs to enable integration into the PCEHR.

Patient controlled eHealth Record System

The department has an agreement with NEHTA for the initial connection to PCEHR via the PCEHR Integration Project. This will allow discharge summaries to be sent to PCEHR and will permit clinicians to view a consumer's electronic health record via the department's The Viewer application.

National Partnership Agreement on Health Services

The *National Partnership Agreement on Health Services* has been developed to improve the health and wellbeing of Australians through the delivery of high-quality health services, such as:

- Human Quarantine Services–provides funding for routine human quarantine services provided by the Australian Quarantine and Inspection Service to protect the Australian public from serious communicable diseases, particularly exotic, new and re-emerging infectious diseases.
- National Perinatal Depression Initiative–provided funding to improve prevention and early detection of antenatal and postnatal depression and provide better support and treatment for expectant and new mothers experiencing depression. This initiative expired on 30 June 2013.
- Implementation plan for *Aedes albopictus* Prevention and Control in the Torres Strait Program–provides funding to assist in the control of *Aedes albopictus* mosquito in the Torres Strait. Where *Aedes albopictus* is detected, the program provides for the attempted elimination of the mosquito from the area. By doing so, it assists with preventing the spread of mosquitoes and dengue fever to neighbouring communities. The program also encourages communities to actively control container breeding mosquitoes in and around their homes.

- Employment of a Torres Strait communications officer—provides funding for the Torres Strait communications officer position to:
  - improve communication between clinicians and health workers in Queensland and Papua New Guinea
  - maintain liaison with key stakeholders of the Torres Strait Cross Border Health Issues Committee
  - contribute to the implementation of the joint Health Issues Committee measures—particularly in the Western Province of Papua New Guinea—and improved surveillance of communicable diseases in the Torres Strait Treaty Zone.
- Vaccine Preventable Disease Surveillance Program—provided funding for ongoing surveillance reporting of nationally notifiable vaccine preventable diseases and allows national monitoring, analysis and timely reporting of data. It involved the ongoing surveillance reporting of nationally notifiable vaccine preventable diseases, as outlined in the National Health Security Agreement's National Notifiable Disease List and covered by the National Immunisation Program. The program expired on 30 June 2013.

National Partnership Agreement Supporting National Mental Health Reform

The *National Partnership Agreement Supporting National Mental Health Reform* was signed by the Council of Australian Governments on 13 April 2012. The agreement aims to provide improved health, social, economic and housing outcomes for people with severe and persistent mental illness by addressing service gaps and preventing ongoing cycling through emergency departments and inpatient mental health facilities.

The implementation plan for Queensland's Supporting Recovery—Coordinated Accommodation and Support Project was signed on 21 June 2012 by the Queensland Minister for Health and the Commonwealth Minister for Health and Ageing, Minister for Social Inclusion and Minister Assisting the Prime Minister on Mental Health Reform. Under the implementation plan, the Australian Government is providing $51.5 million dollars towards the project over the four years 2012–13 to 2015–16, while the Queensland Government is contributing $5.6 million towards capital works associated with the project.

Through the Supporting Recovery—Coordinated Accommodation and Support Project, the department will establish the following services, to be delivered through the mental health community sector, with accommodation, where appropriate, provided by the Department of Housing and Public Works:

- A total of at least 61 places in long-term social housing and support services by June 2016. This component of the project provides community-based support and accommodation for people with severe and persistent mental illness and ongoing support needs who are exiting extended or acute care mental health facilities. In 2012–13, 19 places were allocated in the Metro North (four), Metro South (seven), Darling Downs (two), Sunshine Coast (one), Wide Bay (two), and Cairns and Hinterland (three) HHSs.

- A new transitional recovery service in Mackay providing eight short to medium-term residential places and five outreach places to enable people with severe mental illness to make sustainable transitions from mental health acute care facilities to independent living in the community. Procurement of this service commenced in 2012–13 and service delivery is expected to commence in late 2013.
- Brokered-lease social housing places through the Community Rent Scheme administered by the Department of Housing and Public Works, to help overcome transitional recovery service throughput problems caused by shortages of affordable local housing for people ready to move to independent living in the community. In 2012–13, four places were funded to assist the transitional recovery service in Logan (Metro South HHS), and two to assist the Caboolture transitional recovery service (Metro North HHS).
- Personalised support services for people who live in social housing and whose tenancy is at risk due to mental ill health. Procurement of five new community-based mental health support services, to support people in the Gold Coast, West Moreton, Darling Downs, Central Queensland, Townsville, and Cairns and Hinterland HHS areas, commenced in 2012–13. These services will support at least 44 people at any one time, and are expected to commence by October 2013.

National Partnership Agreement on Preventive Health

The *National Partnership Agreement on Preventive Health* commenced in 2009–10 and provides funding to address preventable chronic diseases. The agreement focuses on the rising prevalence of lifestyle-related chronic disease by promoting healthy behaviours and developing implementation plans for social marketing, healthy children and healthy workers.

Healthy children

The Healthy Children Program provides funding to reduce the risk of chronic disease by reducing the prevalence of obesity and overweight children. The program aims to improve nutrition, and increase levels of physical activity in children and young people through the implementation of a range of initiatives across a variety of settings in Queensland.

The program includes:

- the provision of physical and social environments that support healthy lifestyles, including safe places and spaces for physical activity, both incidental and planned
- the provision of consistent evidence-based information to parents, carers and children, consistent with the *National Health and Medical Research Council's Dietary Guidelines* and *National Physical Activity Guidelines*.

Healthy workers

Workplaces for Wellness is an initiative to support Queensland workers in making positive lifestyle behaviour changes to reduce chronic disease risk factors and improve their health.

The focus is to encourage healthy lifestyle behaviours:

- healthy eating
- healthy weight
- physical activity
- quitting smoking
- social and emotional wellness
- reduce harmful alcohol consumption.

In a supportive workplace, people are more likely to make healthier choices. To support businesses, a Workplaces for Wellness website will be launched in August 2013 (www.workplacesforwellness.qld.gov.au).

The website will provide guidance and resources to implement workplace wellness programs for workers. Workplaces can also apply for recognition to demonstrate ongoing commitment to employee health and wellbeing.

Enabling infrastructure

The Enabling Infrastructure Program provides funding to support effective implementation and evaluation of the agreement through the establishment of soft infrastructure including:

- expansion of the National Nutrition and Physical Activity Survey to include individuals of all ages, Indigenous Australians and bio-medical measures
- a research fund which aims to build an evidence base for future preventive health activities, increase the capacity for future research, and create a focus on translational research
- a workforce audit and strategy to identify any gaps and options to resolve them
- an eating disorders collaboration that brings together a range of experts to progress a national approach to prevention, early intervention and best practice treatment strategies for eating disorders
- a national preventive health agency.

The program is staffed with population health experts who are responsible for:

- providing evidence-based policy advice to the Minister for Health and other ministers with an interest in preventive health
- administering social marketing programs and national preventive health programs
- overseeing national surveillance and research activities
- undertaking stakeholder consultation.

Social marketing

The social marketing initiative provides funding to engage and support Queenslanders to make positive and sustainable lifestyle changes to improve their health. The initiative expands the capacity of existing programs and activities to deliver and extend the reach of the national *Swap It, Don't Stop It* campaign messages by non-government partners, including Diabetes Queensland, the Queensland Aboriginal and Torres Strait Islander Health Council, and the Ethnic Communities Council of Queensland.

This initiative focuses on people at a community level, including:

- people living in rural and remote areas
- Aboriginal and Torres Strait Islander people
- people living in areas of socio-economic disadvantage
- people at risk of chronic disease.

National Partnership Agreement on Essential Vaccines

In August 2009, the Council of Australian Governments established the *National Partnership Agreement on Essential Vaccines* to provide funding to improve health and wellbeing of Australians through the cost-effective delivery of immunisation programs under the National Immunisation Program. The agreement is intended to:

- minimise the incidence of major vaccine preventable diseases in Australia
- maintain and, where possible, increase immunisation coverage rates for vulnerable groups and, in particular, minimise disparities between Indigenous and non-Indigenous Australians
- enable access for all eligible Australians to high quality and free essential vaccines
- increase community understanding and support for the public health benefits of immunisation.

In 2012–13:

- more than 1.3 million vaccines funded under the National Partnership Agreement on Essential Vaccines for the National Immunisation Program were distributed across Queensland
- Queensland achieved three of the four performance benchmarks and is eligible for incentive payments.

National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes

The *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* aims to achieve the Council of Australian Government's target to close the gap in life expectancy between Aboriginal and Torres Strait Islanders and non-Indigenous Australians within a generation.

The Queensland implementation plan under this agreement includes initiatives funded by the department across five nationally agreed priority areas:

1. Tackling smoking—smoking is a leading cause of chronic disease.
2. Primary healthcare services that can deliver—early intervention and treatment can help extend the life of Aboriginal and Torres Strait Islander people with chronic disease.
3. Fixing the gaps and improving the patient journey—providing new services to support the treatment and the journey of patients within our healthcare system.
4. Healthy transition to adulthood—to address young people's behaviours during high-risk periods in their life.
5. Making Indigenous health everyone's business—supporting vulnerable individuals and groups.

Key achievements include:

- establishment of a Southern Queensland Centre of Excellence for Indigenous Primary Health Care in Inala, Brisbane, to provide best practice health services, training of health professionals and service delivery research
- implementation of an Indigenous Cardiac Outreach Program to service 28 rural and remote sites across northern Queensland
- implementation of expanded respiratory services for rural and remote communities and a statewide spirometry training program for Indigenous health workers
- establishment of 17 new multidisciplinary care teams in Aboriginal and Torres Strait Islander Community Controlled Health Services in high demand locations across Queensland
- establishment of the Regional Indigenous Youth Alcohol and Other Drugs Treatment Network across seven locations: Brisbane, Gold Coast, Cherbourg, Rockhampton, Mt Isa, Townsville and Cairns. The network receives clinical and program support from Dovetail Alcohol and Other Drugs Youth Support Program and provides an outreach and treatment service for Aboriginal and Torres Strait Islander young people in those locations who are marginalised and 'at risk'.

National Partnership Agreement on Indigenous Early Childhood Development

The *National Partnership Agreement on Indigenous Early Childhood Development* aims to achieve the Council of Australian Government's target to halve the Indigenous child mortality gap for Indigenous children under five years of age by 2018. To achieve this commitment, the department has established multiple initiatives to address key risk factors, such as smoking and substance abuse and to address service gaps by improving antenatal care, teenage sexual and reproductive health, and pre-pregnancy care services.

Key achievements include:

- establishment of eight maternal and infant care teams in regional, rural and remote locations to increase access to antenatal services, especially in the first trimester, resulting in improved birth weights and improved peri-natal outcomes
- recruitment of sexual health workers in Queensland schools and custodial and community settings to provide teenage sexual and reproductive health promotion, testing and treatment services
- development and launch of the *For Me and Bub*, a smoking and alcohol prevention program, to assist clinical staff with their work in Indigenous communities.

Project Agreement for Torres Strait Health Protection—Saibai Health Clinic

The *Project Agreement for Torres Strait Health Protection—Saibai Health Clinic* provides funding to support additional staff for the management of communicable diseases, and the development and implementation of a culturally-appropriate sexual health education campaign for the Torres Strait Islands at the healthcare clinic on Saibai Island.

Services provided at the Saibai Island Clinic include:

- women's health screening, including pap smear screening
- HIV management
- contact tracing for sexually transmissible infections, blood-borne viruses, HIV and AIDS counselling and follow-up
- family planning advice
- condom distribution
- diagnosis, treatment and prevention measures to ensure the effective management of acute rheumatic fever (ARF) and rheumatic heart disease (RHD)
- health promotion and prevention activities for communicable diseases
- promotion of good nutrition to people with nutrition-related conditions and people with high rates of ill health from type 2 diabetes, cardiovascular disease, renal disease and dental health problems
- tuberculosis services in consultation with the Queensland Tuberculosis Control Centre and Cairns Tuberculosis Control Clinic
- appropriate advice on prevention, vaccination, testing and management of a range of vector-borne and tropical diseases
- surveillance and reporting of communicable diseases in line with clinical guidelines.

Project Agreement for Improving Ear Health Services for Indigenous Australian Children

The *Project Agreement for Improving Ear Health Services for Indigenous Australian Children* provided funding to support the delivery of additional surgical services, clinical leadership

programs, and ear, nose and throat services to Queenslanders. This funding formed part of the broader Australian Government Closing the Gap–Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes Initiative.

This funding supported the better diagnosis, treatment and management of ear disease in Indigenous children by increasing the number of:

- primary healthcare services receiving clinical leadership support to enhance ear health management of Indigenous children
- ear health outreach services provided by specialist workers targeting Indigenous children
- coordinated ear surgical procedures for Indigenous children
- Indigenous children receiving ear, nose and throat specialist services (non-surgical).

This agreement expired on 30 June 2013.

Project Agreement on Improving Trachoma Control Services for Indigenous Australians

The *Project Agreement on Improving Trachoma Control Services for Indigenous Australians* provided funding to support the delivery of additional trachoma control services and additional activities to improve the mapping, identification, screening and treatment of trachoma for Indigenous Australians.

This funding formed part of the broader Australian Government's Closing the Gap–Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes Initiative through:

- conducting one-off trachoma screening in selected potential 'at risk communities' in order to map the prevalence of trachoma
- undertaking trachoma treatment/screening of Aboriginal and Torres Strait Islander children aged 5–9 years in the communities of Aurukun, Doomadgee, Camooweal, Dajarra and Moa Island. If trachoma was found, screening was conducted on Thursday Island.

This agreement expired on 30 June 2013.

Project Agreement for the Rheumatic Fever Strategy

The *Project Agreement for the Rheumatic Fever Strategy* provides funding to support the delivery of the *Rheumatic Fever Strategy* to improve the detection, monitoring and management of ARF and RHD in Aboriginal and Torres Strait Islander communities.

The strategy includes a coordinated disease register and control programs through:

- implementation and expansion/maintenance of a dedicated statewide patient register and recall system for RHD and ARF
- improved clinical care, including improved delivery of, and adherence to, secondary prophylaxis antibiotics

- provision of education and training for healthcare providers, individuals, families and communities
- collection and provision of data for national monitoring and reporting of ARF and RHD and measuring program effectiveness in the detection and management of ARF and RHD.

This agreement began on 1 January 2012 and will expire on 30 June 2016.

Project Agreement for the National Bowel Cancer Screening Program—Participant Follow-up Function

The *Project Agreement for the National Bowel Cancer Screening Program—Participant Follow-up Function* provides funding to support the delivery of the National Bowel Cancer Screening Program (NBCSP)—Participant Follow-up Function (PFUF). In accordance with the NBCSP screening pathway, a PFUF officer contacts participants' who have received a positive faecal occult blood test result, but are not recorded on the NBCSP register as having attended a consultation with a relevant health professional. The PFUF officer provides encouragement, support and information about local health services to the participant, where appropriate. When the participant has taken the relevant action and is progressing along the NBCSP screening pathway, the PFUF officer has no further contact with the participant.

In 2012–13, more than 3000 NBCSP participants with a positive faecal occult blood test result in Queensland required follow-up by a participant follow-up officer.

Project Agreement for the OzFoodNet Program

The *Project Agreement for the OzFoodNet Program* provides funding to support the delivery of OzFoodNet, a national system of enhanced surveillance that provides comprehensive information on food-borne disease and the capacity to rapidly identify and respond to outbreaks of food-borne disease.

OzFoodNet sites are overseen by an epidemiologist, or other suitably qualified person, that undertakes active surveillance and investigation of food-borne or suspected food-borne diseases, and contributes to national data on food-borne disease outbreaks.

This agreement began on 1 January 2012 and will expire on 30 June 2016.

2. Empowering the community and our health workforce

Objectives

- The control of local healthcare decisions belongs with local HHBs and healthcare professionals.
- Improved collaboration with non-government providers will maximise the value of health investment.
- Transparency promotes public confidence.
- Workforce flexibility supports local healthcare decision-making, improved patient access and quality service delivery.

Key performance indicators

- Percentage of complaints about high-risk public health issues acknowledged within five days.
- Compliance with the National Health Performance Authority's data reporting requirements.
- Change in the number of HHSs implementing new and expanded clinical roles.
- Number of public patients receiving treatment in private hospitals funded through the public healthcare sector.

Local healthcare decisions made locally

As previously outlined, the *Hospital and Health Boards Act 2011* has enabled HHBs and local people to be involved in making local decisions in the best interests of the community.

Significant amendments to the Act made since March 2012 allow HHSs, once they have demonstrated appropriate capability and capacity, to take on additional responsibilities to become:

- the legal owner of all land and building assets in their service area
- the prescribed employer of staff working in and for the service.

Transfer of prescribed employer function

Planning for the transfer of the employer function to each HHS began during 2012–13. Before an HHS becomes a prescribed employer it will need to demonstrate the capacity and capability to be an employer. The Minister for Health will review and approve when an HHS is ready to become a prescribed employer. The move will allow HHSs to hold all authorities and accountabilities for HR functions and any matters requiring escalation will be dealt with by the HHB.

Employment terms and conditions, including pay, superannuation and fringe benefits tax, will be unchanged. The director-general will remain responsible for setting terms and

conditions of employment, including remuneration and classification structures, and for negotiating enterprise agreements.

In preparation, in 2012–13 the director-general progressively increased the number of HR delegations to HHSs. Each HHS will remain accountable to the director-general for the administration of these HR delegations. This will be supported by a HR assurance framework to ensure there is a rigorous, evidence-based process for the transition and continued performance of this important responsibility.

Transfer of ownership of land and buildings

During 2012–13, the Land and Buildings Transfer Project (LBTP) was established to work in collaboration with HHSs to progressively transfer the ownership of $5 billion worth of land and building assets. The transfer will mean each HHS has complete responsibility for the management of their land and buildings.

All HHSs will undergo a readiness assessment process to assess their capability and capacity to manage their own land and buildings. An asset management capability assessment framework is being developed to provide the basis for a rigorous, evidence-based process for assessment prior to a transition of asset ownership, roles and responsibilities and asset management functions to HHSs.

The LBTP has started working in partnership with HHSs to collaboratively assess their capability to sustainably manage their land and building assets, and to facilitate the timely transfer of legal ownership.

Collaboration with non-government providers to maximise value

Procurement of services

Where appropriate, the department is undertaking procurement collaborations with non-government and private sector providers to ensure health resources are used effectively, efficiently and economically for targeted population group and priority areas.

The department has developed clear definitions of its funding arrangements with non-government providers in terms of grants or procurement contracts. This sets appropriate expectations and guides contract negotiation for the services delivered.

New arrangements for community grants have been established which improve value-for-money and align outcomes with the department's strategic direction. Improved financial accountability and reporting arrangements which clearly reflect the type of arrangement, its associated risk, and the services and outcomes being delivered are being progressively implemented for all funding arrangements with non-government providers.

The challenges facing the department include the improvement and streamlining of contract management arrangements to facilitate the early identification and implementation of remedial action when expected contractual requirements are not being met.

Transparency in the Queensland public healthcare sector

The establishment of HHSs as independent statutory bodies provides for local accountability for performance, and promotes increased transparency of the Queensland public healthcare sector. An example of increased transparency is the publishing of the service agreements between each HHS and the department on the Queensland State Budget website (www.budget.qld.gov.au). A report on each HHS's performance against targets and measures within the service agreement are also publicly available on the website. In addition, the department actively supports the publication of the National Health Performance Authority reports. The service delivery statement includes a range of service standards relating to overall Queensland Health and individual HHS performance.

Each HHS is required to have a consumer and community engagement strategy which enables active participation in shaping health policy, planning, service provision and evaluation. The requirement for the strategy recognises the contribution local communities make to an increased sense of ownership and confidence in the public healthcare sector. HHBs are required to make a summary of the key issues discussed and decisions made in each board meeting publicly available to the community, consumers, health professionals working in the service and primary healthcare organisations.

Dental

To provide the community with greater detail about public dental waiting lists, the number of people on the waiting list for every public dental clinic, how long people have been waiting, and the number of patients who recently commenced dental care are now published on the Queensland Health website (www.health.qld.gov.au).

Queensland Mental Health Commission

The Queensland Mental Health Commission was established as an independent statutory body on 1 July 2013 under the *Queensland Mental Health Commission Act 2013*.

The commission will partner with government, non-government and community stakeholders to drive reform to improve mental health and address the impact of substance abuse in Queensland communities through a range of functions, including:

- monitoring and reporting on service planning, investment and delivery
- developing a whole-of-government strategic plan
- monitoring and reporting on emerging mental health and substance misuse issues and trends
- promoting and facilitating opportunities for public consultation and engagement.

The Act also establishes the Queensland Mental Health and Drug Advisory Council which will influence the work of the commission by making recommendations and providing advice regarding its functions.

Hospital performance statistics online

The Hospital Performance site on the Queensland Health website (www.health.qld.gov.au/performance) provides information on the activity and performance of public hospitals. It is updated regularly and includes current data on the performance of emergency departments, elective surgery waiting lists, hospital inpatients, the health workforce, radiation treatment, specialist outpatients and oral health services.

From October 2012, information on specialist outpatient waiting times by clinic and by category has been published quarterly to provide an indication to patients and GPs of the waiting time to see a specialist. In addition, graphs showing historical trends were added to show the activity and performance for elective surgery and emergency departments for the previous 15 months. In November 2012, information on the waiting times for oral health services for each dental clinic was added.

The *Blueprint for better healthcare in Queensland* committed the department to expanding the number of hospitals included on the Hospital Performance site by 24 by the end of 2013. Work to meet this commitment is on track, with five hospitals added in January 2013 and a further six added in June 2013.

Publication of quarterly performance reports

In May 2013, the first quarterly performance reports were published in local newspapers to allow communities to compare performance of HHSs across the state. The press advertisements were supported by a television commercial to raise awareness regarding the publication of the reports. The reports compare the performance of HHSs against six common statewide targets:

1. Shorter stays in emergency departments.
2. Shorter waits for elective surgery.
3. Shorter waits for specialist outpatient clinics.
4. Increased support for families with newborns.
5. Fewer hospital acquired infections.
6. Value-for-money.

Flexible workforce and local decisions improving patient care

Ongoing support for implementation of models of care projects

The Allied Health Professions' Office implemented the Health Practitioner Models of Care Project—a large-scale program of projects to examine new models of care. It comprised 59 demonstration projects over four years and through two rounds of funding. Projects covered 14 allied health disciplines in a diverse range of activities and geographic locations.

Outcomes to date have demonstrated that allied health professionals working to full scope and in expanded roles can decrease patient waiting time, minimise the number of steps in a patient's journey, improve access to services, and improve patient satisfaction and outcomes.

Further use of the allied health workforce has better enabled the professional workforce to work to their full abilities. The results have provided comprehensive data sets to guide future workforce reform.

Continued implementation of the Calderdale Framework to inform workforce redesign

The *Calderdale Framework* provides a formalised, risk-managed and structured framework to provide quality, efficient, responsive and clinically governed services. The Allied Health Professions' Office has facilitated training in the use of the framework and has supported the implementation of the framework across HHSs to inform workforce redesign initiatives.

Rural graduate initiatives

A key strategy in maintaining the capacity of health services in rural and remote communities is ensuring the sustainability of the nursing and midwifery workforce. Approximately one-third of registered nurses delivering frontline services in rural and remote areas are 55 years and older and are likely to retire within the next 5–10 years. To offset this expected retirement peak, Queensland Health has prioritised employing and skilling registered nurse graduates into rural and remote areas to ensure ongoing quality and accessible care for these communities. Employment of registered nurse graduates was also expected to reduce agency nurse costs across participating HHSs.

During 2012–13, the department provided $1.83 million to support registered nurse employment in rural and remote communities. The funding allowed for HHSs to support the upskilling of 101 registered nurse graduates in rural and remote positions:

- 25 in the South West HHS
- 18 in the Central West HHS
- 17 in the North West HHS
- 15 in the Mackay HHS
- 13 in the Central Queensland HHS
- 8 in Townsville HHS
- 4 in the Torres Strait-Northern Peninsula HHS
- 1 in Cairns and Hinterland HHS.

Comparisons of agency nurse costs between 2011–12 and 2012–13 indicated a reduction of $8.6 million across participating HHSs.

The Office of the Principal Medical Officer supports networked vocational training pathways for intensive care, adult medicine, paediatrics and child health, geriatric medicine, and palliative medicine. This support has improved both the quality of, and capacity for, training positions across Queensland, particularly in regional and rural Queensland.

National partnership agreements

National Partnership Agreement on Treating More Public Dental Patients

The *National Partnership Agreement on Treating More Public Dental Patients* aims to alleviate pressure on public dental waiting lists, with a particular focus on Indigenous patients, patients at a high risk of major oral health problems and patients from rural areas. Each HHS has determined appropriate strategies to increase services within their local context, including partnerships with private dental providers, as well as recruitment of additional staff and the provision of overtime for current staff.

The agreement commenced on 27 February 2013 and has seen a reduction in the number of people on the waiting list for check-ups for longer than the recommended waiting time of two years, from 62,630 patients to 38,927—a reduction of more than 37 per cent.

Queensland did not meet the performance benchmarks for 30 June 2013. However, HHS oral health services are progressing well towards the next major milestone at 31 December 2013.

National Partnership Agreement on Hospital and Health Workforce Reform

The *National Partnership Agreement on Hospital and Health Workforce Reform* has been established to improve the efficiency and capacity of public hospitals through the implementation of reform.

Activity based funding

The agreement provided funding for the implementation of a nationally-consistent approach to ABF for services provided in public hospitals and which also reflected the community service obligations required for the maintenance of small and regional hospital services.

ABF:

- captured consistent and detailed information on hospital sector activity and accurately measures the cost of delivery
- created an explicit relationship between funds allocated and services provided
- strengthened management focus on outputs, outcomes and quality
- encouraged 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
- provided a mechanism to reward good practice and support quality initiatives.

This component of the agreement expired on 30 June 2013.

Subacute services

The agreement provided funding to improve health outcomes, functional capacity and quality-of-life of patients by increasing the volume and quality of the subacute care services in hospital and community settings. This funding expanded service provision levels by five per cent annually over the period 2009–10 to 2012–13, and better addressed regional availability.

Service levels and outcomes in subacute care were collected and reported publicly, and the capacity of the multidisciplinary subacute workforce was strengthened. The setting of targets at a regional level, aggregated by state and territory, enabled monitoring of access to subacute care services in a range of geographical areas, such as urban, rural and remote, to help inform service planning.

This component of the agreement expired on 30 June 2013.

Taking pressure off public hospitals

The agreement provided a one-off grant to improve the operations of emergency departments in recognition that they were treating an increased number of patients, including some patients who could otherwise be treated in a primary care setting. This resulted in added pressure on emergency departments and longer waiting times for patients—in turn adding avoidable costs to the public healthcare sector.

This injection of funds helped to relieve some of the immediate pressure on public hospital emergency departments while initiatives to improve the efficiency of public hospitals and the primary care reforms of the Australian Government were implemented. As part of this funding, several infrastructure projects were implemented to improve emergency departments and other facilities:

- Caboolture Hospital Emergency Department (construction completed February 2013)
- Redland Emergency Department (construction completed September 2012)
- The Prince Charles Hospital Emergency Department (construction completed November 2012)
- Ipswich Hospital Emergency Department (forecast for construction completion March 2014)
- Logan Hospital Emergency Department (forecast for construction completion June 2014)
- Logan Hospital Paediatric Services (forecast for construction completion August 2014)
- Queen Elizabeth II Hospital Emergency Department (forecast for construction completion September 2013)
- Townsville Parklands (forecast for construction completion July 2014)—delivered in conjunction with National Health Reform Agreement—National Partnership Agreement on Improving Public Hospital Services—Subacute Beds (Schedule E) at Townsville.

This component of the agreement expired on 30 June 2013.

Workforce enablers

The agreement provides funding to improve health workforce capacity, efficiency and productivity primarily through:

- improving clinical training
- facilitating more efficient use of the workforce
- improving international recruitment efforts
- effective and accurate planning of health workforce requirements.

These reforms are needed to address workforce shortages and to ensure Australia's health workforce can meet the increasing demand for services resulting from factors, such as an aging population, increasing levels of chronic disease and greater community expectation.

3. Providing Queenslanders with value in health services

Objectives

- Queenslanders expect that money provided for healthcare is spent wisely.
- Public, private and not-for-profit partnerships will improve the healthcare system to meet the needs and choices of Queenslanders.
- Replacing a system concerned with inputs with one that values outcomes.
- Contestability and new measures for financial accountability will improve performance.
- Cutting waste.

Key performance indicators

- Proportion of goods and services procured through standing offer agreements.
- Year-on-year growth in own source revenue.
- Variance between the average cost per weighted activity unit in Queensland and the benchmark set by the Independent Hospital Pricing Authority.
- Number of wards adopting the productive wards program.
- Compliance with the Independent Hospital Pricing Authority data reporting requirements.
- Percentage of clinical redesign projects delivered on time and within budget +/-2 per cent (target=100 per cent).

Healthcare funds spent wisely

Value in purchasing decisions

The department is responsible for purchasing public hospital services for the population of Queensland. This is primarily done through service agreements between the department and each HHS.

Each year, the department consults with HHSs regarding purchasing priorities and intentions for the coming financial year. Estimations of future health service activity requirements for the relevant population group underpins purchasing decisions made under the service agreements. During 2012–13, HHSs, HHB chairs and key stakeholders were actively engaged through three rounds of consultation and industry briefings to inform these purchasing decisions. Healthcare purchasing actively promotes models of care that are evidenced as patient-centred, safe, effective and good value-for-money. Examples include Hospital in the Home and the Acute Stroke Unit.

To drive ongoing value-for-money, HHS performance is measured against the national efficient price for hospital services. These performance measures are published quarterly—in line with the commitment made by the Queensland Government in the *Blueprint for better*

healthcare in Queensland. In addition, the *Hospital and Health Service Performance Framework* enables a high level of accountability over the healthcare budget through the monitoring of HHS performance to ensure that the services funded by the department are delivered at agreed price and quality.

In 2013–14, Queensland will adopt the key parameters of the National ABF Model for the funding of the largest 34 public hospitals. To reflect the unique characteristics of some Queensland facilities, the Queensland Healthcare Purchasing Model will include a number of modifications to the national model.

The *Blueprint for better healthcare in Queensland* sets a goal to improve the efficiency of the healthcare system to match the national average by mid-2014. It is expected this goal will be achieved, with most HHSs projected to have costs below the Queensland efficient price of $4660 in 2013–14. The Queensland efficient price is equivalent to the national efficient price, adjusted to reflect the differences in the Queensland ABF Model compared to the national model.

Value through health support services

The department has supported HHSs in achieving increased efficiency and savings.

In 2012–13, HSSA delivered savings through the following initiatives:

- Radiology Support helped HHSs to optimise radiology own source revenue to achieve around $60 million. This is a 33 per cent increase from the 2011–12. The number of facilities billing for eligible radiology services has also increased from 65 in 2011–12 to 71 in 2012–13.
- HHSs were supported through the transition to online claiming of reimbursements for all Pharmaceutical Benefits Scheme (PBS) medicines via PBS Online. Queensland Health claims approximately $170 million per year in reimbursement. Previously paid monthly, reimbursement is now paid on a weekly basis.
- Central Pharmacy's ongoing collaboration with Queensland Health Medicines Advisory Committee and Procurement Logistics and Health Technology has resulted in a saving of $5.885 million in pharmaceutical expenditure.
- A Clinical Imprest Management System was implemented at the Royal Brisbane and Women's Hospital. This system freed up clinical staff time and delivered cost savings through reduced product wastage and other efficiencies of around $1 million.
- The Patient Choice Program was implemented to improve own source revenue for pathology. Under the program, patients are advised of their option to have their pathology tests bulk-billed to Medicare. This program achieved savings of more than $8 million for HHSs.
- The time taken to undertake a whole-of-Queensland Health procurement process for goods or services was reduced by an average of 20 per cent through streamlining processes and increasing productivity.

- Savings delivered through more efficient procurement activities continued to increase, with $18 million saved in the purchasing of pharmaceuticals, clinical consumables and prostheses since February 2013.
- Operational savings of more than $900,000 per annum was achieved by consolidating purchase orders for clinical goods, reducing the number of product lines and merging freight deliveries across Queensland.

Partnering to improve the healthcare system

Queensland has a long and well established relationship with private partners and is exploring and expanding partnership arrangements in areas, such as aged care, home and community care services and hospital services.

Public dental services

Provision of funding under the National Partnership Agreement on Treating More Public Dental Patients has allowed HHS oral health services to expand partnerships with private dental providers. During the agreement period from 27 February to 30 June 2013, more than $8.4 million of private dental treatment was provided to eligible patients, including approximately 14,000 emergency courses of care, 7000 patients requiring general dental care and 620 patients requiring dentures. A further $1 million was claimed during the remainder of 2012–13.

Reducing the elective surgery waiting list using private providers

Commencing in 2012–13, the Queensland Government committed $55 million across 27 hospitals over four years to reduce pressure on elective surgery waiting lists in public hospitals by engaging private providers to treat long wait patients through the Surgery Connect Program.

In 2012–13, more than $30.4 million was spent via the Surgery Connect Program to reduce elective surgery waiting lists. Private providers carried out 3562 procedures at an estimated cost of $15.8 million. Additionally, $14.6 million was allocated to public hospitals to treat long wait elective surgery patients internally.

Hospital in the Home

Hospital in the Home is a service which allows patients to be treated in their own home for acute conditions which would have otherwise required treatment in a hospital environment. The program supports the rights of Queenslanders to choose their preferred way to meet their healthcare needs.

In 2012–13:

- program use increased, including the commencement of three new services
- a statewide advisory committee and working group was established
- processes were developed to streamline the journey of patients who are admitted to the program and then require transfer back to hospital

- a suite of clinical tools was developed to support patient safety, including patient selection criteria, governance requirements, Adult Deterioration Detection System for Hospital in the Home, home visiting screening tool and standard work instructions in relation to anticoagulation management and anaphylaxis.

Queensland Regional Training Networks

The department, in partnership with Health Workforce Australia, supports the activities of the Queensland Regional Training Networks (QRTN) and the Clinical Supervisor Support Program (CSSP) to enhance clinical placements and clinical supervision within the Queensland healthcare system.

The main aim of QRTN is to increase clinical education and clinical placement capacity within Queensland. In 2012–13, QRTN funded 22 local projects that provided innovative solutions to expand capacity of clinical training placements.

The main aim of CSSP is to enhance clinical supervision activity and capacity across all health professions. In 2012–13, 962 supervisors across the state took part in CSSP training initiatives.

Improving partnership arrangements

Throughout 2012–13, existing contractual arrangements with non-government providers were subjected to review by a grants review committee which assessed all arrangements for value and alignment with the department's strategic objectives. Any future arrangements entered into with non-government providers will be subject to the same level of scrutiny and regulated by funding guidelines which have been developed to improve the value realised from both grants and procurement of services. The future challenges lie in accurately measuring and subsequently demonstrating the value of these types of funding arrangements to the Queensland public healthcare sector.

The introduction of the department's Contestability Branch will further assist in the improvement of partnerships across the Queensland healthcare system. Contestability is a process of reviewing the delivery of our services, to ensure all Queenslanders get the best services, when and where they need them, for generations to come. It encourages innovation and smarter thinking and focuses on building partnerships to improve access to public services, for all Queenslanders. This will involve creating opportunities and partnerships with the public, private and not-for-profit sectors. The money saved through increased efficiencies, alternative service delivery models and improved performance will be returned to local communities, enabling improved performance.

In 2012–13, the Sunshine Coast Public University Hospital became the department's first public-private partnership (PPP) project. Contracts were signed with Exemplar Health in July 2012 for the delivery of the hospital and provision of certain facilities, including security, pest control, grounds maintenance and car parking services, over a 25-year operating term. The department also completed a preliminary assessment to determine alternate health-related uses for the Royal Children's Hospital site, potentially via a public-private partnership. A business case is being prepared by Projects Queensland, in close cooperation with the department.

Replacing a system concerned with inputs with one that values outcomes

Queensland Health Renewal Taskforce

The Queensland Health Renewal Taskforce (QHRT) was established in August 2012 to provide targeted assistance to Queensland Health in realising the policy and service delivery reforms of the Queensland Government. Lead by Dr Brett Heyward as Chief Executive and comprised of senior officers from Department of Premier and Cabinet, Treasury, and the Public Service Commission, the QHRT worked closely with the Minister, Director-General, the department and the 17 HHSs to redesign processes and systems to improve the sustainability of public health care.

The QHRT assisted the Minister in the development of the *Blueprint for better healthcare in Queensland*. In addition, the QHRT guided the department in the establishment of the Contestability Branch, which provides strategic oversight and coordination of contestability reforms and builds commercial capability and capacity across the entire health system.

QHRT continues to work with Queensland Health on the delivery of key elements of the blueprint, including:

- financial efficiency and sustainability—reviewing non-activity based funding and block funded activity, such as funding for community health care
- reforming strategic sourcing practices—achieving more efficient and effective sourcing arrangements, including alignment with the implementation of the whole-of-government procurement review
- infrastructure and assets—implementing strategic asset management practices, and oversighting selected infrastructure projects to promote greater levels of public-private partnerships.

The QHRT conducted a strategic analysis of HSIA, and assisted the department in implementing changes in HSIA's operational focus and governance. In a similar exercise, QHRT is currently reviewing HSSA to provide further direction to the strategic commissioning practices of the department.

An external evaluation of the QHRT was undertaken in first quarter of 2013 which found the initiative was a strong catalyst in the renewal processes currently underway within Queensland Health. In 2013–14, QHRT will continue to work with the department on a range of renewal activities designed to establish best practice governance and service arrangements across the public health system.

Health Innovation Fund to support local models of care

The Health Innovation Fund was established to support locally driven and innovative models of care which are economically sustainable and have the potential to deliver improved outcomes on a statewide level, such as reductions in morbidity/mortality and improvements in patient quality-of-life.

In addition, the key performance indicators used to track HHS performance are shifting to outcomes rather than input-based measures.

Contestability and new measures for financial accountability

Contestability encourages innovation and creates opportunities and partnerships that support positive outcomes and a focus on improved performance rather than just delivery and regulation. By identifying key contestability capabilities required, the skills of staff will be developed to identify and assess opportunities for improving performance across the healthcare system. In addition to empowering staff, they will be provided with specific tools and support to identify and deliver business improvements in their workplace to maximise existing potential. The money saved through increased efficiencies, alternative service delivery models and improved performance will be returned to local communities, enabling improved performance.

In the past, the focus of the healthcare system has been on hospital bed numbers or the number of patient admissions, with limited assessment of the impact on outcomes. Contestability is part of a long-term process of changing how Queensland Health does business. It changes the focus from inputs to outcomes that meet the health needs of Queenslanders. Contestability involves an evidence-based decision-making process that looks at alternative value-for-money service options that reflect contracting for outcomes.

Cutting waste

The department is committed to finding efficiencies in the provision of healthcare while delivering improvements in the safety and quality.

Payroll improvements

In 2012–13, the department continued to operate, maintain and enhance the Queensland Health payroll and rostering environment to:

- improve the pay outcomes for Queensland Health staff
- reduce the level of fortnightly overpayments
- reduce recurrent operational payroll costs.

Initiatives undertaken in 2012–13 included:

- changing the staff pay date by one week to enable more time to submit, approve and process payroll forms for each roster period
- implementing a payroll forms lodgement campaign to encourage timely submission of payroll forms by staff and managers
- recovery of overpayments
- preparation for the progressive introduction of automated recovery of any new overpayments from July 2013
- progressive implementation of Payroll Self Service to provide staff with online access to payslips, payment summaries and overpayment records, and to allow staff to lodge and track payroll enquiries
- improvements in workforce management practices
- rostering and payroll system changes and upgrades.

These initiatives have led to a more than 50 per cent reduction in the time taken to produce the fortnightly pay and a 52 per cent reduction in the incidences of new overpayments.

Health service support improvements

In 2012–13, efficiencies were achieved within pathology operations through:

- the rationalisation of pathology laboratories—the Central Microbiology Laboratory is now providing all bacteriology testing for eight metropolitan and two non-metropolitan hospitals and all blood culture processing for 12 hospitals, creating greater economies of scale
- the centralisation of automated blood-borne virus testing, resulting in savings from reduced staff and fewer service contracts
- the implementation of business improvement plans to eliminate waste in laboratories.

The Biomedical Technology Services:

- introduced online service requests and report generation, reducing paper-based requests and reports
- improved activity reporting resulting in greater achievement against key performance indicators, including revenue targets, high-risk device maintenance backlog and productivity.

The department's Group Linen Services:

- improved efficiency and achieved cost savings by streamlining production work flows and processing for core items
- achieved cost savings by removing pyjamas from linen supply—pyjamas were costly to replace and required labour intensive processing
- eliminated the need for regular weekend overtime by restructuring operational hours and shift times to maximise production within standard operating hours.

Financial process improvements

In 2012–13, the department identified and implemented several financial process improvements, including:

- implementation of the Budget Planning Tool, allowing a consistent methodology and improved controls for HHSs and the department for budget build processes
- provision of access to management reporting and analysis of business data via the Decision Support System
- the Central Coordination of the Annual Asset Revaluation Program, in relation to land and buildings assets, on behalf of the department and HHSs. This resulted in cost savings through having a single point of contact and engagement with the external valuers. The program was undertaken in collaboration with the HHSs and proved to be more efficient than multiple engagements between the HHSs and the external supplier
- the procurement of software from an external vendor to help facilitate the preparation of HHS annual financial statements. This approach provides cost efficiencies across Queensland Health and ensures consistency in the style and approach to the preparation of financial statements
- the continued implementation of the Automated Accounts Payable System to significantly reduce invoice payment processing times through improved processing accuracy
- development and delivery of the *Internal Control Framework*, *Control Framework for Expenditure*, *Financial Delegations Framework* and *Gifts and Benefits Framework* to strengthen the control and compliance environment of the department
- provision of a standardised HHS *Finance Management Practice Manual* to guide and assist HHS compliance and controls
- contributing to the HHSs' and the department's positive financial outcomes through analysis and advice provided within the *Queensland Health Performance Management Framework*
- developing policies, processes and systems to enable funding flows under the new national health reform funding arrangements.

4. Investing, innovation and planning for the future

Objectives

- A lasting commitment to collaborative effort and improvement will provide Queenslanders with a world-class healthcare system.
- A simplified employment and industrial relations environment.
- A highly-skilled, capable and sustainable workforce with access to flexible opportunities for employment.
- New opportunities to promote and review infrastructure investment.

Key performance indicators

- Timeliness of industrial relations dispute management processes.
- Percentage of HHSs achieving performance improvements per annum.
- Rate of satisfactory annual audits in relation to the Queensland Government Safer Healthier Workplaces Standards.
- Number of capital projects delivered on scope, time, cost and quality with a variance to budget of less than five per cent.
- Sustainability scenarios developed and costed, and used to inform policy advice to the Minister.

Collaboration and improvement to provide a world-class healthcare system

The department is committed to driving high quality healthcare and continuous improvement. The challenge as the main provider of public health services is the safe provision of quality services across Queensland and across the diversity of needs within the annual budget. This challenge is being met through a strong commitment and focus on local decision-making and collaboration with service partners, including HHSs, to contribute to a world-class health system in Queensland.

Health Innovation Fund

The department established the Health Innovation Fund to support improvements in health service delivery and patient care by providing grants for one to three years for innovative proposals with the potential for statewide application. A governance process for the fund was established, including an innovation board and expert advisory panel, which includes representatives from outside Queensland.

A total of 66 applications for funding were received from across the state in 2012–13. Successful applicants will be notified in 2013–14.

Biopharmaceutical research

The Translational Research Institute is a joint initiative of Queensland Health, the University of Queensland, Queensland University of Technology and the Mater Medical Research Institute to improve and enhance the translation of medical research into greater patient services and care.

Based in South Brisbane, the institute is the only one of its kind in the southern hemisphere intended for biopharmaceutical research, discovery, and production and testing. Work on the facility commenced in July 2010 and practical completion was reached in May 2013.

A simplified employment and industrial relations system

Queensland Health's current industrial system is highly complex, encompassing nine awards, six certified agreements and 189 HR policies covering more than 64,000 full-time equivalent staff. The *Blueprint for better healthcare in Queensland* outlines a program of industrial reform, which includes a simplified award system and better wages and conditions for Queensland Health staff.

In 2012–13, the department commenced research into possible models for the implementation of a more flexible and easy to understand employment and industrial relations system that facilitates local decision making.

The *Industrial Relations Act 1999* was amended to provide consistency across industrial instruments on matters of contracting out services, permanent employment and organisational change. As a result of these amendments, Queensland Health's organisational change processes were significantly reformed to allow implementation of structural changes in a more efficient and timely manner. The department partnered with HHSs in providing strategic employee relations solutions to suit local service delivery needs, including change management and dispute resolution.

During 2012–13, the following enterprise agreements were certified:

- *Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012*
- *Medical Officers' (Queensland Health) Certified Agreement (No. 3) 2012*.

A highly-skilled, capable and sustainable workforce

The department is committed to maintaining a highly-skilled, capable and sustainable workforce. This challenge is being met through a strong commitment to more flexible workforce models, a focus on recruitment in rural and remote areas, closer engagement with clinicians, and improved workforce development and training strategies.

Flexible workforce models for allied health professionals

The Allied Health Professions' Office has developed a suite of tools based on best available evidence to support the use of allied health professionals in flexible workforce models.

These include:

- *Allied Health Advanced Clinical Practice Framework*
- *Allied Health Prescribing Framework*
- *Guidelines for Allied Health Professionals Requesting Pathology Tests*.

These resources have been developed to enable HHSs to improve the use of the allied health workforce to contribute to improved patient flow, increased access to treatment and enhanced service efficiency.

Building a sustainable workforce for rural and remote sites

The Office of the Principal Medical Officer administers the annual statewide recruitment campaign for all junior medical staff to facilitate HHSs to recruit a highly skilled and capable medical workforce, and to enable the development of a sustainable workforce into the future.

In 2013, a total of 4602 junior medical staff were offered a position within the public healthcare sector. This includes 683 intern positions and 3919 resident medical officer positions, which exceeds the number of positions offered in previous years. Between 2011–14, 80 per cent of the growth in intern positions was allocated to regional and rural hospitals.

The Office of the Principal Medical Officer is further enabling the growth of a highly-skilled, capable and sustainable workforce by supporting the vocational training pathways for intensive care, adult medicine, paediatrics and child health, geriatric medicine, and palliative medicine. This has improved both the quality of, and capacity for, training positions across Queensland, particularly in rural and remote Queensland.

The Allied Health Professions' Office of Queensland has introduced two key programs to build a sustainable and capable allied health workforce in rural and remote sites.

The Allied Health HP3 to HP4 Rural Remote Development Pathway is a HR and workforce development strategy which supports rural and remote services to recruit early career professionals and enables these professionals to rapidly develop the skills required to practice in rural and remote settings. The pathway includes a framework which can be individualised to meet both clinician and service needs and a range of learning and support resources to enhance the development of practice capabilities.

The Rural and Remote Allied Health Priority Transfer Scheme (RRAHPTS) was designed to reduce or eliminate the perceived negative impacts of rural and remote allied health positions on career mobility and progression. RRAHPTS allows eligible permanent allied health employees to apply for priority transfer to a vacant position in a metropolitan, regional, rural or remote location of their preference after a designated period of service in a rural or remote setting. It is anticipated that this strategy will enhance the capacity of rural and remote services to attract allied health professionals, including those with who have a degree of professional experience. The success of this scheme will be evaluated in 2013–14.

Queensland's participation in the inaugural Voluntary Dental Graduate Year Program has provided opportunities for graduates to be placed in rural and remote locations, with planned and appropriate support and skill development opportunities.

Clinician workforce and leadership

The creation of new clinical workforce options is critical to achieving the clinical workforce in Queensland that is needed into the future. A range of leadership and management development programs is being provided to assist clinical staff to lead clinical improvement initiatives and innovation.

During 2012–13, a total of 13 leadership development programs were delivered to 235 clinical leaders including:

- Emerging Clinical Leaders Program—two programs, 46 participants
- Step Up for Registrars Program—five programs, 68 participants
- Medical Leadership in Action Program—two programs, 57 Participants
- Top 500 Program—four programs, 64 participants.

Workforce Mapping Analysis and Planning Projections System

The Workforce Mapping Analysis and Planning Projections is an online workforce planning system, provides a comprehensive, unified, effective and efficient clinical workforce planning tool. The system was implemented statewide in 2010–11. During 2012–13, the number of registered users had grown to more than 400. The system is now integrated into the planning processes of the Queensland public healthcare sector.

Development plans for Health Service Chief Executives

Following the recruitment of 17 HSCEs, development plans were produced using reports gathered from the recruitment process. These reports presented a tailored, personalised development plan for each chief executive who participated. The plans will guide the personal development of each chief executive to assist them as they lead the transformation of their HHS.

Public Sector Management Program scholarships

In 2012–13, seven Public Sector Management Program scholarships were offered to Queensland Health staff in the Leadership and Management Education Program which targets senior to middle managers and emerging leaders. The 18-month program is a joint venture between Federal, State and Local Governments and combines tertiary study with experiential learning. Upon successful completion, students are awarded a Graduate Certificate in Public Sector Management by Flinders University.

Scholarships for Australia and New Zealand School of Government programs

Two staff were offered a scholarship to participate in Australia and New Zealand School of Government programs, one in each of the Executive Fellow and Executive Master of Public Administration Programs. The Australia and New Zealand School of Government is a world leading educational institution teaching strategic management and high-level public policy.

The Queensland Government offers scholarships each year for both the Executive Fellow and Executive Master of Public Administration Programs to outstanding Queensland public sector leaders. Nominations for scholarships are endorsed by the Director-General.

Recruitment services

In 2012–13, limited recruitment activity took place as a result of a wide-scale separation program undertaken across the Queensland Government. As part of organisational transformation activities to streamline corporate functions, responsibility relating to operational recruitment was progressively transferred to HHSs.

The department continues to:

- maintain recruitment systems for Queensland Health, including an online attraction presence (the *Work For Us* website—www.health.qld.gov.au/workforus) as a single point of reference for all roles within Queensland Health
- provide strategic advice on recruitment and selection initiatives and assistance to HHSs to develop capability for recruitment and selection activity
- maintain and review guidelines, forms, templates and policies that assist HHSs to recruit effectively
- support recruitment of Queensland Health's most senior executives and critical talent
- support Queensland Health-wide recruitment efforts, including nursing and graduate recruitment campaigns, by providing expertise and recruitment management systems to deal effectively with large volume recruitment activities.

Pre-employment screening

Queensland Health is committed to screening potential new employees to maintain the absolute integrity of the workforce and to reduce the risk of internal fraud and other illegal activities that may affect public confidence. During 2012–13, 15,835 pre-employment screening activities were carried out. These activities comprised 11,208 criminal history checks, 4157 aged care checks and 470 Blue Card or Corrective Services screening processes. Of these assessments, approximately 1.5 per cent of applicants were identified as potential risks and referred for further review regarding employment suitability.

New opportunities to promote and review infrastructure investment

In 2012–13, $1.626 billion was invested in new capital acquisitions across Queensland Health. The Queensland Institute of Medical Research also invested $21.8 million. Queensland's investment in health infrastructure includes three new tertiary hospitals to be delivered by 2016—the Gold Coast University Hospital ($1.76 billion, due for completion in September 2013), the Queensland Children's Hospital ($1.43 billion, due for completion in late 2014) and the Sunshine Coast Public University Hospital ($1.87 billion, including capitalised interest, due for completion in 2016).

The department's Capital Infrastructure Program includes more than 100 projects across a broad range of health infrastructure, including community health centres, hospitals, health technology, pathology, research and scientific services, mental health services, residential care, staff accommodation and ICT. Other projects include the capital redevelopments at Cairns, Mackay, Mount Isa, Rockhampton and Townsville Hospitals. These projects represent a total investment of $1.408 billion.

The 750-bed Gold Coast University Hospital is part of a major expansion of health services for South East Queensland. The hospital will feature leading edge technology and will be one of the state's largest clinical teaching and research facilities, providing specialised health services that meet the needs of patients and the learning requirements of students. The hospital design incorporates future-proofing initiatives that provide the ability for the facility to expand by around 60 per cent and caters for changing models of care and technology.

The Queensland Children's Hospital is the largest single capital investment in children's health services in Queensland. The hospital will be a purpose-built facility and once completed, will be the major specialist children's hospital for the state, providing clinical, educational and support services to the statewide network of children's health services.

The Sunshine Coast Public University Hospital is the centrepiece of a network of health services offering a comprehensive range of community and primary healthcare for the Sunshine Coast. The hospital represents the department's first PPP hospital project. Key features of the hospital include a comprehensive cancer centre, specialised trauma service, neurosurgery, cardiac surgery, maxillofacial surgery, vascular surgery, orthopaedics and interventional cardiology. The hospital will open in late 2016 with 450 beds and expand to a 738 bed facility by 2021. Other services and facilities on the Kawana Health Campus site will include a skills, academic and research centre, 3500 parking spaces and a co-located private hospital. The first of two stages of design development have been undertaken and initial construction works have commenced on the site.

The department's contestability reforms also have the potential to change infrastructure investment by strengthening and expanding the health system through partnerships with the public, private and non-government sectors. By aligning contestability review outcomes with infrastructure planning and asset usage there is an opportunity to significantly reduce the cost of delivering health infrastructure investment and to realise one-off savings. In addition, through arrangements with the private and not-for-profit sectors, the cost of delivering health infrastructure can be significantly reduced.

Community engagement

The department will continue to engage with partners to develop collaborative and proactive solutions to meet the health needs of Queenslanders, now and into the future. Community engagement has continued to be a high priority throughout the construction stage of the Gold Coast University Hospital. The project's stakeholder advisory group—comprising members that represent the local community, universities, health service providers and local

business—have been meeting every two months with executive team members of the project team. A community advisory group has been engaged to provide input to a number of aspects for the project, including art, wayfinding and prototype patient rooms. A number of community open days have been held, including exclusive opportunities to tour buildings as they achieve practical completion, in addition to presentations made to local community groups.

Static displays in shopping centres and libraries provide further project information to members of the general public. The Gold Coast University Hospital project website (www.health.qld.gov.au/goldcoasthealth) continues to experience high volumes of traffic and includes functionality to direct general enquiries to members of the project team.

The Queensland Children's Hospital project team regularly engages with the local and broader community to ensure they are kept informed about the project, including its benefits, future services and amenities, key construction milestones and activities, and planning for the move into the new hospital in late 2014. The project team met every two months with its community liaison group to provide representatives of the community with information about the construction of the hospital and its full program of works. The team also provided presentations to stakeholder groups about the hospital and its progress towards opening in late 2014. Program updates were distributed to 2500 residents and small businesses in South Brisbane on a quarterly basis.

The last major concrete pour on the Queensland Children's Hospital site took place in March 2013, marking external structural completion of the building. To acknowledge this project milestone Lawrence Springborg, Minister for Health, and Children's Health Queensland Chief Executive, Dr Peter Steer, toured the hospital site and officially handed over eight signature boards to the managing contractor. In April 2013, these signature boards, which had been signed by more than 300 Children's Health Queensland and Mater Children's Hospital staff, patients and their families, were installed within the walls of the hospital on level 2, next to the future cafeteria—thus becoming a permanent fixture in the building.

The Sunshine Coast Public University Hospital has enjoyed the input and advice of its community reference group which is comprised of representatives of the local community and community interest groups.

In addition, a community liaison group is being established to address the impact of the construction of the Sunshine Coast Public University Hospital on the local community and the Sunshine Coast HHS is establishing a range of consumer groups which will have input into specific aspects of the hospital's design.

Regular community engagement and consultation activities have been undertaken at each of the large hospital redevelopments in Cairns, Townsville, Mackay, Rockhampton and Mount Isa, Logan and Ipswich.

The Mental Health Capital Works Program—Stage 2 will deliver five mental health community care units across the state. Significant community consultation regarding the design and location of the facilities will be undertaken as part of the process.

Rural and Remote Infrastructure Rectification Works Program

The Rural and Remote Infrastructure Rectification Works Program was announced by the Minister for Health in August 2012 and targets the critical and essential infrastructure needs of 12 rural and remote hospitals to improve and upgrade health services in country areas and prolong the useful life of the facilities. The facilities at Thursday Island, Mareeba, Atherton, Charters Towers, Ayr, Sarina, Longreach, Emerald, Biloela, Kingaroy, Charleville and Roma received a share of $51.58 million in funding to undertake prioritised works following the publication of preliminary infrastructure planning reports in 2010. The program strengthens the commitment to improving health services in rural, regional and remote areas.

Redevelopment of the Royal Children's Hospital site

The department completed a preliminary assessment to determine alternate health-related uses for the Royal Children's Hospital site. This assessment concluded that a planned procedure centre was the preferred health-related option for the site.

Projects Queensland, in conjunction with Queensland Health, is developing a business case for a planned procedure centre on the site which is due for submission in October 2013.

Infrastructure completed in 2012–13

Queensland Health's Capital Works Portfolio includes more than 100 projects, ranging from the delivery of new tertiary hospitals on greenfield sites to the expansion and refurbishment of smaller regional hospitals and community-based facilities across the state. Projects completed in the 2012–13 financial year include:

- Mental Health Redcliffe/Caboolture Acute and Secure Mental Health Rehabilitation Units (July 2012)
- Mental Health West Moreton Extended Treatment Unit (July 2012)
- Robina Hospital Expansion (July 2012)
- Mackay Hospital Mental Health Unit (August 2012)
- Croydon Primary Health Care Centre and Staff Accommodation (August 2012)
- Forsayth Primary Health Care Centre and Staff Accommodation (August 2012)
- Redland Hospital Emergency Department (September 2012)
- Toowoomba Hospital Subacute Services Expansion Stage 1—Clinical (September 2012)
- Townsville Hospital Neo-natal Intensive Care Unit (October 2012)
- Translational Research Institute—Stage 1 TRI Building (November 2012)
- Mackay Base Hospital Redevelopment—Stage 2 (November 2012)
- The Prince Charles Hospital Paediatric Emergency Services (November 2012)
- Maryborough Hospital Rehabilitation Services (December 2012)

- Bayside Mental Health Community Care Unit (January 2013)
- Logan Acute Mental Health Unit (February 2013)
- Caboolture Hospital Paediatric Emergency Services (February 2013)
- Mount Isa Regional Cancer Centre (March 2013)
- Caloundra Hospital Department of Emergency Medicine Upgrade (March 2013)
- Rockhampton Hospital Expansion—Stage 1 (March 2013)
- Injune and Surat Longer Stay Older Persons Multipurpose Health Centre Upgrades (March 2013)
- Translational Research Institute—Stage 2 Right Wing and Bio-Pharmaceuticals Australia components (May 2013)
- Thursday Island Chronic Disease Centre (June 2013)
- Southern Queensland Centre of Excellence for Indigenous Primary Health Care (May 2013)
- Caboolture Hospital Education and Skills Centre (April 2013)
- Ipswich Hospital Multi-level Carpark (May 2013)
- Logan Hospital Paediatric and Medical Outpatient Upgrade (May 2013).

National partnership agreements

The National Partnership Agreement on the Digital Regions Initiative

The *National Partnership Agreement on the Digital Regions Initiative* aimed to deliver innovative digital enablement projects supporting improved health, education and emergency services in regional, rural and remote communities throughout Australia.

The two projects funded in Queensland under this agreement were the:

- Townsville National Broadband Network Telehealth Diabetes Trial
- Princess Alexandra Hospital Online Outreach Services.

The Townsville National Broadband Network Telehealth Diabetes Trial assessed the benefits of home monitoring for people with diabetes. It examined the impacts, outcomes, benefits and costs of National Broadband Network-enabled Telehealth in Townsville. The model of service delivery included Telehealth monitoring, home management, education and support. The trial was implemented by the Townsville-Mackay Medicare Local through a service agreement with the department. Recruitment of patients to the trial was limited due to the delayed rollout of the National Broadband Network in Townsville and the trial did not yield any significant results within the timeframe of the agreement. The department's involvement in this project ended with the expiry of the agreement on 30 June 2013.

The agreement also supported the establishment of the Princess Alexandra Hospital Telehealth Centre which was officially opened on 14 November 2012. The centre is fully operational and is providing a range of medical specialist services via Telehealth to patients in 24 locations across the state. These patients attend their local hospital and are able to consult a Brisbane specialist via videoconference.

Telehealth services:

- improve access to healthcare service by encouraging and extending the use of Telehealth through remote consultations, diagnosis and treatment
- reduce patient travel and the need to spend time away from home
- provide professional support to health service providers
- reduce specialist travel and increase the number of Telehealth clinics available.

State funding has been provided to the Metro South HHS recurrently to support the operation of the Princess Alexandra Hospital Telehealth Centre beyond the end of the agreement.

This agreement expired on 30 June 2013.

National Partnership Agreement on Health Infrastructure

The *National Partnership Agreement on Health Infrastructure* provides funding to improve the health and wellbeing of Australians through the provision of high-quality physical and technological health infrastructure. Some projects under the agreement are funded through the Australian Government's Health and Hospitals Fund (HHF).

HHF was established on 1 January 2009 to invest in major health infrastructure programs that will make significant progress towards achieving the Australian Government's health reform targets and to make strategic investments in the health system that will underpin major improvements in efficiency, access or outcomes of healthcare.

Several projects have been initiated to support the outcomes of the agreement:

- Indigenous Mobile Dental Infrastructure—funding was provided to procure three suitable Drover Mobile Dental Clinics and mobile dental equipment for the provision of dental services to improve the oral health of Indigenous Australians in Cherbourg, the Torres Strait and Cape York, and surrounding communities in Queensland.

- Townsville and Mount Isa Integrated Regional Cancer Service—funding was allocated from HHF to enhance Townsville Cancer Centre's provision of integrated care across Townsville, Cairns, Mackay and Mount Isa by expanding the physical infrastructure and existing regional cancer services provided by the Townsville and Mount Isa Hospitals.

  The initiative provides access to essential cancer services for people living in rural, regional and remote areas, and aims to help close the gap in cancer outcomes between Queenslanders living in metropolitan and rural and remote areas.

Operational funding to support hospital expansion is funded through a growth component in the HHS service agreement. In 2012–13, Townsville HHS received funding for 6149 WAUs equating to $26.8 million growth funding. A portion of this growth funding, at the discretion of the HHS, will be used to support the hospital expansion. The 2012–13 weighted activity unit growth was made up of:

- 996 for sub- and non-acute patients/rehabilitation
- 911 for cancer
- 267 for mental health
- 839 for a paediatric intensive care units
- 3136 for general growth.

The Townsville Regional Cancer Centre is forecast for construction completion in February 2014 and the Mount Isa Regional Cancer Centre was completed in March 2013.

- Rockhampton Hospital Expansion—funding was allocated from HHF to expand facilities at the Rockhampton Hospital, including inpatient bed stock, operating theatres, clinical training areas and services accessibility options. Operational funding to support hospital expansion is funded through a growth component in the HHS service agreement.

  In 2012–13, Central Queensland HHS received funding for 2509 WAUs equating to $10.9 million growth funding. A portion of this growth funding, at the discretion of the HHS, will be used at Rockhampton to support the hospital expansion. The 2012–13 weighted activity unit growth was made up of:

  - 1362 for sub- and non-acute patients/rehabilitation
  - 661 for cancer
  - 485 for general growth.

  Rockhampton Hospital Expansion—Stage 1B is forecast for construction completion in December 2013.

- Digital technology for BreastScreen—funding was allocated from HHF to provide one-off capital funding for the replacement of analogue mammography machines with 20 digital mammography machines for the BreastScreen Queensland Program. Two additional mobile vans were commissioned and commenced operation in regional Queensland (Darling Downs/South West HHS and Wide Bay HHS). A new satellite screening service was also established in Browns Plains and Logan City. Implementation of the BreastScreen Queensland Picture Archiving Communication System was also completed in 2012–13.

- Central Integrated Regional Cancer Service Queensland—funding was allocated from HHF to develop three regional cancer centres in Rockhampton, Bundaberg and Hervey Bay with appropriate networking and linkages to comprehensive cancer services. The aim of the centres is to provide better access to essential cancer services for people living in

rural, regional and remote areas and to help close the gap in cancer outcomes between people living in metropolitan and rural and remote areas. The forecast construction completion dates for the centres are:

- Rockhampton Regional Cancer Centre (February 2014)
- Bundaberg Regional Cancer Centre (March 2015)
- Hervey Bay Regional Cancer Centre (September 2015).

- HHF 2010 Regional Priority Round Projects in Cairns and Townsville—funding was provided for investment in major health infrastructure programs that will make significant progress towards achieving the Australian Government's health reform targets, and to make strategic investment in the healthcare system that will underpin major improvements in efficiency, access or outcomes of healthcare.

  Funding outputs for Cairns Base Hospital and Townsville Base Hospital through this regional priority round includes assistance with purchase of furniture and equipment, and the construction and fit-out of a new planned procedure centre within the Clinical Services Building at Cairns Base Hospital.

  The new planned procedure centre will enhance patient access to elective surgery services in the Far North Queensland and will include:

  - approximately 1800 square metres of floor area
  - two specific purpose procedure rooms
  - pre-procedure and perioperative recovery areas (three stage recovery) with 12 beds
  - outpatient consultation rooms
  - reception and admissions areas
  - patient change rooms/ensuites
  - procedural support areas and necessary ancillary areas to function independently of the main hospital and its operating theatre environment
  - easy access to clinical support services including pathology, medical imaging and pharmacy.

  The Cairns Base Hospital Planned Procedure Centre is forecast for completion in April 2014 and the Townsville Hospital Planned Procedures Centre is forecast for construction completion in February 2015.

- HHF 2010 Regional Priority Round Projects in Sunshine Coast, Bundaberg, Rockhampton and Toowoomba—funding was provided for investment in major health infrastructure programs that will make significant progress towards achieving the Australian Government's health reform targets, and to make strategic investment in the healthcare system that will underpin major improvements in efficiency, access or outcomes of healthcare.

Funding outputs for this regional priority round includes:

- four mental health community care units located in Sunshine Coast—Nambour, Bundaberg, Rockhampton and Toowoomba
- a total of 7245 square metres new gross floor area
- 79 individual supported residential units with clinical office blocks (15 units in the Sunshine Coast—Nambour, 20 units in Bundaberg, 20 units in Rockhampton and 24 units in Toowoomba).

The forecast construction completion dates for the units are:

- Sunshine Coast Mental Health Community Care Unit (September 2014)
- Bundaberg Mental Health Community Care Unit (September 2014)
- Rockhampton Mental Health Community Care Unit (September 2014)
- Toowoomba Mental Health Community Care Unit (September 2014).

Project Agreement for BreastScreen Australia Radiography Workforce Initiatives

The *Project Agreement for BreastScreen Australia Radiography Workforce Initiatives* provided one-off funding in 2012–13 to support the delivery of strategies that will increase the capacity of BreastScreen Australia's radiography workforce through the provision of recruitment and retention activities, such as professional development, training or employment opportunities, for both trainee and experienced radiographers.

Funds were provided to each of the 11 BreastScreen Queensland Services to allow locally-relevant strategies to be implemented. The focus was on increasing capacity by providing leadership and management skills training, as well as opportunities for rural and remote radiographers to attend training and professional development opportunities. Examples of strategies implemented include development of a comprehensive orientation manual for radiographers working on the mobile vans and undertaking accredited courses, including the Certificate IV in Training and Assessment, ultrasound training, communication courses and leadership courses.

The agreement expired on 30 June 2013.

Our people

Staffing

Queensland Health comprises a Department of Health and 17 independent HHSs. Queensland Health employed 64,192 full-time equivalent (FTE) staff during 2012–13. Of these, 6788 FTE staff were employed by, and worked in, the department. The remaining 57,335 FTE staff were employed by the department and contracted to HHSs under service agreements between the director-general and each HHS. The remaining 69 FTE staff were employed directly by HHSs*.

**Staffing figures for individual HHSs are reported in annual reports for those entities.*

Department of Health profile

Table 4 shows the number of FTE staff working for the Department of Health in 2012–13 by gender and appointment type.

Table 4: 2012–13 FTE staff working in the Department of Health, by gender and appointment type

FTE staff	Permanent	Temporary	Casual	Contract	Total
Female	3310	688	18	33	4049
Male	2205	470	15	49	2739
Total	**5515**	**1158**	**33**	**82**	**6788**

In 2012–13, the average fortnightly earnings for staff working in the department was $3081 for females and $3850 for males.

Of the 6788 FTE staff working in the department, 4054 staff work in the two commercialised business units, HSSA and HSIA.

Figure 5 shows the number of staff working in the department by employment stream. Approximately 58 per cent of staff working in the department are managerial or clerical employees.

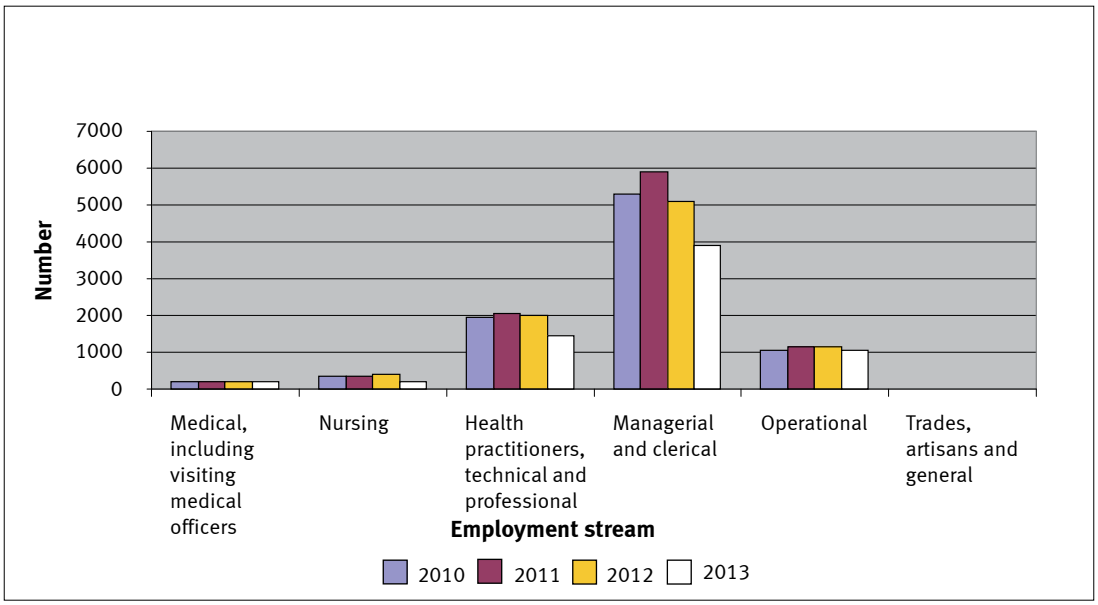


Figure 5: Department of Health minimum obligatory human resource information occupied full-time equivalent by employment stream.

In 2012–13, the department's retention rate for permanent employees was 75.3 per cent. The retention rate is the number (headcount) of permanent staff employed by and working in the department at the start of the financial year and who remain employed at the end of the financial year, expressed as a percentage of total staff employed.

The department's separation rate for 2012–13 was 16.4 per cent and describes the number (headcount) of permanent employees who separated from the department during the year as a percentage of permanent employees.

Queensland Health profile

Table 5 shows the number of FTE Queensland Health staff (Department of Health and HHSs), by gender and appointment type.

Table 5: 2012–13 Full-time equivalent Queensland Health staff, by gender and appointment type

FTE staff	Permanent	Temporary	Casual	Contract	Total
Female	38,191	7,175	1,395	73	46,834
Male	12,554	4,218	488	98	17,358
Total	**50,745**	**11,393**	**1,883**	**171**	**64,192**

In 2012–13, the average fortnightly earnings for Queensland Health staff was $2978 for females and $4419 for males.

Figure 6 shows the number of Queensland Health FTE staff by employment stream. Approximately 65 per cent of Queensland Health staff are health practitioners, professionals and technicians, medical, including visiting medical officers, or nursing employees.

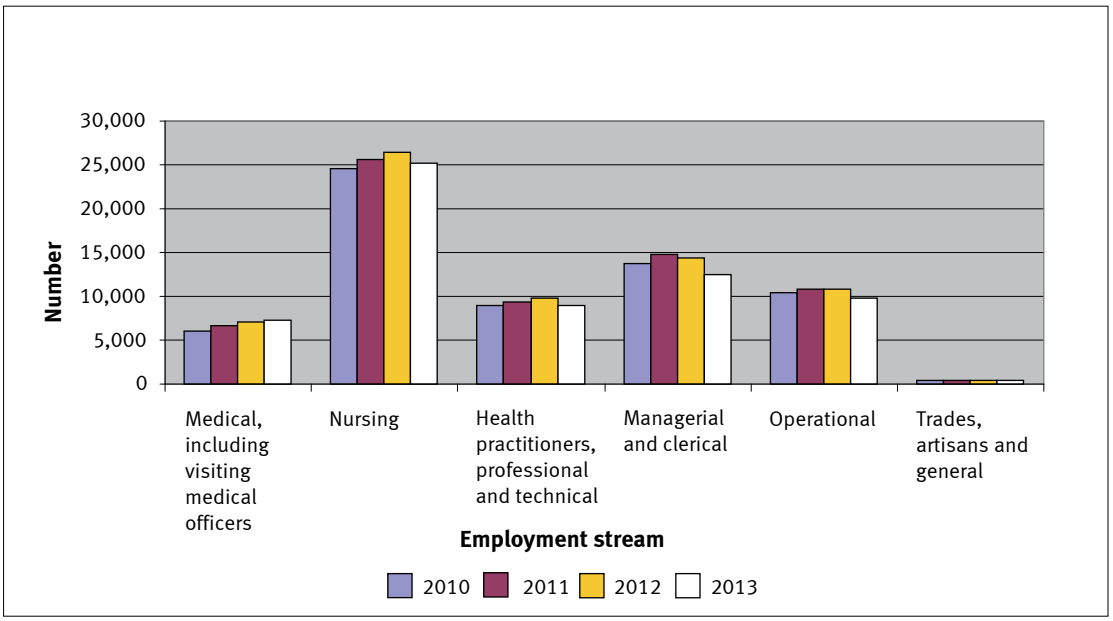


Figure 6: Queensland Health minimum obligatory human resource information occupied full-time equivalent by employment stream.

In 2012–13, Queensland Health's retention rate for permanent employees was 86.8 per cent. The retention rate is the number (headcount) of permanent staff employed by Queensland Health at the start of the financial year and who remain employed at the end of the financial year, expressed as a percentage of total staff employed.

Queensland Health's separation rate for 2012–13 was 11.8 per cent and describes the number (headcount) of permanent employees who separated from the organisation during the year as a percentage of permanent employees.

Retention and separation rates for permanent employees in 2012–13 were significantly different from 2011–2012 due to the implementation of a program of redundancies across Queensland Health in 2012–13.

Aboriginal and Torres Strait Islander workforce

An *Aboriginal and Torres Strait Islander Workforce Strategy* has been implemented as a positive and effective way to position Queensland Health as a responsive employer of Aboriginal and Torres Strait Islander people. Queensland Health has an obligation to meet employment targets and to deliver better health service outcomes for Aboriginal and Torres Strait Islander people. Queensland Health's stated policy outcome is to close the life expectancy gap between Indigenous and non-Indigenous Australians within a generation.

At 30 June 2013, staff who identify as Aboriginal or Torres Strait Islander made up two per cent (based on headcount) of total staff employed in Queensland Health. Approximately 61 per cent of Aboriginal and Torres Strait Islander staff in Queensland Health are employed in non-clinical streams (trades, artisans, operational, managerial and clerical staff) with the remaining 39 per cent employed in clinical streams (nursing, health practitioners, medical, technical and professional staff).

Figure 7 shows the number of Aboriginal and Torres Strait Islander staff in Queensland Health by employment stream.

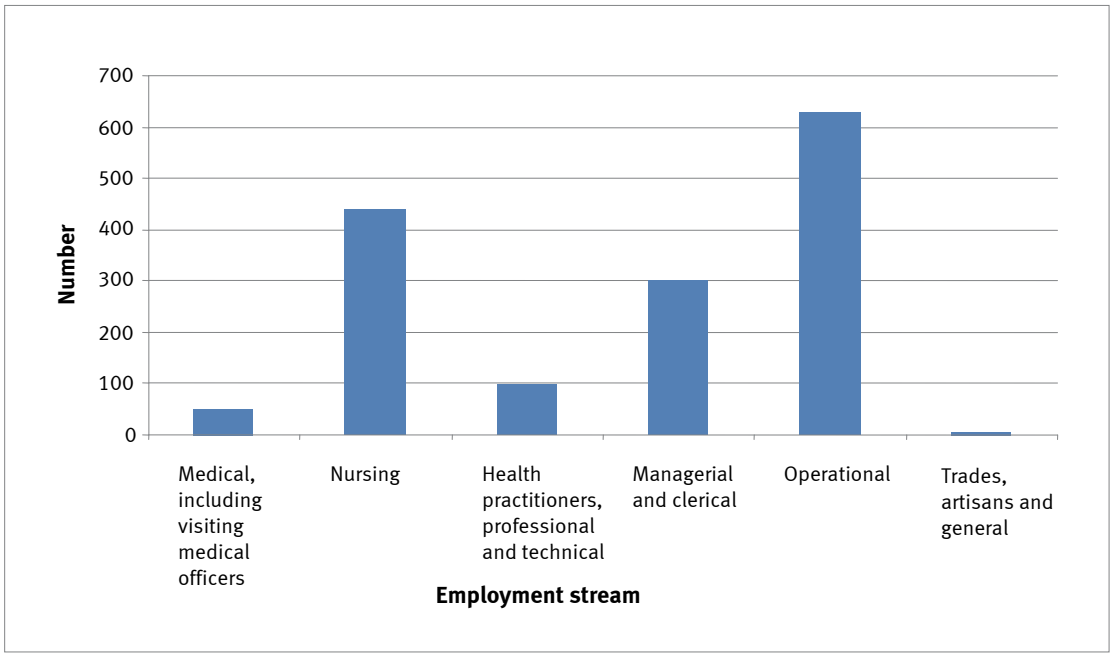


Figure 7: Number of Aboriginal and Torres Strait Islander staff by stream for Queensland Health, June 2013

Early retirement, redundancy and retrenchment

A program of redundancies was implemented during 2012–13. During the period, 3181 Queensland Health staff received redundancy packages at a cost of $297.18 million. Staff 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. At the conclusion of this period, and where it was deemed that continued attempts of ongoing placement were no longer appropriate, staff yet to be placed were terminated and paid a retrenchment package.

At 30 June 2013, 135 employees had been considered for alternative roles. Of these, 72 were placed in permanent roles and a further nine staff were placed in temporary roles of 12 months or more. During the period, five Queensland Health employees received retrenchment packages at a cost of $0.705 million. In 2012–13, more than 70 Career Management Workshops were conducted to assist Queensland Health staff affected by organisational change. These workshops were designed to help employees gain confidence in their own career management and remain resilient when faced with an organisation-wide program of redundancies.

Voluntary Separation Program

A Voluntary Separation Program was implemented during 2011–12. The program ceased during 2011–12, however 27 Queensland Health staff received their voluntary separation packages during 2012–13 at a cost of $4.91 million.

Flexible working arrangements and work-life balance

The department values the contribution of workers with family responsibilities to the delivery of quality services. The department recognises employees' needs to balance their work and family life and is committed to supporting employees in achieving a work-life balance.

Policies or arrangements in place to support this commitment include:

- work-life balance (incorporating policy for breastfeeding at work and options for child care)
- telecommuting
- purchased leave
- carers leave
- parental leave
- flexible working hours
- permanent part-time work arrangements
- job sharing.

Ethics and code of conduct

The department is committed to upholding the values and standards of conduct outlined in the Code of Conduct for the Queensland Public Service, which came into effect on 1 January 2011.

The code of conduct applies to all Queensland Health staff. It was developed under the *Public Sector Ethics Act 1994* and consists of four core principles:

1. Integrity and impartiality.
2. Promoting the public good.
3. Commitment to the system of government.
4. Accountability and transparency.

Each principle is strengthened by a set of values and standards of conduct describing the behaviour that will demonstrate that principle.

All Queensland Health staff are required to undertake training in the code of conduct during their induction and re-familiarise themselves annually. A campaign to ensure staff are aware of the code of conduct was implemented and included resources, training and face-to-face awareness activities.

Workplace harassment

The department remains committed to a culture free from all forms of harassment. It continues to support and develop strategies for the department and HHSs to address workplace harassment when it occurs and to educate staff about appropriate workplace conduct. Strategies include the Workplace Equity and Harassment Officer Network and

awareness campaigns. When instances of workplace harassment occur, employees can access a number of sources of information and advice, including:

- workplace equity and harassment officers
- a workplace harassment hotline
- the Staff Complaints Liaison Office
- local HR units
- the Employee Assistance Service.

Workplace Equity and Harassment Officer Network

Workplace equity and harassment officers play an important role in Queensland Health's response to resolving equity and harassment issues in the workplace. Workplace equity and harassment officers are Queensland Health staff who have been trained to provide confidential advice and support to other Queensland Health staff on a number of subjects, including:

- bullying/workplace harassment
- sexual harassment
- discrimination
- other equity issues.

In 2012–13, the department conducted extensive workplace equity and harassment officer training. During 2012–13, there was a reduction in the number of workplace equity and harassment officers across Queensland Health from 340 to 330—approximately three per cent.

Employee performance management

Queensland Health uses a suite of online and face-to-face induction and orientation tools that comprise mandatory compliance training, ethical decision making, workplace health and safety, public sector values, cultural awareness and fraud prevention.

The Queensland Health Performance and Development Policy is designed to enhance work performance and career development of staff by:

- clarifying performance expectations for staff
- ensuring feedback and guidance on performance
- collaboratively identifying learning and development needs and activities.

Under the policy, staff and managers are required to develop a performance and development plan, conduct performance meetings to assess previous performance and participate in ongoing management of workplace performance. In November 2012, a review of the existing performance and development planning and review resources commenced and a new planning template and associated process was designed and piloted.

The Public Sector Renewal Program

The program was delivered by the Public Service Commission and was designed to:

- refocus the public service on government priorities, and support the delivery of frontline services in a constrained fiscal environment
- confirm the Queensland Government's commitment to returning the budget to surplus and restoring Queensland's AAA credit rating, and finding savings to fund election commitments
- transform the Queensland Government into a better organisation for staff and enable the provision of better services for Queenslanders and includes a review of the roles and functions of agencies, including government owned corporations, to ensure expenditure is focused on delivering better services.

The department was actively involved in the program through encouraging staff to participate in program activities.

Executive Management Team (as at 30 June 2013)

Dr Tony O'Connell MBBS (Hons), FANZCA, FCICM, GAICD, FCHSM (Hon)
Director-General

Dr Tony O'Connell was appointed the department's Director-General in June 2011. He is an experienced clinician with specialist qualifications in intensive care and anaesthesia. He previously held the roles of Deputy Director-General in the New South Wales Department of Health and Queensland Health.

Tony has led major statewide redesign programs, strategic resource allocation and performance management systems which have delivered record-breaking elective surgery and emergency department performances in Queensland and New South Wales. He is focussed on improving both patient experiences and the culture of large complex systems.

Tony delivered on the Queensland Government's renewal agenda and drove the exploration of value-for-money opportunities in Queensland Health through the Contestability Branch. Queensland Health delivered budget surpluses in the first two years Tony was Director-General.

Philip Davies

Deputy Director-General, System Policy and Performance

Prior to joining the department, in May 2013, Philip was a Professor of Health Systems and Policy in the School of Population Health at the University of Queensland for four years.

Philip has significant experience as a health policy professional and has held diverse public and private sector roles in Australia, New Zealand and the United Kingdom. These have included positions, such as Deputy Secretary, Commonwealth Department of Health and Ageing, Senior Health Economist, World Health Organization, and Deputy Director-General Policy, Ministry of Health New Zealand. Philip also has a long history of involvement at board level in a range of Queensland and national public sector and not-for-profit organisations.

Kathy Byrne

Chief Executive, Health Services Support Agency

Kathy Byrne's career in the public and private health sectors spans more than 25 years.

Kathy was previously a HSCE and has a significant track record in strategic and operational leadership and achievement in five Australian states and territories. She has been the Chief Executive of HSSA (formerly Clinical and Statewide Services) since May 2009.

Ray Brown

Chief Information Officer, Health Services Information Agency

Ray's ICT career spans more than 35 years, predominantly in the public sector. Ray has previously undertaken senior roles in the Commonwealth Department of Families and Community Services, the Queensland Department of Corrective Services and the Queensland Police Service. He also spent two years working in the not-for-profit sector.

In August 2009, Ray was appointed Chief Information Officer for Queensland Health. In this role, he is responsible for providing executive-level leadership, governance, planning, architecture and strategic direction in the provision of ICT services.

Dr Michael Cleary

Deputy Director-General, Health Service and Clinical Innovation

Michael is an emergency physician who has been with the department for 27 years. He has held a range of executive roles and is the department's pre-eminent staff specialist. He is also a Professor at the School of Public Health at the Queensland University of Technology.

Michael was previously Executive Director and Director of Medical Services for Logan and Beaudesert Hospitals, the former Metro South Health Service District and the former The Prince Charles Hospital Health Service District. In April 2010, he was appointed to lead the Policy, Strategy and Resourcing division of the department. In July 2012, he was appointed to the role of Deputy Director-General of HSCI.

Dr Jeannette Young

Chief Health Officer

Jeannette has been Queensland's Chief Health Officer since August 2005. Previously, Jeannette was Executive Director of Medical Services at the Princess Alexandra Hospital, Executive Director of Medical Services at Rockhampton Hospital, and held a range of positions in Sydney.

Jeannette's clinical background is in emergency medicine and she has specialist qualifications as a Fellow of the Royal Australasian College of Medical Administrators and a Fellow by Distinction of the Faculty of Public Health of the Royal College of Physicians of the United Kingdom. She is an Adjunct Professor at Queensland University of Technology and Griffith University.

Jeannette is a member of numerous Queensland and national committees and boards, including the Queensland Institute of Medical Research Council, the National Health and Medical Research Council, the Australian Health Protection Committee, and the Australian National Preventive Health Agency.

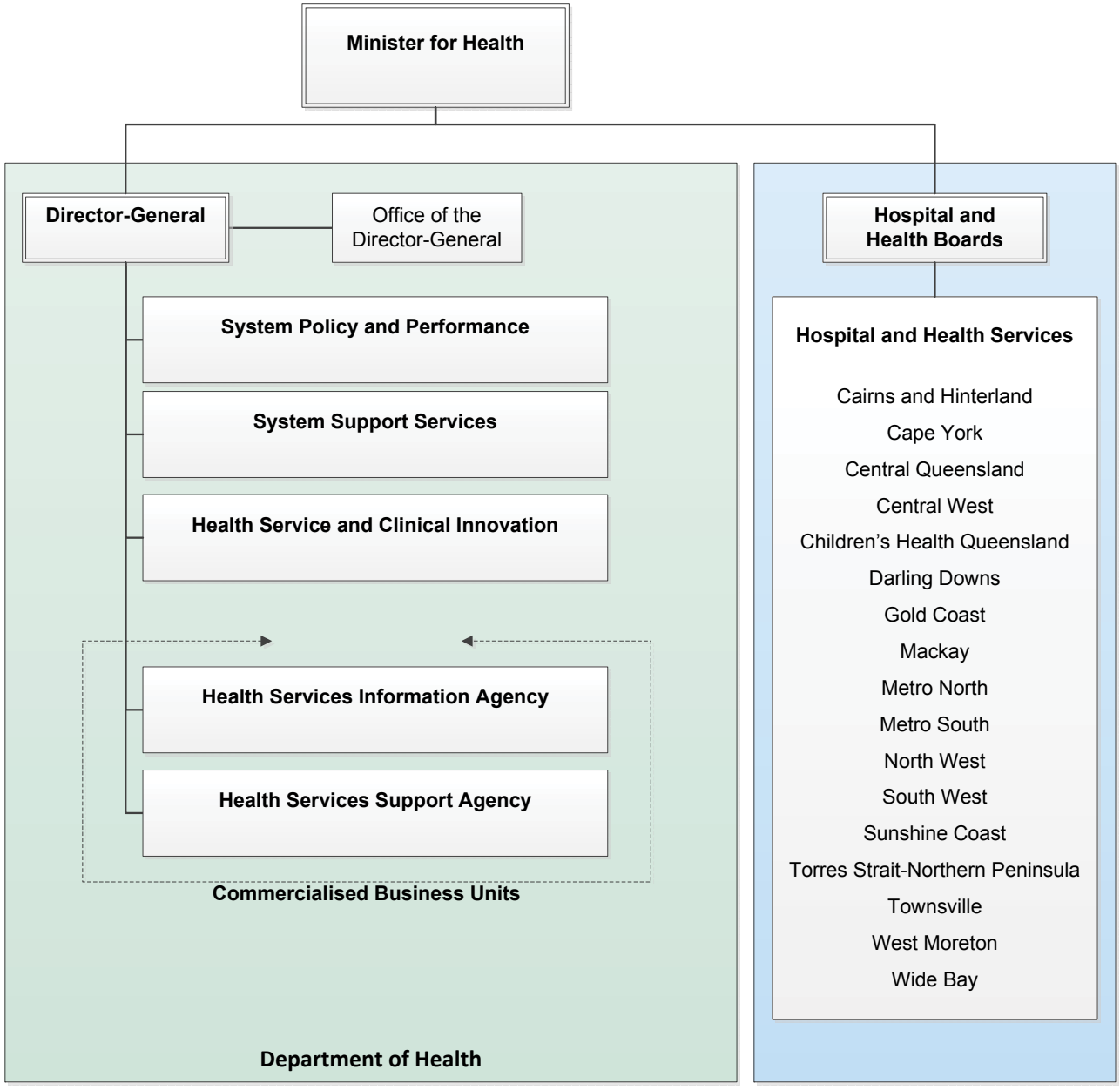
Susan Middleditch

Deputy Director-General, System Support Services

Susan has a proven track record in delivering results in high performing organisations. As a certified practicing accountant, she has extensive financial and business experience. High-level experience in strategic planning, risk management, HR policy development and commercial finance has allowed Susan to successfully drive change and transformation within corporate services teams.

Susan has a mix of both private and public sector experience. She was appointed to her first chief finance officer role at the age of 25 for the Commonwealth Department of Employment Education and Training. She has worked with New Zealand Treasury where she was responsible for assisting organisations, such as Air New Zealand, New Zealand Post, Transpower and New Zealand Rail Corporation to strategically change and grow their business.

Queensland Health organisational chart



Governance and accountability

Executive committees

Executive Management Team

The purpose of EMT is to:

- support the Director-General in meeting responsibilities outlined in the *Public Service Act 2008*, the *Hospital and Health Boards Act 2011*, and other relevant legislation
- provide recommendations regarding the strategic direction, priorities and objectives of the organisation and endorsing plans and actions to achieve the objectives
- set an example for the corporate culture throughout the organisation.

EMT's function is to:

- set the department's strategic direction and priorities
- ensure available resources for the delivery of public sector health services are used effective and efficiently
- monitor the organisation's performance against its strategic objectives and key performance indicators
- set a culture of risk-adjusted decision making throughout the organisation
- ensure effective governance systems are in place.

Key achievements for 2012–13 included:

- supporting the establishment and implementation of contestability within the department
- endorsing the department's revised framework for the management of grant funding
- providing leadership for the progressive autonomy of the HHSs.

The team met 46 times in 2012–13.

Closing the Gap Executive Working Group

The Closing the Gap Executive Working Group oversaw the development, approval and publication of the statewide *Indigenous Health Policy* and associated plans, including initiatives funded under the Council of Australian Governments' Indigenous Health Outcomes and Indigenous Early Childhood National Partnership Agreements. The terms of reference, membership and functions of the working group are currently under review.

Health Service Directive Executive Committee

The purpose of the Health Service Directives Executive Committee is to:

- support EMT in meeting responsibilities related to the application of health service directives as defined within the *Hospital and Health Boards Act 2011*
- provide advice to the Director-General regarding the development, consultation and reviewing or rescinding of health service directives
- oversee HHS compliance with health service directives

- ensure health service directives leverage and support benefits for the improvement of the public healthcare system.

The function of the committee is to provide advice and recommendations to EMT on matters, including:

- compliance by directive custodians with Section 47 of the *Hospital and Health Boards Act 2011* when developing a directive
- suitability and applicability of proposed directives and mandated documents
- oversee quality control of draft directives
- readiness to proceed to consultation
- feedback received during consultation
- issues associated with HHS compliance with directives
- rescinding directives
- situations where it may be necessary to deviate from the Health Service Directives Policy and implementation standards
- issues associated with regulatory reform.

In 2012–13, the committee met nine times and provided advice on:

- development of 19 proposed health service directives
- rescinding of one health service directive
- proposed amendments to several existing health service directives.

The committee also reviewed the status of 104 policies and protocols applying to HHSs from 1 July 2012 to 30 June 2013.

The membership of the committee includes:

- Deputy Director-General, SPP (Chair)
- Deputy Director-General, HSCI
- Deputy Director-General, SSS
- Executive Director, ODG.

Performance Management Executive Committee

The Performance Management Executive Committee was established in September 2012 to support the Director-General to:

- fulfil the performance monitoring and management responsibilities for HHSs contained in the *Hospital and Health Boards Act 2011*
- fulfil the performance monitoring and management responsibilities for Mater Health Services, contained in the *Mater Public Health Services Act 2011*
- deliver health service priorities
- oversee performance management activities of HHSs and Mater Health Services.

The committee's functions are to:

- ensure that the available resources for the delivery of public sector health services are used effectively and efficiently
- oversee the development of the service agreement and related frameworks between the department and HHSs, including the *Performance Management Framework*
- receive and review advice and regular reports regarding the performance of HHSs and authorise changes to a HHS's performance level.
- endorse the key performance indicators for HHSs
- authorise remedial action when HHS performance does not meet the standard outlined in the service agreement.

The membership of the committee includes:

- Deputy Director-General, SPP (Chair)
- Deputy Director-General, HSCI
- Deputy Director-General, SSS
- Chief Finance Officer
- Executive Director, Clinical Access and Redesign Unit
- Executive Director, Healthcare Purchasing, Funding and Performance Management Branch.

Queensland Clinical Senate

The Queensland Clinical Senate was established by Queensland Health in 2009 as a structured forum for engaging with clinicians. Its purpose is to represent clinicians in providing strategic advice and leadership on system-wide issues affecting patient care. It plays a key role, particularly through clinician engagement, in safeguarding high standards of patient care and ensuring continuous clinical practice improvement.

Guiding principles for the senate include:

- valuing consumer perspectives and focusing on quality patient outcomes and experiences
- connecting clinicians across the Queensland healthcare system
- representing clinicians from all disciplines
- providing leadership to achieve health reform
- encouraging and supporting stakeholders to empower clinicians to be actively involved in decision making
- providing constructive advice that is timely, inclusive, evidence-based and aligned with the health reform agenda.

The membership of the senate includes:

- Queensland Clinical Senate Chair
- Queensland Clinical Senate Executive Committee (10 people)

- 75 medical practitioners, nurses, allied health professionals, healthcare administrators, consumers and statewide clinical network chairs from metropolitan, regional, rural and remote areas of Queensland.

Table 6: Queensland Clinical Senate Executive Committee members 2012–13

Name	Membership	Dates
Dr David Rosengren	Chair	December 2012 – current
Dr Bill Glasson	Inaugural Chair	2009 – November 2012
Ms Kerrie Frakes	General member	March 2013 – current
Dr Liz Kenny	Ex-officio member	2009 – current
Mr Simon Mitchell	General member	March 2013 – current
Dr Col Owen	General member	March 2013 – current
Dr Tony Russell	Ex-officio member	December 2012 – current
Mr Mark Tucker-Evans	General member	2009 – current
Ms Christine Went	General member	March 2013 – current
Dr Elizabeth Whiting	General member	2009 – current
Dr Glen Wood	General member	March 2013 – current
Ms Jacqueline Nix	General member	2009 – May 2013
Mr Kevin Clark	General member	2009 – May 2013
Dr Paul Cullen	General member	2009 – May 2013
Dr Bruce Chater	General member	2009 – May 2013
Dr Michael Cleary	Queensland Clinical Senate sponsor	2012 – current

In 2012–13, the executive committee met on 25 occasions to provide advice to stakeholders on state and national issues, including:

- Department of Health organisational structure
- Palliative Care Services and Home and Community Care Services Inquiry
- Department of Health Purchasing Intentions 2013–14 to 2015–16
- Department of Health's Position Statement on Primary Health Care
- Bilateral Plan for Primary Health Care Services in Queensland background paper
- Medical Aids Subsidy Scheme trial; 'Public Sector Podiatrists' prescribing of Medical Grade Footwear.

In 2012–13, the executive committee actively participated in the following committees:

- Activity Based Funding Project Board
- Clinical Workforce Board
- Innovation Board
- National Clinicians Network Organising Committee (a subgroup of the National Lead Clinicians Group)
- EMT
- Outreach Purchasing Steering Committee
- Strategic Advisory Committee Meeting
- Ministerial Taskforce on the Health Practitioner Expanded Scope of Practice.

The senate met three times in 2012–13 to deliberate challenges under the themes of:

- health reform
- PPP
- clinician leadership and clinician engagement
- System Manager Purchasing Intentions: 2013–14 to 2015–16. Proposal for consultation
- advance care planning
- disinvestment in health services.

Key achievements and major activities for the period include:

- transition of leadership and membership
  - the inaugural chair, Dr Bill Glasson, stood down from the role, with Dr David Rosengren subsequently appointed in December 2012
  - the membership changed to comprise clinicians from each HHS and Queensland Medicare Local
- new terms of reference for the senate that reflects the organisational changes within the Queensland public healthcare sector
- provision of advice to stakeholders relating to the meeting themes listed above
- development of a *Queensland Clinical Senate Strategic Plan 2013–2015*
- development of a position statement on effective clinician engagement.

Audit and Risk Committee

During 2012–13, the former Audit Committee was replaced by a new Audit and Risk Committee, reflecting departmental structural changes. The committee is responsible for directly providing independent assurance and assistance to the Director-General on the:

- department's risk, control and compliance frameworks
- agency'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.

During 2012–13, the committee met on a total of eight occasions, including two meetings to address the financial statements. The first meeting of the new Audit and Risk Committee, comprising the new members, took place in October 2012.

Table 7: Audit Committee and Audit and Risk Committee members 2012–13

Name	Membership	Dates
Dr Tony O'Connell	Chair, departmental member	July 2012 – June 2013
Len Scanlan	Deputy Chair, external member	July 2012 – June 2013
Ken Brown	External member	July 2012 – June 2013
Dr Judy Graves	External member	July 2012 – June2013
Julie Hartley-Jones	External member	July 2012 – September 2012
Terry Mehan	Departmental member	July 2012 – September 2012
Susan Middleditch	Departmental member	October 2012 – June 2013
Lisa Dalton	External member	October 2012 – June 2013
Chris Johnson	External member	October 2012 – June 2013

External members on the committee are remunerated for their time. The amount paid during 2012–13 was $23,200.

The committee's charter provides the guidance and direction for the operation of the committee, with specific responsibilities across nine key business functions:

1. Financial statements

The committee:

- reviews the appropriateness of accounting policies
- reviews the appropriateness of significant management assumptions in preparing financial statements
- reviews financial statements for compliance with prescribed accounting and other requirements
- reviews, with management and the internal and external auditors, results of the external audit and any significant issues identified
- ensures proper explanations exist for any unusual transactions, trends or material variations from budget
- ensures management provide appropriate assurances on the accuracy and completeness of the financial statements.

2. Fraud, misconduct and corruption oversight

The committee:

- ensures arrangements are in place for the proportionate and independent investigation of fraud and corruption referrals, including follow-up action
- considers the major findings of relevant internal investigations regarding control weaknesses, fraud or misconduct, and management's responses
- oversees and reviews processes for staff to confidentially raise concern over possible fraud or corruption
- considers policies for preventing or detecting fraud and ensures compliance with relevant standards
- ensures the department complies with relevant integrity legislation and whole-of-government principles, policies and guidelines
- provides advice and recommendations as required on relevant integrity issues to the Director-General and EMT.

3. Risk management

The committee:

- reviews whether management has an appropriate *Enterprise Risk Management Framework* for the effective identification and management of the department's risks
- reviews the adequacy and effectiveness of the department's enterprise risk management strategy, policy and procedures, including management's implementation of internal risk controls and risk recommendations
- assesses sufficiency of insurance arrangements with regard to the framework where appropriate
- assesses and contributes to the audit planning process relating to relevant risks and threats to the department.

4. Internal control

The committee:

- reviews, through the internal and external audit functions, the adequacy of the internal control structure and systems, including information technology security and control
- reviews, through the internal and external audit functions, whether relevant policies and procedures are in place and up-to-date, including those for the management and exercise of delegations and if they are being complied with in all material matters
- reviews, through the Chief Financial Officer, whether the financial internal controls are operating efficiently, effectively and economically.

5. Performance management

The committee:

- reviews whether management has implemented a current and comprehensive framework to meet the department's compliance with the performance management and reporting requirements of relevant legislation and the annual report requirements for Queensland Government agencies
- reviews whether management has an appropriate reporting function in place for adequate reporting on performance.

6. Internal audit

The committee:

- reviews the Internal Audit Charter
- reviews adequacy of the budget, staffing, skills and training of the internal audit function, having regard for the department's risk profile
- reviews and recommends the Internal Audit strategic and annual plans, its scope and progress and any significant changes, including difficulties or restrictions on scope of activities or significant disagreements with management
- reviews and considers the findings and recommendations of Internal Audit reports and implemented actions
- reviews and assesses performance of the Internal Audit activities against annual and strategic audit plans
- monitors developments in the audit field and standards issued by professional bodies or other regulatory authorities to encourage use of best practice by Internal Audit.

7. External audit

The committee:

- consults the external auditors, the Queensland Audit Office, on their proposed audit strategy and audit plan for the year
- reviews findings, recommendations and reports issued by External Audit and corresponding responses from management, including alignment to the department's *Enterprise Risk Management Framework*
- reviews implementation of recommendations accepted by management
- assesses whether any material overlap exists between the external and internal audit plans
- assesses the extent of the external auditor's reliance on internal audit work.

8. Compliance

The committee:

- determines whether management has considered legal and compliance risks as part of the department's risk assessment and management arrangements

- reviews the effectiveness of systems implemented for monitoring compliance with relevant laws, regulations and government policies
- reviews findings of any examinations by regulatory agencies and any audit observations.

9. Reporting

The committee:

- submits reports outlining relevant matters it considers need to be brought to the attention of the Director-General,
- submits a summary report of each committee meeting to EMT.

Information and Communications Technology Portfolio Board

The department's Information and Communications Technology Portfolio Board is the body accountable for the governance of ICT central services and other non-core ICT services as identified by the minister, HHSs and the board. The board will enable business-driven participatory governance that supports a strong customer focus across the following key functions:

- strategic alignment
- investment optimisation
- risk governance
- performance and resource governance
- stakeholder transparency
- standards and compliance.

The board provides advice to the Director-General, who, as chair, is responsible for governing the:

- establishment and ongoing delivery of an ICT strategy for the Queensland public healthcare sector and defining supporting service delivery and operating principles to enable strategic alignment
- establishment of an enterprise architecture that categorises clinical systems and defines which corporate applications and infrastructure components are commodities
- establishment of an investment categorisation framework and criteria to enable investments to be aligned with services
- assessment of investment priorities across the Queensland public healthcare sector to ensure alignment with overall strategic goals and consideration of urgent HHS business needs
- oversight of system replacement business cases to ensure benefits are monitored and achieved in line with the *Benefits Management Framework*
- defining the risk appetite, tolerances and reporting requirements across the Queensland public healthcare sector
- review and monitoring of the department's ICT portfolio risks

- establishment of portfolio milestones and service level agreements, reporting frameworks and escalation processes and thresholds with clearly defined roles and responsibilities
- assessment of portfolio and service level performance against enterprise-level performance objectives that are linked to strategic priorities and escalation thresholds
- championing of communication and awareness strategies to implement the refined ICT central governance arrangements
- establishment of a structured and measured approach to the delivery of ICT services to ensure the required business outcomes are achieved
- implementation of the Deloitte's HSIA strategic review outcomes.

The board replaced the ICT Investment Board and had its inaugural meeting in May 2013.

Health Services Support Agency Advisory Board

The purpose of the Health Services Support Agency Advisory Board is to provide authoritative stakeholder advice to assist the chief executive in managing the HSSA to meet its objective of providing HHSs with client-focused statewide services that deliver a quality product at an affordable price.

The board's functions include:

- providing direction to HSSA on strategy, planning and service delivery
- acting as a sounding board for new ideas and developments
- providing appropriate and constructive challenges to the assumptions and operating routines of the Queensland public healthcare sector
- providing a source of credible and authoritative stakeholder advice
- identifying issues, risks and opportunities
- recommending relevant agenda items for its own deliberations.

The board's membership comprises:

- Independent Chair
- Chief Executive, HSSA
- four HHB members
- four HHS executives, including a Chief Executive, Executive Director of Medical Services, Chief Operations Officer or Corporate Services, Chief Financial Officer
- at least one independent expert or other senior customer representative.

The board meets on a quarterly basis and had its inaugural meeting in April 2013. In 2012–13, the board's related expenses were $5000.

Resource Executive Committee

The Resource Executive Committee functions under the authority of the chair, EMT, and is designed to:

- support EMT by providing strategic and executive level guidance and policy direction on management of the department's resources, including finances, HR and infrastructure
- consider matters which extend beyond individual accountabilities of the department's divisions and commercialised business units and which have significant implications for the department's resources.

The committee's functions are to:

- provide strategic context and direction for the development of financial, capital, investment, HR and infrastructure resource plans
- consider matters, such as high-risk strategies with a financial impact, new financial management strategies and oversee the annual budget cycle.

The committee's membership comprises:

- Deputy Director-General, HSCI (Chair)
- Deputy Director-General, SSS
- Chief Human Resources Officer
- Chief Finance Officer
- Chief Health Infrastructure Officer
- Executive Director, Healthcare Purchasing, Funding and Performance Branch
- Chief Executive, HSSA
- Chief Information Officer, HSIA.

Other committees and boards

Mount Isa Lead Health Management Committee

In May 2013, the Mount Isa Lead Health Management Committee developed the *Mount Isa Lead Health Management Strategic Plan 2013–2016* to focus lead health management activities in Mount Isa.

The committee was established in 2012 to address concerns raised over a number of years regarding childhood exposure to lead in Mount Isa and is chaired by the Chief Health Officer. The main objective of the committee is to strengthen health management strategies to ensure young children in Mount Isa are protected from the harmful effects of lead in the environment.

Members of the committee do not receive any remuneration.

Mechanisms to strengthen governance

Risk and Governance Unit

The Risk and Governance Unit provides an effective risk framework for the department and an approach for statewide risk management in partnership with the 17 HHSs. The current framework is consistent with legislation, Queensland Government guidelines and the Australian Standard AS/NZS ISO 31000:2009. Key risks requiring EMT oversight are included in an executive risk profile on a monthly basis. This executive risk profile is also a key means for communicating risks to the Audit and Risk Committee.

In 2012–13, the unit was given responsibility for establishing an effective compliance framework for general legislation and a governance framework to respectively document the department's post-health reform compliance and corporate governance arrangements. These projects are scheduled for completion in 2013–14.

Key 2012–13 activities included the progress and development of the *Roadmap for Health System Risk Management,* commencement of review projects for both the risk and compliance frameworks, and completion of the Fraud Risk and Control Improvement Project. The risk framework review is aimed at refocusing the current risk framework to meet the department's needs without impeding the HHSs in the establishment of their own risk management arrangements as separate statutory bodies.

Roadmap for Health System Risk Management

A *Roadmap for Health System Risk Management* was endorsed by EMT in April 2013. The roadmap is a key document that establishes a model, intended outcomes and activities for Queensland Health-wide risk management for risks that could impact the health system as opposed to a single organisation.

The roadmap will support cooperation on key risk management initiatives between the department, HHSs and private industry partners for an effective health system and delivery of the *Blueprint for better healthcare in Queensland.*

Risk Framework Review Project

The Risk Framework Review project will update the department's Risk Management Policy, standards and other supporting documents. The project will be completed in 2013–14.

Project timing aligns with, supports and recognises each HHS establishing their own separate risk frameworks as statutory bodies with accountabilities under the *Hospital and Health Boards Act 2011.*

Compliance Framework Review Project

The Compliance Framework Review project seeks to ensure the department is compliant with general legislation and acts as an effective mechanism to identify and proactively address non-compliance. The framework will include a revised Legislation Compliance Policy–General Legislation, standard and new procedure and schedule of legislation.

Fraud Risk and Control Improvement Project

The Fraud Risk and Control Improvement project commenced in August 2012 and provided an integrated approach to countering potential fraud within the department. The approach was based on the Australian Standard for Fraud and Corruption Control AS8001-2008 and Crime and Misconduct Commission guidelines.

The project delivered a:

- Queensland Health Fraud Control Policy
- Implementation Standard for Fraud Control Governance, Prevention, Detection and Response
- Guide to Fraud and Corruption Control
- centralised fraud risk register
- comprehensive fraud risk assessment
- fraud awareness training program
- integrated fraud control education program
- increased employee fraud awareness during February–March 2013 with the fraud awareness month activities.

Continuous improvement will continue in 2013–14 through a Fraud and Corruption Control Working Group.

Fluoridation of Queensland water supplies

At the end of 2012, the Queensland Government amended the *Water Fluoridation Act 2008*, removing the mandatory requirement to fluoridate water supplies serving more than 1000 people. All local governments are now able to decide whether the implementation or continuation of fluoridation is in the best interests of their communities.

Since they have been empowered to make fluoridation decisions, 15 local governments have invited Queensland Health to brief their councillors and provide information on the oral health benefits of fluoridation. This opportunity has been offered to all local governments in Queensland. As of 30 June 2013, approximately 80 per cent of the Queensland population was able to access optimally fluoridated water.

Following the amendment of the fluoridation legislation, a number of local governments yet to commence fluoridation of their water supplies have indicated that it is their intention to start prior to the expiry of the Queensland Fluoridation Capital Assistance Program funding on 30 June 2014.

Grants Program review

In 2012–13, the department completed a review of Queensland Health's $1 billion Grants Program to ensure:

- funding is streamlined
- priority health areas are properly targeted

- the risk of waste and fraud is minimised.

The review consisted of two elements—assessment of each grant and service procurement arrangement for alignment with departmental priorities, and review of the framework for their administration. As a result, several funding programs have been reviewed and are being renewed to:

- improve value-for-money
- ensure there is consistent application of robust procurement and contract management processes
- ensure procurement of grants and services closely follows state procurement practices
- ensure a monthly reconciliation of payments to budgets and formal approval processes.

Review to streamline contracts with non-government organisations

As a result of the assessment of each grant and service procurement arrangement, 71 projects with non-government organisations were discontinued in 2012–13 due to being fixed-term, not aligning with departmental priorities or not demonstrating value-for-money. To further enhance alignment of funding programs across government, another four projects which did not align to Queensland Health priorities have been identified for transfer to the Department of Communities, Child Safety and Disability Services.

Commence streamlining quality standards for non-government organisations

An improved, quality reporting framework was implemented during 2012–13 as part of the review of the department's performance framework for the non-government sector. This provides streamlined reporting and assessment of the performance of non-government organisations against the requisite quality standards for funding. Additionally, the performance framework has been mapped against 13 other quality systems in place in Australia, and a system for exemption from the department's quality reporting has been developed for those organisations already meeting equivalent standards.

Mechanisms to strengthen accountability

Ethical standards

The Ethical Standards Unit (ESU) is the department's central point for receiving, reporting and investigating allegations of suspected official misconduct under the *Crime and Misconduct Act 2001,* and public interest disclosures under the *Public Interest Disclosures Act 2010*. ESU is no longer routinely responsible for receiving or dealing with complaints about the conduct of HHS staff, but may undertake investigations in HHSs at the direction of the Director-General. Complaints about HHS staff which were on hand on 1 July 2013 were reviewed and, wherever possible, transitioned to the relevant HHS for ongoing management.

The key role undertaken by ESU enables the Director-General to fulfil the statutory obligation to report public interest disclosures to the Queensland Ombudsman and allegations of suspected official misconduct to the Crime and Misconduct Commission.

Allegations referred back to the department by the Crime and Misconduct Commission are managed or overseen by ESU.

In 2012–13, ESU focussed on fraud and misconduct prevention by raising ethical awareness and promoting integrity in the workplace. ESU advises the Director-General and senior executives about misconduct prevention, managing new allegations of suspected official misconduct or public interest disclosures, and other ethical behaviour issues.

Assessment and investigations

A multi-disciplinary Matters Assessed Committee assesses new allegations of suspected official misconduct.

The committee comprises:

- ESU Director, Assessment Manager and officers
- a senior Workplace Services Unit representative
- Queensland Police Service Inspector attached to the Queensland Health Police Liaison Unit
- other specialist stakeholders relevant to the allegations, as required.

The Queensland Health Police Liaison Unit's seconded Queensland Police Service Acting Inspector gives specialist advice on criminal matters and acts as a liaison point between the department and local police, and HHSs and the police. The unit assists in raising awareness among Queensland Police Service and Queensland Health staff about the memorandum of understanding between the Queensland Police Service and Queensland Health. The memorandum of understanding aims to facilitate the reporting of suspected criminal offences associated with provision of health services, and information sharing between the agencies.

During 2012–13, ESU reviewed 695 open complaints of suspected official misconduct and 215 public interest disclosures and transitioned them to HHSs for ongoing management. ESU also managed 80 complaints about suspected official misconduct comprising 173 allegations, and assessed and advised the department's work units and executives on a further 203 ethical issues. A further 60 complaints were received and assessed, and found to relate to HHS staff. These were referred to the Crime and Misconduct Commission for consideration and necessary action.

The ratio of complaints received per 100 staff has increased from 1.09 in 2011–12 to 1.85 in 2012–13. This may be attributed to increased staff awareness about fraud and misconduct, reporting obligations and how to report concerns.

Checks were undertaken on 5071 employees prior to a final voluntary redundancy payment being made to ensure employees receiving payments were not subject to allegations of suspected official misconduct.

ESU continued to be involved in assisting the Crime and Misconduct Commission to undertake a number of complex and significant investigations, and a proceeds of crime civil confiscation case. Most notable is the significant fraud perpetrated on Queensland Health, discovered in December 2011.

Prevention

In November 2012, the Director-General mandated fraud and ethical awareness training for all departmental staff. During 2012–13, ESU officers delivered 72 ethical awareness sessions to 3525 staff—this compared with 55 ethical awareness sessions to 1102 staff across the state in 2011–12. These sessions were delivered to a range of staff across all levels of seniority and professional streams and were customised according to the audience.

Other notable activities

In 2012–13, ESU also:

- developed and recorded an online training resource for department and HHS managers to deliver fraud and ethical awareness training to their teams
- reviewed the memorandum of understanding between Queensland Health and the Queensland Police Service
- reviewed policies relating to reporting allegations of suspected official misconduct and making a public interest disclosure
- assumed responsibility for liaison between the department and the Queensland Ombudsman regarding complaints about Queensland Health services or staff
- is a key stakeholder in the department's newly formed Fraud and Corruption Working Group.

Internal audit

The Internal Audit Unit performs the functions of internal audit as required under Section 29 of the Financial and Performance Management Standard 2009.

The unit provides an independent, objective assurance and consulting activity designed to add value and enhance Queensland Health's operations. In line with the overriding requirement of independence and objectivity, the head of internal audit reports directly to the Director-General and the Audit and Risk Committee. The head of internal audit attends all committee meetings, where reports on the unit's activities and significant audit findings are tabled.

The unit's purpose, authority and responsibility are formally defined in its charter, which is reviewed by the Audit and Risk Committee and approved by the Director-General. The charter is consistent with the *International Professional Practices Framework* of the Institute of Internal Auditors. All members of the unit are bound by the principles of integrity, objectivity, confidentiality and competency under the institute's code of ethics.

The unit's strategic and annual audit plans provide the direction for work activities. The *Annual Internal Audit Plan* is developed in consultation with the department's senior

management and approved by the Director-General. It is based on assessments of risk and previously identified issues by both the unit and external auditors (the Queensland Audit Office).

As a result of the restructure of Queensland Health, staffing levels of the unit decreased during 2012–13, with a decision being made to co-source internal audit activities. From 1 October 2012, the permanent Internal Audit team decreased to five team members. A tender process was progressed for the co-sourcing of internal audit activities, with the tender being awarded to PricewaterhouseCoopers. Works commenced in December 2012.

During 2012–13, all 10 audits from the originally approved and subsequently revised *Annual Internal Audit Plan* were delivered and reports issued to the Director-General. These reports covered operational/efficiency, information systems, and financial and compliance audits. During 2012–13, the unit continued its Data Analytics Program, in the move towards continuous auditing, with a particular emphasis on payroll and financial activities. The Internal Audit team also contributed to improved governance of the department through independent assurance activities on major projects, including the SAP Assets, Procurement and Financial Information Resource Project.

Information systems and record keeping

The department has a strong commitment to improving record keeping practices and complying with the *Public Records Act 2002*—Information Standard 40: Record keeping and Information Standard 31: Retention and Disposal of Public Records.

Records management training has been provided through two online training modules—Introduction to Record keeping and Records Management Basics. In 2012–13, more than 1100 staff completed online training. Training in the Department of Health's Business Classification Scheme has also been provided to staff from HHSs. The scheme is a records management tool used to categorise information resources in a consistent and organised manner.

The Machinery of Government Network group has continued to assist in the transfer of records from the department to HHSs. A review of the draft Health Sector Functional Retention and Disposal Schedule commenced and is due for submission to Queensland State Archives by September 2013.

Service delivery statements

Table 8: 2012–13 Department of Health performance statement

	Notes	2012–13 target/est.	2012–13 actual
Service area: Performance and governance			
Service standards			
Percentage of HHSs demonstrating an improvement from the starting performance category	1	100%	35%
Service area: Corporate support services			
Service standards			
Proportion of the organisation receiving an outcome rated as 'conforming' in the annual audit for Safer Healthier Workplaces Standard with no major non-conformances recorded	2	100%	100%
Percentage of capital infrastructure projects delivered on scope, time, cost and quality with a variance to budget less than +/- 5%	3	95%	61.1%
Service area: Safety, quality and clinical support			
Service standards			
Percentage of HHSs participating in Statewide Clinical Networks		100%	100%
Percentage of Clinical Service Redesign projects delivered on time and with a variance to budget less than +/- 2%		100%	100%
Percentage of formal reviews undertaken on HHS responses to significant negative variance in Variable Life Adjusted Displays and other National Safety and Quality Indicators.	4	100%	100%
Service area: Human resources			
Service standards			
Percentage of off cycle pays	5	1.4%	1.4%

	Notes	2012–13 target/est.	2012–13 actual
Service area: Health Services Support Agency—safety, quality and clinical support			
Service standards			
Percentage of calls to 13 HEALTH (13 43 25 84) answered within 20 seconds	6	80%	84.3%
Service area: Health Services Information Agency—health information technology			
Service standards			
Percentage of ICT availability for major enterprise applications: • metropolitan • regional • remote.	7	99.8% 95.7% 92%	99.9% 99.8% 99.6%
Percentage of all high-level ICT incidents resolved within targets defined in the service catalogue	8	80%	81.6%
Percentage of initiatives with a status reported as critical (red)	9, 10	<20%	45%

Notes:

1. Under the 2012–13 *HHS Performance Framework*, each HHS was assigned a performance category. The performance category is a measure of the HHS's performance against the escalation Key performance indicators in the service agreement. The framework established the criteria assigned to each performance category and the performance-related triggers that prompt movement to another performance category.
2. The safety audit was completed over a two-year period with eight HHSs audited within 2012–13. A new audit approach was applied in 2012–13 (in line with AS/NZS 4801) which does not include a criterion of 'major non-conformance'. Areas of continual improvement were identified in each of the audits.
3. Percentage of delivery is measured on projects completed and projects forecast to be delivered prior to 30 June 2013 within scope, time, cost and quality. Performance against all domains relates to a number of factors. For example, time is measured on forecast delivery date and/or approved variation where unforseen circumstances (including inclement weather, natural disasters, latent conditions and industrial action) impacts the forecast delivery schedule. The cost element is not included within the overall calculations as final costs cannot be determined until the expiry of a 12 month 'defect period' for each project. This service standard is subject to review during 2013–14.
4. All eligible HHS facilities participate in clinical monitoring including Variable Life Adjusted Displays and other National Patient Safety and Quality Indicators. All mandatory investigations by HHSs into significant negative variation are required to be formally reviewed by the Queensland Health Variable Life Adjusted Displays Committee to ensure clinical appropriateness.
5. Off cycle payments are payments made outside of the normal fortnightly pay run to facilitate employee payments in specific circumstances including separation payments and to address late receipt and

processing of payroll forms in the previous roster period. Figures represent the number of off cycle payments in a year as a percentage of the total number of payments made during the year. In October 2012, the employee pay date was moved by one week to allow additional time to submit, approve and process payroll forms each roster period. Targets/estimates for off cycle payments are based on the estimated impact of the pay date change (part year impact in 2012–13) on the volume of off cycle payments required because of late receipt and processing of payroll forms.

6. The 2012–13 target/estimate was set at 80 per cent as this is internationally recognised as a suitable target/grade of service for health call centres.

7. This service standard measures continuity and availability of ICT services, specifically network availability.

8. This service standard measures ICT incidents resolved within recommended timeframes.

9. This measure relates to all new initiatives and initiatives that are not yet fully operational.

10. The 2012–13 actual exceeded the critical 20 per cent target due in part to the restructure of HSIA over the reporting period. It is noteworthy that the trend for initiatives with a critical status has progressively fallen from 62 per cent (October to December 2012) to 43 per cent (January to March 2013) and to 31 per cent (April to June 2013).

Table 9: 2012–13 Queensland Health performance statement

	Notes	2012–13 target/est.	2012–13 actual
Service area: Prevention, promotion and protection			
Service standards			
Percentage of the Queensland population who consume recommended amounts of:	1		
• fruits		55.6%	55.7%
• vegetables		9.7%	8.8%
Percentage of the Queensland population who engaged in levels of physical activity for health benefit:			
• persons		61.0%	58.9%
• male		65.8%	63.7%
• female		56.3%	54.1%
Percentage of the Queensland population who are overweight or obese:			
• persons		58.3%	58.9%
• male		65.6%	66.4%
• female		51.0%	51.0%
•			
Percentage of the Queensland population who consume alcohol at risky and high-risk levels:			
• persons		11.0%	11.4%
• male		12.3%	13.2%
• female		9.6%	9.6%

	Notes	2012–13 target/est.	2012–13 actual
Percentage of the Queensland population who smoke daily:			
• persons		13.3%	15.8%
• male		14.6%	17.1%
• female		12.1%	14.4%
Percentage of the Queensland population who were sunburnt in the last 12 months:	2	New measure	
• persons			52.3%
• male			55.5%
• female			49.2%
Annual notification rate of HIV infection per 100,000 population	3	5.0%	4.2
Number of rapid HIV tests performed	4	New measure	28
Vaccination rates at designated milestones for:			
• all children 12–15 months		92%	92%
• all children 24–27 months		92%	92.6%
• all children 60–63 months		92%	91.5%
Percentage of target population screened for:	5		
• breast cancer		57.6%	57.6%
• cervical cancer		55.3%	55.3%
• bowel cancer		38.0%	35.5%
Percentage of invasive cancers detected through BreastScreen Queensland that are small (<15mm) in diameter	6	63.9%	57.1%
Rate of healthcare associated *Staphylococcus aureus* (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days	7	New measure	1.0
State contribution ($000)		**$303,075**	**$325,492**
Other revenue ($000)		**$260,940**	**$764,030**
Total cost ($000)		**$564,015**	**$1,089,522**

	Notes	2012–13 target/est.	2012–13 actual

Service area: Primary healthcare

Service standards			
Ratio of potentially preventable hospitalisations—rate of Aboriginal and Torres Strait Islander hospitalisations to the rate of non-Aboriginal and Torres Strait Islander hospitalisations	8	New measure	1.9
Percentage of women who, during their pregnancy, were smoking after 20 weeks: • non-Aboriginal and Torres Strait Islander women • Aboriginal and Torres Strait Islander women		10.5% 41.2%	10% 42%
Number of in-home visits, families with newborns (in accordance with the Mums and Bubs commitment)	9	New measure	57,264
Number of adult oral health weighted occasions of service (ages 16+)	10	1,800,000	1,917,684
Number of children and adolescent oral health weighted occasions of service (0–15 years)		1,300,000	1,298,375
Percentage of oral health weighted occasions of service which are preventive	11	New measure	13.2%
Percentage of oral health weighted occasions of service provided by private dental partners		New measure	5.8%
State contribution ($000)		**$549,536**	**$577,696**
Other revenue ($000)		**$98,333**	**$564,275**
Total cost ($000)		**$647,869**	**$1,141,971**

	Notes	2012–13 target/est.	2012–13 actual
Service area: Ambulatory care			
Service standards			
Percentage of patients transferred off-stretcher within 30 minutes	12	New measure	84%
Percentage of emergency department attendances who depart within four hours of their arrival in the department		74%	72%
Median wait time for treatment in emergency departments (minutes)		20	18
Percentage of emergency department patients seen within recommended timeframes:	13, 14		
• category 1 (within 2 minutes)		100%	100%
• category 2 (within 10 minutes)		80%	84%
• category 3 (within 30 minutes)		75%	67%
• category 4 (within 60 minutes)		70%	72%
• category 5 (within 120 minutes)		70%	90%
• all categories		..	73%
Percentage of specialist outpatients waiting within clinically recommended times:		New measure	
• category 1 (30 days)			45%
• category 2 (90 days)			31%
• category 3 (365 days)			54%
Percentage of babies born of low birth weight to:	15		
• non-Aboriginal and Torres Strait Islander mothers		5.8%	5.1%
• Aboriginal and Torres Strait Islander mothers		9.1%	9.8%
Total weighted activity units:	16, 17		
• emergency department		192,717	191,636
• outpatients		190,249	182,596
• interventions and procedures		131,922	133,207
State contribution ($000)		**$1,549,181**	**$1,607,335**
Other revenue ($000)		**$817,892**	**$1,723,433**
Total cost ($000)		**$2,367,073**	**$3,330,768**

	Notes	2012–13 target/est.	2012–13 actual
Service area: Acute care			
Service standards			
Median wait time for elective surgery (days):	18		
• category 1 (30 days)		..	13
• category 2 (90 days)		..	55
• category 3 (365 days)		..	132
• all categories		25	29
Percentage of elective surgery patients treated within clinically recommended times:			
• category 1 (30 days)		95%	100%
• category 2 (90 days)		84%	91%
• category 3 (365 days)		93%	96%
Percentage of admitted patients discharged against medical advice:			
• non-Aboriginal and Torres Strait Islander patients		0.8%	1.0%
• Aboriginal and Torres Strait Islander patients		1.9%	3.4%
Average cost per weighted activity unit for ABF facilities	19	$4536	$4449
Total WAUs, acute inpatient	17, 20	840,654	847,357
State contribution ($000)		**$3,825,488**	**$3,781,536**
Other revenue ($000)		**$2,376,094**	**$5,575,263**
Total cost ($000)		**$6,201,582**	**$9,356,799**
Service area: Rehabilitation and extended care			
Service standards			
Total WAUs, subacute	17	96,212	96,500
State contribution ($000)		**$522,682**	**$558,014**
Other revenue ($000)		**$486,815**	**$1,081,145**
Total cost ($000)		**$1,009,497**	**$1,639,160**

	Notes	2012–13 target/est.	2012–13 actual

Service area: Integrated mental health services

Service standards			
Proportion of re-admissions to acute psychiatric care within 28 days of discharge	21	10%–14%	14%
Rate of community follow-up within 1–7 days following discharge from an acute mental health inpatient unit		55%–60%	62.9%
Percentage of the population receiving clinical mental healthcare	22	New measure	1.8%
Ambulatory mental health service contact duration	23	New measure	729,642
Total WAUs, mental health	17	115,292	110,889
State contribution ($000)		**$691,166**	**$644,908**
Other revenue ($000)		**$380,930**	**$1,510,028**
Total cost ($000)		**$1,072,096**	**$2,154,936**

Notes:

1. The previous measure 'Percentage of the Queensland population who consume recommended amounts of fruits and vegetables' has been amended to show fruits and vegetables as discrete indicators as the sensitivity to detect change is reduced when fruit and vegetables are reported as a combined indicator. Separating the indicators improves understanding of healthy nutrition behaviours as fruit consumption is good and generally improving while vegetable consumption remains low and static.
2. The previous measure 'Percentage of the Queensland population who were sunburnt on the previous weekend' has been discontinued as the previous measure was not sensitive enough to gauge a true reflection of behaviour across the population. The new measure 'Percentage of the Queensland population who were sunburnt in the last 12 months' better captures behaviour over a 12 month period. The limitation of the previous measure is that it reflects weather and seasonal patterns rather than sustained changed behaviour.
3. The annual notification rate of HIV infection is a reflection of the number of notifications per 100,000 population. The 2012–13 estimated actual figure is an estimate based on the number of first diagnoses of HIV in Queensland for the 2012 calendar year. From 2012, measures to address HIV notifications have been under the direction of the new MAC.
4. Rapid HIV testing was implemented from 3 June 2013 in 11 sexual health services across the state. A HIV rapid test is a point of care test which enables clinicians to test the patient for HIV on-site. It takes 20 minutes to perform and their use is primarily for people at higher risk of HIV than the general population. The rapid tests are not a replacement for existing testing, but are an additional measure designed to increase testing among high-risk populations.

5. The 2012–13 estimated actual data for participation rates for BreastScreen Queensland and the Queensland Cervical Screening Program relate to the latest period for which data is available (2010–11 biennial period). Bowel Cancer Screening participation rates are for the 2011 calendar year. Actual participation rates for Bowel Cancer Screening were lower than expected due to the introduction of 50 year olds to the program. This age group had lower participation rates than the 55 and 65 year olds already being screened and this brought down the overall participation rate.

6. The actual results may fluctuate from year-to-year based on the demographics of the women screened.

7. *Staphylococcus aureus* is bacteria commonly found on around 30 per cent of people's skin and noses and often cause no adverse effects. Infections with this organism can be serious, particularly infections in 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.

8. The previous measure (number and age standardised rate of potentially preventable admitted patient episodes of care) has been discontinued as published time-series data are not comparable due to coding changes over time. The new indicator provides the ratio of total potentially preventable hospitalisations for Aboriginal and Torres Strait Islander hospitalisations as a percentage of total admissions relative to the total number of non-Aboriginal and Torres Strait Islander potentially preventable hospitalisations as a percentage of total admissions.

9. The 2012–13 actual figure is based on an extrapolation of data relating to the final quarter of 2012–13 which takes account of the increase in home visiting numbers with the implementation of the Mums and Bubs commitment.

10. For adult oral health weighted occasions of service, the 2012–13 estimated actual figure includes additional oral health service activity funded under the National Partnership Agreement for Treating More Public Dental Patients which commenced in Queensland on 27 February 2013.

11. Preventive treatment is reported according to item numbers recorded in each patient's clinical record and includes procedures, such as removal of plaque and calculus from teeth, application of fluoride to teeth, dietary advice, oral hygiene instruction, quit smoking advice, mouthguards and fissure sealants. All of these items are important to improve and maintain the health of teeth, gums and soft tissues within the mouth, and also have general health benefits.

12. Off-stretcher time is defined as: the time interval between the ambulance arriving at the emergency department and the patient transferred off the QAS stretcher. (QAS Code 1 and 2 Patients only).

13. A target is not included for 'all categories' as there is no national benchmark, however the service standard is included (without a target) as it is a nationally recognised standard measure of emergency department performance.

14. While performance for triage Category 3 was under target, results have improved from the 2011–12 actual (62 per cent) to the 2012–13 actual (67 per cent). Category 3 patients represent the largest cohort of patients among the categories (42 per cent).

15. Low birth weight is defined as less than 2500 grams and excludes multiple births, stillbirths and births of unknown birth weight.

16. The existing 'total WAUs' measure has been amended to reflect the continued refinement of the ABF Model and implementation of the National ABF Model. WAUs relating to interventions and procedures have been added—these include services which may be delivered in inpatient or outpatient settings, for example chemotherapy, dialysis and endoscopies.

17. Calculations of the number of WAUs are affected by the parameters of the ABF Model and are specific to the ABF Model under which they are calculated. The 2012–13 actuals have been recalculated based on Phase 16 of the ABF Model.

18. A target is not included for categories 1–3 as there is no national benchmark at the 50th percentile. A target has been included for 'all categories' to align with the HHS service agreements. The 2012–13 actuals are preliminary figures and subject to change.

19. Calculation of the average cost per WAU is affected by the parameters of the ABF Model and is specific to the ABF Model under which it is calculated. The 2012–13 target/estimate and the 2012–13 actual have been recalculated based on Phase 16 of the ABF Model. The decrease in the 2012–13 actual figure compared to the 2012–13 target/estimate reflects lower expenditure on public hospital services funded through ABF than projected at the time of the 2012–13 budget.

20. The previous measure 'total WAUs – inpatients (including critical care)' has been amended to 'total WAUs – acute inpatient' as this reflects the continued refinement of the ABF Model and implementation of the National ABF Model.

21. Based on preliminary data for the period 1 July 2012 to 31 May 2013.

22. This indicator provides a mechanism for monitoring population treatment rates and assesses these against what is known about the distribution of mental disorder in the community. This measure is also reported through the National Healthcare Agreement.

23. The previous measure 'number of ambulatory service contacts (mental health)' has been amended to 'ambulatory mental health service contact duration', which is considered a more robust measure of services delivered. This is a measure of community mental health services provided by HHSs, which represent more than 50 per cent of the total expenditure on clinical mental health services in Queensland.

Major audits and reviews

Queensland Government Chief Information Office—Information and Communications Technology Audit

The Queensland Government Chief Information Office undertook a whole-of-government ICT audit, with a focus on identifying savings and waste, risks and issues, and performance and accountability. The audit covered several ICT areas of Queensland Government, comprising:

- strategy and governance
- structure
- service delivery
- procurement
- assets and services
- ICT initiatives.

Auditor-General of Queensland's Report to Parliament No. 4 for 2012–13

The Queensland Audit Office eHealth Program performance report was tabled in Queensland Parliament on November 2012. The objective of this audit was to determine whether the program was implemented as intended, achieving its planned outcomes and realising expected benefits.

The report made six recommendations and concluded that the program should strengthen program governance, monitoring and oversight and, in particular, greater attention be given to benefits management, measurement and realisation at all stages of ICT projects. Three recommendations have been implemented and activities to implement the remaining three recommendations are underway.

The implementation of these recommendations will result in better management of ICT projects as more controls will be implemented across the life cycle of a project.

Review of Health Services Information Agency

Following the release of the *Blueprint for better healthcare in Queensland,* a review of HSIA was carried out by Delloitte to:

- identify the scope of services to be provided by HSIA (or on behalf of HSIA)
- specify the organisational and commercial arrangements by which these services can best be provided to acceptable quality standards and at minimum cost
- specify the most suitable arrangements for governance of ICT in Queensland Health
- develop a realistic high-level plan for implementing the review's recommendations.

The review was completed in April 2013 and HSIA is working to implement the six recommendations. The HSIA ICT Reform Program, established in November 2012 to drive sourcing of the early contestability candidates, will be the mechanism to deliver the outcomes of the review. A high-level program structure and implementation approach has been developed and an implementation plan containing cost, activities resourcing and performance measures will be presented to the department's ICT Portfolio Board.

Right of Private Practice

The Auditor-General carried out a performance audit of Right of Private Practice arrangements in the Queensland public healthcare sector and a report was presented to Parliament on 11 July 2013.

The department established a Right of Private Practice Reform Taskforce on 19 December 2012, to oversee complete reform and redesign of all private medical practice within public health facilities, and to establish a new policy to govern all forms of private practice within public health facilities. The taskforce completed a concept design for all private practice in public sector health services in May 2013.

A new Private Practice Governance Board will be established with responsibility for the existing scheme, the Queensland Audit Office's recommendations for the existing scheme and oversight of a very large system change in implementing a redesigned private practice arrangement.

Health complaints

The Minister for Health commissioned two expert reviews following the tabling on 23 July 2012 of a report by Mr Richard Chesterman QC, who was engaged by the Crime and Misconduct Commission to undertake an independent assessment of a public interest disclosure from Ms Jo-Anna Barber about alleged failures of health complaints and regulatory systems:

- *Hunter Report*—Mr Jeffrey Hunter SC examined previous medical board disciplinary cases and recommended police consider six medical practitioners for possible criminal charges.
- *Forrester Report*—an expert panel headed by former Assistant Commissioner of the Health Quality and Complaints Commission (HQCC), Dr Kim Forrester, examined medical board files and found that about 60 per cent were not handled in a manner that was timely and/or appropriate and/or in compliance with legislative objectives.

Following the tabling of the Hunter and Forrester reports in the Queensland Parliament in April 2013, the Minister for Health introduced legislation in June 2013 to create a Health Ombudsman to head a new and accountable health complaints system.

Queensland Audit Office Fraud Risk Management Report 9: 2012–13

All of the recommendations of *Queensland Audit Office Fraud Risk Management Report 9* have been implemented. The department established a Fraud Risk and Control Improvement Project in August 2012. The project provided an integrated approach to countering fraud through the five key areas of fraud prevention, detection, monitoring, reporting and response strategies. The approach was based on the Australian Standard for Fraud and Corruption Control AS8001-2008 and Crime and Misconduct Commission guidelines.

The project delivered:

- Queensland Health Fraud Control Policy
- Implementation Standard for Fraud Control Governance, Prevention, Detection and Response
- Guide to Fraud and Corruption Control
- centralised fraud risk register
- comprehensive fraud risk assessment
- fraud awareness training program
- integrated fraud control education program
- increased employee fraud awareness during February–March 2013 with the fraud awareness month activities.

To continue a focus on fraud control, a Fraud and Corruption Working Group chaired by the Chief Governance Officer, was established with membership from across the department. The focus of the group is to share recent fraud-related incidents (including fraud trends), risk registers and best practice to ensure all parts of the organisation have adequate fraud control coverage. To ensure ownership and the embedding of an improved fraud awareness and prevention culture across the department, continuous reviews and follow-ups of the responsibilities identified in the implementation standard will be carried out on a regular basis.

Review of the Queensland Health Payroll System

The Department of Health has continued to progress initiatives to address the recommendations of the KPMG report into the Queensland Health Payroll System tabled in the Queensland Parliament on 6 June 2012, through:

- implementation of an overpayments recovery strategy including the automated recovery of overpayments
- moving the pay date by one week in October 2012, allowing a greater percentage of roster changes to be captured and reflected in fortnightly pays
- improving support to HHSs to increase client focus and accountability of payroll services via fortnightly reporting against key performance indicators.

Safety management systems audits

During 2012–13, Queensland Health underwent third party external safety management systems audits for nine representative sites, including the Department of Health and eight HHSs. The process provided assistance in the preparation for transition of HHSs to prescribed services. Identified issues feed into the transition plans and are monitored by the executive management teams within HHSs. The audits were in accordance with *Australian Standard/New Zealand Standard 4801: 2001 Occupational Health and Safety Management Systems*.

Commission of Inquiry into the implementation of the Queensland Health Payroll System

The Commission of Inquiry into the implementation of the Queensland Health Payroll System commenced on 1 February 2013. The Department of Justice and Attorney-General is the administering agency for the commission and the representation on behalf of the state is being coordinated by the Department of the Premier and Cabinet. The Department of Health has responded to requests for information from the commission and other parties since the commencement of the inquiry. Current and former Queensland Health staff have assisted the commission by providing evidence.

Queensland Ombudsman's report into the regulation of asbestos

The *Asbestos report: An investigation into the regulation of asbestos in Queensland* was released by the Queensland Ombudsman on 21 March 2013. The investigation found that the framework for regulating asbestos in Queensland is complex and contains a number of gaps and areas of confusion. The department has accepted the 12 recommendations directed to it by the Queensland Ombudsman. A whole-of-government *Strategic Plan for the Management of Asbestos in Queensland 2013–2018* is being finalised by the Department of Justice and Attorney-General to address the Queensland Ombudsman's recommendations and for ensuring that there is a coordinated approach to the management of asbestos in Queensland.

Related entities

Ministerial Advisory Committee HIV/AIDS

The Ministerial Advisory Committee HIV/AIDS was established in July 2012 to provide independent advice to the Minister for Health on HIV prevention and awareness in Queensland, including the most effective allocation of funds to minimise future HIV transmission.

The scope of the committee includes:

- prevention and awareness campaigns to reduce HIV transmission
- strategies to meet the United Nations targets for reductions in HIV transmission
- advice on the priority actions identified in the *Sixth National HIV Strategy 2010–2013* and any subsequent strategies
- advice to HHBs on targeted HIV/AIDS prevention and care as relevant
- broader aspects relating to HIV, including emerging and topical issues as deemed appropriate by the committee
- input into development of future Department of Health strategies to address HIV/AIDS.

The committee's functions include:

- providing independent strategic advice to the Minister for Health regarding implementation of HIV/AIDS awareness and prevention strategies
- reviewing forums and annual progress reports relating to HIV strategies to progress coordinated responses on priority issues
- monitoring the outcomes of the independent evaluation of strategy investments
- reporting to the Minister for Health on issues and concerns in the implementation of HIV strategies.

The committee's key achievements for 2012–13 include:

- the launch of free rapid testing in Queensland sexual health clinics
- completion of an independent analysis of HIV prevention programs/projects in Queensland
- development of a targeted HIV marketing campaign
- development of a draft *Queensland HIV Strategy 2013–2015*
- appointment of a HIV communications media officer
- development of a HIV and Sexually Transmissible Infections Professorial Chair position to be shared between the department and a Queensland university
- development of a pre-exposure prophylaxis (PrEP) demonstration trial
- advocating with the Australian Government and Pharmaceutical Benefits Advisory Committee regarding restrictions for HIV antiretroviral treatment to enable a greater level of community access for both patients and prescribers.

In 2012–13, the committee met five times. Members are not remunerated. However, the total on-costs per meeting, including flights, accommodation, food and incidentals, is approximately $2900 per meeting. Therefore, total on-costs for the year were approximately $14,500.

Council of the Queensland Institute of Medical Research

The Council of the Queensland Institute of Medical Research was established under the *Queensland Institute of Medical Research Act 1945* as a statutory body. Its function is to ensure the proper control and management of the institute, which was established for the purposes of conducting research into any branch or branches of medical science.

Health Consumers Queensland—Ministerial Advisory Committee

The Health Consumers Queensland—Ministerial Advisory Committee was established under the Hospital and Health Boards Act 2011. The committee contributes to the development and reform of health systems and services in Queensland by giving the Minister for Health information and advice from a consumer perspective, and supporting and promoting consumer engagement and advocacy. From August 2012, Health Consumers Queensland came under the auspice of the Council on the Ageing Queensland to transition to an independent non-government organisation.

Health practitioner registration boards

Two remaining health practitioner registration boards continued to be supported by the Office of Health Practitioner Registration Boards.

The two boards were:

- Dental Technicians Board of Queensland
- Speech Pathologists Board of Queensland.

Each board was established under separate legislation as a statutory body with the primary function of registering their professional group and ensuring healthcare was delivered by registrants in a professional, safe and competent way. The office was also established as a statutory body to provide quality administrative and operational services to the boards.

The legislation for the boards and the office was repealed under the *Health Practitioner Registration and Other Legislation Amendment Act 2013*. The two boards ceased on 20 May 2013 and the office on 30 June 2013.

Health Quality and Complaints Commission

The commission was established under the *Health Quality and Complaints Commission Act 2006* and is responsible for independent review and management of complaints from anyone in relation to health service delivery and for monitoring quality and safety in all public and private health services.

Clinical Advisory Committee

The Clinical Advisory Committee was established under the *Health Quality and Complaints Commission Act 2006* to advise the Health Quality and Complaints Commission about clinical matters relevant to the commission's functions.

Consumer Advisory Committee

The Consumer Advisory Committee was established under the *Health Quality and Complaints Commission Act 2006* to advise the Health Quality and Complaints Commission on consumer concerns about health services and other matters relevant to the commission's functions.

Hospital foundations

Hospital foundations are constituted as statutory bodies under *the Hospitals Foundations Act 1982*. Hospital foundations aim to acquire, manage and apply property and any associated income to continuing projects within or associated with their respective hospitals. The following hospital foundations report directly to the Minister for Health:

- Bundaberg Health Services Foundation
- Children's Health Foundation Queensland
- Far North Queensland Hospital Foundation
- Gold Coast Hospital Foundation
- Ipswich Hospital Foundation
- Mackay Hospital Foundation
- PA Research Foundation
- Redcliffe Hospital Foundation
- Royal Brisbane and Women's Hospital Foundation
- Sunshine Coast Health Foundation
- The Prince Charles Hospital Foundation
- Toowoomba Hospital Foundation
- Townsville Hospital Foundation.

Mental Health Court

The Mental Health Court is a superior court of Queensland established under the *Mental Health Act 2000*. Its primary function is to determine issues such as criminal responsibility and fitness for trial. The court is the appeal body to the Mental Health Review Tribunal—another statutory agency established under the Act—with special powers of inquiry into the lawfulness of detention of people in authorised mental health services.

Mental Health Review Tribunal

The Mental Health Review Tribunal is an independent statutory body established under the *Mental Health Act 2000* and is comprised by a president and other members, including lawyers, psychiatrists and other people with relevant qualifications and/or experience. The tribunal's primary purpose is to protect the rights of people receiving involuntary treatment for mental illness. It provides an independent review, and makes decisions about whether involuntary treatment is required, and whether treatment will be given in hospital or in the community. In making these decisions, the tribunal must balance the rights of the patient with the rights of others and the protection of the community.

Panels of assessors

Panels of assessors were established under the *Health Practitioners (Disciplinary Proceedings) Act 1999* to assist the Queensland Civil and Administrative Tribunal with disciplinary matters about a registrant, other than disciplinary matters that may, if proved, provide grounds for suspending or cancelling the registrant's registration. With the repeal of Queensland's health practitioner registration legislation, the panels operate under transitional provisions of the Health Practitioner Regulation National Law to deal with any matters opened, but not concluded prior to health professions' transition to the national registration scheme.

Queensland Fluoridation Committee

The Queensland Fluoridation Committee was established under the *Water Fluoridation Act 2008* and provided for promotion of good oral health in Queensland by the safe fluoridation of public potable water supplies. The committee ceased in December 2012 following amendments to the Act.

Radiation Advisory Council

The Radiation Advisory Council was established under the *Radiation Safety Act 1999*.

The council's functions are:

- to examine and make recommendations to the Minister for Health about the operation and application of the Act, proposed amendments, radiation safety standards and issues on radiation

- conduct research into radiation practices and transport of radioactive materials in Queensland.

Table 10: Annual reporting arrangements for statutory agencies

Body	Constituting Act	Reporting arrangements
Council of the Queensland Institute of Medical Research	*Queensland Institute of Medical Research Act 1945*	Annual report to Queensland Parliament
Dental Technicians Board*	*Dental Technicians Registration Act 2001*	Annual report to Queensland Parliament
Health Quality and Complaints Commission: • Clinical Advisory Committee • Consumer Advisory Committee	*Health Quality and Complaints Commission Act 2006*	Annual report to Queensland Parliament
HHSs (17)	*Hospital and Health Boards Act 2011*	Annual report to Queensland Parliament
Hospital foundations (13)	*Hospitals Foundations Act 1982*	Annual report to Queensland Parliament
Director of Mental Health (1) Mental Health Court (1) Mental Health Review Tribunal (1)	*Mental Health Act 2000*	Annual report to Queensland Parliament
Office of the Health Practitioner Registration Boards*	*Health Practitioners Registration Boards (Administration) Act 1999*	Annual report to Queensland Parliament
Panels of Assessors (17)	*Health Practitioners (Professional Standards) Act 1999*	Annual report to the Minister for Health
Radiation Advisory Council	*Radiation Safety Act 1999*	Annual report to the Minister for Health
Speech Pathologists Board*	*Speech Pathologists Registration Act 2001*	Annual report to Queensland Parliament

*Note: 2012–13 will be final reports as the legislation for these agencies has been repealed.

Cost of statutory agencies

Table 11 outlines costs associated with those entities in the health portfolio that are not required to prepare separate financial statements.

Table 11: Cost of statutory agencies 2012–13

Authority	Cost
Health Consumers Queensland—Ministerial Advisory Committee	$3023.00
Ministerial Advisory Committee HIV/AIDS	$1,319,326.00
Mental Health Court	$310,842.00
Mental Health Review Tribunal	$3,460,764.00
Panels of Assessors	$5,132.00
Queensland Civil and Administrative Tribunal	$0.00
Queensland Fluoridation Committee	$0.00
Radiation Advisory Council	$7479.90

Establishment of Hospital and Health Boards

On 1 July 2012, 17 HHSs were established as statutory bodies under the *Hospital and Health Boards Act 2011*. HHSs are now responsible for the delivery of public hospital and health services and are governed by independent HHBs. Each HHS is accountable, through the board chair, to the Minister for Health for local performance, delivering local priorities and meeting national standards.

The Act requires boards to consist of five or more members with the knowledge, skills and expertise required for the HHS to function efficiently, effectively and economically. The inaugural appointments for all boards expired on 17 May 2013. Renewal of board appointments occurred on 18 May 2013, with 101 inaugural board members being retained and 127 appointees in total.

As required by the Act and the Hospital and Health Boards Regulation 2012, boards must establish the following committees:

- an executive committee
- a safety and quality committee
- a finance committee
- audit committee (under Section 35 of the Financial and Performance Management Standard 2009).

Under Section 35 of the Financial and Performance Management Standard 2009, boards may also establish an audit committee.

The function of the executive committee is to support the board by working with the HSCE to progress strategic issues identified by the board.

The safety and quality committee's purpose is to advise the board on the safety and quality of health services provided by the HHS. For example on:

- minimising preventable patient harm
- reducing unjustified variation in clinical care
- improving the experience of patients and carers
- ensuring compliance with national and state strategies, policies, agreements and standards, such as the National Safety and Quality Health Service Standards.

The finance committee's function is to advise the board on budget, cash flow, financial operating performance, and to assess and monitor financial risks.

The audit committee plays a key role in assessing the HHS's financial statements and its compliance with systems of risk management and internal control.

In 2012–13, total HHS governance costs were approximately $6.7 million. This included operational expenses, such as board member remuneration, secretariat costs, board expenses, corporate counsel and audit costs.

Board and executive recruitment

Table 12: Cost of board and executive recruitment

Name of consultant	Purpose of consultancy	Outcome
Chandler Macleod—$157,494.22	Provision of consultancy services to assist in the recruitment of board members for the HHBs.	Sixteen HHBs established with at least the minimum number of members by 1 July 2012. Note: the work for this consultancy was undertaken in 2011–12, but the invoice was paid in 2012–13.
Talent 1—$195,500.00	Executive search and recruitment services for HSCEs.	HSCEs recruited.

Acts and subordinate legislation

Chief Health Officer Branch

The Chief Health Officer is responsible for administration of the following Acts:

- *Food Act 2006*
- *Health Act 1937*
- *Pest Management Act 2001*
- *Pharmacy Ownership Act 2001*
- *Research Involving Human Embryos and Prohibition of Human Cloning For Reproduction Act 2003*
- *Private Health Facilities Act 1999*
- *Public Health Act 2005*
- *Public Health (Infection Control for Personal Appearance Services) Act 2003*
- *Radiation Safety Act 1999*
- *Tobacco and Other Smoking Products Act 1998*
- *Transplantation and Anatomy Act 1979*
- *Water Fluoridation Act 2008.*

This legislation is designed to safeguard the community from potential harm or illness caused by exposure to hazards, diseases and harmful practices.

Licensing activities related to public health legislation

In 2012–13:

- A total of 13,108 *Radiation Act 1999* instruments were issued—comprising 1627 (12.35 per cent) possession licences, 9165 (69.60 per cent) use licences, 125 (0.95 per cent) transport licences, 723 (5.49 per cent) radiation safety officer certificates, and 113 (0.86 per cent) accreditation certificates and 1533 (11.64 per cent) approvals.
- A total of 2228 pest management technician licences were issued under the *Pest Management Act 2001*.
- A total of 1869 instruments were issued under the Health (Drugs and Poisons) Regulation 1996—comprising 1285 (68.75 per cent) poisons licences, 294 (14.87 per cent) approvals, 222 (13.42 per cent) permits—68 for 1080, 40 for cyanide and 114 for strychnine and 15 (0.91 per cent) immunisation program certifications.

Other activities related to public health legislation for food and environmental hazards

In 2012–13:

- of the 53 national food recalls, 25 involved the recall of food in Queensland. These were actively monitored by public health units
- there were 379 prescribed contaminant in food notifications
- there were 228 Australian Competition and Consumer Commission mandatory reports related to food
- a total of 1410 food complaints were received and investigated by public health units, and 1964 samples were taken by public health units
- a total of 30 environmental impact statements were considered by the department to ensure health risks and monitoring and compliance requirements are considered prior to the development commencing
- during the period 1 July 2012 to 31 March 2013, 125 complaints relating to asbestos containing material were received and investigated.

In 2012–13, there were 52 private hospitals providing 6629 beds and 51 day hospitals providing 239 primary recovery trolleys and 160 treatment bays. During 2012–13, 116 on-site audits and standards reviews were conducted, 57 licences were issued or amended, 10 complaints were investigated, and 135 sentinel events, 39 root cause analysis reports and 456 adverse outcome reports were submitted.

Regulatory actions related to public health legislation

The department works in partnership with public health units based in HHSs and local governments to undertake compliance activities. These activities range from information provision and awareness-raising, to fines and prosecutions for serious breaches of the law that can cause harm to individuals in the community.

In 2012–13, the department successfully prosecuted an event operator who contributed to 34 cases of food-borne illness. Of the 34 people who were made ill, 11 suffered salmonellosis and 6 people were hospitalised. The matter was fully investigated, resulting in the defendant being convicted in court and fined $5000.

There were four successful prosecution matters relating to the unlawful sale of tobacco to children and young people. Prosecutions for tobacco offences netted $3750 in fines. Other matters successfully prosecuted included offences under the Pest Management Regulations 2003 ($1000 fine) and the Health (Drugs and Poisons) Regulation 1996 ($4000 fine).

In some instances, breaches of public health legislation do not proceed to court, but may be dealt with by a prescribed infringement notice. In 2012–13, $27,770 was collected in fines through prescribed infringement notices.

In 2012–13, eight medical practitioners had their controlled drug and/or restricted drug endorsements cancelled.

Summary of Acts and subordinate legislation

Food Act 2006

Food Regulation 2006

Guardianship and Administration Act 2002

Guardianship and Administration Regulation 2012

Health Act 1937

Health Practitioner Regulation National Law Act 2009

Health Practitioner Regulation National Law Regulation

Health Practitioner Regulation National Law Amendment (Midwife Insurance Exemption) Regulation 2011

Health Practitioner Regulation National Law (Transitional) Regulation 2010

Health Quality And Complaints Commission Act 2006

Health Regulation 1996

Health (Drugs And Poisons) Regulation 1996

Hospitals Foundations Regulation 2005

Hospital and Health Boards Act 2011

Hospital and Health Boards Regulation 2012

Mater Public Health Services Act 2008

Mental Health Act 2000

Mental Health Regulation 2002

Mental Health Review Tribunal Rule 2009

Pest Management Act 2001

Pest Management Regulation 2003

Pharmacy Business Ownership Act 2001

Private Health Facilities Act 1999

Private Health Facilities Regulation 2000

Private Health Facilities (Standards) Notice 2000

Public Health Act 2005

Public Health Regulation 2005

Public Health (Infection Control for Personal Appearance Services) Act 2003

Public Health (Infection Control for Personal Appearance Services) Regulation 2003

Public Health (Infection Control for Personal Appearance Services) (Infection Control Guidelines) Notice 2004

Queensland Institute of Medical Research Act 1945

Radiation Safety Act 1999

Radiation Safety Regulation 2010

Radiation Safety (Radiation Safety Standards) Notice 2010

Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003

Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Regulation 2003

Tobacco and Other Smoking Products Act 1998

Tobacco and Other Smoking Products Regulation 2010

Transplantation and Anatomy Act 1979

Transplantation and Anatomy Regulation 2004

Water Fluoridation Act 2008

Water Fluoridation Regulation 2008

Glossary of terms

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: 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: 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).

Admitted patient: A patient who undergoes a hospital's formal admission process.

Allied health staff: Professional staff who meet mandatory qualifications and regulatory requirements in audiology, clinical measurement sciences, dietetics and nutrition, exercise physiology, leisure therapy, medical imaging, music therapy, nuclear medicine technology,

occupational therapy, orthoptics, pharmacy, physiotherapy, podiatry, prosthetics and orthotics, psychology, radiation therapy, sonography, speech pathology or social work.

Benchmarking: The collection of performance information for the purpose of comparing performance with similar organisations.

Best practice: Cooperative way in which organisations and their staff undertake business activities in all key processes, and use benchmarking that can be expected to lead to sustainable, world class positive outcomes.

Clinical governance: A framework by which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Clinical practice: Professional activity undertaken by health professionals to investigate patient symptoms and prevent and/or manage illness, together with associated professional activities for patient care.

Clinical workforce: Staff who are, or who support, health professionals working in clinical practice, have healthcare specific knowledge/experience, and provide clinical services to health consumers, either directly and/or indirectly, through services that have a direct impact on clinical outcomes.

Decision support system: Consolidates data suitable for finance, HR, pharmacy and pathology related information for decision support purposes.

Emergency department waiting time: Time elapsed for each patient from presentation to the emergency department to start of services by the treating clinician. It is calculated by deducting the date and time the patient presents from the date and time of the service event.

Full-time equivalent: Refers to full-time equivalent staff currently working in a position.

Health outcome: Change in the health of an individual, group of people or population attributable to an intervention or series of interventions.

Health reform: Response to the *National Health and Hospitals Reform Commission Report (2009)* that outlined recommendations for transforming the Australian health system, the National Health and Hospitals Network Agreement (NHHNA) signed by the Australian Government and states and territories, other than Western Australia, in April 2010 and the National Health Reform Heads of Agreement signed in February 2010 by the Australian Government and all states and territories amending the NHHNA.

Hospital: Healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.

Hospital and Health Board: A Hospital and Health Boards is made up of a mix of members with expert skills and knowledge relevant to managing a complex healthcare organisation.

Hospital and Health Service: A Hospital and Health Service is a separate legal entity established by the Queensland Government to deliver public hospital services. The first HHSs commenced on 1 July 2012. Queensland's 17 HHSs replaced existing health service districts.

Hospital in the Home: Provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation.

Immunisation: Process of inducing immunity to an infectious agency by administering a vaccine.

Incidence: Number of new cases of a condition occurring within a given population, over a certain period of time.

Indigenous health worker: An Aboriginal and/or Torres Strait Islander person who holds the specified qualification and works within a primary healthcare framework to improve health outcomes for Indigenous Australians.

Long wait: An elective surgery patient who has waited longer than the clinically recommended time for their surgery, according to the clinical urgency category assigned. That is, more than 30 days for a category 1 patient, more than 90 days for a category 2 patient and more than 365 days for a category 3 patient.

Medicare Local: An organisation established by the Australian Government to coordinate primary healthcare services across all providers in a geographic area. Medicare locals work closely with HHSs to identify and address local health needs. They are selected and funded by the Australian Government and were rolled out progressively from 1 July 2011.

Medical practitioner: A person who is registered with the Medical Board of Australia to practice medicine in Australia, including general and specialist practitioners.

Non-admitted patient: A patient who does not undergo a hospital's formal admission process.

Non-admitted patient service: An examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service facility.

Outpatient: A non-admitted, non-emergency patient who is provided with an outpatient service.

Outpatient service: Examination, consultation, treatment or other service provided to a non-admitted, non-emergency patient in a specialty unit or under an organisational arrangement administered by a hospital.

Patient flow: Optimal patient flow means the patient's journey through the hospital system, be it planned or unplanned, happens in the safest, most streamlined and timely way to deliver good patient care.

Performance indicator: A measure that provides an 'indication' of progress towards achieving the organisation's objectives. Usually has targets that define the level of performance expected against the performance indicator.

Population health: The promotion of healthy lifestyles, prevention or early detection of illness or disease, prevention of injury and protection of health through organised, population-based programs and strategies.

Public health sector: Incorporates the Department of Health and the 17 Hospital and Health Services.

Private hospital: A hospital owned by a for-profit company or a non-profit organisation and privately funded through payment for medical services by patients or insurers. Patients admitted to private hospitals are treated by a doctor of their choice.

Public patient: A public patient is a person who elects to be treated in a public hospital or is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.

Public hospital: Public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.

Queensland Health: Refers to the public health sector, incorporating the Department of Health and the 17 Hospital and Health Services.

Queensland healthcare system: Incorporates the public, private and not-for-profit healthcare sectors.

Registered nurse: An individual registered under national law to practice in the nursing profession as a nurse, other than as a student.

Statutory agency: A non-departmental government body, established under an Act of Parliament. Statutory agencies can include corporations, regulatory authorities and advisory committees/councils.

Statutory bodies: A non-departmental government body, established under an Act of Parliament. Statutory bodies can include corporations, regulatory authorities and advisory committees/councils.

Sustainable health system: A health system that provides infrastructure, such as workforce, facilities and equipment, and is innovative and responsive to emerging needs within available resources.

Telehealth: Delivery of health-related services and information via telecommunication technologies, including:

- live, audio and or/video interactive links for clinical consultations and educational purposes
- store-and-forward Telehealth, including digital images, video, audio and clinical (stored) on a client computer, then transmitted securely (forwarded) to a clinic at another location where they are studied by relevant specialists
- teleradiology for remote reporting and clinical advice for diagnostic images
- Telehealth services and equipment to monitor people's health in their home.

Triage category: Urgency of a patient's need for medical and nursing care.

Wayfinding: Signs, maps and other graphic or audible methods used to convey locations and directions.

Glossary of acronyms

ABF: Activity based funding

ARF: Acute rheumatic fever

ARRs: Annual report requirements

CC: Creative Commons

CSSP: Clinical Supervisor Support Program

DSS: Decision Support System

EMT: Executive Management team

ESU: Ethical Standards Unit

FAA: Financial Accountability Act

FPMS: Financial and Performance Management Standard

FSS: Forensic and Scientific Services

FTE: Full-time equivalent

GOS: Grade of service

GP: General practitioner

HHB: Hospital and Health Board

HHF: Health and Hospital Fund

HHS: Hospital and Health Services

HQCC: Health Quality and Complaints Commission

HSCE: Health Service Chief Executive

HSCI: Health Service and Clinical Innovation

HSIA: Health Services Information Agency

HSSA: Health Services Support Agency

HR: Human resources

ICT: Information and communications technology

ieMR: Integrated Electronic Medical Record

IHI: Individual Healthcare Identifiers

LBTP: Land and Building Transfer Project

MAC: Ministerial Advisory Committee

MEDAI: Metropolitan Emergency Department Access Initiative

MRSA: Methicillin Resistant Staphylococcus Aureus

NBCSP: National Bowel Cancer Screening Program

NEAT: National Emergency Access Target

NEHTA: National E-Health Transition Authority

NEST: National Elective Surgery Target

NHHNA: National Health and Hospital Network Agreement

NHIS: National Healthcare Identifiers Service

ODG: Office of the Director-General

PBS: Pharmaceutical Benefits Scheme

PCEHR: Personally Controlled Electronic Health Record

PFUF: Participant Follow-up Function

PPP: Public-private partnership

PrEP: Pre-exposure prophyaxis

QAS: Queensland Ambulance Service

QRTN: Queensland Regional Training Networks

RHD: Rheumatic heart disease

RRAHPTS: Rural and Remote Allied Health Priority Transfer Scheme

SPP: System Policy and Performance

SSS: System Support Services

VLAD: Variable Life Adjusted Display

WAU: Weighted activity units

Compliance checklist—annual report

The characteristics of a quality annual report are that it:

- complies with statutory and policy requirements
- presents information in a concise manner
- is written in plain English
- provides a balanced account of performance.

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

Table 13: Annual report compliance checklist

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	A letter of compliance from the accountable officer or statutory body to the relevant Minister	ARRs – section 8	Page 1
Accessibility	Table of contents Glossary	ARRs – section 10.1	Page 2
	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	Page 4
	Agency role and main functions	ARRs – section 11.2	Pages 8-9
	Operating environment	ARRs – section 11.3	Pages 3-7;11-15
	Machinery-of-government changes	ARRs – section 11.4	Pages 21-22
Non-financial performance	Government objectives for the community	ARRs – section 12.1	Pages 4-9, 32, 59,67,75
	Other whole-of-government plans/specific initiatives	ARRs – section 12.2	Pages 39-40

Summary of requirement		Basis for requirement	Annual report reference
	Agency objectives and performance indicators	ARRs – section 12.3	Page pages, 10, 32, 59,67,75
	Agency service areas, service standards and other measures	ARRs – section 12.4	Pages 115-124
Financial performance	Summary of financial performance	ARRs – section 13.1	Pages 23-28
	Chief Finance Officer statement	ARRs – section 13.2	Page 28
Governance – management and structure	Organisational structure	ARRs – section 14.1	Page 97
	Executive management	ARRs – section 14.2	Pages 94-96
	Related entities	ARRs – section 14.3	Pages 129-135
	Boards and committees	ARRs – section 14.4	Pages 98-108
	Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* (section 23 and Schedule) ARRs – section 14.5	Pages 109-114
Governance – risk management and accountability	Risk management	ARRs – section 15.1	Pages 109-114
	External scrutiny	ARRs – section 15.2	Pages 125-128
	Audit committee	ARRs – section 15.3	Pages 102-107
	Internal audit	ARRs – section 15.4	Page 113
	Public Sector Renewal Program	ARRs – section 15.5	Page 94
	Information systems and recordkeeping	ARRs – section 15.7	Page 114
Governance – HR	Workforce planning, attraction and retention and performance	ARRs – section 16.1	Pages 88-94
	Early retirement, redundancy and retrenchment	*Directive No.11/12 Early Retirement, Redundancy and Retrenchment* ARRs – section 16.2	Page 91
	Voluntary Separation Program	ARRs – section 16.3	Page 91
Open Data	Open Data	ARRs – section 17	Inside front cover
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 18.1	Pages 150-213
	Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 18.2	Pages 212-213

Summary of requirement		Basis for requirement	Annual report reference
	Remuneration disclosures	*Financial Reporting Requirements for Queensland Government Agencies* ARRs – section 18.3	Page 194-199

Department of Health financial statements 2012–13

General information

The Department of Health is a Queensland Government department established under the *Public Service Act 2008* and its registered trading name is Queensland Health.

Queensland Health is controlled by the State of Queensland which is the ultimate parent entity.

The head office and principal place of business of the department is:
147–163 Charlotte Street
Brisbane
Queensland 4000

A description of the nature of the department's operations and its principal activities are included in the notes to the financial statements.

For information in relation to the Department of Health's financial statements, email FIN_Corro@health.qld.gov.au or visit www.health.qld.gov.au

Department of Health
Statement of profit or loss and other comprehensive income
For the year ended 30 June 2013

	Note	2013 $'000	2012 $'000
Revenue			
Departmental services revenue	4	7,853,570	10,053,900
User charges	5	1,396,834	892,790
Labour recoveries	6	6,693,409	-
Grants and other contributions	7	2,734,388	329,977
Other revenue	8	32,815	48,399
Gains	9	2,093	3,419
Share of profit from associates	10	14,147	28,596
Expenses			
Employee expenses	11	(7,482,141)	(7,297,935)
Supplies and services	12	(906,879)	(2,405,194)
Health services	13	(9,662,826)	(743,145)
Grants and subsidies	14	(259,284)	(243,870)
Depreciation and amortisation	15	(85,884)	(371,944)
Impairment losses	16	(13,487)	(47,718)
Appropriation returned		(120,453)	(67,559)
Other expenses	17	(182,202)	(137,382)
Surplus for the year		14,100	42,334
Other comprehensive income			
Items that will not be reclassified subsequently to profit or loss			
Increase / Decrease in asset revaluation surplus		18,166	(147,344)
Opening balance adjustments	26, 52	77,724	-
Other comprehensive income for the year		95,890	(147,344)
Total comprehensive income for the year		109,990	(105,010)

The above statement of profit or loss and other comprehensive income should be read in conjunction with the accompanying notes

Department of Health
Statement of financial position
As at 30 June 2013

	Note	2013 $'000	2012 $'000
Assets			
Current assets			
Cash and cash equivalents	18	(181,785)	(64,742)
Loans and receivables	19	974,024	652,123
Inventories	20	48,747	130,086
Other assets	21	137,521	111,618
		978,507	829,085
Non-current assets classified as held for sale	22	-	75
Total current assets		978,507	829,160
Non-current assets			
Loans and receivables	23	424,464	20,911
Investment in associates	24	83,339	69,192
Other financial assets	25	20,000	20,000
Property, plant and equipment	26	3,532,114	8,384,794
Intangibles	27	229,861	149,464
Other assets	28	3,394	7,629
Total non-current assets		4,293,172	8,651,990
Total assets		5,271,679	9,481,150
Liabilities			
Current liabilities			
Payables	29	551,815	497,766
Other liabilities	30	9,073	-
Accrued employee benefits	31	611,207	406,523
Unearned revenue	32	40	466
Total current liabilities		1,172,135	904,755
Non-current liabilities			
Other liabilities	33	263,665	194,398
Unearned revenue	34	4,953	2,536
Total non-current liabilities		268,618	196,934
Total liabilities		1,440,753	1,101,689
Net assets		3,830,926	8,379,461
Equity			
Contributed equity		335,593	4,984,167
Asset revaluation surplus	35	78,249	944,461
Retained surpluses		3,417,084	2,450,833
Total equity		3,830,926	8,379,461

The above statement of financial position should be read in conjunction with the accompanying notes

Department of Health
Statement of changes in equity
For the year ended 30 June 2013

	Note	Contributed equity $'000	Reserves $'000	Retained surpluses $'000	Total equity $'000
Balance at 1 July 2011		3,815,959	1,091,805	2,414,995	7,322,759
Surplus for the year		-	-	42,334	42,334
Other comprehensive income for the year		-	(147,344)	-	(147,344)
Total comprehensive income for the year		-	(147,344)	42,334	(105,010)
Transactions with owners in their capacity as owners:					
Equity injections		1,405,045	-	-	1,405,045
Equity withdrawals		(260,991)	-	-	(260,991)
	4	1,144,054	-	-	1,144,054
Correction of (asset)/liability previously recognised		-	-	(6,498)	(6,498)
Non-appropriated equity transfer		24,156	-	-	24,156
Balance at 30 June 2012		4,984,169	944,461	2,450,831	8,379,461

The above statement of changes in equity should be read in conjunction with the accompanying notes

Department of Health
Statement of changes in equity
For the year ended 30 June 2013

	Note	Contributed equity $'000	Reserves $'000	Retained surpluses $'000	Total equity $'000
Balance at 1 July 2012		4,984,169	944,461	2,450,833	8,379,463
Surplus for the year		-	-	14,100	14,100
Increase in asset revaluation surplus			18,166		18,166
Opening balance adjustments (Note 52)		9,950	77,724	(9,950)	77,724
Other comprehensive income for the year		9,950	95,890	(9,950)	95,890
Total comprehensive income for the year		9,950	95,890	4,150	109,990
Transactions with owners in their capacity as owners:					
Equity injections		1,265,148	-	-	1,265,148
Equity withdrawals		(239,430)	-	-	(239,430)
	4	1,025,718	-	-	1,025,718
HHS equity injections		197,618	-	-	197,618
Reclassification of revaluation reserve		-	(962,102)	962,102	-
Net assets transferred (via machinery-of-Government change):					
- to HHSs (Note 41)		(5,492,655)	-	-	(5,492,655)
- other		(389,208)	-	-	(389,208)
Balance at 30 June 2013		335,592	78,249	3,417,085	3,830,926

The above statement of changes in equity should be read in conjunction with the accompanying notes

Department of Health
Statement of cash flows
For the year ended 30 June 2013

	Note	2013 $'000	2012 $'000
Cash flows from operating activities			
Departmental services receipts		7,786,011	10,053,900
User charges		734,696	783,110
Grants and other contributions		2,721,551	322,673
Interest received		1,710	6,075
GST collected from customers		12,425	45,419
GST input tax credits		138,625	476,712
Other revenue		31,105	33,216
Labour recoveries		6,693,409	-
Employee expenses		(7,315,388)	(7,249,547)
Supplies and services		(585,489)	(2,406,596)
Grants and subsidies		(259,284)	(244,297)
Insurance		(102,760)	(90,407)
GST paid to suppliers		(129,698)	(475,008)
GST remitted		(15,254)	(43,389)
Other expenses		(48,209)	(50,674)
Health services		(9,335,799)	(731,909)
Net cash from operating activities	49	327,651	429,278
Cash flows from investing activities			
Payments for property, plant and equipment	26	(1,276,825)	(1,722,851)
Payments for intangibles	27	(64,711)	(44,080)
Loans and advances paid		(1,046)	(16,640)
Loans and advances redeemed		-	5,255
Proceeds from sale of property, plant and equipment		1,597	11,854
Net cash used in investing activities		(1,340,985)	(1,766,462)
Cash flows from financing activities			
Equity injections		1,293,130	1,429,200
Equity withdrawals		(396,821)	134,421
Transfer of cash to HHSs		(78,359)	-
Finance lease advanced		78,340	(260,991)
Net cash from financing activities		896,290	1,302,630
Net decrease in cash and cash equivalents		(117,044)	(34,554)
Cash and cash equivalents at the beginning of the financial year		(64,741)	(30,188)
Cash and cash equivalents at the end of the financial year	18	(181,785)	(64,742)

The above statement of cash flows should be read in conjunction with the accompanying notes

Department of Health
Statement of profit or loss and other comprehensive income by major departmental services and shared service partner
For the year ended 30 June 2013

	Prevention, Promotion, Protection		Primary Health Care		Ambulatory Care		Acute Care		Rehabilitation and Extended Care		Integrated Mental Health Services		Subtotal All Major Departmental Services	
	2013 $'000	2012 $'000	2013 $'000	2012 $'000	2013 $'000	2012 $'000	2013 $'000	2012 $'000	2013 $'000	2012 $'000	2013 $'000	2012 $'000	2013 $'000	2012 $'000
Revenue														
Departmental services revenue	341,065	497,984	605,335	627,083	1,684,236	2,085,972	3,962,459	5,079,688	584,712	700,532	675,763	920,123	7,853,570	9,911,382
User charges	44,509	17,887	3,005	1,992	277,642	142,348	1,003,487	672,775	30,832	41,800	37,359	15,556	1,396,834	892,358
Labour recoveries from Hospital and Health Services	407,263	-	362,371	-	1,430,287	-	3,444,869	-	451,900	-	596,719	-	6,693,409	-
Grants and other contributions	777,431	12,741	280,685	22,487	40,041	17,450	298,823	40,007	1,325,814	232,632	11,594	4,660	2,734,388	329,977
Other revenue	10,707	13,617	956	1,543	7,805	7,462	10,769	22,681	544	1,526	2,034	1,631	32,815	48,460
Gains	61	95	148	228	366	571	1,091	1,721	270	533	157	251	2,093	3,399
Share of profit from associates	899	1,470	718	1,609	2,967	5,696	7,286	14,848	1,091	2,431	1,186	2,542	14,147	28,596
													-	-
Expenses													-	-
Employee expenses	(403,035)	(264,843)	(443,553)	(427,282)	(1,357,836)	(1,433,352)	(3,793,177)	(3,610,767)	(643,207)	(657,331)	(841,333)	(745,578)	(7,482,141)	(7,139,153)
Supplies and services	(86,925)	(141,078)	(63,247)	(136,342)	(138,010)	(560,449)	(420,740)	(1,260,212)	(87,440)	(186,177)	(110,517)	(134,451)	(906,879)	(2,418,709)
Health services	(556,943)	(52,547)	(594,409)	(41,958)	(1,714,898)	(135,667)	(4,814,642)	(453,899)	(852,577)	(40,574)	(1,129,357)	(18,874)	(9,662,826)	(743,519)
Grants and subsidies	(14,569)	(17,533)	(16,210)	(13,763)	(45,798)	(43,309)	(128,308)	(151,036)	(23,190)	(12,767)	(31,209)	(5,462)	(259,284)	(243,870)
Depreciation and amortisation	(7,148)	(18,265)	(3,581)	(20,731)	(18,683)	(74,271)	(45,211)	(195,484)	(5,546)	(33,943)	(5,715)	(26,507)	(85,884)	(369,201)
Impairment losses	(2,408)	(2,228)	(1,124)	(2,240)	(1,963)	(7,168)	(5,231)	(20,904)	(988)	(3,878)	(1,773)	(11,300)	(13,487)	(47,718)
Appropriation returned	(6,943)	(3,346)	(7,410)	(4,214)	(21,377)	(14,017)	(60,017)	(34,134)	(10,628)	(4,707)	(14,078)	(6,183)	(120,453)	(66,601)
Other expenses	(11,551)	(15,704)	(12,437)	(13,243)	(32,203)	(21,545)	(89,473)	(59,880)	(15,584)	(10,681)	(20,954)	(15,954)	(182,202)	(137,007)
Surplus/(deficit) for the year	492,413	28,250	111,247	(4,831)	112,576	(30,279)	(628,015)	45,404	756,003	29,396	(830,124)	(19,546)	14,100	48,394
Other comprehensive income														
Items that will not be reclassified subsequently to profit or loss														
Increase/Decrease in asset revaluation surplus	1,047	(6,359)	1,117	(8,136)	3,223	(28,180)	9,053	(71,242)	1,603	(11,714)	2,123	(11,844)	18,166	(137,475)
Opening balance adjustment	4,480	-	4,781	-	13,794	-	38,727	-	6,858	-	9,084	-	77,724	-
Other comprehensive income for the year	5,527	(6,359)	5,898	(8,136)	17,017	(28,180)	47,780	(71,242)	8,461	(11,714)	11,207	(11,844)	95,890	(137,475)
Total comprehensive income for the year	497,940	21,891	117,145	(12,967)	129,593	(58,459)	(580,235)	(25,838)	764,464	17,682	(818,917)	(31,390)	109,990	(89,081)

The above statement of profit or loss and other comprehensive income should be read in conjunction with the accompanying notes

Department of Health
Statement of profit or loss and other comprehensive income by major departmental services and shared service partner
For the year ended 30 June 2013

	Subtotal All Major Departmental Services		Queensland Health Shared Service Partner		Inter-Departmental Services Elimination		Total	
	2013 $'000	2012 $'000	2013 $'000	2012 $'000	2013 $'000	2012 $'000	2013 $'000	2012 $'000
Revenue								
Departmental services revenue	7,853,570	9,911,382	-	142,518	-	-	7,853,570	10,053,900
User charges	1,396,834	892,358	-	35,783	-	(35,351)	1,396,834	892,790
Labour recoveries from Hospital and Health Services	6,693,409	-	-	-	-	-	6,693,409	-
Grants and other contributions	2,734,388	329,977	-	-	-	-	2,734,388	329,977
Other revenue	32,815	48,460	-	(61)	-	-	32,815	48,399
Gains	2,093	3,399	-	20	-	-	2,093	3,419
Share of profit from associates	14,147	28,596	-	-	-	-	14,147	28,596
	-	-						
Expenses	-	-						
Employee expenses	(7,482,141)	(7,139,153)	-	(158,782)	-	-	(7,482,141)	(7,297,935)
Supplies and services	(906,879)	(2,418,709)	-	(20,411)	-	33,926	(906,879)	(2,405,194)
Health services	(9,662,826)	(743,519)	-	(565)	-	939	(9,662,826)	(743,145)
Grants and subsidies	(259,284)	(243,870)	-	-	-	-	(259,284)	(243,870)
Depreciation and amortisation	(85,884)	(369,201)	-	(2,743)	-	-	(85,884)	(371,944)
Impairment losses	(13,487)	(47,718)	-	-	-	-	(13,487)	(47,718)
Appropriation returned	(120,453)	(66,601)	-	(958)	-	-	(120,453)	(67,559)
Other expenses	(182,202)	(137,007)	-	(861)	-	486	(182,202)	(137,382)
Surplus/(deficit) for the year	14,100	48,394	-	(6,060)	-	-	14,100	42,334
Other comprehensive income								
Items that will not be reclassified subsequently to profit or loss								
Increase/Decrease in asset revaluation surplus	18,166	(137,475)	-	(9,869)	-	-	18,166	(147,344)
Opening Balance adjustments	77,724	-	-	-	-	-	77,724	-
Other comprehensive income for the year	95,890	(137,475)	-	(9,869)	-	-	95,890	(147,344)
Total comprehensive income for the year	109,990	(89,081)	-	(15,929)	-	-	109,990	(105,010)

The above statement of profit or loss and other comprehensive income should be read in conjunction with the accompanying notes

Department of Health
Statement of assets and liabilities by major departmental services and shared service partner
As at 30 June 2013

	Prevention, Promotion, Protection		Primary Health Care		Ambulatory Care		Acute Care		Rehabilitation and Extended Care		Integrated Mental Health Services		Subtotal All Major Departmental Services	
	2013 $'000	2012 $'000	2013 $'000	2012 $'000	2013 $'000	2012 $'000	2013 $'000	2012 $'000	2013 $'000	2012 $'000	2013 $'000	2012 $'000	2013 $'000	2012 $'000
Current assets														
Cash and cash equivalents	(10,478)	(3,911)	(11,183)	(5,004)	(32,263)	(17,330)	(90,574)	(43,811)	(16,040)	(7,203)	(21,247)	(7,283)	(181,785)	(84,542)
Trade and other receivables	56,140	30,005	59,917	38,393	172,863	132,975	485,323	336,177	85,940	55,269	113,841	55,884	974,024	648,703
Inventories	2,809	6,017	2,998	7,699	8,651	26,665	24,290	67,415	4,302	11,084	5,697	11,206	48,747	130,086
Other	7,926	5,162	8,459	6,606	24,406	22,880	68,524	57,845	12,133	9,510	16,073	9,615	137,521	111,618
Non-current assets classified as held for sale	-	3	-	4	-	16	-	39	-	7	-	6	-	75
Total current assets	56,397	37,276	60,191	47,698	173,657	165,206	487,563	417,665	86,335	68,667	114,364	69,428	978,507	805,940
Non-current assets														
Receivables	24,465	967	26,110	1,237	75,332	4,287	211,496	10,837	37,452	1,782	49,609	1,801	424,464	20,911
Investments accounted for using the equity method	4,803	3,200	5,126	4,095	14,790	14,183	41,526	35,858	7,354	5,896	9,740	5,960	83,339	69,192
Other financial assets	1,152	925	1,230	1,183	3,550	4,100	9,966	10,365	1,765	1,705	2,337	1,722	20,000	20,000
Property, plant and equipment	203,583	386,566	217,278	494,624	626,857	1,713,115	1,759,928	4,330,959	311,647	712,040	412,821	719,938	3,532,114	8,357,242
Intangibles	13,248	6,877	14,140	8,800	40,794	30,477	114,533	77,052	20,281	12,667	26,865	12,808	229,861	148,681
Other	195	352	208	452	603	1,563	1,693	3,956	299	649	396	657	3,394	7,629
Total non-current assets	247,446	398,887	264,092	510,391	761,926	1,767,725	2,139,142	4,469,027	378,798	734,739	501,768	742,886	4,293,172	8,623,655
Total assets	303,843	436,163	324,283	558,089	935,583	1,932,931	2,626,705	4,886,692	465,133	803,406	616,132	812,314	5,271,679	9,429,595
Current liabilities														
Trade and other payables	31,805	22,928	33,944	29,337	97,932	101,611	274,951	256,888	48,688	42,234	64,495	42,702	551,815	495,700
Other financial liabilities	522	-	558	-	1,611	-	4,522	-	800	-	1,060	-	9,073	-
Accrued employee benefits	35,228	18,316	37,598	23,436	108,474	81,170	304,542	205,216	53,929	33,738	71,436	34,112	611,207	395,988
Unearned revenue	2	22	2	28	8	96	20	240	4	40	4	40	40	466
Total current liabilities	67,557	41,266	72,102	52,801	208,025	182,877	584,035	462,344	103,421	76,012	136,995	76,854	1,172,135	892,154
Non-current liabilities														
Financial guarantee contracts	15,197	8,991	16,220	11,506	46,793	39,848	131,375	100,744	23,264	16,563	30,816	16,746	263,665	194,398
Unearned revenue	285	116	304	150	879	518	2,468	1,318	438	216	579	218	4,953	2,536
Total non-current liabilities	15,482	9,107	16,524	11,656	47,672	40,366	133,843	102,062	23,702	16,779	31,395	16,964	268,618	196,934
Total liabilities	83,039	50,373	88,626	64,457	255,697	223,243	717,878	564,406	127,123	92,791	168,390	93,818	1,440,753	1,089,088
Net assets	220,804	385,790	235,657	493,632	679,886	1,709,688	1,908,827	4,322,286	338,010	710,615	447,742	718,496	3,830,926	8,340,507

The above statement of assets and liabilities should be read in conjunction with the accompanying notes

Department of Health
Statement of assets and liabilities by major departmental services and shared service partner
As at 30 June 2013

	Subtotal All Major Departmental Services		Queensland Health Shared Service Partner		Inter-Departmental Services Elimination		Total	
	2013 $'000	2012 $'000	2013 $'000	2012 $'000	2013 $'000	2012 $'000	2013 $'000	2012 $'000
Current assets								
Cash and cash equivalents	(181,785)	(84,542)	-	19,800	-	-	(181,785)	(64,742)
Trade and other receivables	974,024	648,703	-	3,420	-	-	974,024	652,123
Inventories	48,747	130,086	-	-	-	-	48,747	130,086
Other	137,521	111,618	-	-	-	-	137,521	111,618
Non-current assets classified as held for sale	-	75	-	-	-	-	-	75
Total current assets	978,507	805,940	-	23,220	-	-	978,507	829,160
Non-current assets								
Receivables	424,464	20,911	-		-	-	424,464	20,911
Investments accounted for using the equity method	83,339	69,192	-	-	-	-	83,339	69,192
Other financial assets	20,000	20,000	-	-	-	-	20,000	20,000
Property, plant and equipment	3,532,114	8,357,242	-	27,552	-	-	3,532,114	8,384,794
Intangibles	229,861	148,681	-	783	-	-	229,861	149,464
Other	3,394	7,629	-	-	-	-	3,394	7,629
Total non-current assets	4,293,172	8,623,655	-	28,335	-	-	4,293,172	8,651,990
Total assets	5,271,679	9,429,595	-	51,555	-	-	5,271,679	9,481,150
Current liabilities								
Trade and other payables	551,815	495,700	-	2,066	-	-	551,815	497,766
Other financial liabilities	9,073	-	-	-	-	-	9,073	-
Accrued employee benefits	611,207	395,988	-	10,535	-	-	611,207	406,523
Unearned revenue	40	466	-	-	-	-	40	466
Total current liabilities	1,172,135	892,154	-	12,601	-	-	1,172,135	904,755
Non-current liabilities								
Financial guarantee contracts	263,665	194,398	-	-	-	-	263,665	194,398
Unearned revenue	4,953	2,536	-	-	-	-	4,953	2,536
Total non-current liabilities	268,618	196,934	-	-	-	-	268,618	196,934
Total liabilities	1,440,753	1,089,088	-	12,601	-	-	1,440,753	1,101,689
Net assets	3,830,926	8,340,507	-	38,954	-	-	3,830,926	8,379,461

The above statement of assets and liabilities should be read in conjunction with the accompanying notes

Note 1. Objectives and strategic priorities of the Department of Health

The Department of Health's vision is quality healthcare that Queenslanders value. The Department of Health has responsibility for overall system stewardship and management on behalf of the Minister for Health, as well as provision of statewide public health and support services. The 17 independent Hospital and Health Services (HHSs) are responsible for the delivery of public hospital services and a range of primary and community services.

The role of the Department of Health is one of system-wide policy and regulation, planning and service purchasing, supporting system-wide quality and safety, and service innovation. The Department of Health also provides a range of governance, corporate and information and communication technology functions, administers major infrastructure programs and manages the delivery of statewide services such as forensic and scientific services and Telehealth. This is reflected in the Department of Health's strategic objectives:

- Facilitate the integration of health system services that focus on keeping patients, people and communities well.
- Ensure access to appropriate health services is simple, equitable and timely for all Queenslanders.
- Focus healthcare resources on models of care that are patient-centred, safe, effective, economically sustainable and responsive to community needs.
- Provide value in health services by maximising public investment in multi-sector partnerships in service delivery, health and medical research, infrastructure and assets.
- Foster a health system that is transparent, accountable and innovative.
- Cultivate a high quality health system through positive engagement and cooperation with our workforce and health system partners.

Note 2. Significant accounting policies

The principal accounting policies adopted in the preparation of the financial statements are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated.

2(a) Statement of compliance

The financial statements have been prepared in compliance with section 42 of the *Financial and Performance Management Standard 2009*. These financial statements are general purpose financial statements. These have been prepared on an accrual basis in accordance with Australian Accounting Standards and Interpretations applicable to not-for-profit entities as the Department of Health is a not-for-profit entity. In addition, the financial statements comply with Queensland Treasury and Trade's Minimum Reporting Requirements for the year ending 30 June 2013, and other authoritative pronouncements. Except where stated, the historical cost convention is used.

2(b) The reporting entity

The Department of Health is responsible for the overall management of the public sector health system in the state of Queensland and is focused on system-wide policy, planning and service purchasing in addition to the well established functions such as supporting system-wide quality and safety and service innovation. The major services undertaken by the Queensland Health system are disclosed in Note 3. The financial statements include the value of all assets, liabilities, equity, revenues and expenses of the Department of Health.

The Department of Health purchases services from 17 HHSs and the Mater Misericordiae Public Hospital under service agreements. HHSs provide a range of health care activities and operate hospital facilities, community, mental and residential health centres. HHSs were created as separate reporting entities on 1 July 2012 (refer Note 3).

The Torres Strait and Northern Peninsula Hospital and Health Service was administered by the Director-General of the Department of Health during the 2012-13 financial year and is therefore considered to be a controlled entity. Refer Note 51.

Note 2. Significant accounting policies (continued)

2(c) Investment in associate

The associated entities are those entities over which the Department of Health has significant influence but no control, and are neither subsidiaries nor joint ventures. Significant influence is the power to participate in the financial and operating policy decisions of the investee but is not control or joint control over those policies. As at 30 June 2013, Department of Health has two associates: Translational Research Institute Pty Ltd and Translational Research Institute Trust (TRI). See Notes 24, 33 and 42.

Investments in associates are accounted for using the equity method in accordance with AASB 128 *Investments in Associates* . Under the equity method, investments in associates are carried in the Statement of Financial Position at cost plus post-acquisition changes in the Department of Health's share of net assets. The Department of Health's share of post-acquisition profits or losses is recognised in the Statement of Profit or Loss and Other Comprehensive Income. Changes in the associates' other comprehensive income are recognised in the Department of Health's Other Comprehensive Income. The Department of Health's share of income, expenses and equity movements of equity accounted investees are adjusted to align the accounting policies of the investee with those of the Department of Health.

When the Department of Health transacts with an associate, profits and losses resulting from the transactions with the associate are recognised in the financial statements only to the extent of interests in the associate that are not related to the Department of Health. Dividends receivable from associates are recognised in the Statement of Profit or Loss and Other Comprehensive Income as a component of other income. The Department of Health has reinvested all distributions from TRI in accordance with the TRI Trust Deed.

When the share of losses in an associate equals or exceeds its interest in the associate, including any unsecured long-term receivables and loans, the Department of Health does not recognise further losses, unless it has incurred obligations or made payments on behalf of the associate.

The Department of Health holds a 43 per cent shareholding in the Queensland Children's Medical Research Institute (QCMRI). As the Department of Health has no rights to the net assets of QCMRI and no economic benefit is expected to flow to the Department of Health, an investment in associate asset has not been recognised.

2(d) Administered transactions and balances

The Department of Health administers, but does not control, certain resources on behalf of the Government. In doing so, it has responsibility and is accountable for administering related transactions and items, but does not have the discretion to deploy the resources for the achievement of its objectives. These transactions and balances are not significant in comparison to the Department of Health's overall financial performance and financial position and are disclosed in Note 46.

2(e) Trust transactions and balances

The Department of Health acted in a fiduciary trust capacity in relation to patient trust accounts. Consequently, these transactions and balances were not recognised in the financial statements. Although patient funds were not controlled by the Department of Health, trust activities were included in the audit performed annually by the Auditor-General of Queensland. The HHSs now act in this capacity for the current year. Note 43 provides additional information on the balances held in patient trust accounts.

2(f) Major departmental services revenue and administered revenue

Appropriations provided under the *Appropriation Act 2012* are recognised as revenue when received or as a receivable when approved by Queensland Treasury and Trade. Amounts appropriated to Department of Health for transfer to other entities in accordance with legislative or other requirements are reported as an administered appropriation item.

Note 2. Significant accounting policies (continued)

2(g) User charges, fees and fines

User charges and fees are controlled by the Department of Health when they can be deployed for the achievement of departmental objectives. User charges and fees controlled by the Department of Health comprise of hospital fees and sales of goods and services. Hospital fees mainly consist of private patient hospital fees, interstate patient revenue and Department of Veterans' Affairs revenue. The sale of goods and services comprises drugs, medical supplies, linen, pathology and other services provided to HHSs.

2(h) Labour recoveries from Hospital and Health Services

The Department of Health continues to be the employer for all health service employees (excluding persons appointed as a Health Executive). Employees are provided by the Department of Health to perform work for the HHSs under a fee for service agreement. Under this agreement the Department of Health recovers all employee expenses and associated on-costs from the HHSs (Note 6).

2(i) 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 Department of Health obtains control over them. This includes amounts received from the Australian Government for programs that have not been fully completed at the end of the financial year.

Contributed assets are recognised at their fair value. Contributions of services are recognised only when a fair value can be determined reliably and the services would be purchased if they had not been donated.

2(j) Finance and borrowing costs

Finance and borrowing costs are recognised as an expense in the period in which they are incurred. Borrowing costs include interest on short-term and long-term borrowings and ancillary administration charges.

2(k) Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with financial institutions, other short-term, highly liquid investments with original maturities of three months or less that are readily convertible to known amounts of cash and which are subject to an insignificant risk of changes in value.

2(l) Loans and receivables

Trade debtors are recognised at their carrying value less any impairment. The recoverability of trade debtors is reviewed on an ongoing basis at an operating unit level. Trade receivables are generally settled within 60 days, while other receivables may take longer than twelve months. Any allowance for impairment is based on loss events disclosed in Note 19. All known bad debts are written off when identified.

Payroll receivables are measured at amortised cost and include interim cash payments made to employees, salary overpayments and amounts advanced to employees to align the payment of salaries and wages to a uniform pay day throughout the Department of Health. The Department of Health is undertaking a process to recover these debts by working with the individuals affected. Refer Notes 3, 19 and 23.

The change in pay date transitional loan was measured at fair value on initial recognition, in accordance with AASB 139 *Financial Instruments: Recognition and Measurement* . The fair value has been calculated as the present value of the expected future cash flows over the life of the loan, discounted using a risk-free effective interest rate of 3.05%. As the loan was interest-free for employees, the Department of Health recognised a loan discount expense of$17.661 million to account for the time value of money.

Note 2. Significant accounting policies (continued)

2(m) Loans and receivables

The loan is considered to be risk-free as it is legislatively recoverable from recipients upon termination of their employment with the Department of Health. The loan is expected to be recovered over the next 10 years.

The non-current portion of payroll overpayments and interim cash payments has not been discounted to present value as this could not be reliably estimated, due to the uncertainty of the timing of future cash receipts. However, an impairment expense of $31.93 million has been recognised in relation to these loans.

Loans to other entities are financial assets with fixed or determinable payments that are not quoted in an active market. These are recognised at amortised cost, using the effective interest method. Refer Notes 19, 23 and 36.

These loans are approved by the Treasurer under the Financial Accountability Act 2009 , as the Department of Health does not have the capacity to grant loans to other entities. Approval also exists to the extent of the financial arrangements for funding the public hospital component of the redevelopment of the Mater Hospital.

These balances are regarded as administered and are recorded at book value with no interest charged. Refer Note 46. Approval also exists to the extent of a Transaction Agreement between the Department of Health and Telstra for the relocation of the South Brisbane Telephone Exchange as part of the Queensland Children's Hospital Development. Refer Note 19.

2(n) Inventories

The Department of Health controls two inventory distribution centres. Inventories consist mainly of pharmacy and general medical supplies held for distribution to hospitals. Pharmacy supplies are sold to the HHSs including a predetermined mark-up percentage whilst general medical supplies are provided to the HHSs at cost. Inventories are measured at weighted average cost, adjusted for obsolescence, other than vaccine stock which is held at cost.

2(o) Property, plant and equipment

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

- buildings and land improvements: $10,000;
- land: $1; and
- plant and equipment: $5,000.

Property, plant and equipment are initially recorded at consideration plus any other costs directly incurred in bringing the asset to the condition ready for use. Items or components that form an integral part of an asset are recognised as a single asset. The cost of items acquired during the financial year has been judged by management to materially represent the fair value at the end of the reporting period.

Where assets are received for no consideration from another Queensland Government department (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 initially recognised at their fair value at the date of acquisition.

Land and buildings are measured at fair value in accordance with AASB 116 *Property, Plant and Equipment* and Queensland Treasury and Trade's *Non-Current Asset Policies for the Queensland Public Sector* . Land is measured at fair value each year using independent revaluations, desktop market revaluations or indexation by the State Valuation Service within the Department of Natural Resources and Mines.

Note 2. Significant accounting policies (continued)

Buildings are measured at fair value utilising either independent revaluation or applying an interim revaluation methodology developed by the independent valuer. Assets under construction are reported at cost and are not revalued until they are ready for use. Fair value is determined using the depreciated replacement cost methodology. Depreciated replacement cost is determined as the replacement cost less the cost to bring to current standards.

In determining the depreciated replacement cost of each building, the independent valuers consider a number of factors such as size, functionality and physical condition. In assessing the building condition, the following criteria are applied: Condition rating 1 - very good condition requiring normal maintenance; Condition rating 2 - minor defects only requiring minor maintenance; Condition rating 3 - maintenance required to return to accepted level of service; Condition rating 4 - requires renewal; and Condition rating 5 - asset unserviceable.

In 2012-13, there was a change to the condition criteria applied by the independent valuer. In prior years, the condition category was significantly influenced by the age of the facility. A change has been made to include age within the overall condition assessment but to greater align the reduction to replacement cost with the condition of the asset. The financial impact of this change is immaterial.

For interim revaluations, the Department of Health uses an index developed by the independent valuer, Davis Langdon. Davis Langdon was engaged in 2012-13 to disaggregate the existing state-wide indexation to an indexation based on specific geographic areas. This indexation is based on cost escalation and specialised factors such as building design code and building standard changes. Facilities have been categorised based on location and type of asset to enable the modelling of more accurate indices reflective of the smaller asset portfolio now controlled by the Department of Health. The financial impact of this change is immaterial.

Revaluation increments are credited to the asset revaluation surplus of the appropriate class, except to the extent it reverses a revaluation decrement for the class previously recognised as an expense. A decrease in the carrying amount on revaluation is charged as an expense, to the extent it exceeds the balance, if any, in the revaluation surplus relating to that asset class.

Plant and equipment (other than major plant and equipment) is measured at cost net of accumulated depreciation and any impairment in accordance with Queensland Treasury and Trade's *Non-Current Asset Policies for the Queensland Public Sector*.

Depreciation
Property, plant and equipment are depreciated on a straight-line basis. Annual depreciation is based on fair values and the Department of Health's assessments of the remaining useful life of individual assets. Land is not depreciated. Assets under construction (work-in-progress) are not depreciated until they are ready for use.

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 spares purchased specifically for particular assets are capitalised and depreciated on the same basis as the asset to which they relate.

The depreciable amount of improvements to or on leasehold land is allocated progressively over the shorter of the estimated useful lives of the improvements or the unexpired period of the lease. The unexpired period of leases includes any option period where exercise of the option is probable.

For buildings and improvements the depreciation rate is between 2.5 per cent and 3.33 per cent; for plant and equipment the depreciation rate is between 5 per cent and 20 per cent.

Leased property, plant and equipment
Operating lease payments, being representative of benefits derived from the leased assets, are recognised as an expense in the period in which they are incurred. The Department of Health has one finance lease asset building as at 30 June 2013. Leases are classified as finance leases when the terms of the lease transfer substantially all the risks and rewards of ownership to the lessee. Finance lease payments received in advance are recorded as liabilities.

Note 2. Significant accounting policies (continued)

During the year, the Department of Health entered into a finance lease with the Translational Research Institute Pty Ltd to lease the Translational Research Institute Building upon practical completion. Advanced lease payments for the term of the lease were received during the construction phase of this facility. Refer Notes 19, 30 and 33.

The Department of Health owns land and buildings which are operationally controlled by HHSs and recognised within their individual financial statements under a legal arrangement. Refer to Note 3.

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 impairment exists, the Department of Health 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 Profit or Loss and Other 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.

2(p) Intangible assets

Intangible assets are only recognised if they satisfy recognition criteria in accordance with AASB 138 *Intangible Assets*. Intangible assets are recorded at cost, which is consideration plus costs incidental to the acquisition, less accumulated amortisation and impairment losses. An intangible asset is recognised only if its cost is equal to or greater than $100,000. Internally generated software cost includes all direct costs associated with development of that software. All other costs are expensed as incurred.

Intangible assets are amortised on a straight-line basis over their estimated useful life with a residual value of zero. The estimated useful life and amortisation method are reviewed periodically, with the effect of any changes in estimate being accounted for on a prospective basis.

Software is amortised from the time of acquisition or, in respect of internally developed software, from the time the asset is completed and held ready for use. The amortisation rates for the Department of Health's software are between 10 per cent and 20 per cent.

Intellectual property
The Department of Health controls both registered intellectual property in the form of patents, designs and trademarks and other unregistered intellectual property in the form of copyright. At the reporting dates these intellectual property assets do not meet the recognition criteria.

2(q) Arrangements for the provision of public infrastructure by other entities

The Department of Health has entered into a number of contractual arrangements with private sector entities for the construction and operation of public infrastructure facilities for a period of time on departmental land. After an agreed period of time, ownership of the facilities will pass to the Department of Health or the relevant HHS (see Note 44). Arrangements of this type are known as Public Private Partnerships (PPPs).

Note 2. Significant accounting policies (continued)

The Department of Health does not control the facilities associated with these arrangements. Therefore these facilities are not recorded as assets. The Department of Health receives rights and incurs obligations under these arrangements including: rights to receive the facility at the end of the contractual terms; and rights and obligations to receive and pay cash flows in accordance with the respective contractual arrangements, other than those which are received by the respective Hospital Foundations under a Deed of Assignment.

The arrangements have been structured to minimise risk exposure for the Department of Health. The Department of Health has not recognised any rights or obligations that may attach to those arrangements, other than those recognised under generally accepted accounting principles.

2(r) Collocation arrangements

The Department of Health has entered into a number of contractual arrangements with private sector entities for the construction and operation of private health facilities for a period of time on departmental land. After an agreed period of time, ownership of the facilities will pass to the Department of Health or to the relevant HHS.

As with PPP type agreements, the Department of Health does not recognise these facilities as assets. Consequently, the Department of Health has not recognised any rights or obligations that may attach to those agreements, other than those recognised under generally accepted accounting principles. Current collocation agreements in operation are listed in Note 45.

2(s) Other financial assets

The Department of Health has fixed rate deposits with Queensland Treasury Corporation approved by the Treasurer with known receipts and fixed maturity dates. The Department of Health has the ability and intention to continue to hold investments until maturity as the investments contribute towards the Government's objective of promoting high quality health research. Refer Notes 25 and 36.

2(t) Trade and other payables

Payables are recognised for amounts to be paid in the future for goods and/or services received. Trade creditors are measured at the agreed purchase/contract price, gross of applicable trade and other discounts. The amounts are unsecured and normally settled within 60 days. Refer Note 29.

Payables also includes appropriation payable to Queensland Treasury and Trade and payables to HHSs.

2(u) Other financial liabilities

Administered borrowings
The Department of Health is responsible for the administration of the Mater Hospital redevelopment loan. There is no financial benefit derived from the transactions by the Department of Health. The financial risk associated with the public component of the project has been covered by the State Government and is treated as an administered balance. Refer Note 46.

Note 2. Significant accounting policies (continued)

Other financial liabilities

2(v) Financial instruments

A financial instrument is any contract that gives rise to both a financial asset of one entity and a financial liability or equity instrument of another entity. The Department of Health holds financial instruments in the form of cash, call deposits, loans, receivables and payables. The Department of Health accounts for its financial instruments in accordance with AASB 139 *Financial Instruments: Recognition and Measurement* and reports instruments under AASB 7 *Financial Instruments: Disclosures*. The Department of Health does not enter into transactions for speculative purposes, or for hedging. Financial assets and financial liabilities are recognised in the Statement of Financial Position when the Department of Health becomes a party to the contractual provisions of the financial instrument.

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; loans to other entities – held at amortised cost; payables – held at amortised cost; fixed rate deposits – held to maturity.

Loans to other entities are initially recognised at fair value plus directly attributable transaction costs. They are subsequently recorded at amortised cost, using the effective interest method, net of any allowance for impairment. The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of a financial instrument (or, when appropriate, a shorter period) to the net carrying amount of that instrument.

Financial assets, other than those held at fair value through profit or loss, are assessed for indicators of impairment at the end of each reporting period. For certain categories of financial asset, such as trade receivables, assets that are assessed not to be impaired individually are additionally assessed for impairment on a collective basis. 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 profit or loss.

Financial assets (excluding cash) and liabilities held by the Department of Health are classified as level 3 in the fair value hierarchy. Fair values are derived from data not observable in a market. Other disclosures relating to the measurement and financial risk management of other financial instruments are included in Note 36.

2(w) Employee benefits

The Department of Health 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 11). Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at current salary rates.

Under the Queensland Government's Annual Leave Central Scheme and Long Service Leave Central Scheme, levies are payable by the Department of Health to cover the cost of employees' annual leave (including leave loading and on-costs) and long service leave. The provisions for these schemes are reported on a Whole-of-Government basis pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting*. These levies are expensed in the period in which they are paid or payable. Amounts paid to employees for annual leave and long service leave are claimed from the schemes quarterly in arrears. Refer Note 31. Non-vesting employee benefits such as sick leave are recognised as an expense when taken.

Note 2. Significant accounting policies (continued)

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. The QSuper scheme has defined benefit and defined contribution categories. Contributions are expensed in the period in which they are paid or payable and the Department of Health's obligation is limited to its contribution to QSuper. 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*.

2(x) Allocation of overheads to major departmental services

The revenues and expenses of the Department of Health's corporate services are allocated to departmental services on the basis of the services they primarily support and are included in the Statement of profit or loss and other comprehensive income by Major Services. Refer Note 3.

2(y) Insurance

Property and general losses above a $10,000 threshold are insured through the Queensland Government Insurance Fund (QGIF). Health litigation payments above a $20,000 threshold and associated legal fees are also insured through QGIF. Premiums are calculated by QGIF on a risk assessed basis. The Department of Health pays premiums to WorkCover Queensland in respect of its obligations for employee compensation.

2(z) Services received free of charge or for a nominal 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. When this is the case, an equal amount is recognised as revenue and an expense.

2(aa) Contributed equity

Non-reciprocal transfers of assets and liabilities between wholly-owned Queensland State Public Sector 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.

2(bb) Goods and Services Tax ('GST') and other similar taxes

Queensland Health 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). FBT and GST are the only Commonwealth taxes recognised by the Department of Health. Refer Note 19.

2(cc) Special Payments

Special payments include ex gratia expenditure and other expenditure that the department is not contractually or legally obligated to make to other parties. In compliance with the Financial and Performance Management Standard 2009 , the department maintains a register setting out details of all special payments greater than $5,000. The total of all special payments (including those of $5,000 or less) is disclosed separately within Other Expenses (Note 17). However, descriptions of the nature of special payments are only provided for special payments greater than $5,000.

Note 2. Significant accounting policies (continued)

2(dd) Critical accounting judgements and key sources of estimation uncertainty

The preparation of financial statements necessarily requires the determination and use of certain critical accounting estimates, assumptions and management judgements. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant, and are reviewed on an ongoing basis. Actual results may differ from these estimates. Revisions to accounting estimates are recognised in the period in which the estimate is revised, if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

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

User charges – Note 5
Loans and receivables – Note 19
Property, plant and equipment – Note 26
Credit risk exposure – Note 36
Contingencies – Note 38

2(ee) Rounding of amounts

Amounts in this report have been rounded off to the nearest thousand dollars, or in certain cases, the nearest dollar.

2(ff) Change in accounting policy - Classification of expenditure

The Department of Health voluntarily revised its definitions of 'Grants and subsidies' expenditure and 'Service procurement' expenditure during the 2012-13 financial year. A project to review the classification of all departmental funding arrangements against these revised definitions is in progress, with agreements comprising approximately 80 per cent of expenditure previously classified as ‘Grants and subsidies’ having been reviewed as at 30 June 2013. The remaining arrangements, which are not considered material for financial statement purposes, will be reviewed during the 2013-14 financial year.

The Department of Health considers that a service procurement arrangement will generally exist where the following criteria are met:

- The Department of Health has an obligation to deliver the service being purchased from the Service Organisation.
- The Department of Health clearly identifies the service being purchased and the Department is required to provide consideration for the service.
- The consideration provided by the Department of Health is approximately equal to the value, on a full cost recovery basis, of the service delivered by the Service Organisation.
- The terms and conditions of the Agreement are sufficiently specific and directive to ensure the objectives of the Department of Health are achieved.

The impact of this policy change is that prior year expenditure of approximately $743.2 million relating to procurement of hospital services, aero-medical services and hospital supplies has been re-classified from Note 14 - Grant and subsidies expenditure to Note 13 - Health services expenditure. This change has been applied retrospectively. This revision does not affect the timing of expense recognition and has no impact on the treatment of GST.

Note 2. Significant accounting policies (continued)

2(gg) New Accounting Standards and Interpretations not yet mandatory or early adopted

Australian Accounting Standards and Interpretations that have recently been issued or amended but are not yet mandatory, have not been early adopted by the department for the annual reporting period ended 30 June 2013. The department's assessment of the impact of these new or amended Accounting Standards and Interpretations, most relevant to the department, are set out below.

The Department of Health is not permitted to early adopt accounting standard unless approved by Queensland Treasury and Trade. Accounting Standards effective for the first time in the current year have had no effect on the reported results or financial position.

The following Accounting Standards in issue but not yet effective are expected to impact the Department in future periods. The potential effect of the revised Standards and Interpretations on the Department's financial statements has not yet been determined.

Standards effective for annual periods beginning on or after 1 January 2013:

AASB 13 *Fair Value Measurement* provides a new definition of fair value, establishes a framework for measuring fair value, and requires extensive disclosures about fair value measurements. Quantitative and qualitative disclosures based on the three-level fair value hierarchy currently required for financial instruments only under AASB 7 *Financial Instruments: Disclosures* will be extended to cover all assets and liabilities within the scope of AASB 13.

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

AASB 10 *Consolidated Financial Statements* redefines the concept of control of another entity. When the AASB amends AASB 10 to clarify how the principles of control should be applied by not-for-profit entities, the Department will reassess the nature of its relationships with other entities, including entities that aren't currently consolidated.

AASB 1055 *Budgetary Reporting* requires Government Departments to include in their financial statements the original budgeted statements (based on what is currently published in the Queensland Government's Budgetary Service Delivery Statements) for the Statement of Profit or Loss and Other Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity, Statement of Cash Flows and major classes of Administered balances. These budgeted statements will need to be presented consistently with the corresponding (actuals) financial statements, and must be accompanied by explanations of major variances between the actual amounts and the corresponding budgeted financial statement.

Standards effective for annual periods beginning on or after 1 January 2015:

AASB 9 *Financial Instruments* requires all financial assets to be subsequently measured at amortised cost or fair value. 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.

2(hh) Right of Private Practice

Under the right of private practice scheme, Senior Medical Officers (SMOs) employed in the public health system are permitted to treat individuals who elect to be treated as private patients. In order to do so, the SMOs receive a private practice allowance and in return assign any private practice revenue to the Hospital. A variation of this model allows the SMOs to pay a facility charge and administration fee to the Hospital and to retain a proportion of the private practice revenue. The remaining revenue is deposited into a trust account to fund research and education of all staff. Effective 1 July 2012, the balances relating to Right of Private Practice were transferred to the respective HHSs.

Note 3. Major services, activities and other events

Major services

There are six major health services delivered by the Queensland Health system. These reflect the Department of Health's planning priorities as articulated in the Department of Health Strategic Plan 2012-2016 and support investment decision-making based on the health continuum. The identity and purpose of each service is summarised as follows:

Prevention, Promotion, Protection
Aims to prevent illness or injury, promote and protect good health and well-being of the population and reduce the health status gap between the most and least advantaged in the community.

Primary Health Care
Address health problems or established risk factors of individuals and small targeted groups providing curative, promotive, preventative and rehabilitation services. The services include early detection and intervention services and risk factor management programs.

Ambulatory Care
Aims to provide equitable access to quality emergency and outpatient services provided by Queensland's public hospitals and incorporate activities of Queensland public hospitals outpatient department as well as emergency medical services provided in the public hospital emergency departments.

Acute Care
Aims to increase equity and access to high quality acute hospital services for patients on a Statewide basis and includes the provision of medical, surgical and obstetric service in Queensland hospitals.

Rehabilitation and Extended Care
Aims to improve the functional status of patients with an impairment or disability, slow the progression of a person's health condition and assist them to maintain and better manager their health condition. This major departmental service predominantly targets the needs of people with long-term conditions that have chronic consequences.

Integrated Mental Health Services
This major departmental service spans the health continuum through the provision of mental health promotion, community based illness prevention activities, acute mental health services, outpatient treatment and mental health support services as well as the extended treatment services provided through designated mental health units.

Note 3. Major services, activities and other events (continued)

Major activities

Health Reform
On 2 August 2011, the state of Queensland, as a member of the Council of Australian Governments signed the National Health Reform Agreement, committing to major changes in the way that health services in Australia are funded and governed. These changes took effect from 1 July 2012 and include:

- moving to a purchaser-provider model, with health service delivery to be purchased from legally independent networks (statutory bodies known as Hospital and Health Services in Queensland).

- introducing national funding models and a national efficient price for services, with the majority of services to be funded on an activity unit basis into the future.

- defining a refocused role for state governments in managing the health system, including:

  - the use of purchasing arrangements and other levers to drive access and clinical service improvements within and across the HHSs.

  - the use of purchasing arrangements and other levers to drive access and clinical service improvements within and across the HHSs.

Information is also available on the Department of Health web site at: www.health.qld.gov.au/health-reform

System manager role
Under the new arrangements, the role of Queensland Health's former corporate office transitioned to the role of system manager and now purchases services from the HHSs under publicly available Service Agreements negotiated between the two entities. Service Agreements for 2012-13 have been determined by the Director-General of the Department of Health under the transitional provisions in the *Hospital and Health Boards Act 2011*. The Department of Health is not involved in the day-to-day functioning of health services and has devolved responsibility for frontline service delivery to the HHSs unless there is a significant economic or similar benefit to maintaining a state-wide function.

The Health Services Information Agency provides information and communications technology support for the HHSs and the Department of Health as well as administering important technology programs such as eHealth. The Health Services Support Agency provides services in relation to pathology, forensic services and central pharmacy. These entities operate on a fee-for-service basis within a commercial structure to ensure prices and volumes for services reflect industry best practice.

Note 3. Major services, activities and other events (continued)

With the devolution of functions to the HHSs, the Department of Health retains responsibility for:

- developing system-wide strategy, policy and standards.
- focusing the direction of activities of the health system in Queensland by interpreting wider public health objectives, understanding the needs of Queensland's health consumers, and setting system-wide objectives and targets in line with government policy direction.
- planning and forecasting the delivery of health services required by the Queensland population, guided by policy and strategy objectives.
- integrating workforce, infrastructure, health technology and finance needs to ensure aligned planning across the HHSs, which will deliver services under a contractual, service agreement arrangement.
- acting as the purchaser and contract manager on behalf of the state managing the relationship with the National Health Funding Pool Administrator and Independent Hospital Pricing Authority.
- managing enterprise bargaining arrangements at a state-wide level, while devolving other day-to-day decisions in relation to human resource management to the HHSs, based on their performance.
- monitoring the system's attainment of targets and identifying activities and processes which can assist HHSs to improve performance.
- providing guidance and performing regulatory functions relating to public health and private health licensing as required under relevant legislation, as well as health protection programs and emergency preparedness activities.
- providing state-wide crisis coordination.
- supporting Queensland Government strategy and policy.
- employment of the Health Service Employees.
- operating the payroll system for the Department and HHSs.
- recovery of the payroll receivables.
- construction and management of major hospital infrastructure.
- provision of drugs and medical inventory.

The new structure functionally commenced from 1 July 2012, in support of the new HHS arrangements.

Hospital and Health Services
On 1 July 2012, 17 HHSs were established as independent statutory bodies. HHSs are governed by a Hospital and Health Board that is accountable to the local community and the Queensland Parliament for its performance. The Director-General of the Department of Health has been appointed by Governor in Council as the Administrator for the Torres Strait and Northern Peninsula Hospital and Health Service, while consultation with the community and readiness preparation activities continue. It is the department's intent to move this HHS to a Board model as soon as practicable.

Transfer of Health Service Land and Buildings to Hospital and Health Services
The Department of Health is the legal owner of all health service land and buildings. From 1 July 2012, HHSs were granted operational control of land and buildings via Deed of Lease arrangements.

As health service land and buildings are controlled by HHSs, these assets are recognised within the financial statements of each HHS, not within the financial statements of the Department. Any revaluation surpluses or decrements associated with these assets are recognised by the HHS. Refer Notes 26, 27, 35 and 41.

It is intended that legal title of health service land and buildings will transfer from the Department of Health to HHSs when both entities have mutual confidence that the HHSs have the capacity and capability to be effective asset managers.

Note 3. Major services, activities and other events (continued)

Funding reforms
Funding is provided to the HHSs in accordance with Service Agreements.

The Commonwealth and State contribution for Activity Based Funding is pooled and allocated transparently via a National Health Funding Pool. The Commonwealth and State contribution for block funding and training, teaching and research funds is pooled and allocated transparently via a State Managed Fund. Public Health funding from the Commonwealth is managed by Department of Health.

An Independent Hospital Pricing Authority (IHPA) has been established independently from the Commonwealth to develop and specify national classifications to be used to classify activity in public hospitals for the purposes of Activity Based Funding. IHPA will determine the national efficient price for services provided on an activity basis in public hospitals and will develop data and coding standards to support uniform provision of data. In addition to this, IHPA will determine block funded criteria and what other public hospital services are eligible for Commonwealth funding.

The National Health Funding Body and National Health Funding Pool have complete transparency in reporting and accounting for contributions into and out of pool accounts. The Administrator is an independent statutory office holder, distinct from Commonwealth and State departments.

Debt Facility
HHS bank accounts form part of the whole-of-Government banking arrangement with the Commonwealth Bank of Australia. Under this arrangement, HHSs have access to the Whole-of-Government debt facility with limits assigned to the Department of Health and individual HHSs which are approved by the Under-Treasurer.

Assets and liabilities transferred on 1 July 2012
On 1 July 2012, certain balances were transferred from Queensland Health to HHSs (refer Note 41). This was effected via a transfer notice signed by the Minister for Health, designating that the transfer be recognised as a contribution by owners through equity. The transfer notices were approved by the Director-General of the Department of Health and the Chairman and Chief Executive of each Health Service Board. Balances transferred to HHSs materially reflected the closing balances of Health Service Districts (HSD) as at 30 June 2012 and these balances became the opening balances of HHSs. The cash balance transferred to individual HHSs was the amount required to ensure entities commence operations with a balanced working capital position.

Payroll improvements
In 2012-13 the Department of Health continued to operate, maintain and enhance the payroll and rostering environment to improve the pay outcomes for employees in the Department of Health and HHSs, reduce the level of fortnightly overpayments and reduce recurrent operational payroll costs. Initiatives undertaken in 2012-13 include:

- Moving the employee pay day by one week to enable more time to submit, approve and process payroll forms each roster period and before the fortnightly pay run commences
- A payroll forms lodgement campaign to encourage timely submission of payroll forms by employees and managers
- Recovery of overpayments
- Preparation of the progressive introduction of automated recovery of any new overpayments from July 2013
- Progressive rollout of Employee Self Service to provide staff with online access to their payslips, payment summaries and overpayment records and to allow staff to lodge and track payroll enquiries
- Improvements in workforce management practices
- Rostering and payroll system changes and upgrades

Note 3. Major services, activities and other events (continued)

Overpayments receivables and recovery actions
Included in receivables is an amount of $96.54 million (2011-12: $96.495 million) relating to salary overpayments and interim cash payments (of which $16.183 million classified as current and $80.357 million classified as non-current) and pay date loan of $113.155 million (2011-12: Nil) to provide a transitional loan equal to two weeks' net pay (of which $11.13 million classified as current and $102.025 million classified as non-current). Refer Notes 19 and 23.

The Department has made significant progress in implementing its comprehensive strategy to prevent the occurrence of overpayments and to manage those overpayments that have occurred.

In late June 2012, the Department directly notified 49,040 current and former staff of their overpayment situation as at 13 May 2012 and advised of its intention to seek repayment.

During 2012-13, $18.5 million in overpayments was recovered and 9,157 repayment plans or intentions to repay were agreed with current and former employees. As at 30 June 2013, approximately $35.5 million of total overpayments to date have been voluntarily repaid and there is a committed total of $6.4 million still to be repaid by employees with active repayment plans in place.

Approximately 25,000 employees received a waiver of overpayments between 1 July 2012 and 30 June 2013 with a value of $1.9 million. Of this total, $1.7 million related to employees with cumulative overpayment amounts up to and including $200 between 1 July 2011 and 13 May 2012.

Change in pay date
The Department of Health transitioned to a new pay period from October 2012. The change in pay date has allowed payroll staff additional time to process and review pay forms, and has improved the accuracy of staff pays during the 2012-13 financial year. To ensure no employee was financially disadvantaged by this change, employees were provided with a transitional loan equal to two weeks' net pay. As at 30 June 2013, the balance of this loan is $113.155 million. Loans will be recovered automatically when employees leave the Department of Health or employees may choose to repay the balance early. No allowance for impairment has been recognised for this pay date loan.

Note 3. Major services, activities and other events (continued)

Other events

Natural Disaster Relief and Recovery Arrangements
The National Disaster Relief and Recovery Arrangements (NDRRA), a joint Commonwealth/State program, has provided funding to the Queensland Reconstruction Authority to assist with the natural disaster relief and recovery costs. The Authority coordinates the distribution of funding for NDRRA claims to enable Department of Health to fund these activities.

Voluntary Separation Payments
A Voluntary Separation Program was implemented during 2011-12. The program ceased during 2011-12; however, 27 employees received their voluntary separation packages during 2012-13 at a cost of $4.91 million.

Voluntary Redundancy Payments
A program of redundancies was implemented during 2012-13. During the period, 3,181 Department of Health employees received redundancy packages at a cost of $297.18 million. This is inclusive of all employee entitlements and associated on-costs. 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. At the conclusion of this period, and where it was deemed that continued attempts of ongoing placement were no longer appropriate, employees yet to be placed were terminated and paid a retrenchment package. During 2012-13, 5 employees received retrenchment packages at a cost of $0.705 million.

Devolvement of Finance Transactional Services
Financial Accounting services that were performed within the centrally managed Finance Transactional Services area were transitioned from the Department of Health to the HHSs from 1 April 2013. Budget and resources, including established positions associated with the financial accounting functions, including taxation, general ledger and asset accounting, formed part of the transition.

Fraud incident
During 2011-12, Department of Health management became aware of an incident of fraud involving misappropriated grants expense. This matter was referred immediately to the Queensland Police Service and the Crime and Misconduct Commission (CMC).

In December 2011, the matter was accepted for proceeds of crime litigation under the civil confiscation provisions of the *Criminal Proceeds Confiscation Act 2002*. The litigation by the CMC Proceeds of Crime Team is conducted in three phases, being:
• Restraint of property;
• Forfeiture and Proceeds Assessment Orders; and
• Realisation of property and payment of monies to the Consolidated Fund.

On 13 June 2013, the Supreme Court in Brisbane granted a forfeiture order worth approximately $11.88 million, which was calculated after the costs of selling property had been deducted. On 18 June 2013, $11.69 million being the net proceeds of forfeited property under the *Criminal Proceeds Confiscation Act 2002*, was released from the Public Trustee and paid to the Queensland Government's Consolidated Fund. This amount will be returned to the Department in the 2013-14 financial year.

The Department of Health has implemented significant strategies to strengthen its internal control structure to reduce the incidence of fraud occurring in the future. These strategies include the development and implementation of an Internal Control Framework, development and implementation of fraud control risk management framework, fraud risk register, and the development of fraud risk awareness training, which is mandatory for all employees to attend. The Department remains committed to improving fraud prevention and corruption control strategies to ensure the effective, efficient and economic management of public resources.

Note 4. Departmental services revenue

	2013 $'000	2012 $'000
Budgeted departmental services appropriation	7,725,314	9,935,644
Transfers from other headings	-	59,972
Unforeseen expenditure	-	58,284
Lapsed departmental services appropriation	(50,848)	-
Add: Appropriation Receivable	111,545	-
Add: Opening Balance Departmental Services Appropriation Payable	67,559	-
Departmental services revenue recognised in the Statement of Profit or Loss and Other Comprehensive Income	7,853,570	10,053,900

Budgeted departmental services appropriation includes Australian Government contributions of $352.8 million (2011-12:$2,816 million) appropriated through Queensland Treasury and Trade.

Departmental services revenue recognised in the Statement of Profit or Loss and Other Comprehensive Income includes accrual adjustments of $179.1 million. The amount of cash receipts in 2012-13 is $7,674.466 million (2011-12: $10,053.90 million).

	2013 $'000	2012 $'000
Reconciliation of payments from Consolidated Fund to equity adjustment		
Budgeted equity adjustment appropriation	1,354,981	1,203,991
Transfers to other headings	-	(59,936)
Lapsed appropriation	(329,263)	-
Equity adjustment recognised in contributed equity	1,025,718	1,144,055

Note 5. User charges

	2013 $'000	2012 $'000
Sale of goods and services	1,090,620	272,130
Hospital fees	306,214	620,660
	1,396,834	892,790

Note 6. Labour recoveries

	2013 $'000	2012 $'000
Labour recoveries from Hospital and Health Services	6,693,409	-

Note 7. Grants and other contributions

	2013 $'000	2012 $'000
Australian Government - nursing home grants	-	64,343
Australian Government - other specific purpose recurrent grants	2,699,793	118,647
Australian Government - other specific purpose capital grants	-	6,500
Other grants	21,223	127,446
Donations other	-	5,738
Donations inventory*	12,814	6,035
Donations non-current physical assets	23	593
Other	535	675
	2,734,388	329,977

* Inventory is donated by the Australian Government as part of the Australia wide vaccinations initiative.

Note 8. Other revenue

	2013 $'000	2012 $'000
Interest	1,710	6,065
Rental income	4,774	8,667
Sale proceeds of non-capitalised assets	702	202
Licences and registration charges	3,136	2,686
Recoveries	10,555	11,524
Grants returned	5,005	10,487
Other	6,933	8,768
	32,815	48,399

Note 9. Gains

	2013 $'000	2012 $'000
Gain on sale of property, plant and equipment	2,093	3,419

Note 10. Share of profit from associates

	2013 $'000	2012 $'000
Share of profit from associates	14,147	28,596

Note 11. Employee expenses

	2013 $'000	2012 $'000
Wages and salaries	5,722,267	5,643,608
Employer superannuation contributions	596,739	595,765
Annual leave expense	665,857	643,436
Long service leave levy	122,381	122,022
Redundancies	221,776	100,263
Workers' compensation premium	71,730	82,167
Payroll tax	40,347	40,268
Professional development of nurses	34,663	33,310
Other employee related expenses	6,381	37,096
	7,482,141	7,297,935

	2013	2012
Number of employees		
Hospital and Health Services	57,404	60,114
The Department of Health State-wide Services	4,676	5,274
The Department of Health Corporate	2,112	3,476
	64,192	68,864

The number of employees includes full-time employees and part-time employees measured on a full-time equivalent basis. Key executive management and personnel are reported in Note 37.

Note 12. Supplies and services

	2013 $'000	2012 $'000
Consultants and contractors	120,691	351,965
Electricity and other energy	5,802	69,610
Patient travel	21	52,112
Other travel	6,910	54,927
Water	759	10,602
Building services	4,461	17,156
Computer services	64,240	98,575
Motor vehicles	2,710	12,152
Communications	42,382	63,612
Repairs and maintenance	72,886	207,285
Expenses relating to capital works	28,510	27,087
Operating lease rentals	57,109	130,450
Drugs	335,497	417,340
Clinical supplies and services	131,932	697,860
Catering and domestic supplies	10,224	142,644
Other	22,745	51,817
	906,879	2,405,194

Note 13. Health services

	2013 $'000	2012 $'000
Hospital and Health Services	8,916,774	-
Mater Hospitals	509,126	485,563
National Blood Authority	80,358	88,413
Aeromedical services	70,905	60,810
Ambulance services	68,877	66,576
Other health service providers	16,786	41,783
	9,662,826	743,145

The Department of Health voluntarily revised its definitions of 'Grants and subsidies' expenditure and 'Service procurement' expenditure during the 2012-13 financial year. A project to review the classification of all departmental funding arrangements against these revised definitions is in progress, with agreements comprising approximately 80 per cent of expenditure previously classified as ‘Grants and subsidies’ having been reviewed as at 30 June 2013. The remaining arrangements, which are not considered material for financial statement purposes, will be reviewed during the 2013-14 financial year. Refer to Note 2(ff).

Note 14. Grants and subsidies

	2013 $'000	2012 $'000
Public hospital support services	23,552	48,056
Home, community and rural health services	104,527	128,825
Mental health services	63,956	3,831
Medical research programs	63,340	57,286
Other	3,909	5,872
	259,284	243,870

Note 15. Depreciation and amortisation

	2013 $'000	2012 $'000
Buildings and land improvements	6,051	206,788
Plant and equipment	59,521	147,788
Software purchased	4,930	4,301
Software developed	15,382	13,067
	85,884	371,944

Note 16. Impairment losses

	2013 $'000	2012 $'000
Impairment losses on receivables	11,260	26,088
Bad debts written off	2,227	21,630
	13,487	47,718

Refer Notes 19, 23 and 36 for further detail on impairment losses.

Note 17. Other expenses

	2013 $'000	2012 $'000
External audit fees*	1,200	1,593
Bank fees	141	536
Insurance**	90,619	75,754
Inventory written off	4,791	5,121
Losses from disposal / transfer of non-current assets	2,071	5,013
Write off of capital work-in-progress	42,241	-
Losses - public monies	1	11,275
Losses - public property	-	4
Pay day loan fair value adjustment	17,661	-
Special payments - donations/gifts	-	23
Special payments - ex-gratia payments	60	1,367
Other legal costs	3,153	7,359
Journals and subscriptions	6,070	7,899
Advertising	4,755	12,954
Interpreter fees	85	5,114
Write-off of finance lease receivable	3,062	-
Other	6,292	3,370
	182,202	137,382

* Total audit fees paid to the Queensland Audit Office relating to the 2012-13 financial year are $1.20 million (2011-12: $1.59 million). This balance is inclusive of $0.249 million relating to an engagement to provide assurance on controls at the Department of Health in its capacity as a service organisation for HHSs.

** Balance comprises the premium for insurance with the Queensland Government Insurance Fund.

Note 18. Current assets - cash and cash equivalents

	2013 $'000	2012 $'000
Cash on hand	-	2
Cash at bank and on hand	(191,515)	(146,879)
24 hour call deposits	9,730	82,135
	(181,785)	(64,742)

The Department of Health's bank accounts are grouped within the whole-of-Government set-off arrangement with the Queensland Treasury Corporation. The Department of Health does not earn interest on surplus funds and is not charged interest or fees for accessing its approved cash overdraft facility as it is part of the whole-of-Government banking arrangements.

Interest earned on the aggregate set-off arrangement balance accrues to the Consolidated Fund. Cash deposited at call with the Queensland Treasury Corporation earns interest at a rate of 4.15% (2011-12: 3.95%).

Note 19. Current assets - loans and receivables

	2013 $'000	2012 $'000
Trade receivables	581,736	381,847
Payroll receivables	27,314	96,495
Less: Provision for impairment of receivables	(11,323)	(59,615)
Less: Pay day loan fair value adjustment	(384)	-
	597,343	418,727
GST input tax credits receivable	53,168	62,095
GST payable	(1,511)	(4,340)
	51,657	57,755
Finance lease receivable	9,073	-
Annual leave reimbursements	142,995	141,260
Long service leave reimbursements	49,295	23,782
Advances	11,977	10,003
Appropriation receivable	111,545	-
Other	139	596
	974,024	652,123

Note 19. Current assets - loans and receivables (continued)

Trade receivables includes outstanding amounts of $26.45 million (2011-12: $69.03 million) from the Commonwealth Department of Veteran Affairs for patient revenue and $69.46 million ($147.81 million in 2011-12) from other state Governments for treatment of interstate patients. The prior year receivable and retained surpluses balances have been restated to correct the under-recognition of interstate revenue of $15.2 million. The loan receivable forms part of a transaction agreement between the Department of Health and Telstra for the relocation of the South Brisbane Telephone Exchange.

In the 2011-12 financial year, the Department of Health classified the total balance of overpayments and interim cash payments receivable as current. Due to improved recovery data available in the 2012-13 financial year, the Department of Health has been able to more reliably estimate the timing of the recovery of total overpayments and interim cash payments, and has classified these items as current and non-current accordingly.

Payroll receivables includes an amount of $16.183 million (2011-12: $18.5 million) relating to salary overpayments and interim cash payments and pay date loan of $11.13 million (2011-12: Nil) to provide a transitional loan equal to two weeks' net pay. Refer Notes 3 and 23 for the disclosure of the non-current balance.

In the 2011-12 financial year, the Department of Health classified the total balance of overpayments and interim cash payments receivable as current. Due to improved recovery data available in the 2012-13 financial year, the Department of Health has been able to more reliably estimate the timing of the recovery of total overpayments and interim cash payments, and has classified these items as current and non-current accordingly.

Finance lease receivable relates to the Translational Research Institute Facility. The Department Health entered into a 30 year finance lease with the Translational Research Institute Facility on 14 November 2012. The total value of the minimum lease payments for this facility is $272.7 million. As at 30 June 2013, the Department of Health has received $272.7 million in advanced lease payments for this facility. Both the finance lease receivable and the finance lease prepayment are being unwound over the course of the lease term.

Unguaranteed residual values of assets leased under finance leases at the end of the reporting period are estimated at nil. The finance lease receivables at the end of the reporting period are neither past due nor impaired and there is no allowance for uncollectible lease payments.

Impairment of receivables
The ageing of the impaired receivables provided for above are as follows:

	2013 $'000	2012 $'000
Less than 30 days	-	1,428
30-60 days	44	928
61-90 days	38	2,657
More than 90 days	37,503	54,602
	37,585	59,615

Note 19. Current assets - loans and receivables (continued)

Movements in the provision for impairment of receivables are as follows:

	2013 $'000	2012 $'000
Opening balance	59,615	33,527
Transfer to HHSs (note 41)	(17,994)	-
Increase/(decrease) in allowance recognised in operating result	13,486	47,719
Recovery of amount previously written off	-	(22)
Receivables written off during the year as uncollectable	(17,522)	(21,609)
Closing balance	37,585	59,615

Past due but not impaired
Customers with balances past due but without provision for impairment of receivables amount to $974.024 million as at 30 June 2013 ($652.123 million as at 30 June 2012).

The ageing of the past due but not impaired receivables are as follows:

	2013 $'000	2012 $'000
Less than 30 days	905,407	595,865
30-60 days	2,052	14,165
61-90 days	760	5,854
More than 90 days	65,805	36,239
	974,024	652,123

The due date of payroll receivables is the date the recipient terminates employment with the Department of Health.

The balance of payroll receivables past due but not impaired of $21.651 million represents balances owing fromcurrent and former employees which are considered likely to be recovered. In determining this balance, consideration was given to the value, quantity and age of the amounts receivable.

Impairment of financial assets
At the end of each reporting period, the Department of Health 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 60 days. The provision for impairment reflects the Department of Health's assessment of the credit risk associated with receivables balances and is determined based on consideration of objective evidence of impairment, past experience and management judgement. (Refer also Note 36).

Impaired Financial Assets are comprised of:
a) Payroll receivables of $36.707 million (2011-12: $26.493 million). The increase in this provision is mainly due to an increase in the age of overpayments and interim cash payments receivables relating to former employees.

b) Other receivables (including patient receivables) $0.879 million (2011-12: $33.122 million). The majority of this provision previously reported by the Department of Health is now reported by HHSs.

Note 20. Current assets - inventories

	2013 $'000	2012 $'000
Medical supplies and equipment	49,694	127,482
Catering and domestic	1,301	2,741
Less: Provision for impairment	(4,604)	(3,347)
	46,391	126,876
Engineering	1,573	1,916
Other	783	1,294
	48,747	130,086

Note 21. Current assets - other assets

	2013 $'000	2012 $'000
Insurance premium prepayment	102,548	90,407
Other prepayments	34,973	21,211
	137,521	111,618

Note 22. Current assets - non-current assets classified as held for sale

	2013 $'000	2012 $'000
Land	-	75

Note 23. Non-current assets - loans and receivables

	2013 $'000	2012 $'000
Payroll receivables	182,381	-
Less: Pay day loan fair value adjustment	(17,277)	-
	165,104	-
Less: Provision for impairment of receivables	(26,262)	-
Loans to other entities	21,957	20,911
Finance lease receivable	263,665	-
	424,464	20,911

Payroll receivables comprises $80.357 million (2011-12: $77.995 million) relating to salary overpayments and interim cash payments and pay date loan of $102.024 million (2011-12: Nil) to provide a transitional loan equal to two weeks' net pay. Refer Notes 3 and 19 for the disclosure of the current balance.

Note 24. Non-current assets - investment in associates

	2013 $'000	2012 $'000
Translational Research Institute Trust	83,339	69,192

Refer to note 42 for further information on investments in associates.

Note 25. Non-current assets - other financial assets

	2013 $'000	2012 $'000
Fixed rate deposit	20,000	20,000

The Treasurer approved the investment of $20 million with Queensland Treasury Corporation (QTC) with the interest earned being used for the funding of the Smart State Research Grants Program. Interest earned from this investment totalled $0.689 million (2011-12: $1.109 million). As at 30 June 2013 there is one deposit with QTC for $20 million. Refer Note 36.

Note 26. Non-current assets - property, plant and equipment

	2013 $'000	2012 $'000
Land - at independent valuation	90,239	1,084,181
	90,239	1,084,181
Buildings - at independent valuation	202,180	6,857,621
Less: Accumulated depreciation	(70,488)	(2,996,031)
	131,692	3,861,590
Plant and equipment - at cost	479,598	1,609,094
Less: Accumulated depreciation	(265,386)	(797,433)
	214,212	811,661
Capital works in progress - at cost	3,095,971	2,627,362
	3,095,971	2,627,362
	3,532,114	8,384,794

Note 26. Non-current assets - property, plant and equipment (continued)

Reconciliations
Reconciliations of the written down values at the beginning and end of the current and previous financial year are set out below:

	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Balance at 1 July 2011	1,112,805	3,719,427	761,420	1,584,912	7,178,564
Additions	5,154	159,484	206,358	1,350,649	1,721,645
Donations received	-	-	644	-	644
Classified as held for sale (Note 22)	(75)	-	-	-	(75)
Disposals	(7,969)	(472)	(6,068)	-	(14,509)
Donations made	-	(55)	(9)	-	(64)
Revaluation increments/ (decrements)	(26,074)	(54,551)	-	-	(80,625)
Transfers between classes	393	310,773	(2,967)	(308,199)	-
Transfers in/(out)	4	437	70	-	511
Impairment of assets	(57)	(66,662)	-	-	(66,719)
Depreciation expense	-	(206,791)	(147,787)	-	(354,578)
Balance at 30 June 2012	1,084,181	3,861,590	811,661	2,627,362	8,384,794
Transfer to HHSs on 1 July 2012 (Note 41)	(997,448)	(3,813,041)	(580,234)	(18,839)	(5,409,562)
Corrections to opening balances *	-	77,723	-	-	77,723
Additions	3,506	449	32,908	1,239,949	1,276,812
Disposals	-	-	(1,501)	-	(1,501)
Write off of capital works in progress **	-	-	-	(42,241)	(42,241)
Donations received	-	-	38	-	38
Revaluation increments/ (decrements)	-	18,166	-	-	18,166
Transfers between classes	-	1,159	17,169	(18,328)	-
Transfers in/(out)	-	(17)	3,960	(275,800)	(271,857)
Transfer to HHSs	-	(8,287)	(10,259)	(416,132)	(434,678)
Depreciation expense	-	(6,050)	(59,530)	-	(65,580)
Balance at 30 June 2013	90,239	131,692	214,212	3,095,971	3,532,114

* Corrections to opening balances relates to three assets which received corrected valuation reports in relation to prior years. Each of these buildings has been transferred to HHSs at fair value, adjusted for these corrections.

** Balance relates to write off of completed capital work in progress prior to transfer to HHS at fair value. Refer Note 17.

Note 26. Non-current assets - property, plant and equipment (continued)

Included in the valuation of buildings are 2 heritage buildings held at gross value of $1.14 million (2011-12: 78 buildings at gross value of $108.213 million).

Land

Land was fair valued using the following methodologies: In 2012-13 and 2011-12, the majority of land was indexed using the appropriate indices sourced from the State Valuation Service. These indices are based on actual market movements for the relevant location and asset category; and, in 2010-11, an independent market revaluation was performed on all land with a value greater than $0.415 million by the State Valuation Service. For all land under $0.415 million, a desktop market valuation was performed. The revaluation program resulted in nil increment / decrement (a decrement of $26.074 million in 2011-12) to the carrying amount of land.

Buildings

An independent revaluation of 71 per cent of the gross value of the building portfolio was performed during 2012-13. For buildings not subject to independent revaluations during 2012-13, an index between 0 and 1 per cent was applied. Refer Note 2(o). The buildings valuations for 2012-13 resulted in a net increment to the Department's building portfolio of$18.166 million (2011-12: $54.551 million decrement).

The Department has plant and equipment with an original cost of $3.06 million (2011-12: $14.324 million) or 1 per cent (2011-12: 0.9 per cent) of total plant and equipment gross value and a written down value of zero still being used in the provision of services.

The effective date of valuations is 30 June 2013 (2012: 30 June 2012).

Capital work in progress

The Department of Health is responsible for managing major health infrastructure projects for the HHSs. During the construction phase these projects remain on the Department's Statement of Financial Position as a work-in-progress asset. Upon completion of these infrastructure projects, these assets are transferred to the respective HHS for use and depreciation. Current works in progress balances are attributable across the portfolio of capital works and include the Gold Coast University Hospital, the Sunshine Coast University Hospital and the Queensland Children's Hospital as well as redevelopments in Cairns, Rockhampton, Townsville, Mackay and Logan.

For a range of projects the Department has entered into varied contractual arrangements with private sector entities for the construction and in some cases, the operation of public infrastructure facilities for a period of time. See Note 44.

Note 27. Non-current assets - intangibles

	2013 $'000	2012 $'000
Software purchased - at cost	151,893	27,660
Less: Accumulated amortisation	(94,849)	(16,399)
	57,044	11,261
Software internally generated - at cost	240,865	231,487
Less: Accumulated amortisation	(192,482)	(180,547)
	48,383	50,940
Software work in progress - at cost	124,434	87,263
	124,434	87,263
	229,861	149,464

Reconciliations
Reconciliations of the written down values at the beginning and end of the current and previous financial year are set out below:

	Software purchased $'000	Software generated $'000	Software work in progress $'000	Total $'000
Balance at 1 July 2011	12,573	54,666	54,356	121,595
Additions	2,756	1,575	38,609	42,940
Transfers between classes	233	7,767	(5,702)	2,298
Amortisation expense	(4,301)	(13,068)	-	(17,369)
Balance at 30 June 2012	11,261	50,940	87,263	149,464
Transfer to HHSs (Note 41)	(3,711)	(527)	(360)	(4,598)
Additions	13,175	2,791	48,745	64,711
Transfers between classes	-	11,213	(11,213)	-
Transfers in/(out)	41,248	(652)	-	40,596
Amortisation expense	(4,930)	(15,382)	-	(20,312)
Balance at 30 June 2013	57,043	48,383	124,435	229,861

The Department of Health's Hospital Based Corporate Information System (HBCIS) has an original cost of $0.952 million (0.43 per cent) of the total gross value of the class of assets. HBCIS has been written down to zero and is still being used in the provision of services. Work is underway in relation to development and progression of a business case to undertake a patient admission system replacement for consideration of investment by government.

Costs associated with projects in the research phase of the software development program were expensed and were mainly included as salaries and wages costs in 2012-13. The total balance of these costs is $0.840 million (2011-12: $2.175 million).

Transfers in of $41.248 million relates to a machinery-of-Government transfer of assets from Queensland Shared Services.

Note 28. Non-current assets - other assets

	2013 $'000	2012 $'000
Other prepayment	3,394	7,629

Note 29. Current liabilities - payables

	2013 $'000	2012 $'000
Trade payables	279,346	420,794
Appropriations payable	120,453	67,559
Hospital and Health Services payables	140,505	-
Other payables	11,511	9,413
	551,815	497,766

Refer to note 36 for further information on financial instruments.

Trade payables includes amounts of $57.146 million (2011-12: $137.329 million) owed to other state Governments for treatment of interstate patients.

Note 30. Current liabilities - other liabilities

	2013 $'000	2012 $'000
Finance lease advanced	9,073	-

This is the current liability arising from the advanced lease payments received from the Translational Research Institute Trust. Refer Note 33 for the non-current balance.

Note 31. Current liabilities - accrued employee benefits

	2013 $'000	2012 $'000
Salaries and wages accrued	429,264	218,690
Other employee entitlements payable	8,327	11,314
Annual leave levy payable	139,405	142,155
Long service leave levy payable	34,211	34,364
	611,207	406,523

The increase in salaries and wages accrued is due additional days accrued as a result of the change in pay date. Refer to Note 3.

Note 32. Current liabilities - unearned revenue

	2013 $'000	2012 $'000
Unearned other revenue	40	466

Note 33. Non-current liabilities - other liabilities

	2013 $'000	2012 $'000
Finance lease advanced	263,665	194,398

This is the non-current liability arising from the advanced lease payments received from the Translational Research Institute Trust. Refer Note 30 for the current balance.

Note 34. Non-current liabilities - unearned revenue

	2013 $'000	2012 $'000
Unearned other revenue	4,953	2,536

Note 35. Equity - asset revaluation surplus

	2013 $'000	2012 $'000
Asset revaluation surplus reserve - land	52,963	662,098
Asset revaluation surplus reserve - buildings	25,286	282,363
	78,249	944,461

Note 35. Equity - asset revaluation surplus (continued)

	Asset revaluation surplus land $'000	Asset revaluation surplus buildings $'000	Total $'000
Balance at 1 July 2011	688,229	403,576	1,091,805
Revaluation	(26,074)	(54,551)	(80,625)
Impairment loss*	(57)	(66,662)	(66,719)
Balance at 30 June 2012	662,098	282,363	944,461
Asset revaluation increment	-	18,166	18,166
Correction of prior year error **	-	77,724	77,724
Transfer to retained earnings***	(609,135)	(352,967)	(962,102)
Balance at 30 June 2013	52,963	25,286	78,249

* The land impairment loss of approximately $0.06 million recognised in 2011-12 related to unusable land leases. The building impairment loss recognised in 2011-12: $66.662 million predominantly related to buildings with shorter than expected useful lives located on the site of health facility redevelopments. The majority of the buildings impaired have been demolished as at reporting date.

** Correction of prior year error relates to two buildings found to be overvalued through errors in prior year valuations. Control of these buildings was transferred to HHSs and the resulting revaluation decrement has been transferred to retained surpluses.

*** The transfer to retained surplus of $962.1 million recognised in 2012-13 (2011-12: nil) represents the proportion of revaluation surplus attributable to land and buildings transferred to the control of HHSs. Refer Note 3.

Note 36. Financial instruments

As at the reporting date, the Department of Health had the following financial assets and liabilities:

	2013		**2012**	
	Weighted average interest rate %	**Balance $'000**	**Weighted average interest rate %**	**Balance $'000**
Cash and cash equivalents	-	(191,516)	-	(146,877)
24 hour call deposits	4.15	9,730	3.95	82,135
Loans and receivables	-	1,398,488	-	657,798
Fixed rate deposits	3.44	20,000	4.28	20,000
Total financial assets		1,236,702		613,056

An analysis by remaining contractual maturities is shown in 'liquidity and interest rate risk management' below.

Note 36. Financial instruments (continued)

The Department of Health has the below financial liabilities payable. Financial assets are shown in the table above.

	2013 $'000	2012 $'000
Payables	551,815	497,766

Financial risk management

The Department of Health is exposed to a variety of financial risks – credit risk, liquidity risk and market risk.

Financial risk is managed in accordance with Queensland Government and departmental policies. The Department of Health's policies provide written principles for overall risk management and aim to minimise potential adverse effects of risk events on the financial performance of the department.

Credit risk is measured by ageing analysis and cash inflows at risk. Liquidity risk is measured by monitoring of cash flows and by active management of accrual accounts. Market risk is measured by interest rate sensitivity analysis.

Credit risk exposure

Credit risk is the potential for financial loss arising from a counterparty defaulting on its obligations. The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the financial asset, inclusive of any allowance for impairment. The carrying amount of receivables represents the maximum exposure to credit risk. As such, receivables are not included in the disclosure below. Refer Notes 19 and 23 for further information.

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

The maximum exposure to credit risk for cash is $181.79 million (2011-12: $64.74 million) and for fixed rate deposits is $20 million (2011-12: $20 million).

Liquidity risk

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

The Department of Health is exposed to liquidity risk through its trading in the normal course of business. The department aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations at all times. The Department of Health has an approved debt facility of $520 million under Whole-of-Government banking arrangements to manage any short term cash shortfalls.

The following tables detail the department's remaining contractual maturity for its financial instrument liabilities. The tables have been drawn up based on the undiscounted cash flows of financial liabilities based on the earliest date on which the financial liabilities are required to be paid. The tables include both interest and principal cash flows disclosed as remaining contractual maturities and therefore these totals may differ from their carrying amount in the statement of financial position.

Note 36. Financial instruments (continued)

2013	Weighted average interest rate %	1 year or less $'000	Between 1 and 2 years $'000	Between 2 and 5 years $'000	Over 5 years $'000	Remaining contractual maturities $'000
Non-derivatives						
Non-interest bearing						
Trade payables	-	551,815	-	-	-	551,815
Total non-derivatives		551,815	-	-	-	551,815

2012	Weighted average interest rate %	1 year or less $'000	Between 1 and 2 years $'000	Between 2 and 5 years $'000	Over 5 years $'000	Remaining contractual maturities $'000
Non-derivatives						
Non-interest bearing						
Trade payables	-	497,766	-	-	-	497,766
Total non-derivatives		497,766	-	-	-	497,766

The cash flows in the maturity analysis above are not expected to occur significantly earlier than contractually disclosed above.

Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises: foreign exchange risk; interest rate risk; and other price risk. The Department of Health has interest rate exposure on the 24 hour call deposits and there is no interest rate exposure on its cash and fixed rate deposits. The Department of Health does not undertake any hedging in relation to interest rate risk. Changes in interest rate have a minimal effect on the operating result of the department.

Unless otherwise stated, the carrying amounts of financial instruments reflect their fair value. The carrying amounts of trade receivables and trade payables are assumed to approximate their fair values due to their short-term nature. The fair value of financial liabilities is estimated by discounting the remaining contractual maturities at the current market interest rate that is available for similar financial instruments.

Note 37. Key management personnel disclosures

The following details for key executive management personnel include those positions that had authority and responsibility for planning, directing and controlling the activities of the Department of Health during 2012-13. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management.

Note 37. Key management personnel disclosures (continued)

Key management personnel

Name and position of current incumbents	**Responsibilities**	**Contract classification appointment authority**	**Appointment date**
Director-General - Dr Anthony O'Connell	Responsible for the overall management of the Department of Health through major functional areas to ensure the delivery of key government objectives in improving the health and well being of all Queenslanders.	s92 Contract/CEO Governor in Council/Public Service Act 2008	23/06/2011
Deputy Director-General, Health Service and Clinical Innovation Division - Professor Michael Cleary*	Lead the development of policy, strategy and clinical workforce development to meet current and future health challenges.	s24 & s28E Contract/HES 4 Chief Executive/Health Services Act 1991	10/05/2010
Deputy Director-General, System Policy and Performance - Terry Mehan	Lead and manage the functions relating to accountability and governance across Queensland Health. Responsible for developing governance, strategic planning and performance management frameworks.	s24 & s28E Contract/HES 4 Chief Executive/Health Services Act 1991	19/11/2008
Deputy Director-General, System Support Services - Susan Middleditch**	Responsible for the provision of enabling corporate services that allow both the Department and the HHSs to function effectively and deliver essential services, including financial, legal, human resources services, administers the infrastructure program and has oversight of key governance functions.	s24 & s28E Contract/HES 4 Chief Executive/Health Services Act 1991	14/05/2012
Chief Health Officer - Dr Jeannette Young	Lead and manage the development of strategic policy, regulation, legislative frameworks and programs for public health function, including mental health, population health and health service regulation as well as the provision of advice to the Minister and government relating to emergencies such as pandemics, epidemics, or major disasters.	s24 & s28E Contract/HES 4 Chief Executive/Health Services Act 1991	08/10/2007
Chief Information Officer, Health Services Information Agency - Raymond Brown	Provide leadership and strategic direction for the provision of information management and information communication technology services to Queensland Health.	s24 & s28E Contract/HES 4 Chief Executive/Health Services Act 1991	02/06/2008

Note 37. Key management personnel disclosures (continued)

Name and position of current incumbents	Responsibilities	Contract classification appointment authority	Appointment date
Chief Executive Officer, Health Service Support Agency - Kathleen Byrne	Responsible for managing the strategic functions relating to the Clinical and Statewide Service provided by Queensland Health including Pathology, Medication Services, Radiology, Forensic and Scientific Services, Biomedical Technology Services and Queensland Blood Management.	s24 & s28E Contract/HES 4 Chief Executive/Health Services Act 1991	02/06/2009

* Effective 1 July 2012, the Deputy Director-General, Policy Strategy and Resourcing Division has been re-named as Deputy Director-General, Health Service and Clinical Innovation Division.

** Effective 1 July 2012, the Deputy Director-General, Finance Procurement and Legal Services has been re-named as Deputy Director-General, System Support Services.

Remuneration

Remuneration policy for the Department of Health's key executive management personnel is set by the Queensland Public Service Commission as provided for under the *Public Service Act 2008*. The remuneration and other terms of employment for the key executive management personnel are specified in employment contracts. For the 2012-13 year, the remuneration of key executive management personnel 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 expensed 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 Profit or Loss and Other Comprehensive Income.
  - Non-monetary benefits - consisting of provision of vehicle together with fringe benefits tax applicable to the benefit.
- Long term employee benefits include long service leave accrued.
- Post employment benefits include superannuation contributions.
- 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 2012-13 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.

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

Note 37. Key management personnel disclosures (continued)

2013	Short-term benefits		Post-employment benefits	Long-term benefits	Termination benefits	Total
Name and position	Base $'000	Non-monetary $'000				
Director-General Dr Anthony O'Connell (from 23 June 2011 to 15 August 2013)	385	28	35	9	-	457
Deputy Director-General, System Support Services Susan Middleditch (from 14 May 2011 to present)	309	6	36	7	-	358
Deputy Director-General, Health Service and Clinical Innovation Division Professor Michael Cleary (from 10 May 2010 to present)	375	31	43	9	-	458
Deputy Director-General, System Policy and Performance Terry Mehan (from 9 November 2008 to 30 June 2013)	405	41	44	8	-	498
Deputy Director-General, System Policy and Performance Philip Davies (from 27 May 2013 to present)	12	-	1	-	-	13
Chief Health Officer Dr Jeanette Young (from 8 October 2005 to present)	474	30	50	10	-	564
Chief Information Officer, Health Services Information Agency Ray Brown (from 2 June 2008 to present)	286	32	32	6	-	356
Chief Executive Officer Health Services Support Agency Kathleen Byrne (from 2 June 2009 to present)	286	15	30	6	-	337

Note 37. Key management personnel disclosures (continued)

2012	Short-term benefits		Post-employment benefits	Long-term benefits	Termination benefits	Total
Name and position	Base $'000	Non-monetary $'000	$'000	$'000	$'000	$'000
Director-General - Dr Anthony O'Connell (from 23 June 2011 to 15 August 2013)	406	26	41	10	-	483
Deputy Director-General, Human Resource Services Division - Lyn Rowland (from 7 February 2012 to 30 June 2012)	111	6	12	2	-	131
Deputy Director-General, Human Resource Services Division - John Cairns (from 1 July 2011 to 30 March 2012)	214	5	25	5	5	254
Deputy Director-General, Policy Strategy and Resourcing Division - Professor Michael Cleary (from 10 May 2010 to present)	382	29	47	9	-	467
Deputy Director-General, Health Planning and Infrastructure Division - Glenn Rashleigh (from 4 April 2012 to present)	85	1	9	2	-	97
Deputy Director-General, Performance and Accountability Division - Terry Mehan (from 19 November 2008 to 30 June 2013)	355	41	44	9	-	449
Deputy Director-General, Finance, Procurement and Legal Services Division - Susan Middleditch (from 14 May 2012 to present)	45	-	4	1	-	50

Note 37. Key management personnel disclosures (continued)

2012	Short-term benefits		Post-employment	Long-term	Termination	
Name and position	Base $'000	Non-monetary $'000	benefits $'000	benefits $'000	benefits $'000	Total $'000
Deputy Director-General, Finance Procurement and Legal Services - Neil Castles (from 24 January 2011 to 30 April 2012)	300	6	43	7	-	356
Chief Executive Officer, Centre for Healthcare Improvement - Jan Phillips (from 17 October 2011 to present)	118	11	11	3	-	143
Chief Health Officer - Dr Jeannette Young (from 8 October 2005 to present)	436	27	54	11	-	528
Chief Information Officer - Raymond Brown (from 2 June 2008 to present)	274	18	34	6	-	332
Chief Executive Officer, Clinical and Statewide Services - Kathleen Byrne (from 2 June 2009 to present)	275	16	33	7	-	331

Note 38. Contingencies

(a) Guarantees and undertaking

As at 30 June 2013, the Department of Health held the following guarantees and undertakings from third parties. These amounts have not been recognised as assets in the financial statements.

	2013 $'000	**2012 $'000**
Guarantees	110,262	13,645

The increase in guarantees is attributable to the Sunshine Coast University Hospital project.

Note 38. Contingencies (continued)

(b) Litigation in progress

	2013 cases
Cases have been filed with the courts as follows:	
Supreme Court	16
District Court	8
Magistrates Court	3
Tribunals, commissions and boards	26
	53

	2012 cases
Supreme Court	17
District Court	11
Magistrates Court	2
Tribunals, commissions and boards	77
	107

Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). The Department of Health's liability in this area is limited to an excess per insurance event. Refer Note 2(y). The Department of Health's legal advisers and management believe it would be misleading to estimate the final amounts payable (if any) in respect of litigation before the courts at this time.

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

From 1 July 2010, QGIF has taken over the management of all Department of Health indemnified claims. As at 30 June 2013 there were 311 (377 as at 30 June 2012) claims managed by QGIF, some of which may never be litigated or result in payments to claims. The maximum exposure to the Department of Health under this policy is up to $20,000 for each insurable event.

It is noted the above figures do not include matters that are the responsibility of a HHS (i.e. that occurred post 30 June 2012). As statutory bodies, such matters are included in individual HHS' annual financial statements.

The special claims management process ("the special process") established by the Queensland Government in 2005 to expeditiously resolve claims as a result of healthcare treatment provided by Dr Patel has continued. The key features of the special process are an acceptance of liability by the State, payment of the cost of medical assessment, a contribution to the claimants' legal fees and payment of the cost of mediation (if required). These features are a significant departure from the prevailing legislative scheme. Since the commencement of the special process up until 30 June 2013, 387 special process claims had been received with all claims now resolved.

Note 38. Contingencies (continued)

(c) Native Title

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

All business pertaining to land held by or on behalf of the Department of Health must 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. Real Property Dealings may proceed on department owned land where native title continues to exist, provided native title holders or claimants receive the necessary procedural rights.

The Department of Health undertakes native title assessments over real property when required and is currently negotiating a number of Indigenous Land Use Agreements (ILUA) with native title holders. These ILUAs will provide trustee leases to validate the tenure of current and future health facilities. The National Title Tribunal reported a total of 16 native title claims (2011-12: 16 claims).

(d) Other contingencies

The following liabilities are contingent upon future Government and management decisions and cannot be estimated with reasonable certainty at balance date.

Costs to rectify payroll system
Measures will continue to be undertaken to resolve outstanding issues and stabilise the Department of Health payroll system (refer Note 3).

eHealth
The objective of the eHealth program is to provide integrated and accurate clinical information to support safe, timely and high quality care with the key component an integrated electronic medical record (ieMR). The rollout of these programs is likely to require additional ICT infrastructure and necessitate implementation costs.

Property maintenance backlog
This represents the total cost of repairs, maintenance and assets due for replacement, with these activities to occur over future years. The total liability due to be incurred in the next 12 months is contingent on an assessment of maintenance requirements and priorities.

Note 39. Commitments for expenditure

	2013 $'000	2012 $'000
Capital commitments - Property, plant and equipment		
Committed at the reporting date but not recognised as liabilities, payable:		
Within one year	1,438,705	1,170,419
One to five years	588,504	2,054,136
	2,027,209	3,224,555

Note 39. Commitments for expenditure (continued)

	2013 $'000	2012 $'000
Lease commitments - operating		
Committed at the reporting date but not recognised as liabilities, payable:		
Within one year	84,372	73,180
One to five years	140,879	155,549
More than five years	17,639	28,318
	242,890	257,047
Grants and other contributions		
Grants and contribution commitments inclusive of anticipated GST, committed to provide at reporting date, but not recognised in the accounts are payable as follows:		
Within one year	126,440	167,064
One to five years	53,592	45,841
	180,032	212,905
Other commitments		
Committed at the reporting date but not recognised as liabilities, payable:		
Within one year	352,291	335,316
One to five years	261,123	43,427
	613,414	378,743

Capital commitments includes capital expenditure for the development of three new tertiary hospitals and continuing redevelopment and refurbishment of existing hospitals and health care facilities. Capital projects are delivered under a partnering agreement between the Department of Health and the Department of Public Works, Project Services Division. These projects have been approved by the Cabinet Budget Review Committee and have been included as commitments for the total project amounts. Each of these projects is currently at a different stage of the contractual cycle. The contracted commitments for the approved projects are $828.17 million (2011-12: $11.591 million). Refer to additional disclosure in Note 44.

The above balances do not include cash flows in respect of the Sunshine Coast University Hospital PPP arrangment. Refer to Note 44.

All of the above figures are nominal and have not been discounted.

Note 40. Restricted assets

The Department of Health 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. At 30 June 2013, amounts of $10.132 million (2011-12: $85.993 million) in General Trust and $0.01 million (2011-12: $9.046 million) for Clinical Drug Trials are set aside for the specified purposes underlying the contribution. The significant decrease in the current year is attributable to balances transferred to HHSs.

Note 40. Restricted assets (continued)

The Department of Health has received $2.097 million in the current year from the Office Health Practitioner Registration Boards relating to the abolishment of the Dental Technicians Board and the Speech Pathologist Board.

Note 41. Transfer of assets and liabilities to Hospital and Health Services

The fair value of assets and liabilities transferred to HHSs on 1 July 2012 were as follows:

	Fair value $'000
Cash and cash equivalents	78,749
Other receivables	213,636
Inventories	72,981
Other current assets	9,072
Intangible assets	4,598
Property, plant and equipment	5,409,562
Other non-current assets	179
Trade payables	(294,964)
Employee benefits	(492)
Other current liabilities	(366)
Other non-current liabilities	(300)
Net assets acquired	5,492,655

Note 42. Investments in associates

The *Translational Research Institute Pty Ltd* (the Company) was registered as an Australian proprietary company, limited by shares, on 12 June 2009. The Department of Health is one of four founding shareholders, each holding 25 shares at $1 per share in the Company. The Company does not trade and its sole purpose is to act as trustee of the Translational Research Institute Trust (TRI Trust). There were no transactions recorded in this entity in the period 1 July 2012 to 30 June 2013. As the Company is a non-trading entity, it has not prepared financial statements for the financial year ended 30 June 2013. Refer Notes 2(c) and 24.

The *Translational Research Institute Trust* (TRI Trust) was created as a Discretionary Unit Trust on 16 June 2009. The Department of Health is one of four founding members, each holding 25 units in the TRI Trust and equal voting rights. The objectives of the TRI Trust are to design, construct and maintain the Translational Research Institute Facility (TRI Facility); and operate and manage the TRI Facility to promote medical study, research and education. The Trust's annual reporting period is on a calendar year basis. Audited financial statements were prepared for the financial year ending 31 December 2012. A set of Board endorsed Management Accounts were prepared for the period 1 June 2012 to 30 June 2013. Refer Notes 2(c) and 24.

		Percentage interest	
		2013	2012
Associate	**Principal activities**	**%**	**%**
Translational Research Institute Pty Limited	Act as trustee of TRI Trust. Maintain TRI facility and promote medical study, research and education.	25.00	25.00

Note 42. Investments in associates (continued)

Interests in associates are accounted for using the equity method of accounting. Information relating to associates is set out below:

	2013 $'000	2012 $'000
Share of assets and liabilities		
Current assets	15,717	30,292
Non-current assets	75,013	49,575
Total assets	90,730	79,867
Current liabilities	1,539	36,144
Non-current liabilities	5,937	3,125
Total liabilities	7,476	39,269
Net assets	83,254	40,598
Share of revenue, expenses and results		
Revenue	14,147	28,596
Profit	14,147	28,596

Note 43. Fiduciary trust transactions and balances

The Department of Health no longer acts in a custodial role in respect of these transactions and balances as all such balances have been transferred to the HHSs. As such, there are no disclosed balances for 2013.

	2013 $'000	2012 $'000
Trust receipts and payments		
Receipts		
Patient trust receipts	-	34,368
Total receipts	-	34,368
Payments		
Patient trust related payments	-	34,078
Total payments	-	34,078
Trust assets and liabilities		
Assets		
Patient trust deposits	-	5,003
Other refundable deposits	-	98
Total assets	-	5,101

The above balances were transferred to HHSs on 1 July 2012. Monies held in general trust pertaining to Right of Private Practice were also transferred to HHSs on 1 July 2012. Refer Note 40.

Note 44. Arrangements for the provision of public infrastructure by other entities

Public Private Partnership (PPP) arrangements operating for all or part of the financial year are as follows. Refer Note 2(q).

Note that all of the following are Build-Own-Operate-Transfer (BOOT) arrangements.

Facility	Hospital and Health Service	Counterparty	Terms of Agreement	Commencement date
Butterfield Street Car Park	Metro North Children's	International Parking Group Pty Limited	25 years	January 1998
Bramston Terrace Car Park	Health Services	International Parking Group Pty Limited	25 years	November 1998
The Prince Charles Hospital Car Park	Metro North	International Parking Group Pty Limited	25 years	November 2000
The Prince Charles Hospital Early Education Centre	Metro North	Queensland Child Care Services Pty Limited	25 years	April 2007
Townsville Hospital Support Facilities Building and Walkway	Townsville	Trilogy Funds Management Limited	40 years	April 2002
Childcare Centre	Townsville	Trilogy Funds Management Limited	40 years	September 2004
The Princess Alexandra Hospital Multi Storey Car Park	Metro South	International Parking Group Pty Limited	25 years	February 2008
The Gold Coast University Hospital Western Car Park	Gold Coast	Surepark Pty Limited	31 years	July 2010

The land where the facilities have been constructed is recognised as departmental land, subject to an operating lease. Neither the land nor the registered leases or agreements to lease were transferred to the HHSs under the Transfer Notices in 2012. However, under the Transfer Notices the Department of Health granted a Deed of Lease to each HHS which enabled the HHS to use their hospital premises including any car-parks and other parts of the premises, required the HHS to perform the obligations of the Department of Health as landlord and enabled the HHS to retain any rent and other payments.

Pending the finalisation of a formal accounting standard for these types of arrangements, the department has not recognised any rights or obligations relating to these facilities other than those associated with land rental and the provision of services under the agreements.

Butterfield Street Car Park
A $2.5 million up-front payment for rental of land on which the car park has been built was received at the commencement of car park operations in January 1998. Rent of $0.3 million per annum is received from the car park operator up to January 2019 increasing to $0.6 million for the remainder of the lease period. All relevant amounts have been assigned to Royal Brisbane and Women's Hospital Foundation. Department of Health staff are entitled to concessional rates when using the car park.

Note 44. Arrangements for the provision of public infrastructure by other entities (continued)

The Prince Charles Hospital Car Park
A $1.0 million up-front payment for rental of land on which the car park has been built was received at the commencement of car park operations in November 2000. This amount is being recognised over the term of the agreement. Rent of $0.05 million per annum is also received from the car park operator. All relevant amounts have been assigned to The Prince Charles Hospital Foundation. Under the agreement, Department of Health staff are entitled to concessional rates when using the car park.

The Prince Charles Hospital Early Education Centre
The developer constructed a 150 place early education centre in April 2007 on site at the hospital. The developer operates and maintains the facility at its sole cost and risk. Under the agreement staff on site are given priority access to child care. Rent of $0.07 million per annum is charged for the land and is adjusted for CPI annually.

Bramston Terrace Car Park
A $1.32 million upfront payment for rent of land on which the car park has been built was received on commencement of car park operations in November 1998. This amount was fully recognised in the year of receipt. Rent of $1 is paid each year over the term of the agreement and Department of Health staff are entitled to concessional rates when using the car park.

Townsville Support Facilities Building, Walkway and Childcare Centre
Under this arrangement, a support facilities building and childcare centre have been constructed on the department's land with a walkway linking the support facilities building to the Townsville Hospital. This facility has been in operation since April 2002. Annual rental of $0.035 million is charged for the land, varying with tenant turnover figures and adjusted for CPI annually.

The Princess Alexandra Hospital Multi Storey Car Park
The developer has constructed a 1,403 space multi storey car park on site at the hospital. Rent of $0.295 million per annum escalated for CPI annually will be received from the car park operator up to February 2033. The developer operates and maintains the facility at its sole cost and risk. The Department of Health staff are entitled to concessional rates when using the car park.

Gold Coast University Hospital Western Car Park
SurePark Pty Ltd was appointed on 23 July 2010, to design, construct, finance, and operate the Gold Coast University Hospital Western Car Park for a period of 31 years. The Facilities Agreement also provides revenue returns to the Department of Health if any revenue for any twelve months period exceeds 100 per cent of the base case equity return. There were no upfront payments made to SurePark Pty Ltd.

Social Public Private Partnership (PPP) Arrangements
'Social' PPP arrangements are recorded in the financial statements and accounted for in accordance with AASB 117 *Leases* . Refer Note 2(r) Arrangements for the provision of public infrastructure by other entities.

On 17 July 2012, the Department of Health entered into contractual arrangements with Exemplar Health (SCUH) Partnership (Exemplar Health), a consortium comprising Lend Lease (building), Spotless (facilities manager), Capella Capital and Siemens (financiers) to design, construct, commission, maintain and partially finance the Sunshine Coast University Hospital (SCUH) for a period of 25 years. At the expiry of the 25 years period, the facility will transfer to the Department of Health for nil consideration, which will be transferred to the Sunshine Coast HHS (SCHHS).

Construction of the SCUH has commenced and is scheduled for completion in November 2016.

The SCUH PPP includes a limited scope of operational support services that are closely linked to the hospital building and its systems, such as security, pest control and car parking services but does not include the provision of any clinical services. The collocated private hospital will be designed, built and operated by Ramsay Health Care.

The Department of Health will lease back the SCUH from Exemplar Health and make lease payments as well as payments for the maintenance, refurbishment and other services to be provided by Exemplar Health over the term of the agreement.

Note 44. Arrangements for the provision of public infrastructure by other entities (continued)

The land on which the SCUH is being constructed is legally owned by the Department of Health but controlled and recognised as an asset by the SCHHS. Exemplar Health has been granted a licence that gives the consortium the right to enter and operate on the site.

	The Sunshine Cost University Hospital	The Prince Charles Hospital Early Education Centre	Townsville Support Facilities and Childcare Centre	The Princess Alexandra Hospital Multi Storey Car Park	Total
	$'000	$'000	$'000	$'000	$'000
Indicative cash flows					
Inflows					
Up to 1 year	-	87	49	353	489
More than 1 year but less than 5 years	-	376	212	1,520	2,108
More than 5 years but less than 10 years	-	538	303	2,170	3,011
Later than 10 years	-	491	1,686	5,175	7,352
Outflows					
Up to 1 year	(82,769)	-	-	-	(82,769)
More than 1 year but less than 5 years	(832,747)	-	-	-	(832,747)
More than 5 years but less than 10 years	(386,138)	-	-	-	(386,138)
Later than 10 years	(1,957,079)	-	-	-	(1,957,079)
Net indicative cash flows	(3,258,733)	1,492	2,250	9,218	(3,245,773)

The indicative cash flows are prepared by applying an uplift factor of 3% for inflation to the notinal cash flows, which are based on the underlying contracts with third parties. None of the above indicative cash flow is discounted.

All of these cash flows are recognisable by HHSs upon receipt.

Note 45. Collocation arrangements

Collocation arrangements operating for all or part of the financial year are as follows. Refer Note 2(r).

Facility	Hospital and Health Service	Counterparty	Terms of Agreement	Commencement date
Caboolture Private Hospital	Metro North	Affinity Health Ltd	25 years	September 1997
Redlands Private Hospital	Metro South	Sister of Mercy	25 years	August 1999
Holy Spirit Northside Private Hospital	Metro North	The Holy Spirit Northside Private Hospital Limited	25 years	July 2001

Note 46. Administered transactions and balances

Administered transactions and balances are comprised primarily of Health Quality and Complaints Commission (HQCC) and Mater Hospital related transactions.

The HQCC provides assurance to the community that health care service providers in Queensland provide the highest possible standard in the quality of care.

The Mater Public Hospital redevelopment was completed in June 2008 with funding provided from Government borrowings managed as administered transactions. Further details on this arrangement are outlined below.
The Administered transactions and balances for 2012-13 are as follows.

	2013 $'000	2012 $'000
Administered revenues		
Administered item appropriation	25,725	25,272
Taxes, fees and fines	76	294
Total administered revenues	25,801	25,566
Administered expenses		
Grants	19,784	18,746
Borrowing costs	5,941	6,527
Taxes, fees and fines	76	293
Total administered expenses	25,801	25,566
Administered assets		
Current		
Cash	5	21
Receivables	10,057	9,441
Non-current		
Receivables	75,971	86,028
Total administered assets	86,033	95,490
Administered liabilities		
Current		
Payables	5	29
Other financial liabilities	10,057	9,433
Non-current		
Other financial liabilities	75,971	86,028
Total administered liabilities	86,033	95,490

Receivables

Receivables reflect the passing on of funds to the Mater Hospital for the redevelopment of the public hospital component. The receivable for this will be extinguished over a ten year term, ending in 2018.

Payables

Borrowings are provided by Queensland Treasury Corporation. The interest rate on borrowings is fixed at 6.46%. The repayment term is ten years.

The market value of the debt as notified by Queensland Treasury Corporation at 30 June 2013 was $93.738 million (2011-12: $104.009 million). This represents the value of the debt if the department repaid the debt at 30 June 2013.

An amount of $5.941 million (2011-12: $6.527 million) comprising interest on funds and administration fees from Queensland Treasury Corporation has been recognised as an expense in the reporting period.

Note 47. Events after the reporting period

No matter or circumstance has arisen since 30 June 2013 that has significantly affected, or may significantly affect the Department of Health's operations, the results of those operations, or the Department of Health's state of affairs in future financial years.

Note 48. Reconciliation of payments from Consolidated Fund to administered revenue

	2013 $'000	2012 $'000
Budgeted appropriation	25,545	25,309
Transfers from other headings	180	(36)
Administered revenue recognised in Note 46	25,725	25,273

Note 49. Reconciliation of surplus to net cash from operating activities

	2013 $'000	2012 $'000
Surplus for the year	14,100	42,334
Adjustments for:		
Depreciation and amortisation	85,892	371,946
Write off of non-current assets	42,241	(327)
Net loss/(gain) on disposal of non-current assets	(21)	2,655
Share of profit - associates	(14,147)	(28,596)
Asset transferred non-cash	276,342	-
Non-cash finance lease receivable	(272,738)	-
Depreciation funding non-cash	327,027	-
Contributed assets and other non-cash donations	(23)	(7,303)
Other non-cash supplies	-	6,035
Other non-cash items	17,661	938
Change in operating assets and liabilities:		
Increase in trade and other receivables	(682,968)	(88,376)
Decrease/(increase) in inventories	8,358	(8,283)
Increase in prepayments	(30,740)	(22,184)
Increase in other operating assets	(179)	-
Increase in trade and other payables	349,379	160,439
Increase in employee benefits	205,176	-
Increase in other operating liabilities	2,291	-
Net cash from operating activities	327,651	429,278

Note 50. Non-cash investing and financing activities

Assets and liabilities received or transferred by the department are set out in the Statement of Changes in Equity.

Note 51. Controlled entity

On 1 July 2012, seventeen HHSs were established as independent statutory bodies under the *Hospital and Health Boards Act 2011* . The primary function of the HHSs is to deliver frontline health services. As at 30 June 2013, the Torres Strait and Northern Peninsula Hospital and Health Service (TSHHS) was administered by the Director-General of the Department of Health. It is therefore considered to be controlled by the Department under AASB 127 *Consolidated and Separate Financial Statements*. The TSHHS prepares and publishes separate financial statements which are audited by the Auditor-General of Queensland and tabled in the Queensland Parliament.

The TSHHS prepares and publishes separate financial statements which are audited by the Auditor-General of Queensland and tabled in the Queensland Parliament.

Summarised balances and transactions for the financial year ended 30 June 2013 are as follows:

	2013 $'000	2012 $'000
Assets	130,457	-
Liabilities	(9,880)	-
Net assets	120,577	-
Revenue	81,577	-
Expenses	(80,347)	-
Other comprehensive income	3,121	-
Total comprehensive income	4,351	-

The balances and transactions of TSHHS have not been consolidated in these financial statements as they do not materially affect the reported financial position and operating result. Their exclusion is not considered to influence the economic decisions of users taken on the basis of the financial statements or affect the discharge of accountability by the management or governing body of the entity.

Comparative financial information is not presented as the TSHHS did not exist prior to its establishment as a statutory body on 1 July 2012.

Note 52. Opening balance adjustments

	2013 $'000	2012 $'000
South West HHS	(1,023)	-
Cairns and Hinterland HHS	(15,408)	-
Metro South HHS	94,155	-
Total	77,724	-

The above adjustments have been made to correct errors noted in prior year external valuation reports for three buildings. In respect of the Cairns and Hinterland HHS and Metro South HHS adjustments, these errors were due to incomplete floor plans available at the time of valuation. The South West HHS amendment arose from completed work in progress included in the external valuation report.

The value of these assets was adjusted prior to transfer at fair value to the relevant HHS on 1 July 2012.

Department of Health

Management Certificate

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

(a) the prescribed requirements for establishing and keeping the accounts have been complied with in all material respects and

(b) the statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of the Department of Health for the financial year ended 30 June 2013 and of the financial position of the Department at the end of that year.

Mark Davey
Acting Chief Finance Officer
30/8/13

Dr Michael Cleary
Acting Director-General
30/8/2013

INDEPENDENT AUDITOR'S REPORT

To the Accountable Officer of the Department of Health

Report on the Financial Report

I have audited the accompanying financial report of Department of Health, which comprises the statement of financial position and statement of assets and liabilities by major departmental services as at 30 June 2013, the statement of profit or loss and other comprehensive income, statement of changes in equity, statement of cash flows and statement of profit and loss and comprehensive income by major departmental services for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and the certificates given by the Acting Director-General and the Acting Chief Finance Officer.

The Accountable Officer's Responsibility for the Financial Report

The Accountable Officer 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 Accountable Officer's responsibility also includes such internal control as the Accountable Officer 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 Accountable Officer, 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

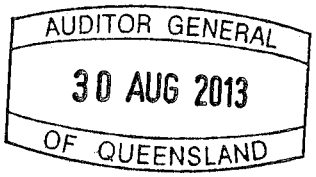
(b) in my opinion –

  (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 Department of Health for the financial year 1 July 2012 to 30 June 2013 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.



A M GREAVES FCA FCPA
Auditor-General of Queensland

Queensland Audit Office
Brisbane