Central Queensland Hospital and Health Service

2012–13 **Annual Report**

Great state. Great opportunity.

Queensland Government

Central Queensland Hospital and Health Service, 2012-13 Annual Report
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Message from the Board Chair

The Newman government's commitment to establish local hospital and health boards answerable to the Minister for Health but accountable to the Central Queensland community has delivered outstanding results for Central Queenslanders in 2012-13.

Twelve months ago, the Independent Hospital Pricing Authority ranked Queensland second-last among mainland states in the efficient provision of healthcare services. Queensland health providers were up to 11% less efficient than the national average. Guided by the principles in the Blueprint for better healthcare in Queensland – health services focused on patients and people, empowering the community and our health workforce, providing Central Queenslanders with value in health services and investing, innovating and planning for the future – the Central Queensland Hospital and Health Board began the big task of repair.

In its first year of operation, the Board achieved an $18.74 million surplus, despite the Commonwealth removing $4.8 million in funding mid-year. That surplus is the Central Queensland community's dividend payment to be reinvested to further improve health services in Central Queensland.

This result was achieved by targeting inefficiencies and waste to obtain best value for the taxpayer's health dollar. We reviewed the services we deliver and the way they are delivered. We partner with other health providers to reduce fragmentation of services and to ensure services are delivered by the most appropriate provider.

To align with national health reforms, we re-defined our core business as being a provider of acute care in a hospital setting. For this reason, we relinquished the provision of Home and Community Care services to the not-for-profit sector and are ceasing our role as a provider of aged care services at North Rockhampton Nursing Centre and Eventide Home. We work closely with Central Queensland Medicare Local to develop a closer working relationship between general practitioners and the hospital system.

The level of engagement with the community, consumers, clinicians and our staff will increase to meet their expectations for safe health care. Patients and people are at the centre of all that we do. Developing a culture that delivers this outcome on a sustainable basis is a continuing challenge.

Completion of the $160 million Stage 2 redevelopment at Rockhampton Hospital will be a milestone in the year ahead. This facility will accommodate the Regional Cancer Care Centre and reduce the need for many patients receiving cancer treatment to leave Central Queensland.

The Rural and Remote Infrastructure Rectification works at Biloela Hospital ($7.15 million) and Emerald Hospital ($8.0 million) will start and the Moura Community Hospital Model, developed after extensive community consultation, will be implemented.

Our staff are determined to deliver quality health services to the Central Queensland community. The Central Queensland Hospital and Health Board will continue to develop the tools to succeed.

As we complete the difficult phase of repair and move on to recovery and investment, we must work to improve our performance to match the national average by mid-2014. This remains a work in progress but will emphasise the development of true partnerships with other health care providers in Central Queensland to achieve integrated health service outcomes and the exposure of our services to contestability to drive continuing cost savings.

I acknowledge the hard work of all Board members in our first year. In particular, I acknowledge the contribution of Emeritus Professor Robert Miles as the foundation Chair.

Charles Ware
Chairman
Central Queensland
Hospital and Health Board
July 2013

Foreword

Message from the Chief Executive

The establishment of the Central Queensland Hospital and Health Service (CQHHS) on 1 July 2012 introduced greater requirements for responsibility in public health service provision to Central Queensland communities.

The Executive Management Team had taken a deliberate approach in the previous financial year to improve clinical and corporate systems and processes and lay a foundation of planned service developments and performance accountability. Rigour and discipline applied to FTE management and budget expenditure patterns delivered an end-of-year balanced budget and positioned CQHHS well for the anticipated challenges of 2012-2013.

The organisational structure of CQHHS had to support safe quality patient care provision with demonstrated outcomes. Services have been realigned into Divisional structures that include:

- Divisions of Clinical Support Services, Medicine, Surgery and Family, Women and Children in Rockhampton Hospital;
- Gladstone Hospital;
- Rural Health Services Division;
- Mental Health and Alcohol and Other Drugs Services Division;
- Subacute and Community Services Division.

CQHHS achieved the National Emergency Access Targets (NEAT), National Elective Surgery Targets (NEST), Minimum Obligatory Human Resource Indicator (MOHRI) and posted a surplus budget in 2012-2013. This excellent result, along with many other service improvements demonstrate the commitment that CQHHS staff have made to their communities this year.

The Blueprint for better healthcare in Queensland provides opportunities for reviewing and redesigning service delivery models across the regional and rural settings through engaged communities. CQHHS embarked on consultation in Moura on the future health service needs of the community which culminated in the endorsement by a public forum of the Moura Community Hospital Model. A new facility is being built to support the model and the local community will play an active role in the planning and development process.

CQHHS reviewed its approach to the provision of subacute care in hospital and community settings. A renewed focus on the treatment and management of ambulatory patients within the community aims to promote service efficiencies and greater productivity and reduce demand on acute hospitals. Internal clinical redesign together with partnership arrangements with external agencies including the Central Queensland Medicare Local will encourage realignment of primary health care services to the appropriate service settings within communities.

CQHHS is strong and dynamic. We aim to deliver the highest quality care to our communities through a workforce that is highly skilled, valued, respected and proud to be recognised as CQHHS employees.

I commend the efforts of CQHHS in delivering an excellent performance record and look forward to the challenges on the horizon of 2013-2014.

Rod Boddice
A/ Health Service Chief Executive
Central Queensland
Hospital and Health Service
July 2013

Who we are

The Central Queensland Hospital and Health Board (CQHHB) and Central Queensland Hospital and Health Service (CQHHS) were established on1 July 2013.

Our Vision

Delivering quality, integrated health services focused on the patient.

Our Mission

Delivering quality, evidence-based, integrated health services focused around the patient's journey, that are effective, efficient and meet the needs of the community.

Our Values

Our Values are intended to drive all that we do in pursuit of our vision and mission.

Care:

We will care and provide care for our communities, individuals, groups and all of our stakeholders

Commitment:

We will always direct our efforts to delivering the best health care to Central Queenslanders.

Integrity:

We will be accountable for everything we do. We will conduct ourselves and our business professionally at all times.

Collaboration:

We will work with other providers, educators and researchers, our communities and stakeholders to ensure our collective services are seamlessly delivered across the patient experience.

Innovation:

We will utilise and contribute to the development of new and effective practices for the delivery of leading edge healthcare.

Respect:

We will respect everyone we deal with in all that we do.

Our key objectives:

- delivering integrated health services in partnership with other providers;
- providing accessible, sustainable, network services in a quality framework;
- striving for better care in Central Queensland;
- providing a great place to work;
- underpinning our business through stakeholder, clinician, consumer and community engagement; and
- living within our means.

In accord with our Strategic Plan, the CQHHS key priorities for 2013-14 include:

- providing better access to health services;
- addressing and improving key population health challenges and risks;
- supporting the Government commitments to revitalise frontline services for families and deliver better infrastructure;
- enhancing engagement and developing closer working relationships with patients, families, community groups, GPs and other primary health providers.

Where we are

Central Queensland Hospital and Health Service links the Great Barrier Reef to Western Queensland in a footprint extending from South of Gladstone to North of Rockhampton, from the Capricorn Coast west to the Gemfields. This largely rural area is impacted by significant coal mining in the Central and Southern Highlands and industrial developments in and around Gladstone.

The year in review

This establishment year of the Central Queensland Hospital and Health Board was one of challenges, learning and successes.

Challenges

The CQHH Board was required to develop a model for the effective engagement of clinicians and health professionals, stakeholders, consumers and the broader community. Consumer and Community Engagement and Clinician Engagement strategies were developed as frameworks for formalising the process while the Board travelled to as many locations as possible throughout the year to meet local consumers and key community members. The Board appreciated hearing and understanding the expectations of individuals and community groups.

A significant budget reduction was imposed in November 2012, leaving CQHHS with a reduced income but no agreed reduction in service activity levels. The organisation responded strategically with improved efficiency measures that realised a budget surplus and identified CQHHS as a high-performing organisation.

Recruiting and retaining clinical staff – medical, nursing and midwifery and allied health practitioners – has proven difficult at times, due in part to general skill shortages for some disciplines in Queensland and nationally, while encouraging regional and rural practice carries its own challenges. More often health professionals are seeking incentives such as assisted accommodation and fly-in-fly-out arrangements in order to consider employment in Central Queensland.

The CQHH Board sought in 2012 - 2013 to strengthen its business focus on hospital and hospital-aligned health services and communicated this to the community. Decisions were made that resulted in the transfer of Home and Community Care (HACC) services in many locations to non-government organisations. A planned strategy led to the divestment of residential aged care provision to other accredited aged care providers which will be completed in the first part of 2014. A new Community Hospital model was approved for Moura following a structured and outcome-driven community consultative process.

Highlights

- CQHHS realised a budget surplus of $18.74 million and established itself as one of the top performers for the State Department of Health.
- CQHHS achieved a National Emergency Access Target (NEAT) score (measuring the percentage of patients admitted, referred for treatment to another hospital or discharged within four hours of presentation) of 80%, exceeding and compared with the national target of 77%.
- All patients presenting to Emergency Departments in CQHHS had been seen within the clinically recommended time frame as at June 2013.
- Median wait time in CQHHS Emergency Departments decreased from 21 minutes in June 2012 to 17 minutes in June 2013. At Rockhampton Hospital Emergency Department the median wait time reduced from 22 minutes in June 2012 to 16 minutes in June 2013.
- Attendances at Emergency Departments across CQHHS increased from 76,826 in 2011-2012 to 77,212 in 2012-2013. Rockhampton Hospital Emergency Department presentations have increased by 2.5% (year on year).
- At June 2013 all Rockhampton Hospital elective surgery patients had been seen in the clinically recommended time frame.
- CQHHS exceeded the number of elective surgery patients target for 2013, with 1935 patients treated against the target of 1854.
- The number of available beds and bed alternatives in CQHHS increased almost 5% from 453 in July 2012 to 474 in July 2013.
- The number of Occupied Bed Days for Sub and Non-Acute Patients across CQHHS increased 16% from 18,369 in 2011-2012 to 21,290 in 2012-

2013.
- The number of Occupied Bed Days for Critical Care Patients increased from 6001 in 2011-2012 to 6132 in 2012-2013.
- The number of Full Time Equivalent staff reduced from 2602 in July 2012 to 2569 in July 2013.
- Ambulatory chronic disease management services were consolidated in the Allied Health Clinic at CQUniversity, further strengthening our partnership arrangements.
- Telehealth clinics for orthopaedic fracture assessment and review were implemented in Gladstone and Emerald Hospitals from the Orthopaedic Department of Rockhampton Hospital.

Capital planning and infrastructure development programs continued across CQHHS in 2012-2013. Major projects include:

- The highly visible $160 million new ward block project at Rockhampton Hospital. When completed in mid-2014, it will house the Rockhampton Regional Cancer Centre, a 32-bed general ward, 16 sub-acute beds and space to cater for future hospital expansion.
- Planning for the $7.15 million Rural and Remote Infrastructure Rectification Works at Biloela has commenced. This includes essential fire safety repairs, electrical safety upgrades, asbestos removal, relocation of Community Health onto Hospital campus and upgrade of the Emergency Department physical environment to address service and safety issues. The project is to be completed in March 2014.
- Planning for the $8 million Rural and Remote Infrastructure Rectification Works at Emerald Hospital has commenced. This will involve essential fire safety repairs, asbestos removal, replacement of generator and chillers. The project is to be completed in March 2014.

Further detail of performance highlights and strategic decisions for the HHS can be found in Chapter 4 *Our Inaugural Year*.

The future

CQHHS is focussed on developing the range of acute and ambulatory services that promote regional self-sufficiency for health care provision over the next 10 to 15 years. The Regional Cancer Centre being constructed at Rockhampton Hospital will allow a range of oncology services, including radiation oncology, to be delivered locally and reduce referrals to metropolitan hospitals for assessment and treatment. Gastroenterology and ophthalmology services are priority developments for the future, as outlined in the *Central Queensland Health Services Plan 2011 – 2026-27*.

CQHHS will continue to pursue partnerships with Central Queensland Medicare Local and General Practitioners, as well as the private and non-government health sectors, to clarify its role in primary health care service delivery and to better configure its hospital and hospital-related services.

The introduction of the National Efficient Price (NEP) funding model from 2013-14 presents considerable challenges for CQHHS. The two Activity-Based Funded (ABF) facilities of Rockhampton and Gladstone hospitals represent less than 50% of the total CQHHS budget allocation, with the remainder allocated to non-ABF facilities across the rural health, and community-based mental health sectors. This new model will require careful allocation of funds to prioritised areas and projects to ensure services to our communities remain sustainable and relevant.

Letter of compliance

Queensland Government

Central Queensland
Hospital and Health Service

4 September 2013

The Honorable Lawrence Springborg
Minister for Health
GPO Box 48
Brisbane QLD 4001

Dear Minister Springborg

I am pleased to present the Annual Report 2012 – 2013 and financial statements for the Central Queensland Hospital and Health Service (CQHHS).

I certify that this Annual Report complies with:

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

A checklist outlining the annual reporting requirements can be found at page 104 of this Annual Report or accessed online at www.health.qld.gov.au/cq/annual-report-2012-13.

Yours sincerely

Charles Ware
Chair
Central Queensland
Hospital and Health Board

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Our people

Central Queensland Hospital and Health Service (CQHHS) is all about people. We provide health services to the people of Central Queensland. Our staff are one of our most important resource and we strive to care for them just as much as our staff strive to care for our patients and communities.

We aim to make CQHHS a great place to work, where everyone is treated with respect, is given opportunities to develop their skills and to join a high quality, responsive and professional workforce. Our people are the backbone of our success and it is our intention to boast a loyal, dedicated staff who share the strategic objectives of CQHHS and who understand their individual roles is in achieving those objectives.

CQHHS employs some 3224 staff (2580 FTE), which makes it one of the largest single employers in the region.

In this Chapter

- Workforce planning, attraction and retention and performance
- Retention/separation rates
- Workforce planning framework
- Performance management framework
- Retention strategies
- Leadership and management development framework
- Early retirement, redundancy and retrenchment
- Voluntary separation program

Chapter 1

1.1. Workforce planning, attraction and retention and performance

1.1.1. Workforce profile

Recruiting and retaining quality staff is a challenge in regional centres and CQHHS acknowledges that recruiting quality medical staff to the region remains particularly difficult. The CQHHS website includes staff profiles, community profiles and experiential narrative from staff who love where they live. Potential employees can access information about the services and the community to assist with their decisions. We are committed to employing quality staff at all times.

Table 1.1 describes MOHRI full time equivalent (FTE) appointments by employment type as at 28 April 2013.

1.1.2. Retention/separation rates

At April 2013, a total of 699 separations had occurred in 2012-13, inclusive of 346 (49.5%) separations were permanent employees.

The CQHHS staff permanent retention rate is 97% while permanent separation rate is 13%, indicating that our efforts to recruit and retain quality staff are proving fruitful. Strategic promotion of the region and opportunities within CQHHS continue to underwrite our efforts to attract and retain quality, dedicated staff in the region.

During this same period (year ended 30 June 2013), 397 appointments have been made of which 327 (82%) are temporary in nature.

1.1.3. Workforce planning framework

CQHHS collaborates with the general practice and tertiary education sectors to identify opportunities for developing service models, clinical research and clinical skills enhancement. Integral to this process is the need to assess and review workforce requirements so that team-based interdisciplinary care becomes central to the planning and development of health services.

It is important to acknowledge a number of external factors when planning for our future workforce, including:

- fluctuating unemployment rates
- ongoing skills shortages in a number of health professions
- increased competition for talent
- regional population growth.

The downturn in mining activity in Central Queensland in 2013 influenced the employment market and it is anticipated that the trend will continue as the economy slows. Workforce planning will continue to address strategic objectives of CQHHS, but will be sufficiently flexible to accommodate a

Table 1.1: 2012-13 Staff Establishment

Measures by Employee Type Hierarchy		
	MOHRI Occupied FTE	MOHRI Occupied Headcount
Casual	124.06	284.49
Temporary	449.80	558.03
FT - Shift - Temp	101.00	101.00
FT - Temp	129.00	129.00
FT - Temp Cont Shift	88.50	88.50
PT - Shift - Temp	23.42	51.00
PT - Temp	49.82	100.33
PT - Temp Cont Shift	58.06	88.20
Full Time	*318.50*	*318.50*
Part Time	*131.30*	*239.53*
Permanent	2,010.74	2,382.01
FT - Perm	1,005.74	1,005.74
FT - Perm Cont Shift	272.30	272.30
FT - Shift - Perm	132.50	132.50
PT - Perm	260.44	451.69
PT - Perm Cont Shift	263.73	399.21
PT - Shift - Perm	76.03	120.57
Full Time	*1,410.54*	*1,410.54*
Part Time	*600.20*	*971.47*
Internal	2,584.60	3,224.53
External		
External		
All Employ Type Hierarchy	2,584.60	3,224.53

Table 1.2: Annual Separation Details as at 23 June 2013

Separations by Status by Paypoint		
	Permanent	Temporary
Managerial and Clerical	**31.00**	**55.00**
Admin Officer - Level 1		2.00
Admin Officer - Level 2	2.00	8.00
Admin Officer - Level 3	19.00	40.00
Admin Officer - Level 4	5.00	2.00
Admin Officer - Level 5	2.00	1.00
Admin Officer - Level 6	2.00	
Admin Officer - Level 7		1.00
Admin Officer - Level 8		1.00
District Senior Officer	1.00	
Medical incl. VMOs	**4.00**	**40.00**
Medical	*4.00*	*39.00*
Medical Senior Officer		1.00
Medical Staff Specialists	4.00	
Medical Officer (Right of Private Prac)		1.00
Medical Registrar / Principal House Officer		22.00
Resident Medical Officer		15.00
Visiting Medical Staff		*1.00*
Visiting Specialist		1.00
Nursing	**101.00**	**128.00**
Assistant In Nursing - Grade 1	13.00	24.00
Enrolled Nurses - Grade 3	8.00	27.00
Enrolled Nurse Advanced Practice - Grade 4	3.00	
Registered Nurses / Midwife - Grade 5	43.00	57.00
Clinical Nurse / Midwife - Grade 6	19.00	16.00
Clinical Nurse Consultant, Manager, Educator - Grade 7	10.00	4.00
Nurse Director, Assistant Director of Nursing - Grade 9	1.00	
Director of Nursing - Grade 10	4.00	
Operational	**84.00**	**128.00**
Operational -Level 2	63.00	111.00
Operational - Level 3	12.00	14.00
Operational - Level 4	3.00	1.00
Operational - Level 5	1.00	2.00
Operational - Level 6	4.00	
Operational - Level 7	1.00	
Trade and Artisans	**2.00**	**0.00**
HBEA Trades Level 06 (Inc01)	1.00	
HBEA Trades Level 06 (Inc03)	1.00	
Professional and Technical	**32.00**	**32.00**
Professional	*7.00*	*1.00*
Dental Officer - Level 1	6.00	
Dental Officer - Level 2	1.00	
Professional - Level 2		1.00
Health Practitioners	*25.00*	*31.00*
Health Practitioner - Level 3	15.00	26.00
Health Practitioner - Level 4	8.00	5.00
Health Practitioner - Level 5	2.00	
All Paypoints	254.00	383.00

particularly dynamic operating environment. At the same time, Central Queensland continues to experience exponential growth in its population.

CQHHS promotes itself as an employer of choice to attract and retain high quality employees. The Australian Bureau of Statistics Regional Population Growth data shows growth in the CQHHS footprint for 2011-2012 exceeding the State average by 0.8 percentage points. (ABS 3218.0, *Regional Population Growth, Australia, 2011-12*). We will face the challenges associated with service demand from that increasing population by continuing to recruit and retain quality staff. We will continue to provide family-friendly working environments, encourage innovation and reward exceptional service and achievements.

1.1.4. Performance management framework

CQHHS has introduced a new performance management framework that promotes and supports a high performance culture. The framework is based on the Balanced Scorecard approach and is strategically linked to the Queensland Health Strategic Plan, the Blueprint for better health care in Queensland and the CQHHS Strategic and Operational plans.

By utilising this approach, the framework functions as a means of measuring organisational performance, clarifying objectives and managing the critical success factors to achieve the six key performance indicators (KPIs) identified in the State Government's *Blueprint*.

1.1.5. Retention strategies

The broader CQHHS retention strategy includes a number of initiatives such as the *Peer Support Program* and the Aboriginal and Torres Strait Islander Mentoring (*You Pla, Me Pla*) Program.

The *You Pla, Me Pla* mentoring program is a key initiative of the Aboriginal and Torres Strait Islander Workforce Strategy 2009-2012 to help retain, support and develop Aboriginal and Torres Strait Islander staff within Queensland Health. The name "*You Pla, Me Pla*" is Torres Strait Creole and means "you fellas, us fellas". It represents the mentoring partnership between the mentee and mentor.

Through *You Pla, Me Pla* mentoring can be performed on a formal or informal basis. Accredited mentoring training is also available and supported by Department of Health. Specific program modules are offered at a number of tertiary institutions.

The Peer Support Program is designed to help new employees to get to know CQHHS, the Service, the facility and the work environment in which they function. Members of staff volunteer to help incoming employees through personal contacts and support in a variety of contexts.

- The new employee can turn to the Peer for direction and support with life within CQHHS.
- The Peer can offer a tour of the city, CQHHS and introductions to other staff.
- The Peer can assist the new employee before arrival with tips on what is available within the area, eg: housing, whether a car is needed, where to find information etc.
- The Peer will be sensitive to cultural and religious requirements.
- The Peer Program is about offering peer support, not therapy.

Peers preferably are employees who have worked for CQHHS for over one year. This ensures that Peers have enough knowledge about CQHHS and QH to impart to the new employees.

CQHHS also delivers a range of recognition programs intended to increase rapport and collegiality throughout the year such as:

- "Deck The Wards Christmas Decoration Competition" – An opportunity for work teams to decorate their ward/office/work area with a prize awarded to the location selected as the best of the competition by a group of nominated judges.
- Culture Club – A peer voted staff recognition strategy encompassing the principles of change, responsibilities, education, care, outcomes, diversity, expectations and safety.
- Bright Ideas – Employees (teams) are encouraged to submit their ideas and compete for a $1,000 professional development fund. The winning entry is determined by a Panel.

- Monthly Mingle – A themed lunchtime networking opportunity for staff and management with entertainment, games and prizes.

CQHHS offers employees a wide range of in-service and external training and development opportunities which enhance their career aspirations. With the expanded use of e-Learning for internal programs, a competition was run with prizes awarded to the 1,000th user on completion of any of the training modules.

The extended skill sets achieved by employees are highly valued within the workplace and the industry, ensuring that employees are aware of how they are appreciated by the organisation. Supervisors and Managers play key roles in reinforcing employee commitment and sense of belonging within CQHHS.

CQHHS promotes flexible working arrangements and work life balance, as demonstrated by the suite of policies described below. It is our intention to enable our staff to enjoy the benefits of being part of a flexible workforce, with a focus on family first. In some instances, geography makes it difficult for staff to exercise all aspects of a flexible work environment, however CQHHS remains committed to ensuring all of its staff benefit wherever possible from a work environment that endorses a "family first" philosophy and encourages innovative approaches to the delivery of services.

- Job Sharing http://www.health.qld.gov.au/qhpolicy/docs/pol/qh-pol-160.pdf
- **HR Policy C4 – Work Life Balance** http://www.health.qld.gov.au/qhpolicy/docs/pol/qh-pol-263.pdf and
- **Central Queensland Hospital and Health Service Procedure – Transition to Retirement Program for Nurses** http://qheps.health.qld.gov.au/cqld/policy_procedure/docs/district/cq_h9.pdf
- **HR Policy C9 – Carers Leave** http://www.health.qld.gov.au/qhpolicy/docs/pol/qh-pol-109.pdf
- **HR Policy C21 – Purchased Leave** http://www.health.qld.gov.au/qhpolicy/docs/pol/qh-pol-203.pdf
- **HR Policy C26 – Parental Leave** http://www.health.qld.gov.au/qhpolicy/docs/pol/qh-pol-187.pdf and
- **Public Service Commission Directive 26/2010** http://www.psc.qld.gov.au/publications/directives/assets/2010-26-paid-parental-leave.pdf
- **HR Policy G2 – Equal Employment Opportunity** http://www.health.qld.gov.au/qhpolicy/docs/pol/qh-pol-132.pdf
- *Public Sector Ethics Act 1994* - Code of Conduct

1.1.6. Leadership and management development framework

The CQHHS Leadership Development Framework has incorporated an innovative approach to ensuring aspiring leaders develop along an upward path that ultimately builds their own, and the organisation's desired capabilities.

The Framework is strategically driven by an integrated leadership system which adapts the NHS Leadership Framework and channels that through the Leadership Pipeline Model.

The Framework offers developmental pathways including non-accredited in-service courses; on-the-job opportunities, accredited programs, and mentoring and coaching aimed to develop and nurture the intellectual capital that exists within employees at all levels of the service.

The Framework will facilitate the roll-out of unique training and development options, act in support of Performance and Development Agreements (PaD), and initiate establishment of the Leadership Development Pool and an accompanying Mentoring program. The Framework will also be an integral component in the development of future succession planning strategies in line with the CQHHS Workforce Plan.

1.1.7. Early retirement, redundancy and retrenchment

A program of redundancies was implemented during 2012-13. During the period, 114 employees received redundancy packages at a cost of $4,540,098.77. No employees received voluntary separation packages during 2012-2013.

Our role

Central Queensland Hospital and Health Service (CQHHS) was established in July 2012 as a statutory body overseen by the Central Queensland Hospital and Health Board. The Board was established under the provisions of the *Hospital and Health Boards Act 2011* and functions within the parameters of that legislation.

In this Chapter

Chapter 2

2.1. Central Queensland Hospital and Health Board

The CQHH Board has oversight of the strategic management of CQHHS and is responsible for compliance, government and setting and pursuit of strategic goals and objectives. Since its initial establishment, the constitution of the Board has varied, due to varying personal circumstances of individual members and a statutory requirement that the Board membership be revised by a process of nomination in March 2013. The Board membership at 30 June 2013 was:

CQHH Board

Chair

Charles Ware

Deputy Chair

Dr David Austin

Board Members

Frank Houlihan

Graeme Kanofski

Elizabeth Baker

Sandra Corfield

Karen Smith

Kurt Heidecker

Bronwyn Christensen

Leone Hinton

Chair:
Mr Charles Ware
person with legal expertise
(current term 3 years)

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

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

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

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

Deputy Chair:
Dr David Austin
person with clinical expertise (current term 3 years)

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

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

David has worked within Anaesthesia and Intensive Care Medicine within rural and metropolitan hospitals across New Zealand and Australia.

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

David is currently a Manuscript Reviewer for: *The Lancet* (1998 – present), *Anaesthesia and Intensive Care* (2010 – present), *Wilderness and Environmental Medicine* (1998 – present) and an Examiner for the Australian and New Zealand College of Anaesthesia (2005 – present), the College of Intensive Care Medicine (2009 – present) and a member of the Primary Exam Committee – CICM (2010 – present). David is also a member of the Steering Group for the Statewide Intensive Care Network Queensland (2011 – present).

David also holds membership for the following:

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

David is a Clinical Champion for Central Queensland District for the Deteriorating Patient Project (2009 – present).
David is a Fellow of the Australian and New Zealand College of Anaesthesia and Fellow of the College of Intensive Care Medicine.

Member:
Ms Sandra Corfield
person with knowledge of health consumer and community issues relevant to the operations of the Service (current term 1 year)

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

Sandra is a Registered Nurse and Midwife and has practiced as a Community Nurse, Accident and Emergency Nurse and Neonatal Special Care Nurse in her diverse nursing career. She holds a postgraduate Midwifery Certificate and was a finalist in the Australian Institute of Management Rural Manager Awards Program in 2012.

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

Sandra and her family run a successful primary production venture at their property "Vandeena", outside Monto.

Member:
Ms Bronwyn Christensen
person with knowledge of health consumer and community issues relevant to the operations of the Service (current term 1 year)

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

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

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

From 2001 to 2005, Bronwyn played a key role in setting up the Theodore District health Council Inc office, Youth Centre, and in the development of the council's primary health care project plan. She was also instrumental in the submission for and awarding of Queensland's Healthiest Town to Theodore in 2003.

In the same year, Bronwyn was awarded the Australian Institute of Management's Rural and Remote Manager of the Year.

Member:
Mr Frances (Frank) Houlihan
person with expertise in business management, financial management and human resource management (current term 3 years)

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

With over 30 years experience, Frank graduated with a Bachelor of Commerce from James Cook University before working for a three-partner accountancy firm where he went on to become office manager.

Frank is also a Director of the Central Queensland Rural Division of General Practice, Director of Central Queensland Primary Health Care Pty Ltd and a member of the GP SuperClinic Reference Group.

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

Member:
Mr Kurt Heidecker
person with other areas of expertise the Minister considers relevant to a Service performing its functions (current term 1 year)

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

Kurt brings with him a wealth of business and industry experience. In his current role, Kurt is responsible for overseeing a team aimed at building an open and trusting relationship between industry and the community. Some of his achievements include forming strong relationships with industry, activist, government and community and the development of successful Board Advisory Committees.

From 2006 to 2008, Kurt led a team of implementation, network and support training specialists in the software company, Amlink Technologies (now part of Certain Software).

Kurt holds various board positions including:
- Director – Fitzroy Basin Association,
- Director – Gladstone Area Promotion and Development Limited and
- Member – Central Queensland Institute of TAFE Advisory Council.

Kurt's qualifications include:
- Bachelor of Engineering (Civil), Masters of Design Science (Building),
- Graduate Diploma of Management and
- Master Practitioner of Neuro-Linguistic Programming.

Member:
Professor Leone Hinton
person from universities, clinical schools or research centres with expertise relevant to the operations of the Service (current term 3 years)

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

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

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

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

Member:
Ms Elizabeth Baker
person with expertise in health management, business management, financial management and human resource management (current term 1 year)

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

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

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

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

Member:
Mr Graeme Kanofski
person with expertise in business management, financial management and human resource management (current term 1 year)

Mr Graeme Kanofski has 36 years of experience in Local Government in Queensland, including five years as Chief Executive Officer of the Gladstone Regional Council. He holds a Bachelor of Business degree and has served as President of Local Government Managers Australia. Graeme is a well respected local who has an extensive career history in local Government and associated organisations in the Gladstone region. He has studied local Government management in El Segundo City in the USA and in the United Kingdom and has a wealth of experience in local government organisations, including: the State Emergency Service, Council Disaster Response Management, Local Government Managers Australia, Gladstone Regional Council, Calliope Shire Council, Director – Gladstone Economic and Industry Development Board, Port Curtis Alliance of Councils and Australian Airport Owners Association.

Graeme has received a number of awards for his contributions to local government and the public service and has owned and operated small businesses in the Gladstone Region. Graeme retired in 2008 and now resides in Calliope.

Member:
Ms Karen Smith
person with clinical expertise; (current term 1 year)

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

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

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

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

Non returning members who served as members in 2012-2013 were:

- Emeritus Professor Robert Miles
- Dr David Shaker.

The CQHH Board has met 12 times since its establishment in July 2012 and meets monthly. Committees meet either quarterly or bi-monthly, with provision for extraordinary meetings as required.

Costs associated with committee members fees and incidental expenses totaled $239,000 for the 2012-2013 financial year. Both clinicians appointed to the inaugural Board membership (Dr D Austin and Dr D Shaker) elected to have their remuneration for Board activities directed to a nurse education fund, which is managed by CQHHS Director of Nursing and utilised to enhance education opportunities for nursing staff within the region. This arrangement has been maintained for Dr Austin, as he remains a Board member. See Chapter 5 page 43 for full detail of costs associated with the Board and its function.

The Board has three Committees:

2.1.1. Finance and Resource Committee

Chaired by Mr Kurt Heidecker, the Finance and Resource Committee is responsible for monitoring and assessing the financial management and reporting obligations of the HHS. It oversees resource utilisation strategies and is responsible for bringing the attention of the Board to any unusual financial practices. The Finance and Resource Committee works in close cooperation with the Executive Director (People and Culture) and the Chief Finance Officer and has oversight of financial planning, human resource management and other resource management functions of CQHHS. The Committee receives regular reports from these areas.

2.1.2. Quality and Safety Committee

Chaired by Professor Leone Hinton, the Quality and Safety Committee is responsible for advising the Board on matters relating to the safety and quality of health services provided by the Service, including the Service's strategies to address the maintenance of high quality, safe, contemporary health services to patients. The Committee meets bi-monthly, except where circumstances require a special meeting. All reports are forwarded to the Board for consideration at its next meeting. The Committee works in close cooperation with the Clinical Governance Committee and plays a strategic role in responding to Category 1 incidents and management thereof.

2.1.3. Audit and Risk Committee

Chaired by Mr Frank Houlihan, the Audit and Risk Committee is responsible for the oversight of internal and external audit functions of CQHHS and management of corporate risk across clinical, operational, financial and management portfolios. The Committee receives regular reports from the Internal Auditors, External Auditors and Chief Finance Officer and works in close tandem with the Chief Executive to identify and strategically manage risk. The Audit and Risk Committee has oversight of financial reporting and compliance for the HHS.

The Audit and Risk Committee meets at least quarterly and its charter is to provide independent assurance and assistance to the Board of CQHHS on:

- The CQHHS risk, control and compliance frameworks.
- CQHHS's external accountability responsibilities as prescribed in the *Financial Accountability Act 2009*, The *Auditor-General Act 2009*, the *Financial Accountability Regulation* and the *Financial and Performance Management Standard*.

The duties and responsibilities of the Audit and Risk Committee include but are not limited to:

Internal Control

- Review, through the audit planning and reporting process of internal and external audit, the adequacy of the internal control structure and systems, including information technology security and control.
- Review, through the audit planning and reporting process of internal and external audit functions, whether relevant policies and procedures are in place and up-to-date, including those for the management and exercise of delegations, and whether they are being complied with in all material matters.

Internal Audit

- Review the Internal Audit Charter as required.
- Review the adequacy of the budget, staffing, skills and training of the internal audit function, having regard for the Agency's risk profile.
- Review and approve the internal audit strategic and annual plan, scope and progress, and any significant changes, including any difficulties or restrictions on scope of activities, or significant disagreements with management.
- Review the proposed internal Audit Plan for the coming year to ensure that it covers key risks and that there is appropriate co-ordination with the external auditor.
- Reviewing and monitoring internal audit reports and action taken.
- Reviewing and assessing performance of the Internal Audit operations against the annual and strategic audit plans.
- Monitoring developments in the audit field and standards issued by professional bodies and other regulatory authorities, in order to encourage the usage of best practice by Internal Audit.

External Audit

- Consult with external audit on the function's proposed audit strategy, audit plan and audit fees for the year.
- Review the findings and recommendations of external audit and the response to them by management.
- Assess whether there is a material overlap between the internal and external audit plans.
- Assessing the extent of reliance placed by the external auditor on internal audit work and monitoring external audit reports and CQHHS's response to those reports.

Compliance

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

Reporting

- Submit reports as required to the CQHHS Board outlining relevant matters that it considers require specific or further attention in addition to those included in the minutes of the Committee's meeting.
- Circulate minutes of the Committee meetings to the Board and other members of the Executive Management Team, Committee members and invited guests as appropriate.
- Prepare an Annual Report to the CQHHS Board summarising the performance for the previous year. An interim program of the planned activities for the coming year also is to be provided.
- Submit a summary of its activities for inclusion in CQHHS Annual Report.

Risk Management

- Lead the strategic direction of the service in the management of corporate and clinical risks
- Oversight the establishment and implementation of the Risk Management Framework
- Review the effectiveness of the Risk Management Framework in identifying and managing risk and controlling internal processes

Membership of the Committee at 30 June was, in accord with the requirements of the *Hospital and Health Boards Act 2012*:

Chair: Mr Frank Houlihan

Members: Mr Charles Ware
Mr Daniel Nolan
(External nominee with relevant experience)
Mr Nik Fokas
(standing rights of attendance as CFO)
Mr Les Harley
(internal auditor ArkAeon)
Mr Richard Wanstall
(external auditor Deloitte Touche Tohmatsu)

Mr Houlihan and Mr Ware are members of the CQHH Board and are remunerated for that role. No other Committee members receive remuneration for their services to the Committee.

In its first year of operation, CQHHS has not received audit recommendations by the QAO.

The Audit and Risk Committee has observed the terms of its charter

and had due regard to the *Audit Committee Guidelines* at all times.

2.1.4. Internal audit

The internal audit function at CQHHS is critical to the success of our governance, overseeing risk management and underwriting a key objective of achieving efficiency and effectiveness for our resources management. In its inaugural year, the internal audit function was established in accord with the *Institute of Internal Auditors standards*.

The internal auditor reports to and is a member of the Audit and Risk Committee of the CQHH Board. The relationship between the Board and the Internal Audit function is in accord with the *Internal Audit Guidelines*.

The internal auditor is accountable for:

- Reviewing performance, efficiency and effectiveness and reporting against those KPIs to management and the Board
- Contributing to the risk management function
- Assessing effectiveness and efficiency of operating systems, activities and reporting thereof
- Identifying compliance challenges for legislation and prescribed requirements and providing solutions to those challenges
- Proposing and monitoring the implementation of strategies and solutions to instances of non-compliance.

Our internal audit function is working in close tandem with consultants engaged from ArkAeon and Deloitte Touche Tohmatsu to develop audit reports, identify operational areas for audit review, develop a plan of proposed audits, provide advice and guidance as required for key projects and initiatives and monitor the success of audit recommendations as implemented by CQHHS.

The Internal Audit function at CQHHS in our inaugural year was focused on the baseline controls audits and consideration of lines of defense. This approach provided the greatest level of value to both the Board and HHS management, by matching audit outcomes closely with the needs of HHS during its initial period of development. The Internal Audit function operates under the charter of the CQHH Audit and Risk Committee, which has been endorsed by the CQHH Board and complies with the *Financial and Performance Management Standard 2009* and is devised with due regard to the *Audit Committee Guidelines*. Internal Audit is directly relevant to the CQHHS Strategic Plan 2012-2017 and is approved by the CQHH Board, by way of recommendation from the Audit and Risk Committee. The Audit and Risk Committee is responsible for ensuring the Internal Audit function at CQHHS is efficient, effective and operates economically. Accordingly, any decision to engage internal auditors or to amend the terms of such engagement must be with the endorsement of the Audit and Risk Committee. The Audit and Risk Committee receives regular reports from the Internal Auditor and has oversight of the conduct of the internal audit function for CQHHS. The internal audit function at CQHHS operates independently of management and authorised external auditors and is responsible to the Audit and Risk Committee, which assures the integrity and independence of that function.

As the internal audit function was established in the second half of the first year of operations for CQHHS, the purpose of the function has been to focus our effort on the baseline controls audits and consideration of lines of defense. Our focus has been on establishing procedures and precedents to enable us to undertake our own internal audit function in future by building internal capacity and benefit from enhanced internal efficiencies. In 2013-2014, we propose to undertake audits of financial, governance and compliance functions to identify gaps and recommend appropriate strategies to meet the requirements of the *Hospital and Health Board Act, Financial Accountability Act*, and *Financial and Performance Management Standard*; to establish systems, practices and controls to ensure efficient, effective and economic financial and performance management of the Statutory Body; and to be proactive in monitoring systems, operations and the HHSs financial position and performance.

It is our intention to establish a clear direction for internal audit for future years beyond 2012-13, including its focus, structure and best resourcing model (and potential involvement in an internal audit hub). We reasonably expect this objective to be successfully fulfilled and

reported in 2013-2014. The proposal for an internal audit hub has been accepted in principle and strategies are now being devised to establish and activate that facility, of which CQHHS has agreed to be a member.

2.1.5. Strategic Planning

As the body responsible for Strategic Management and Planning for the HHS, the Board generates and revises the CQHHS Strategic Plan 2013-2017 (see Appendix page 106). Underwritten by the Operational Plan, the Strategic Plan 2013-2017 identifies the pillars of a strong future for CQHHS but also acknowledges the challenges that lie ahead of the service and identifies strategies to address them. At all times, the Strategic Plan is driven by the single goal of providing a quality health service to everyone in Central Queensland, with a focus at all times on the patient.

2.2. Central Queensland Hospital and Health Service Executive Management Team

At 30 June 2013, the CQHHS Executive Management Team comprised 8 members.

View *Figure 2.2* on page 18 for the CQHHS Executive Team.

View *Figure 2.3* on page 19 for the CQHHS Organisational Structure.

2.2.1. CQHHS Committee Structure

Senior management groups and/or committees and their roles:

- Executive Management Committee
- Central Queensland Leadership Group
- Rockhampton Hospital Management Group
- Gladstone Hospital Management Group
- Rural Health Management Group
- Mental Health and Alcohol and Other Drug Services Management Group
- Sub Acute and Community Services Management Group
- Division of Medicine Management Group
- Division of Surgery Management Group
- Division of Family, Women and Children Management Group
- Clinical Directors Forum
- Nursing Executive Committee
- District Consultative Forum and associated Local Consultative Forums
- Clinical Governance Committee
- Credentialing and Scope of Practice Committee
- Local Ambulance Service Network Committee.

View *Figure 2.4* on page 20 for the CQHHS Committee Structure

As the primary provider of health care services, Central Queensland Hospital and Health Service is obliged to work in close association and cooperation with external agencies and expends considerable energy on ensuring those external relationships are meaningful and enduring.

Our relationship with CQ Medicare Local is guided by an Engagement Protocol (see Appendix page 110), which is endorsed by Medicare Local and is a legislative requirement. The Protocol identifies shared objectives for the two agencies and outlines activities in which we will collaborate for the benefit of our communities, patients and other stakeholders.

We understand that our service delivery relies significantly on the cooperation and commitment of our clinical staff. To that end, the Clinician Engagement Strategy has been developed (see Appendix page 112) to describe a transparent and effective means of ensuring clinicians across the footprint of the HHS (including those who work outside the HHS services) are consulted, given a voice and considered in our decision making processes. The Clinician Engagement Strategy is a legislative requirement and is an innovative approach to attracting the considered input of clinicians at all levels from within CQHHS borders. The strategy encourages and welcomes frank and fearless discussions and overtly engages clinicians from employers other than CQHHS, to ensure a vibrant and representative membership.

The Consumer and Community Engagement Strategy (see Appendix page 118) describes how the HHS will engage with our communities and individual consumers, including the continued use of Community Action Networks (CANs) and establishment of new strategies including use of internet, newsletters and social media. The Strategy is a legislative requirement and is intended to guide the effective and efficient interaction of CQHHS with its communities.

CQHHS Executive Team

Chief Executive
Maree Geraghty
Overall accountability for the strategic development and operational delivery of services.

Chief Operations Officer
Rod Boddice
Responsibility for the efficiency and effectiveness of all operating facilities and services.

District Director of Nursing
Karen Wade
Responsibility for nursing practice, nursing standards of practice, workload processes and education.

Executive Director Medical Services
Dr Mark Mattiussi
Responsibility for professional oversight for medical recruitment, scope of practice and clinical governance.

Director Clinical Support Services
Kerrie-Anne Frakes
Responsibility for the provision and operation of all Allied Health services.

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

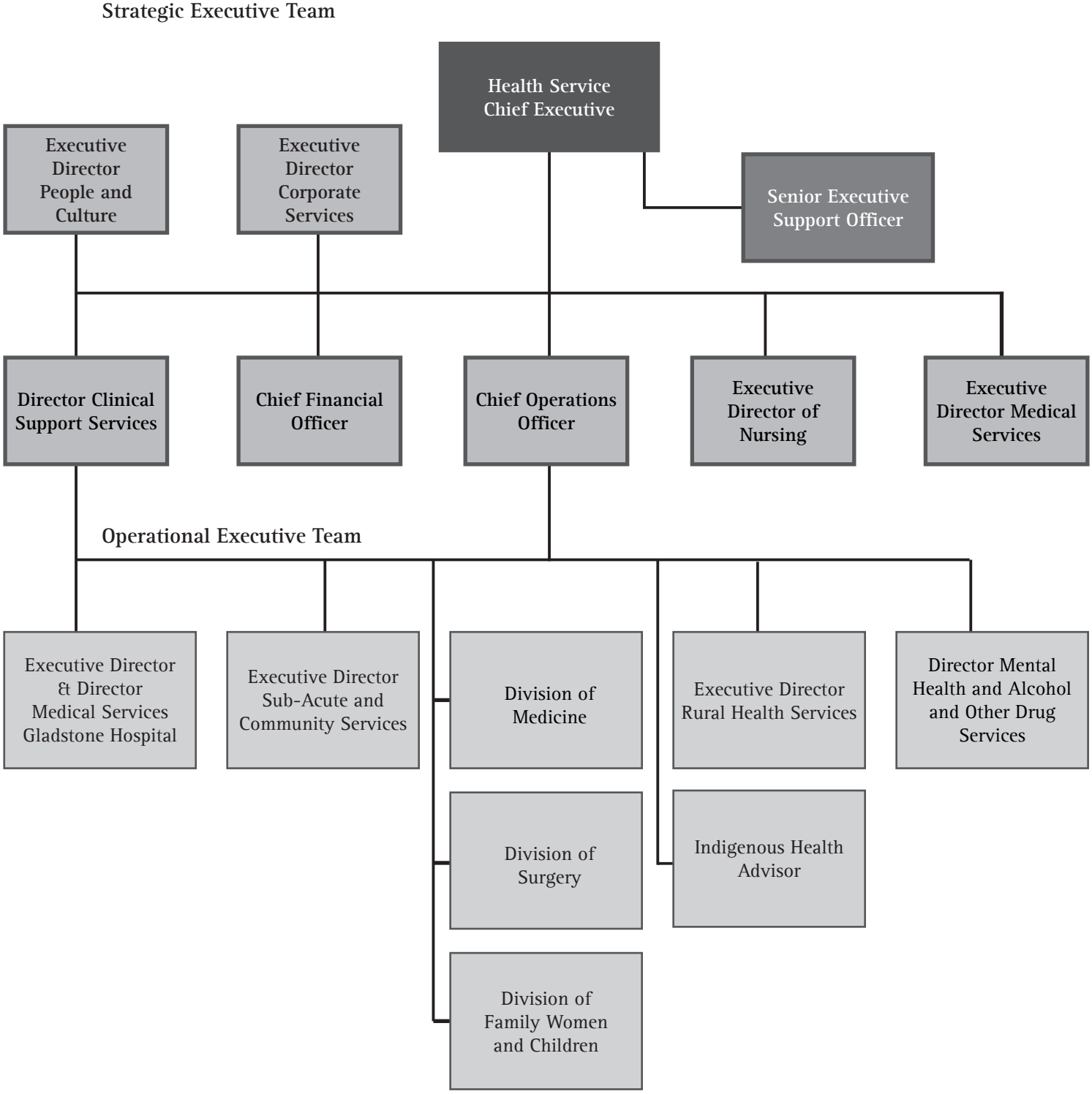
Executive Director Corporate Services (acting)
Grant Searles
Responsibility for capital development program, asset management and maintenance programs of equipment and buildings, fleet and accommodation management.

Executive Director People and Culture
Louise Riddell
Responsibility for workforce planning, employee relations, organisational development and occupational health and safety.

2.2 Executive Management Team

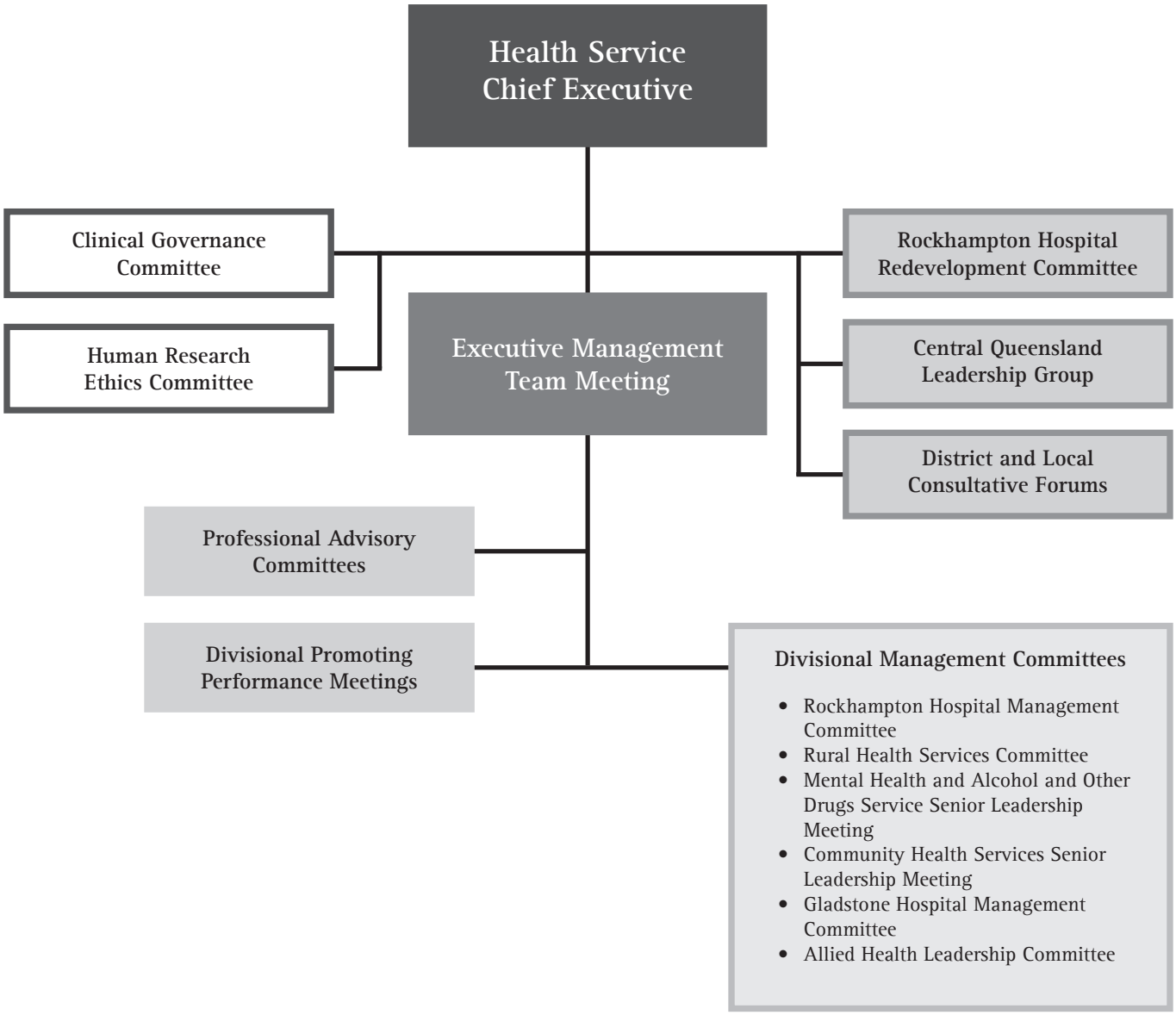
Chapter 2

CQHHS Organisational Structure



2.3 CQHHS organisational structure

CQHHS Service Delivery Committee Structure



2.4 CQHHS service delivery committee structure

2.2.2. External scrutiny

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

Since July 2012, one formal investigation has been completed at CQHHS. The Coroner's findings regarding the inquest into the death of Judith McNaught presented a series of four key recommendations, to which CQHHS has responded. Paragraph 204 (pages 37 & 38) of the coroner's report provides the following recommendations:

Recommendation 1:

That the Rockhampton Hospital seriously consider the allocation of resources for dedicated discharge planners in its major acute wards, with additional resources allocated for nursing care in those wards to replace the nurses performing discharge planning duties where possible.

Recommendation 2:

That the Rockhampton Hospital seriously consider whether the patient outlay system is necessary and appropriate for acute and post-surgical patients at all, particularly having reference to the expert opinion on the issues in this Inquest.

Recommendation 3:

That in the event that it is considered that patient outlay is necessary and appropriate for acute and post-surgical patients, the Rockhampton Hospital conduct a complete review of the patient outlay system using input from key frontline personnel to ensure that if the practice needs to continue that all precautions are taken to ensure patient safety, including patient reviews before transfer, appropriate and complete handover of patients to receiving wards, detailed nursing care plan for the patient and consultation with treating doctors before the transfer as well as the supervisor of the sending and receiving wards before the transfer is effected, and regular reviews of the patient and the appropriateness of their remaining in the receiving ward.

Recommendation 4:

That those conducting Root Cause Analyses at Rockhampton Hospital ensure that all relevant care providers be interviewed in the investigation. It is clearly desirable that the nurses and doctors who are involved in an adverse incident be given the opportunity to give information to an investigating RCA team which is protected by statutory privilege so that the health care team can speak freely. Such participation can only assist in the early identification of issues which may need to be addressed to prevent tragedies from occurring in the future. It is noted that previous coronial comment on this issue has been made.

Each of the four recommendations has been implemented in full.

Further investigations involving CQHHS remain incomplete at the time of this report.

2.3. Information systems and record keeping

2.3.1. Information Systems:

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

2.3.2. Record keeping

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

The Machinery of Government (MoG) network Group has assisted with the transfer of records from the Department of Health to CQHHS.

Central Queensland Hospital and Health Service manages its administrative records in accordance with the requirements of the *Public Records Act 2002* and relevant Information Standards (IS); IS 40 (Record keeping); IS 34 (Metadata); IS 31 (Retention and Disposal of Public Records) and IS 18 (Information Security).

Central Queensland Hospital and Health Service utilises an electronic system to manage all of the communications of its Executive Office.

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

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

In August 2012, Health Service Chief Executives were notified by the State Archivist that ownership of administrative, functional and clinical records was to be transferred, via a Machinery-of-Government (MoG) change process.

The Machinery of Government Transfer of Records Project for Central Queensland Hospital and Health Service is now complete. Retention and disposal of public records is undertaken by an officer trained in the requirements of IS 31: Retention and Disposal of Public Records under the oversight of a qualified Health Information Practitioner.

In 2012-2013 CQHHS commenced works around an improved Business Classification System (BCS) to assist with standardising naming conventions across the Health Service.

2.3.3. Medical Records:

All patients and clients are registered on a patient administration system, with a unique identifier and Medical Records are stored, managed and accessed in accordance with relevant legislation and standards. Routine data quality monitoring is undertaken, via a number of mechanisms, including routine and ad-hoc audits. In accordance with the *Public Records Act 2002*, the intellectual control of approximately 850,000 clinical records was transferred from the Queensland Department of Health to the CE of CQHHS. Once transferred, the CE became responsible for the management and safe custody of these clinical records in accordance with s.8 of the *Public Records Act 2002* and Queensland Government Information Standard: 40 Record keeping and Queensland Government Information Standard: 31 Retention and Disposal of Public Records. The safety and security of these records will be monitored via a Records Management Framework and regularly reported to the CE.

All patients and clients are registered on a patient administration system, with a unique identifier and Medical Records are stored, managed and accessed in accordance with relevant legislation and standards. Queensland legislation which ensures privacy and confidentiality protections for personal information and which is applied at CQHHS include:

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

2.3.4. Risk management

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

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

all CQHHS sites.

CQHHS risks are reported to the CQHH Board, by either direct report from an Executive team member or through a relevant Committee. Procedurally, clinical risk is reported through the Quality and Safety Committee (through the Clinical Governance Committee), HR-related risk is reported through the Finance and Resource Committee and Corporate and financial risk is reported to the Audit and Risk Committee. The Audit and Risk Committee is responsible for establishment and maintenance of a single Risk Register to capture all high level risk and reports same to the CQHH Board.

CQHHS continually monitors and improves risk management practices across the region, enabling the delivery of effective, appropriate and efficient clinical, corporate and governance services. CQHHS follows best practice principles as described in Risk Management – Principles and Guidelines Standard AS/NZS ISO 31000: 2009.

Corporate Services manages risk by the provision of advice and support to assist with decision-making related to risk, performance and capability.

Our place

CQHHS delivers public hospital and health services including medical, surgical, emergency, obstetrics, paediatrics, specialist outpatient clinics, mental health, critical care and clinical support services from Miriam Vale in the south, inland to the Southern and Central Highlands and north along the Capricorn Coast, serving a population of around 225,000 people.

The geographic footprint of CQHHS is diverse, ranging from regional cities to remote townships in the West and beach side communities along the coast. The 2011 census identified Central Queensland as having 5.5% of its population Aboriginal and Torres Strait Islander people where the same figure for all of Australia is 2.5%. 5.1% of the population identify as unemployed, which is comparable to the national figure of 5.6%. The most common occupation in Rockhampton is Trade and Technical Workers, representing some 17.4% of the workforce.

Central Queensland has experienced rapid economic development as a result of significant resource sector development in the region. The Western region has sustained growth through increased demand in the mining sector, while Gladstone region has experienced exponential growth as a result of the Wiggins Island Coal Export Terminal and Liquid Natural Gas projects. Maintaining health services to address such rapid growth presents a challenge to CQHHS, as does balancing that growth against the continuing needs of more stable communities.

In this Chapter

Chapter 3

3.1. Our place in Central Queensland

CQHHS is responsible for the direct management of facilities within the its geographical boundaries including:

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

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

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

Outpatient clinics are located at:

- Boyne Valley
- Capella
- Gemfields
- Tieri.

photo: Emerald Hospital

photo: Blackwater MPHS


photo: Gladstone Hospital


photo: Mount Morgan MPHS

photo: Moura Hospital


photo: Springsure MPHS

photo: Biloela Hospital


photo: Rockhampton Hospital

photo: Theodore MPHS


photo: Capricorn Coast Hospital and Health Service

photo: Baralaba MPHS


photo: Woorabinda MPHS

3.2. CQHHS geographical boundaries map

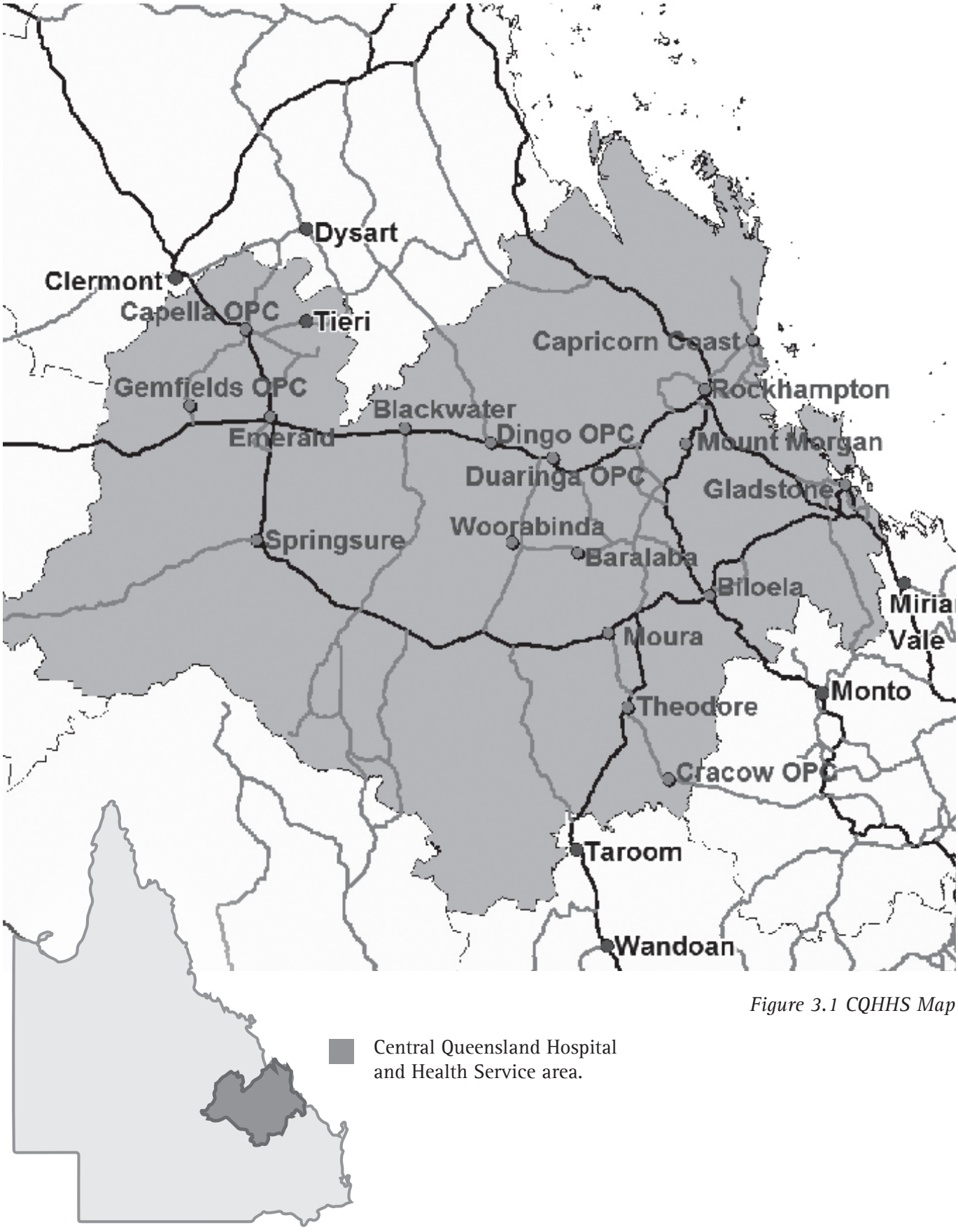


Figure 3.1 CQHHS Map

Distance is a challenge to service delivery for CQHHS. Our large geographic area means we often service rural or remote communities, where it is not possible to have immediate access to 24 hour clinical services. In 2012-13 CQHHS introduced and embraced telehealth, enabling real-time interaction between specialist clinicians and remote communities. Telehealth is used to provide services ranging from core clinical diagnostics to mental health care and antenatal care. Telehealth enables efficiencies in the delivery of quality health care services across CQHHS.

3.3. Our place is safe

Work related death, injury and disease are not inevitable and can be prevented. Our vision is to ensure that occupational health and safety (OHS) is integrated into all our management systems and core operations so that prevention of occupational injury and illness and property damage becomes an integral part of our organisational culture.

CQHHS is committed to employing Workplace Health and Safety (WHS) best practice across the full range of activities undertaken within Central Queensland.

The following strategies and objectives (from the Safety Assurance Strategic Plan 2013 – 2017) clearly define the intentions of the unit to ensure CQHHS staff and management operate in a safe environment with a culture that embraces the well-being of its workforce:

Strategic Priority 1:
Build capacity for all staff to move forward and work towards the development of a safety culture.

Strategic Priority 2:
Develop preventative measures to ensure workplace injury and harm is minimised.

Strategic Priority 3:
Develop a recruitment and workplace strategy to ensure all staff are fit for the requirements of their employment.

Strategic Priority 4:
Develop a marketing strategy to increase the profile of the Occupational Health and Safety Unit and increase awareness of the importance of safety within the health service.

Strategic Priority 5:
Occupational Health and Safety will utilise CQHHS Integrated Systems.

Strategic Priority 6:
Develop Compliance Strategies in line with legislation and ensure communication to all staff.

Recent initiatives by CQHHS to promote the core message of a zero harm workplace and work culture include:

1 Take 5 for Safety Drift Articles (monthly). Launched in 2012 to promote safety and provide learning's of incidents to staff throughout CQHHS. Topics have included: driver safety, body fluid/biological exposure, slips trips and falls. These relate to incident trends at the time.

2 Healthy morning teas commencing Gladstone in June 2013. Part of the Healthy Lifestyle Initiative, held on a bimonthly basis where promotion of activity and healthy lifestyles is undertaken. In addition fruit bowls with seasonal fruit are placed in staff lunch rooms to encourage healthy snacks.

3 Healthy recipe book (created by staff for staff and nutritionally researched) for release Christmas 2013. Initiative from Gladstone to be rolled out throughout CQHHS.

4 Safety Week 2011 & 2012 & 2013 (October):

- 2011 - Implementation of the LIVE SAFE WORK SAFE CQ message
- 2012 - raising awareness for fire safety
- 2013 - preparations are underway with the release of our cook book, hazard rectification competition, focus on healthy life and reducing injuries.

5 Creation of OHS Fact Sheets and Development of Manager OHS Guidebook (soon to be released). In conjunction with newly developed OHS information sessions for staff on Checklist audit, Incident reporting, Chemalert and WHS representative information sessions.

6 Release of the CQHHS QHEPS OHS site in 2010 with a revamp of the look in 2013. This makes accessing information for safety easier for staff. http://qheps.health.qld.gov.au/cqld/ohs/

Congruent with our commitment to a safe work environment, CQHHS is also equally committed to successfully returning staff to the workplace after sustaining a work-related injury.

Table 3.1 demonstrates our success in securing medical clearance for 33 of our 53 injured staff to return to the workforce.

Table 3.1: Reasons for closure of claims in June 2013

Reason for closure	Number
Resigned	3
Permanent Impairment Assessment	4
Medical clearance	33
Total and permanent disability payout/ Voluntary redundancy	4
Contract ended	1
Medical expenses only ceased	1
Denied by insurer	4
Settled at common law	1
Withdrawn damages claim	1
Withdrawn statutory claim	1

In 2012-2013, 7 WHS incidents were deemed notifiable and were escalated to the Safety Regulator. A summary of those incidents is provided below:

Reason for Notification to WHSQ	Status at 30 June 2013
An injury or illness requiring a person to have immediate treatment as an in-patient in a hospital	BEMS rectifying fence before pool to be opened. To advise OHS when this happens.
A serious electrical incident involving electrical equipment where a person received an electric shock and was treated for shock by a Doctor	Actions completed. Closed
An infection reliably attributed to carrying out work with micro-organisms	Consultation still occurring
An injury or illness requiring a person to have immediate treatment as an in-patient in a hospital	Recommendations completed
An injury or illness requiring a person to have immediate treatment as an in-patient in a hospital	Finalisation in progress.
An infection reliably attributed to carrying out work that involved treatment of a patient	In progress
An infection reliably attributed to carrying out work that involved treatment of a patient	In progress

3.4. Our place is diverse

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

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

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

Our diverse workforce is made up of 3% staff who identify as Aboriginal and Torres Strait Islanders, 8.5% of staff from non-English speaking backgrounds and 3% of staff who identify as having a disability. Resources and initiatives have been implemented to ensure a fair and equitable workplace for all our employees including:

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

Central Queensland Hospital and Health Service complies with the Queensland Health Cultural Competency Framework. This Framework identifies the four foundation areas which are necessary to achieve organisational cultural competency including:

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

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

3.5. Our place is innovative

CQHHS encourages innovation and fosters an environment that rewards new processes, procedures and approaches. We are proud of our track record in developing innovative approaches.

Dr Don Knowles received a prestigious community service award in 2013 to honour his service to public dentistry in Queensland and the wider Central Queensland community through 32 years of service to the Yeppoon Lions Club. In his career, he has mentored dental students and young graduate dentists through public dental clinics. He has passionately provided treatment for disabled and other disadvantaged individuals in the community as well as ensuring the provision of specialist dental services to government clinics. A recipient of the Tony Rotondo medal, he is recognised for his boundless energy, infectious enthusiasm, ability to boost morale and the ability to encourage leadership.

In early 2012, CQHHS identified that its hospitals were experiencing challenges in achieving National Access Targets in Emergency Medicine (NEAT) and Elective Surgery (NEST), with specific reference to long wait category one patients and an unrealised opportunity to reduce the average length of stay. The Clinical Services Redesign Project was established to address these issues, with core focus areas of:

- The development of the Local Hospital Health Network
- Clinical Streaming across the District
- Capital Development
- A requirement to implement the Patient Flow Strategy 2010.

The project addressed the impact, capacity, resources, policy change and role change associated with a number of key issues relevant to clinical redesign. As a result, CQHHS has implemented a series of innovative changes to clinical services delivery which has contributed significantly to the major change in progress against NEAT and NEST targets for CQHHS. At 30 June 2013, CQHHS was among the top 3 performers in the State for those indicators, where it had started in June 2012 among the bottom of the same league table. It is a shared view that the Clinical Redesign process, in tandem with strategic change at HR and Finance levels underpinned the rapid turnaround of CQHHS performance in NEAT and NEST, among other indicators.

The Sub-Acute Chronic Care Rehabilitation Interdisciplinary Student Clinic (SACCR) provides an opportunity to concurrently address service delivery gaps; health workforce recruitment and retention difficulties; efficient and effective service delivery; and inter-professional clinical education.

Through a partnership with CQUniversity, the SACCR team integrates and coordinates clinical placements for over 150 pre-entry students per year, to create a functional workforce that provides Sub-Acute Care to clients with a range of complex chronic diseases via an interdisciplinary goal oriented, time-limited intervention aimed at assessing and managing complex conditions that have the potential for functional gain to maximise independence and quality of life for people with disabling conditions. Preliminary research data has demonstrated a significant reduction in hospitalisations and average length of stay for a client group with multi-morbidity; and a significant effect on patient's quality of life (physical functioning, bodily pain and social functioning).

The service targets client groups with:

- Complex chronic conditions who demonstrate a historically high hospital utilisation – either on an emergency or planned basis;
- Identified risk of extended lengths of stay in an inpatient setting that may be better managed through an alternative community based care delivery model; and
- Evidence that a planned interdisciplinary secondary intervention interaction can demonstrate prevention of possible hospitalisations.

This service provision model aims to:

- Encourage an interdisciplinary approach to health care provision and provide clinical activity that is currently considered a gap in the community leading to improved client health outcomes
- Provide a catalyst for strengthening partnerships with general practice and other public and private primary health providers through engagement in

primary care partnerships
- Support clinical education and training opportunities for allied health pre-entry students, in an inter-professional environment to enhance working relationships and workforce participation
- Strengthen workforce recruitment, retention and service delivery capabilities through innovative service delivery design.

SACCR was Australia's first interdisciplinary student assisted clinic based in a health service and currently supports clinical placements from over 10 Universities across Australia, for students of the disciples of Occupational Therapy, Podiatry, Physiotherapy, Speech Pathology, Exercise Physiology, Nutrition and Dietetics, Social Work, Pharmacy, Nursing and Medical Science. The award-winning team moved into their new premises on-campus at CQUniversity in August 2012 and the clinic was officially opened by Federal Minister of Health Tanya Plibersek in October 2012.

Preliminary research data has demonstrated a significant reduction in hospitalisations and average length of stay for a client group with multi-morbidity; and a significant effect on patient's quality of life (physical functioning, bodily pain and social functioning).

3.6. Our place is unique

Central Queensland benefits from having a diverse geography that is home to a culturally diverse population with equally diverse needs. CQHHS aims to always accurately identify and respond to those needs, regardless of how challenging they might be. We meet the challenge of distance and isolation head-on by using innovative techniques and strategies to deliver quality health care services and we work in close tandem with other forward-thinking agencies to achieve that shared outcome. Our services are required to work independently and often in isolation, by virtue of there often being no other service provider in the region. As such we are developing new and contemporary ways to for the people of Central Queensland to access health care services equal to or better than those available elsewhere in Queensland. We aim to keep our patients close to home.

Our inaugural year

The first year of operation for CQHHS and the CQHH Board was one of landmark successes and of interesting challenges. It is testimony to the hard work and dedication of CQHHS that we have closed the year with so many success stories. The first months of the CQHH Board were spent establishing structures for CQHHS and ensuring the Board had a strong relationship with CQHHS Executive Management Team, however the Board was rapidly engaged in strategic management functions as the impact of changing budgets and community responses to decisions was experienced. The Board has contributed to CQHHS being in the enviable position it enjoys now and aims to continue supporting CQHHS with strong leadership, informed decision-making and contemporary and relevant guidance across all functions of a statutory agency.

In this Chapter

Chapter 4

4.1. Major challenges and success stories

4.1.1. Clinical Governance Opportunities

An external review of Clinical Governance Opportunities reported that CQHHS operates in a safe, compliant environment. The review identified a small number of recommended improvements, each of which has been or is being implemented. There were no major adverse findings and the review found overall that CQHHS was compliant with relevant regulations.

4.1.2. Regional Cancer Care Centre Rockhampton

The Regional Cancer Care Centre began to take shape in 2012-2013 as the building was erected and fit-out commenced. The community is eager to see the facility operational and has embraced the installation of Zeus, the onsite crane which is pivotal to construction. The Cancer Centre has already changed the skyline of Rockhampton and will soon change the delivery of critical cancer services to the people of Central Queensland. The program of building works will be completed in 2014. This important initiative will enable the delivery of cancer services which were previously only available in Brisbane or Townsville. Central Queenslanders recognise that the Centre will change many lives and are supportive of all aspects of the facility.

4.1.3. Clinical Services Redesign (Energise project)

The Clinical Services Redesign project identified obstacles to achieving NEAT and NEST targets and provided solutions to the obstacles. The recommendations adopted by CQHHS resulted in a massive performance turnaround which placed CQHHS among the top 3 performers for NEAT and NEST in the State.

photo: construction zone, Rockhampton Hospital

4.1.4. 12-bed Extended Emergency Care Unit (EECU) at Rockhampton Hospital

The Extended Emergency Care Unit (EECU) was opened in early 2013 at Rockhampton Hospital. The EECU contributes significantly to the effective and efficient delivery of health services to Emergency patients and has underwritten enhanced performance in NEAT and NEST targets.

4.1.5. Central Queensland Mental Health Services

The summer flood events of 2010-2011 resulted in the Division receiving considerable support through Commonwealth and State agreements and led to the introduction of a Recovery and Resilience Team (RRT). The team was implemented for a time limited period to provide a proactive response to the psychological trauma individuals and communities experienced during the summer flood events and provided a range of interventions ranging from one-one counselling, cognitive support, telephone counselling, attendance at Men's Sheds and community events to promote awareness and support to reduce the long term impact on individual's mental health and wellbeing.

During the year, the medical workforce was stabilised through strong clinical leadership and provided an increased focus to promote opportunities for medical staff to enter or continue their Psychiatric Registrar Training within the rich learning environment that the Division

provides.

The Mental Health Division has optimised service provision through very effective and efficient utilisation of Telehealth supplemented by consultant psychiatrist clinics within our major rural centres and strengthened by the provision of our Nurse Practitioner. Whilst meeting increased activity, the Division has a consistent record of achieving above key performance parameters within established mental health measures

The Division operates a number of strong collaborative working relationships including that with the Hillcrest Mental Health Service which has both improved our consumer outcomes while also assisting to meet previously unmet community need. The Division also provides an Advisory Service Role to local private psychiatrist to enable to enable the facility to admit youth from 16 to 18 years of age.

Our other major service partner is the CQ Medicare Local which we have collaborated with in conjunction with other mental health sector partners to achieve approval to establish a local Headspace as well as contracts to secure Partners in Recovery funding.

At the General Practice (GP) level the Division has developed a strong relationship with Central Highlands GP practice to facilitate GP Registrar Training which enables a GP Registrar to work within a mental health setting, assisting in the growth of local medical workforce capacity to provide mental health specialist services to supplement the provision of public mental health service.

At a research level the Division has established strong partnerships with CQUniversity to undertake a number of major research projects. Of particular note the Division is currently progressing major research with the University in relation to "Cardiometabolic Montoring" with the aim to measure options to reduce the impacts of co-morbidities within individuals with chronic or long term mental illness.

The Central Queensland Mental Health Alcohol and Other Drugs Division also has worked collaboratively with other state mental health services to complete a Suicide Prevention project. Outcomes of the project include provision of education and training in relation to suicide assessment for health clinicians, (medical, nursing and allied health). The project is currently focusing on the area of postvention. The Division also conducted an extensive 3 day workshop in June 2013 to improve the level of complex skill capability when assessing and managing individuals at risk of suicide.

4.1.6. Director of Medical Services - Gladstone and Emerald

Recruitment to key positions in Central Queensland has historically been difficult. The vacant positions of Director Medical Services (DMS) were a priority for CQHHS as they play a pivotal part in the leadership of clinical services for Gladstone and Emerald. CQHHS successfully recruited to both positions in mid-2013 and is now committed to ensuring those appointees remain in its employ.

4.1.7. Strategic Plan (and supporting strategies)

The 2013-2017 Strategic Plan for CQHHS was finalised in May 2013. The Plan provides direction and specific goals to lead CQHHS into the future. It is underpinned by the Clinician Engagement Strategy, Engagement Protocol with CQ Medicare Local, Community and Consumer Engagement Strategy and the Integrated Strategic Marketing and Communications Plan, whilst being driven by obligations for service delivery as outlined in the CQHHS Service Agreement for each year. The Plan and strategies address compliance obligations and are utilised as important tools in planning for the future of CQHHS and the health service needs of Central Queensland.

4.1.8. Organisational redesign

The transition of CQHHS to a statutory body highlighted the requirement for the executive structure to be redesigned to best support the future direction of health, increasing the focus on identifying existing and future needs, innovative solutions, developing appropriate implementation strategies and monitoring performance.

The new position of Executive Director Performance, Planning and Innovation will provide this focus. The portfolio will generate and implement a relevant reform agenda whilst ensuring that the

development of a performance culture remains a priority.

This position will focus on governance, planning, innovation and reform and a performance culture.

The existing positions of Executive Director People and Culture, and Executive Director Corporate Services will be merged to become Executive Director Corporate Services.

4.1.9. Accreditation and certification

CQHHS completed an Australian Council of Healthcare Standards accreditation and certification survey for the first time in 2012-2013. A number of services had previously been accredited under other standards bodies. These were brought into alignment through certification in order for the whole organisation to seek a single survey process in the future. The CQHHS ACHS Recommendations report was received by CQHHS outlining recommendations from the Accreditation and Certification Survey. CQHHS continues to function with relevant authorisations and assessments in place.

4.1.10. Infrastructure maintenance program

Highlights for the 2012-2013 financial year included, as part of the $244 million Rockhampton Hospital Expansion Project, a new Maternity Unit, Paediatric Unit, Extended Emergency Care Unit and Mortuary. Planning works commenced for a number of projects across the Central Queensland Hospital and Health Service region including:

- upgrades to High Dependency Unit and Theatres at Gladstone
- new staff accommodation at Woorabinda
- Private Practice Clinic at Theodore
- Community Care Unit in Rockhampton (Mental Health) and
- extensive rectification works at Biloela and Emerald.

4.2. Our performance in NEAT and NEST: an overview

- CQHHS Emergency Departments are currently achieving the required "Seen in Time" targets for each of the respective Triage Categories. In addition, the Health Service continues to improve on its "Average Wait Times in ED", having reduced the waiting times from 24 minutes in July 2012 to 15 minutes in April 2013. This also represents a further reduction in wait times of 1 minute in comparison to the previous month.
- The Rockhampton Hospital ABF facility recorded an Average Wait Time of 13 minutes for March while Gladstone Hospital ABF facility recorded an Average Wait Time of 19 minutes.
- Across CQHHS, patients with a discharge status of "Did Not Wait" have decreased from 230 in March 2013 (2.4% of all presentations) to 186 in April 2013 (2.0% of all presentations). Total "Did Not Waits" for the current Fiscal Year to date are 2,271 compared with 3,053 same period (year to date) last year. While this continues to represent a significant improvement year-on-year, it should be noted that the target set for patients with a Discharge Status of "Did Not Wait" under the current Health Purchasing Agreement is zero.
- The National Emergency Admissions Target (NEAT) is currently being achieved across CQHHS. This is a result of continued strong performance in the Gladstone Hospital Emergency Department, although Gladstone's performance sustained a small decline in April 2013.
- While there has been some improvement in the "ED Controlled" component of the patient journey at the Rockhampton Hospital (i.e. Admission to Short Stay or Acute Assessment Units) there has been little improvement in the overall admissions to the Inpatient Wards. This matter was discussed at the Clinical Directors forum on 17 May 2013 and strategies are being devised to address it in 2013 – 2014.
- It is noteworthy that while Rockhampton Hospital has had lower performance in overall NEAT compliance, it does have a strong "Seen In Time" performance with all 5 triage categories sitting at, or above, the national benchmarks. Conversely, while Gladstone Hospital shows strong compliance with the overall NEAT, its

"Seen In Time" demonstrates a need for some improvement (particularly across the Triage Categories 2, 3 & 4).

- For month 4 of the second year of the National Partnership Agreement National Elective Surgery Targets (NEST), CQHHS continues to show improvement in target achievement.
- NEST still requires 4 criteria to be met on a calendar year to date basis:
    - Part 1 – Patients treated in time:
    - Category 1 targets - 100%, April achievement – 99%
    - Category 2 targets - 87%, April achievement – 92%
    - Category 3 targets - 94%, April achievement – 100%

Strong performance is being sustained this year in treating Category 2 patients. This area was a significant challenge for CQHHS last year and, in part, this improvement has been due to more appropriate patient categorisation practices.

4.3. Achievement of objectives

Strategic Plan performance indicators – our own objectives

We measure our success and progress carefully against the priorities identified in our *Strategic Plan 2013 – 2017*. A summary of that success and progress is provided below.

Strategic Plan Measures – Progress Report for 2012-13

Evidence against Strategic Directions and Strategies

1 Delivering integrated health services in partnership with other providers

- Evidence: Allied Health Student-Assisted Clinic located at CQUniversity is operating as a partnership arrangement under a joint-membership Governance Committee
- Evidence: Diabetes Taskforce established in conjunction with Central Queensland Medicare Local
- Evidence: Committee meetings held bi-monthly
- Evidence: Clinical Leaders Forum established
- Evidence: Community advisory groups meet regularly in Baralaba, Blackwater, Springsure, Woorabinda and Mount Morgan
- Evidence: CQHHS input to community forums through membership of Central Queensland Primary Care Partnership (CQPCP).

2 Providing accessible, sustainable, networked services in a quality framework

- Evidence: Specialist medical appointments jointly established for surgery and general medicine between Gladstone Hospital and Gladstone Mater Private Hospital
- Evidence: Initial planning commenced for development of District-wide Surgery and Maternity Plans
- Evidence: CQHHS Division of Subacute and Community Services established
- Evidence: Extended Emergency Care Unit (EECU) established at Rockhampton Hospital
- Evidence: NPA-funded Dental Program implemented with combination of public and privately-contracted services
- Evidence: Planning commenced for implementation of APCC in Gladstone Hospital
- Evidence: Hospital in the Home (HITH) service operating in Rockhampton and Gladstone
- Evidence: Hospital in the Nursing Home (HITNH) service operating in Rockhampton
- Evidence: Community-based Palliative Care Service operating in Rockhampton
- Evidence: Planning commenced for step-down services to Gladstone Hospital and rural hospitals/MPHS.

3 Striving for better care in Central Queensland

- Evidence: Initial planning commenced for development of District-wide Surgery and Maternity Plans
- Evidence: Moura Community Hospital Model with capital redevelopment program approved
- Evidence: Nurse Research and Allied Health Research

Studies continue to be implemented
- Evidence: Orthopaedic fracture telehealth clinics operating from Rockhampton Hospital to Gladstone and Emerald Hospitals.

4 Providing a great place to work
- Evidence: Planning commenced on concept of Integrated LDRC
- Evidence: Planning Committee organising 2013 Academic Day
- Evidence: CQHHS Workforce Strategy developed and Workforce Plan under development
- Evidence: Staff nominations routinely made to relevant clinical leadership programs eg Emerging Clinical Leaders, Executive Coaching, Medical Leadership in Action Program.

5 Underpinning our business through stakeholder, clinician, consumer and community engagement
- Evidence: CQHHS Consumer and Community Engagement Strategy implemented
- Evidence: CQ Clinical Leaders Forum established
- Evidence: CQHHS Clinician Engagement Strategy developed.

6 Living within our means
- Evidence: Planning commenced on development of high-priority Ophthalmology and Gastroenterology Services
- Evidence: National and State Access Targets (NEAT and NEST) achieved
- Evidence: CQHHS Strategic Asset and Maintenance Plan implemented.

4.4. Getting Queensland Back on Track – Government objectives

Getting Queensland Back on Track describes five pillars for Queensland. CQHHS has addressed each of those objectives through internal strategies and accountabilities.

Objective 1:
Grow a four pillar economy

The Queensland Government is renewing focus on developing Queensland's strengths in tourism, agriculture, resources and construction.

CQHHS is committed to providing appropriate Hospital services and developing effective models of care to complement changes in the health requirements of the population.

Objective 2:
Lower the cost of living

The Queensland Government, in its *Blueprint for better healthcare in Queensland*, has stated "public health services will be exposed to contestability – that is, there will be a deliberate opening up of these services to competition or the credible threat of competition".

CQHHS has started a systematic review of service delivery models and the associated cost of delivering support services within a contestability framework. It aims to demonstrate that health care is being provided on a value-for-money return basis to the organisation and the community overall.

Streamlining the internal structure and redesigning service teams and units will:
- Achieve consistency of administrative and clinical support functions;
- Enhance business support and reporting that informs effective decision making;
- Eliminate duplication and waste of effort;
- Maintain safe and effective models of care.

Objective 3:
Invest in better infrastructure and better planning

Construction work and planning of infrastructure improvements continued across CQHHS.
- The most notable and visible outcome was the continued work on the $160 million Stage 2 redevelopment at Rockhampton Hospital. When completed in 2014, the new ward block will incorporate Cancer Care Services, additional general wards, medical officer facilities and provision for future expansion of services including an expanded Intensive Care Unit and helipad on top of the building.
- The $80 million Stage 1 redevelopment included a new Geriatric and Rehabilitation Services (GARS) building and Learning and Development

Centre, extension to the clinical services building to house a new Emergency Department and a refurbishment of parts of the Clinical Services Building. The result was 30 additional beds with increases in paediatrics, maternity, renal and GARS beds and the establishment of an Extended Emergency Care Unit.

- Planning commenced on the Rural and Remote Infrastructure Rectification Works at Biloela and Emerald Hospitals.
    - Biloela Hospital is a $7.15 million project that includes essential fire safety repairs, electrical safety upgrades and asbestos removal. Community Health Services will be relocated onto the Hospital Campus and there will be an upgrade of the Emergency Department to address service and safety issues. This work is due to be completed in March 2014.
    - Emerald Hospital project is an $8.0 million project that includes essential fire safety repairs, asbestos removal and generator and chillers replacement. This work is due to be completed in March 2014.
- The Moura Community Hospital Model was developed after extensive community consultation. Approval has been granted for the construction of a new facility in association with the existing Moura Medical Centre. The work is expected to commence in 2013-14.

Objective 4:
Revitalise front-line services

CQHHS implemented a program of service reviews and remodelling to revitalise front-line services. Examples of the revitalisation include:

- Allied Health Student-Assisted Clinic located at CQUniversity operating as a partnership arrangement under a joint-membership Governance Committee
- Specialist medical appointments jointly established for surgery and general medicine between Gladstone Hospital and Gladstone Mater Private Hospital
- Planning commenced for development of District-wide Surgery and Maternity Plans
- CQHHS Division of Sub-Acute and Community Services was established
- Extended Emergency Care Unit (EECU) established at Rockhampton Hospital
- Hospital in the Home (HITH) service operating in Rockhampton and Gladstone
- Hospital in the Nursing Home (HITNH) service operating in Rockhampton
- Community-based Palliative Care Service operating in Rockhampton
- Initial planning commenced for development of District-wide Surgery and Maternity Plans.

Objective 5:
Restore accountability in government

The Department of Health continues to increase its openness and accountability through the publication of information and statistics regarding the provision of Hospital and Health Services.

CQHHS performance is displayed and regularly updated on the Queensland Health "Our Performance" web page.

The inaugural CQHHS Annual Report is one example of that increased accountability.

4.5. Blueprint for Better Health Care in Queensland – government objectives

The *Blueprint for Better Health Care in Queensland* describes the future of healthcare in Queensland and is based on four principal themes:

1. Health services focused on patients and people.
2. Empowering the community and our health workforce.
3. Providing Queenslanders with value in health services.
4. Investing, innovating and planning for the future.

CQHHS demonstrated a number of achievements for the Central Queensland community in 2012-2013 which align with the identified themes.

Health services focused on patients and people

- Implementation of telehealth service models, for example, specialist orthopaedic service referrals and reviews in Gladstone and Emerald Hospitals
- Joint specialist appointments

of Physician and General Surgeon between Gladstone Hospital and Gladstone Mater Private Hospital
- Joint arrangements between CQHHS and CQ Medicare Local for funding of provision of Diabetes Clinic at Emerald Hospital
- Implementation of Hospital in the Home (HITH) service at Gladstone Hospital
- Implementation of Caseload Midwifery Model at Emerald Hospital
- Establishment of after-hours GP Clinic at Emerald Hospital to improve the management of Category 4 and 5 patients in the Emergency Department.

Empowering the community and our health workforce

- Engagement of Moura community for agreement on Moura Community Hospital Model
- Development of Consumer and Community Engagement Strategy in partnership with CQ Medical Local
- Development of Clinician Engagement Strategy in partnership with CQ Medicare Local
- Establishment of Clinical Leaders Forum in partnership with CQ Medicare Local
- Development of CQHHS-CQUniversity Collaborative Health Clinic Strategic Direction 2013-2018.

Providing Queenslanders with value in health services

- Achievement of Key Performance Indicators (KPI) for NEAT, NEST, FTE management and balanced budget
- Implementation of performance management processes encompassing KPIs to promote cost efficiencies and effectiveness
- Implementation of coordinated approach to system-wide CQHHS accreditation program.

Investing, innovating and planning for the future

- The Rockhampton Hospital is currently undergoing a $244 million enhancement program with financial year expenditure of ($58.9 million) and the remaining ($65.9 million) in 2013-2014.
- Biloela Hospital ($7.15 million), Emerald Hospital ($8.0 million), Theodore Private Practice Clinic ($1.75 million), Moura Hospital, Woorabinda staff accommodation ($1 million), Gladstone Hospital High Dependency Unit and Theatre Complex ($2 million) are progressing with completion of all projects anticipated in 2013-2014.
- Clinical redesign programs in Rockhampton and Gladstone Hospital to improve patient-flow management and appropriateness of hospitalisation.

4.6. Summary of financial performance

Chapter five of this report provides comprehensive financial performance data for CQHHS in the financial year 2012 – 2013. In summary, our inaugural year demonstrated that CQHHS is robust and well positioned to maintain strong, positive financial performance.

Own Source Revenue

In 2012-13, the HHS was allocated a budget of $21.4 million in private revenue to achieve in 2012-13. The HHS actually achieved $23.1 million or 8.0 % above budget. The main areas of improvement were;

	Actual	Budget
Inpatient fees	$12.0M	$11.5M
Outpatient fees	$5.3M	$5.0M
Non patient fees	$5.8M	$4.9M

The main area of achievement was in the private room fees that achieved $0.6 million, radiology services recovery $0.5 million and Pharmaceutical Benefits Scheme (PBS) reimbursement $0.5 million above budget. Other areas of positive performance were prosthetic recovery $0.1 million and fees from multi-purpose nursing homes $0.1 million.

Labour expenses

Upon the HHS transitioning to a statutory body, the treatment of labour altered. All staff except for non- clinical Executive were Department of Health staff and reflected in CQHHS budgets as contractors while non- clinical Executive were treated as salary and wages expenses. It is the

intention of CQHHS that all staff will become HHS employees when the HHS becomes a prescribed employee. This process is expected to take some 2-5 years. The overall labour cost for the HHS was $312.5 million against a budget of $316.8 million representing an underspend of $4.3 million or 1.4%.

The main areas of improvement were:	
Health Practitioners	$3.1M
Managerial & Clerical	$2.0M
Professional	$8.8M
Other Employee related expenses	$0.9M

Offset by overruns in:	
Medical	$8.8M
Nursing	$1.7M

The main reason for the over-run in medical labour costs is attributed to the high locum reliance. In nursing the over-run is largely due to high usage of agency services and overtime. It is envisaged the high locum reliance will continue for some years due to the limited number of medical staff choosing to move to Central Queensland. The number of medical staff who will come to Rockhampton and Gladstone has improved with universities increasing medical placements, but that benefit is not expected to be realised for at least 3-5 years. A nursing shortage world-wide has contributed to the higher than expected reliance on agency services and overtime. Improved recruitment and flexible working hours should assist with resolving some of this usage.

Other expenses

Supplies and Service Expenses

Through tight controls and review of practices the HHS was able to achieve a favourable variance to budget of $6.9 million. This saving was largely achieved by key areas including catering and domestic expenses($1.6 million), staff travel ($1.4 million), transport expenses ($3.1 million), communication and clinical supplies ($0.4 million) and building supplies and water supplies ($0.5 million).

Our inaugural year has been busy and productive. CQHHS and the CQHH Board welcome the challenges that the next year of our operations bring. We are enthusiastic about our future and committed to continue our positive track record of performance, service delivery, innovation and engagement.

Our performance

In its first financial year CQHHS's operating performance was strong, returning a surplus of $18.7 million, strengthening its cash position during the year. This was achieved through strong growth in own source revenue and sound fiscal management strategies. The reduction in funding from the Australian Government in 2012-13, under the National Health Reform Agreement, had a significant impact on the ability of CQHHS to plan and deliver services, particularly given the timing of the advice and the need to retrospectively adjust activity targets for 2012-13.

Key financial highlights are outlined in the table below:

Key Results	2012-13 Actuals $'000	2012-13 Target $'000
Income	454,283	431,889
Expenses	435,548	431,889
Operating surplus	18,735	-
Revaluation increments on land and buildings	23,361	2,069
Cash and cash equivalents	39,645	8,075
Total Assets	364,048	358,449
Total Liabilities	28,168	15,768
Total Equity	335,880	342,681
Current Ratio	2.29	>=1.5
Quick Ratio	1.75	>1

In this Chapter

Chapter 5

5.1. CQHHS Financial Statements 2012-13

Contents

General Information

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

The Central Queensland Hospital and Health Service was established on 1st July 2012 as a statutory body under the *Hospital and Health Boards Act 2011*.

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

The head office and principal place of business of CQHHS is:

Rockhampton Hospital Campus
Canning Street
Rockhampton QLD 4700

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

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

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

5.1.1. Statement of Comprehensive Income for the year ended 30 June 2013

	Notes	2012-13
		$'000
Income from Continuing Operations		
User Charges	3	23,998
Grants and other contributions	4	425,662
Interest		225
Other revenue	5	4,398
Total Revenue		454,283
Gains		-
Total Income from Continuing Operations		454,283
Expenses from Continuing Operations		
Employee expenses	6	1,403
Health service labour expenses	7	277,352
Supplies and services	8	132,908
Grants and subsidies	9	461
Depreciation and amortisation	10	17,125
Impairment losses	11	220
Other expenses	12	6,079
Total Expenses from Continuing Operations		435,548
Total Operating Results from Continuing Operations		18,735
Other Comprehensive Income		
Items that will not be reclassified subsequently to Operating Result		
Increase in Asset Revaluation Surplus	22	18,021
Other		-
Total items that will not be reclassified subsequently to Operating Result		18,021
Items that will be reclassified subsequently to Operating Result		
Net gain on available-for-sale financial assets		-
Other		-
Total items that will be reclassified subsequently to Operating Result		-
Total Other Comprehensive Income		18,021
Total Comprehensive Income		36,756

5.1.2. Statement of Financial Position

	Notes	2012-13
		$'000
Current Assets		
Cash and cash equivalents	13	39,645
Receivables	14	9,080
Inventories	15	2,901
Other	16	610
		52,237
Assets classified as held for sale	17	6,959
Total Current Assets		59,195
Non-Current Assets		
Property, plant and equipment	18	299,513
Total Non-Current Assets		299,513
Total Assets		358,708
Current Liabilities		
Payables	19	28,047
Accrued employee benefits	20	79
Unearned revenue	21	42
Total Current Liabilities		28,168
Total Liabilities		28,168
Net Assets		330,540
Equity		
Contributed equity		293,784
Accumulated surplus/(deficit)		18,735
Asset revaluation surplus	22	18,021
Total Equity		330,540

5.1.3. Statement of Changes in Equity

	Accumulated Surplus	*Asset Revaluation Surplus (Note 22)*	*Contributed Equity*	*TOTAL*
	$'000	$'000	$'000	$'000
Balance as at 1 July 2012	-	-	-	-
Operating Result from Continuing Operations	18,735	-	-	18,735
Other Comprehensive Income				
Increase in Asset Revaluation Surplus	-	18,021	-	18,021
Total Comprehensive Income for the year	-	18,021	-	18,021
Transactions with Owners as Owners:				
Net assets received (transferred during year via machinery-of-Government change) Note 2 (g)			12,513	12,513
Net assets received (transferred under Administrative Arrangement Note 2 (g) at 1 July 2012)	-	-	293,132	293,132
Non appropriated equity injections (Minor Capital works) Note 2 (g)			5,123	5,123
Non appropriated equity withdrawals (Depreciation funding) Note 2 (g)	-	-	(16,982)	(16,982)
Total changes to contributed equity	-	-	293,786	293,786
Balance as at 30 June 2013	18,735	18,021	293,786	330,540

5.1.4. Statement of Cash Flows

	Notes	2012-13
		$'000
Cash flows from operating activities		
Inflows:		
User Charges		34,171
Grants and other contributions		404,518
Interest receipts		225
GST input tax credits from ATO		7,516
GST collected from customers		293
Other receipts		3,506
		450,228
Outflows:		
Employee expenses		(1,311)
Health service labour expenses		(267,814)
Supplies and services		(398,144)
Grants and subsidies		(1,726)
GST paid to suppliers		(8,307)
GST remitted to ATO		(238)
Other		(5,942)
		(415,668)
Net cash provided by (used in) operating activities	23	34,561
Cash flows from investing activities		
Inflows:		
Sales of property, plant and equipment		16
Outflows:		
Payments for property, plant and equipment		(4,664)
Net cash provided by (used in) investing activities		(4,649)
Cash flows from financing activities		
Inflows:		
Cash transferred in under administrative arrangement (Note 1 (g))		4,610
Equity Injections		5,123
Net cash provided by (used in) financing activities		9,733
Net increase/(decreased) in cash and cash equivalents		39,645
Cash and cash equivalents at the beginning of the financial year		-
Cash and cash equivalents at the end of the financial year		39,645

5.1.5. Notes To and Forming Part of the Financial Statements

Index of Notes

Chapter 5

1 Objectives and Principal Activities of the Hospital and Health Service

Central Queensland Hospital and Health Service (CQHHS) was established on 1 July 2012, as a not-for-profit statutory body under the *Hospital and Health Boards Act 2012* (part of National Health Reform refer Note 2(g)).

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

This includes responsibility for the direct management of six hospital facilities, six multi-purpose health centres and five outpatient/primary health care clinics and two aged care facilities.

Rockhampton Hospital is the main referral hospital, providing secondary level care, with referral to Brisbane for tertiary services.

Funding is obtained predominantly through the purchase of health services by the Department of Health - a combination of grants from the department and the Australian Government (refer Note 2 (g)). In addition, health services are provided on a fee for service basis mainly for private patient care.

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

2 Summary of Significant Accounting Policies

(a) Statement of Compliance

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

These financial statements are general purpose financial statements, and have been prepared on an accrual basis in accordance with Australian Accounting Standards and Interpretations. In addition, the financial statements comply with Queensland Treasury and Trade's *Minimum Reporting Requirements* for the year ending 30 June 2013, and other authoritative pronouncements.

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

(b) The Reporting Entity

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

(c) Trust Transactions and Balances

The Hospital and Health Service acts in a fiduciary trust capacity in relation to patient trust accounts.

Consequently, these transactions and balances are not recognised in the financial statements. Although patient funds are not controlled by CQHHS, trust activities are included in the audit performed annually by the Auditor-General of Queensland. Note 28 provides additional information on the balances held in patient trust accounts.

(d) User Charges, Taxes, Penalties and Fines

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

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

(e) Grants and Contributions

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

(f) Other Revenue

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

(g) Administrative Arrangements under National Health Reform

Health Reform

On 2 August 2011, 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 hospital networks (statutory bodies to be known as Hospital and Health Services (HHSs) 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
    - a responsibility to intervene to remediate poor performance, either at the state's initiative or in response to prompting by the National Health Performance Authority, which will publicly report on performance of the HHSs and healthcare facilities.

The *Health and Hospitals Network Act 2011* (HHNA), enabling the establishment of the new health service entities and the System Manager role for the Department of Health in Queensland, was passed by the Queensland Parliament in October 2011. On 17 May 2012, the Minister for Health introduced amending legislation into the Parliament to expand the functions of HHSs under the HHNA. The amended legislation is known as the *Hospital and Health Boards Act 2012 (HHBA)*.

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 will be an independent statutory office holder, distinct from Commonwealth and State departments.

Depreciation funding

CQHHS receives grant revenue from the Department of Health to cover depreciation costs. However as depreciation is a non-cash expenditure item, the Health Minister has approved a withdrawal of equity by the State for the same amount, resulting in a non-cash revenue and non-cash equity withdrawal.

Minor capital works

Purchases of clinical equipment, furniture and fittings associated with capital works projects are managed by CQHHS. Theses outlays are funded by the State through the Department of Health as equity injections throughout the year.

Transfer of assets on practical completion

Construction of major health infrastructure continues to be managed and funded by the Department of Health. Upon practical completion of a project, assets are transferred from the Department to CQHHS by the Minister Health as a contribution by the State through equity.

Opening Balances

On 1 July 2012, certain balances were transferred from the Department of Health to Hospital and Health Services. This was effected via a transfer notice signed by the Minister for Health, designating that the transfer be recognised as a contribution by owners through equity.

The transfer notices were approved by the Director-General of the Department of Health and the Chairman and Chief Executive Officer of each Hospital and Health Board.

Balances transferred to HHSs materially reflected the closing balances of Health Service District's 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.

On the 3rd January 2013 a subsequent contribution of $650,000 by the Minister representing the fair value of specialist dental vans previously held by the Department of Health was transferred into the asset pool of CQHHS.

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

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

* Legal title to land and building has not been transferred as at 30 June 2013. The Department of Health retains legal ownership, however control of these assets was transferred to CQHHS, via a concurrent lease representing its right to use the assets. Under the Deeds of Lease, CQHHS has full exposure to the risks and rewards of asset ownership however proceeds from the sale of major infrastructure assets cannot be retained by CQHHS, with funds to be returned to Consolidated Fund (the State).

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

Transfer of assets on practical completion

Construction of major health infrastructure continues to be managed and funded by the Department of Health. Upon practical completion of a project, assets are transferred from the Department to CQHHS by the Minister Health as a contribution by the State through equity.

(h) Cash and Cash Equivalents

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

Debit facility

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

(i) Receivables

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

Impairment of financial assets

Throughout the year, CQHHS assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. Objective evidence includes financial difficulties of the debtor, changes in debtor credit ratings and current outstanding accounts over 120 days. The allowance for impairment reflects CQHHS's assessment of the credit risk associated with receivables balances and is determined based on historical rates of bad debts (by category) over the past three years and management judgement. This differs from the approach adopted by the Department of Health (balances transferred in on 1 July 2012) which provided for all outstanding accounts over 60 days, resulting in a reversal of impairment loss of $873,117.

All known bad debts are written off when identified.

(j) Inventories

Inventories consist mainly of medical supplies held for distribution in hospitals and are provided to public admitted patients free of charge except for pharmaceuticals which are provided at a subsidised rate. Inventories are measured at weighted average cost, adjusted for obsolescence.

(k) Other non-financial assets

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

(l) Assets classified as held for sale

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

Assets held for sale are measured at the lower of it's carrying amount and fair value less costs to sell and are no longer amortised or depreciated upon being classified as held for sale.

(m) Property, Plant and Equipment

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

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

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

Property, plant and equipment are initially recorded at consideration plus any other costs directly incurred in bringing the asset ready for use. Items or components that form an integral part of an asset are recognised as a single (functional) 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 entity (whether as a result of a machinery-of-Government change or other involuntary transfer), the acquisition cost is recognised as the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation. Assets acquired at no cost or for nominal consideration, other than from an involuntary transfer from another Queensland Government entity, are initially recognised at their fair value at the date of acquisition.

The majority of assets in this first year of operation as a HHS, were acquired under this arrangement (initial values based on the fair value at 30 June 2012 in the Department of Health's records).

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

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

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

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

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 either independent revaluations, desktop market revaluations or indexation by the State Valuation Service within the Department of Natural Resources

and Mines. Independent revaluations are performed with sufficient regularity to ensure assets are carried at fair value.

The Department of Health in 2010-11, engaged the State Valuation Office to comprehensively revalue all land holdings. Since then indices from independent sources have been applied to land values until the date of transfer to HHS on 1 July 2012.

In 2012-13 CQHHS engaged the State Valuation Service to provide indices for all land holdings at 14 February 2013 excluding properties which do not have a liquid market, for example properties under Deed of grant (recorded at a nominal value of $1.50).

Indices are based on actual market movements for each local government area issued by the Valuer-General. An individual factor change per property has been developed from review of market transactions, having regard to the review of land values undertaken for each local government area and has been endorsed by the Queensland Audit Office.

Reflecting the specialised nature of health service buildings and on hospital-site residential facilities, fair value is determined using depreciated replacement cost methodology. Depreciated replacement cost is determined as the replacement cost less the cost to bring an asset to current standards.

Buildings are measured at fair value by applying either, a revised estimates of individual asset's depreciated replacement cost, or an interim indices which approximates movement in price and design standards as at reporting date. These estimates are developed by independent quantity surveyors . In 2012-13, CQHHS engaged independent quantity surveyors, Davis Langdon Australia Pty Ltd (Davis Langdon) to comprehensively revalue all buildings exceeding a predetermined materiality threshold and calculate relevant indices for all other assets.

In determining the replacement cost of each building, the estimated replacement cost of the asset, or the likely cost of construction including fees and on costs if tendered on the valuation date is assessed. This is based on historical and current construction contracts. Assets are priced using Brisbane rates with published industry benchmark location indices applied. Revaluations are then compared and assessed against current construction contracts for reasonableness. The valuation assumes a replacement building will provide the same service function and form (shape and size) as the original building but built consistent with current building standards.

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

Area estimates were compiled by measuring floor areas of Project Services e-plan room or drawings obtained from the Department of Health. Refurbishment costs were derived from specific projects and are therefore indicative of actual costs.

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

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

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

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

The balance of assets (previously comprehensively revalued by the Department of Health) have had indices applied, approximating movement in market prices for labour and other key resource inputs, as well as changes in design standards as at reporting date. These estimates were developed by Davis Langdon.

Revaluation increments are credited to the asset revaluation surplus of the appropriate class, and decrements charged as an expense. As this is the first year of revaluation for the HHS there are no previous year balances in the asset revaluation reserves to enable decrements to be offset.

The Hospital and Health Service has adopted the gross method of reporting comprehensively revalued assets. This method restates separately the gross amount and related accumulated depreciation of the assets comprising the class of revalued assets. Accumulated depreciation is restated proportionally in accordance with the independent advice of the appointed valuers/quantity surveyors. The proportionate method has been applied to those assets that have been revalued by way of indexation.

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

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 CQHHS's assessments of the useful remaining life of individual assets.
Land is not depreciated.

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

Class	Depreciation rates
Buildings and Improvements	2.5% - 3.33%
Plant and Equipment	5.0% - 20.0%

Leased property, plant and equipment

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

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, CQHHS determines the asset's recoverable amount (higher of value in use and fair value less costs to sell). Any amount by which the asset's carrying amount exceeds the recoverable amount is considered an impairment loss. An impairment loss is recognised immediately in the Statement of Comprehensive Income, unless the asset is carried at a revalued amount, in which case the impairment loss is offset against the asset revaluation surplus of the relevant class to the extent available.

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

(n) Payables

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

(o) Financial instruments

Recognition

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

Classification

Financial instruments are classified and measured as follows:

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

Central Queensland Hospital and Health Service does not enter into transactions for speculative purposes, nor for hedging. Apart from cash and cash equivalents, the HHS holds no financial assets classified at fair value through profit and loss. All other disclosures relating to the measurement and financial risk management of financial instruments held by CQHHS are include in Note 29.

(p) Employee benefits and Health Service labour expenses

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

(i) Health Service labour expenses

In 2012-13 Central Queensland Hospital and Health Service was not a prescribed service and accordingly all non-executive staff were employed by the department. Provisions in the HHB Act enable HHS to perform functions and exercise powers to ensure the delivery of its operational plan.

Under this arrangement:
- The department provides employees to perform work for the HHS, and acknowledges and accepts its obligations as the employer of these employees.
- The HHS is responsible for the day to day management of these departmental employees.
- The HHS reimburses the department for the salaries and on-costs of these employees.

As a result of this arrangement, the Hospital and Health Service treats the reimbursements to the Department of Health for departmental employees in these financial statements as health service labour expenses and detailed in Note 7.

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

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

CQHHS classifies salaries and wages, rostered days-off, sick leave, annual leave and long service leave

levies and employer superannuation contributions as employee benefits in accordance with *AASB 119 Employee Benefits* (Note 6). Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at current salary rates. Non-vesting employee benefits such as sick leave are recognised as an expense when taken.

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

Annual leave

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

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

Long Service Leave

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

Superannuation

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

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

Key management personnel and remuneration

Key management personnel and remuneration disclosures are made in accordance with section 5 of the *Financial Reporting Requirements for Queensland Government Agencies* issued by Queensland Treasury and Trade. Refer to Note 30 for the disclosures on key executive management personnel and remuneration.

(q) Unearned revenue

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

(r) Insurance

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

The Insurance Arrangements for Public Health Entities Health Service Directive (directive number QH-HSD-011:2012) enables Hospital and Health Services to be named insured parties under the department's policy. For the 2012-13 policy year, the premium was allocated to each HHS according to the underlying risk of an individual insured party. The Hospital and Health Service premiums cover claims from 1 July 2012, pre 1 July 2012 claims remain the responsibility of the department, however CQHHS must pay the $20,000 excess payment on these claims.

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

(s) Special payments

Special payments include ex gratia expenditure and other payments not under a contract. In compliance with the *Financial and Performance Management Standard 2009*, the HHS maintains a register of all details for special payments exceeding $5,000. Refer Note 12.

(t) 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.

(u) Contributed equity

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

(v) Federal taxation charges

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

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

(w) Issuance of Financial Statements

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

(x) 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:

- Property, plant and equipment – Note 18
- Contingencies – Note 26

(y) Rounding and comparatives

Amounts included in the financial statements are in Australian dollars and have been rounded to the nearest $1,000 or, where that amount is $500 or less, to zero, unless disclosure of the full amount is specifically required. As Central Queensland Hospital and Health Service commenced operations on 1 July 2012, there are no comparative figures in the financial statements.

(z) New and revised accounting standards

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

At the date of authorisation of the financial report, the following new or amended Australian

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

Standards effective for annual periods beginning on or after 1 July 2013:

- *AASB 9 Financial Instruments* applies to reporting periods beginning on or after 1 January 2015 and requires all financial assets to be subsequently measured at amortised cost or fair value. Financial assets can only be measured at amortised cost if: (a) the asset is held within a business model whose objective is to hold assets in order to collect contractual cash flows; and (b) the contractual terms of the asset give rise to cash flows that are solely payments of principal and interest. The only financial asset currently disclosed at amortised cost is receivables and as as they are short term in nature, the carrying amount is expected to be a reasonable approximate of fair value so the impact of this standard is minimal. For financial liabilities which are designated as at fair value through profit or loss, the amount of change in fair value that is attributable to changes in the liability's credit risk will be recognised in other comprehensive income.

- 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. Disclosures will be extended to cover all assets and liabilities within the scope of AASB 13. Review of current fair value methodologies for compliance (including instructions to valuers, data used and assumptions made) for land and buildings measured at fair value will be necessary. To the extent that the methodologies don't comply, changes will be necessary. While this review is yet to be completed no substantial changes are anticipated.

- AASB 119 *Employee Benefits* applies to reporting periods beginning on or after 1 January 2013 with the majority of changes to be applied retrospectively. As the HHS is a member of the Whole of Government (WoG) Annual Leave Central Scheme, the WoG Long Service Leave Scheme and makes employer superannuation contributions only for defined benefits as part of the State's QSuper scheme, the impact of changes to this standard is expected to be minimal. The only implication for the HHS is the clarification of the 'concept of termination benefits', with the recognition criteria for these liabilities differing. If termination benefits meet the timeframe criterion for 'short-term employee benefits' they will be measured according to the AASB119 requirements for "short-term employee benefits', otherwise these benefits will need to be accounted for according to most of the requirements for defined benefit plans.

- AASB 1053 *Application of Tiers of Australian Accounting Standards* applies to reporting periods beginning on or after 1 July 2013. Essentially this standard allows for differential reporting frameworks, however Queensland Treasury and Trade has advised that it is its policy decision to require full disclosure and adoption of Tier 1 reporting by all Queensland government entities consolidated into the whole-of-Government financial statements. Therefore, there is no change from the current reporting requirements applicable to CQHHS.

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

(aa) Other events

Restructure of Hospital and Health Service

In 2012-13, in response to further budget reduction for the Central Queensland Hospital and Health Service (CQHHS) it became necessary to accelerate the process of reform and respond decisively to the changing external environment. A major strategy to achieve this was to call for Expressions of Interest from employees interested in a Voluntary Redundancy Package.

Subsequent to 30 June 2013, a further 76 voluntary redundancies were offered to staff, with final completion expected by September 2013. The impact of these redundancies are not reflected in the 2012-13 accounts. All redundancy cost will be funded by the Department of Health in 2013-14.

This initiative allowed the opportunity to review the Service and re-engineer through better delivery of quality care using innovation, technology and contemporary models of care.

This re-engineering was to ensure CQHHS Service reprioritised spending to frontline service delivery and put the Health Service in a strong position for the future. It also ensures the Health Service is aligned with the future direction of the Board.

Payroll system

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

3 User Charges

	2013
	$'000
Sales of goods and services	6,237
Hospital fees	17,761
	23,998

4 Grants and other contributions

	2013
	$'000
Australian Government grants	
Nursing home grants	9,881
Home and community care grants	2,394
Specific purpose payments	5,956
Total Australian Government grants	18,232

	Share of funding		*2013*
	State	*Australian Government*	*$'000*
*National Health Reform**			
Activity based funding	132,111	68,126	
Block funding	63,916	27,800	
Teacher Training funding	9,966	4,365	
General purpose funding	99,488	-	
Total National Health Reform funding			405,772
Other			
Other grants			1,658
			425,662

* -The Australian Government pays it share of National Health funding directly to the Department of Health, for on forwarding to the Hospital and Health Service.

5 Other revenue

	2013 $'000
Sale proceeds for assets	10
Licences and registration charges	29
Recoveries	3,170
Reversal impairment loss*	873
Rental charges	230
Rental charges	86
	4,398

*Refer Note 2 (i).

6 Employee expenses

	2013 $'000
Employee benefits	
Wages and Salaries	
Annual leave levy*	1,031
Employer superannuation contributions*	141
Long service leave levy*	108
Redundancies	17
	1
Employee related expenses	
Workers compensation premium	6
Payroll tax	52
Other employee related expense	47
*	**1,403**

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

Number of Employees*	**5**

* Refer to Note 2(p).

Key executive management and personnel are reported in Note 30.

7 Health service labour expenses

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

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

8 Supplies and services

	2013 $'000
Consultants and contractors	36,650
Electricity and other energy	4,279
Patient travel#	21,213
Other travel	1,194
Building services	1,704
Computer services	1,511
Motor vehicles	520
Communications	2,817
Repairs and maintenance	6,504
Minor works including plant and equipment	1,065
Operating lease rentals	4,187
Inventories held for distribution	
Drugs	12,871
Clinical supplies and services	17,480
Catering and domestic supplies	4,916
Pathology, blood and parts	11,465
Other	4,533
	132,907

Includes aeromedical payments to Royal Flying Doctors and ambulance fees.

9 Grants and subsidies

	2013 *$'000*
Community	367
Mental health	94
	461

10 Depreciation and amortisation

Depreciation and amortisation expenses for the financial year were charged in respect of:	*2013* *$'000*
Buildings and land improvements	12,366
Plant and equipment	4,759
	* **17,125**

* Refer Note 18

11 Impairment losses

	2013 *$'000*
Plant and equipment	53
Bad debts written off*	167
	220

* Refer Note 14

12 Other expenses

	2013
	$'000
External audit fees*	89
Bank fees#	13
Insurance**	5,226
Losses from the disposal of non-current assets	79
Special payments - ex-gratia payments	11
Other legal costs	395
Advertising	107
Interpreter fees	33
Other	127
	6,079

*Total audit fees paid to the Queensland Audit Office relating to the 2012-13 financial year are $89,000. There are no non-audit services included in this amount.

** Includes payments to Department of Health representing share of the departments QGIF premium. Certain losses of public property and health litigation costs are insured with the Queensland Government Insurance Fund refer Note 2 (q).

Relates to general trust bank accounts only.

13 Cash and cash equivalents

	2013
	$'000
Imprest accounts	10
Cash at bank*	35,516
QTC cash funds*	4,119
	39,645

* Refer Note 27 restricted assets

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

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

14 Receivables

	2013
	$'000
Trade debtors	4,438
Payroll receivables	8
Less: Allowance for impairment	(264)
Sub total	4,182
GST receivable	792
GST payable	(55)
Sub total	736
Grants receivable	4,162
Total	9,080
Movements in the allowance for impairment loss	
Balance transferred in on establishment of HHS	1,137
Amounts written off during the year	(167)
Amount recovered during the year	-
Increase/(decrease) in allowance recognised in operating result	(706)
Balance at the end of the year	264

Trade debtors includes receivables of $3.1 million from health funds (reimbursement of patient fees) and $562 thousand from the Australian Government for Multi Purpose Health Services and Pharmacy Pharmaceutical Benefits Scheme claims. Payroll receivables represent interim cash payments and salary overpayments for executive staff.

15 Inventories

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

16 Other

	2013 $'000
Prepayments	610
	610

17 Assets classified as held for sale

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

* Licencing rights and other internally generated assets held by CQHHS for aged care services have not been recognised in the accounts as they do not meet the recognition criteria in accordance with AASB138 Intangible Assets.

In January 2013, CQHHS announced its intention to withdraw from the provision of Aged Care services and divest its share of residential aged care facilities (Eventide Rockhampton and North Rockhampton Nursing Centre) as a going concern to a private provider. Submissions closed on 14 June 2013. It is management's expectation that these facilities will be disposed within the next twelve months. Any voluntary redundancy offered to displaced staff will be funded by the State and cash proceeds from the sale will return to the State via consolidated fund.

18 Property, plant and equipment

	2013
	$'000
Land*	
At fair value	34,383
Buildings*	
At fair value	440,922
Less: Accumulated depreciation	(201,345)
	239,577
Plant and equipment	
At cost	50,603
Less: Accumulated depreciation	(27,066)
	23,537
Capital works in progress	
At cost	2,015
Total property, plant and equipment	299,513

* Refer Note 2 (g).

Land

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

In 2012-13 CQHHS engaged the State Valuation Service to provide indices for all land holdings at 14 February 2013 excluding properties which do not have a liquid market, for example properties under Deed of grant (recorded at a nominal value of $1.50). Indices are based on actual market movements for each local government area issued by the Valuer-General and were applied to the fair value of land transferred from the Department of Health on 1 July 2012. These land holdings were comprehensively revalued by the State Valuation Office in 2010-11 with indices from independent sources applied in 2011-12 by the department.

The revaluation program resulted in a increment of $1.6 million to the carrying amount of land.

Building

An independent revaluation of 86 per cent (net book value) of the building portfolio was performed during 2012-13 by independent quantity surveyors Davis Langdon. Valuations were based on the estimated replacement cost less the cost to bring the building to current standards. The valuation assumes a replacement building will provide the same service function and form (shape and size) as the original building but built consistent with current building standards.

The balance of assets (previously comprehensively revalued by the Department of Health) have had indices applied, approximating movement in market prices for labour and other key resource inputs, as well as changes in design standards as at reporting date. Only 1% of assets have never had a comprehensive revaluation, representing new constructions completed between 2009 - 2012. Refer Note 2 (m) for further details on the revaluation methodology applied.

Initial building valuations for 2012-13 resulted in a net increment to the HHS's building portfolio of $21.7 million. This was offset by a impairment to the value of buildings used in the delivery of aged care services of $5.3 million reflecting the board's decision to not replace these assets. These buildings were valued based on fair value less cost to sell rather than depreciated replacement cost in accordance with Queensland Treasury and Trade's Non-Current Asset Policies for the Queensland Public Sector, and subsequently transferred to Assets Held for Sale as at 30 June 2013.

CQHHS has plant and equipment with an original cost of $1.4 million or 0.03% of total plant and equipment gross value and a written down value of zero still being used in the provision of services. 35% of these assets with a gross cost of $209 thousand are expected to be replaced in 2013-14.

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

	Land	Buildings	Plant & equipment	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000
As at 1 July 2012	-	-	-	-	-
Acquisitions through restructuring (Note 2 g)	34,744	227,300	25,002	1,486	288,533
Acquisition major infrastructure transfers	-	12,497	-	-	12,497
Acquisitions	-	229	3,905	529	4,664
Disposals	-	-	(94)	-	(94)
Assets reclassified as held for sale	(2,855)	(3,602)	(488)	-	(6,945)
Transfer between classes	-	(8)	8	-	-
Transfers in from Public Health	-	-	15	-	15
Revaluation Increments/(decrements)	1,642	21,719	-	-	23,361
Impairment gains/(loss) recognised in equity	852	(6,192)	-	-	(5,340)
Impairment losses recognised in operating surplus/(deficit)	-	-	(53)	-	(53)
Depreciation charge - year	-	(12,366)	(4,759)	-	(17,125)
As at 30 June 2013	**34,383**	**239,577**	**23,537**	**2,015**	**299,513**

19 Payables

	2013
	$'000
Trade creditors	12,847
Accrued health service labour - Department of Health*	15,196
Other	4
	28,047

* Refer Note 2 (p) (i)

20 Accrued employee benefits

	2013
	$'000
Salaries and wages accrued	71
Other employee entitlements payable	8
	80

21 Unearned revenue

	2013
	$'000
Revenue in advance	42
	42

22 Asset revaluation surplus by class

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

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

* CQHHS policy decision to not replace current aged care facilities has resulted in a change in the valuation method applied from depreciated replacement cost to fair value less cost to sell.

23 Cash flows

Reconciliation of operating result to net cash flows from operating activities

	2013 *$'000*
Operating Result	18,735
Non-cash movements:	
Depreciation and amortisation	17,125
Depreciation grant funding	(16,982)
Net (gain)/loss on disposal/revaluation of non-current assets	78
Impairment loss on plant and equipment	53
Reversal of impairment loss receivables	(873)
Change in assets and liabilities after adjustment for transfers in form restructure:*	
(Increase)/decrease in receivables	10,334
(Increase)/decrease in grants receivables	(4,162)
(Increase)/decrease in GST receivables	(792)
(Increase)/decrease in GST receivables	(552)
(Increase)/decrease in prepayments	(128)
Increase/(decrease) in accounts payable	2,054
Increase/(decrease) in accrued contract labour	9,538
Increase/(decrease) in accrued employee benefits	79
(Increase)/decrease in GST payable	55
Increase/(decrease) in unearned grant revenue	(2)
Total non-cash movements	15,824
Cash flows from operating activities	**34,560**

* Refer Note 2 (g).

24 Non-cash financing and investing activities

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

25 Expenditure commitments

(a) Non-cancellable operating leases

	2013 *$'000*
Commitments under operating leases at reporting date are inclusive of anticipated GST and are payable as follows:	
Not later than one year	45
Later than one year and not later than five years	136
Total	181

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

(b) Capital expenditure commitments

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

	2013 *$'000*
	Plant and Equipment
Not later than one year	1,424
Total	1,424

26 Contingent assets and liabilities

(a) Litigation in progress

As at 30 June 2013, the following cases were filed in the courts naming the State of Queensland acting through the Central Queensland Hospital and Health Service as defendant:

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

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

b) Native Title

As at 30 June 2013, the Central Queensland Hospital and Health Services does not have legal title to properties under its control, refer Note 2 (g). The Department of Health remains the legal owner of health service properties. Currently two of these properties are subject to a Deed of Grant in Trust (land is held by traditional owners) and recorded at nominal value.

The Queensland Government's Native Title Work Procedures were designed to ensure that native title issues are considered in all land and natural resource management activities. All dealings pertaining to land held by or on behalf of the department must take native title into account before proceeding. These dealings include disposal, acquisition, development, redevelopment, clearing, fencing and the granting of leases, licences or permits and so on. 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.

Queensland 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 six native title claims against property under the control of the Central Queensland Hospital and Health Service.

c) Other contingencies

The following liabilities are contingent upon future Government and management decisions:

Property maintenance backlog - this represents the total cost of repairs, maintenance and assets due for replacement, over the next four years. The total commitment is dependent on final negotiations with the Department of Health. CQHHS estimated share of backlog maintenance over the next four years (as at 31 December 2012) is:

	2013
	$'000
	Buildings
Not later than one year	705
Later than one year and not later than five years	2,115
	2,820

27 Restricted assets

CQHHS receives cash contributions primarily from private practice clinicians and external entities to provide for education, study and research in clinical areas. Contributions are also received from benefactors in the form of gifts, donations and bequests for stipulated purposes. At 30 June 2013, amounts of $4.3 million in General Trust, $0.362 million for excess earnings under Right of Private Practice option B and $6.3 thousand for Clinical Drug Trials, were set aside for the specified purposes underlying the contribution.

	2013
	$'000
Right of Private Practice (ROPP) Option B receipts and payments	
*Receipts**	
Billings - Option B (Doctors and Visiting Medical Officers)	623
Total receipts	623
*Payments**	
Payments to Doctors	426
Hospital and Health Service recoverable administrative costs	90
Hospital and Health Service education/travel fund	54
Total payments	570
Right of Private Practice trust assets	
Current assets	
Cash at bank and on hand at beginning	295
Travel fund excess receipts	54
Interest earnings	13
Closing balance cash at bank	**362**

*Under the agreement for Right of Private Practice (Option B) all receipts and payments are included by CQHHS in its operating result. Any excess of billings over the upper threshold established for doctors is restricted and placed into the general trust fund for specific educational and travel purposes.

All monies received for Right of Private Practice (Option A & B) are deposited into a separate trust bank account. Funds relating to ROPP Option B are subsequently deposited into the CQHHS operating bank account and included in the receipts and payments disclosed above. In addition to the restricted cash balance of $362 thousand, a further $37 thousand is held in the Right of Private Practice Trust bank account at 30 June 2013.

28 Fiduciary trust transactions and balances

CQHHS acts in a custodial role in respect of these transactions and balances. As such, they are not recognised in the financial statements, but are disclosed below for information purposes.

		2013
		$'000
Patient Trust receipts and payments		
Receipts		
Patient trust receipts		4,338
Total receipts		4,338
Payments		
Patient trust related payments		4,435
Total payments		4,435
Increase/ in net patient trust assets		(97)
Patient trust assets transferred from Department of Health on 1 July 2012		1,007
Patient trust assets		
Current assets		
Cash at bank and on hand		537
Patient trust and refundable deposits		373
Total current assets	*	**910**

** Eventide Rockhampton and North Rockhampton Nursing Centre represent $693k of patient trust funds*

29 Financial Instruments

(a) Categorisation of financial instruments

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

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

(b) Financial risk management

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

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

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

(c) Credit risk exposure

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

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

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

No collateral is held as security and no credit enhancements relate to financial assets held by CQHHS.

CQHHS manages credit risk through the use of a credit management strategy. This strategy aims to reduce the exposure to credit default by ensuring that CQHHS invests in secure assets and monitors all funds owed on a timely basis. Exposure to credit risk is monitored on an ongoing basis.

No financial assets have had their terms renegotiated as to prevent them from being past due or impaired and are stated at the carrying amounts as indicated. No financial assets and financial liabilities have been offset and presented net in the Statement of Financial Position.

Through out the year, CQHHS assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. Objective evidence includes financial difficulties of the debtor, changes in debtor credit ratings and current outstanding accounts over 120 days. The allowance for impairment reflects CQHHS's assessment of the credit risk associated with receivables balances and is determined based on historical rates of bad debts (by category) over the past three years and management judgement.

The allowance for impairment reflects the occurrence of loss events. If no loss events have arisen in respect of a particular debtor, or group of debtors, no allowance for impairment is made in respect of that debt/group of debtors.

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

Financial assets past due but not impaired 2012-13

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

Individually impaired financial assets 2012-13

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

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

(d) Liquidity risk

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

CQHHS is exposed to liquidity risk through its trading in the normal course of business and aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations at all times. An approved debt facility of $4.5 million under Whole-of-Government banking arrangements to manage any short term cash shortfalls has been established.

(e) Market risk

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

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

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

(f) Interest rate risk

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

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

(g) Fair value

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

30 Key executive management personnel and remuneration

(a) Key executive management personnel

The following details for key executive management personnel include those positions that had authority and responsibility for planning, directing and controlling the activities of CQHHS 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..

Position	*Responsibilities*	*Current Incumbents*	
		Contract classification and appointment	*Date appointed to position (date resigned*
Health Service Chief Executive	Responsible for the overall leadership and management of the Central Queensland Hospital and Health Service to ensure that CQHHS meets its strategic and operational objectives.	s24 & s70 Appointed by Board under *Hospital and Health Board Act 2011* (Section 7 (3)).	1 July 2012 to 30 June 2013.
Chief Operations Officer	Responsible for strategic direction, and operational functions for CQHHS clinical operations.	HES 2 Appointed by Chief Executive (CE) under *Hospital and Health Board (HHB) Act 2011*	1 July 2012
Chief Finance Officer	Responsible for management and oversight of the CQHHS finance framework including financial accounting processes, budget and revenue systems, activity measurement and reporting, performance management frameworks and financial-corporate governance systems.	HES 2 Appointed by CE under *HHB Act 2011*	1 July 2012
Executive Director, Medical Services	Responsible for strategic and professional responsibility for CQHHS medical workforce, and clinical governance.	MMOI1-MMOI2 Appointed by CE under *HHB Act 2011*	29 Aug 2011 - 2 June 2013.
District Director, Nursing	Responsible for strategic and professional leadership of nursing workforce .	NRG11 Appointed by CE under *HHB Act 2011*	29 April 2013
District Director, Nursing			Acting 26 Nov 2012 - 28 April 2013
District Director, Nursing			1 July 2012 - 25 Nov 2012
Executive Director, People and Culture	Responsible for provision of leadership and oversight of human resource, occupational health and safety functions, Indigenous training and development, and cultural awareness programs for the Health Service.	HES 2 Appointed by CE under *HHB Act 2011*	1 July 2012
Executive Director, People and Culture			Acting 6 Mar 2013 to 30 June 2013
Executive Director, Corporate Services	Responsible for management of corporate service functions including capital works projects, asset management, legal issues, contract management and non financial-corporate governance systems.	DSO1 Appointed by CE under *HHB Act 2011*	Acting 1 July 2012 to 30 June 2013

(b) Remuneration

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

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

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

- Short-term employee benefits which include:
  - Base – consisting of base salary, allowances and leave entitlements paid and provided for the entire year or for that part of the year during which the employee occupied the specified position. Amounts disclosed equal the amount expensed in the Statement of Comprehensive Income.
  - Non-monetary benefits – consisting of provision of vehicle and expense payments together with fringe benefits tax applicable to the benefit.

- 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.

- Performance bonuses are not paid under the contracts in place.

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

1 July 2012 - 30 June 2013

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

(c) Board remuneration

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

Board member	Position	Date of appointment
Roy (Charles) Ware	Chairperson Board member	2 November 2012 29 June to 1 November 2012
Robert Miles	Chairperson Board member	29 June to 1 November 2012 2 November 2012 to 19 May 2013
Bronwyn Christensen	Board member	29 June 2012
Kurt Heidecker	Board member	29 June 2012
Leone Hinton	Board member	29 June 2012
Francis Houlihan	Board member	9 November 2012
Dr David Austin*	Deputy Chair	29 June 2012
Dr David Shaker*	Board member	29 June 2012 to 19 May 2013
Sandra Corfield	Board member	18 May 2013
Elizabeth Baker	Board member	18 May 2013
Karen Smith*	Board member	18 May 2013
Graeme Kanofski	Board member	18 May 2013

Remuneration paid or owing to Board members during 2012-13 was as follows:

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

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

5.1.6. Certificate of Central Queensland Hospital and Health Service

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

a) the prescribed requirements for establishing and keeping the accounts have been complied with in all material respects; and

b) the statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Central Queensland Hospital and Health Service for the financial year ended 30 June 2013 and of the financial position of the Hospital and Health Service at the end of that year.

Charles Ware	Rod Boddice	Colin Bartlem
Chairperson, BA, LLB (Hons) MBus, LLM	B. Science, G.D. Nutrition & Dietetics, B. Business, G.D. Management	MAcc, MBA
Chair CQHH Board	Interim Chief Executive Officer	Acting Chief Finance Officer
23/8/13	23/08/2013	23/8/13

5.1.7. Independent Auditor's Report

INDEPENDENT AUDITOR'S REPORT

To the Board of Central Queensland Hospital and Health Service

Report on the Financial Report

I have audited the accompanying financial report of Central Queensland Hospital and Health Service, which comprises the statement of financial position as at 30 June 2013, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and certificates given by the Chair, Interim Chief Executive Officer and the Acting Chief Finance Officer.

The Board's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

Independence

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

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

Opinion

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

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

(b) in my opinion –

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

(ii) the financial report presents a true and fair view, in accordance with the prescribed accounting standards, of the transactions of the Central Queensland Hospital and Health Service for the financial year 1 July 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.

QUEENSLAND
30 AUG 2013
AUDIT OFFICE

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

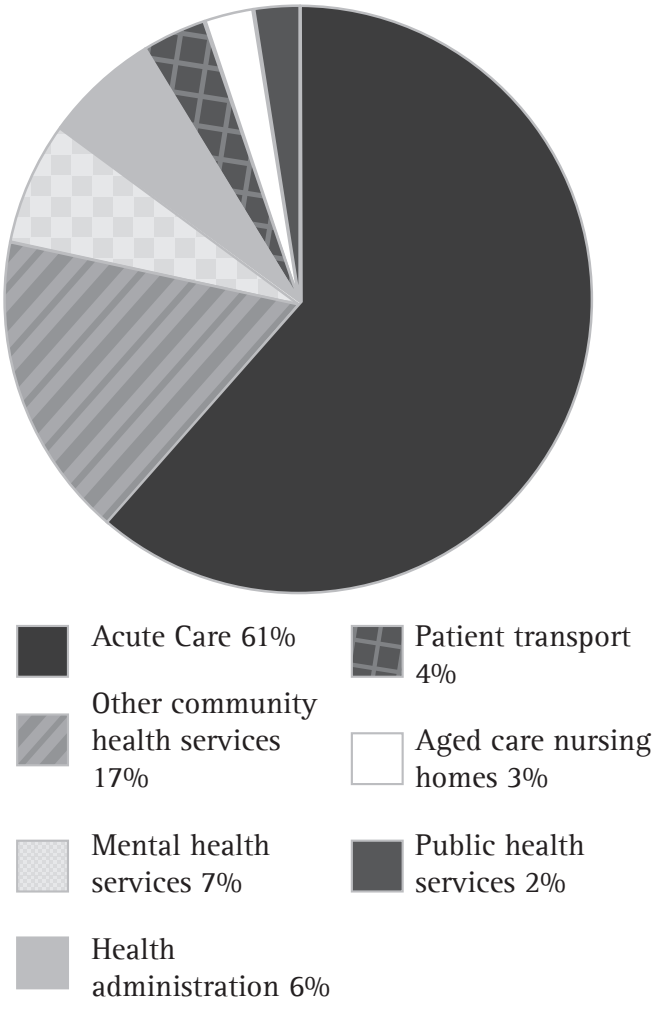
Queensland Audit Office
Brisbane

5.2. How the money was spent

CQHHS is responsible for the delivery of public hospital and health services in line with government priorities. The cost of these services in 2012-13 are outlined in **Chart 1** below:

CQHHS is actively pursuing partnerships with the Central Queensland Medicare Local and GPs, as well as the private and non-government health sectors, to clarify its role in primary health care service delivery and to better configure its hospital and hospital-related services to improve health outcomes within the community.

Chart 1: Expense by purchase



5.3. Sources of funding

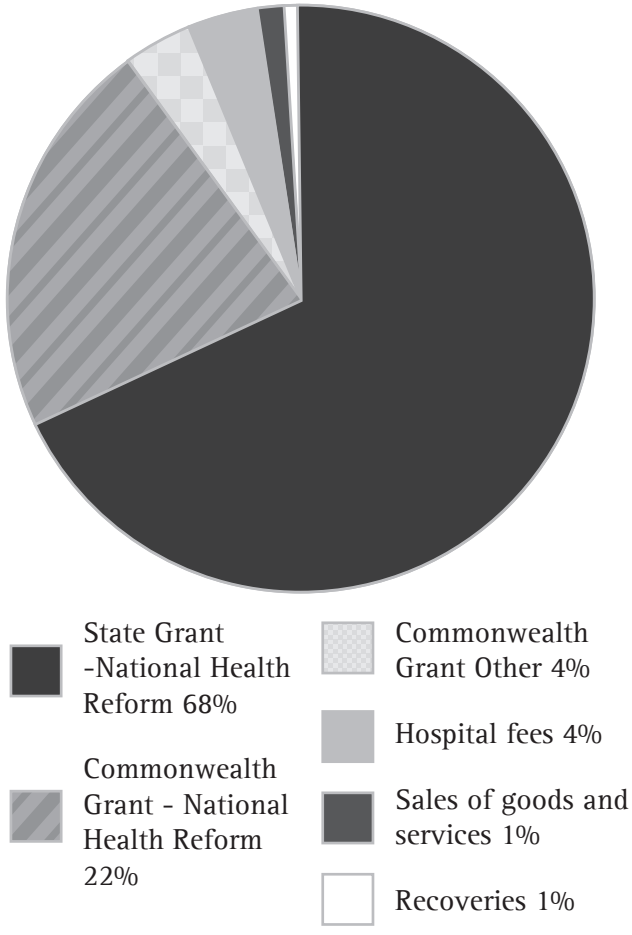
In providing services to the public, CQHHS's predominate source of funding is grants from both the State and Australian Governments. **Chart** 2 demonstrates all sources of funding and their contribution to total income for 2012-13.

5.4. Other financial impacts

In January 2013, CQHHS announced its intention to withdraw from the provision of aged care services and divest its share of residential aged care facilities (Eventide Rockhampton and North Rockhampton Nursing Centre) to a private provider. Submissions closed on 14 June 2013. It is management's expectation that these facilities will be disposed within the next twelve months. Any voluntary redundancy offered to displaced staff will be funded by the State.

During the financial year CQHHS conducted a revaluation of its land and building portfolio. This resulted in an increase in land values of 4.7% and buildings 9.6% reflecting the rising cost to replace specialised buildings and improvements in the market value of properties within the region.

Chart 2: Revenue by source



5.5. Comparison of actual financial results with budget

CQHHS's actual performance in comparison to its budget as published in the State Budget Papers 2013-14 Service Delivery Statements are presented in the following tables 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 from Operations				
User Charges	1	24,148	21,374	13%
Grants and other contributions	2	425,511	409,947	4%
Interest		225	240	-6%
Other revenue	3	4,398	328	1241%
Total income		454,283	431,889	5%
Expenses from Operations				
Employee expenses	4	1,403	498	182%
Health service labour expenses	5	277,352	270,098	3%
Supplies and services	6	132,908	134,680	-1%
Grants and subsidies	7	461	9,218	-95%
Depreciation and amortisation	8	17,125	15,570	10%
Impairment losses	9	220	-	100%
Other expenses	10	6,079	1,825	233%
Total Expenses from Operations		435,548	431,889	1%
Total Operating Results		18,735	-	

Notes:

1 Variation is a result of improved performance for owned source revenue such as private prosthetics, inpatient fees and radiology services combined with higher reimbursements from the Pharmaceutical Benefits Scheme.

2 Increase reflects additional grant funding as a result of amendments to the Service Agreement between CQHHS and the Department of Health, including growth in activity and non-labour escalation.

3 Recovery of Health Service labour costs from third parties such as universities were treated as contra expenses in the budget but other revenue in the actuals.

4 Reclassification of Health Executive costs from Health service labour expenses to employee expenses.

5 Growth in activity to support additional services purchased through the Service Agreements between CQHHS and the Department of Health. This is offset by the growth in grant funding revenue.

6 After adjustments for reclassifications from grants and other expenses, supplies and services experienced a decline representing tightening in fiscal spending.

7 Primarily represents the reclassification of aeromedical services from grants to supplies and services.

8 Early completion of building projects in 2011-12 resulted in depreciation charges in 2012-13 exceeding original forecasts.

9 Impairment losses represent bad debts and obsolete minor equipment written off during the year. These losses were not forecast at the time of the budget.

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

Table 2: Statement of financial position as at 30 June 2013

	Notes	2012-13 Actual	2012-13 Budget	Variance
		$'000	$'000	%
Current Assets				
Cash and cash equivalents	11	39,645	8,075	391%
Receivables	12	9,080	6,380	42%
Inventories		2,901	2,328	25%
Other		610	644	-5%
		52,237	17,427	200%
Assets classified as held for sale	13	12,299	-	100%
Total Current Assets		64,535	17,427	270%
Non-Current Assets				
Property, plant and equipment	14	299,513	341,022	-12%
Total Non-Current Assets		299,513	341,022	
Total Assets		364,048	358,449	2%
Current Liabilities				
Payables	15	28,047	15,758	78%
Accrued employee benefits		79	10	687%
Unearned revenue		42	-	100%
Total Current Liabilities		28,168	15,768	79%
Total Liabilities		28,168	15,768	
Net Assets		335,880	342,681	-2%
Equity				
Contributed equity	16	293,784	340,612	-14%
Accumulated surplus/ (deficit)		18,735	-	
Asset revaluation surplus	17	23,361	2,069	1029%
Total Equity		335,880	342,681	-2%

Notes:

11 The improved cash position reflects higher operating results plus additional cash as a flow on from a change in the timing of the pay date in October 2012. This has led to higher than forecast payables for labour costs. Refer Note 15.

12 Additional grants receivable from the Department of Health representing the final variation in the Service Agreement for 2012-13 has resulted in higher receivables than forecast at budget time.

13 As a result of the recommendations in the Forster Report on National Health Reform, the Board announced its decision to divest CQHHS from the provision of aged care facilities. The associated assets are now classified as assets held for sale. This was not forecast at the time of the original budget.

14 Delays in completion of buildings by the Department (transferred to CQHHS on commissioning) combined with higher depreciation charges has resulted in lower net book values being recorded for Property Plant and Equipment. Declines were partially offset by higher than anticipated revaluations for land and buildings - refer Note 17.

15 A consequential flow on from a change in the timing of the pay date (for labour costs) is a significant increase in payables outstanding. The timing of recoupment of costs and charges for medical services such as pathology and patient ambulance fees between the Department of Health and CQHHS has also contributed to higher payables at 30 June 2013.

16 A delay in commissioning of buildings has resulted in lower than forecast transfers from the Department of Health to CQHHS. These transfers are represented as contributions from owners - see Note 14.

17 The budget revalued land and buildings using an index supplied by Treasury based on CPI, however the growth in real costs associated with buildings was approximately 9.6%.

5.6. Post balance date events

To the best of our knowledge and belief there have been no material changes subsequent to the period 1 July 2012 to 30 June 2013. Up to 28 August 2013 there have been no issues in relation to the CQHHS control environment that would present a significant risk to CQHHS financial reporting.

5.7. Department of Health - Management assurance

A management assurance report has been provided by the Department of Health to CQHHS confirming that the Department of Health has had appropriate controls in place in relation to key business services delivered by the department.

5.8. Future outlook

The introduction of the National Efficient Price (NEP) funding model from 2013-14 presents considerable challenges for CQHHS. The two Activity-Based Funded (ABF) facilities are Rockhampton and Gladstone Hospitals. These represent less than 50% of the total CQHHS budget allocation, with the remaining budget allocated to non-ABF facilities across the rural health, community-based mental health and aged care sectors.

The model of the Department of Health being the purchaser of services and CQHHS the provider of services will continue to develop. The need for CQHHS to establish a stronger Health Needs Assessment with a stronger understanding of the future needs is required and will be one of the focus areas for the next medium term. In addition, CQHHS is required to continue on the efficient and effective journey to ensure the delivery of the services is provided within the NEP.

The success of CQHHS in achieving most of its KPIs will need to be maintained and those services and defined performance indicators and targets continually recognised to ensure outputs and outcomes are achieved.

CQHHS has an operating budget of $447.1 million for the 2013-14 financial year, an increase of 2.7% above the 2012-13 actual expenditure of $435.5 million. The 2013-14 budget allocation includes funding reductions of $12.45 million in relation to the achievement of savings targets. CQHHS is required to achieve 62,991 Queensland Weighted Activity Units (QWAUs) for 2013-14, an increase of 4.1 % above the actual QWAUs achieved in 2012-13. To maintain budget integrity, CQHHS will need to improve efficiency in service delivery cost by reducing its cost per QWAU by $102.

A project to expand Rockhampton Hospital is underway. This has delivered a number of improvements to the hospital including a new Emergency Department which was opened in April 2011. A Regional Cancer Care Centre on the Rockhampton Hospital site comprising radiation oncology and day oncology is scheduled to be completed in 2014. This will reduce referrals to metropolitan hospitals for assessment and treatment.

5.9. Tier 1 Key performance indicators

	2012-13 Target/ Estimate	2012-13 Estimated Actual	2012-13 Actual
Performance measure as published in the 2012-13 SDS	*(published target in 2012-13 Service Delivery Statement)*	*(published estimated actual data in 2013-14 Service Delivery Statement)*	*(Actual data as at 30 June 2013*
"Variance Reporting *1. (variance reporting does not need to be lengthy, it just has to be clear to a user of the Annual Report as to what happened over the year's performance)."*			
E4: National Emergency Access Target (NEAT) % of Emergency Department attendances who depart within 4 hours of their arrival in the Emergency Department	77.00%	80.00%	79.80%
"Variance Reporting: CQHHS has met and exceeded the NEAT Target for attendances who depart within 4 hours of their arrival in the Emergency Department"			
E5:Emergency Department: % seen within recommended time frame			
E5.1: Category 1 (within 2 minutes)	100.00%	100.00%	100.00%
"Variance Reporting: All Category 1 patients are being seen immediately upon arrival in the Emergency Department"			
E5.2: Category 2 (within 10 minutes)	80%	80.00%	86.90%
"Variance Reporting: CQHHS has met and exceeded the target for Category 2 patients seen in time"			
E5.3: Category 3 (within 30 minutes)	75.00%	75.00%	80.80%
"Variance Reporting: CQHHS has met and exceeded the target for Category 3 patients seen in time"			
E5.4 Category 4 (within 60 minutes)	70.00%	70.00%	75.30%
"Variance Reporting: CQHHS has met and exceeded the target for Category 4 patients seen in time"			
E5.5 Category 5 (within 120 minutes)	70.00%	70.00%	90.10%
"Variance Reporting: CQHHS has met and exceeded the target for Category 5 patients seen in time"			
E6: Patient Off Stretcher Time (POST): < 30minutes (%)	90.00%	N/A	97.00%
"Variance Reporting: CQHHS has met and exceeded the target for Patient Off Stretcher Time"			

	2012-13 Target/ Estimate	2012-13 Estimated Actual	2012-13 Actual
E7: Elective Surgery: % treated within clinically recommended time frames			
E7.1: Category 1: within 30 days	100.00%	100.00%	98.50%
"Variance Reporting: CQHHS has achieved 100% throughout the majority of the 2012-13 Financial Year. The last 3 months of the 2012-13 Financial Year an average of just under 98% was achieved"			
E7.2: Category 2: within 90 days	87.00%	91.00%	90.40%
"Variance Reporting: CQHHS has met and exceeded the target for Category 1 patients being seen in time"			
E7.3: Category 3: within 365 days	94.00%	96.00%	100.00%
"Variance Reporting: CQHHS has met and exceeded the target for Category 3 patients being seen in time"			
E8 Elective Surgery: Number of patients waiting more than the clinically recommended time frame:			
E8.1: Category 1: within 30 days	0	0	0
"Variance Reporting: CQHHS was the only HHS in Queensland to achieve 0 for Category 1 patients seen within clinically recommended time frames"			
E8.2: Category 2: within 90 days	0	0	0
"Variance Reporting: CQHHS was the only HHS in Queensland to achieve 0 for Category 2 patients seen within clinically recommended time frames"			
E8.3: Category 3: within 365 days	0	0	0
"Variance Reporting: CQHHS was the only HHS in Queensland to achieve 0 for Category 3 patients seen within clinically recommended time frames"			
E9: Activity: variance between Purchased activity and Year to Date activity:			
E9.1: Inpatients			1,613.7
E9.2: Outpatients			1,334.10
E9.3: Emergency Department			92.90
E9.4: Mental Health			-32.00
E9.5: Critical Care			31.40
E9.6: Sub and Non-Acute Patients			-648.50

Chapter 6

Our future

CQHHS is proud of its achievements in 2012-2013 and will continue to build a service of excellence of which the community can be proud and be assured of its high quality standards in health care provision.

Service reviews and reform will focus on the delivery of front line services to our community. We will achieve this by:

- realigning organisational structures and functions to deliver key priorities, functions and objectives
- developing a Contestability Unit to ensure value for money in the delivery of clinical services and non-clinical support
- inviting staff involvement in the identification of initiatives and efficiencies
- realising opportunities for revenue optimations
- opening of the Regional Cancer Care Centre at Rockhampton
- revising service models to prioritise sub-acute and ambulatory care provision
- developing District Service Plans for Surgery, Maternity and Paediatric services
- underpinning access to health services in rural communities through telehealth
- addressing and improving key population health challenges and risks
- supporting the Government commitments to revitalise frontline services for families and deliver better infrastructure
- enhancing engagement and developing closer working relationships with patients, families, community groups, GPs and other primary health providers.

In this Chapter

Chapter 6

6.1. The future operating environment

The introduction of the National Efficient Price (NEP) funding model from 2013-2014 presents considerable challenges for CQHHS. The two Activity-Based Funded (ABF) facilities of Rockhampton and Gladstone Hospitals represent less than 50% of the total Central Queensland HHS Budget allocation, with the remainder allocated to non-ABF facilities across the rural health, community-based and mental health sectors. The NEP will require changes in practice for clinical and governance models of care to achieve enhanced efficiency.

6.2. Resources and performance

CQHHS has an operating budget of $447.1 million for 2013-14 which is an increase of $15.2 million (3.5%) from its 2012-13 operating budget of $431.9 million.

The Service Agreement between CQHHS and the Department of Health (see Appendix page 124) identifies the services to be provided, the funding arrangements for those services and defined performance indicators and targets to ensure outputs and outcomes are achieved. CQHHS was among the top three performers in 2012-2013 against all Performance KPIs identified in the Service Agreement and aims to maintain that level of performance in 2013-2014.

The CQHHS *Strategic Plan 2013-2017* reflects local priorities in line with whole-of-Government statewide plans and commitments. CQHHS will pursue specific projects during 2013-2014.

6.3. Key projects

6.3.1. Gladstone Health Plan

CQHHS is committed to enhancing its reputation in Gladstone. As a member of the Gladstone Health Partnership, CQHHS is contributing to the development of a Health Plan for Gladstone and surrounding communities. The Health Plan will reflect the current and future health needs of the region.

6.3.2. Moura Hospital

Negotiations in 2013 with the Moura Community Reference Group achieved and agreement to implement a Community Hospital model. This service model will be delivered from a newly constructed facility.

6.3.3. Recruitment and selection processes (maintain MOHRI)

CQHHS is required to meet an agreed Minimal Obligatory Human Resource Indicators (MOHRI) target of 2,696 FTE staff for 2013-2014. Work redesign and changes to models of care are needed to improve efficiencies in service delivery and achieve the MOHRI target.

6.3.4. Relationship building

CQHHS is actively pursuing partnerships with the Central Queensland Medicare Local and GPs, as well as the private and non-government health sectors, to clarify its role in primary health care service delivery within the community. Our Clinical Engagement Strategy will be implemented in 2013-2014 and will result in the establishment of a clinical leaders forum for the region which addresses matters of clinical leadership and best practice in public and private practice. We will continue to engage with service providers to enhance and underwrite our service delivery achievements for the region.

6.3.5. Regional Cancer Care Centre

CQHHS is focused on developing the range of acute and ambulatory services that promote regional self-sufficiency for health care provision over the next 10 to 15 years. The Regional Cancer Centre being constructed at Rockhampton Hospital will allow a range of oncology services, including radiation oncology, to be delivered locally and reduce referrals to metropolitan hospitals for assessment and treatment.

6.3.6. Capital infrastructure and maintenance program

The CQHHS Asset Management Plan and Annual Maintenance Plan outlines the building and infrastructure maintenance program for the 2013-2014 financial year.

CQHHS will be undertaking a significant body of work on the Backlog Maintenance Remediation Program (BMRP) in 2013-2014 particularly around Biloela, Emerald and Gladstone. As part of the four year BMRP, CQHHS has committed to deliver $2.3 million of these works in the

2013-2014 year which will include Biloela and Emerald. These works will be undertaken in conjunction with significant works occurring under the Rural and Remote Infrastructure Rectification Works Program (RRIRWP) totalling $15 million.

Appendices

7. Compliance checklist

Summary of requirement		Basis for requirement	Annual Report reference
Letter of compliance	• A letter of compliance from the accountable officer or statutory body to the relevant Minister	ARRs – section 8	Page vi
Accessibility	• Table of contents • Glossary	ARRs – section 10.1	Page vii Page 128-131
	• 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 iii
	• Agency role and main functions	ARRs – section 11.2	Page iii
	• Operating environment	ARRs – section 11.3	Page iv
	• Machinery of Government changes	ARRs – section 11.4	Page 20
Non-financial performance	• Government objectives for the community	ARRs – section 12.1	Page 38
	• Other whole-of-government plans/ specific initiatives	ARRs – section 12.2	Page 39
	• Agency objectives and performance indicators	ARRs – section 12.3	Page 96-97
	• Agency service areas, service standards and other measures	ARRs – section 12.4	Page 96-97
Financial performance	• Summary of financial performance	ARRs – section 13.1	Page 92-94
	• Chief Finance Officer (CFO) statement	ARRs – section 13.2	Not applicable

Appendices

Summary of requirement		Basis for requirement	Annual Report reference
Governance – management and structure	• Organisational structure	ARRs – section 14.1	Page 19
	• Executive management	ARRs – section 14.2	Page 17-18
	• Related entities	ARRs – section 14.3	Not applicable
	• Boards and Committees	ARRs – section 14.4	Page 8-16
	• Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* (section 23 and Schedule) ARRs – section 14.5	Page 5
Governance – risk management and accountability	• Risk management	ARRs – section 15.1	Page 15
	• External scrutiny	ARRs – section 15.2	Page 15
	• Audit committee	ARRs – section 15.3	Page 14
	• Internal audit	ARRs – section 15.4	Page 15
	• Public Sector Renewal Program	ARRs – section 15.5	Page ii
	• Information systems and record keeping	ARRs – section 15.7	Page 21
Governance – human resources	• Workforce planning, attraction and retention and performance	ARRs – section 16.1	Page 2
	• Early retirement, redundancy and retrenchment	Directive No. 11/12 Early *Retirement, Redundancy and Retrenchment* ARRs – section 16.2	Page 5
	• Voluntary Separation Program	ARRs – section 16.3	Page 5
Open Data	• Open Data	ARRs – section 17	Inside front cover
Financial Statements	Certification of financial statements	FAA – section 62	Page 89
		FPMS – sections 42, 43 and 50	Page 89
		ARRs – section 18.1	Page 89
	Independent Auditors Report	FAA – section 62	Page 90-91
		FPMS – section 50	Page 90-91
		ARRs – section 18.2	Page 90-91
	Remuneration disclosures	*Financial Reporting Requirements for Queensland Government Agencies* ARRs – section 18.3	Page 86-88

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

8. CQHHS Strategic Plan: 2013–17

Message from CQHHS Chair

The Central Queensland Hospital and Health Service (CQHHS) Strategic Plan 2013-2017 communicates to our staff and to the Central Queensland community the broad direction for local health, and will be continually informed by stakeholder expectations.

As the delivery of public health services in Central Queensland continues to evolve under the National Health Reform, our ethos remains the same – we are here to serve and meet the ever-changing needs of our community.

CQHHS is implementing a business-oriented model of service delivery to ensure it can continue to meet the needs of communities across the diverse area that is Central Queensland.

This continuing transition will ensure we are well placed to meet demands within our environment of continuing legislative reform, fiscal constraints, transport limitations, dynamic population growth, increasing burden of diseases, and technology advances.

CQHHS will continue to consult and plan, identify the issues, develop innovative solutions, encourage partnerships and empower its workforce with the single focus of serving the health needs of our community.

Regards

Charles Ware
Chair
Central Queensland
Hospital and Health Board

Our Role

On 1 July 2012, the Central Queensland Hospital and Health Service (CQHHS) commenced operation as an independent statutory body overseen by a local Hospital and Health Board.

With a 2013-14 budget of almost $450 million and with approximately 2530 full time equivalent (FTE) staff the HHS is one of the largest employers in the region.

The Central Queensland HHS is responsible for the delivery of public hospital and health services including medical, surgical, emergency, obstetrics, paediatrics, specialist outpatient clinics, mental health, critical care and clinical support services from Miriam Vale in the south, inland to the Southern and Central Highlands and north along the Capricorn Coast, serving a population of around 225,000 people.

CQHHS is responsible for the direct management of facilities including:

- Rockhampton Hospital
- Gladstone Hospital
- Capricorn Coast Hospital (Yeppoon)
- Moura Hospital
- Emerald Hospital, and
- Biloela Hospital.

CQHHS has identified key challenges and risks that may impact on our ability to achieve the Mission and Vision:

- **Culture** – create a supportive environment that promotes a learning culture, aligns performance with strategic objectives and recognises our people for their contributions.

- **Workforce** – develop strategies to build capacity and capability through the retention of existing and recruitment of permanent staff to the right role, at the right time and in the right place across Central Queensland.

- **Access** – continue to develop services as close to where people live as possible based on the local health needs and changing environments (population, burden of disease, economy and medical advances).

- **Infrastructure** – closely monitor the infrastructure, resources, skills and technological requirements, ensuring sound planning for the continuous improvement of the capacity of our region's health services.

- **Resources** – continue the efficient and effective delivery of safe and sustainable health services across Central Queensland while ensuring budget integrity.

- **Partnerships** – develop evidence-based, integrated models of care in partnership with Government, Non-Government and the private sectors.

- **Transport** – continue to engage with our stakeholders to improve the availability and efficiency of linkages between cities, towns and communities.

However CQHHS has identified key priorities including:

- providing better access to health services
- addressing and improving key population health challenges and risks
- supporting the Government commitments to revitalise frontline services for families and deliver better infrastructure
- enhancing engagement and developing closer working relationships with patients, families, community groups, GPs and other primary health providers.

Leading to our vision of ...

Delivering quality, integrated health services focused on the patient

Mission: Delivering quality, evidence-based, integrated health services focused around the patient's journey, that are effective, efficient and meet the needs of the community

Values We will ...

Care
... and provide care for our communities, individuals, groups and stakeholders

Collaboration
... work with other providers, educators and researchers, our communities and stakeholders

Commitment
... always direct our efforts to delivering the best health care to Central Queenslanders

Innovation
... utilise and contribute to the development of new and effective practices

Integrity
... be accountable in everything we do

Respect
... everyone we deal with in all that we do

Delivering integrated health services in partnership with other providers

- Work with stakeholders to ensure integrated delivery of contemporary health care
- Work with our partners to report and monitor health outcomes
- Collaborate with communities to facilitate access to timely and appropriate health care for all
- Implement innovative communication strategies to reach at-risk and vulnerable groups

Providing accessible, sustainable, networked services in a quality framework

- Develop seamless models of service delivery across the Central Queensland Hospital and Health Service
- Integrate local hospitals and their associated community services
- Provide continuity of care for patients, families and carers
- Provide care for patients at home or as close to their home as possible
- Develop a model to ensure the community has equity of access to quality and timely health care

Striving for better care in Central Queensland

- Develop regional capacity, experience and knowledge to deliver best practice health care
- Provide targeted, innovative and appropriate care for patients across the region
- Develop evidence-based practice to deliver integrated and effective quality health care
- Support effective clinical practice through research and education
- Use information technologies to provide consistent health service data to inform health service provision

Providing a great place to work

- Develop and foster a positive organisational culture
- Attract and retain a high quality, responsive, skilled professional workforce
- Be an employer of choice
- Commit to continuous development of staff skills

Engage with clinicians, consumers and community

- Develop sound communication, information and knowledge networks
- Establish partnerships with local communities
- Enhance community engagement and improve health literacy
- Promote healthy lifestyles

Living within our means

- Effectively advocate for the changing needs of our communities
- Promote best-practice accountability and transparency
- Deliver cost-effective services, maximise value and resource planning for the future

Motto — One Service, Many Providers

Strategic Directions and Strategies

1. Delivering integrated health services in partnership with other providers

Objective	Measure
1.1. Working in partnership with stakeholders to establish effective multidisciplinary teams to ensure integrated service delivery of contemporary healthcare.	Service delivery models demonstrate input from private sector and tertiary education providers Chronic Disease Management Taskforces implemented
1.2. Working with our partners to monitor and report health outcomes of our region's population.	Rio Tinto-facilitated Health Community Collaborative Committee in Gladstone Inter-agency CQ Clinical Leaders Forum Community-based Advisory Groups in rural communities
1.3. Collaborating with community partners to facilitate access to timely and appropriate health care by identified at-risk and vulnerable groups (e.g. Aboriginal and Torres Strait Islander peoples, refugees, offenders and those of culturally and linguistically diverse (CALD) origins).	Membership of inter-agency service planning and review forums
1.4. Implementation of innovative communication strategies to reach at-risk and vulnerable groups in regional and rural areas.	

2. Providing accessible, sustainable, networked services in a quality framework

Objective	Measure
2.1 Developing seamless models of service delivery which integrate across CQHHS to ensure a smooth transition throughout the patient journey.	Public/private health sector agreements for shared staff appointments District-wide Service Models
2.2 Integration of local hospitals and their associated community services.	Integrated acute, subacute and ambulatory care models developed
2.3 Provision of continuity of care for patients, families and carers within the system.	Extended Emergency Care Models at Rockhampton and Gladstone Hospitals Acute Primary Care Clinics at Rockhampton and Gladstone Hospitals National Partnership Agreement on Treating More Public Dental Patients
2.4 Provision of care for patients either at home or as close as possible to where the patient lives.	Community-based service models for palliative care, hospital avoidance and alternatives-to-hospital care
2.5 Development of a model for cohesive health and hospital services to ensure all the community has equity of access to quality and timely health care by using hub-and-spoke and other integrated models.	Step-down Rehabilitation and Subacute Service Models

3. Striving for better care in Central Queensland

Objective	Measure
3.1 Development of the regional capacity, experience and knowledge to deliver internationally benchmarked best practice in health care and service delivery.	District-wide Service Plans for Surgery, Obstetrics, Paediatrics
3.2 Provision of innovative services that are targeted and deliver appropriate care for patients across the region.	Moura Community Hospital Model Rural Mental Health Service Model
3.3 Development of evidence-based practice and procedures to deliver integrated, quality and effective health care throughout the patient's journey.	
3.4 Demonstrated support of effective clinical practice through research and education.	Cardio-metabolic Mental Health Nurse Research Study Allied Health Student-Assisted Chronic Disease Management Research Study
3.5 Utilisation of information technologies that provide consistent health service data which will influence and ensure health services reflect health trends.	Telehealth models for chronic disease management and paediatrics management

4. Providing a great place to work

Objective	Measure
4.1 Development and fostering of a positive organisational culture as evidenced by qualitative measures.	Integrated CQHHS Learning, Development and Research Centre Reward and Recognition Program Celebrations of staff achievements eg Annual Academic Day
4.2 Attraction and retention of a high quality, responsive and skilled professional workforce.	CQHHS Workforce Strategy & Plan Retention Plans for Medical, Nursing and Allied Health Practitioners Workforce development initiatives eg Nurse Practitioners, Advanced Allied Health Practitioners
4.3 Recognition as an employer of choice within clinical and professional groups.	Student placement programs reflect workforce planning requirements Student-to-Graduate employment
4.4 Commitment to continuous development of staff skills, career pathways and professional opportunities.	Mandatory training needs of workforce met or exceeded Uptake of leadership and management development programs by all staff categories

5. Underpinning our business through stakeholder, clinician, consumer and community engagement

Objective	Measure
5.1 Development of sound communication, information and knowledge networks to engage and work with the region's leaders, industry and the community in order to drive better health care outcomes regionally, state wide and nationally.	CQHHS Information, Communication and Technology Plan developed Optimal ICT system utilisation
5.2 Establishment of partnerships with local communities to ensure that they are engaged in decision making on how health and hospital services are delivered.	CQHHS Consumer and Community Engagement Strategy implemented CQHHS Clinician Engagement Strategy implemented CQ Clinical Leaders Forum implemented
5.3 Enhancing community engagement and improving health literacy to ensure the community has ownership of and input into decisions affecting health and hospital services.	As above
5.4 Promotion of healthy lifestyle information to health consumers throughout the Hospital and Health Service.	Primary Health Care Protocols developed with community partners

6. Living within our means

Objective	Measure
6.1 Effectively advocating for the changing needs of all communities within the CQHHS footprint and health demographic.	CQ Health Services Plan 2011-2026/27 future priority areas developed Whole-of-Government National and State Plan and Priorities implemented Closing the Gap Initiatives implemented
6.2 Promotion of accountability and transparency through best practice governance, the provision of frank and fearless advice and implementation of robust business practices.	Governance Framework implemented Performance Framework implemented Patient Safety and Quality targets achieved National and State Access Targets met Skills development in financial and risk management
6.3 Delivery of cost-effective services, maximising value and planning future resource allocation and investment.	CQHHS Strategic Asset and Maintenance Plan developed 5-Year Budget Management Strategy developed

9. CQHHS Engagement Protocol

9.1. Objectives

The Central Queensland Hospital and Health Service (CQHHS) and Central Queensland Medicare Local (CQML), recognise the important role that Primary Care (including General Practice) and Acute Care play in the delivery of health services. The purpose of this protocol is to outline how the parties will work together in order to achieve our joint objectives in line with State and national strategies, policies, agreements and health care standards.

CQHHS will refer to its Community and Consumer Engagement Strategy and Clinician Engagement Strategy in contributing to agendas and projects, ensuring that the process of consultation with stakeholders remains robust and appropriate. The outcomes of this protocol should inform the Strategies and the future engagement activity of CQHHS and Medicare Local with its communities.

The Parties agree to promote cooperation with one another in the planning, delivery and continuous improvement of health services to the Central Queensland community. Such cooperative efforts will include the establishment of processes to enable sharing of information, sharing of staff and facilities where appropriate and granting of limited access to information management systems where possible.

The Parties agree to collaborate wherever possible and practical on matters and issues of common concern and interest. The Parties will collaboratively address shared priorities of health service integration, the protection and promotion of public health, service planning and design for CQHHS and Medicare Local and local clinical governance arrangements.

9.2. Deliverables

The Parties have established the protocol based on delivery of the following outcomes:

1 Ensure alignment of planning for new services and programs, after-hours emergency medical services, Indigenous health services and overall strategic directions.

2 Improve understanding and coordination of services provided by Primary Care and CQHHS by enhancing clinical engagement and communication between Primary Care Practitioners and CQHHS clinicians, including opportunities for ongoing education and research.

3 Improve collaboration between CQHHS, public/private hospitals, general practice and other primary care providers, aged care and disability service providers to ensure patients receive the most appropriate care, by the most appropriate health care provider in the right setting in the most appropriate time.

4 Jointly develop and implement models of shared care that embrace the fundamental value of the patient continuum of care.

5 Jointly develop a range of initiatives that help general practitioners better manage chronic disease in the community and away from hospital.

6 Ensure collaborative service delivery and shared care models are implemented in a staged and organised process with open communication and transparency between both Parties.

7 Jointly develop initiatives that improve the exchange of patient health information between hospitals, General Practice, Aged Care Facilities and other community providers.

8 Work collaboratively on the management of hospital waiting lists including improvements to the ‘new to review’ ratio for outpatient clinics.

9 Ensure that CQHHS, General Practice and Primary Care staff are encouraged and supported to focus on a collaborative approach to the development and implementation of services for Aboriginal and Torres Strait Islander people.

10 Ensure that all programs implemented under the auspices of this protocol provide evidence and consideration of consumer participation.

11 Continue to develop joint initiatives to ensure the relevance and delivery of these outcomes.

The signatories to this protocol are committed to working with each other, with national and State governments and the community to achieve, maintain and deploy the highest standards and quality in health care provision to the community.

9.3. Performance Outcomes

Central Queensland Hospital and Health Service (CQHHS) and Central Queensland Medicare Local (CQML) management will meet on a monthly basis to discuss issues, strategies and progress on joint initiatives. A record of key discussions and recommendations from each meeting shall be retained and disseminated to relevant Primary Healthcare organisations within the service, with due regard to privacy and confidentiality obligations of the organisations.

The Parties will invite each other to relevant planning or strategic meetings as deemed appropriate.

CQHHS and CQML will review and evaluate the protocol annually.

CQHHS and CQML will jointly develop by March 2013 an annual Work plan with agreed priorities, timeframes and clearly assigned responsibilities.

CQHHS and CQML will jointly develop by March 2013 valid and reliable performance and evaluation criteria and identify the process for public reporting in order to measure the value and effectiveness of this protocol.

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10. CQHHS Clinician Engagement Strategy

10.1. Background

The introduction of Hospital and Health Boards is under pinned by the *Hospital and Health Boards Act 2011* and *Hospital and Health Board Regulation 2012*. Within this Act and Regulation, Engagement Strategies are described including the prescribed requirement for "*a clinician engagement strategy*" to promote consultation with health professionals working within the service.....". The Act also describes that the Service must consult with "health professionals working in the service" when developing this strategy. There is also a requirement for a review of the strategy to be performed "*within 3 years after it is made and afterwards within 3 years after the previous review*" .

In early 2012 the Queensland Government released the *Queensland Health Clinician Engagement Framework*, which describes the development and delivery processes for a Clinician Engagement Strategy and is intended to inform region-specific Clinician Engagement Strategies. The Framework paper provides a Participation Model (below), which has been adopted as the platform upon which this Clinician Engagement Strategy is being built.

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
	Goal:	**Goal:**	**Goal:**	**Goal:**	**Goal:**
Points of Influence	To provide stakeholders with balanced and objective information to assist them in understanding the problems, alternatives, opportunities and/ or solutions.	To obtain stakeholder feedback on analysis, alternatives and/ or decisions.	To work directly with stakeholders throughout the process to ensure that stakeholder concerns and aspirations are consistently understood and considered.	To partner in each aspect of the decision including the development of alternatives and identification of the preferred solution.	To place final decision-making in the hands of stakeholders.
	Promise:	**Promise:**	**Promise:**	**Promise:**	**Promise:**
How to Engage	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and provide feedback on how stakeholder input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives / options developed and provide feedback on how clinician input influenced the decision.	We will look to you for direct advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.
	Strategies:	**Strategies:**	**Strategies:**	**Strategies:**	**Strategies:**

Expected Outputs	• Internet
	• Intranet
	  ○ inc Fact Sheets
	  ○ Information papers
	  ○ FAQs
	  ○ Link to satellite broadcasts
	  ○ Link to Federal website
	• 'Keep Informed' email group broadcasts
	• Media releases
		• Consultation papers
		• Working groups
		• Clinician Advisory Groups
		• Union briefings
			• Targeted meetings ie. Local Clinical Council and/ or Committees
			• Forums
			• Workshops
				• Targeted working groups
				• Establishing advisory panels
					• Delegated Decisions

For a number of years now, and since the events that unfolded in 2005 as a consequence of the Patel incident, Queensland Health has progressed agendas to further engage clinical staff. There has been the establishment of the Queensland Clinical Senate which is a forum made up of a dynamic group of clinicians who draw on their collective knowledge of the clinical environment to formulate recommendations for Queensland Health on how to deliver the best health care to Queenslanders. The membership is drawn from multidisciplinary clinicians practising in the disciplines of medicine, nursing and allied health. Members include some from academic backgrounds and are also drawn from across the health care sector including metropolitan, regional and rural areas. This Senate meets 2 to 3 times per year to debate pressing clinical issues and consider innovative solutions to the challenges that the health system faces in order to develop a set of concrete recommendations for the Director-General, Queensland Health.

In parallel to this State-wide initiative, many of the Queensland Health hospitals have progressed development of Clinical Councils. These bodies have been formed by the Health Service Districts to complete a variety of tasks, though primarily responsible for providing clinical leadership and direction, advice and sometimes decision making on safety and quality, service planning and model of care development and implementation. The Clinical Councils report directly to the District Chief Executive Officers in undertaking their role as the peak body for clinical leadership.

The purpose of this discussion paper is to progress the establishment of a Clinician Engagement Strategy in Central Queensland Hospital and Health Service (CQHHS) as an integral component of the transition to a Hospital and Health Service. This paper outlines the key clinical engagement initiatives and can be used to support consultation throughout the Hospital and Health Service, including health professionals working within the service, and support discussion with key stakeholders including the Central Queensland Medicare Local (CQML) with which parts of this strategy have been jointly developed.

A draft Clinician Engagement Strategy was presented to the CQHHS Board on 23 November 2012 and received in principle support, with a directive that the Strategy should be the subject of some revision, then should be circulated for further input from key stakeholders prior to final acceptance by the Boards. The Clinical Leaders Group proposal which has been jointly developed between CQHHS and CQML was presented and accepted by the CQML Board.

This Discussion Paper includes the revised draft Clinician Engagement Strategy which includes changes to the Clinical Leaders Group which were requested by the CQHHS Board.

10.2. Structure and Framework

It is proposed that the Clinician Engagement Strategy for the Central Queensland Hospital and Health Service (CQHHS) comprise a two pronged approach - the first being the implementation of a clinician led Organisational Structure and second will be the development of a Clinical Leaders Group.

It is envisaged that clinician engagement becomes entrenched into the core operations of CQHHS, therefore the organisational structure is realigned to support clinical streams which are designed around the patient journey. This organisational realignment is the subject of separate discussion papers and change process. The alignment involves clinicians being supported in direct service line management (initially at Rockhampton Hospital Clinical Streams/Divisions with extension into the rest of CQHHS) and this will improve clinician engagement and strengthen community ties. The documents surrounding these are available separately..

The development of a Clinical Leaders Group is also proposed. It is envisaged that in Central Queensland this Clinical Leaders Group would emulate the functions that were previously proposed by the Australian Government for the Local Lead Clinician Group supporting both the CQML and CQHHS. There has been active discussion with the CQML and collaborative effort to develop the Terms of Reference for a CQ Health

Clinical Leaders Group.

The proposed Terms of Reference for the CQ Health Clinical Leaders Group is included for consultation and discussion. It describes the Purpose, Principles, Scope, Membership and proposed operational management of the Clinical Leaders Group.

The mechanism for appointment to membership is briefly outlined within the Terms of Reference, and it is envisaged that there will be a two pronged approach with an advertising campaign seeking nominations within the community, and local intra-organisational (within the CQML and CQHHS) advertisement of the nomination process to the clinical staff within the target areas outlined in the membership of the Terms of Reference. The assessment panel as described within the Terms of Reference will comprise both the Chairs of the CQML and CQHHS, and a nominated clinical executive member from each organisation.

It is not proposed that the CQ Health Clinical Leaders Group will replace pre-existing clinical engagement and management forums within the CQML and CQHHS as these will continue, though it is conceivable that a review of these forums may be undertaken if there are areas of duplication.

10.3. Consultation and Implementation of the Clinician Engagement Strategy

There will be a need to consult with the "health professionals working in the Service" for the Clinician Engagement Strategy. It is proposed that once the CQHHS Board is comfortable with the strategy, the professional groups under the leadership of the relevant professional executive leaders socialise the Terms of Reference for the CQ Health Clinical Leaders Group and the nomination process and advertisement plans with their professional teams.

It is proposed to advertise for nominations for the CQ Health Clinical Leaders Group in accord with an agreed advertising strategy which is being devised. This will include intra and extra organisational advertising. Within CQHHS, nominations will be sought by advertising within the DRIFT, via professional streams through the usual management, communication and professional meetings, via email broadcast to CQHHS staff group email listing and by utilising screen savers to encourage nominations. The proposed advertising flyer and website and screen saver mock-ups are attached for information and included as Appendix 1. It should be noted that the actual content of the mock-ups will be revised to reflect appropriate dates and contact details prior to publication.

10.4. Have your say

This Discussion Paper has been distributed to a wide population in order to secure input from as many stakeholders as possible. In order to provide your considered response, including suggestions, corrections or other recommendations, please use the following methods:

By email:
C/O Executive Director of Medical Services
Central Queensland Hospital and Health Service
CQHealth_Clinical_Leaders_Group@health.qld.gov.au

By hard copy:
C/O Executive Director of Medical Services
Central Queensland Hospital and Health Service
PO Box 871
Rockhampton Q 4700

All input will be received until close of business Friday 15 February 2013.

10.5. Terms of Reference CQ Health Clinical Leaders Group

1 Purpose

CQ Health is a partnering collaboration between the Central Queensland Medicare Local (CQML) and the Central Queensland Hospital and Health Service (CQHHS).

The CQ Health Clinical Leaders Group (CLG) enables clinicians to provide formal advice to CQ Health.

The aim of the CLG is to ensure that clinicians are involved in decision making that impacts on local health service delivery throughout Central Queensland. The development of the CLG presents a unique opportunity for multi-disciplinary representation and input across the continuum of care.

Through the direct engagement and participation of clinicians, the CLG will support CQ Health by:

- informing decision making processes by providing advice on matters of interest to the clinicians, CQ Health and the respective Boards of CQML and CQHHS;
- improving patient outcomes by providing advice and recommendations on the local implementation of CQ clinical service initiatives across the continuum of care;
- improving health outcomes by ensuring the application of evidence-based clinical guidelines and best practice standards, improvement and contemporary care models;
- supporting quality patient outcomes by advising on robust safety and quality measures;
- informing decision making through advice and recommendations reflective of local clinical and community needs and priorities for service development and planning;
- supporting increased patient access through advising on workforce education and training developments and opportunities;
- supporting clinical engagement throughout the region through dissemination of information and advice to local clinicians.

Context

The Clinician Engagement Strategy complements the CQHHS Consumer and Community Engagement Strategy. It is a core component of a commitment from and requirement of the CQHHS Board to engage with all of its stakeholders in designing and delivering a health service that best meets the needs of Central Queensland. The Strategy articulates specific intent of the CQHHS/Medicare Local Working Together protocol, enabling the collection and sharing of information pertinent to delivering best practice health care across the region.

2 Principles for the CLG

The CLG aims to:

- provide the clinician's perspective;
- give advice based on considered opinion;
- communicate its outputs and outcomes to stakeholders;
- champion implementation of better practice and improved service delivery;
- focus on the coordination of patient care across all sectors of the health system;
- promote collaboration between health professionals across the health system.

3 Scope of the CLG

To contribute to the management and delivery of health services by CQ Health, the CLG will undertake the following:

- Assist in identifying the health needs of the community and advising CQ Health on appropriate services

and models of care which may be required to meet those needs;
- Participate in the planning and development of quality programs that support better integrated care across the continuum;
- Develop and implement an open and supportive mechanism for all clinicians involved in the delivery of clinical services to raise issues to CQ Health;
- Provide clinical leadership and direction to support CQ Health in the delivery of evidence-based care;
- Assist in monitoring performance of the CQ Health partners and provide informed strategies to meet key performance indicators and other clinical mandatory reporting requirements and standards.

4 Membership

Nominations will be sought from respected clinicians. Nominations will be assessed by a Panel consisting of the Chairs of the Boards of CQML and CQHHS and a nominated clinical executive from both organisations. The Panel will seek to include members across the following clinical disciplines and sectors: medical, nursing, allied health, primary care, specialist, clinical education, rural and remote, Indigenous health, mental health and aged care. A clinician who is external to the CQHHS service footprint shall be appointed at the discretion of the Assessment Panel.

Appointments will be valid for a two year term. Appointees may express an interest in being re-appointed at the conclusion of their two year term.

Not more than 20 clinical members will be appointed to the CLG.

5 Chair

The Assessment Panel will identify and appoint the inaugural Chair. The Chair will be appointed by the CLG after the first meeting.

The Chair will be appointed for a two year term.

6 Invitees

The CLG may invite other staff/visitors external to CQ Health to attend meetings in order to provide members with specialist information or advice. Such invitees shall not have voting capacity.

7 Evaluation

The CLG will undertake annual evaluation. Evaluation may be self-evaluation or an independent evaluation and shall be formalised in a report to be received annually by CQHHS and CQ Medicare Local Boards. A comprehensive evaluation will be undertaken every three years. Where changes are made to the Strategy as a result of that Evaluation, the revised Strategy must be made publicly available.

8 Quorum

The Quorum for the CLG will be half the members plus one. In the absence of a quorum the meeting may continue at the Chair's discretion. Any items requiring a decision or resolution will proceed or be deferred at the discretion of the Chair.

Group recommendations are to be made by consensus. Members are individually accountable and collectively

responsible to contribute to advice provided by the CLG to CQ Health.

Issues not agreed to by consensus can be referred for resolution to CQ Health. In such instances, the Chair will be responsible for ensuring CQ Health is apprised of all points of view pertinent to the matter at hand.

9 Reporting Responsibilities

The Clinician Engagement Strategy is a requirement of the provisions of the Hospital and Health Service Act 2011 as it applies to the CQHHS Board. The strategy shall be devised and implemented in accord with the Act and in accord with the Hospital and Health Board Regulation 2012.

The CLG shall conduct itself in accord with the generic provisions of the Standing Orders and Terms of Reference for Committees of the CQHHS Board. Accordingly, each meeting shall be minuted or otherwise recorded and a report shall be made available to CQHHS and CQML Boards from each meeting.

10 Committees

The CLG reports directly to the Boards of CQML and CQHHS through the Board representatives who attend as core members. There are no designated Committees however the CLG has the option to form Committees as required.

11 Frequency of Meetings

The CLG will meet quarterly.

11. CQHHS Consumer and community engagement strategy 2012-15

11.1. Background

Hospital and Health Board Act 2011 requires both the Central Queensland Health and Hospital Service (CQHHS) and the Central Queensland Medicare Local (CQML) to develop and publish a Consumer and Community Engagement Strategy to be implemented within the Central Queensland health service region. The following strategy has been developed in consultation with health consumers and members of the Central Queensland community and complying with the following regulations as outlined in the Health and Hospitals Network Regulation 2012 and the Medicare Local Contractual Responsibilities as stated in the document.

CQHHS Consumer and Community Engagement Strategy Regulations:	Common Consumer and Community Engagement Strategy Regulations:	Medicare Local Contractual Responsibilities:
• identify strategies to engage with consumers and communities at the individual, service and network levels • identify strategies to actively seek out and engage with consumers and communities that experience poor health outcomes or access issues, or are otherwise disadvantaged *Example: For disadvantaged individuals it may be necessary to collaborate with community services* • state the key issues on which consumers and communities are to be consulted, including in the areas of service planning and design, service delivery, and monitoring and evaluation	• state the objectives for the strategy • have regard to relevant national and State strategies, policies, agreements and standards *Examples: Australian Charter of Health Care Rights, Public Patients' Hospital Charter, ACSQHC standards, Lead Clinician Groups* • state how the strategy will contribute to the achievement of organisational objectives • outline the relationship between the consumer and community engagement strategy, the clinician engagement strategy, and the protocol between the network and the local primary healthcare organisation • provide for the publication of summaries of Governing Council meetings • state how the effectiveness of the engagement with consumers and communities is to be measured and reported on • identify mechanisms to learn from the implementation of the strategy to continuously improve engagement under the strategy	To be accountable to local communities to make sure services are effective and of high quality. All activities are to be developed and implemented from a consumer centred perspective, and in consultation with local stakeholders. The key principles of consumer centred approaches for CQML include: • treating patients, consumers, carers and families with dignity and respect • encouraging and supporting participation in decision making by patients, consumers, carers and families, • communicating and sharing information with patients, consumers, carers and families; and • fostering collaboration with patients, consumers, carers, families and health professionals in program and policy development, and in health service design, delivery and evaluation.

In order to develop this strategy in collaboration with consumers and community, the CQ Consumer and Community Engagement Working Group was formed. The working group was originally formed as a CQHHS

internal working group that has now evolved into a joint partnership initiative of CQHHS and the CQML. The CQ Consumer and Community Engagement Working Group provided direction in the development of this strategy that will be implemented across the Central Queensland region over the next three years.

Through a collaborative approach with other primary health care organisations within the Central Queensland area, the CQ Consumer and Community Engagement Working Group's membership base has a diverse range of skills, experience and knowledge from within the community.

This level of collaboration will assist in developing a clearer understanding of consumer and community priorities and needs to maintain both a Health and Hospital Service and a Medicare Local in this region that are comprehensive, inclusive, well-informed, accessible, robust, and innovative.

11.2. Policy and Legislative Context

11.2.1. Legislation

The Hospital and Health Boards Act 2011 sections 40 and 41 requires each HHS to develop and publish a Consumer and Community Engagement Strategy to promote consultation with consumers and members of the community about the provision of health services. The legislation outlines that HHSs must consult with consumers and community in the development of their Strategy, satisfy any requirements prescribed by regulations, give effect to the Strategy in performing their functions, and review within three years.

This legislation also requires HHSs to develop a Clinician Engagement Strategy and along with the Consumer and Community Engagement Strategy will enable HHSs to gain valuable input from patients and families who use the services, people in the community who need access to services and the HHS workforce. Legislation also requires HHS to use their best endeavours to develop protocols with Medicare Locals to provide opportunities to work collaboratively with local primary health services, towards more integrated, responsive health services.

11.2.2. Boards and Executive Committees

Hospital and Health Boards (the Boards) are accountable for the overall performance of the HHSs they govern and manage resources to purchase and provide health services to meet local priorities and national standards. The Boards have responsibility to oversee the operation of the HHS, which includes the Consumer and Community Engagement Strategy.

Boards are required to establish an executive committee of the Board, chaired by the Chair or Deputy Chair which includes two other Board members, one of which is a clinician. All meetings will be attended by the Health Service Chief Executive.

The core functions of the Executive Committee include:

- Progressing strategic issues and strengthening the communication and relationship between the Board and health service chief executive
- Overseeing the performance of the service against performance measures within the service agreement
- Supporting the Board in the development of engagement strategies and protocols with Medicare Locals, monitoring their implementation and addressing issues that arise in their implementation
- Developing service plans and other plans for the service
- Critical emergent issues in the service and other functions given by the Board

The Executive Committee's role includes working with the health service chief executives to oversee strategic

issues, including consumer and community engagement strategies, clinician engagement strategies and protocols with Medicare locals.

The establishment of the Executive Committee does not preclude HHSs from establishing other committees or advisory mechanisms for consumer and community engagement.

11.2.3. Regulations

Minimum Requirements for Strategies and Protocols provide the guidelines for the consumer and community engagement strategy, clinician engagement strategy and the protocol with the Medicare Local. HHSs are required to ensure their strategies meet the requirements prescribed under a regulation, and to publish the strategy in such a way that it allows public access, for example, on the Internet.
The regulations include requirements that the strategy

- includes clear objectives, outcomes and measures of effectiveness;
- links to organisational objectives;
- have regard to relevant national and State strategies, policies and agreements and standards;
- Identifies key issues that consumers and community are to be consulted on at three levels and how it will inform service planning, design, delivery, monitoring and evaluation;
- outlines the relationship between the consumer and community engagement strategy, the clinician engagement strategy, and the protocol between the HHS and the local primary healthcare organisation
- Includes strategies to actively engage with, consumers and community that experience poor health outcomes or access issues, or are otherwise disadvantaged, eg. Aboriginal and Torres Strait Islanders, people from culturally and linguistically people with disability,
- Outlines continuous improvement mechanisms.

11.2.4. National Safety and Quality Health Service Standards

Australian Health Ministers endorsed the National Safety and Quality Health Service Standards in 2011, to focus accreditation and quality improvement processes for health services such as hospitals, day surgeries, community health services and some dental practices. The Australian Commission on Safety and Quality in Healthcare has developed the set of national standards to provide a clear statement of the level of care consumers can expect from health services, and has a specific standard focused on consumer engagement, Standard 2: Partnering with Consumers.

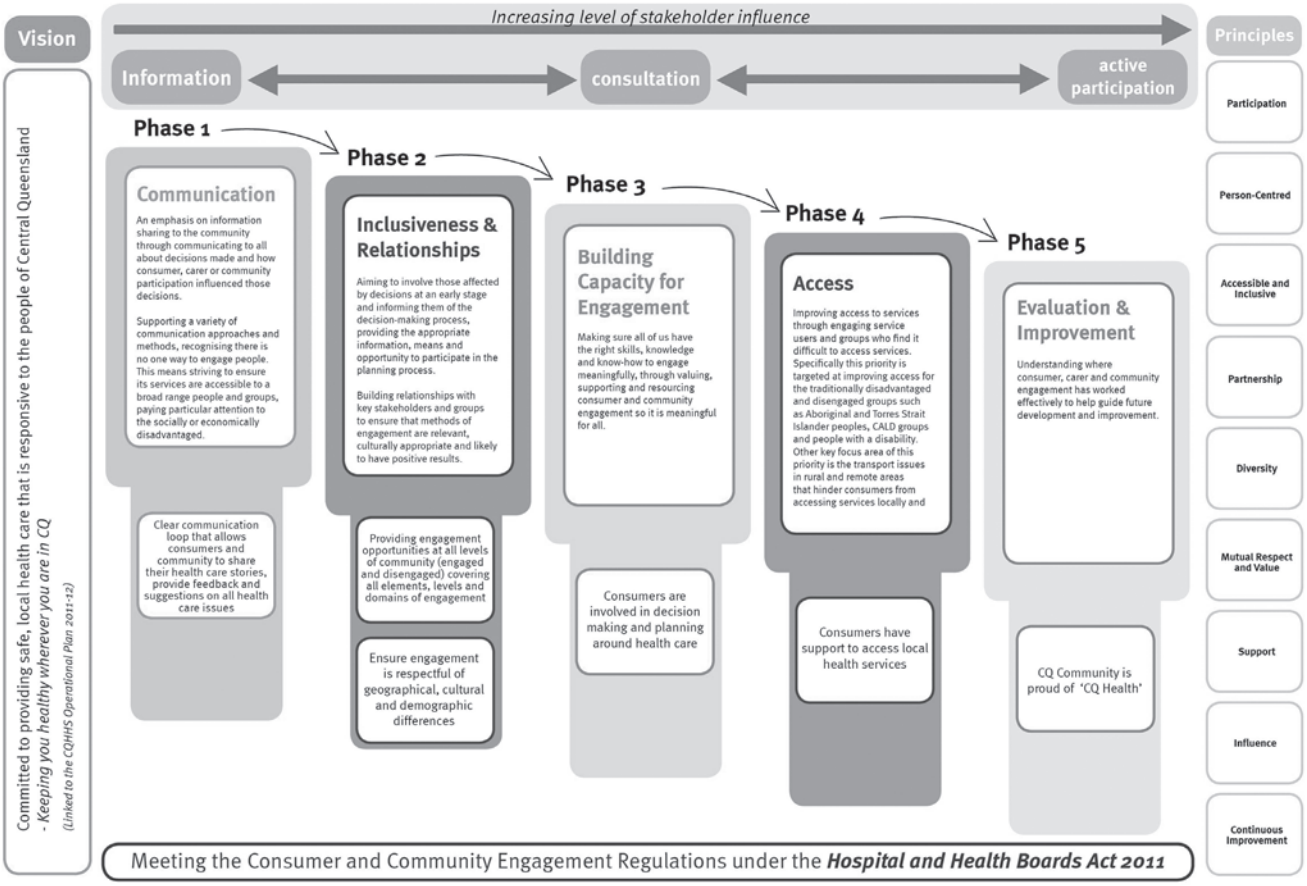
These standards will form part of the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme which will commence from 1 January 2013.

11.2.5. Australian Charter of Health Care Rights

The Australian Commission on Safety and Quality in Health Care developed the Australian Charter of Healthcare Rights in 2008 following extensive consultation. The charter specifies the key rights of patients and consumers when seeking or receiving healthcare services and was endorsed by Australian Health Ministers in July 2008. The Charter applies to all health settings in Queensland, including public hospitals, private hospitals, general practice and other community environments. It allows patients, consumers, families, carers and service providers to have a common understanding of the rights of people receiving health care.

11.3. CQ Health Consumer and Community Engagement Strategic Framework

see diagram over page.



11.4. Consumer and Community Engagement Objectives

With a view to achieving 'Best Practice' consumer and community engagement for health across the Central Queensland region, the Health Consumers Queensland Consumer and Community Engagement Framework was consulted throughout the development of this strategy.

It is recognised that consumer and community engagement is an ongoing process that relies on collaboration and consultation with key stakeholders and groups in order to form better decisions and outcomes for the health service. In order to achieve this, the Central Queensland Consumer and Community Engagement Working Group completed a half day workshop to identify the key issues and communication channels for effective consumer and community engagement for health services within Central Queensland. These findings were used in establishing the key strategic priorities, engagement tools and objectives that this working group will focus on achieving moving forward.

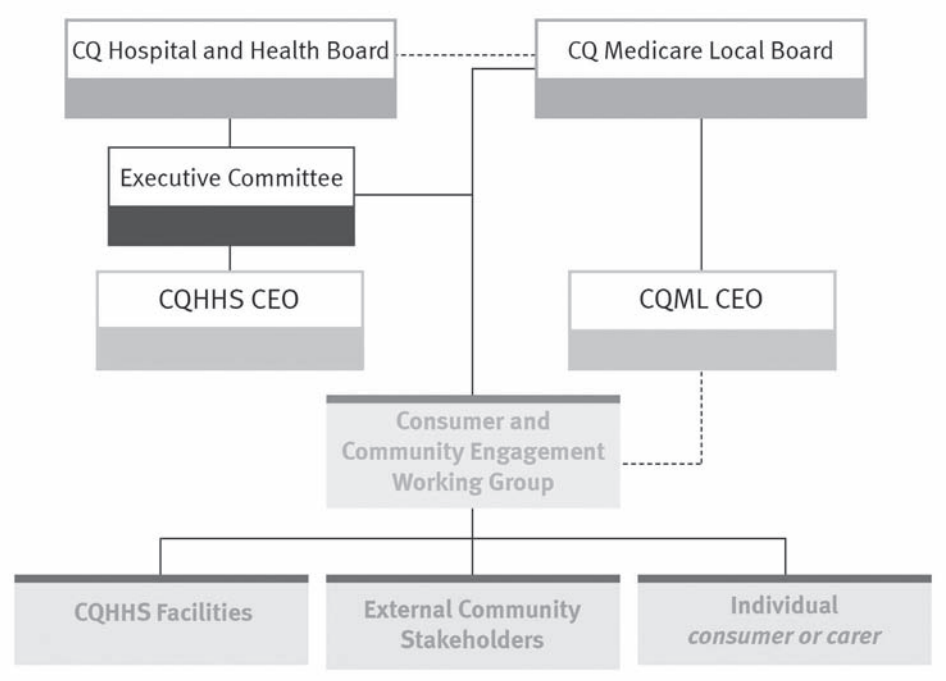
The following are the identified Consumer and Community Engagement Objectives that this strategy will aim fulfill:

- CQ Community is proud of 'CQ Health'
- Consumers are involved in decision making and planning around health care
- Consumers have support to access local health services
- Clear communication loop that allows consumers and community to share their health care stories, provide feedback and suggestions on all health care issues
- Providing engagement opportunities at all levels of community (engaged and disengaged) covering all elements, levels and domains of engagement
- Ensure engagement is respectful of geographical, cultural and demographic differences

11.5. Consumer and Community Engagement Tools

Information *(information exchange; low consumer/ community involvement and influence)*	Consultation *(information gathering, discussion; some consumer community involvement and influence)*	Involvement *(Shared consumer/ community/LHHN agenda setting; some influence over differing opinions)*	Collaboration *(high consumer/ community involvement and influence)*	Empowerment *(consumer/community control)*
• Web / Internet – CQ Focus Portal • Tablet and smartphone apps • Media (local, printed, newsletters, flyers, noticeboards etc.) • Opportunistic communication (waiting rooms, airline magazines etc.) • Health information kiosks • Radio / TV	• Tap into cultural groups, NGOs, community groups • Incentives for engaging • Local consultation meetings • Surveys (online, paper, focus groups etc.) • Social Media – Web 2.0	• Engage industry • Education Providers – primary, secondary, tertiary	• Public and private partnerships • Collaboration with CQLGA • CQ wide organised event calendar • Collaboration with cultural groups, NGOs, community groups	• Consumer involved in health process (interview panels, committees etc.)

11.6. Consumer and Community Engagement Reporting Structure and Guidelines



Appendices

Evaluation and reporting will be against the implemented actions of each of the Consumer and Community Engagement Strategic Priorities – Access; Communication; Inclusiveness and Relationships; Building Capacity for Engagement and; Evaluation and Improvement – and will follow the below structure:

Method	What techniques were used? *For example, interviews and focus groups. (Outline domain, level and element of engagement)*
	
Indicators	How was engagement measured? *For example, the estimates people make about their level of involvement.*
	
Evaluation criteria	What was the level and intensity of engagement achieved? How were consumers and community involved in evaluation and review process? What ACHS or EQuIP5 accreditation standards where achieved? *For example, the extent to which community members were involved in developing new services.*
	
Outcomes (Why?) and Improvements	What did the community engagement activity achieve? What are possible improvements for future activities? *For example, community members have ownership of new services.*

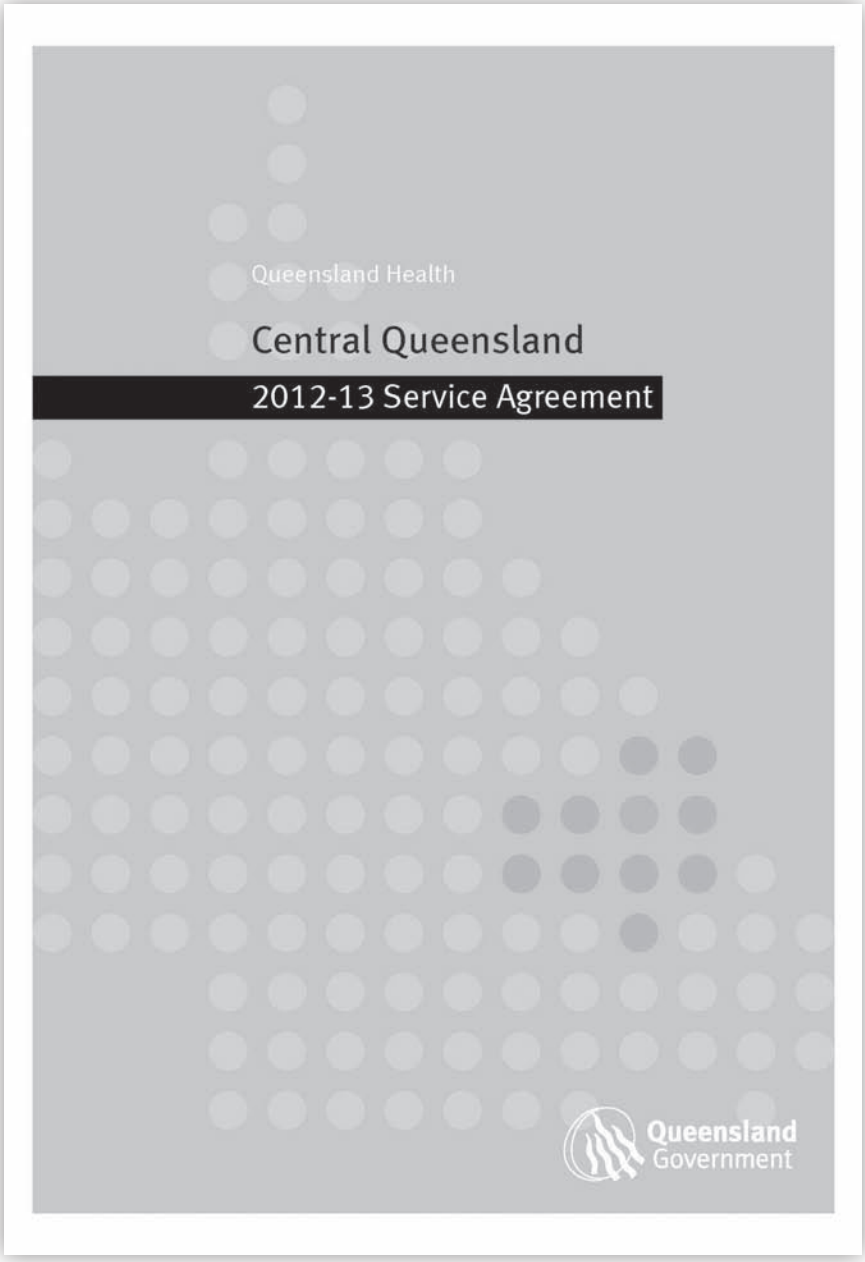
The above evaluation and reporting structure will be provided half-yearly to both CQHHS and CQML boards, with the basis of the report informing the summary of consumer and community engagement activities included in the public reports of both the Central Queensland Hospital and Health Service and the Central Queensland Medicare Local.

12. Central Queensland 2012-13 Service Agreement

12.1. Document Request

For information on this document contact:

Central Queensland Hospital and Health Service (CQHHS)
Marketing and Communication Department
Phone (07) 4920 5778 or
Email your request to CQHHSCommunications@health.qld.gov.au.

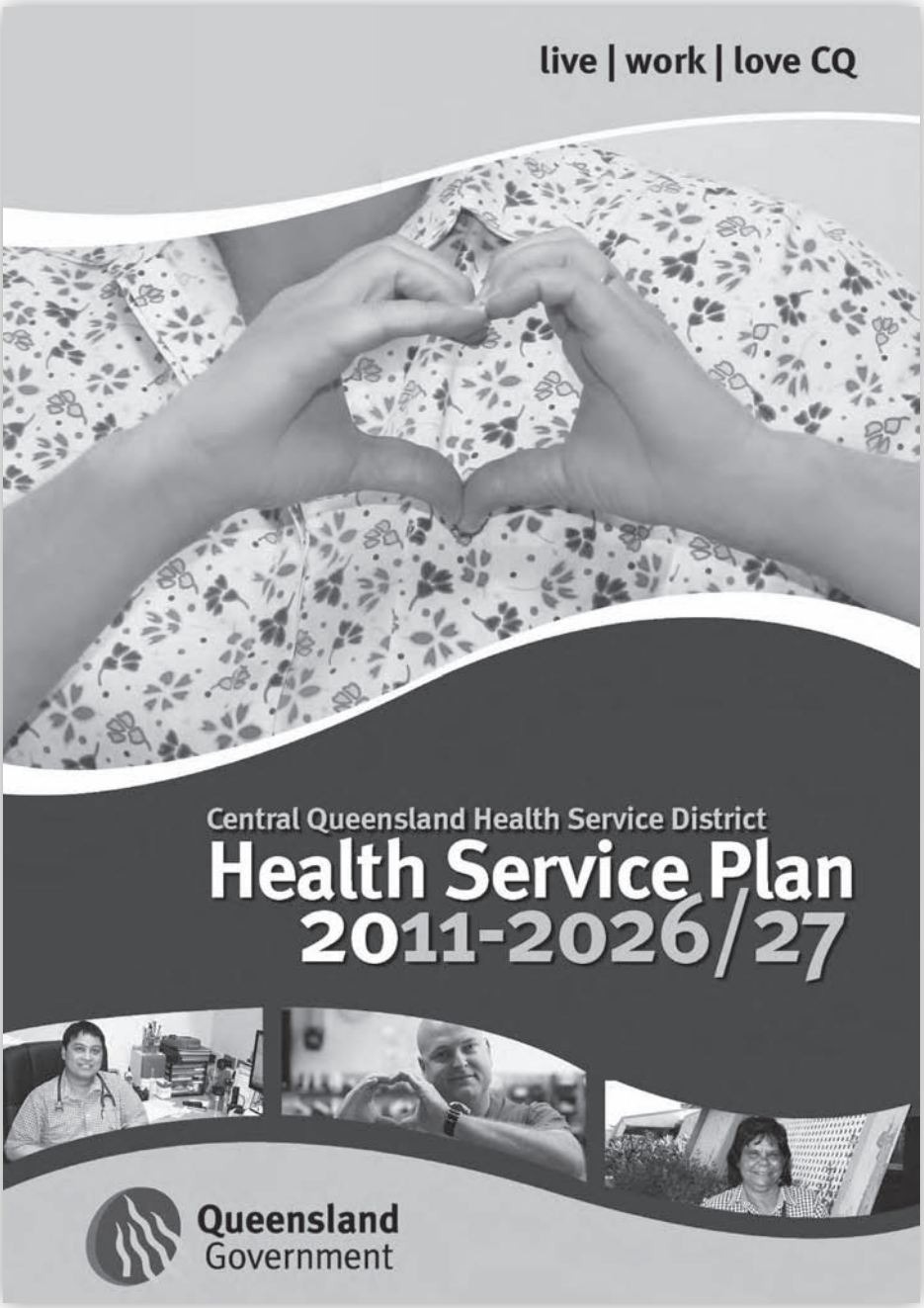


13. CQHHS Health Service Plan 2011-2026/27

13.1. Document Request

For information on this document contact:

Central Queensland Hospital and Health Service (CQHHS)
Marketing and Communication Department
Phone (07) 4920 5778 or
Email your request to CQHHSCommunications@health.qld.gov.au.



Abbreviations

Abbreviation	Full Name
ABF	Activity-Based Funding
ACHS	The Australian Council on Healthcare Standards
AHSSQA	Australian Health Service Safety and Quality Accreditation
ALCS	Annual Leave Central Scheme
APCC	Acute Primary Care Clinic
ATO	Australian Taxation Office
BCS	Business Classification System
BMRP	Backlog Maintenance Remediation Program
CANs	Community Action Networks
CE	Chief Executive
CFO	Chief Finance Officer
CLG	Clinical Leaders Group
CMC	Crime and Misconduct Commission
CoAG	Council of Australian Governments
CPI	Consumer Price Index
CQ	Central Queensland
CQHH	Central Queensland Hospital and Health
CQHHB	Central Queensland Hospital and Health Board
CQHHS	Central Queensland Hospital and Health Service
CQLGA	Central Queensland Local Government Association
CQML	Central Queensland Medicare Local
CQPCP	Central Queensland Primary Care Partnership
DMS	Director Medical Services
ED	Emergency Department
EECU	Extended Emergency Care Unit
EMLO	e-Learning Modular Objects
EMT	Executive Management Team
EQuIP5	5th edition of the ACHS Evaluation and Quality Improvement Program
FAA	Financial Accountability Act 2009
FBT	Fringe Benefit Tax
FPMS	Financial and Performance Management Standard 2009
FTE	Full time equivalent
GAPDL	Gladstone Area Promotion and Development Ltd
GARS	Geriatric and Rehabilitation Services
GP	General Practice
GST	Goods and Services Tax
HACC	Home and Community Care
HHS	Hospital and Health Service
HITH	Hospital in the Home
HITNH	Hospital in the Nursing Home
HR	Human Resources
HRIS	Human Resource Information Systems

Abbreviations

Abbreviation	Full Name
IHPA	Independent Hospital Pricing Authority
ILUA	Indigenous Land Use Agreement
IT	Information Technology
KPI	Key Performance Indicator
LDRC	Learning and Development Resource Centre
MMF	Maintenance Management Framework
MoG	Machinery of Government
MOHRI	Minimum Obligatory Human Resource Indicator
MPHS	Multi-Purpose Health Service
NEAT	National Emergency Access Times
NEP	National Efficient Price
NEST	National Emergency Service Times
NGO	Non-Government Organisation
NHS	National Health Service
NPA	National Partnership Agreement
OHS	Occupational Health and Safety
PaD	Performance and Development Agreements
PBS	Pharmaceutical Benefits Scheme
PCEHR	Personally Controlled Electronic Health Record
PSEA	Public Service Ethics Act 1994
QAO	Queensland Audit Office
QCAT	Queensland Civil and Administrative Tribunal
QGIF	Queensland Government Insurance Fund
QH	Queensland Health
QWAU	Queensland Weighted Activity Unit
RCA	Root Cause Analyses
ROPP	Right of Private Practice
RRIRWP	Rural and Remote Infrastructure Rectification Works Program
RRT	Recovery and Resilience Team
SACCR	Sub-Acute Chronic Care Rehabilitation Interdisciplinary Student Clinic
WHS	Workplace Health and Safety
WoG	Whole of Government

Glossary

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

Glossary

Word	Definition
e-Health	Since 2007 Queensland Health has been working on an e-Health agenda that aims to create a single shared electronic medical record (eMR) which will be delivered through the use of information and communication technology. The vision of the e-Health Program is to enable a patient-centric focus to healthcare delivery across a networked model of care.
e-Learning	QH Online Training Environments. ELMO http://elmolearning.com.au/ and iLearn
e-plan	Computerised plan storage room.
Emergency department waiting time	Time elapsed for each patient from presentation to the emergency department to start of services by the treating clinician. It is calculated by deducting the date and time the patient presents from the date and time of the service event.
Full time equivalent (FTE)	Refers to full-time equivalent staff currently working in a position.
Health outcome	Change in the health of an individual, group of people or population attributable to an intervention or series of interventions.
Health reform	Response to the National Health and Hospitals Reform Commission Report (2009) that outlined recommendations for transforming the Australian health system, the National Health and Hospitals Network Agreement (NHHNA) signed by the Commonwealth and states and territories, other than Western Australia, in April 2010 and the National Health Reform Heads of Agreement (HoA) signed in February 2010 by the Commonwealth and all states and territories amending the NHHNA.
Hospital	Healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.
Hospital and Health Board	The Hospital and Health Boards are made up of a mix of members with expert skills and knowledge relevant to managing a complex health care organisation.
Hospital and Health Service	Hospital and Health Service (HHS) is a separate legal entity established by Queensland Government to deliver public hospital services.
Hospital in the home (HITH)	Provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation.
Incidence	Number of new cases of a condition occurring within a given population, over a certain period of time.
Indigenous health worker	An Aboriginal and/or Torres Strait Islander person who holds the specified qualification and works within a primary healthcare framework to improve health outcomes for Indigenous Australians.
Long wait	A 'long wait' elective surgery patient is one who has waited longer than the clinically recommended time for their surgery, according to the clinical urgency category assigned. That is, more than 30 days for a category 1 patient, more than 90 days for a category 2 patient and more than 365 days for a category 3 patient.
Medicare Local	Established by the Commonwealth to coordinate primary health care services across all providers in a geographic area. Works closely with HHSs to identify and address local health needs.
Medical practitioner	A person who is registered with the Medical Board of Australia to practice medicine in Australia, including general and specialist practitioners.

Glossary

Word	Definition
Nurse practitioner	A registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessing and managing clients using nursing knowledge and skills and may include, but is not limited to, direct referral of clients to other healthcare professionals, prescribing medications, and ordering diagnostic investigations.
Outpatient	Non-admitted health service provided or accessed by an individual at a hospital or health service facility.
Outpatient service	Examination, consultation, treatment or other service provided to non-admitted non-emergency patients in a speciality unit or under an organisational arrangement administered by a hospital.
Overnight stay patient	A patient who is admitted to, and separated from, the hospital on different dates (not same-day patients).
Patient flow	Optimal patient flow means the patient's journey through the hospital system, be it planned or unplanned, happens in the safest, most streamlined and timely way to deliver good patient care.
Performance indicator	A measure that provides an 'indication' of progress towards achieving the organisation's objectives. Usually has targets that define the level of performance expected against the performance indicator.
Private hospital	A private hospital or free-standing day hospital, and either a hospital owned by a for-profit company or a non-profit organisation and privately funded through payment for medical services by patients or insurers. Patients admitted to private hospitals are treated by a doctor of their choice.
Public patient	A public patient is one who elects to be treated as a public patient, so cannot choose the doctor who treats them, or is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.
Public hospital	Public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.
Registered nurse	An individual registered under national law to practice in the nursing profession as a nurse, other than as a student.
Statutory bodies / authorities	A non-departmental government body, established under an Act of Parliament. Statutory bodies can include corporations, regulatory authorities and advisory committees/councils.
Sustainable	A health system that provides infrastructure, such as workforce, facilities and equipment, and is innovative and responsive to emerging needs, for example, research and monitoring within available resources.
Telehealth	Delivery of health-related services and information via telecommunication technologies, including: • live, audio and/or video inter-active links for clinical consultations and educational purposes • store-and-forward Telehealth, including digital images, video, audio and clinical (stored) on a client computer, then transmitted securely (forwarded) to a clinic at another location where they are studied by relevant specialists • teleradiology for remote reporting and clinical advice for diagnostic images • Telehealth services and equipment to monitor people's health in their home.
The Viewer	The Viewer is a read-only web-based application that displays consolidated clinical information sourced from a number of existing Queensland Health enterprise clinical and administrative systems.

Glossary

Word	Definition
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.