Annual Report 2013–2014

Great state. Great opportunity.

Queensland Government

Purpose of the report

This annual report details the non-financial and financial performance of the North West Hospital and Health Service (North West HHS) from 1 July 2013 to 30 June 2014. It highlights the achievements, performance, outlook and financial position of the North West HHS, and satisfies the requirements of the *Financial Accountability Act 2009* (Qld).

Public availability statement

This annual report can be accessed at **www.health.qld.gov.au/mt_isa/**

Copies can be obtained by contacting the Media and Communications Officer, Office of the Chief Executive, on (07) 4764 0210 or **NWHHS.Secretariat@health.qld.gov.au**.

Interpreter service statement

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Attribution

Content from this annual report should be attributed as: North West Hospital and Health Service Annual Report 2013–2014.

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Your feedback

The annual report is an important communication and accountability document. The North West Hospital and Health Service values comments and welcomes feedback from readers.

To provide feedback, please contact us at:

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Phone: (07) 4764 0210
Email: **NWHHS.Secretariat@health.qld.gov.au**

You may also provide feedback by completing a survey at **www.getinvolved.qld.gov.au**

Disclaimer

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Images contained within this document are courtesy of the North West Hospital and Health Service.

Letter of compliance

The Honourable Lawrence Springborg MP
Minister for Health
Member for Southern Downs

GPO Box 48
Brisbane QLD 4001

30 September 2014

Dear Minister

I am pleased to present the Annual Report 2013–2014 and financial statements for the North West Hospital and Health Service.

I certify that this Annual Report complies with:

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

A checklist outlining the annual reporting requirements can be found on pages 60–61 of this annual report.

Yours sincerely

Paul Woodhouse
Board Chair
North West Hospital and Health Service

Acknowledgement of traditional owners

The North West Hospital and Health Service respectfully acknowledges the traditional owners and custodians both past and present of the land, sea and waterways which we service and declare the North West Hospital and Health Service commitment to reducing inequalities between Indigenous and non-Indigenous health outcomes in line with the *National Indigenous Reform Agreement (Closing the Gap)*.

The July 2014 NAIDOC celebrations were particularly significant, with the flags of the Aboriginal and Torres Strait Islander peoples flying alongside the Queensland and Australian flags in front of the Mount Isa Hospital for the first time.

Contents

Chair's report

I am pleased to report that the North West Hospital and Health Service has continued to perform well. A modest financial surplus has been brought about by improved financial management and oversight. Improvements in the quality of our services have been recognised and measurable, as has improved program delivery and participation rates across the region.

Vital too, has been the search for better practice driven largely by willingness to contest all that we do, and to challenge ourselves and encourage others to do the same. This result is a shared one across all of our staff and many communities throughout the region we serve.

Our communities remain supportive and engaged. Operational structural reforms led by the Chief Executive have created unique leadership opportunities and both clinical and operational involvement in Board decisions. Further improvements in clinical and workforce engagement will soon follow in the 2014/2015 reporting year.

Our challenges remain not only ones simply created by distance, but primarily personal acceptance by people of responsibility for their own health, and a willingness to seek intervention help or otherwise before they are caught in the service net of acute care. Challenging also is the design of improved services at a lower unit cost. The increasing use and acceptance of Telehealth is however one example of how all communities can directly access appropriate specialist services which may not otherwise be available in the North West region.

Our opportunities are confronting but doable. We will find better ways to reduce the burden of chronic disease amongst a number of our communities. As we move forward, we can no longer support historical programs which cannot demonstrate success. Such programs wherever they may exist are often a product of self interest, lack of integration or inefficient modelling and are a misdirected use of valuable health funding. Worse, the targeted health problem remains, and grows.

A desire for continual improvement should be a constant companion to any organisation or individual, especially as we all continue to build an even better Hospital and Health Service for the future of this region.

In closing I thank the Board, the Chief Executive and each of the more than 600 Staff of the North West Hospital and Health Service. I recognise your professionalism and your efforts throughout the reporting period as the North West 'Team' continues to evolve and continually improve.

Paul Woodhouse
Chair, North West Hospital and Health Board

Chief Executive's overview

The second year of operation of the North West Hospital and Health Service has seen further enhancements in hospital and health services being delivered to our community. We have maintained efficient, effective and high quality care while demonstrating resilience in response to significant challenges.

We have implemented key service renewal initiatives in line with the recommendations of the Independent Commission of Audit Report and the State Government's Plan for Better Services in Queensland. Telehealth services have been significantly improved with a broader scope of service being provided at additional sites, and the appointment of Telehealth coordinators.

The five Queensland Public Service value statements underpin how we work and are reflected in our strategic and operational planning frameworks. Our staff are actively encouraged to implement the values of engaging with our community, embracing new ideas, unleashing their own potential and the potential of their colleagues, being accountable for their work, and empowerment through self-development. Our role descriptions require compliance with these values, and employee performance is measured against how well each staff member demonstrates these values in their daily work activities.

In March 2014 the Board endorsed a revised Strategic Plan. The strategies detailed in the plan will be implemented over the next three years. The revised plan highlights the Hospital and Health Service's vision, purpose and service commitment. Implementation of the plan will ensure alignment with our community's needs, State Government priorities, and national health reform priorities. Over the coming year we will develop clinical service plans aimed at guiding the delivery of targeted, sustainable and socially inclusive hospital and health care services that are consistent with our Strategic Plan and Government directions.

Quality, safety and risk continues to be a priority focus across the North West HHS. We have a strong commitment to patient-centred health care. Results from our participation in the State-wide Emergency Department Patient Experience Survey and our own patient satisfaction survey have informed ongoing continuous improvement activities across the service. Strategic level clinical governance structures were reviewed in late 2013. A new executive level position was established in May 2014 to drive improvements in safety, quality and risk management across the organisation. In addition a Clinical Operational Leadership Team was established to oversee and drive clinical innovation in all service areas.

The North West HHS has performed exceptionally well against the 2013–2014 Service Agreement with the Department of Health. We have achieved most financial and efficiency targets. The budget position for the year met forecasts despite the challenges that are inherent in delivery of health services in rural and remote communities.

A highlight during 2013–2014 was the continued excellent performance against waiting time for emergency department care and elective surgery targets. We are working hard to improve waiting times for general dental treatment with additional dental locum staff being contracted to help patients in outreach areas.

We continue to forge close partnerships with other government departments and local non-government organisations. We collaborate closely with Central and North West Queensland Medicare Local and community based Aboriginal and Torres Strait Islander Health Services. Our planned collaboration with our key partners in health service delivery over the coming years will facilitate adoption of innovative, integrated and sustainable service delivery models in key priority areas.

Partnership with our community is another key component of our strategic and operational activities. Our local communities have contributed enthusiastically in a range of forums and service projects throughout the year. The Inaugural Mount Isa Health Expo, a collaborative event with our key health care partners, was held in July 2014. The event proved to be very popular with community members. Attendees appreciated the opportunity to hear from expert health professionals and learn more about the health services provided in the North West HHS.

Substantial challenges have arisen over the last twelve months, not the least being the structural issues in Block C at the Mount Isa Hospital. Rectification works were completed in early 2014 and clinical care units were recanted back into the refurbished accommodation in March 2014. I again commend the commitment of our staff to maintaining safe and high quality care throughout the period of refurbishment.

Also during this last year the Board, after much deliberation, reached a decision to relinquish Home and Community Care Services to the non-government sector to enable resources to be refocused into core service delivery areas.

We have successfully achieved one of the key elements of national health reform in obtaining "prescribed employer" status from 1 July 2014. This means that the Board, in addition to being responsible for financial management and for management of the Service's land and buildings, now controls the management of the Service's staff. While the Department of Health will retain responsibility for setting the terms and conditions for staff, the North West HHS is now responsible for all other HR management functions.

I would like to thank the Board for their leadership, guidance and support over the last twelve months. My thanks too to the executive team and all our staff for their hard work and commitment to providing accessible, responsive, quality health services and care. I would also particularly like to acknowledge and thank our volunteers. Staff and patients alike appreciate the dedication and contribution of our Red Cross Service, Hospital Auxiliary and other volunteers.

I look forward to the next twelve months, working together with our staff, community and partners, in continuing along our path to becoming Queensland's leading Hospital and Health Service.

Sue Belsham
Chief Executive, North West Hospital and Health Service

Key achievements 2013–2014

July 2013

- NAIDOC week celebrations were held under the Mount Isa Hospital Healing Tree.
- North West HHS first birthday celebrations.

August 2013

- Community health forums were held at Burketown, Doomadgee, Camooweal and Dajarra.

September 2013

- McKinlay Shire Multipurpose Health Service Health Advisory Panel meeting.
- Cloncurry Community Advisory Network meeting.
- Rural Birth Summit conducted – collaboration between the North West HHS maternity services and the Queensland Centre for Mothers and Babies.
- New Cancer Care Unit at Mount Isa Hospital was officially opened by the Minister for Health and North West HHS Board Chair. This new Unit provides increased capability to provide care for cancer patients in the North West.

New Cancer Care Unit at Mount Isa Hospital

- Redeveloped Mount Isa Hospital Emergency Department was officially opened by the Minister for Health and North West HHS Board Chair, increasing from a 14 to 27 bed unit, including 3 short stay beds.
- McKinlay Shire Multipurpose Health Service was officially opened by the Minister for Health and North West HHS Board Chair.
- Expansion of telehealth services was launched by the Minister for Health in Normanton – a new evaluation site under the State Government's Rural Telehealth Service program.
- Official opening of helipads in Mount Isa and Cloncurry.

October 2013

- Allocation of a rural and remote allied health graduate position (Dietetics) under the Allied Health Rural Generalist Training program to provide on the job training and mentoring during first year of career.
- Mornington Island health summit.

November 2013

- Executive structure review implemented and Clinical Operational Leadership Team (COLT) established.
- Purchase of a 30-unit staff accommodation complex in Mount Isa with funding allocated through the Commonwealth Government Hospital and Health Funding.
- The Minister allocated funding to the North West HHS to continue service provision at the McKinlay Clinic.

December 2013

- Occupation of aged care annex at Cloncurry Multipurpose Health Service.

January 2014

- Renal services boosted with approval for the addition of a Nurse Practitioner to provide end stage chronic kidney disease services and the location of self-care dialysis chairs at both Mount Isa and Normanton Hospitals.
- Collaborative project established with Central and North West Queensland Medicare Local to improve access, service delivery and community engagement in Mornington Island, with the intention of service wide roll out on successful completion of the project.

February 2014

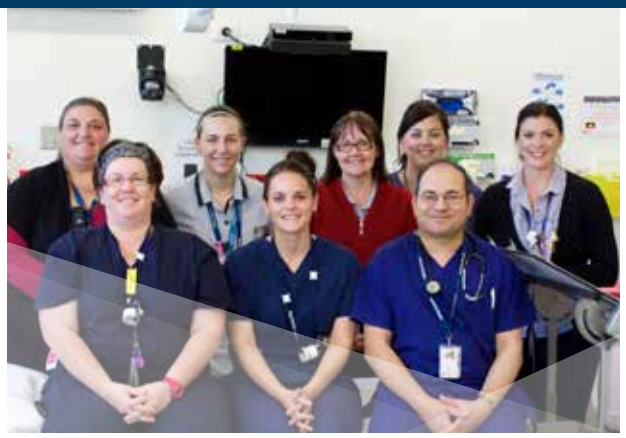
- Funding secured to purchase and implement Communicare patient database (electronic medical record system).

March 2014

- Following repairs to address structural integrity issues and upgrade of the fire hydrant system, Block C at Mount Isa Hospital was re-occupied.
- Opening of the Mount Isa Hospital Kiosk 'Café on Camooweal'.

April 2014

- Capacity at McKinlay Shire MPHS increased to 4 beds (total of 8 beds including 4 acute beds).



May 2014

- Opening of Urandangie Health Clinic by respected elder Uncle Billy Tommy, four year-old Roseanne Age, and Rob Katter, Member for Mount Isa.
- Urandangie Health Forum.
- Further expansion in Nurse Practitioner roles – currently 11 Nurse Practitioners specialising in chronic disease, renal, cardiac, maternal child health, emergency and rural and remote health care – over the coming months additional positions to include sexual health and diabetes Nurse Practitioners.
- Successful negotiation of employment contracts with all Senior Medical Officers.

June 2014

- Mount Isa Hospital has maintained strong performance throughout the year with excellent access indicators for emergency department and elective surgery.
- Credentialing of all Allied Health Practitioners within the North West HHS.
- ACHS accreditation periodic review completed.
- Received notification of successful application for prescribed employer status to commence 1 July 2014.

Significant issues 2013–2014

Mount Isa Hospital Block C structural repair

In September 2012 concrete cancer was identified in the under croft of Block C at Mount Isa Hospital. During rectification works it was identified that significant fire hydrant works were required. Rectification works and fire hydrant compliance works were completed in March 2014.

Following extensive consultation with staff, clinical services were relocated back into Block C in March 2014. The Board determined to re-establish separate medical and surgical wards, with the day surgery unit co-located in the surgical ward. Reconfigured bed numbers included provision for eight flexi beds to optimise bed management within the hospital during peak periods.

Staff managed the extreme conditions that arose during rectification works with patience and continued to put patient care first. Patients and staff have expressed satisfaction with the refurbished accommodation.

The total cost of the rectification works and fire hydrant works was in excess of $1.5m. The North West HHS received funding assistance from the Department of Health to meet the cost of this work.

Relinquishment of Home and Community Care Services

After much deliberation the North West HHS Board reached a decision to relinquish Home and Community Care Services. This decision was made to enable the North West HHS to focus its resources on core service delivery areas such as emergency medicine, surgery, cancer services, maternal and child health services, chronic disease services and mental health care.

North West HHS Drought Recovery Collaborative

In May 2014 the Minister of Health called a Ministerial Round Table in Charleville to discuss the drought situation across the state, and the mental health concerns for those directly affected by the drought. Those affected are primarily graziers and their families but the concern also extends to the local communities, schools, businesses and anyone who is associated with the affected community members.

As a result of this round table the North West HHS coordinated the implementation of a Drought Recovery Collaborative to develop and implement localised approaches and initiatives. This collaborative has been instrumental in the coordination of drought specific activities and local programs. One of these activities has been the development of double sided magnets that hold health contact numbers and signs and symptoms of depression. The magnets have been delivered throughout the region to local stations and businesses directly linked with drought affected families. Mr Paul Woodhouse, North West HHS Board Chair, personally delivered some of these magnets to West Wing Aviation for delivery on the local mail run.

The collaborative includes many local government and non-government agencies. Participants include Agforce, Medicare Local, Centacare, Department of Communities, Human Services, Education Queensland, North West Catholic Social Services, and Mr Rob Katter, the State Member for Mount Isa. Service delivery and approaches are monitored and streamlined for optimum results utilising the partnerships with these members through the collaboration. Mr Paul Woodhouse and Ms Sandra Kennedy, Director Mental Health and ATODS, are members of the collaborative.

Staff accommodation

The availability of suitable accommodation for staff continues to be a priority issue for the North West HHS as it is a critical component of recruitment and retention strategies. Forward planning for accommodation needs is in progress. The purchase of a 30-unit complex in Mount Isa has assisted to meet urgent accommodation needs for Mount Isa based employees.

Recruitment and retention

Ensuring that we have the 'right person for each and every job' is critical to meeting our commitment to provide high quality hospital and health care to the communities in our service areas. Ongoing workforce planning, including recruitment and retention activities, are priority issues for all service areas.

Meeting community expectations for health care in a remote location with finite resources

The Board has actively engaged in community consultation throughout the year, with regular visits to all service areas. Community engagement and participation in planning, delivery and evaluation of health services is being implemented into health service activities at all levels of the organisation. The last twelve months has seen significant improvements in the availability and use of telehealth services within the North West HHS.

Looking ahead 2014–2015

Our activities will be aimed at:

- 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.

Service plans under development include:

- Quality, Safety and Risk plan.
- Cultural Capability plan.

These service-wide plans will be finalised and implemented over the next twelve months.

Key projects to be undertaken during 2014–2015

- A number of projects funded under the Queensland Aboriginal and Torres Strait Islander Health Investment Strategy will commence in July 2014.
- A seamless model of care for maternal and child health services will be introduced across the North West HHS from late 2014. Funding has been obtained to establish a Nursing Director position to lead the development and implementation of this innovative model of care.
- National Partnership Agreement funding will enable the Community Rehabilitation Program, conducted in partnership with James Cook University and the Central and North West Queensland Medicare Local, to continue to provide post hospital neuro-rehabilitation services across the North West HHS.
- The Paediatric Connected Care Program will help meet the needs of families and children with chronic and complex health care needs.
- The Strengthened Lead Prevention Program will help identify risks factors, and offer targeted interventions designed to minimise the risk of continued lead exposure.

Our community's health

Health service areas

The North West Hospital and Health Service (HHS) delivers public hospital and other health services to a population of around 33,000 people residing in north western Queensland and the Gulf of Carpentaria. Service areas include Mount Isa, Burketown, Camooweal, Cloncurry, Dajarra, Doomadgee, Julia Creek, McKinlay, Karumba, Mornington Island, Normanton and Urandangie.

Population

The Australian Bureau of Statistics' estimated resident population of the North West HHS region as at 30 June 2013 was 32,654 which accounts for approximately 0.7% of the total population of Queensland. The Indigenous population accounts for 23% of the total population of the North West HHS.

Table 1. Estimated resident population by age and LGA, North West HHS Region and Queensland, 30 June 2012

Region LGA/State	Age Group									
	0–14		15–24		25–44		45–64		65+	
	Number	%	Number	%	Number	%	Number	%	Number	%
NWHHS Region	**7,637**	**23.5**	**4,786**	**14.7**	**10,756**	**33.1**	**7,147**	**22.0**	**2,142**	**6.6**
Burke (S)	102	18.4	79	14.2	193	34.8	151	27.2	30	5.4
Carpentaria (S)	460	21.0	250	11.4	588	26.9	649	29.7	239	10.9
Cloncurry (S)	677	19.8	488	14.2	1,151	33.6	869	25.4	240	7.0
Doomadgee (S)	493	35.9	216	15.7	416	30.3	211	15.4	38	2.8
McKinlay (S)	186	17.1	146	13.4	390	35.9	264	24.3	100	9.2
Mornington (S)	420	34.6	146	12.0	347	28.6	247	20.3	54	4.4
Mount Isa (C)	5,299	23.4	3,461	15.3	7,671	33.9	4,756	21.0	1,441	6.4
Queensland	**907,035**	**19.9**	**633,335**	**13.9**	**1,289,071**	**28.2**	**1,127,456**	**24.7**	**608,632**	**13.3**

Source: ABS 32356.0 Population by Age and Sex, Regions of Australia, 2012 and Queensland Treasury and Trade estimates in Queensland Government Statistician's Office, Queensland Regional Profiles, The State of Queensland (Queensland Treasury and Trade) 2014

Population growth rate

The average annual population growth rate within the North West HHS for the five years to 30 June 2013 was 1.2%. This compared with an average annual growth rate in Queensland of 2% over that period.

The population for the North West HHS region is projected to increase by an annual rate of 0.8% over the 25 years from 2011 to 2036. The projected population of the region in 2036 is 38,833. In contrast, the population of Queensland is projected to increase by 1.9% per year over that period to a total of 7,095,177 by 2036.

Indigenous population

The number of people living in the North West HHS Region who identified as Indigenous in the 2011 Census was 7,037 or 23.1% of the population. Doomadgee Shire had the largest percentage of Indigenous people (92%).

Table 2: Indigenous status by LGA, North West HHS Region and Queensland 2011

Region/ LGA/ State	Indigenous persons					Non-Indigenous persons		Total persons
	Aboriginal	Torres Strait Islander	Both	Total				
	Number			Number	%	Number	%	Number
NWHHS Region	**6,703**	**136**	**198**	**7,037**	**23.1**	**19,722**	**64.6**	**30,511**
Burke (S)	140	0	3	143	27.8	286	55.6	514
Carpentaria (S)	714	7	36	757	36.8	1,046	50.9	2,055
Cloncurry (S)	661	22	19	702	21.8	2,158	66.9	3,227
Doomadgee (S)	1,179	3	3	1,185	92.0	95	7.4	1,288
McKinlay (S)	39	0	0	39	3.7	894	85.3	1,048
Mornington (S)	986	4	15	1,005	88.0	131	11.5	1,142
Mount Isa (C)	2,984	100	122	3,206	15.1	15,112	71.2	21,237
Queensland	**122,896**	**20,094**	**12,834**	**155,824**	**3.6**	**3,952,707**	**91.2**	**4,332,740**

Source: ABS, Census of Population and Housing, 2011, Indigenous Profile – 102 (usual residence) and Queensland Treasury and Trade in Queensland Government Statistician's Office, Queensland Regional Profiles, The State of Queensland (Queensland Treasury and Trade) 2014

Total persons includes Indigenous status not stated.

Births and deaths

The number of registered births in 2012 to mothers with a usual residence in the North West HHS Region was 618. There were 134 registered deaths in the North West HHS Region in 2012.

Country of birth and languages

12% of people living in the North West HHS Region in 2011 were born overseas. In 2011 approximately 2.6% of those people born overseas reported that they did not speak English well.

The top five non-English languages spoken at home in the North West HHS Region in 2011 were:

1. Southeast Asian Austronesian
2. Australian Indigenous languages
3. Indo Aryan
4. Italian
5. Chinese.

Internet connection

69% of occupied private dwellings in the North West HHS Region had internet connections in 2011.

Table 3: Occupied private dwellings without internet connection by LGA, North West HHS Region and Queensland 2011

Region/ LGA/State	No internet connection		Total dwellings (a)(b)
	number	%	number
NWHHS Region	**2,232**	**25.3**	**8,827**
Burke (S)	36	31	116
Carpentaria (S)	229	35.6	643
Cloncurry (S)	267	29.4	907
Doomadgee (S)	131	60.9	215
McKinlay (S)	68	22.7	299
Mornington (S)	169	68.1	248
Mount Isa (C)	1,332	20.8	6,399
Queensland	**281,467**	**18.2**	**1,547,301**

(a) Excludes visitors only and other not classifiable households.
(b) Includes internet connection not stated.

Source: ABS, Census of Population and Housing, 2011, Basic Community Profile – B35 (occupied private dwellings) and Queensland Treasury and Trade estimates in Queensland Government Statistician's Office, Queensland Regional Profiles, The State of Queensland (Queensland Treasury and Trade) 2014.

Social and economic conditions

In 2011 a Socio-economic Index of Disadvantage was produced from Census data, ranking geographical areas to reflect disadvantage of social and economic conditions. The index focuses on low-income earners, relatively lower education attainment, high unemployment and dwellings without motor vehicles.

The percentage of people in the North West HHS Region in the least disadvantaged group was 5.4%. In contrast, the percentage of all Queenslanders in the least disadvantaged group was 20%.

24.9% of people in the North West HHS Region were in the most disadvantaged group. In contrast, 20% of all Queenslanders were in the most disadvantaged group.

Areas with the highest percentage of people in the most disadvantaged group were Carpentaria, Doomadgee and Mornington.

Key health conditions and determinants of disease

Significant diseases and health conditions experienced by people living in the North West HHS Region include coronary heart disease, stroke, mental illnesses, chronic lung disease, diabetes, renal failure, and asthma.

Health determinants of significant impact for people living in the North West HHS Region include smoking, poor nutrition, harmful alcohol consumption, overweight and obesity, physical inactivity, and risk and protective factors for mental health.

A 2012 Queensland Health* study found that many unhealthy behaviours are more common in regional and remote areas of Queensland.

- The percentage of people living in very remote areas who were obese was 54% higher than for people living in major cities.
- The percentage of people living in very remote areas who smoked daily was 53% higher than people living in major cities.
- The percentage of people living in very remote areas who reported alcohol consumption that was risky (over the lifetime) was 29% higher than for people living in major cities.

Sun safe behaviours were an exception: the percentage of people living in very remote areas who used three or more sun protection behaviours in summer was 24% higher than for people living in major cities.

Implications of population characteristics on health care needs

In comparison to Queensland, the North West HHS Region has:

- A higher proportion of children.
- A higher proportion of males.
- A higher proportion of Indigenous people.
- A remote location.

Demand for health services in the North West HHS continues to be influenced by the mining sector and the impact of 'fly-in, fly-out' workers, a mature pastoral industry and a developing tourism industry.

Strategies to address the burden of disease in the North West HHS Region:

- Involve community services and sectors working together.
- Address social, behavioural, economic and environmental factors.
- Specifically address equity and reduce disparities by focusing on the needs of the most disadvantaged communities and population groups.

**Self-reported health status 2011–2012. Health indicators: chronic disease and behavioural risk factors: 2011 socioeconomic (SEIFA) and remoteness (ARIA+) results. Queensland, Hospital and Health Services and Medicare Locals. Department of Health, Queensland Government: Brisbane: 2013*

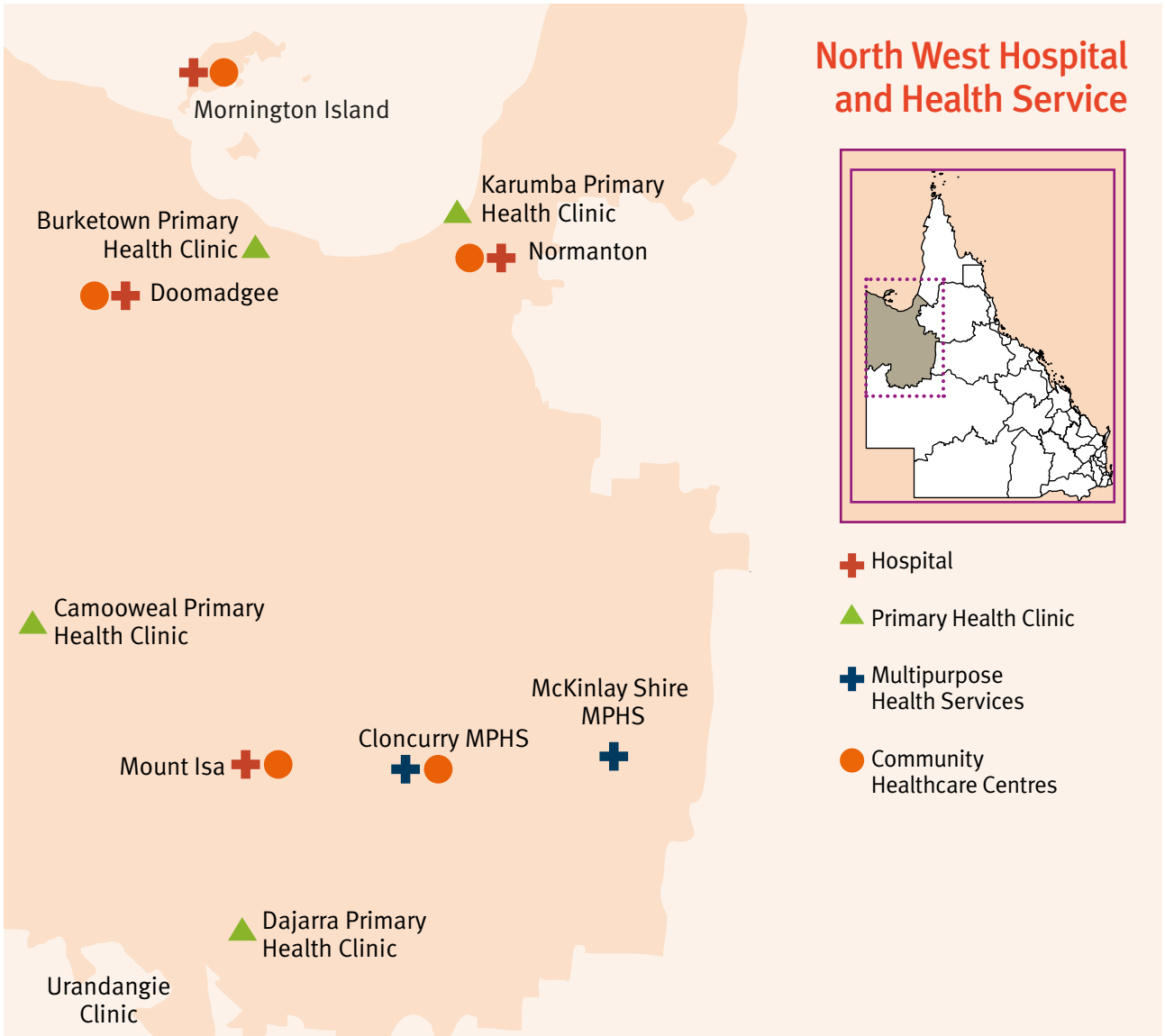
Our health services

North West Hospital and Health Service (HHS) is an independent statutory body established under the *Hospital and Health Boards Act 2011*. A local Hospital and Health Board controls the service. The North West HHS is responsible for the direct management of the facilities within the HHS's geographical boundaries including its main referral centre, the Mount Isa Hospital, two multipurpose health services, three rural/remote hospitals, four primary health clinics and five community health centres.

The North West HHS provides a comprehensive range of community and primary health services including aged care assessment; Aboriginal and Torres Strait Islander health programs; child and maternal health services; mental health services; alcohol, tobacco and other drug services; community health nursing; sexual health service; allied health; oral health and health promotion programs.

The North West HHS also provides emergency ambulance retrieval and treatment support services across the Northern Territory border for communities towards Tennant Creek and Lake Nash.

The Townsville Hospital and Health Service provides support for public health services within North West HHS.



Mount Isa City – Mount Isa Hospital

1,900km north west of Brisbane | 1,330km north west of Rockhampton
887km west of Townsville

Mount Isa is the major service centre for North West Queensland. The City was established in 1932 following discovery of one of the world's richest deposits of copper, silver, lead and zinc ore. Mount Isa is a progressive industrial, commercial and tourist centre with a thriving mining industry. The Kalkadoon people are the traditional owners of the land surrounding the Mount Isa region.

Mount Isa Hospital is the main referral centre within the North West HHS. In March 2014 the number of inpatient beds was 60. There is capacity to increase inpatient bed numbers by a total of 8 beds as required during peak periods. Patients who require specialist treatment and care are referred to either the Mount Isa Hospital or to major centres outside of the HHS including Cairns, Townsville and Brisbane hospitals.

Inpatient and outpatient service areas include medical, palliative care, surgical, obstetrics, paediatrics, and critical care services. Haematology and rheumatology outpatient services are provided by telehealth. Ambulatory care services include emergency department and allied health services. Chemotherapy and endoscopy services are provided at the hospital. The Townsville HHS provides renal services (dialysis) from an eight chair Renal Unit on site at Mount Isa Hospital.

Key achievements 2013–2014

- Implementation of SHARED clinical handover framework across all streams including nursing, medical and allied health staff.
- Accreditation with the Australian College of Rural and Remote Medicine to deliver primary rural and remote skills training and advanced skills training in emergency medicine, obstetrics and anaesthetics for junior doctors, with plans to take the first cohort of interns in early 2015.
- Trial of two Aboriginal Liaison Indigenous Traineeships in maternity services and emergency department.
- Implementation of the Queensland Health Nutrition Standard for Meals and Food.
- Award of a state-wide Rural Allied Health training position.
- Occupational therapy commenced a rheumatic heart disease research project.
- Improved clinical pharmacy services with wards having a regular pharmacy service and pharmacists taking part in multidisciplinary ward rounds.
- Improved recruitment and retention of pharmacists allowing resumption of pharmacy opening hours and employment of an Outreach Pharmacist to provide services to outreach sites within the HHS.
- Achievement of excellent indicators for physiotherapy services for both volume and cost.
- Maintenance of orthotics service and achievement of monthly service targets.

- Social work service provided to Youth Justice conferencing through Social Work Clinics.
- Creation of speech therapy resources for use on wards with patients who have communication difficulties.
- Implementation of daily discharge planning rounds by Clinical Nurse Consultant (Discharge Facilitator) to all clinical areas to facilitate enhanced discharge planning.
- Trial and implementation of Maternity Emergency Warning Tool (Q-MEWT).
- Successful application for a further year of funding for the Clinical Nurse Consultant Wound Care with strong evidence of positive outcomes.
- Introduction of wound care telehealth services providing outreach wound clinics to priority sites of Mornington Island, Normanton, Doomadgee and Julia Creek.
- Increased occasions of service in nurse-led clinics in areas of wound management, influenza and pneumonia vaccinations, staff vaccinations, rheumatic heart disease, diabetes, heart failure, pulmonary rehabilitation screening, nephrology, smoking cessation, and midwifery review.
- Recruitment of experienced oncology nurse specialist, reducing the need for out of area referrals for chemotherapy; and recruitment of experienced Breast Care Nurse.

Looking ahead 2014–2015

- Trial of Aboriginal Liaison Officer attending medical ward rounds and discharge planning meetings to address discharge against medical advice (DAMA) by Aboriginal and Torres Strait Islander patients.
- Allied health service mapping exercise with Central and North West Queensland Medicare Local to identify gaps in service.
- Introduction of Paediatric Acute Complex Care Management (PACCMan) Outreach program funded under the Connected Care program.
- Implementation of the Strengthened Lead Prevention Program to enhance screening for lead within the HHS.
- Implementation of a sustainable midwifery model of care contextualised for the North West HHS.

Telehealth services

The North West HHS supports the implementation of the 'Rural Telehealth Service', including the telehealth emergency support service, outlined in the *Blueprint for better healthcare in Queensland*. Telehealth services benefit patients by improving access to clinical services closer to home.

The North West HHS collaborates with the Department of Health, other Hospital and Health Services, relevant non-government organisations and primary care stakeholders to contribute to an expanded network of telehealth services.

Telehealth has been funded in the North West HHS since 2009. The North West HHS has established dedicated telehealth coordinators to progress the telehealth agenda locally, driving stakeholder engagement, adoption, planning and implementation of activities that will support telehealth enabled services through supplementation of existing face to face services and identification of new telehealth enabled models of care.

Key achievements 2013–2014

- Appointment of North West HHS Telehealth Coordinator: Appointment of a full-time Clinical Nurse Consultant to the role of Telehealth Coordinator. The position is responsible for coordination and service direction across the North West HHS.
- Appointment of Rural Telehealth Coordinator: Appointment of a full-time Clinical Nurse to the role of Telehealth Coordinator for Normanton Hospital. Under the Minister's Initiative, Normanton has been identified as a targeted evaluation site to trial and implement the Rural Telehealth Service model of care.
- Appointment of 0.5 FTE administration officer.
- Expansion of telehealth services for endocrinology patients with four extra clinics per month from February 2014 providing potential for 20 additional occasions of service per month.
- Expansion of telehealth services for renal patients with two extra clinics per month from March 2014 providing potential for eight additional occasions of service per month.
- Development of specialist paediatric endocrine telehealth services offering access to both public and private options for the North West HHS community.

Looking ahead 2014–2015

- Further the development of nurse led clinics offered via telehealth.
- Continued expansion of telehealth services across the North West HHS.
- Introduction of Telehealth Emergency Management Support Unit (TEMSU) to coordinate video consultations between small rural facilities and larger hospitals for non-critical emergency patients.
- Investigating the use of telehealth services to decrease the need for patients to travel to medical appointments and reviews.

Mornington Shire – Mornington Island Hospital and Primary Health Clinic

2,270km north west of Brisbane | **444km** north of Mount Isa
125km north west of Burketown

Mornington Island is part of the Wellesley Island Group in the Gulf of Carpentaria and is home to a small Indigenous community. The Island achieved self-governance in 1978 and is now controlled by the Mornington Shire Council. Mornington Island is accessible only by boat and air.

Mornington Island Hospital is a rural and remote hospital with 11 inpatient beds. The facility provides 24 hour acute inpatient and accident and emergency care, and outpatient services Monday to Friday.

Community health services are provided Monday to Friday. North West HHS outreach services include alcohol and other drugs counselling, maternal health, mental health, dental, diabetic education, renal services (Nurse Practitioner), mobile women's health services and sexual health.

Other outreach services include Royal Flying Doctor Service (women's health and child health), Royal Children's Hospital (Deadly Ears service), Central and North West Queensland Medicare Local (allied health services), The Prince Charles Hospital (cardiac and respiratory).

Top inpatient care diagnoses include:

- Cellulitis
- Respiratory infections
- Alcohol related conditions
- Poisoning
- Kidney and urinary tract infections

Key achievements 2013–2014

- Appointment of a Nurse Practitioner to support new model of care.
- Commencement of a health service mapping exercise.
- Commencement of the collaborative project with Central and North West Queensland Medicare Local aimed at identifying ways to improve the coordination and integration of care between health organisations.

Looking ahead 2014–2015

- Continue to collaborate and work in partnership with the local community.
- A specialist Indigenous respiratory outreach clinical team will visit Mornington Island in September 2014 to hold adult and child clinics. The clinics will be delivered by the Indigenous Respiratory Outreach Care (IROC) Program.

Doomadgee Shire – Doomadgee Hospital

2,200km north west of Brisbane | **470km** north west of Mount Isa
100km south west of Burketown

Doomadgee is an Indigenous community located on the Nicholson River in the far north-western corner of Queensland, near the Gulf of Carpentaria. Today Doomadgee is a Deed of Grant in Trust community governed by the Dooomadgee Aboriginal Shire Council.

Significant lengths of the main road providing access to Doomadgee are unsealed. Road access to Dooomadgee can be cut off for weeks during the wet season. A commercial airstrip provides year round access to the community.

Doomadgee hospital has six acute inpatient beds and a 24 hour per day emergency department. The outpatients department provides general outpatient clinics including dressings, immunisations, rheumatic heart program and medical clinics.

Visiting services including Paediatrician, Royal Flying Doctor Service, Child Health and Immunisation Clinic, Deadly Ears Team, Dietitian, Surgeon, Vascular Surgeon, Gynaecologist, Mental Health Team, Chest Physicians, Psychologist, Diabetic Outreach Team, Cardiac Team, Dental Outreach, mobile women's health and Renal Nurse Practitioner services.

The hospital works in close collaboration with community health staff who offer services including assistance with discharge planning, home visits, health screening, patient liaison/advocacy, health education and promotion activities.

Top inpatient care diagnoses include:

- Immune system condition
- Respiratory infections
- Cellulitis
- Viral illness
- Circulation disorders

Key achievements 2013–2014

- Staffing model reviewed and strategies formulated to create sustainable recruitment and retention of nursing and operational staff.
- Commenced work on a model of care based on *Closing the Gap* objectives.

Looking ahead 2014–2015

- Prioritise increased use of telehealth services.
- Continue to participate in local networks and local stakeholder meetings.
- A specialist Indigenous respiratory outreach clinical team will visit Doomadgee in September 2014 to hold adult and child clinics. The clinics will be delivered by the Indigenous Respiratory Outreach Care (IROC) Program.

Carpentaria Shire – Normanton Hospital and Primary Health Clinic

2,100km north west of Brisbane | **700km** west of Cairns
500km north east of Mount Isa

Normanton is a small community situated on the banks of the Norman River in the Gulf of Carpentaria. Fishing and prawning industries are the mainstay of the area. Tourism brings transient increases in population during the year. The Gkuthaarn, Kukatj, Kurtijar and Kokoberrin peoples are the traditional owners of lands in the Normanton area.

Normanton is accessible via a network of sealed and unsealed roads. Some roads may be closed during the wet season (December–March). A sealed airstrip provides year round access to the community.

Normanton Hospital has 14 acute inpatient beds and 4 respite/palliative care beds. The accident and emergency department operates 24 hours per day.

Community health services operate Monday to Friday and provide a range of services including discharge planning, home visits, health screening, patient liaison/advocacy, education and support. Visiting services include Royal Flying Doctors, Central and North West Queensland Medicare Local (allied health services), women's health, a private hearing service and regular visiting specialty services.

Top inpatient care diagnoses include

- Cellulitis
- Chronic obstructive airways disease
- Digestive system disorders
- Skin ulcers
- Chest pain

Key achievements 2013–2014

- Commencement of a telehealth Clinical Nurse position and increased use of telehealth services.
- Participation in local networks and events including the Carpentaria Health Committee, Interagency meetings, mental health network, housing advisory group, and disaster management group.
- Introduction of a Nurse Practitioner two days a week at Normanton Hospital and Community Health.

Looking ahead 2014–2015

- Further integration of telehealth services into daily practice and continuing the increase in use of telehealth services.
- Development of the Nurse Practitioner model of care including clinic appointments and discharge planning.

Carpentaria Shire – Karumba Primary Health Clinic

2,222km north west of Brisbane | **570km** north west of Mount Isa
70km north of Normanton

Karumba is a fishing port located at the mouth of the Norman River on the coast of the Gulf of Carpentaria. Karumba's main industries are based around fishing. Tourism brings significant increases in the population between April and October.

Karumba Health Clinic provides a low risk ambulatory service only. A registered nurse provides services and a general practitioner visits once or twice per week. Patients requiring higher levels of care are managed for short periods prior to transfer to a higher level service.

Services include triage for lower acuity medical conditions and minor procedures, life support and stabilisation prior to transfer to a higher level service, coordination of visiting services, medication services, and chronic disease management. Central and North West Queensland Medicare Local provides allied health services, diabetes education and continence advice. There are visiting optometry and ophthalmology services. Other visiting outreach services include cardiology, respiratory, surgery, obstetrics and gynaecology, and women's health.

Key achievements 2013–2014

- In February 2014 the Karumba Health Clinic received a state-wide quality award for outstanding quality compliance and technical performance in point of care blood testing.
- Development and trial of a Nurse Practitioner role with dual reporting to Karumba and Normanton, with a reduction in waiting time for general practitioner from four weeks to one week.
- Nurse Practitioner model of care provided access to services during wet season – despite road closure the Nurse Practitioner service continued via telehealth service.
- Mums and Bubs program: fortnightly meetings in the Civic Centre support the North West HHS midwifery and neonatal strategies with adherence to state-wide maternal and neonatal guidelines.
- Strong community engagement with the Director of Nursing participating on local committees.

Looking ahead 2014–2015

- Implementation of Communicare and staff training to enhance data capture and reporting capacity.

Cloncurry Shire – Cloncurry Multipurpose Health Service (MPHS)

1,708km north west of Brisbane | **766km** east of Townsville
120km east of Mount Isa

Cloncurry is located on the Cloncurry River in central-west Queensland. The town supports major mines (silver, gold, copper and zinc) and has thriving cattle and sheep industries. In 1928 the Royal Flying Doctor Service launched its inaugural flight from Cloncurry. The town is accessible via sealed roads.

Cloncurry Multipurpose Health Service provides rural and remote hospital services including a 15 inpatient bed facility, 10 bed residential aged care facility, emergency department and outpatient department. Inpatient services are supported by the Medical Superintendent, local and locum medical officers.

Community health services include aged care assessment team, sexual health, chronic disease management, diabetes education, mental health, alcohol and drug service, school health, child and youth health, women's health, palliative care, physiotherapy, dietitian, and optometry services. Central and North West Medical Local provides allied health services and diabetes education services.

A multidisciplinary model of care is implemented at the Multipurpose Health Service. Residential care is integrated into health service delivery to provide care across the continuum from emergency and outpatient departments to acute patient and residential care services.

Top inpatient diagnoses include:

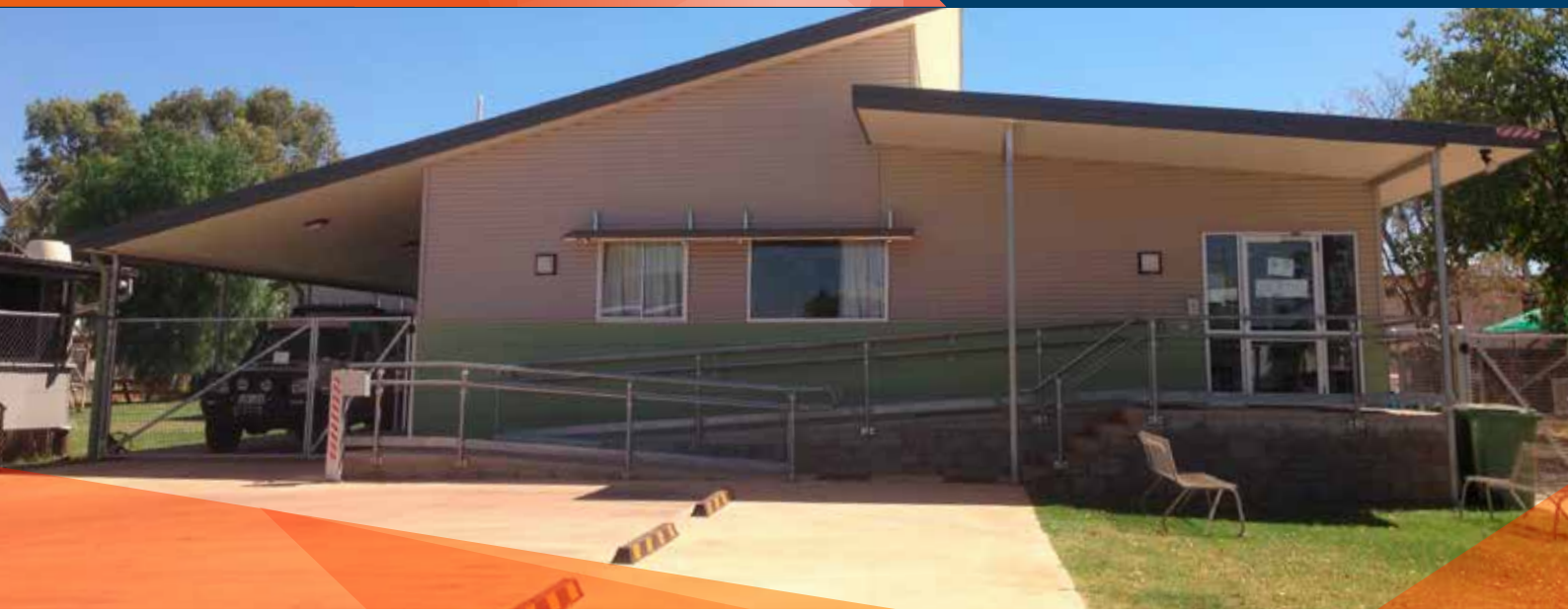
- Respiratory infections
- Digestive system disorders
- Cellulitis
- Otitis media and upper respiratory infections
- Oesophagitis and gastroenterology disorders

Key achievements 2013–2014

- Completion of 10 bed annexure for residential aged care.
- Recruitment of personal care attendants to care for residents and support current health workforce at Cloncurry Multipurpose Health Service.
- Gradual increase in capacity from three to six residents in January 2014, with four respite care residents, and increased to 10 residential aged care places from April 2014.
- Community Advisory Network evolved to reflect the MPHS with high participation by community stakeholders.
- Introduction of the Mums and Bubs program: group sessions in the community for expectant mothers and new mothers, and expansion of program for mothers of toddlers by the Child Health Nurse (Community Health).
- Completion of a helipad to allow more responsive and efficient aeromedical retrievals.

Looking ahead 2014–2015

- Implement Communicare informatics system including system integration with current reporting requirements and complete staff training.
- Review staffing model and model of care in line with activity and acuity following expansion of residential aged care beds.



Cloncurry Shire – Dajarra Primary Health Clinic

1,950km north west of Brisbane | **150km** south of Mount Isa

Dajarra is located south of Mount Isa, towards Boulia. The area has a rich Aboriginal heritage. The roads to Mount Isa and Boulia are sealed, and the road to Cloncurry is unsealed.

Dajarra is a primary health care clinic staffed by one advanced clinician registered nurse and a small team of Indigenous Health Workers. Clinic services operate Monday to Friday. Emergency on call and hospital based ambulance services are available 24 hours a day, 7 days per week.

Services include primary health care and chronic disease management, antenatal and postnatal care, home visiting, point of care pathology testing, short stay observation (less than 4 hours), community health promotion and prevention programs and coordination of visiting services.

Visiting services include women's health, alcohol and drug, surgical clinic, Deadly Ears and cardiology outreach services. The Royal Flying Doctor Service provides general practitioner, child health, women's health and emergency retrieval and clinical support services. The Central and North West Queensland Medicare Local provides a range of allied health services and diabetes education.

Key achievements 2013–2014

- Upskilling of local Aboriginal workforce with the achievement of Certificate III qualification.
- Workshop titled 'recognising and supporting people in crisis' conducted in May 2014 to educate community on skills to support each other run by Psych Aware.
- Local Dajarra Primacy Health Care Clinic database implemented to assist with health planning.

Looking ahead 2014–2015

- Joint health promotion and prevention initiative with the Department of Education for children in Dajarra with focus on skin, hair and ears.
- Review and implementation of a Mums and Bubs postnatal visiting program.
- Implementation of Communicare system and staff training to enhance data capture and reporting capacity.

McKinlay Shire – McKinlay Shire Multipurpose Health Service

1,633km north west of Brisbane | **260km** east of Mount Isa | **650km** west of Townsville

Julia Creek is located on the Flinders Highway, an important interstate road route. The town is a cattle and sheep grazing area, and supports a silver, lead and zinc mine. Julia Creek sits above the Great Artesian Basin and has a flowing bore of heated water in the centre of town.

From May 2014 the McKinlay Multipurpose Health Service (MPHS) has six acute inpatient beds, four residential aged care places, and five flexible care packages. The Multipurpose Health Service has a 24 hour emergency department, an outpatients department, and physiotherapy services. Community health services are provided by one nursing position which is jointly funded by the Multipurpose Health Service and McKinlay Shire Council.

The McKinlay Nurse Led Clinic, jointly supported with the McKinlay Shire Council, provides community nursing services to the township and surrounds.

Top inpatient diagnoses include:

- Respiratory disorders
- Musculoskeletal disorders
- Infectious and parasitic diseases
- Nervous system disorders
- Injuries, poisoning and toxic effects of drugs.

Key achievements 2013–2014

- Development and expansion of Home Care Services to offer a wider range of assistance to community clients.
- Implementation of Aged Care Funding Instrument (ACFI) documentation for accreditation purposes.
- Community engagement continued through the Community Advisory Network and McKinlay Shire Health Advisory Panel.

Looking ahead 2014–2015

- Implement Communicare informatics system and provide education for staff.
- Promote and further develop telehealth service.

Burke Shire – Burketown Primary Health Clinic

2,174 north west of Brisbane | **418km** north of Mount Isa

Burketown is a small town located on the Albert River about 25 kilometres from the Gulf of Carpentaria. There is road access to Mount Isa and Cloncurry except during wet season closures. There is an all-weather airport with regular scheduled services to Mount Isa and Cairns.

Burketown Primary Health Clinic is located in a remote setting that experiences 'wet' and 'drought' variances. The clinic has capacity to provide emergency response and outpatient clinic activity. There are no inpatient services available. Patients requiring more complex care are transferred to Mount Isa Hospital or Townsville depending on their clinical needs. Emergency services are available 24 hours a day 7 days per week as are hospital based ambulance services. The service is a sole nurse clinic.

Services include emergency, outpatient and chronic disease care, outpatient pharmacy service, point of care pathology testing and coordination of visiting services. Visiting services include Royal Flying Doctor Services and visiting medical specialists. Central and North West Queensland Medicare Local provides allied health services.

Key achievements 2013–2014

- Facilitated placement of 4 third year nursing students to allow local students to have an opportunity to experience remote nursing practice.
- Continued participation in the Local Disaster Management Group.

Looking ahead 2014–2015

- Review and implement Mums and Bubs postnatal visiting and check up program, working in partnership with the Royal Flying Doctor Service and Mount Isa maternity and neonates service.
- Implement Communicare system and provide education for staff.

Mount Isa City – Camooweal Primary Health Clinic

2,019km north west of Brisbane
330km south of Burketown
188km from Mount Isa

Camooweal is a country town situated 13 kilometres from the Northern Territory border. Camooweal was established in 1884 as a service centre for surrounding cattle properties. Camooweal is now referred to as the 'gateway' between Queensland and the Northern Territory.

The clinic operates Monday to Friday and provides 24 hour 7 day a week emergency response including hospital based ambulance services. The service provides a low risk ambulatory care service which is mainly delivered by a sole registered nurse.

The clinic coordinates visiting services from public sector and non-government health service providers. Central and North West Queensland Medicare Local provides allied health services. The Royal Flying Doctor Service provides a general practice clinic once a week. If a patient requires more complex review they are transferred to Mount Isa Hospital either by road or by aeromedical transfer.

Key achievements 2013–2014

- Workshop for community members titled 'recognising and supporting people in crisis' provided by Psych Aware in May 2014.
- Strong community engagement with a post acute home visiting program supported in home where operational activity permits.
- Preceptorship and mentorship of two registered nurses and a first year registered nurse.

Looking ahead 2014–2015

- Review of Dajarra school collaborative initiative to replicate similar program performing healthy skin and hair promotion dependent on operational requirements and resourcing.

Boulia Shire – Urandangie Health Clinic

2,007km north west of Brisbane
187km south west of Mount Isa
295km from Boulia

The community of Urandangie, in the local government area of Boulia Shire, falls within the North West HHS service area. The township is located on the banks of the Georgina River and has a population of approximately 100 people. The Marmanya people are the traditional owners of the land in the Urandangie area.

Urandangie is serviced by outreach services from North West HHS, Central and North West Queensland Medicare Local and the Royal Flying Doctor Service.

Key achievements 2013–2014

- Opening of Urandangie Health Clinic by respected elder Uncle Billy Tommy, four year old Roseanne Age, and Rob Katter, Member for Mount Isa.

Looking ahead 2014–2015

- Continued provision of outreach services to the Urgandangie community.

North West HHS Community and Primary Health Care

North West HHS Community and Primary Health Care (CPHC) are an outpatient and outreach service with primary, secondary and tertiary prevention activities. The service provides culturally appropriate and supported clinical and education services to the HHS and supports the growth and development of the Indigenous Workforce.

Services are delivered via a hub and spoke model where staff have offices in the CPHC building on Camooweal Street in Mount Isa but deliver their service in various communities within the HHS, within different suburbs within the city or in the outpatients department at the Mount Isa Hospital.

The current full-time equivalent staffing for the services is 54 FTE including five Nurse Practitioners and 13 Aboriginal Health workers. Services consist of chronic disease specialists, maternal and child health team, Indigenous Workforce Development Unit, sexual health and women's health and aged care.

Chronic Disease Services

- Rheumatic Heart Disease
- Heart Failure
- Diabetes
- Chronic and End Stage Kidney disease
- Smoking Cessation
- Cardiac Rehabilitation
- Pulmonary Rehabilitation
- Respiratory Services

Women's and Sexual Health Services

- Sexual Health Screening and treatment
- Women's health management
- Blood Borne Virus Care
- Harm Minimisation Program

Aged Care Team

- Aged Care Assessment
- Gerentology
- Falls prevention programs
- Community nursing assessments

Maternal, Child and Family Health

- Ante-natal and post-natal care and education
- School Based Health and Diversion Programs
- Child milestone assessment clinics
- School Based Hearing Health assessments
- Indigenous Child Hearing assessment
- School based Immunisation program
- Childhood Immunisations

Indigenous Workforce Development Unit

- Indigenous Primary Health Care Trainee Support
- Health Promotion
- Health Education
- Medical Student Indigenous Mentoring Program

Key achievements 2013–2014

- Securing $3,764,248 funding for primary care programs in quality improvement, renal health, diabetes care, rheumatic heart disease, maternal and child health and sexual health.
- Queensland Midwifery Award 'Reducing Inequalities' for community outreach programs.
- Successful implementation of Mums and Bubs Home Visiting Program.
- Implementation of Child and Maternal Health services at Ngukuthati Child and Family centre for Indigenous families.
- Expansion of Hearing Health Services.
- ATODS diversion program replacing suspension for first time offenders in schools.
- Rural leader in sexual health by implementation of Point of Care (POC) HIV testing and the use of Syphilis rapid testing.
- Re-commencement of Smoking Cessation and Pulmonary rehabilitation programs.
- Partnership with Townsville Rheumatic Heart Disease (RHD) and Occupational therapy and NWHHS Occupational therapy to deliver Buzzi Bee Diversion program for RHD clients.
- Otago and Tai Chi falls prevention programs established.
- Publication of the "Closing the Gap Gulf in Renal Healthcare: A Collaborative Workshop".
- Weekly case conferencing of complex chronic disease clients with Aboriginal Medical Services.
- Funding and delivery of type 1 diabetes youth camp.

Looking ahead 2014–2015

- Service restructure and realignment will continue into 2014–2015 for the Community and Primary Health Care team.
- Development of a sustainable model of care for Phase 2 Community Renal Service expansion.
- Implement Communicare system and provide education for staff.
- Implementation of Indigenous specific antenatal classes and Belly Casting Art Project.
- Develop and implement responsive Chronic Disease Models of Care for the HHS with a focus on diabetes models, complex care models and renal health expansion.
- Expansion of Rehabilitation programs in response to client needs.
- Further expansion of Smoking Cessation support programs within the HHS.

Mental Health and Alcohol and other Drug Services

The North West HHS provides a range of integrated mental health services and specialised alcohol and other drug services from locations in Doomadgee, Mornington Island, Mount Isa and Normanton.

The current full-time equivalent staffing for these services is 64 FTE. A business support team facilitates service integration and quality activities, and provides clinical and administrative support for the services.

Community ambulatory mental health services

- Child and youth community mental health
- Community adult mental health
- Court liaison
- Evolve therapeutic services
- Homeless health outreach team program
- Indigenous mental health
- Mental health intervention program
- Rural and remote community mental health.

Alcohol tobacco and other drugs services

- Alcohol management reform initiative treatment
- Consultation and liaison
- Court referral treatment
- Family support
- Indigenous outreach
- Indigenous youth (12–17 years) treatment programs
- Inpatient withdrawal support
- Opioid treatment program
- Queensland illicit drug diversion initiative.

Key achievements 2013–2014

- Alignment of mental health and ATODS services to improve the patient journey, access, and transition of care, and promotion of positive outcomes based on the 'every door is the right door' framework.
- **Workforce management initiatives:**
  - Restructure of the senior management team including upskilling.
  - Implementation of clinical performance management team.
  - Implementation of Operational Management Team.
- **Quality and safety initiatives:**
  - Establishment of multidisciplinary quality and safety committee.
  - Establishment of multidisciplinary Audit and Risk Committee.
- **Clinical service enhancements:**
  - Introduction of a Western Corridor Outreach Team (psychiatry, adult mental health and ATODS) to service communities not previously visited or previously visited on an as per needs basis: each community now has access to specialist services.
  - Increased psychiatry services to three FTE to facilitate sustainable services in areas of general adult psychiatry, alcohol and drugs/addition medicine, child and youth mental health.
  - Implementation of an early psychosis clinical nurse position in child and youth mental health services to provide assessment and early intervention for 17–25 year olds.

- Implementation of a clinical nurse consultation liaison position to improve linkages between hospital and community based ATOD services, providing specialist advice, assessment and support for inpatient and emergency department areas.

- **Community engagement and partnerships**
  - Commencement of a collaborative partnership with the Department of Justice and community stakeholders aimed at addressing factors associated with offending behaviour: assessment, case management and intervention for people suspected of experiencing a mental illness or significant alcohol and drug problem.

Looking ahead 2014–2015

A number of strategies are proposed for introduction during 2014–2015 that are aimed at improving integration of mental health services across care settings and enhancing early intervention, prevention and management of mental health in the community.

- Proposal to implement a combined mental health, homeless health outreach team, alcohol and other drugs acute care service (with extended operating hours to 18 hours per day, 7 days per week) to provide timely assessment, early intervention, crisis support and intervention, and improve access for consumers.
- Proposal to implement a 1800 mental health call number to further improve access to mental health services.
- Proposal to implement a Consultation Liaison Psychiatry Service to support acute care hospital clinical teams and general practitioners.

Public health services

The North West HHS provides office accommodation and support to Townsville Public Health Unit staff who provide specialist communicable disease epidemiology and surveillance, disease prevention and control and environmental health services to North West HHS.

Government strategies and plans

The North West HHS provides health services in accordance with the requirements of the *Hospital and Health Boards Act 2011* within a national framework of intergovernmental agreements, strategies and plans. The State of Queensland purchases health services from the North West HHS and monitors health service performance indicators established under a service agreement between the Department of Health and the North West HHS.

The *National Health Reform Agreement* (2011) introduced new arrangements for a national framework for health care delivery with locally controlled health services. The Australian Government develops national strategies to address health priority areas in consultation with States and Territories. Under the *National Health Care Agreement* (2012) the Queensland Government is responsible for provision of health and emergency services through the public hospital system, and jointly funds other services including mental health and Aboriginal and Torres Strait Islander health services.

National priority issues are addressed through Australian, State and Territory Government National Partnership Agreements (NPA). For example:

- The *NPA on Closing the Gap in Indigenous Health Outcomes* (2009) sets out six targets for closing the gap between Indigenous and non-Indigenous Australians across urban, rural and remote areas.
- The *NPA on Improving Public Hospital Services* (2011) sets targets for access to emergency departments (NEAT) and elective surgery (NEST).
- The *NPA for Adult Dental Services* (2013) aims to decrease pressure on public dental waiting lists with a particular focus on Indigenous patients, patients at high risk of, or from, major oral health problems and those from rural areas.

The State Government's response to the 2013 Independent Commission of Audit was set out in '*A plan-Better services in Queensland*'. This plan noted acceptance of a number of the Independent Commission of Audit's recommendations, including that the Government:

- Set a target to improve the efficiency of public hospitals.
- Concentrate emergency departments on delivering appropriate emergency care.
- Work in partnership with the Australian Government in relation to primary care services.
- Refocus community health services to reducing demand on public hospitals and expanding hospital substitution programs (such as Hospital in the Home).
- Develop opportunities for the non-government sector to provide rural and remote health services.
- Leverage technology services such as telehealth to support new and innovative forms of service delivery.

The Hospital and Health Boards Act 2011 gives effect to the principles and objectives of the national health system. Priorities for the Queensland public sector health system are defined in the Queensland Health Strategic Plan and the *Blueprint for better healthcare in Queensland*.

The Department of Health Strategic Plan 2014–2018 outlines the department's strategies for supporting the achievement of the Queensland Government's objectives and the themes in the *Blueprint for better healthcare in Queensland*.

The Queensland Government's objectives for the community are:

1. Grow a four pillar economy
2. Lower the cost of living for families
3. Deliver better infrastructure and better planning
4. Revitalise frontline services for families
5. Restore accountability in government.

The *Blueprint for better healthcare in Queensland* (2013) has four principle themes:

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

The Department of Health's strategic objectives are:

1. Healthy Queenslanders: facilitates the integration of health system services that focus on keeping patients, people and communities well.
2. Accessible services: ensure equitable access to safe, timely, and quality health services for all Queenslanders.
3. Innovation and research: foster innovation and research that contributes to quality patient care and outcomes, and health system improvement.
4. Governance and partnerships: provide effective governance of the health system and engage with key partners to provide health services that are sustainable and value for money.
5. Workforce: cultivate an engaged, capable, innovative and efficient workforce.

Queensland Government Plans and Strategies

Mums and Bubs Initiative

Strategy to ensure families have access to two home visits in the first month of a baby's life.

Queensland Plan for Mental Health 2007–2017

Plan to facilitate access to a comprehensive, recovery-oriented mental health system that improves mental health for Queenslanders.

Queensland Health Service Plans

Better health for the bush 2014

Developed by the Statewide Rural and Remote Clinical Network (SRRCN), defines clearer service capability standards for rural and remote communities.

Queensland Health Disability Services Plan 2014–2016

Aims to improve access and participation of people with disabilities across the system, including Queensland Health employees, people seeking employment, or people accessing health services provided by Queensland Health.

Queensland Immunisation Strategy 2014–2017

Identifies strategies for all immunisation provider agencies including general practice, local government, Hospital and Health Services and other providers.

Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033

Outlines four principles (cultural respect and recognition, communication, relationships and partnerships, and capacity building) that provide guidance for enhancing an organisation's cultural capability and to deliver culturally responsive health services.

These national and state agreements, strategies and plans provided the basis for the development of the North West HHS Strategic Plan. The strategic direction established by these agreements, strategies and plans will guide development of North West HHS clinical service plans during 2014.

Our strategic plan

The *North West HHS Strategic Plan 2012–2016* was reviewed in early 2014. The service's strategic priorities were reframed during this review to better align with current Queensland Government plans and strategies and the *Blueprint for better health care in Queensland*. This report will set out the newly defined strategic priorities, and will detail the progress made towards meeting the strategic priorities noted in the 2012–2013 Annual Report.

Our vision

To be Queensland's leading Hospital and Health Service delivering excellence in rural and remote healthcare. We will lead Queensland's transformation to locally accountable Hospital and Health Service management by being innovative, creative and fiscally responsible. We will embrace change and forge close partnerships with others in the health sector, and with the private sector, in order to exceed the Government's expectations and to become a proud employer of choice for our staff throughout Queensland.

Our purpose

The North West Hospital and Health Service is responsible for providing high quality hospital and health care to the communities of North West Queensland. We are to secure our financial and statutory position by meeting our expenditure budgets and achieving revenue targets on a financial year basis. We are to embrace the need for change and make it work effectively and efficiently for the people of our region and our staff. The efficient delivery of our core hospital and health business services will be guided by the organisation's vision and values.

Our service commitment

The North West Hospital and Health Service is committed to the vision of becoming Queensland's leading Hospital and Health Service. To achieve this it is essential that the Service is responsive to the needs of our stakeholders, in particular the communities we serve and our valued workforce. Our Strategic Plan will be continually informed by all stakeholders. These steps are necessary to build accountability and confidence in the health system.

Our values

Our patients

Provide accessible, responsive, quality health services and care.

Our communities

Work in partnership with communities to produce better health outcomes for all.

Our staff

Build a culture of professionalism and excellence through developing leaders in rural and remote health care.

Our ownership, accountability and transparency

Partner with individuals, families and communities to enhance and shape our future health care and services, whilst being operationally accountable and optimising use of resources to achieve value for money.

Our health service delivery

Develop innovative models of care reflective of evidenced based practice and National Safety and Quality Standards whilst being efficient and delivering better health outcomes for the community.

Health Priorities

North West Hospital and Health Service is committed to aligning to the Queensland Government's objectives for the community. Guided by the *Department of Health Strategic Plan 2014–2018* and the *Blueprint for better healthcare in Queensland* we will work together to achieve our vision for the health of individuals, families and communities of the North West region.

We will do this by ensuring we adopt a life course perspective to future health and wellbeing and focus on integrated service delivery models. Fundamental to this are early intervention and prevention models of care, improved health equity and access to health care for all the communities we serve.

Strategic Priorities – Reviewed March 2014

Strategic Priority 1: Safe, quality service delivery through continuous improvement

Objective	Strategies
• The North West Hospital and Health Service will be recognised as delivering best practice in contemporary health care service in remote locations.	• Build an organisational culture that is driven by safety, quality and innovation • Embed robust governance systems to maximise performance, safety quality and risk management • Develop and action a North West Hospital and Health Service safety and quality plan to ensure provision of safe, timely and appropriate care • Embed systems to ensure achievement of continuing accreditation against National EQuIP standards and all required service delivery Key Performance Indictors • Link the organisation strategy and risk management to ensure the focus of risk management is on both creating value as well as protecting value.

Strategic Priority 2: Implement priority strategies to recruit and retain staff

Objective	Strategies
• The North West Hospital and Health Service will be regarded as an employer of choice for rural and remote health care.	• Through workforce planning and development meet the current and future workforce needs of the North West Hospital and Health Service • Enable staff to access training to enhance the North West Hospital and Health Service capacity to deliver expert rural and remote healthcare • Enhance management and leadership capability at all levels of the North West Hospital and Health Service • Implement a communication strategy to ensure inclusive communication with all staff • Create an environment across the North West Hospital and Health Service that promotes and supports the values of the North West Hospital and Health Service promoting inclusive behaviour and respect for diversity • Improve the standard of housing and accommodation available to recruit and retain staff.

Strategic Priority 3: Deliver coordinated, integrated and sustainable services in the North West region

Objective	Strategies
• Sustainable improvements in our rates of avoidable admissions will be achieved.	• Anticipate current and future demand through effective business planning • Services are aligned to community health needs and changing environments and are delivered in the most appropriate setting • Develop seamless models of service delivery across the North West Hospital and Health Service • Utilise reliable health service data to inform and improve health service delivery • Work with our partners to ensure integrated delivery of contemporary health care and reduce duplication of services • Develop innovative strategies to engage with at-risk and vulnerable population groups • Improve health literacy across the North West Hospital and Health Service to enable consumers and communities to be engaged in their own health.

Strategic Priority 4: Implementation of State and National Health priorities to enhance and produce better health for the individual, family and community

Objective	Strategies
• Culturally appropriate and equitable health care will be accessible for all individuals, families and communities of the North West Hospital and Health Service.	• Engage Aboriginal and Torres Strait Islander health service providers and communities in the development and delivery of all health services • Improve access to culturally appropriate services for the Aboriginal and Torres Strait Islander people • Manage chronic conditions to reduce avoidable hospital admissions which will improve health status and quality of life • Engage and partner with internal and external Primary Health Care providers to ensure a focus on early intervention and prevention.

Strategic Priority 5: A financially accountable and responsible Hospital and Health Service

Objective	Strategies
• The delivery of contemporary safe, quality health care to meet the needs of the community in a remote location in a cost effective manner.	• Deliver health services that are informed through Service Level Agreement negotiation • Develop a financially sustainable organisation and a culture of accountability • Review systems and develop innovative business practices in order to eliminate waste and achieve efficiencies • Optimise current and planned infrastructure to ensure effective and efficient usage. Advocate for future infrastructure requirements to support business development • North West Hospital and Health Service manages assets proactively through the development of a strategic asset and maintenance plan.

Key achievements in strategic priority areas during 2013–2014

Strategic Priority 1 Safe, quality service delivery through continuous improvement

Key achievements 2013–3014

1. Governance structure enhancements implemented following review of executive management structure, including introduction of Executive Director People and Performance position and establishment of Clinical Operational Leadership Team.
2. North West HHS Safety and Quality Plan 2014–2016 developed with implementation strategy underway.
3. Accreditation periodic review conducted.

Strategic Priority 2 Implement priority strategies to recruit and retain staff

Key achievements 2013–3014

1. Staff accommodation options increased with the purchase of 30 unit complex in Mount Isa.
2. Staff training prioritised with increased emphasis on achieving 100% compliance with mandatory training requirements.
3. Casual and temporary nursing staffing pool increased to support effective workload management during period of increased unplanned leave over winter period.

Strategic Priority 3 Deliver coordinated, integrated sustainable services in the North West Region

Key achievements 2013–3014

1. Business planning undertaken for all clinical service units and facilities to assist in anticipating future demands.
2. Mount Isa Hospital Block C refurbished achieving improved inpatient accommodation.
3. Telehealth services increased significantly.
4. Allied health services completed service mapping, including defining the scope of practice for allied health practitioners across North West HHS.

Strategic Priority 4 Implementation of State and National Health Priorities to enhance and produce better health for the individual, family and community

Key achievements 2013–3014

1. Further expansion of Nurse Practitioner roles, specialising in chronic disease, cardiac care, maternal and child health care, emergency care and rural and remote health care.
2. Renal services boosted with approval for the addition of a Nurse Practitioner to provide end stage chronic kidney disease services, and the location of self-care dialysis chairs at both Mount Isa and Normanton Hospitals.
3. Rural Birth Summit conducted: a collaboration between the North West HHS and the Queensland Centre for Mothers and Babies.
4. Continuation of the Mums and Bubs initiative at sites across the HHS.

Strategic Priority 5 A financially accountable and responsible Hospital and Health Service

Key achievements 2013–3014

1. Funding secured to purchase and implement Communicare patient database (electronic medical record system).
2. Stage 3 redevelopment of Mount Isa Hospital project planning progressed.
3. Mount Isa Hospital has maintained strong performance throughout the year with excellent access indicators for emergency department and elective surgery.
4. The North West HHS has achieved a budget surplus for the second year running.
5. The North West HHS received an unqualified audit for its Financial Statements.

Our governance

Our Board

The North West Hospital and Health Board governs the service as provided for under the *Hospital and Health Boards Act 2011* (Qld), other State and Commonwealth legislation, and relevant policy and administrative requirements. The Board is responsible for strategic direction setting and monitoring the financial and operational performance of the service.

Paul Woodhouse

Chair

A Grazier, Paul has been involved with a number of local and regional bodies across North and North West Queensland, over several years. After more than 12 years in Local Government, including 8 years as Mayor of McKinlay Shire, Paul is presently serving as Chairman of Regional Development Australia for the Townsville and North West region.

He is also currently a Member of the Northern Australia Health Roundtable, as well as a Member of the Ministerial Health Infrastructure Advisory Council.

Annie Clarke

Deputy Chair (Chair Engagement Committee)

Annie has lived in the Gulf Country in north-west Queensland for more than 40 years. Annie has 18 years experience in local government, including 15 years as Mayor of Burke Shire. Annie has hands on experience in small business and economic development, roads and transport infrastructure, tourism and sports development, education and training, health and social issues, and disaster management. Annie is also currently a member of the Central and North West Queensland Medicare Local Board.

Annie's work with the community has been recognised at local and national levels. In 2001 Annie was awarded the Australian Centenary Medal for distinguished service in local government. Annie received the Women in Local Government Professional Development Bursary in 2011. In 2012 Annie was awarded the title of Community Champion in the Burke Shire Australia Day Awards.

Richard Stevens OAM

Board member (Chair Finance, Audit and Risk Management Committee)

Richard has more than 30 years experience in public sector administration across all tiers of government. Richard has expertise in natural resource management, fishing industry operations and economics.

Richard is currently Deputy Chair of the Australian Fisheries Management Authority (AFMA), an organisation responsible for the efficient and sustainable management of Commonwealth fish resources on behalf of the Australian community.

Richard is also the Deputy Presiding Member of the Fisheries Council of South Australia.

Previous board appointments include Chair of the South Australian Country Fire Service Board, member of the New South Wales Natural Resources Advisory Council, member of the Queensland Rural Adjustment Authority, non-executive Director of the Fisheries Research and Development Corporation, and Chair of the AFMA Finance and Audit Committee.

Rowena McNally

Board member (Chair Quality, Safety and Risk Committee)

Rowena is an experienced company director and corporate lawyer specialising in health, infrastructure, and corporate governance. She has previously held positions as Chair of the Quality and Risk Committees for Mount Olivet Hospital, St Vincent's Hospital, and Holy Spirit Hospital.

Rowena is currently Chair of Mount Isa Water Board and a director of Ergon Energy. Rowena is Chair of Catholic Health Australia, which represents Catholic health and aged care services to shape national health and aged care policies.

She is National President of the Institute of Arbitrators and Mediators Australia, the country's leading not-for-profit alternative dispute resolution organisation.

Previous board appointments include Chair of the Queensland Cerebral Palsy League of Queensland, Deputy Chair of Cerebral Palsy Australia, St Vincent's and Holy Spirit Health Limited, Mount Olivet Hospital, Holy Spirit Hospital (Chermside), and St Vincent's Hospital (Toowoomba).

Dr Christopher Appleby

Board member (Chair Business Development Committee)

Chris is co-owner and practice manager of Flinders Medical Group Pty Ltd in Cloncurry. The centre acts as the general practice primary healthcare facility in collaboration with the local council and hospital.

The practice employs 7 general practitioners (GP) and has been an accredited GP training facility since 2006. The practice is affiliated with James Cook University and accommodates medical students and nursing students in collaboration with the Mount Isa Centre for Rural and Remote Health.

Following transfer of ownership of the Maleny and Montville Flinders Medical Centres to Ochre Health, Chris is currently the Queensland Operations Manager for Ochre Health. Chris has a Bachelor of Science (Honours) and a Doctor of Philosophy. He is an Adjunct Senior Lecturer at James Cook University.

Ron Page

Board member

Ron is employed as a Recognised Entity Cultural Appropriate Officer with the Aboriginal and Islander Development Recreational Women Association. Ron has vast experience with the North West Indigenous community and a deep familiarity with the health issues affecting Aboriginal and Torres Strait Islander people.

Ron previously worked as Program Manager, KASH Aboriginal Corporation in Mount Isa. He also previously held the position of Chief Executive Officer at Yallambee Aboriginal Corporation. Ron is currently a Director of Gidgee Healing.

Dr Stephanie De La Rue
Board Member

Stephanie is the Regional Manager (North West Qld), Royal Flying Doctor Service (RFDS). She manages bases in Mount Isa and Longreach and supports the delivery of RFDS services to remote communities.

Stephanie previously held the position of Deputy Director and Head of Research at the Mount Isa Centre for Rural and Remote Health (MICRRH). In that role she participated in community engagement about national health reform, and secured funding for projects that expanded infrastructure and training across western Queensland.

Stephanie has a Bachelor of Science (Honours), a Master of Business Administration and a Doctor of Philosophy. Stephanie's research interests include rural and remote health, Indigenous health, workforce recruitment and retention, and remote population health. She is a regular presenter at national conferences and symposia.

Dr Don Bowley OAM
Board Member

Don has been a medical officer with the Royal Flying Doctor Service (RFDS) for more than 18 years and has been based at Mount Isa for the last 16 years. Don was a member of the Mount Isa District Health Community Council from 1999 to 2011. Don's dedication, friendship, support and care of people living in the area's remote townships, rural stations and Indigenous communities is legendary, and community members acknowledge him as "the best in the west".

Don has made significant contributions to health service improvements through education, training and development. He has previously been Medical Student Supervisor at James Cook University (Mount Isa Centre for Rural and Remote Health) and Senior Lecturer (Professional), School of Public Health, Tropical Medicine and Rehabilitation Sciences at James Cook University.

Don's community and professional contributions have been recognised over many years. In 2005 and 2011 Don received Mount Isa City Council Special Achievement awards for Outstanding Service to the City and Region. In 2009 Don received a Distinguished Service Award from the Australian College of Rural and Remote Medicine. And in 2011 Don was the recipient of the Australian of the Year Queensland Local Hero Award.

Karen (Kari) Arbouin
Board member

Kari is the Director of Campus Development at Central Queensland University. She previously worked in senior management positions at James Cook University for 11 years, including acting in the role of CEO of the Singapore campus. Kari was involved in major business development projects including planning of the successful funding bid for the Cairns Research Institute.

Kari is a registered nurse and practising midwife. While in the role of Director of Nursing at Julia Creek she led the hospital to being the first ACHS accredited hospital in north-west Queensland. She has also held the position of Director of Nursing at The Wesley Hospital in Townsville. Kari was awarded Julia Creek Hospital, Australia Day and Queensland Health awards for her service to the hospital and community.

Kari was a founding Board member for the James Cook University's health practice, and Board Chair of the University's child care facilities. She holds academic qualifications in health, business, law and public health. Kari is an international reviewer for universities in the United Kingdom and Bahrain. She is a Fellow of the Australian Institute of Management.

Board Committees

North West HHS has established four committees to oversee key activities and priorities. The Committees do not replace or replicate established management responsibilities and delegations, the responsibilities of other executive management groups within the North West HHS, or the reporting lines and responsibilities of either internal audit or external audit functions. The Business Development Committee has been established in addition to the other Committees which are required to be established under the *Hospital and Health Boards Act 2011*.

Finance, Audit and Risk Management Committee

The North West HHS established the Finance, Audit and Risk Management (FARM) Committee on 6 November 2012.

The role of the Committee is to:

a) oversee the financial management of the Health Service in accordance with statutory obligations and report to the North West HHS Board;

b) oversee the identification and implementation of efficiencies and innovation in the areas of finance, audit and risk management in accordance with the *Blueprint for better healthcare in Queensland*.

The Committee provides independent assurance and assistance to the North West HHS Board regarding:

a) risk, control and compliance frameworks within the North West HHS;

b) the agency's external and internal accountability responsibilities as prescribed in the *Financial Accountability Act 2009* and subordinate legislation.

Key activities 2013–2014

The Finance, Audit and Risk Management Committee met on five occasions during the 2013–2014 financial year. Key items for discussion included the following:

- The Committee continued to monitor the financial health of the NWHHS in accordance with the Board's strategic priority to have 'A financially accountable and responsible Hospital and Health Service'. It is pleasing to report that the NWHHS was able to achieve a budget surplus for the Financial Year 2013–2014 and to also receive an unqualified audit for its Financial Statements.
- The Committee appointed Crowe Horwarth as the NWHHS Internal Auditors, and agreed an Internal Audit Plan for 2013–2014 Financial Year focusing on the following four areas:
  - Delegations of authority
  - Payroll and rostering
  - Fraud Risk Management
  - Financial Management Assurance.

  Reports were received on each of the above. No major issues were identified, and the reports will now form the basis for informing the FARM Internal Audit Work Plan for 2014–2015.
- The Committee received regular reports on the development and implementation of a Strategic Asset Management Plan covering assessment of existing assets, including maintenance, the capital works program for the North West, and state-wide projects relevant to the North West.
- The Committee continued to progress a suitable process for management of Trust Funds to ensure appropriate and relevant use of these funds in support of the Board's Strategic Plan and the wishes of donors.
- The Committee continued to monitor the implementation of the FARM Work Plan as approved by the Board.

Engagement Committee

The Engagement Committee continued to enact the North West HHS Strategic Plan during the 2013–2014 financial year. The Committee met on ten occasions to drive the effective relationships and communication with our consumers, communities and workforce throughout the North West.

Consumer Engagement

Improvements were made to engage with consumers right across the continuum of care.

To improve consumer access in the largest centre of Mount Isa, the Committee suggested an Inaugural Mount Isa Health Expo. A group of service providers collaborated to host an event for exhibitors and invited speakers to promote access to health care services. Work is underway to improve the NWHHS website and social media presence.

To enhance the point of service, there was an increased focus on compliance of mandatory vocational training, together with a rollout of communication training and software systems. The Committee plan to evaluate these strategies to improve communication between clinicians and the consumer at the bedside and on discharge.

The Committee considered aftercare. Patient surveys were conducted and the results guided serviced improvements. The Committee will work towards expanding the role of consumer representative in service development.

Community Engagement

The Committee's guidance and support for local decision making at the community level was evident in 2013–2014.

Each community has a dedicated Executive Sponsor to provide a sustained, high level focus and to streamline communication channels.

The Committee co-hosted health forums in the small townships of Dajarra, Camooweal, Burketown and Urandangie. These communities continue to be supported as they choose their own engagement format.

Regional advisory panels are building local strategic direction.

- Normanton and Karumba stakeholders established a Carpentaria Health Committee as the conduit for their healthcare issues.
- The Doomadgee Health Council remains active within the remote indigenous community.
- The McKinlay MPHS Community Advisory Network formalised their dual – model: a Health Advisory Panel for clinical issues and a Community Advisory Network for broader issues.
- The Mornington Island Health Partnership was established and their Strategic Plan was developed and circulated.
- The Cloncurry Community Advisory Network co-authored a formal "Community Health Vision" document containing strategies to address their health needs.

Workforce Engagement

The Committee has plans to expand active engagement with clinicians and workforce by establishing a workforce leaders group.

The development of the workforce leaders group has been deferred whilst the organisation was managing complications caused by structural integrity issues within Mount Isa Hospital Block C, as well as an executive restructure.

In the interim, a multidisciplinary workforce group known as the COLT (Clinical and Operational Leaders Team) was established. The Executive and Engagement Committee have sought and valued the advice from the COLT on operational matters and service direction.

Quality, Safety and Risk Committee

The North West HHS established the Quality, Safety and Risk Committee on 31 July 2012.

The committee's role is to:

a) oversight the identification and implementation of efficiencies and innovation in the areas of quality and safety in health care;

b) provide independent assurance and assistance to the North West HHS Board regarding, amongst other things, provision of effective governance frameworks, delivery of safe and quality clinical patient services in any environment that fosters the wellbeing of patients and staff, and the identification and mitigation of risks for those receiving care, and occupational health and safety risks for employees and others in the facilities.

Key activities 2013–2014

Throughout 2013–2014 the Quality, Safety and Risk Committee has continued to build on the work of last year ensuring consistent implementation of high quality health service delivery across the North West HHS. We are further developing the established reporting frameworks to enhance quality management and oversight on both a day to day basis and to support the development of long term strategies for continued improvement.

With the changes implemented for accreditation all Australian hospitals are now required to meet the ten (10) National Safety and Quality Health Service (NSQHS) Standards. These Standards have a particularly strong focus on patient safety and quality of care, as well as partnering with our consumers in all aspects of their care. North West HHS has also chosen to be measured against the extra five standards developed by the Australian Council on Healthcare Standards. By undertaking measurement against

Note: Board members absent from photograph are Rowena McNally, Annie Clarke, Dr Don Bowley and Dr Stephanie De La Rue.

these fifteen (15) standards the North West HHS will be able to ensure delivery of high quality services to our patients and consumers.

This year the Committee provided oversight of the Hospital and Health Service preparations to undertake the 'Periodic Review' phase of the accreditation cycle that occurred in June 2014. A key outcome of this survey was the significant improvement achieved since the previous 'Organisation Wide Survey' in December 2011. The Committee will continue to monitor the delivery of health services across the North West HHS against the National EQuIP Standards as the organisation prepares for the next phase of the accreditation cycle being the Organisational Wide Survey in December 2015.

The Quality, Safety and Risk Committee, through the ongoing development of reporting frameworks against the National Standards, saw significant improvements in the identification and management of clinical incidents across the North West HHS. The excellent work undertaken by the Patient Safety Officers together with the establishment of the Weekly Incident Panel has seen strengthening and timeliness of clinical risk management across the health service.

Medications are one of the most common causes of harm in health care and can lead to adverse patient outcomes and as such medication safety has been a priority for the Committee. Review of incidents and multidisciplinary management (medical, pharmacy, nursing, education) with a focus on reducing risk of errors and thereby reducing harm to our patients has been a priority.

Key achievements have also included:

- Improvements in hand hygiene compliance with achievement of higher than the National benchmark percentage by May 2014.
- Establishment of the multidisciplinary Antimicrobial Stewardship working group which has seen significant improvement in management in this area.
- Establishment of the Procedural documentation working group providing governance to all procedural documentation across the NWHHS.

Throughout 2013–2014 the Committee has continued to oversight and provide assurance to the North West HHS Board regarding the identification and mitigation of clinical risks and occupational health and safety risks for employees and others in the facilities.

Orientation, training and ongoing professional development remain as a priority for the Committee to ensure consistent implementation of standards and a highly skilled competent workforce delivering healthcare to the individuals and communities of the North West.

Over the past year we have made considerable progress and will continue to work hard to ensure we remain focused on providing high quality integrated and patient-centred care and manage the challenges faced by all in delivering high quality healthcare.

Business Development Committee

The Committee's role is to challenge the performance of a number of service divisions of the North West Hospital and Health Service from a business perspective in order to identify any efficiencies or waste.

The Committee may investigate and recommend the introduction by the Board of new models of operation that are consistent with the principle and themes of the *Blueprint for better healthcare in Queensland*, and the strategic direction of the NWHHS.

The Committee has developed a selection matrix to assist with the prioritisation and ranking of eligible projects for progression, and committed to project development via a structured six-step work plan as identified:

1. Determine categories and areas for review.
2. Develop project selection matrix.
3. Undertake test of project selection matrix.
4. Complete project selection matrix.
5. Develop business case development and review process.
6. Undertake initial review/s.

Throughout the year, the Committee gave consideration to a number of current models of care and researched potential areas for improved options for the North West Hospital and Health Service.

Consequently, this year has seen the Committee involved in the progression of the Radiology Contract, as well as direct cooperation with the contestability branch and engagement with the Clinical and Operational Leaders Team.

Our Executive Management Group

The Chief Executive is responsible for the operations of the North West HHS. The Executive Management Group, led by the Chief Executive, is accountable to the Board for making and implementing decisions about the North West HHS services within the strategic framework set by the Board. The Executive Management Group met on 43 occasions during 2013–2014.

Sue Belsham

Chief Executive Officer

Sue was appointed the inaugural Chief Executive Officer of the North West HHS in July 2012. She has held chief executive positions previously in New Zealand and at The Queen Elizabeth Hospital (TQEH) in Adelaide, South Australia, between 2003 and 2005. In these roles Sue led major organisational change and was responsible for strategic thinking and direction setting, organisational development, budget realignment and cultural change.

Sue's achievements while Chief Executive at TQEH included ensuring greater clinical involvement, leading to a cultural shift that reflected shared accountability. Sue also achieved significant financial savings, while enhancing recruitment and reducing external labour costs.

Sue has worked in consultancy roles with the Fijian Ministry of Health, Australian Department of Veteran Affairs, New South Wales Health Department, Justice Health New South Wales, Hunter New England Area Health Service, Queensland Health and BlueCare. Sue has exceptionally well developed people skills, which, when coupled with her results-driven approach, ensures she delivers optimal performance outcomes.

Sue has experience in nursing and obstetric nursing roles in New Zealand. She holds a Bachelor of Education and has post graduate qualifications business studies and health management.

Brett Oates

Chief Finance Officer

Brett was appointed to the position of Chief Finance Officer in 2012. Brett has extensive international experience in hospital costing systems. He has led the development of cost and revenue models in Germany, Ireland, Slovenia, Singapore and Australia.

In Bosnia and Herzegovina, Brett developed and tested payments and formulas related to primary and secondary health services across care settings.

Brett was the lead costing technical advisor for the development of a national fee schedule for the Supreme Council of Health in the State of Qatar. He has developed clinical costing systems for services across a number of large hospitals in the United Kingdom.

Most recently in Australia, Brett contributed to the development of efficient price lists for hospital services in Australia in his role as Co-Director for Hospital Costing, Interim Independent Hospital Pricing Authority.

Our Executive Management Group

Associate Professor Alan Sandford

Executive Director of Medical Services

Associate Professor Sandford, a Specialist Medical Administrator, is an experienced health executive and clinical consultant with over 26 years of executive health management experience. He commenced in the role of Executive Director of Medical Services in early 2014. Professor Sandford has held executive level management positions in a variety of health settings both in Australia and internationally.

Working with groups of senior clinicians to optimise engagement is a priority for Professor Sandford. In his work as a consultant he has focused on reformation of health workforce and medical administrative functionality within organisations. He was previously the head of Health Workforce for Victoria with the Department of Human Services. He also chaired a number of Commonwealth committees in the area of medical workforce.

Professor Sandford has over 17 years' experience as an Australian Council on Healthcare Standards (ACHS) surveyor. As an ACHS coordinating surveyor he contributed to the development of the current accreditation program used by the ACHS in both the public and private health sectors across Australia.

Professor Sandford is a Fellow of the Royal Australian College of Medical Administrators, and is currently the Censor in Chief. He holds postgraduate qualifications in health management. He is an Adjunct Associate Professor with the University of Queensland's Rural Clinical School and Clinical Associate Professor with the University of Tasmania. Professor Sandford has also recently joined the academic programs with James Cook University and will soon be appointed Adjunct Associate Professor.

Michelle Garner

Executive Director of Nursing and Midwifery

Michelle has held the position of Executive Director of Nursing and Midwifery since 2008. Michelle is an endorsed nurse practitioner, and has a special interest in advanced pathways for the nursing and midwifery professions. While in this role, Michelle has prioritised support and development of nurse practitioner roles in rural, remote and specialised areas of practice.

Michelle represents rural and remote nurses on state-wide committees and at strategic level forums.

She is a member of the Department of Health's Rural and Remote Clinical Network, and is a member of joint Department of Health and Queensland Nurses' Union enterprise bargaining committees and working groups.

Michelle holds a Bachelor of Nursing, Graduate Diploma in Advanced Critical Care Nursing, and a Masters Nurse Practitioner. She is a Board Member of the Good Shepherd Catholic College in Mount Isa, and a Board Member of the Queensland Board of the Nursing and Midwifery Board of Australia.

Barbara Davis

Executive Director of Corporate Services

Barb was appointed to the position of Executive Director of Corporate Services in 2007. Barb has more than 35 years experience in nursing and administrative roles in a wide range of locations throughout Australia.

Barb is responsible for the dedicated team of staff who manage most non-clinical areas within North West HHS.

Team members are client focussed and provide high quality services that support health care delivery.

Barb is a former registered nurse, neonatal intensive care nurse, and midwife. She holds a Bachelor of Health Science and a Masters of Health Management.

Leigh Purvis

Executive Director People and Performance

Leigh joined the North West HHS in August 2012 in the position of Nursing Director, Community and Primary Health Care (in an acting capacity). She worked temporarily in the role of Executive Director Community and Primary Health Care and in a project role before being appointed to the position of Executive Director People and Performance in May 2014.

Leigh has more then 35 years experience in acute and community based health care settings in Queensland and South Australia. Her experience includes clinical and management roles in urban and rural settings. She has experience in state wide Indigenous health roles.

Leigh has particular interest in safety and quality management. Her priorities include ensuring health services focus on safety and quality while maintaining alignment across all domains including financial targets to ensure the right service is provided at the right time in the right place. Leigh also has specific interests in workforce development – particularly leadership development and ensuring sustainability of the workforce.

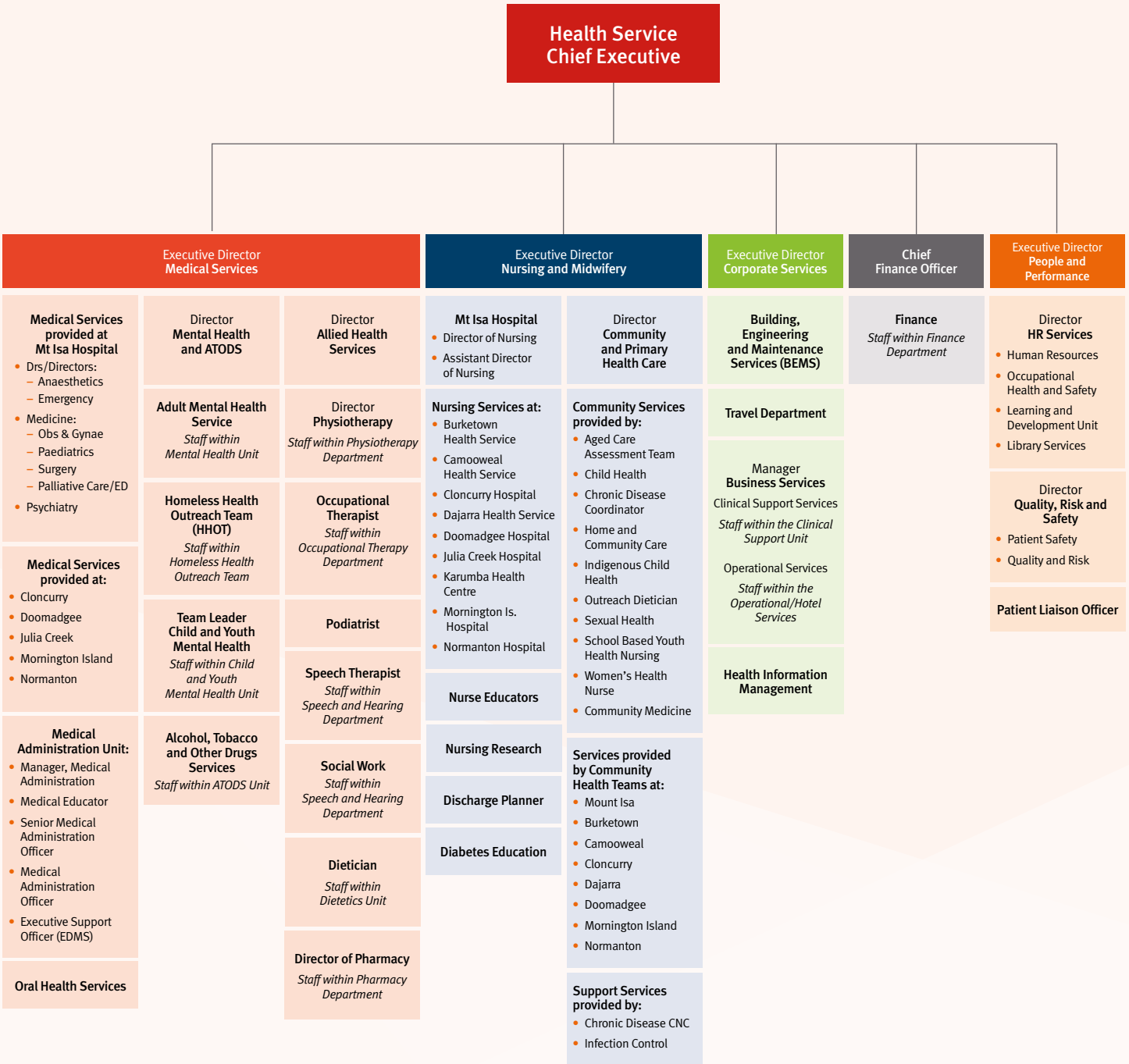
Review of executive structure

In August 2013 a review of the organisational executive management structure was undertaken.

A new position of Executive Director People and Performance was established. The position has oversight and leadership of quality safety and risk strategy and planning across the North West HHS. The position also has oversight of human resource and occupational heath and safety functions.

In addition, a Clinical Operational Leadership Team was established to oversee and drive clinical innovation and improvements across the North West HHS.

Organisational structure



Safety, quality and risk management

The North West HHS Strategic Plan declares our vision to become Queensland's leading Hospital and Health Service delivering excellence in rural and remote healthcare. Strategies to achieve our vision include building an organisational culture that is driven by safety, quality and innovation, and embedding robust governance systems to maximise continuous improvements in our performance.

Risks identified within the North West HHS are managed in accordance with the Department of Health's Integrated Risk Management Policy. The North West HHS risk management procedure details a standard approach for managing risks across clinical and non-clinical areas.

Governance for safety, quality and risk management

The North West HHS Board Quality, Safety and Risk Committee oversees quality, safety, and risk management across the service. This Committee is chaired by a member of the North West HHS Board. The Chief Executive, other members of the executive, senior managers, and quality and safety officers are invited members. This Committee monitors risks within the organisation and identifies strategies to mitigate those risks. The Committee reviews and monitors patient safety indicators and occupational health and safety indicators. Performance against infection control indicators are reviewed, including hand hygiene compliance rates. The Committee reviews patient complaints and compliments and recommends remedial actions as required.

During 2013–2014 the organisation's clinical governance structures were reviewed. A new executive level position was established in May 2014 to drive improvements in safety, quality and risk management across the organisation. The Executive Director of People and Performance is a key strategic role, accountable for the leadership of organisational strategy to continuously develop and implement people and performance strategies that are essential for the achievement of the organisation's strategic objectives.

In addition, recruitment is underway for a newly established Nursing Director (Quality, Safety and Risk) position. This role will lead the establishment and implementation of a central Quality, Safety and Risk Unit that will coordinate and monitor safety, quality and risk activities across the service.

The Governance for Safety, Quality and Risk Committee undertook a review of its terms of reference during 2014. The Committee is responsible for the development, implementation, maintenance, review and ongoing improvement of the North West HHS governance structure in order to ensure efficient, safe and effective delivery of service. The Committee will identify strategic opportunities for improvement in the safety, quality and effectiveness of care systems and processes and report on the current status of safety and quality across the North West HHS.

North West HHS Safety and Quality Plan

The North West HHS Safety and Quality Plan has been developed around the National Safety and Quality Health Service Standards. The plan sets out evidence based improvement strategies and performance indicators that will drive development of an organisational culture that is driven by safety, quality and innovation.

Accreditation

We are committed to maintaining accreditation under the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme. Our service is evaluated on a continuous basis against ten clinical National Safety and Quality Health Service Standards (NSQHS) and five EQuIP National standards developed by the Australian Council on Healthcare Standards. Mental health services are assessed against the NSQHS standards and the National Standards for Mental Health Services.

The North West HHS is currently accredited for the period 2011–2015. As accreditation to the NSQHS Standards commenced in 2013, the North West HHS was assessed against these standards for the first time during a periodic review survey in June 2014. All services maintained accreditation during 2013–2014. A full organisation wide accreditation survey is scheduled for late 2015.

Scope of practice and credentialing of health professionals

The scope of practice of all health professionals is established in accordance with the Department of Health *Credentialing and defining the scope of clinical practice policy* (2013). North West HHS policies related to scope of practice and credentialing of health professionals are consistent with relevant registration standards set by the Australian Health Practitioner Regulation Agency National Boards.

Patient experience

The North West HHS has a strong commitment to patient-centred health care delivery. Knowing what our patients experience during their journey through our health services is a key component in ensuring we deliver high quality health care.

During 2013–2014 the North West HHS participated in the state-wide Emergency Department Patient Experience Survey. Results from this survey have informed ongoing continuous improvement activities across the service.

The North West HHS conducted a patient satisfaction survey in July 2013. The survey sought to obtain information from patients who had received care during the redevelopment of Block C. Survey methods included face-to-face interview, mail out survey and advertising through local media. The information obtained from the survey was used to identify training and development needs, and further planned development of facilities and staff.

Patient liaison

The Patient Liaison Officer completed a full review of all consumer feedback policies, procedures, processes and systems in 2014 to ensure compliance with the NSQHS Standards. Changes to our internal processes and data bases were made resulting in more effective service delivery, including achieving 100% compliance with response times to patient comments. Over the next year the Patient Liaison Officer will implement a training program for all staff about responding to patient feedback, and develop an auditing program for the 'partnering with consumers' NSQHS Standard.

Patient safety

The North West HHS patient safety officers provide expertise and support for patient safety related activities. Services include monitoring and reporting on clinical incidents, and provision of staff education about incident reporting, analysis and monitoring.

Queensland Bedside Audit

The Queensland Bedside Audit is a clinical bedside patient safety audit conducted throughout Queensland Health. The North West HHS participates in this audit each year. The results are used as evidence in meeting actions in the NSQHS Standards, and facilitate identification of actions that can be taken locally to directly improve patient care. Preparations are underway for the next audit to be conducted in October 2014.

Infection prevention

A Clinical Nurse Consultant manages the North West HHS infection prevention program. Key activities include monitoring of healthcare associated infections, workforce immunisation programs, and monitoring key indicators such as hand hygiene compliance.

Clinical Handover

The SHARED framework for clinical handover was introduced across the North West HHS in April 2014. SHARED was developed by the Mater Health Services Brisbane with support and funding from the Australian Commission for Safety and Quality in Health Care (ACSQHC). The North West HHS has endorsed SHARED as the minimum data set for clinical handover and communication regarding patient care.

The SHARED framework incorporates essential components of clinical handover described in the NSQHS Standard for Clinical Handover. The framework helps clinicians exchange comprehensive, appropriate and safe communication about a patient's health status. The framework ensures that clinical handovers include information about the patient's situation, their history, current assessment details, any risks (e.g. drug allergies), the patient's expected plan of care, and documentation requirements.

Patient and carer involvement in handover is a critical element of the framework. The North West HHS is championing a culturally capable bedside handover project 'Sharing and Caring – Yarning Circles at the Bedside' to reflect the cultural requirements when communicating handover at the bedside for Aboriginal and Torres Strait Islander clients and families.

Ryan's Rule

The North West HHS has developed a procedure that adopts Ryan's Rule. Ryan's Rule provides a three-step process that can be used by patients, families and carers to escalate their concerns when they feel that the patient's condition is worsening or not improving. A comprehensive training program has been completed with medical, nursing and other clinical staff. The new procedure will be implemented in August 2014.

Recognition and response to clinical deterioration

Over 2013–2014 the North West HHS has implemented tools that allow accurate and timely recognition of clinical deterioration, and prompt action when deterioration is observed in adult, paediatric, and maternity patients.

Research

The North West HHS Nursing Research Fellow is currently conducting a study looking at factors contributing to attraction, retention, and attrition of nursing staff in the North West HHS.

A Mount Isa Hospital Podiatrist is co-investigator and co-author for the Foot Disease in Inpatient Study. This study will determine prevalence of foot disease complications in inpatients and investigate any associations with demography, social determinants, medical conditions, self-care ability, foot disease history and past foot health service use. The study was an observational multi-site point-prevalence study. Mount Isa was chosen as the remote setting for the study.

Information systems and record keeping

North West HHS employees are informed of their responsibilities regarding security, confidentiality and management of records during orientation and departmental inductions. Administration officers with responsibility for medical records complete training, and competency assessments are undertaken to ensure staff are able to comply with record keeping requirements. Written and electronic resources are available at all times to assist in maintaining a high level of service.

Appropriately skilled staff are responsible for management of information systems and record keeping. The medical records department is responsible for lifecycle management of clinical records. A regular audit schedule has been implemented. Staff are informed of audit results and involved in continuous improvement activities. Service areas manage non-clinical records.

During 2013–2014 access to the medical records department has been upgraded to specific staff with swipe card access as part of an ongoing commitment to information standards and information storage. In addition, access to the culling storage area is restricted by lock and key access to the Culling Officer and relevant managers in accordance with the *Information Privacy Act 2009*.

Medical records are tracked with the Hospital Based Corporate Information System (HBCIS). Public records are retained and disposed of in accordance with the Health Sector (Clinical Records) Retention and Disposal Schedule (QDAN 683). Public records are kept in accordance with the *Public Records Act 2002*.

The North West HHS has proposed the implementation of the Communicare integrated electronic health and practice management system for use in primary health care and community care settings.

Chief Finance Officer Statement

The North West Health and Hospital Service has successfully managed through its second year of operation with a surplus of $0.249M, and managed to substantially meet its service delivery obligations under the Service Agreement with the Department of Health.

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

This CFO Statement has been prepared with support from a number of sources including the internal financial controls. The internal financial control framework consists of the following elements:

- Legislative framework
- Legislative requirements
- Governance Structures
- Board
- Executive Committee
- Finance, Audit and Risk Committee
- Safety and Quality Committee
- Business Development Committee
- Service Provider Assurance
- Delegation Framework and policies
- Financial Management Practice Manual
- Organisational structures aligned to best practice
- Internal Audit Function
- External Audit Function
- Education and communication in relation to policies, processes and procedures.

Following the interrogation of the internal control framework, I consider that:

- The financial records of the North West Hospital and Health Service have been properly maintained throughout the reporting period in accordance with legislation and prescribed requirements.
- No material misstatement of transactions has been reported in the financial statements for the year ended 30 June 2014.
- The risk management and internal compliance and control systems of the North West Hospital and Health Service relating to financial management have been operating efficiently and effectively throughout the reporting period.
- No material changes or other issues that may have a material effect on the operation of the risk management and internal compliance and control systems of the North West Hospital and Health Service have arisen since balance date.
- An assurance report has been received from the Department of Health (DoH) in its capacity as a service provider to the North West Hospital and Health Service. The DoH assurance report indicated that there had been control failures in the DoH accounts payable and payroll processing. A number of these failures were rated as high risk and the North West HHS CFO has relied on the results, review, follow up and corrective measures undertaken by the DoH in relation control failures identified in the giving of this CFO Statement.
- There are a number of key areas where improvements can be made to strengthen North West HHS's internal control environment that will lead to a more robust, efficient, effective and economic assurance process, and these are being pursued and monitored in the 2014–2015 internal and external audit programs.
- No significant risks have been identified by the Finance, Audit and Risk Management (FARM) Committee that impacted, or may impact on the achievement of North West HHS's targets and goals. Risk registers are also maintained by North West HHS and a risk management and a fraud management framework exists. Fraud management has been the focus of internal audit and a strengthening of these policies are being undertaking with regular reporting to the FARM Committee.
- Audit recommendations, both internal and external have been considered and addressed in liaison with the FARM Committee. Regular updates about audit recommendations (both internal and external) and their implementation status is provided to the FARM Committee by the relevant audit director at the committee meetings.

Based on the foregoing, I consider

- The financial records of the North West Hospital and Health Service have been properly maintained from 1 July 2013 to 30 June 2014;
- The financial statements for that period are fairly stated; and
- There has been compliance with the requirement of the Financial Accountability Act 2009 and other prescribed requirements, including relevant Australian Accounting Standards, where applicable.

Brett Oates
Chief Finance Officer
North West Hospital and Health Service
22 August 2014

Performance Summary 2013–2014

Key Performance Indicators	Target	Actual
Shorter waits for emergency departments		
Category 1: within 2 minutes	100%	100%
Category 2: within 10 minutes	80%	94.8%
Category 3: within 30 minutes	75%	85.1%
Category 4: within 60 minutes	70%	73.2%
Category 5: within 120 minutes	70%	85.8%
Treating elective surgery patients in turn	60%	65.1%
Shorter maximum wait for elective surgery (days)		
General	365	293
Gynaecology	365	106
Ophthalmology	365	335
Fewer long waiting patients		
Category 2: % waiting › 90 days	2%	0%
Category 3: % waiting › 365 days	2%	0%
Shorter waits for specialist outpatient clinics		
Category 1: % within 30 days	95%	43.4%
Category 2: % within 90 days	90%	57.7%
Category 3: % within 365 days	90%	63.1%
Postnatal-in-home visiting	85%	127.7%
Aboriginal and Torres Strait Islander PPH	17.7%	*Not available*
Potentially Preventable Hospitalisations Chronic Conditions	4.9%	*Not available*
Aboriginal and Torres Strait Islander Discharge Against Medical Advice (DAMA)	3.5%	*Not available*
Rate of post discharge community contact - Mental Health	60%	*Not available*
Ambulatory mental health activity	95%	*Not available*
Dental waiting lists	0%	0%

Please note that a full suite of end of year performance results will be published once available.

Financial performance summary 2013–2014

The North West HHS total revenue for 2013–2014 increased by $7.930M to $146.433M with the final total expenditure of $146.184M providing a community dividend (or surplus) of $0.249M. This surplus is expected to be invested in capital projects for 2014–2015.

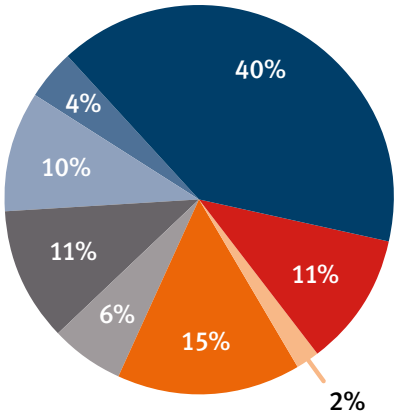
Throughout 2013–2014, the finances were expended largely as per expectation, with a significant shift in clinical patterns with the reoccupation of clinical space after a period of significant renovation works. A strong result was demonstrated in the achievement of the activity targets with a projected 108.3 per cent combined achievement of activity in activity-based and block funding targets. Cost pressures on the North West HHS, continue to be the provision of a health service in a large remote region in Queensland, with issues of specialist recruitment, short term medical specialist placements and contracted nursing services being significant cost lines in the North West HHS ledger. Other costs associated with remoteness including, staff and patient travel, support service staff, and minimum staffing models in outlying areas of the North West HHS continue to provide budgetary challenges to the service. Innovation in service delivery models and the integration of business focus as a component of the decision making process will see continued success in the management of these costs.

Service agreement and purchased services – North West HHS 2013–2014

The funding for the North West HHS is split into major products which are purchased by Queensland Health on behalf of the residents of North West HHS. The broad services are represented in the table “Purchased Services”. The national health reform agenda created the opportunity for Queensland Health (QH) to purchase specified services from North West HHS statutory bodies for residents of North West Queensland. The resultant service agreement has taken the form of a negotiated contract between QH, representing the purchaser of services and the North West HHS Board, representing the provider of services.

In simple terms QH is able to liaise and negotiate with Queensland Treasury and the Minister of Health, and the North West HHS Board is able to engage with the community, oversight quality, and ensure an efficient delivery of services. The charts below are an indicator of the broad purchasing intentions as they were negotiated in the service agreements. The total funding available to finance these purchasing intentions moved from $133.993M at the beginning of the period to $143.668M after the final budgetary adjustments were made for changing circumstances throughout the year

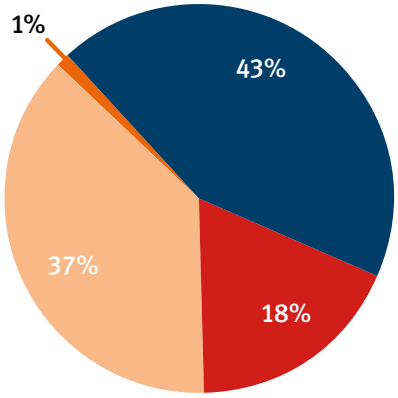
Purchased Services



- **Activity Based Funding (Mount Isa Campus)** 40%
- **Transition Grant (ABF and Block)** ... 11%
- **Other ABF Grants** 2%
- **Block Funded Hospitals** 15%
- **Mental Health and ATODS** 6%
- Community and Primary Health 11%
- Patient Transport 10%
- Depreciation, Redevelopment and other Services 4%

The”Transition Grant (ABF and Block)” represents the difference between the national efficient price and the expected funding requirement of the North West HHS for 2013–2014. The transition grant is made up of costs attributed specifically to the North West HHS and comprises of costs associated with remoteness, burden of disease, scale disability and regional cost factors.

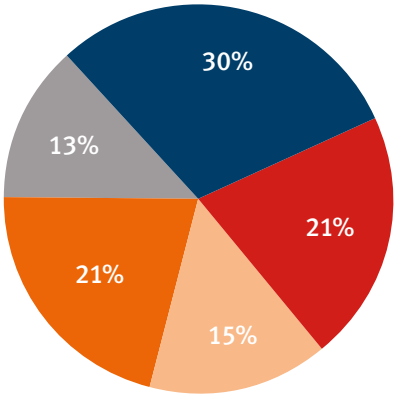
ABF Purchased Activity – throughput by major patient category



- **Inpatient** 43%
- **Outpatient** 18%
- **Emergency Care** 37%
- **Subacute and Mental Health** 1%

The purchased service of Activity Based Funding – Mount Isa campus is further broken down into major categories of purchased services including Inpatients (patients admitted to a hospital bed for same day or overnight medical and surgical services), Outpatients (patients booked for specialist nursing and allied health outpatient appointments), Emergency Care (patients presenting to the emergency department), Critical Care (Intensive Care Unit) and Subacute and Mental Health services.

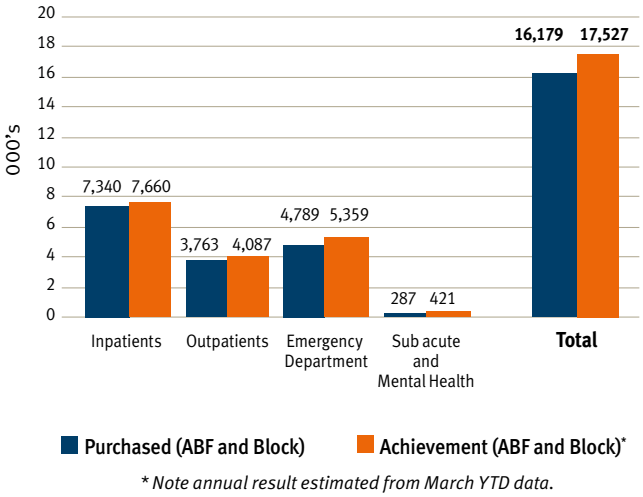
Purchased Services – Block Funded Hospitals (Rural and Remote)



- **Cloncurry Hospital** 30%
- **Doomagee Hospital** 21%
- **Julia Creek Hospital** 15%
- **Mornington Island Hospital** 21%
- **Normanton Hospital** 13%

All of the facilities outside of Mount Isa campus are deemed to be "block funded" and their service agreement is separate from the funding allocated to Mount Isa. These hospitals are funded according to a number of factors including the national efficient price of rural and remote hospitals. The transition grant for these hospitals recognises the difference between the national efficient price and the expected funding requirement for these facilities. This represents several issues, including medical coverage, minimum staffing models and circumstances peculiar to the Northwest Queensland.

Purchased vs Achieved Activity – North West Hospital and Health Service



** Note annual result estimated from March YTD data.*

Part of the service agreement is the negotiation of a planned level of activity to be undertaken at the Mount Isa campus. The unit of measure known as the Queensland Weighted Activity Unit (QWAU) is a statistical unit of production based partially on the national efficient price. This unit of production is a proxy for the resources consumed in providing patient care in different settings.

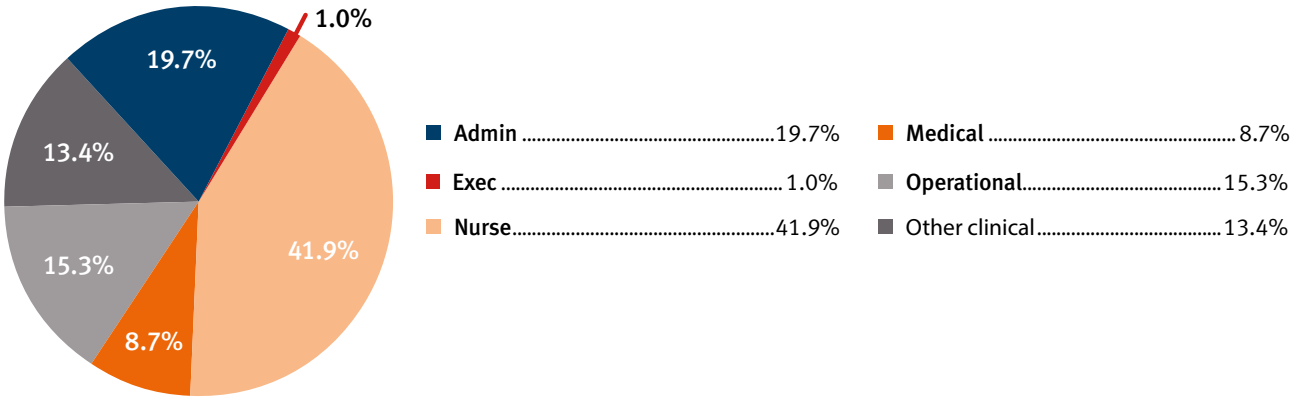
Overall, North West HHS estimated overachievement is 1,348 QWAU or 8.3 per cent. There is a requirement for the North West HHS to improve the reliability of the activity projections as the significant variations across ABF, Block funded and patient category partitions should be reduced to improve the predictability of the total throughput for year end reporting. Significant effort is planned for the North West HHS to improve the reliability of these projections in 2014–2015.

Expenditure required to meet the service agreement obligations

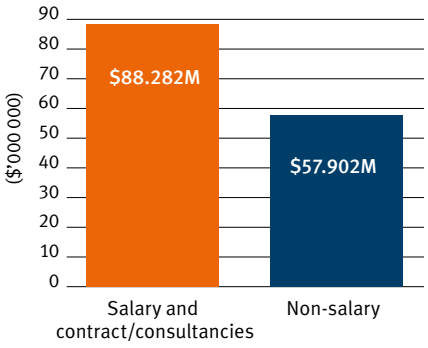
The expenditure for the North West HHS is itemised in the Financial Statements at the end of this Annual Report. The result for 2013–2014 was a surplus of $0.249M, or 0.2 per cent of total revenue. The staffing and related costs (including contract employees) account for 60.3 per cent of expenditure, and as at 30 June 2013 this employed 609 full-time equivalents. The percentage age breakdown by major staff category showing nursing positions are 41.9 per cent of the total.

For the non-salary expenditure, patient travel is by far the largest component (25 per cent of non-salary costs), and this cost is reflective of the wide spread of residents in Northwest Queensland.

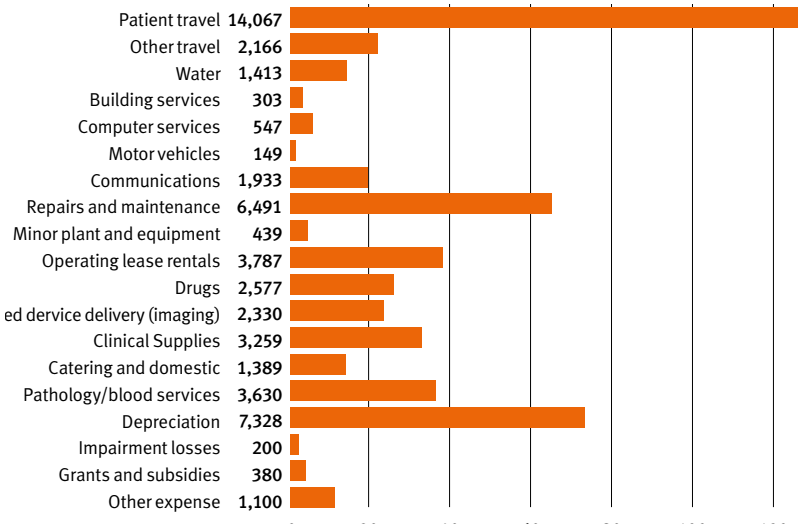
Staff Type – staff by discipline (FTE % age)



Salary



Non-salary costs



Our people

Workforce management

Prior to 1 July 2014 the North West HHS was responsible for HR management functions subject to a delegation by the Director-General of Queensland Health. From 1 July 2014 the North West HHS became a prescribed employer under the *Hospital and Health Boards Act 2011*. The service is now responsible for all HR management functions, including:

- Recruitment and selection
- Induction and orientation
- Training and professional development
- Industrial and employee relations
- Performance management
- Work health and safety and well being
- Workforce planning
- Equity and diversity
- Workforce consultation, engagement and communication.

The Minimum Obligatory Human Resources Information (MOHRI) FTE within the North West HHS remained under the target of 646 FTE during 2013–2014.

Newly appointed staff attend a central onboarding program and work level orientation. A cultural awareness program is included in the central onboarding program.

North West HHS has developed and implemented a range of policies and procedures to promote flexible working arrangements for staff of all categories and levels. These policies are promoted through avenues such as role descriptions, professional appraisal and development, consultative forums, staff forums, relevant meetings and committees, and via intranet sites.

During the period, 1 employee received a redundancy package at a cost of $99,526.33.

Code of Conduct and Public Sector Ethics

North West HHS is committed to upholding the values and standards in the Code of Conduct for the Queensland Public Service. All staff employed within the North West HHS are required to undertake training related to the Code of Conduct for the Queensland Public Service and Public Sector Ethics and Ethical Decision Making. Training is provided in the central onboarding program and via online training modules. Human Resource Officers provide in-house training where requested. Code of Conduct requirements are included in the terms of employment in all appointment letters.

Occupational health and safety

Occupational health and safety services are available for all North West HHS employees. These services include safety arrangements for incident investigation, workers compensation, rehabilitation and reporting.

Open Data

Annual reporting requirements for expenditure on consultancy and overseas travel will be published on the Queensland government's open data website, available via: **www.data.qld.gov.au.**

Celebrating our achievements

During 2013–2014 the North West Hospital and Health Service has celebrated with staff who have been recognised for their valuable contribution to our health services.

Mount Isa Hospital Clinical Service Achievements

Allied health Superstar Award (June 2014)
Amanda Watson-Brown

Amanda is a new graduate Occupational Therapist. She worked as a sole practitioner during a period of senior staff leave and performed exceptionally well. Inpatients and outpatients reported a high level of satisfaction with the services provided by Amanda during this period.

Ellen Fels, Operational Services
Ellen has worked at the Julia Creek Hospital for the past 48 years. This year Ellen received assistance into training at Mount Isa Group Apprenticeship, Traineeship and Employment (MIGATE). Ellen turns 80 in July 2014. Ellen was keen to undertake the Certificate III qualification so she can help with patient care.

North West Hospital and Health Service Awards

Elder Award
Ron Page, Board Member
Awarded in recognition of cultural support and dedication to the community.

Aboriginal Leadership and Encouragement Award
Elijah Douglas, Senior Health Worker
Awarded for showing leadership and creating pathways for young Aboriginal and Torres Strait Islander.

Health Worker Achievement Award
Helen Burns, Senior Health Worker and
Doris Craigie, Senior Health Worker
For all-round dedication to the community and outreach.

Service of the Year Award – Hearing Health
Helen Burns, Senior Health Worker and
Michael Parker, Senior Health Worker
For outstanding services and commitment to the community.

Spirit of Reconciliation Award
Cita Maddicks, Administration Officer and
Peter Lehmann, Manager of Specialist Services
For dedication and commitment to Indigenous health.

Nursing Achievement Award
Kayleen Bax, Enrolled Nurse and
Charlotte Mullins, Enrolled Nurse
For dedication and commitment to excellence in health services.

Queensland Health Awards

Vibeke Roux, Clinical Nurse Consultant Infection Prevention Services

Vibeke received second prize in a Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP) and Tuberculosis Control competition.

Vibeke's abstract told the story of how staff at Mount Isa Hospital managed the infection prevention challenges involved in the emergent decanting of Block C at Mount Isa Hospital.

Vibeke received a gift voucher for $500 which she spent on hosting a morning tea for Hand Hygiene Day in May 2014.

National Awards

Sally Goold Award for Nursing Excellence
Noela Baigrie, Indigenous Nurse Educator

Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)

The Sally Goold Award recognises the achievements of an Aboriginal and/or Torres Strait Islander nurse or midwife who has made a substantial contribution to the nursing and midwifery profession and to the health of Aboriginal and Torres Strait Islander Peoples through their work.

Noela's colleagues gave her a standing ovation when she was awarded the inaugural Sally Goold Award for individual nursing excellence at the CATSINaM conference in Canberra in October 2013.

Noela is a founding member of CATSINaM and is widely recognised for her professionalism in working towards achieving improved health outcomes for Aboriginal and Torres Strait Islander people.

Public Service Medal
Frances Page (Aunty Fran), Senior Health Worker and Team Leader (Community Health

'Aunty Fran', was recognised in the 2013 Queen's Birthday Honors List with a Public Service Medal for her outstanding service to Aboriginal and Torres Strait Islander health in the North West region.

Glossary

Annual report: A written report on the operations of the agency during the financial year, as prescribed by section 63 of the *Financial Accountability Act 2009*.

Activity based funding (ABF): The funding framework which is used to fund public health care services delivered across Queensland. The ABF framework applies to those Queensland Health facilities which are operationally large enough and have the systems which are required to support the framework. The ABF framework allocates health funding to these hospitals based on standardized costs of health care services (referred to as 'activities') delivered.

Acute care: Healthcare in which a patient is treated for an acute (immediate and severe) episode of illness; for the subsequent treatment of injuries related to an accident or other trauma; or during recovery from surgery. Acute care is usually provided in hospitals by specialised personnel using complex and sophisticated technical equipment and materials. Unlike chronic care, acute care is often necessary only for a short time.

Ambulatory care: The care provided to hospital patients who are not admitted to the hospital, such as patients of emergency departments and outpatient clinics.

Blueprint for better healthcare in Queensland: Outlines structural and cultural improvements to establish Queensland as the leader in Australian healthcare.

It marks a significant step towards ensuring Queensland is the pace-setter for value-for-money, performance and delivery.

The Blueprint focuses on four principal themes:

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

Central and North West Queensland Medicare Local (CNWQML): Is an independent, locally operated organisation, working to create healthy communities in the inland parts of Queensland. A non-profit entity, established under Federal health reforms to coordinate primary health care delivery by connecting the local community with health services.

Community service: Means non-admitted patient health services, excluding hospital outpatient services, typically delivered outside of a hospital setting.

Day case: A treatment or procedure undertaken where the patient is admitted and discharged on the same day

Emergency Department: The emergency department is the dedicated area in a hospital that is organised and administered to provide a high standard of emergency care to those in the community who perceive the need for or are in need of acute or urgent care.

Emergency Department Information System (EDIS): Is an electronic health record system designed specifically to manage data and workflow in support of Emergency Department patient care and operations.

Government objectives for the community: The FAA (section 10) requires that the government prepares and tables a statement of the government's broad objectives for the community.

Getting Queensland back on track currently addresses this requirement.

Getting Queensland back on track outlines five pledges:

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

Hospital and Health Service Area: The geographical area for the HHS, determined by the Hospital and Health Boards Regulation 2012.

Hospital Performance: The website contains detailed, up-to-date and regular information on the activity and performance of Queensland Health's reporting hospitals. Mount Isa Hospital is the only reporting hospital in the North West HHS.

Inpatient service: A service provided under a hospital's formal admission process. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

Interventions and procedures: Are services delivered to non-emergency department patients for specified services: chemotherapy, dialysis, endoscopy.

Mount Isa Centre for Rural and Remote Health (MICRRH): Is a "participating university's centre for population health, education and research".

National Emergency Access Target (NEAT) : As part of the National Health Reform agenda, Queensland Health is committed to reducing the length of time patients spend in the emergency department. NEAT is measured as the percentage of patients who leave the emergency department within four hours of their arrival. The higher the percentage, the better the performance. This is measured from the time the patient arrives at the emergency department to the time the patient has physically left, whether the patient is admitted to a bed in a ward, transferred to another hospital, or goes home.

National Elective Surgery Targets (NEST): Is a component of the National Performance Agreement (NPA) and aim to ensure that surgical patients are treated within their recommended clinical priority timeframe.

National Health Reform: Commonwealth, State and Territory governments have agreed to transform the Australian health system. Health reform for Queensland will mean:

- decision-making and accountability that is more responsive to local health priorities
- stronger clinician, consumer and community participation
- a more 'seamless' patient experience across sectors of the health system.

National Partnership Agreement (NPA) on Improving Public Hospital Services: The objective of this agreement is to drive major improvements in public hospital service delivery and better health outcomes for Australians.

North Queensland Helicopter Rescue Service (RACQ NQ Rescue): Is a not for profit charity established in Mount Isa in early 2007. The charter of the organisation is to provide a full-time dedicated community rescue helicopter service for the people of the North West.

Performance indicator: Measures the extent to which agencies are achieving their objectives.

Performance information: A generic term used to describe information about the performance of an agency or the government at any level of the performance management framework.

Performance management: Considered to be a system which integrates organisational strategic management, performance information, evaluation, performance monitoring, assessment, and performance reporting.

Performance management framework: The framework is designed to improve the quality, analysis and application of performance information to identify and address risks and opportunities for agencies, government and the community.

Permanent retention rate: Means the percentage of permanent employees still employed after a period of time. For example, if an organisation had 100 permanent employees 12 months ago and 90 of those employees are still employed, the permanent retention rate is 90 per cent.

Permanent separation rate: Calculated by dividing the number of permanent employees who separated during a period of time by the number of permanent employees in the organisation. For example, if 12 permanent employees departed from an organisation of 100 employees over a period of time the permanent separation rate would be 12 per cent.

Primary care: First level healthcare provided by a range of healthcare professionals in socially appropriate and accessible ways and supported by integrated referral systems. It includes health promotion, illness prevention, care of the sick, advocacy and community development.

Public health services: Programs that prevent illness and injury, promote health and wellbeing, create healthy and safe environments, reduce health inequalities and address factors in those communities whose health status is the lowest.

Royal Flying Doctor Service (RFDS): The RFDS is a not-for-profit organisation. While supported by the Commonwealth, State and Territory Governments, the RFDS relies heavily on fundraising and donations from the community to purchase and medically-equip its aircraft, and to finance other major capital initiatives. Today, the RFDS has a fleet of 60 aircraft operating from 21 bases located across the nation and provides medical assistance to over 270,000 people every year – that's one every two minutes.

Service standard: A standard of efficiency and effectiveness to which an agency will deliver services within its budget. Standards define a level of performance that is appropriate for the service and are expected to be achieved.

Services: Services are the deliverables that will help an agency to achieve its objectives. They describe the areas in which an agency delivers services to its clients at a level appropriate to the agency.

Strategic plan: A short, concise, forward-looking document used by an agency to set its direction, align the agency with the government's objectives for the community and provide objectives and strategies for the agency.

Telehealth: The delivery of health services and information using telecommunication technology, including:

- Live interactive video and audio links for clinical consultations and education.
- Store and forward systems to enable the capture of digital images, video, audio and clinical data stored on a computer and forwarded to another location to be studied and reported on by specialists.
- Teleradiology to support remote reporting and provision of clinical advice associated with diagnostic images.
- Telehealth services and equipment for home monitoring of health.

Vision: Specifies what an agency hopes to become or create. A vision statement takes into account the current status of the agency and serves to point the direction of where the agency wishes to go.

Compliance checklist

Summary of requirement	Basis for requirement	Annual report reference
Letter of compliance		
A letter of compliance from the accountable officer or statutory body to the relevant Minister	ARRs – section 8	Page 1
Accessibility		
Table of contents	ARRs – section 10.1	Page 3
Glossary		Pages 58–59
Public availability	ARRs – section 10.2	Inside front cover
Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 10.3	Inside front cover
Copyright notice	*Copyright Act 1968* ARRs – section 10.4	Inside front cover
Information Licensing	*QGEA – Information Licensing* ARRs – section 10.5	Inside front cover
General information		
Introductory Information	ARRs – section 11.1	Pages 4–5
Agency role and main functions	ARRs – section 11.2	Pages 13–29
Operating environment	ARRs – section 11.3	Pages 10–12
Machinery of government changes	ARRs – section 11.4	NA
Non-financial performance		
Government's objectives for the community	ARRs – section 12.1	Pages 30–31
Other whole-of-government plans / specific initiatives	ARRs – section 12.2	Pages 30–31
Agency objectives and performance indicators	ARRs – section 12.3	Pages 31 – 36
Agency service areas, and service standards	ARRs – section 12.4	Page 51
Financial performance		
Summary of financial performance	ARRs – section 13.1	Pages 52–54
Governance – management and structure		
Organisational structure	ARRs – section 14.1	Page 46
Executive management	ARRs – section 14.2	Pages 37–45
Related entities	ARRs – section 14.3	NA
Government bodies	ARRs – section 14.4	NA

Summary of requirement	Basis for requirement	Annual report reference
Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* (section 23 and Schedule) ARRs – section 14.5	Page 55
Governance – risk management and accountability		
Risk management	ARRs – section 15.1	Page 40 Page 47
External scrutiny	ARRs – section 15.2	Page 40
Audit Committee	ARRs – section 15.3	Page 40
Internal audit	ARRs – section 15.4	Page 40
Public Sector Renewal	ARRs – section 15.5	Page 5 Page 30
Information systems and record keeping	ARRs – section 15.6	Page 49
Governance – human resources		
Workforce planning, attraction and retention, and performance	ARRs – section 16.1	Page 55
Early retirement, redundancy and retrenchment	Directive No. 11/12 *Early Retirement, Redundancy and Retrenchment* ARRs – section 16.2	NA
Open Data		
Open Data	ARRs – section 17	Page 55
Financial statements		
Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 18.1	From page 63
Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 18.2	From page 63
Remuneration disclosures	*Financial Reporting Requirements for Queensland Government Agencies* ARRs – section 18.3	From page 63

FAA *Financial Accountability Act 2009*

FPMS *Financial and Performance Management Standard 2009*

ARRs *Annual report requirements for Queensland Government agencies*

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North West Hospital and Health Service

ABN 22 406 683 778

Financial Statements – 30 June 2014

Contents

General information

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

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

The head office and principal place of business of North West Hospital and Health Service is:

30 Camooweal Street
Mount Isa QLD 4825

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

For information in relation to North West Hospital and Health Service's financial statements, email mt_isa_finance@health.qld.gov.au or visit the North West Hospital and Health Service website at www.health.qld.gov.au/mt_isa.

Statement of comprehensive income
For the year ended 30 June 2014

	Notes	2014 $'000	2013 $'000
Revenue			
User charges and fees	3	141,780	135,419
Grants and other contributions	4	3,810	2,670
Other revenue	5	843	402
Other income	6	-	12
Total revenue		**146,433**	**138,503**
Expenses			
Employee expenses	7	909	477
Health service employee expenses	8	69,593	67,330
Supplies and services	9	65,503	60,346
Grants and subsidies	10	380	745
Depreciation and amortisation	11	7,328	5,638
Impairment losses	12	200	70
Other expenses	13	2,271	2,758
Total expenditure		**146,184**	**137,364**
Surplus for the year	24	**249**	**1,139**
Other comprehensive income			
Items that will not be reclassified subsequently to surplus for the year			
(Decrease) / Increase in asset revaluation surplus	23	(2,011)	12,621
Total other comprehensive (loss) / income for the year		**(2,011)**	**12,621**
Total comprehensive (loss) / income for the year		**(1,762)**	**13,760**

The accompanying notes form part of these statements.

	Notes	2,014 $'000	2013 $'000
Assets			
Current assets			
Cash and cash equivalents	14	9,809	6,382
Trade and other receivables	15	4,202	3,511
Inventories	16	504	448
Other	17	28	80
Total current assets		**14,543**	**10,421**
Non-current assets			
Property, plant and equipment	18	111,317	103,148
Total non-current assets		**111,317**	**103,148**
Total assets		**125,860**	**113,569**
Liabilities			
Current liabilities			
Trade and other payables	20	11,499	8,101
Accrued employee benefits	21	50	45
Total current liabilities		**11,549**	**8,146**
Total liabilities		**11,549**	**8,146**
Net assets		**114,311**	**105,423**
Equity			
Contributed equity	22	102,313	91,663
Asset revaluation surplus	23	10,610	12,621
Retained surpluses	24	1,388	1,139
Total equity		**114,311**	**105,423**

The accompanying notes form part of these statements.

	Notes	Contributed equity	Asset revaluation surplus	Retained surplus	Total equity
		$'000	$'000	$'000	$'000
Balance at 1 July 2012		**-**	**-**	**-**	**-**
Surplus for the year		-	-	1,139	1,139
Other comprehensive income for the period		-	12,621	-	12,621
Total comprehensive income for the year		-	12,621	1,139	13,760
Transactions with owners in their capacity as owners:					
Transfer under National Health Reform		86,271	-	-	86,271
Non-appropriated equity injections		2,195	-	-	2,195
Non-appropriated equity withdrawal		(5,635)	-	-	(5,635)
Non-appropriated equity transfer		8,832	-	-	8,832
Balance at 30 June 2013		**91,663**	**12,621**	**1,139**	**105,423**
Balance at 1 July 2013		**91,663**	**12,621**	**1,139**	**105,423**
Surplus for the year		-	-	249	249
Other comprehensive income for the period		-	(2,011)	-	(2,011)
Total comprehensive income for the year		-	(2,011)	249	(1,762)
Transactions with owners in their capacity as owners:					
Non-appropriated equity injections	22	1,297	-	-	1,297
Non-appropriated equity withdrawal	22	(7,327)	-	-	(7,327)
Non-appropriated equity transfer	22	16,680	-	-	16,680
Balance at 30 June 2014		**102,313**	**10,610**	**1,388**	**114,311**

The accompanying notes form part of these statements.

	Notes	2014 $'000	2013 $'000
Cash flows from operating activities			
Inflows			
User charges		131,305	127,806
Grants and other contributions		4,559	3,356
GST collected from customers		265	88
GST input tax credits from ATO		3,879	3,022
Other		2,244	631
Outflows			
Employee expenses		(909)	(477)
Health service employee expenses		(71,544)	(64,911)
GST paid to suppliers		(3,822)	(3,424)
GST remitted to ATO		(215)	(100)
Supplies and services		(60,197)	(57,753)
Grants and subsidies		(380)	(745)
Other expenditure		(2,204)	(2,031)
Net cash from operating activities	34	**2,981**	**5,462**
Cash flows from investing activities			
Inflows			
Proceeds from sale of property, plant and equipment		0	22
Outflows			
Payments for property, plant and equipment	18	(851)	(1,661)
Net cash used in investing activities		**(851)**	**(1,639)**
Cash flows from financing activities			
Inflows			
Equity injections		1,297	2,195
Net cash from financing activities		**1,297**	**2,195**
Net increase in cash and cash equivalents		3,427	6,018
Cash and cash equivalents at the beginning of the financial year		6,382	364
Cash and cash equivalents at the end of the financial year	14	**9,809**	**6,382**

The accompanying notes form part of these statements.

Note 1. Objectives and strategic activities

North West Hospital and Health Service is responsible for providing public sector health services to communities within North Western Queensland, including to the city of Mount Isa and to the towns and areas of Burketown, Camooweal, Cloncurry, Dajarra, Doomadgee, Julia Creek, Karumba, Normanton and Mornington Island.

North West Hospital and Health Service provides services and outcomes as defined in a Service Agreement (a publicly available document) with the Queensland Department of Health (Department of Health). Key services for 2013-14 include:

- Community and primary health services, including aged care assessment, Aboriginal and Torres Strait Islander health programs;
- child and maternal health services;
- alcohol, tobacco and other drug services;
- home care services; and
- community health nursing, sexual health service, allied health, oral health and health promotion programs.

North West Hospital and Health Service is committed to becoming Queensland's leading Hospital and Health Service and has identified the following six strategic aims as necessary to achieve this vision:

- A financially accountable and responsible Hospital and Health Service;
- a Hospital and Health wide service delivery model that provides and supports safe and sustainable services;
- better coordinated and integrated services within and between Hospital and Health Services and external service providers, particularly for chronic and complex conditions, child and maternal health, mental health and sexual health;
- implementation of priority strategies in Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033 including maternal health, healthy start to life, addressing risk factors, managing illness better, effective health services and improving data and evidence;
- implementation of priority strategies to recruit and retain staff; and
- implementation of innovative models of care and accreditation.

North West Hospital and Health Service is predominantly funded through the Service Agreement with the Department of Health, which comprises funding from Department of Health and the Australian Government.

Note 2. Significant accounting policies

The principal accounting policies adopted in the preparation of the financial statements are set out below.

(a) Basis of preparation

North West Hospital and Health Service have 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.

The financial statements are general purpose financial statements that have been prepared on an accrual basis in accordance with Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board ('AASB'), as appropriate for not-for-profit oriented entities.

Historical cost convention

The financial statements have been prepared under the historical cost convention, except for, where applicable, the revaluation of available-for-sale financial assets, financial assets and liabilities at fair value through profit or loss, investment properties, certain classes of property, plant and equipment and derivative financial instruments.

(b) The reporting entity

The financial statements include the value of all revenues, expenses, assets, liabilities and equity of North West Hospital and Health Service. North West Hospital and Health Service does not have any controlled entities.

(c) Administrative arrangements under the National 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 the health services in Australia are funded and governed.

North West Hospital and Health Service was established under the *Health and Hospitals Network* Act 2011 with effect from 1 July 2012. North West Hospital and Health Service is an independent statutory body and a reporting entity, which is domiciled in Australia, and is accountable to the local community and the Queensland Parliament.

On 17 May 2012, the Minister for Health introduced amending legislation into Parliament to expand the functions of Hospital and Health Services as outlined under the Health and Hospitals Network Act 2011. The amended legislation is known as the Hospital and Health Boards Act 2012.

Note 2. Significant accounting policies (continued)

Funding reforms
Funding is provided to North West Hospital and Health Service in accordance with the Service Agreement with the Department of Health. 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 is managed by the Department of Health.

Balances transferred in on 1 July 2012
Asset, liability and equity balances were transferred from Department of Health to North West Hospital and Health Service with effect from 1 July 2012. This was effected by a transfer notice signed by the Minister of Health, designating that the transfers be recognised as a contribution by owners through equity. The transfer notice was approved by the Director-General Department of Health and the Chair of the North West Hospital and Health Service Board. Balances transferred to North West Hospital and Health Service materially reflected the closing balances of the North West Health Service District as at 30 June 2012.

The value of assets and liabilities transferred (pursuant to the *Hospital and Health Boards Act* 2011) to the North West Hospital and Health Service on 1 July 2012 is outlined in Note 30 Transfer of assets and liabilities from Department of Health.

While control of land and building assets rests with the North West Hospital and Health Service, the Department of Health retains legal ownership of all land and building assets. North West Hospital and Health Service has full right of use, along with managerial control of land and buildings assets and is responsible for the maintenance. Department of Health generates no economic benefit from these assets. In accordance with the definition of control under Australian Accounting Standards, North West Hospital and Health Service recognises the value of land and buildings in the statement of financial position.

(d) Fiduciary trust transactions and balances
North West Hospital and Health Service acts in a fiduciary capacity in relation to patient monies provided to the service to safe keep in a specific patient trust bank account. As North West Hospital and Health Service acts only in a custodial role in respect of these transactions and balances, they are not recognised in the financial statements.

Note 31 Fiduciary trust transactions and balances provides additional information on the balances held in patient trust accounts by North West Hospital and Health Service.

Note 2. Significant accounting policies (continued)

(e) Revenue recognition

Revenue is recognised when it is probable that the economic benefit will flow to North West Hospital and Health Service and the revenue can be reliably measured. Revenue is measured at the fair value of the consideration received or receivable.

User charges and fees

User charges and fees primarily comprises Department of Health funding, hospital fees, reimbursement of pharmaceutical benefits and sales of goods and services. There has been a change in the recognition of Department of Health funding from grants and other contributions in 2012-13 to user charges and fees this year, refer Note 3 User charges and fees.

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

The funding from Department of Health is provided predominantly for specific public health services purchased by the Department from North West Hospital and Health Service in accordance with a service agreement between the Department and North West Hospital and Health Service. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by North West Hospital and Health Service. Refer Note 3 for more information on this funding arrangement.

The funding from Department of Health is received fortnightly in advance. At the end of the financial year, a financial adjustment may be required where the level of services provided is above or below the agreed level.

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

Grants and other contributions

Grants, contributions, donations and gifts that are non-reciprocal in nature are recognised as revenue in the year in which North West Hospital and Health Service obtains control over them. This includes amounts received from the Australian Government for programs that have not been fully completed at the end of the financial year. 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.

Note 2. Significant accounting policies (continued)

(f) Income tax

North West Hospital and Health Service is a State body as defined under the *Income Tax Assessment Act 1936* and it is exempt from paying income tax.

(g) Special Payments

Special payments include ex gratia expenditure and other expenditure that the department is not contractually or legally obligated to make to other parties. In compliance with the Financial and Performance Management Standard 2009 , the department maintains a register setting out details of all special payments greater than $5,000. The total of all special payments (including those of $5,000 or less) is disclosed separately within Other Expenses (Note 13). However, descriptions of the nature of special payments are only provided for special payments greater than $5,000.

(h) Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with financial institutions, other short-term, highly liquid investments with original maturities of three months or less that are readily convertible to known amounts of cash and which are subject to an insignificant risk of changes in value.

Overdraft Facility

North West Hospital and Health Service has approval from Queensland Treasury and Trade to operate bank accounts in overdraft up to a limit of $1,500,000.

(i) Trade and other receivables

Trade receivables are initially recognised at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment. Trade receivables are generally due for settlement within 30 days.

Collectability of trade receivables is reviewed on an on-going basis. Receivables which are known to be uncollectable are written off by reducing the carrying amount directly. A provision for impairment of trade receivables is raised when there is objective evidence that North West Hospital and Health Service will not be able to collect all amounts due according to the original terms of the receivables.

Significant financial difficulties of the debtor, probability that the debtor will enter bankruptcy or financial reorganisation and default or delinquency in payments (more than 60 days overdue) are considered indicators that the trade receivable may be impaired. The amount of the impairment allowance is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the original effective interest rate. Cash flows relating to short-term receivables are not discounted if the effect of discounting is immaterial.

Other receivables are recognised at amortised cost, less any provision for impairment.

Note 2. Significant accounting policies (continued)

(j) Inventories

Inventories consist mainly of medical supplies held for distribution in hospitals and health clinics, and are provided to patients at a subsidised rate. Inventories are measured at weighted average cost, adjusted for obsolescence. Unless material, inventories do not include supplies held ready for use in the wards through the hospital and health clinic facilities and are expensed on issue from storage facilities.

(k) Investments and other financial assets

Investments and other financial assets are initially measured at fair value. Transaction costs are included as part of the initial measurement, except for financial assets at fair value through profit or loss. They are subsequently measured at either amortised cost or fair value depending on their classification. Classification is determined based on the purpose of the acquisition and subsequent reclassification to other categories is restricted. The fair values of quoted investments are based on current bid prices. For unlisted investments, the North West Hospital and Health Service establishes fair value by using valuation techniques. These include the use of recent arm's length transactions, reference to other instruments that are substantially the same, discounted cash flow analysis, and option pricing models.

Financial assets are derecognised when the rights to receive cash flows from the financial assets have expired or have been transferred and North West Hospital and Health Service has transferred substantially all the risks and rewards of ownership.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are carried at amortised cost using the effective interest rate method. Gains and losses are recognised in profit or loss when the asset is derecognised or impaired.

Impairment of financial assets

North West Hospital and Health Service assesses at the end of each reporting period whether there is any objective evidence that a financial asset or group of financial assets is impaired. Objective evidence includes significant financial difficulty of the issuer or obligor; a breach of contract such as default or delinquency in payments; the lender granting to a borrower concessions due to economic or legal reasons that the lender would not otherwise do; it becomes probable that the borrower will enter bankruptcy or other financial reorganisation; the disappearance of an active market for the financial asset; or observable data indicating that there is a measurable decrease in estimated future cash flows.

The amount of the impairment allowance for loans and receivables carried at amortised cost is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the original effective interest rate. If there is a reversal of impairment, the reversal cannot exceed the amortised cost that would have been recognised had the impairment not been made and is reversed to profit or loss.

Note 2. Significant accounting policies (continued)

Subsequent measurement

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

In respect of the abovementioned asset classes, the cost of item acquired during the financial year have been judged by the management of North West Hospital and Health Service to materially represent their fair value at the end of the reporting period.

Land is measured at fair value each year using independent revaluations, desktop market revaluations or indexation by the State Valuation Service within the Department of Natural Resources and Mines.

North West Hospital and Health Service carries its buildings at fair value. Buildings are measured at fair value each year utilising either independent revaluations or by interim revaluation methodology of applying an indexation supplied by an external registered valuer. Buildings are valued based on the observable or unobservable input data available. Building can be broadly categorised as:

Residential buildings - Residential buildings are valued taking into consideration the size, location and condition of the property against comparable properties that have sold in the local property market.

Health service delivery buildings - North West Hospital and Health Service's buildings are predominantly of a specialised nature and as such there is no active market for such properties. Management consider the advice of external valuers in conjunction with internal knowledge of building condition when adopting fair values for these assets.

Assets under construction are measured at cost and are not revalued until at least one year after their commissioning date.

Independent valuations are performed with sufficient regularity to ensure buildings are carried at fair value.

The fair values reported by North West Hospital and Health Service are based on appropriate valuation techniques that maximise the use of available and relevant observable inputs and minimise the use of unobservable inputs - refer Note 2(m).

Note 2. Significant accounting policies (continued)

(I) Property, plant and equipment

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. Land improvements undertaken by North West Hospital and Health Service are included with buildings. Items below these values are expensed on acquisition.

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

Items with a lesser value are expensed in the year of acquisition.

Land improvements undertaken by North West Hospital and Health Service are included with buildings.

Control of property, plant and equipment held by Department of Health for North West District was transferred to North West Hospital and Health Service on 1 July 2012. The property, plant and equipment was transferred at the carrying value of the item recorded at 30 June 2012. Department of Health retains legal ownership of all land and building assets.

Initial measurement

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 have been judged by management to materially represent the fair value at the end of the reporting period.

Where assets are received for no consideration from another Queensland Government department (whether as a result of a machinery-of-Government change or other involuntary transfer), the acquisition cost is recognised as the gross carrying amount in the books of the transferor 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.

Subsequent costs

Subsequent expenditure is only capitalised when it is probable that future economic benefits associated with the expenditure will flow to North West Hospital and Health Service. Ongoing repairs and maintenance are expensed as incurred.

Note 2. Significant accounting policies (continued)

In the 2013-2014 financial year, only two of North West Hospital and Health Service's buildings were comprehensively revalued. An index provided by Davis Langdon was used to value the remaining buildings. The comprehensive revaluations and the indexation used in the revaluation process have been reviewed by North West Hospital and Health Service to ensure the result is a valid estimation of the asset's fair value at reporting date.

Fair value is generally considered to be market value. However, in accordance with Queensland Treasury's Non Current Asset Policies for the Queensland Public Sector, where no market-based evidence exists to derive fair value, the fair value will be calculated using depreciated replacement cost. Depreciated replacement cost is the cost of replacing the future service potential embedded in that asset, adjusted to reflect the condition of the asset being currently valued.

This method is applicable to the specialised properties used for health service provision. A summary of fair value methodology for North West Hospital and Health Service buildings is below:

- Staff accommodation (Off-site) – Market Value
- Staff accommodation (On-site) – Depreciated replacement Cost
- Health Service Delivery – Depreciated replacement Cost

In determining the depreciated replacement cost of each building, the valuers consider a number of factors such as age, functionality and physical condition. A 'Replacement Cost' is estimated by creating a cost plan (cost estimate) of the asset through the measurement of key quantities such as:

- Gross Floor Area
- Number of floors
- Girth of the building
- Height of the building
- Number of lifts and staircases

The model developed by the valuer creates an elemental cost plan using these quantities. The model includes multiple building types and is based on the valuer's experience of cost managing construction contracts.

The cost model is updated each year and tests are done to compare the model outputs on actual recent projects to ensure it produces a true representation of the cost of replacement. The costs are at Brisbane prices and published location indices are used to adjust the pricing to suit local market conditions. Live project costs from across the state are also assessed to inform current market changes that may influence the published factors.

The key assumption on the replacement cost is that the estimate is based on replacing the current function of the building with a building of the same form (size and shape). This assumption has a significant impact if an asset's function changes.

Note 2. Significant accounting policies (continued)

The 'Cost to Bring to Current Standards' is the estimated cost of refurbishing the asset to bring it to current standards and a new condition. For each of the five condition ratings the estimate is based on professional opinion as well as having regard to historical project costs.

In assessing the cost to bring to current standards, a condition rating is applied based upon the following information:

- Visual inspection of the asset
- Asset condition data provided by the Department of Health
- Information from the asset manager
- Previous reports and inspection photographs if available (to show the change in condition over time).

The following table outlines the condition assessment rating applied to each building which assists the valuer in determining the current depreciated replacement cost. Each category has sub-categories to ensure that assets do not experience significant change in value as the condition rating changes.

Category	Condition Criteria
1	Very good condition Only normal maintenance required
2	Minor defects only Minor maintenance required
3	Maintenance required to return the Significant maintenance required building to accepted level of service (up to 50% of capital replacement cost)
4	Requires renewal Complete renewal of the internal fit out and engineering services required (up to 70% of capital replacement cost)
5	Asset unserviceable, complete asset replacement required

These condition ratings are linked to the Cost to bring to current standards.

Estimates of remaining life are based on the assumption that the asset remains in its current function and will be maintained. Buildings have been revalued on the basis that there is no residual value.

Note 2. Significant accounting policies (continued)

Where assets have not been specifically appraised in the reporting period, their previous valuations are materially kept up-to-date via the application of relevant indices. North West Hospital and Health Service ensures that the application of such indices results in a valid estimation of the assets' fair values at reporting date.
The State Valuation Service (SVS) supplies the indices used for the various types of assets. Such indices are either publicly available, or are derived from market information available to SVS. SVS provides assurance of their robustness, validity and appropriateness for application to the relevant assets.

Early in the reporting period, North West Hospital and Health Service reviewed all fair value methodologies in light of the new principles in AASB 13. Some minor adjustments were made to methodologies to take into account the more exit-oriented approach to fair value under AASB 13, as well as the availability of more observable data for certain assets. Such adjustments in themselves did not result in a material impact on the values for the affected Property, Plant and Equipment classes.

Any revaluation increment arising on the revaluation of an asset are credited to the asset revaluation surplus of the appropriate class, except to the extent it reverses a revaluation decrement for the class previously recognised as an expense. A decrease in the carrying amount on revaluation is charged as an expense, to the extent that it exceeds the balance, if any, in the revaluation surplus relating to that asset class.

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

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

Plant and equipment is stated at historical cost less accumulated depreciation and impairment. Historical cost includes expenditure that is directly attributable to the acquisition of the items.

Depreciation

Depreciation is calculated on a straight-line basis to write off the net cost of each item of property, plant and equipment (excluding land) over their expected useful lives as follows:

Buildings	30-80 years
Leasehold improvements	3-10 years
Plant and equipment	3-7 years
Plant and equipment under lease	2-5 years

The residual values, useful lives and depreciation methods are reviewed, and adjusted if appropriate, at each reporting date.

Note 2. Significant accounting policies (continued)

Leasehold improvements and plant and equipment under lease are depreciated over the unexpired period of the lease or the estimated useful life of the assets, whichever is shorter.

An item of property, plant and equipment is derecognised upon disposal or when there is no future economic benefit to North West Hospital and Health Service. Gains and losses between the carrying amount and the disposal proceeds are taken to profit or loss. Any revaluation surplus reserve relating to the item disposed of is transferred directly to retained profits.

A gain or loss on disposal of an item of property, plant and equipment (calculated as the difference between the net proceeds from disposal and the carrying amount of the item) is recognised in the statement of comprehensive income.

(m) Fair value measurement

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

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

Unobservable inputs are data, assumptions and judgements that are not available publicly, but are relevant to the characteristics of the assets/liabilities being valued. Significant unobservable inputs include, but are not limited to, subjective adjustments made to observable data to take account of the characteristics of the department assets/liabilities, internal records of recent construction costs (and/or estimates of such costs) for assets' characteristics/functionality, and assessments of physical condition and remaining useful life. Unobservable inputs are used to the extent that sufficient relevant and reliable observable inputs are not available for similar assets/liabilities.

A fair value measurement of a non-financial asset takes into account a market participant's ability to generate economic benefits by using the asset in its highest and best use.

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

Note 2. Significant accounting policies (continued)

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

None of the North West Hospital and Health Service's valuations of assets or liabilities are eligible for categorisation into level 1 of the fair value hierarchy. As 2013-14 is the first year of application of AASB 13 by the North West Hospital and Health Service, there were no transfers of assets between fair value hierarchy levels during the period.

More specific fair value information about North West Hospital and Health Service's Property, Plant and Equipment in Note 18.

(n) Impairment of non-current physical assets

All non-current assets are assessed for indicators of impairment on an annual basis in accordance with AASB 136 Impairment of Assets. If an indicator of impairment exists, the North West Hospital and Health Service determines the asset's recoverable amount (higher of value in use and fair value less costs to sell and depreciated replacement cost). 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.

(o) Leases

A distinction is made in the financial statements between finance leases that effectively transfer from the lessor to the lessee substantially all risks and benefits incidental to ownership, and operating leases, under which the lessor retains substantially all risks and benefits.

Where a non-current physical asset is acquired by means of a finance lease, the asset is recognised at the lower of the fair value of the leased property and the present value of the minimum lease payments. The lease liability is recognised at the same amount. Lease payments are allocated between the principal component of the lease liability and the interest expense. For the reporting period, there were no finance leases.

Operating lease payments are representative of the pattern of benefits derived from the leased assets and are expensed in the periods in which they are incurred.

Incentives received on entering into operating leases are recognised as liabilities. Lease payments are allocated between rental expense and reduction of the liability. For the financial year, there were no lease incentives received.

Note 2. Significant accounting policies (continued)

(p) Trade and other payables

These amounts represent liabilities for goods and services provided to the North West Hospital and Health Service prior to the end of the financial year and which are unpaid. Due to their short-term nature they are measured at amortised cost and are not discounted. The amounts are unsecured and are usually paid within 30 days of recognition.

(q) Employee benefits

Pursuant to section 80 of the *Hospital and Health Boards Act 2011*, on establishment of the North West Hospital and Health Service, the health service employees of the Department of Health are taken to be employed by the Health and Hospital Service on the same terms, conditions and entitlements.

Under this arrangement the health service employees remain as Department of Health employees, while the North West Hospital and Health Service is responsible for the day to day management of these Department of Health employees. North West Hospital and Health Service reimburses Department of Health for the salaries and on-costs of these Department of Health employees.

As a result of this arrangement, North West Hospital and Health Service treats the reimbursement to the Department of Health for Department of Health employees in these financial statements as health service employees'. These reimbursements are shown under Note 8 Health service employee expenses.

In addition to the employees engaged through the Department of Health, North West Hospital and Health Service has employees engaged directly. Payments to employees engaged directly by North West Hospital and Health Service are shown under Note 7 Employee expenses. The information detailed below relates specifically to the directly engaged employees.

Salaries and wages due but unpaid at reporting date are recognised in the statement of financial position at the remuneration rates expected to apply at the time of settlement.

Payroll tax and workers' compensation 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.

Note 2. Significant accounting policies (continued)

Annual leave, long service leave and sick leave
Under the Queensland Government's Annual Leave Central Scheme (established on 30 June 2008) and Long Service Leave Central Scheme (established on 1 July 1999), levies are payable by North West Hospital and Health Service to cover the cost of employees' annual leave (including leave loading and on-costs) and long service leave. No provisions for long service leave or annual leave are recognised in North West Hospital and Health Service financial statements as the provisions for these schemes are reported on a Whole-of-Government basis pursuant to AASB 1049 Whole of Government and General Government Sector Financial Reporting. These levies are expensed in the period in which they are paid or payable. Amounts paid to employees for annual leave and long service leave are claimed from the schemes quarterly in arrears. Non-vesting employee benefits such as sick leave are recognised as an expense when taken.

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 North West Hospital and Health Service's obligation is limited to its contribution to QSuper.
The QSuper scheme has defined benefit and defined contribution categories. The liability for defined benefits is held on a Whole-of-Government basis and reported in those financial statements pursuant to AASB 1049 Whole of Government and General Government Sector Financial Reporting.

Redundancy Payments
Liabilities for redundancy payments are recognised, and are measured at the values that represent the existing obligations, including on-costs, at the reporting date.

Key executive 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.

These disclosures are shown under Note 26 Key executive management personnel and remuneration.

(r) Insurance
Property and general losses above a $10,000 threshold are insured through the Queensland Government Insurance Fund (QGIF). Health litigation payments above a $20,000 threshold and associated legal fees are also insured through QGIF. Premiums are calculated by QGIF on a risk assessed basis.

The Department of Health pays premiums to Work Cover Queensland on behalf of North West Hospital and Health Service in respect of its employee compensation. These costs are reimbursed on a monthly basis to the Department of Health and form part of the Health Service employee expenses at Note 8 Health service employee expenses.

Note 2. Significant accounting policies (continued)

(s) Services received free of charge or for 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.

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

(t) Contributed equity

Non-reciprocal transfers of assets and liabilities between wholly-owned Queensland State Public Sector entities as a result of machinery-of-Government changes are adjusted to contributed equity in accordance with Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities*. Appropriations for equity adjustments are similarly designated.

(u) Goods and Services Tax ('GST') and other similar taxes

North West Hospital and Health Service is a State body as defined under the *Income Tax Assessment Act 1936* and is exempt from Commonwealth taxation with the exception of Fringe Benefits Tax (FBT) and GST. FBT and GST are the only Commonwealth taxes recognised by North West Hospital and Health Service.

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

Revenues, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the tax authority. In this case it is recognised as part of the cost of the acquisition of the asset or as part of the expense.

Receivables and payables are stated inclusive of the amount of GST receivable or payable.

All FBT and GST reporting to the Australian Taxation Office is managed centrally by the Department of Health, with payments and receipts made on behalf of North West Hospital and Health Service reimbursed from or paid to the Department of Health on a monthly basis. GST credits receivable from, and GST payable to the Australian Taxation Office, are recognised on this basis.

Note 2. Significant accounting policies (continued)

(v) Issuance of financial statements

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

(w) Critical accounting judgements, estimates and assumptions

The preparation of the financial statements requires management to make judgements, estimates and assumptions that affect the reported amounts in the financial statements. Management continually evaluates its judgements and estimates in relation to assets, liabilities, contingent liabilities, revenue and expenses. Management bases its judgements, estimates and assumptions on historical experience and on other various factors, including expectations of future events; management believes to be reasonable under the circumstances. The resulting accounting judgements and estimates will seldom equal the related actual results. The judgements, estimates and assumptions that have a potential significant effect to the carrying amounts of assets and liabilities are outlined in the following financial statement notes:

Provision for impairment of trade and other receivables, refer Note 15 Current assets - trade and other receivables.

Valuation of land and buildings, refer Note 2(k) and Note 18 Non-current assets - property, plant and equipment.

(x) Rounding and comparatives

Amounts in this report have been rounded off to the nearest thousand dollars, or in certain cases, the nearest dollar.

Comparative information has been restated where necessary to be consistent with disclosures in the current reporting period. In particular Notes 3 and 4 have been amended to reflect a change in accounting policy with respect to the recognition of funding provided by the Department of Health. For further detail of these changes refer Note 2(z) Voluntary change in accounting policy.

(y) New Accounting Standards and Interpretations not yet mandatory or early adopted

North West Hospital and Health Service did not voluntarily change any of its accounting policies during 2013-14. The only Australian Accounting Standard changes applicable for the first time as from 2013-14 that have had a significant impact on North West Hospital and Health Service's financial statements are those arising from *AASB 13 Fair Value Measurement*, as explained below.

Note 2. Significant accounting policies (continued)

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

North West Hospital and Health Service reviewed its fair value methodologies (including instructions to valuers, data used and assumptions made) for all items of property, plant and equipment measured at fair value to assess whether those methodologies comply with AASB 13. To the extent that the previous methodologies were not in compliance with AASB 13, valuation methodologies were revised accordingly to be in line with AASB 13. The revised valuation methodologies have not resulted in material differences from the previous methodologies.

AASB 13 has required an increased amount of information to be disclosed in relation to fair value measurements for both assets and liabilities. For those fair value measurements of assets or liabilities that substantially are based on data that is not 'observable' (i.e. accessible outside North West Hospital and Health Service), the amount of information disclosed has significantly increased. Note 2(m) explains some of the principles underpinning the additional fair value information disclosed. Most of this additional information is set out in Notes 2(l) and 18.

A revised version of AASB 119 *Employee Benefits* became effective for reporting periods beginning on or after 1 January 2013. As North West Hospital and Health Service does not directly recognise any employee benefit liabilities (refer to Note 2(q)), the only implications for North West Hospital and Health Service were the revised concept of 'termination benefits' and the revised recognition criteria for termination benefit liabilities. If termination benefits meet the AASB 119 timeframe criterion for short-term employee benefits', they will be measured according to the AASB 119 requirements for short- term employee benefits'. Otherwise, termination benefits need to be measured according to the AASB 119 requirements for 'other long-term employee benefits'. Under the revised standard, the recognition and measurement of 'other long-term employee benefits' are accounted for according to most of the requirements for defined benefit plans.

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

Note 2. Significant accounting policies (continued)

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

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

Australian Accounting Standards and Interpretations that have recently been issued or amended but are not yet mandatory, have not been early adopted by the North West Hospital and Health Service for the annual reporting period ended 30 June 2014. The North West Hospital and Health Service's assessment of the impact of these new or amended Accounting Standards and Interpretations, most relevant to the service, are set out below.

Note 2. Significant accounting policies (continued)

AASB 9 Financial Instruments, 2009-11 Amendments to Australian Accounting Standards arising from AASB 9, 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 and 2012-6 Amendments to Australian Accounting Standards arising from AASB 9
This standard and its consequential amendments completes phase I of the IASB's project to replace IAS 39 (being the international equivalent to AASB 139 'Financial Instruments: Recognition and Measurement'). This standard introduces new classification and measurement models for financial assets, using a single approach to determine whether a financial asset is measured at amortised cost or fair value. The accounting for financial liabilities continues to be classified and measured in accordance with AASB 139, with one exception, being that the portion of a change of fair value relating to the entity's own credit risk is to be presented in other comprehensive income unless it would create an accounting mismatch.

The standard is not applicable until 1 January 2015 and North West Hospital and Health Service is yet to assess its full impact. North West Hospital and Health Service does not expect to adopt the new standard before its operative date. It would therefore be first applied in the financial statements for the annual reporting period ending 30 June 2016.

AASB 10 Consolidated Financial Statements (effective 1 January 2014)
AASB 10 replaces all of the guidance on control and consolidation in AASB 127 Consolidated and Separate Financial Statements, and Interpretation 12 Consolidation – Special Purpose Entities. The core principle that a consolidated entity presents a parent and its subsidiaries as if they are a single economic entity remains unchanged, as do the mechanics of consolidation. However, the standard introduces a single definition of control that applies to all entities. It focuses on the need to have both power and rights or exposure to variable returns. Power is the current ability to direct the activities that significantly influence returns. Returns must vary and can be positive, negative or both. Control exists when the investor can use its power to affect the amount of its returns. There is also new guidance on participating and protective rights and on agent/principal relationships. North West Hospital and Health Service does not expect this new standard to have a significant impact as it does not prepare consolidated financial statements.

In December 2012, the AASB issued AASB 2012—10 Amendments to Australian Accounting Standards – Transition Guidance and Other Amendments [AASB 1 5, 8, 10, 11, 12, 13, 101, 102, 108, 112, 118, 119, 127, 128, 132, 133, 134, 137, 1023, 1038, 1039, 1049 & 2011-7 and Interpretation 12] These amendments relate largely to the AASB's decision to defer the mandatory application of AASB 10 Consolidated Financial Statements and to not-for-profit entities until annual reporting periods beginning on or after 1 January 2014.

North West Hospital and Health Service does not expect to adopt the new standard before their operative date. It would therefore be first applied in the financial statements for the annual reporting period ending 30 June 2015.

Note 2. Significant accounting policies (continued)

AASB 1055 Budgetary Reporting and 2013-1 Amendments to AASB 1049 – Relocation of Budgetary Reporting Requirements (effective 1July 2014)
This Standard specifies budgetary disclosure requirements for the whole of government, General Government Sector (GGS) and not-for-profit entities within the GGS of each government. Disclosures made in accordance with this Standard will provide users with information relevant to assessing performance of an entity, including accountability for resources entrusted to it. North West Hospital and Health Service will be required to include the original budgeted financial statements as presented to parliament in the same format as the statutory financial statements together with explanations of major variances between the actual amounts presented in the financial statements and the corresponding original budget amounts.

North West Hospital and Health Service does not intend to adopt the revised standard before its operative date, which means that it would be first applied in the annual reporting period ending 30 June 2015.

(z) Voluntary change in accounting policy

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

In 2012-13 the Department of Health provided this funding as grant payments but for 2013-14 has determined that the payment is not of a grants nature but rather is procurement of public health services. Specific public health services are received by the department under a service agreement and the department has determined that it receives approximately equal value for the payment provided, and directly receives an intended benefit.

To align with this basis of funding provided by the Department of Health under a service agreement, North West Hospital and Health Service now recognises the 2013-14 funding of $138.219 million as User Charges and Fees revenue for 2013-14 rather than as grants revenue which occurred in 2012-13. The main affect is that the revenue is now recognised under the criteria detailed in AASB 118 Revenue for 2013-14, rather than under AASB 1004 Contributions in 2012-13. The revenue recognition criteria is described in Note 2(e) Revenue recognition.

This change in accounting policy has been applied retrospectively with the affect that Grants and Other Contributions revenue for 2012-13 has reduced by $129.910 million and User Charges and Fees revenue has increased by the same amount.

Note 3. User charges and fees

	2014 $'000	2013 $'000
Department of Health funding		
Activity based funding	64,099	57,855
Block funding	18,778	30,140
Department of Health funding	47,108	36,280
Depreciation funding	7,328	5,635
Total Department of Health funding	137,313	129,910
Other user charges		
Sale of goods and services	1,546	3,039
Hospital fees	2,167	1,757
Rent	6	27
Remote Indigenous S100 arrangements (Australian Government)	749	686
Total Other user charges	4,468	5,509
	141,780	135,419

Note 4. Grants and other contributions

	2014 $'000	2013 $'000
Australian Government grants and contributions		
Home and community care grants	1,075	963
Rural and Remote Medical Benefits Scheme	722	707
Indigenous health programs	439	-
Multi-purpose centre funding	835	423
Community aged care packages	36	86
Total Australian Government grants and contributions	3,106	2,179
State Government grants and contributions		
Home and community care grants	152	239
Other	120	-
Total State Government grants and contributions	272	239
Other grants and contributions		
Other	404	245
Donations	28	7
Total other grants and contributions	432	252
Total grants and other contributions	3,810	2,670

Note 5. Other revenue

	2014 $'000	2013 $'000
Interest	15	16
Other	828	386
	843	402

Note 6. Other income

	2014 $'000	2013 $'000
Gain on sale of property, plant and equipment	-	12

Note 7. Employee expenses

	2014 $'000	2013 $'000
Employee benefits		
Wages and salaries	748	402
Employer superannuation contributions	66	35
Annual leave levy	65	17
Long service leave levy	10	5
Redundancies	-	-
	889	459
Employee related expenses		
Payroll tax	14	17
Other employee related expenses	6	1
	909	477

During the reporting period only the Board, Chief Executive and Chief Finance Officer were employed directly by North West Hospital and Health Service. Further details in relation to employment benefits are reported in Note 26 Key management personnel disclosures.

Note 8. Health service employee expenses

	2014 $'000	2013 $'000
Health service employee expenses	69,593	67,330

At 30 June 2014 the number of health service and health executive employees including full-time and part-time employees measured on a full time equivalent basis (reflecting Minimum Obligatory Human Resource Information (MOHRI)):

	30 June 2014	30 June 2013
Number of employees	637	603

Note 9. Supplies and services

	2014 $'000	2013 $'000
Consultancies and other contract labour	17,780	16,299
Electricity and other energy	2,142	1,820
Patient travel	14,067	13,057
Other travel	2,166	1,770
Water	1,413	1,271
Building services	303	277
Computer services	547	882
Motor vehicles	149	173
Communications	1,933	756
Repairs and maintenance	6,491	5,275
Minor plant and equipment	439	1,349
Operating lease rentals	3,787	4,085
Drugs	2,577	2,580
Outsourced service delivery	2,330	2,311
Clinical supplies and services	3,259	2,860
Catering and domestic supplies	1,389	1,470
Pathology and blood supplies and services	3,630	3,526
Other	1,100	585
	65,503	60,346

Note 10. Grants and subsidies

	2014 $'000	2013 $'000
Public hospital support services	380	560
Home, community and rural health services	-	184
Other	-	1
	380	745

Note 11. Depreciation and amortisation

	2014 $'000	2013 $'000
Buildings	6,280	4,675
Plant and equipment	1,048	954
Software developed	-	9
	7,328	5,638

Note 12. Impairment losses

	2014 $'000	2013 $'000
Impairment losses on receivables	34	2
Bad debts written off	166	68
	200	70

Note 13. Other expenses

	2014 $'000	2013 $'000
External audit fees	222	149
Other audit fees	71	-
Bank fees	4	4
Insurance	1,400	1,473
Inventory written off	132	455
Net losses from disposal of property, plant and equipment	23	230
Other legal costs	293	360
Journals and subscriptions	17	16
Advertising	62	56
Interpreter fees	1	2
Other	46	13
	2,271	2,758

Note 14. Current assets - cash and cash equivalents

	2014 $'000	2013 $'000
Cash at bank and on hand	9,448	6,033
Queensland Treasury Corporation cash fund	361	349
	9,809	6,382

Restricted cash

North West Hospital and Health Service also receives cash contributions from external entities and other benefactors in the form of gifts, donations and bequests for specific purposes. These funds are retained in separate bank accounts and set aside for specific purposes underlying the contribution. Restricted cash within the cash and cash equivalents balance as at 30 June 2014 amounted to $479,585 (2013: $350,516).

Interest rates

Queensland Treasury Corporation cash fund earns interest at an average rate of 3.43% (2013: 4.10%). All interest and excess restricted cash is reinvested within the Queensland Treasury Corporation cash fund.

Note 15. Current assets - trade and other receivables

	2014 $'000	2013 $'000
Trade receivables	4,101	3,268
Less: Provision for impairment of receivables	(205)	(171)
	3,896	3,097
GST input tax credits receivable	345	414
GST payable	(38)	-
	306	414
	4,202	3,511

Refer to Note 25 Financial instruments (Credit Risk Exposure) for an analysis of movements in the allowance for impairment loss.

Note 16. Current assets - inventories

	2014 $'000	2013 $'000
Medical supplies and equipment	490	448
Catering and domestic	1	
Other	12	
	504	448

Note 17. Current assets - other

	2014 $'000	2013 $'000
Other prepayment	28	80

Note 18. Non-current assets - property, plant and equipment

	2014 $'000	2013 $'000
Land - at independent valuation	6,452	6,355
	6,452	6,355
Buildings - at independent valuation	216,088	200,276
Less: Accumulated depreciation	(116,630)	(109,206)
	99,458	91,070
Plant and equipment - at cost	10,803	10,985
Less: Accumulated depreciation	(5,531)	(5,262)
	5,272	5,723
Capital works in progress	135	-
	135	-
	111,317	103,148

Note 18. Non-current assets - property, plant and equipment (continued)

Reconciliations

Reconciliations of the written down values at the beginning and end of the current financial year are set out below:
below:

0

	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Balance at 1 July 2012	-	-	-	-	-
Additions	-	-	1,661	-	1,661
Transfer in (Note 30)	4,914	76,328	4,661	-	85,903
Disposals	-	(198)	(42)	-	(240)
Revaluation increments	1,441	11,180	-	-	12,621
Transfer of assets from Department of Health	-	8,435	397	-	8,832
Depreciation expense	-	(4,675)	(954)	-	(5,629)
Balance at 30 June 2013	6,355	91,070	5,723	-	103,148
Carrying amount at 1 July 2013	6,355	91,070	5,723	-	103,148
Additions	-	121	595	135	851
Disposals	-	-	(23)	-	(23)
Revaluation increments	97	-	-	-	97
Revaluation decrements	-	(2,108)	-	-	(2,108)
Transfer of assets from Department of Health	-	16,655	25	-	16,680
Depreciation expense	-	(6,279)	(1,048)	-	(7,328)
Balance at 30 June 2014	6,452	99,458	5,272	135	111,317

Note 18. Non-current assets - property, plant and equipment (continued)

Valuations of land and buildings
Land was measured at fair value using appropriate indices sourced from the State Valuation Service. These indices are based on actual market movements for the relevant location and asset category. The revaluation program resulted in an increase of $0.097 million to the carrying amount of land.

In 2012-13 an independent valuation of buildings was completed, representing 89 per cent of the gross value of the building portfolio. Following the introduction of AASB 13 Davis Langdon (independent valuers) was engaged to assess the effects of AASB 13 on the 2012-13 valuations, and where necessary review and reissue valuations to ensure compliance. This did not result in a material change in existing valuations.

In 2013-14 only two buildings and one site land improvement asset, representing 19 per cent of the gross value of the building portfolio, were the subject of independent revaluation.

For buildings not subject to independent valuations during 2013-14 Davis Langdon was engaged to provide indexation rates for the North West region. The report highlighted due to a flat construction market there has been negligible cost escalation across Queensland in 2013-14. As such, Davis Langdon recommended application of nil change to current asset values.

In determining the indexation rate Davis Langdon reviewed three data sources (Davis Langdon Cost Model, Davis Langdon Tender Price Index and the Department of Public Work's Building Price Index) which confirmed that cost escalation across the state ranged from nil to 1.0 per cent during the 2013-14 financial year. Davis Langdon assessed that over the same period there had been a negligible change in the Health Design Factor, as such no increase was included for this factor.

The building valuations for 2013-14 resulted in a net decrement to the portfolio of $2.108 million.

North West Hospital and Health Service has plant and equipment with an original cost of $0.401 million (or 3.71% of total plant and equipment gross value) and a written down value of zero still being used in the provision of services.

Note 18. Non-current assets - property, plant and equipment (continued)

(a) Fair value hierarchy

The following table details the fair value hierarchy for Land and Buildings at 30 June 2014:

	Level 2 $'000	Level 3 $'000	Total $'000
Land	6,452		6,452
Buildings	4,712	94,746	99,458

In respect of the abovementioned asset classes, the cost of items acquired during the financial year have been judged by the management of North West Hospital and Health Service to materially represent their fair value at the end of the reporting period. In particular the Cloncurry Hospital Aged Care Annexe was acquired in the current financial year and the net book value recorded at 30 June 2014 is $6,434,658.

(b) Valuation methodology for level 2 and 3 fair values

Land (level 2)

Land was revalued by the State Valuation Service as at 30June 2014. The fair value of land was based on publicly available data on recent sales of similar land in nearby localities. In determining the values, adjustments were made to the sales data to take into account the location of the land, its size, street/road frontage and access, and any significant restrictions.

Buildings – Non-health service delivery (level 2)

Non-health service delivery buildings were revalued by Davis Langdon as at 30 June 2014. The methodology reflects the likely exit price in the principal market for an asset of this type.

Buildings – Health service delivery (level 3)

Health service delivery buildings were revalued by Davis Langdon as at 30 June 2014. Due to their specialised nature, health service delivery buildings were valued based on a depreciated replacement cost methodology to simulate a'market or income approach'. The methodology reflects the likely exit price in the principal market for an asset of this type.

(c) Change in valuation technique

The introduction of AASB 13 *Fair Value Measurement* requires that land and buildings are valued at an 'exit' price in the principal market rather than an 'entry' price.

(d) Fair value measurements using significant unobservable inputs (level 3)

The following table details a reconciliation of level 3 movements:

	Buildings $'000	Total $'000
Carrying amount a 1 July 2013	86,099	86,099
Transfers between levels		
Transfers in	-	-
Transfers out	-	-
Total gains or losses recognised in operating result		
Revaluation increment	-	-
Total gains or losses recognised in other comprehensive income		
Increase / (decrease) in asset revaluation reserve	(2,108)	(2,108)
Additions	10,755	10,755
Fair value at 30 June 2014	94,746	94,746

Note 18. Non-current assets - property, plant and equipment (continued)

(e) Level 3 significant valuation inputs and sensitivity

The following table summarises the quantitative information about the significant unobservable inputs used in recurring level 3 fair value measurements and a sensitivity analysis:

Description	Significant unobservable inputs	Unobservable inputs quantitative measures ranges used in valuations	Unobservable inputs - general effect on fair value measurement
Buildings – health service sites (fair value $84m)	Replacement cost estimates	Health assets $70,000 to $58,000,000 Other buildings $16,000 to $7,300,000	Replacement cost is based on tender pricing and historical building cost data. An increase in the estimated replacement cost would increase the fair value of the assets. A decrease in the estimated replacement cost would reduce the fair value of the assets.
	Remaining lives estimates	Nil years to 35 years	The remaining useful lives are based on industry benchmarks. An increase in the estimated remaining useful lives would increase the fair value of the assets. A decrease in the estimated remaining useful lives would reduce the fair value of the assets.
	Costs to bring to current standards	Health assets $ Nil to $6,480,000 Other buildings $ Nil to $2,300,000	Costs to bring to current standards are based on tender pricing and historical building cost data. An increase in the estimated costs to bring to current standards would reduce the fair value of the assets. A decrease in the estimated costs to bring to current standards would increase the fair value of the assets.
	Condition rating	1 to 5	The condition rating is based on the physical state of the assets. An improvement in the condition rating (possible high of 1) would increase the fair value of the assets. A decline in the condition rating (possible low of 5) would reduce the fair value of the assets.

For further information on condition ratings refer to Note 2 (l) Property,plant and equipment. Usage of alternative quantitative values (higher or lower) for each unobservable input that are reasonable in the circumstances as at the revaluation date would not result in material changes in the reported fair value.
The condition rating of an asset is used as a mechanism to determine the cost to bring to current standards and also to estimate the remaining life.There are no other direct or significant relationships between the unobservable inputs which materially impact fair value.

(f) Highest and Best Use

Buildings

After considering what is physically possible, legally permissible and financially feasible, the independent valuer considers that the highest and best use of all fair valued assets is their current use.

Note 19. Non-current assets - intangibles

	2014 $'000	2013 $'000
Software internally generated - at cost	-	170
Less: Accumulated amortisation	-	(170)
Disposals		
Software internally generated - at cost	(170)	
Less: Accumulated amortisation	170	
	-	-
	-	-

Reconciliations

Reconciliations of the written down values at the beginning and end of the current financial year are set out below:

	Software purchased $'000	Software internally $'000	Software WIP $'000	Total $'000
Balance at 1 July 2012	-	-	-	-
Transfer in (Note 30)	8	-	-	8
Amortisation expense	(8)	-	-	(8)
Balance at 30 June 2013	-	-	-	-
Amortisation expense	-	-	-	-
Balance at 30 June 2014	-	-	-	-

Note 20. Current liabilities - trade and other payables

	2014 $'000	2013 $'000
Trade payables	9,656	4,305
Accrued health service employees expense	1,842	3,794
Other payables	1	2
	11,499	8,101

Refer to Note 25 for further information on financial instruments.

Note 21. Current liabilities - accrued employee benefits

	2014 $'000	2013 $'000
Employee benefits accrued	50	45

Note 22. Equity - contributed

	2014 $'000	2013 $'000
Non-appropriated equity injections		
Minor capital acquisitions	869	789
Capital acquisition plan projects	428	1,406
	1,297	2,195
Non-appropriated equity withdrawals		
Depreciation funding	(7,327)	(5,635)
	(7,327)	(5,635)
Non-appropriated equity transfers		
Major capital works projects	16,680	8,435
Transfer of dental vans	-	397
	16,680	8,832
	10,650	5,392

Note 23. Equity - reserves

	2014 $'000	2013 $'000
Asset revaluation surplus reserve - land	1,538	1,441
Asset revaluation surplus reserve - buildings	9,072	11,180
	10,610	12,621

	Land revaluation $'000	Building revaluation $'000	Total $'000
Balance at 1 July 2012	-	-	-
Revaluation - gross	1,441	11,180	12,621
Balance at 1 July 2013	1,441	11,180	12,621
Revaluation - gross	97	(2,108)	(2,011)
Balance at 30 June 2014	1,538	9,072	10,610

Revaluation surplus reserve
The reserve is used to recognise increments and decrements in the fair value of land and buildings, excluding

Note 24. Equity - retained surpluses

	2014 $'000	2013 $'000
Retained surpluses at the beginning of the financial year	1,139	-
Surplus for the year	249	1,139
Retained surpluses at the end of the financial year	1,388	1,139

Note 25. Financial instruments

Categorisation of financial instruments

North West Hospital and Health Service has the following categories of financial assets and financial liabilities:

	2014 $'000	2013 $'000
Financial assets		
Cash and cash equivalents	9,809	6,382
Trade and other receivables	4,202	3,511
	14,011	9,893
Financial liabilities		
Trade and other payables	(11,499)	(8,101)
	(11,499)	(8,101)

Financial risk management

North West Hospital and Health Service is exposed to a variety of financial risks – credit risk, liquidity risk and market risk.

Financial risk is managed in accordance with Queensland Government and North West Hospital and Health Service policies. North West Hospital and Health Service's policies provide written principles for overall risk management and aim to minimise potential adverse effects of risk events on the financial performance of the organisation.

North West Hospital and Health Service measures risk exposure using a variety of methods, including:

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

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 currency risk, interest rate risk and other price risk.

North West Hospital and Health Service does not trade in foreign currency and is not exposed to commodity price changes.

North West Hospital and Health Service does not undertake any hedging in relation to interest rate risk. Changes in interest rates have a minimal effect on the operating result of North West Hospital and Health Centre.

Note 25. Financial instruments (continued)

Credit risk

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.

Maximum exposure to credit risk

	2014 $'000	2013 $'000
Cash and cash equivalents	9,809	6,382
Trade and other receivables	4,202	3,511
	14,011	9,893

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

North West Hospital and Health Service manages credit risk through the use of a credit management strategy included in the Financial Management Practice Manual. This strategy aims to reduce the exposure to credit default by ensuring that the department invests in secure assets and monitors all funds owed on a timely basis. Exposure to credit risk is monitored on an on-going basis.

The allowance for impairment reflects the occurrence of loss events. The most readily identifiable loss event is where a debtor is overdue in paying a debt to North West Hospital and Health Service, according to the due date (normally terms of 30 days). Economic changes impacting the debtors, and relevant industry data, also form part of the department's documented risk analysis.

If no loss events have arisen in respect of a particular debtor or group of debtors, no allowance for impairment is made in respect of that debt/group of debtors. If the Service determines that an amount owing by such a debtor does become uncollectible (after appropriate range of debt recovery actions), that amount is recognised as a bad debt expense and written-off directly against receivables. In other cases where a debt becomes uncollectible but the uncollectible amount exceeds the amount already allowed for impairment of that debt, the excess is recognised directly as a bad debt expense and written off directly against receivables.

At the end of each reporting period, North West Hospital and Health Service assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. Objective evidence includes financial difficulties of the debtor, changes in debtor credit ratings and current outstanding accounts over 60 days.

Impairment loss expense for the current year regarding the department's receivables is $166,466 (2013: $67,617).

Note 25. Financial instruments (continued)

The ageing of the impaired receivables provided for above are as follows:

	2014 $'000	2013 $'000
0 to 60 days overdue	-	(17)
61 to 90 days overdue	(116)	(71)
Over 91 days overdue	(89)	(83)
	(205)	(171)

Movements in the provision for impairment of receivables are as follows:

	2014 $'000	2013 $'000
Opening balance	(171)	-
Additional provisions recognised	(200)	(70)
Additions through National Health reform transfer (Note 30)	-	(169)
Receivables written off during the year as uncollectable	166	68
Closing balance	(205)	(171)

Past due but not impaired
Customers with balances past due but without provision for impairment of receivables amount to $nil as at 30 June 2014 (2013: $nil).

Note 25. Financial instruments (continued)

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

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.

Liquidity risk

Liquidity risk is the risk that North West Hospital and Health Service will not have the resources required at a particular time to meet its obligations to settle its financial liabilities.

North West Hospital and Health Service is exposed to liquidity risk through its trading in the normal course of business. North West Hospital and Health Service aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations at all times. Total payables as per the statement of financial position represent the maximum exposure to liquidity risk. These amounts have a contractual maturity within one year from reporting date, and are calculated based on undiscounted cash flows.

North West Hospital and Health Service has an approved debt facility of $1.5 million (2013: $1.5 million) under Whole-of-Government banking arrangements to manage any short term cash shortfalls.

Note 26. Key management personnel disclosures

(a) Key management personnel

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of North West Hospital and Health Service, directly or indirectly, including any director of North West Hospital and Health Service.

The following persons were considered key management personnel of North West Hospital and Health Service during the current financial year.

(i) Board

Name	***Position***
Paul Woodhouse	Chair – Non-executive Director (from 1 July 2012)
Annie Clarke	Deputy Chair – Non-executive Director (from 9 November 2012)
Don Bowley	Non-executive Director (from 1 July 2012)
Stephanie De La Rue	Non-executive Director (from 1 July 2012)
Rowena McNally	Non-executive Director (from 1 July 2012)
Richard Stevens OAM	Non-executive Director (from 1 July 2012)
Christopher Appleby	Non-executive Director (from 9 November 2012)
Karen Arbouin	Non-executive Director (from 17 May 2013)
Ronald Page	Non-executive Director (from 17 May 2013)

Note 26. Key management personnel disclosures (continued)

(ii) Other key management personnel

Following a review of organisational efficiency the Executive Management Group of North West Hospital and Health Service underwent a restructure. As a result of this restructure effective 10 December 2013 the positions of Executive Director Allied Health, Executive Director Primary Health and Community and Executive Director Mental Health and ATODS were redesignated to the level of Director. The Director Allied Health and the Director Mental Health and ATODS now report to the Executive Director Medical Services. The Director of Primary Health and Community reports to the Executive Director Nursing. A new position of Executive Director People and Performance was established.

Name	***Position***	***Contract classification /***
Susan Belsham	Chief Executive (from 30 July 2012)	S24/S70 *Hospital and Health Boards Act 2011*
Brett Oates	Chief Finance Officer (from 11 February 2013)	HES-2 *Hospital and Health Boards Act 2011*
Barbara Davis	Executive Director Corporate Services (from 1 July 2012)	AO8 *District Health Services Employees Award 2012 - Admin*
Dr Greg Coffey	Executive Director Medical Services (from 1 July 2012 to 5 August 2013)	MMOI-1 *District Health Services Senior Medical Officers*
Dr Ross Duncan	Executive Director Medical Services (from 26 August 2013 to 4 May 2014)	MMOI-1 *District Health Services Senior Medical Officers*
Associate Professor Alan Sandford	Executive Director Medical Services (from 5 May 2014)	MMOI-3 *District Health Services Senior Medical Officers*
Michelle Garner	Executive Director Nursing (from 1 July 2012)	NRG11 *Queensland Health Nurses and Midwives Award 2012*
Leigh Purvis	Executive Director People and Performance (from 7 April 2014)	DOS1-1 *Hospital and Health Boards Act 2011*
Fiona McKenzie Lewis *	Executive Director Allied Health (from 28 January 2013 to 11 December 2013)	HP6 *District Health Services Employees Award 2012 - HP*
Marek Klein *	Executive Director Primary and Community Health (from 1 July 2012 to 11 December 2013)	AO8 *District Health Services Employees Award 2012 - Admin*
Sandra Kennedy *	Executive Director Mental Health and ATODS (from 1 July 2012 to 11 December 2013)	HP6 *District Health Services Employees Award 2012 - HP*

* These three Executive Director positions were redesignated to the Director level following a restructure of North West Hospital and Health Service's Executive Management Group.

Note 26. Key management personnel disclosures (continued)

(b) Position descriptions

Position	***Responsibilities***
Chief Executive	Responsible for the overall management of North West Hospital and Health Service through functional areas to ensure the delivery of hospital and health service objectives.
Chief Finance Officer	Responsible for the overall financial management of North West Hospital and Health Service, including budgeting, activity based funding measurement and departmental relationship management.
Executive Director Corporate Services	Responsible for the delivery of non-clinical support services, including building, engineering and maintenance services, capital infrastructure and contract management.
Executive Director Medical Services	Responsible for the overall management and coordination of medical services for the Mount Isa hospital.
Executive Director Nursing Services	Responsible for the professional leadership of nursing services for the Mount Isa Hospital as well as the operational management of the nine outlier facilities and acute areas of the Mount Isa Hospital.
Executive Director People and Performance	Responsible for providing strategic leadership and operational control of human resource and quality functions and to provide management and high level authoritative advice and support on all matters relating to the performance of the HHS.
Executive Director Allied Health	Responsible for the overall coordination of allied health services, including dental, dietetics, occupational therapy, pharmacy, physiotherapy, podiatry, social work and speech therapy.
Executive Director Primary and Community Health	Responsible for the overall coordination of primary health services, including chronic diseases, sexual and child health, aged care, home and community care and health worker services.
Executive Director Mental Health and ATODS	Responsible for the overall coordination of alcohol, tobacco and other drug services and mental health, including psychiatry, homelessness and child and youth mental health.

Note 26. Key management personnel disclosures (continued)

(c) Compensation terms

(i) Board

In accordance with the *Hospital and Health Boards Act 2011*, the Governor in Council appoints Board members, on the recommendation of the Minister, for a period not exceeding 4 years. In appointing a Board member the Governor in Council must have regard to the person's ability to make a contribution to North West to perform its functions effectively and efficiently.

Pursuant to the *Hospital and Health Boards Act 2011*, Board members' fees are determined by the Governor in Council. Board members are paid an annual salary consistent with the government procedure titled "Remuneration procedures for Part-time Chairs and Members of Government Boards" (previously "Remuneration of Part-time Chairs and Board Members of Government Boards, Committees and Statutory Authorities")

Under the revised procedure, Hospital and Health Services were assessed as 'Governance' entities and grouped into different levels of a remuneration matrix based on a range of indicators including: revenue/budget, net and total assets, independence, risk and complexity. The Governor in Council approves the remuneration arrangements for Hospital and Health Board chairs, deputy chairs and members.

Annual salaries are based on the standard categories and are calculated using the daily amounts prescribed for special assignment for the appropriate category.They are based on a five-day per fortnight work commitment for Chairs and three-day per fortnight work commitment for Deputy Chairs and other members, (this projected work commitment includes time spent on Board committee work) 22 fortnights are used in the formula for calculating annual salaries.

North West Hospital and Health Service Board members are paid as follows:

Pre 18th May 2014		Post 18th May 2014	
Special assignment fee ($) full day	***Annualised Chair 5-day fortnight Member 3-day fortnight***	***Special assignment fee ($) fullday***	***Annualised Chair 5-day fortnight Member 3-day fortnight***
Chair: 553	Chair: $60,830 Per month: $5,069	Chair: 620	Chair: $68,243 Per month: $5,687
Member: 453	Member: $29,898 Per month: $2,492	Member: 531	Member: $35,055 Per month: $2,921

A Board member may resign by giving notice in writing.

Note 26. Key management personnel disclosures (continued)

The term and expiry date of the appointment for each Board member are:

Name	*Term*	*Expiry date*
Paul Woodhouse	3 years	17 May 2016
Annie Clarke	3 years	17 May 2016
Don Bowley	3 years	17 May 2017
Stephanie De La Rue	3 years	17 May 2016
Rowena McNally	3 years	17 May 2016
Richard Stevens OAM	3 years	17 May 2016
Christopher Appleby	3 years	17 May 2017
Karen Arbouin	3 years	17 May 2017
Ronald Page	3 years	17 May 2017

(ii) Other key management personnel

Chief Executive
The Chief Executive is appointed by the Board with the approval of the Minister in accordance with the *Hospital and Health Boards Act 2012*. Notice of termination may be made by either party with one month's notice.

Health Executive Service
The appointment of key management personnel who are deemed to be "health executive service" (HES) as defined in the Hospital and Health Boards Act 2011 is subject to an individual written contract with a maximum term of five years. Notice of termination may be made by either party with one month's notice.

Other key management personnel
Other key management personnel are employed under individual employment agreements which incorporate their appropriate award. The contracts have no fixed term. Notice of termination may be made by the employee with two weeks' notice. In the event of redundancy the agreement provides for appropriate notice period to be paid. In addition, North West Hospital and Health Service is required to pay 2 weeks' salary for each year of service subject to a cap of 52 weeks' salary, accrued long service leave and accrued annual leave.

Note 26. Key management personnel disclosures (continued)

Remuneration packages for key management personnel comprise the following components:

- Short-term employee benefits which include:
  - Base – consisting of base salary, allowances and leave entitlements paid and
  - Non-monetary benefits – consisting of provision of vehicle together with fringe
- Long term employee benefits include long service leave accrued.
- Post-employment benefits include superannuation contributions.
- Redundancy payments are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu on termination, regardless of the reason for termination.
- There were no performance bonuses paid in the 2013 -14 financial year.
- Total fixed remuneration is calculated on a 'total cost' basis and includes the base and non-monetary benefits, long term employee benefits and post-employment benefits.

The term and expiry date of these agreements for each key management personnel are:

Name	***Term***	***Expiry date***
Susan Belsham	5 years	29 July 2017
Brett Oates	3 years	10 February 2016
Barbara Davis	No fixed term	N/A
Michelle Garner	No fixed term	N/A
Leigh Purvis	No fixed term	N/A
Assoc. Professor Alan Sandford	No fixed term	N/A
Dr Ross Duncan	No fixed term	4 May 2014
Dr Greg Coffey	No fixed term	5 August 2013
Fiona McKenzie Lewis	No fixed term	11 December 2013
Marek Klein	No fixed term	11 December 2013
Sandra Kennedy	No fixed term	11 December 2013

Note 26. Key management personnel disclosures (continued)

Details of the compensation, of each key management personnel are:

(i) Board

1 July 2012 - 30 June 2013

Name	*Short-term benefits*		*Long-term benefits*	*Post-employment benefits*	*Termination benefits*	*Total remuneration*
	Base	*Non-monetary benefits*				
	$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Paul Woodhouse	67	13	-	7	-	87
Annie Clarke	18	-	-	2	-	20
Stephanie De La Rue	29	-	-	3	-	32
Rowena McNally	29	8	-	3	-	40
Richard Stevens	29	6	-	3	-	38
Christopher Appleby	18	-	-	1	-	19

1 July 2013 - 30 June 2014

Name	*Short-term benefits*		*Long-term benefits*	*Post-employment benefits*	*Termination benefits*	*Total remuneration*
	Base	*Non-monetary benefits*				
	$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Paul Woodhouse	65	23	-	8	-	96
Annie Clarke	32	-	-	3	-	35
Stephanie De La Rue	32	-	-	3	-	35
Rowena McNally	32	-	-	3	-	35
Richard Stevens	32	-	-	3	-	35
Christopher Appleby	32	-	-	3	-	35
Karen Arbouin	32	-	-	3	-	35
Ronald Page	32	-	-	3	-	35

Note 26. Key management personnel disclosures (continued)

(ii) Other key management personnel

1 July 2012 - 30 June 2013

Name	*Short-term benefits*		*Long-term benefits*	*Post-employment benefits*	*Termination benefits*	*Total remuneration*
	Base	*Non-monetary benefits*				
	$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Susan Belsham	162	15	-	15	-	192
Brett Oates	51	12	-	8	-	71
Barbara Davis	111	38	-	19	-	168
Dr Greg Coffey	485	53	-	48	-	586
Michelle Garner	153	30	-	16	-	199
Fiona McKenzie Lewis	58	30	2	14	-	104
Marek Klein	100	35	-	20	-	155
Sandra Kennedy	110	9	-	21	-	140

1 July 2013 - 30 June 2014

Name	*Short-term benefits*		*Long-term benefits*	*Post-employment benefits*	*Termination benefits*	*Total remuneration*
	Base	*Non-monetary benefits*				
	$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Susan Belsham	232	52	5	20	-	309
Brett Oates	166	32	3	18	-	219
Barbara Davis	134	47	3	15	-	199
Dr Greg Coffey	72	1	-	4	-	77
Dr Ross Duncan	280	42	3	23	-	348
Assoc. Prof Alan Sandford	75	3	1	5	-	84
Michelle Garner	170	49	4	18	-	241
Leigh Purvis	34	7	1	4	-	46
Fiona McKenzie Lewis	58	37	1	7	-	103
Marek Klein	56	22	1	7	-	86
Sandra Kennedy	55	7	1	7	-	70

Note 27. Remuneration of auditors

During the financial year the following fees were paid or payable for services provided by Queensland Audit Office, the auditor of North West Hospital and Health Service:

	2014 $	2013 $
Audit services - Queensland Audit Office		
Audit of the financial statements	222	149

Note 28. Contingent assets and liabilities

Litigation in process

As at 30 June 2014 the number of cases filed in the courts naming the State of Queensland acting through the North West Hospital and Health Service as defendant were as follows:

	2014 cases	2013 cases
Litigation in process		
Tribunals, Commissions and Boards	-	1

Health litigation is underwritten by Queensland Government Insurance Fund (QGIF). North West Hospital and Health Service's liability is limited to an excess per insurance event. Refer Note 2 (r).

All North West Hospital and Health Service indemnified claims are managed by QGIF. As at 30 June 2014, North West Hospital and Health Service has nine claims currently managed by QGIF, some of which may never be litigated or result in payments to claims. Tribunals, commissions and board figures represent the matters that have been referred to QGIF for management. The maximum exposure to Queensland Health under this policy is $20,000 for each insurable event.

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

All business pertaining to land held by or on behalf of North West Hospital and Health Service must take native title into account before proceeding. Such activities include disposal, acquisition, development, redevelopment, clearing, fencing of real property including the granting of leases, licences or permits. Real Property Dealings may proceed on department owned land where native title continues to exist, provided native title holders or claimants receive the necessary procedural rights.

Note 28. Contingent assets and liabilities (continued)

North West Hospital and Health Service undertakes native title assessments over real property when required. The National Title Tribunal reported a total of 2 native title claims within the North West Hospital and Health Service district, no new native title claims were added during the current reporting period.

Note 29. Commitments

	2014 $'000	2013 $'000
Lease commitments - operating		
Committed at the reporting date but not recognised as liabilities, payable:		
Within one year	1,969	1,525
One to five years	421	836
	2,390	2,361

Operating lease commitments includes contracted amounts for various residential properties, warehouses, offices and plant and equipment under non-cancellable operating leases expiring within 1 to 5 years with, in some cases, options to extend. The leases have various escalation clauses. On renewal, the terms of the leases are renegotiated.

Note 30. Transfer of assets and liabilities from the Department of Health

The fair value of assets and liabilities transferred from the Department of Health on 1 July 2012 were as follows:

	Fair value $'000
Cash and cash equivalents	364
Trade receivables	2,105
Inventories	917
Land and buildings	81,242
Plant and equipment	4,661
Software	8
Trade and other payables	(3,026)
Net assets acquired	86,271

Note 31. Fiduciary trust transactions and balances

North West Hospital and Health Service 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.

	2014 $'000	2013 $'000
Trust receipts and payments		
Receipts		
Patient trust receipts	7	23
Total receipts	7	23
Payments		
Patient trust related payments	(18)	(22)
Total payments	(18)	(22)
Trust assets and liabilities		
Assets		
Patient trust deposits	52	62
Other refundable deposits	3	4
Total assets	55	66

Note 32. Economic dependency

North West Hospital and Health Service is dependent on funding provided by the Department of Health under a Service Agreement pursuant to the requirements of the *Hospital and Health Boards Act 2011.*

The service agreement outlines the services that the Department of Health will purchase from North West Hospital and Health Service during the 2013-14 financial year and provides an indication of purchased activity and funding for the out years 2014-15 and 2015-16. The service agreements for 2013-14 provides total funding of $141.242 million, with indicative funding of $145.237 million in 2014-15 and $149.195 million in 2015-16 (2012-13 funding was $136.070million).

Note 33. Events after the reporting period

Transfer of housing assets

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

As at 30 June 2014, North West Hospital and Health Service held housing assets with a total net book value of $3,904,339 under a Deed of Lease arrangement with the Department of Health.These housing assets initially transferred to North West Hospital and Health Service at no cost to the HHS. Effective 1 July 2014, the Deed of Lease arrangement in respect of these assets will cease, and the assets will be transferred for no consideration to the Department of Health at their net book value, prior to their transfer to the DHPW.

As this transfer will be designated as a transaction with owners, the transfer will be undertaken through North West Hospital and Health Service's Equity account during 2014-15. Therefore, this transaction will have no impact on the Statement of Comprehensive Income in the 2014-15 financial year.

Transfer of legal ownership of health service land and buildings

The control of health services land and buildings transferred to each Hospital and Health Service (HHS) at no cost to the HHS through deed of lease arrangements when HHSs were established on 1 July 2012. The Department of Health retained legal ownership of the health services land and buildings, however the intention was for legal title of the assets to eventually transfer to each HHS.

Due to effective control of the assets transferring to HHSs, these assets are recognised within the financial statements of each HHSs and not within the Department of Health's financial statements.

On 23 June 2014, the Minister for Health announced that the Queensland government had approved the transfer of legal ownership of health services land and buildings to HHSs in a staged process over the next 12 months.

The transfer of legal ownership of land and buildings to North West HHS will occur from 1 July 2015. There is no material impact for the financial statements as these assets are already controlled and recognised by the HHS.

Note 33. Events after the reporting period (continued)

Transfer of prescribed employer function

As established under the Hospital and Health Boards Act 2011 (Act), the Department of Health is currently the employer of all health service employees (except for chief executives and health executive service employees) and recovers all employee expenses and associated on-costs from the Hospital and Health Service (HHS).

Although the Act allows a HHS to be the employer of health service employees, for this to occur the Minister for Health required HHSs to demonstrate their capacity and capability to be the prescribed employer of health service employees, with the HHS holding all authorities and accountabilities for HR functions. HHSs developed a prescribed employer assessment framework to demonstrate their capacity and capability.

On 23 June 2014, the Minister for Health announced that the employment of existing and future staff would become the responsibility of each HHS and that existing employment conditions, including pay arrangements, would remain unchanged. The Department of Health will remain responsible for setting state-wide terms and conditions of employment, including remuneration and classification structures and for negotiating enterprise agreements.

The North West HHS will become the prescribed employer of health service employees from 1 July 2014. There is no material impact for the financial statements as health service employee costs are currently recognised by the HHS.

Senior Medical Officer and Visiting Medical Officer Contracts

Effective 4 August 2014, Senior Medical Officers and Visiting Medical Officers will transition to individual employment contracts.

Individual contracts mean senior doctors will have a direct employment relationship with their HHS and employment terms and conditions tailored to individual or medical specialty circumstances (within a consistent state-wide framework).

As a direct employment relationship will be established between contracted medical officers and their HHS, employee-related costs for contracted Senior Medical Officers and Visiting Medical Officers will be recognised by the employing HHS (not the department) from the date the contracts are effective.

Non-contracted Senior Medical Officers and Visiting Medical Officers will remain employed under current award arrangements. Where their HHS is not a prescribed employer, they will continue to be employed by the department.

Other matters

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

Note 34. Reconciliation of surplus to net cash from operating activities

	2014 $'000	2013 $'000
Surplus for the year	249	1,139
Non-cash items:		
Depreciation and amortisation	7,328	5,638
Net loss on disposal of property, plant and equipment	24	218
Depreciation and amortisation funding	(7,328)	(5,635)
Change in operating assets and liabilities:		
Increase in trade and other receivables	(691)	(1,406)
(Increase) / Decrease in inventories	(55)	468
Decrease / (Increase) in prepayments	51	(85)
Increase in trade and other payables	3,402	5,125
Net cash from operating activities	2,981	5,462

These general purpose financial statements have been prepared pursuant to s.62(1) of the *Financial Accountability Act 2009* (the Act), section 43 of the *Financial and Performance Management Standard 2009* and other prescribed requirements. In accordance with s.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 within all material respects; and

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

c) these assertions are based on an appropriate system of internal controls and risk management processes being effective, in all material respects, with respect to financial reporting throughout the reporting period.

Susan Belsham
Chief Executive
22/08/2014

Paul Woodhouse
Chair
22/08/2014

Brett Oates
Chief Finance Officer
22/08/2014

To the Board of North West Hospital and Health Service

Report on the Financial Report

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

The Board's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

Independence

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

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

Opinion

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

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

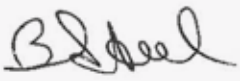
(b) in my opinion –

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

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

Other Matters - Electronic Presentation of the Audited Financial Report

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



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

Queensland Audit Office
Brisbane

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Queensland
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