Central Queensland Hospital
and Health Service

2018–2019 ANNUAL REPORT

ADVANCING Queensland

Queensland Government

Accessibility

Information about consultancies, overseas travel, and the Queensland language services policy is available at the Queensland Government Open Data website (qld.gov.au/data).

An electronic copy of this report is available at www.health.qld.gov.au/cq/

Hard copies of the annual report are available by phoning CQHH Board Secretary on (07) 4920 5759. Alternatively, you can request a copy by emailing CQHHS_Board@health.qld.gov.au

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

Content from this annual report should be attributed as: State of Queensland Central Queensland Hospital and Health Service) Annual Report 2018–19.

ISSN 2202-5332 (Print) ISSN 2652-2640 (Online)

Aboriginal and Torres Strait Islander people are advised that this publication may contain words, names, images and descriptions of people who have passed away.

Acknowledgement

Acknowledgement to Traditional Owners

We respectfully acknowledge the Traditional Owners of the land, as well as the significant spiritual and cultural connection to the animals, waters, plants and country throughout Central Queensland. We also respectfully acknowledge Elders, past present and future, and thank Elders, community and health services to whom we walk with great pride to address the health needs as partners to close the health gap between Aboriginal peoples and Torres Strait Islander peoples and the wider Central Queensland population.

Recognition of Australian South Sea Islanders

CQ Health formally recognises the Australian South Sea Islanders as a distinct cultural group within our geographical boundaries. CQ Health is committed to fulfilling the *Queensland Government Recognition Statement for Australian South Sea Islander Community* to ensure present and future generations of Australian South Sea Islanders have equality of opportunity to participate in and contribute to the economic, social, political and cultural life of the State.

Letter of compliance

Queensland Government

Central Queensland Hospital and Health Service

The Honourable Steven Miles MP
Minister for Health and Minister for Ambulance Services
GPO Box 48
BRISBANE Q 4001

Dear Minister Miles,

I am pleased to submit for presentation to the Parliament the Annual Report 2018-2019 and financial statements for Central Queensland 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 2019;* and
- The detailed requirements set out in the *Annual report requirements for Queensland Government Agencies.*

A checklist outlining the annual reporting requirements can be found at page 105 of this annual report.

Yours sincerely

Cr Paul Bell AM
Chair
Central Queensland Hospital and Health Board

4 September 2019

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Statement on Queensland Government objectives for the community

CQ Health's strategic vision *Destination 2030: Great Care for Central Queenslanders*, and Strategic Plan 2018-22, support the Queensland Government objectives highlighted in *My health, Queensland's future: Advancing Health 2026* and Advancing Queensland's priorities.

Destination 2030 sets a clear ambition – driven by the vision of Great Care for Central Queenslanders – for Central Queenslanders to be among the healthiest in Australia, and for our health service to be among the best in the country.

Achieving CQ Health's strategic vision will support the delivery of the Queensland Government's objectives for the community, particularly:

- Keep Queenslanders healthy by promoting heathier lifestyles and healthier minds and delivering better health outcomes for Central Queenslanders.
- Ensure our children have the best possible start to life by increasing the number of babies born at a healthy weight and increasing immunisation rates amoung young children.
- Support the greater Central Queensland community by growing our health services.
- Ensure that the patient is at the centre of everything we do and that we deliver health services that are easy to navigate.

Message from the Chair

Cr Paul Bell AM

The 2018-19 result highlights the clear vision of the Board, CQ Health, and its staff, to deliver the key objectives identified in *Destination 2030: Great Care for Central Queenslanders*.

The great care and enviable results are highlighted throughout this annual report.

The modest $400,000 surplus – a welcomed improvement from the 2017-18 overrun of $6.7 million – was achieved through fiscal responsibility, improved productivity and efficiency, and a focus on delivering safe and high-value health services.

Optimising budget value will deliver ongoing surpluses that can be reinvested in services for Central Queenslanders. This focus will continue through the implementation of an integrated revenue and cost planning approach with support from external advisors Queensland Treasury Corporation.

Innovative clinical service delivery models, transformative models of care, revenue realisation, infrastructure planning and delivery, and annual planning and performance management will be key elements in the future success of CQ Health.

Significant capital development was completed during the reporting period including the $25 million Rockhampton Hospital Car Park, $8 million upgrade at the North Rockhampton Nursing Centre and the start of the $42 million Gladstone Hospital emergency department.

During 2019-20, the Board's focus will be on:

- delivery of safe and sustainable clinical models that deliver high-value care
- support of Health and Wellbeing Queensland's preventive initiatives through projects such as CQ Health's 10,000 Lives campaign
- recruiting, retaining and rewarding skilled staff who exemplify our shared values
- delivering capital and IT infrastructure that support contemporary care
- supporting innovation and research translation into practice
- aligning the *Clinical Services Master Plan*, *Capital Infrastructure Masterplan*, *Workforce Plan* and other key strategic documents to support delivery of the Destination 2030 vision.

I would like to acknowledge the service of former Board members Frank Houlihan, Graeme Kanofski, Karen Smith and Elizabeth Baker for their service and the current Board members for their commitment to Central Queensland. I also acknowledge the strong leadership of Health Service Chief Executive Steve Williamson and his Executive Leadership Team for their commitment to patients, staff and their community.

Through great people we can deliver great care. Finally, I thank and congratulate the great people who are CQ Health and who are the health service.

Message from the Chief Executive

Steve Williamson

Our great people raised the standard of public health care to a new level during 2018-19 and our unrelenting focus on safe care has delivered outstanding results.

The growing culture as a values-based organisation focused on delivering Great Care for Central Queenslanders is achieving results for staff and our community.

The results highlight that during 2018-19 our 4000 people delivered safer care, more care, more efficient care, care closer to home and friendlier care with our values guiding our actions.

For three consecutive reporting periods, CQ Health staff have delivered reductions in the number of serious clinical incidents with comparative figures showing a 60 per cent decline from 2016 to 2019. The high quality of our health services was highlighted in two independent external reviews. The Office of the Health Ombudsman highlighted significant improvements in maternity services across Central Queensland and, after 17 reviewers spent a week looking at all aspects the health care we deliver, the Australian Council on Healthcare Standards found CQ Health met each and every standard.

The health service engaged with staff, patients and their families, and our communities in the design, delivery and review of services in a collaborative approach that put the patient at the centre of all we do.

CQ Health delivered a six per cent increase in the volume of services when compared to the previous year, yet achieved outstanding access results including that on 30 June 2019 no patient was waiting longer than clinically recommended for surgery, outpatient appointment, scope procedure or oral health appointment. Our Emergency Departments continued to be among the top performers in Queensland.

The commitment to Close the Gap in health outcomes for our Aboriginal and Torres Strait Islander communities was supported by the development of an Aboriginal and Torres Strait Islander Health and Wellbeing unit and the appointment of our inaugural Director.

CQ Health has an exciting future including:

- Growing our own doctors through the development of a full medical program starting in 2022
- Continued implementation of clinical stream across the health service
- Development of new services, such as the soon-to-be introduced cardiac service at Rockhampton Hospital
- Installation of a Positron emission tomography (PET) scanner at Rockhampton that uses a special dye to check for diseases
- Increased medial capacity at Rockhampton and the Capricorn Coast
- Integration of the Project Management Office in strategic and operational planning.

I recognise the support and commitment of Board Chair Paul Bell AM and the Board members past and present. I also recognise the outstanding support and integrity of the Executive Team and their commitment to delivering great care.

CQ Health will continue to mature, innovate and integrate, grow and achieve. Our staff will make it possible.

Highlights

ZERO patients waiting too long for surgery

ZERO patients waiting too long for a dental appointment

ZERO patients waiting too long for a gastrointestinal endoscopy

3108 FTE – up 99 positions

1385 nursing and midwifery positions – up 47

328 doctor positions – up 15

2146 babies delivered

128,237 emergency department presentations

12,003 breast screens performed

8669 emergency and elective surgeries performed

270,594 outpatient occasions of service

218,644 oral health treatments

13,996 Telehealth sessions provided

Chapter 1
About us

1.1. Strategic Direction

The long-term strategic vision *Destination 2030: Great Care for Central Queenslanders* was approved by the Board and adopted by the health service on 27 October 2017.

This strategic vision provides targets for 2020, 2025 and 2030. Annual actions and projects to deliver the vision are identified in a CQ Health roadmap. Similar roadmaps are developed for each of the strategic objectives (see below) and five geographic/project areas: Rockhampton, Gladstone, rural and remote, out-of-hospital services and Closing the Gap.

The vision identified in *Destination 2030: Great Care for Central Queenslanders* informs the new CQ Health Strategic Plan 2018-2022, which also aligns with, and is the health service's contribution, to the ambitions of *My health, Queensland's future: Advancing health 2026*.

1.2. Vision, Purpose, Values

Vision: Great Care for Central Queenslanders

Purpose: Great people, delivering quality care and improving health outcomes

Values: CQ Health is committed to our guiding values:

- Care – We are attentive to individual needs and circumstances
- Integrity – We are consistently true, act diligently and lead by example
- Respect – We will behave with courtesy, dignity and fairness in all we do
- Commitment – We will always do the best we can

1.3. Priorities

CQ Health's priorities are clearly expressed in its strategic vision *Destination 2030: Great Care for Central Queensland*:

- Great Care Great Patient Experience
- Great People Great Place to Work
- Great Partnerships
- Great Learning and Research
- Sustainable Future

These priorities are brought to life with 2020, 2025 and 2030 milestones. The priorities are reflected in the CQ Health Strategic Plan (updated 2019) and throughout this annual report.

In the two years since Destination 2030 was endorsed – following extensive staff and community engagement – the plans and strategies to achieve the vision have been constructed to provide clarity about how the vision will be achieved.

1.3.1. Great Care Great Patient Experience

Safe, compassionate care, delivered to the highest standards, close to home, with patients at the heart of all we do

CQ Health continues to innovate and transform the delivery of health services to Central Queenslanders.

In 2018-19 CQ Health performed approximately 8669 emergency and elective surgeries, 3300 endoscopies, 270,594 outpatient occasions of service, saw 128,000 emergency department presentations, delivered 218,000 oral health services and performed 12,000 breast screens.

Many elements are required to deliver great care, and to deliver the best possible experience for those who need to access public health services.

There is no single element more important than the delivery of safe care, supported by:

- Timely care
- Care closer to home
- Connected care
- Health system that is easy to navigate
- Preventive care and health lifestyle improvement
- Care delivered by the right service and partnership
- Innovative care

In 2018-19, CQ Health delivered safer care, more care, more efficient care on time and closer to home with our values guiding our actions.

Quality and Safety Governance

The key indicator – the number of significant clinical incidents measured in a Severity Assessment Code (SAC) rating – showed outstanding results.

The number of SAC 1 incidents (death or likely permanent harm which is not reasonably expected as an outcome of healthcare) has declined 60 per cent in four years from 29 in 2015-16 to 12 in 2018-19. This result reflects the focus on delivering safe and sustainable services across Central Queensland.

The number of SAC 2 events (temporary harm which is not reasonably expected as an outcome of healthcare) also showed significant decline from 167 to 101 in the same four-year period.

SAC	15-16	16-17	17-18	18-19
1	29	23	18	12
2	167	136	123	101
3	5,341	5,372	4,672	3,237
4			510	3,316

Footnote: There has been a significant increase in the reporting of SAC4 events which are events in which there was no harm and are regarded as a near miss. The introduction of the Riskman Incident Management system in late 2017 has been a factor in the increased reporting of no harm and near miss events as the prior incident report system in place did not provide the opportunity for SAC4 reporting. The significant increase in the reporting of SAC4 events demonstrates a positive improvement in safety culture. The reporting of SAC4 events provides the organisation the proactive opportunity to theme and trend the type and nature of incidents and take pre-emptive action to prevent harm. CQ Health has worked to improve the reporting culture for incidents and the resulting increase in SAC4 events reporting is testimony to this. It reflects an improved safety culture.

Australian Council on Healthcare Standards Accreditation

The results of our accreditation survey in June 2019 reflected the outstanding commitment of our employees to the delivery of great and safe care.

CQ Health had 17 reviewers applying the new standards to facilities and services across Central Queensland and met every one of those standards.

The accreditors made four recommendations on how CQ Health could deliver further improvements relating to:

- Staff safety and security
- Safety of mental health patients in the emergency departments
- Increasing the number of consumer representatives at facility level and ensuring that consumer representatives are orientated and trained.
- Embedding the establishment of Consumer and Community Advisory Groups

The recommendations have been accepted. This result, coupled with our continued improvement in patient safety results, highlights the commitment of the CQ Health Board, leadership team and staff to our patients and our community.

Office of the Health Ombudsman (OHO) Investigation Report

CQ Health's focus on improving health care in our maternity service has delivered great results and it is reassuring that an external and independent review by OHO identified that our services deliver safe, high quality maternity services.

Proactive maternity service reviews and the progressive implementation of service and cultural improvements began at Rockhampton Hospital and have now been progressed at all Central Queensland public birthing facilities.

The improvements highlighted for the Rockhampton Hospital maternity service will be reflected across CQ Health's birthing hubs as improvements and process changes are embedded as business-as-usual.

The recommendations for ongoing improvement in the report are welcomed and reaffirm the actions CQ Health had put in place prior to the OHO review and in the months since OHO's last visit to Central Queensland. There has been a particular focus of service improvement and clinical governance at the Gladstone Hospital maternity unit and CQ Health is determined to deliver improvements that match those achieved at Rockhampton Hospital.

CQ Health is committed to delivering further and ongoing improvements in our maternity services. The OHO recommendations will support our ongoing work.

The findings and recommendations in the report and the work undertaken since the OHO visit were very much supported by the accreditation process.

To achieve such supportive assessments by two independent organisations within months of each other highlight the effectiveness of our approach to improving services and improving the health of Central Queenslanders.

Care closer to home

Telehealth

Central Queensland covers an area twice the size of Tasmania and has a relatively low population, far from major metropolitan areas.

This usually means patients have to travel for care, either within CQ or to a tertiary hospital in South East Queensland, but CQ Health is delivering care closer to home.

From surgical outreach from Rockhampton Hospital, to the use of technology to link patient with clinician without leaving their town, their local hospital or even their home, many techniques are being used to deliver care closer to home.

Telehealth saves thousands of patient journeys. In the two years from 2016-17 – when Destination 2030 was released with the aim of delivering 10,000 fewer patient journeys – the number of Telehealth appointments more than doubled.

Telehealth saved an estimated 5.2 million kilometres of travel in 2018-19 which is a million kilometres more than 2017-18.

CQ Health is the second highest user of telehealth in Queensland and while our budget was for a little over 10,000 outpatient services, our great teams delivered 13,996 appointments, and we are going to keep that growing.

From the innovative tele-chemotherapy to mental health telecommutes, our Telehealth service has been well supported by our staff, our clinicians and our patients.

CQ Health will continue to grow telehealth, and invest in other ways to reduce the needs for patients to travel for care.

Patient involvement in health care planning, improvement and delivery

From document review to participation in strategic planning days, sitting on recruitment panels or key positions, patient experience presentations, reviewing patient safety data to judging our Award of Excellence nominees - patients, their families and community members play a vital role in shaping the health services we deliver in Central Queensland.

CQ Health's Community and Consumer Advisory Committee, and smaller advisory committees at Gladstone and Emerald, provide valuable feedback, input and insight and ensure the health service maintains its focus of putting the patient at the centre of all we do.

The CQ Health advisory committee evaluated the person-centred care education and training module and patient stories are used in educational workshops and leadership summits. Consumers Health Forum of Australia partnered with CQ Health to develop the person-centred care training – Communicating risk: Helping patients make informed decisions - which is now requisite training for all CQ Health clinical staff.

Patients were involved in the review and evaluation of the CQ Health Mandatory and Requisite Training as members of the Workforce and Planning Committee and Education and Research Sub Committee.

Feedback from patients is also used as part of CQ Health's continuous improvement philosophy. CQ Health will implement real-time patient experience software to better measure and evaluate patients' reactions to their experience.

Clinician engagement

CQ Health has more than 2000 clinicians whose knowledge and experience improves the care and experience of Central Queenslanders using the health service.

The doctors, nurses and allied health professionals are represented by clinicians of all specialties, experience levels and geographic locations on CQ Health's Clinical Senate which highlights and discusses trends and opportunities locally and globally.

Two Clinical Senates, which also include Board, executive and other senior staff, and representatives from some external partners, were held in the reporting period with the first, September 2018, focusing on ways to grow our own workforce and address the historic recruitment difficulties facing Central Queensland.

The second, in February 2019, discussed: What does great care look like?

The Clinical Senate is supported by medical, nursing and allied health clinical councils which discuss topics specific to their profession.

In all instances, the discussions, feedback and initiatives are used to improve health service delivery for Central Queenslanders.

Other key engagement tools include joint CQ Health and Primary Health Network Board and executive meetings, the GP (Great Partners) Newsletter which is circulated to General Practitioners, and regular meetings with clinicians within business units.

Public and Community Health

Communicable Diseases Control

There have been a number of outbreaks this year which required our attention, including dengue fever, influenza, pertussis and gastroenteritis.

There has been a total of 13 confirmed cases of dengue fever to date this year. Our Communicable Diseases Control team has been jointly managing this with the Environmental Health team. We have seen an increase in influenza notifications compared with previous years (1352 in 2019 so far, compared with 858 for the whole of 2018) and have conducted a mass vaccination clinic (120 doses given on one day) at Woorabinda in response to the increased notifications of influenza B.

We have also been managing multiple influenza outbreaks across 11 schools and two aged-care facilities elsewhere in CQ. Pertussis notifications have increased compared with last year. In response, the health service is taking a number of actions including isolation of confirmed cases and individual follow up, the provision of information to contacts (parents and schools), advocating for pertussis vaccine in high risk groups and providing education to schools and general practitioners.

Our Public Health Physician has also been involved in the state-wide syphilis outbreak response together with the Blood Borne Virus and Sexual Health team.

CQ Health continue to support local vaccination providers and we are trialling a vaccination reminder service for Indigenous infants. Our pilot project conducted in previous years was particularly successful for Aboriginal and Torres Strait Islander babies and we have extended the reach so that all Indigenous babies born in CQ between 1 October 2018 and 31 March 2020 are included. The project is called the SMS Precall Project – Indigenous rollout and parents receive a reminder to vaccinate their child when the infant is two months, four months, six months, 12 months and 18 months old.

Environmental Health

The Environmental Health team has been involved in projects to monitor and improve compliance with legislation across CQ.

With regards to the *Food Act 2006*, CQ Health started a pilot food sampling project to determine correct labelling for fish speciation in ready-to-eat takeaway foods. CQ Health also investigated five food-related illnesses, four foreign matters in food, two suspected intentional contamination and one food-related injury.

CQ Health responded to dengue notifications to minimise local transmission in the Rockhampton outbreak area, which resulted in 1559 premises being visited and 884 being treated for mosquito harbourage and breeding. Lure and Kill Ovitraps were deployed to over 436 premises to reduce adult and larvae numbers in the outbreak areas.

CQ Youth Connect

The small CQ Youth Connect team is committed to youth advocacy, partnerships and community engagement to re-engaging Aboriginal, Torres Strait Islander and disconnected youth aged 14 to 25 years.

During 2018-19, CQ Youth Connect:

- Distributed 40 hygiene kits developed and provided to high-risk disengaged youth following health and hygiene education sessions
- Distributed 4500 condom kits
- Developed head lice treatment kits distributing 25 after education and treatment
- Launched the 5th edition of CQ Youth Connect Service Directory and

wall charts.

- Developed and distributed 720 service and health information banner pens for youth, which is also used as an antistressor tool
- Engaged 1558 visitors to CQ Youth Connect stalls and interactive youth activities at community events
- Developed a full day professional development model relating to youth health and wellbeing hot topics to increase the knowledge and awareness of staff working with youth across CQ
- Instigated and coordinated a two-day Peer Skill Facilitator training from Brisbane for 18 new peer skills facilitators from Headspace, Darumbal, Youth Justice, PCYC, Youth Plus/Flexi Learning School, Gracemere Primary School, Mount Morgan State High School, North Rockhampton State High School, Livingstone Shire Council, Flexi Learning, School-based Youth Health Nurses and CQ Youth Connect staff
- Hosted and coordinated Core of Life training in Rockhampton for 22 new Core of Life facilitators from Yeppoon, Gladstone, Woorabinda and Rockhampton
- Hosted 4830 youths who attended various evidenced-based health educations sessions across CQ
- Attended to the health needs of 200 clinical clients relating to: sexual health screening, treatment, follow-up and contact tracing; contraception consultation and access; pregnancy testing; dental health; immunisation; alcohol and smoking; mental health; and 715 health checks
- Instigated and helped coordinate Baralaba and Woorabinda wellness camps
- Established and coordinated the Inaugural 2019 Youth Opportunity Day in Rockhampton as part of Youth Week 2019, and
- Coordinated the Woorabinda Colour Fun Run as part of Youth Week 2019.

Health lifestyle improvement

10,000 Lives

CQ Health has a very clear vision highlighted in *Destination 2030: Great Care for Central Queenslanders* – and that is for Central Queenslanders to be among the healthiest in the world.

To achieve this, we must first close the health gap confronting Central Queenslanders. The statistics are quite startling. We die two years younger than the average Queenslander and the reason is directly linked to our lifestyles.

Central Queensland has a high rate of smoking, physical inactivity, obesity, alcohol consumption, inactivity and sun exposure. Diet and nutrition is also an issue.

The result is heart disease, high blood pressure and higher cancer rates and a population unhealthier than the average Queenslander.

CQ Health is delivering results. Through the development of partnerships with other great organisations, the health of Central Queenslanders is improving – particularly among former smokers.

CQ Health's 10,000 Lives program – a program that aims to save the lives of 10,000 people from smoking-related illnesses by 2030 - was launched

in November 2017 and in that time:

- More than 5400 Central Queenslanders have registered on Quitline at double the rate they were registering before the launch.
- While Aboriginal and Torres Strait Islander people comprise about seven per cent of Central Queensland's population – 16 per cent of registrations in 2018-19 were from Central Queensland's Aboriginal and Torres Strait Islander community
- The daily smoking rate in Central Queensland has dropped from 16.7 per cent to 14.1 per cent. Since the 10,000 Lives launch there are 3000 fewer smokers in CQ.

Central Queensland has been collaborating with the Queensland Cancer Council to provide Tackling Tobacco Training to 26 local community service staff who work with disadvantaged populations. B.Strong, a training program developed to assist Aboriginal and Torres Strait Islander health workers to deliver brief interventions for smoking cessation, nutrition and physical activity, has been provided to 27 staff across Gladstone, Rockhampton and Woorabinda. The project has also been promoted at CQ Health and Sports Expo, Moura Health Expo, Youth Pus, Paradise Lagoons Campdraft, Women's Health Expo, Homeless Connect, Deadly Choices World No Tobacco Day, National Youth Week, OneGov Public Servant Week. The culturally and linguistically diverse community has been informed about the project through the Language Café in the Gladstone community

There is more to do and CQ Health looks forward to partnering with the new Health and Wellbeing Queensland to promote healthy lifestyles and better health outcomes.

Health education and screening services

CQ Health is the major sponsor of the annual Rockhampton Regional Council Sport and Health Expo and attends a range of promotional opportunities across Central Queensland each year.

AgGrow, Romp in the Park for under 8s week, NAIDOC celebrations, sporting and community events are just some of events attended by some or all of the preventive health team that includes:

- BreastScreen
- Bowel Screening
- Sexual Health
- DonateLife
- Alcohol and Other Drugs Service
- CQ Youth Connect (Sexual Health Service)
- Women's Health
- Prostate Cancer Nurse
- Emergency Planning and Preparedness
- Sub Acute Chronic Care Rehabilitation
- Public Health
- Aboriginal and Torres Strait Islander Health

1.3.2. Great People Great Place to Work

Great staff working in great teams with a culture of supporting and investing in our people's future

CQ Health has nearly 4000 great people filling more than 3000 positions and all are committed to delivering to their community.

Our staff save lives, improve health outcomes and deliver Central Queenslanders a healthier future.

CQ Health continued to focus on the recruitment of staff who live the organisation's values of Care, Integrity, Respect and Commitment. Delivering the right people with the right skills in the right place at the right time is an essential ingredient to meeting the community's health needs.

Lifestyle, learning and education opportunities for skill development, personal and career opportunities and quality of life are a key attraction to Central Queensland and delivering a great place to work provides the platform for improved staff stability.

During the past five years, CQ Health's separation rate has ranged from five per cent to seven per cent. The health industry is traditionally transient with relatively high separation rates and the health service continues its cultural improvement program to retain the right staff longer. That program includes:

- Staff engagement
- Living our values – Everyone Every Day
- Staff recognition and rewards
- Leadership training and development
- Clarity of role, purpose and vision
- Transparency

Cultural improvement is monitored through the external Working for Queensland survey, and internal Pulse surveys to ensure initiatives are targeted to deliver the best results. After delivering the most significant cultural improvement results in the 2017 Working for Queensland survey, CQ Health maintained the improvement in the 2018 survey.

In 2018-19, CQ Health conducted almost 70 surveys for public and staff receiving 2450 responses.

The outstanding results delivered by CQ Health's staff are showcased across Queensland each year, but the CQ Health staff excellence awards highlight the pinnacle of achievement.

The nominees, finalists and winners were a reflection of the great staff who delivered safe care, more care, more efficient care on time and closer to home with values guiding their actions. CQ Health staff delivered:

- Some of the safest care in Queensland
- Among the best emergency and elective surgery access targets in Queensland
- Met all activity targets efficiently ensuring the volume of care was maximised
- More care closer to home saving millions of kilometres in travel
- Significant increases in the number of elective surgeries

It takes great people to deliver great care and in 2019-20 CQ Health's staff will continue to deliver for Central Queensland.

Across the health service there were 3109 Full Time Equivalent (FTE) positions, an increase of 98 positions including an extra 47 nurses and midwives and 15 doctors – staff who are committed to delivering great care.

2018-19 MedReruit CQ Heath Staff Recognition Awards

More than 200 staff attended the 2018-19 MedReruit CQ Heath Staff Recognition Awards and celebrated the great work of the 140 nominees, 32 finalists and 10 winners.

2018 Working for Queensland Survey

The Working for Queensland survey is an annual survey which measures Queensland public sector employee perceptions of their work, manager, team, and organisation.

The 2018 Working for Queensland Survey was a fantastic success with CQ Health recording a 48 per cent response rate, up from the 44 per cent recorded in 2017.

The information and feedback our staff provided during the 2018 Working for Queensland survey has been very valuable in shaping our future cultural development. The survey highlighted areas with positive responses that we can learn from and areas with less positivity we have targeted for improvement through staff engagement and CQ Health's strategic vision *Destination 2030: Great Care for Central Queenslanders.*

Leadership Development

Along with providing stable and consistent leadership, CQ Health has continued to focus on increasing our leadership and management capability and investing in our leaders.

A full year of targeted leadership development programs have been

implemented as a suite of programs was delivered to a wide cross section of staff. The leadership development activities included:

- Mentoring Program
- Executive Leadership Program
- Manage4Improvement Program
- High Impact Leadership Course
- Leaders in Action Program
- PPA Leaders' Intervention Skills Course
- PPA Peer Messenger Training
- Leadership Summits quarterly
- Team targeted Leadership Development
- Targeted 360º Feedback
- Resilience for Teams sessions

The Resilience for Teams Program was rolled out over four months in 2018 and 59 two-hour sessions were delivered across most CQ Health locations. These sessions were attended by more than 600 CQ Health staff and received overwhelmingly positive feedback.

To ensure the sustainability of an ongoing comprehensive leadership development program, work has been done on building the skills and knowledge of staff to offer some of these activities internally.

The *CQ Health Leadership Development Framework* has been developed to provide a robust leadership development model for current and aspiring leaders, identifying essential knowledge, skills, understandings and professional capabilities to enable values-driven leadership. The framework provides a basis for the coordination of a range of leadership development options to be gathered together to adequately provide a leadership development program to enable current and aspiring leaders to build skills and knowledge in line with the guidelines set out in the *CQ Health Leadership Development Framework*.

Leadership Summits

During the reporting period CQ Health hosted three leadership summits designed to increase the leadership and management capability by investing in existing and emerging leaders.

The summits provide valuable networking opportunities for senior staff who work across the geographic expanse of CQ, attract about 140 participants who discuss strategies; hot issues; pulse survey results; and help identify key priorities for improvement.

Three summits were held over the year with more than 100 staff attending each.

Each summit offered a range of information and development for CQ Health leaders, including patient experience presentations, updates on Working for Queensland survey results, progress of Destination 2030 projects, and a range of development sessions, covering:

- Leveraging diversity
- Vision and action
- Resilience for teams

Workforce Diversity and Inclusion

CQ Health is committed to embedding cultural competence by having the ability to understand, communicate with and effectively interact with people across all cultures ensuring a safe, secure and supportive workplace that enables all employees to participate, contribute and innovate in a cohesive working environment. We recognise our diverse workforce and are aware of the cultural differences and the importance of inclusion is a core component to delivering a culturally competent service to our patients.

Our focus areas and principles include –

- Attract, select and retain talent
- Create a diverse, inclusive and engaged workforce culture
- Develop individuals to achieve their full potential

The seven identified priority groups include Aboriginal and Torres Strait Islander peoples, people with a disability, people from non-English speaking backgrounds, gender equity, mature age (over 45), LGBTIQ, and youth (under 25).

The CQ Health Diversity and Inclusion Steering Committee meets monthly and an Aboriginal and Torres Strait Islander Workforce Working Group meets bimonthly to steer the direction of the diversity and inclusion initiatives for the health service. These committees have been established and actions plans have been developed to support the achievement of the *Destination 2030: Great Care for Central Queenslanders* outcome areas, as well as the Queensland Government direction on diversity and inclusion.

Monthly Workforce Diversity dashboards are presented to the Workforce Management and Planning Committee as well as reporting monthly to both committees. This information also informs and measures the effectiveness of the diversity and inclusion initiatives.

Queensland Health has established targets for diverse workforce groups aligned with the Public Service Commission (PSC), for the Queensland Public Service.

The successful development of targeted recruitment campaigns promoting the inclusion and attraction of a diverse workforce included in -

- Corporate branding
- Employer branding
- Values posters, banners and handbooks
- Talent and attraction promotional videos
- Job advertising and templates
- Advertising of Aboriginal and Torres Strait Islander identified positions in Aboriginal and Torres Islander websites and media.

CQ Health's school-based and full time traineeship program funding has been secured for 2018-2020 to increase priority workforce diversity targets.

Outcomes to date include -

- Four school based trainees will complete traineeship and vocational education (Certificate III in Business Administration) by 2019-20
- Two business administration trainees currently employed for 12 months will complete the vocational education (Certificate III in Business Administration) by 2019-20

- One Indigenous school based trainee in allied health traineeship will complete traineeship and vocational education (Certificate III in Allied Health Assistance) by 2019-20
- One Indigenous school based complete trainees will complete the traineeship and vocational education (Certificate III in Community Service) by 2019-20

Staff health, safety and wellbeing

Delivering a safe working environment and promoting staff health and wellbeing is vital in the delivery of a great place to work.

An effective indicator is the number of Workcover claims lodged and accepted and for CQ Health 2018-19 delivered further reductions with the number of claims lodged, dropping from 206 to 186, and those accepted, dropping from 108 to 97. There was also a significant improvement in the average total incapacity paid days, decreasing from 42 to 26 days.

Strategies implemented such as regular debriefs with executive and line managers, strategic suitable duties plans that enable return to the work environment and frequent communications with workers have contributed to the success.

During the reporting period, CQ Health worked with the Department of Health's Occupational Violence Strategy Unit to complete a training gap analysis. A Training Competency Framework was completed with the strategy unit in November 2018 and a draft dashboard was developed in February 2019. The result of the framework indicated more work was required in the debriefing, resilience and peer support training space which is already in progress. The dashboard is reviewed monthly.

Recruitment and retention

Recruitment and retention of appropriately skilled staff has been historically difficult in Central Queensland, – with particular professions and locations increasing the difficulty.

There were many recruitment successes during 2018-19 including:

- Rockhampton Hospital achieving permanent appointments against every clinical director position
- Gladstone Hospital appointing additional midwives to establish a 24-hour nursery
- Gladstone Hospital appointing additional doctors with the appropriate anaesthetic skills to deliver an upgraded High Dependency Unit
- Community mental health staff across the region
- Director of Medical Services Central Highlands
- Appointment of nine nurse or midwife navigators across CQ
- Two senior dentists and four other full-time dental officers across CQ
- Establishment of and recruitment to Emerald Nursing Resource Unit providing backfill to positions in Emerald Hospital

CQ Health is focused on delivering the right people in the right place to deliver the health services our community demands. To improve the ability to recruit and process of recruiting, the organisation:

- Reviewed and researched visa processes
- Started work with the Department of Health Talent Attraction team to assist with hard to fill positions and link with the strategic recruitment process and design.
- Reviewed recruitment team practices with a focus on value-adding and partnership gaps in current customer service delivery
- Reviewed internal management of advertising and utilisation of electronic resources and review the current advertising matrix developed for strategic recruitment campaigns
- Reviewed recruitment and selection training
- Reviewed process design for hard to fill vacancies
- Started review of the use of electronic resources such as Linkedin, Facebook, online journals and emerging technologies

The Workforce recruitment team delivered significant internal process improvement in line with the implementation of new software platform myHR, resulting in reduced appointment processing time.

Workplace Equity and Harassment Officer Network

CQ Health has a zero tolerance for behaviour that conflicts with its values of Care, Respect, Integrity and Commitment. This zero tolerance approach is sponsored and supported by the executive and senior management of the organisation. The Workplace Equity and Harassment Officer Network was reinvigorated and reintroduced following the 2016 Workforce for Queensland Employee Opinion Survey and remains a confidential service, where staff can safely discuss their workplace concerns and issues.

The network sits outside any informal or formal complaints process in the organisation and allows staff to gather information about options available to their specific situation without being locked into any process before they decide which action would best suit them in their circumstances.

Network members undergo training with the Queensland Human Rights Commission (previously the Anti-Discrimination Commission) prior to commencing in their role and meet regularly throughout the year to ensure consistency of advice, actions and information and to monitor member wellbeing.

Workforce and Human Resource Governance

The Workforce Division undertakes a planned approach to governance management, reviews and consultation. Part of this process is to regularly review the Queensland Health and Public Service Commission governance documents to identify changes and any emerging gaps. These processes ensure human resource (including health and safety) procedural documentation are applicable, consistent and provide a one-stop document to increase both compliance, efficiency and competence for users.

Aligned with this, the division is building an every day is accreditation day culture resulting in the Australian Council on Safety and Quality in Healthcare accreditation assessors acknowledging the achievement of 100 per cent currency across all human resource policies and procedures in June 2019.

1.3.3. Great Partnerships

Working collaboratively with our partners to deliver great care and improve the health of Central Queenslanders

Meeting the health needs of the Central Queensland community within a finite budget setting requires effective partnerships that reduce duplication and maximise value.

Placing the person at the centre of health care requires effective partnerships between CQ Health and those who need our expertise to improve their lives. The effective partnership with our patients and community will support our vision of Great Care – Great Patient Experience.

The partnership between CQ Heath and its staff is key to delivering results. It requires great people to deliver great care, and the standard of care achieved during 2018-19 highlights the strength of the partnership.

Health partners and partnerships come in many forms and include government and non-government organisations that provide or support health service delivery, educators and innovators, training and skill development providers, organisations that support career opportunities, and researchers.

Perhaps the most significant partnership established during the reporting period resulted in the signing of a Memorandum of Understanding – between The University of Queensland, CQUniversity, Wide Bay Hospital and Health Service and CQ Health – to establish a full medical program in Central Queensland by 2022. This historic signing on 20 March 2019

was witnessed and supported by the Minister for Health and Minister for Ambulance Services Steven Miles.

Other effective partnerships include:

- The numerous agencies funded to meet the mental health needs of the community
- Primary Health Network for the delivery of co-ordinated care and effective health care pathways between General Practitioners to the public subacute and acute care sectors. This partnership is essential for the effective management of the community's mental health needs
- Universities and education organisations to deliver effective education, training and upskilling of existing and potential staff and to develop courses that meet the community's future health needs
- James Cook University which contributed $50,000 to develop the pocket simulation training centre and student hub at Emerald Hospital Campus
- Tertiary and private hospitals such as Queensland Children's Hospital, Princess Alexandra Hospital and Royal Brisbane and Women's Hospital, Hillcrest Hospital and Rockhampton Mater Hospital for the partnered delivery of health services in Central Queensland or for the treatment of CQ Health patients.
- GenesisCare, CQ Radiology and other contracted private service providers that support the delivery of sustainable and high value health services from CQ Health facilities.
- Queensland Nursing and Midwifery Union, Australian Workers Union, Together Union and other industrial representatives to ensure the respect of our employee's working conditions.
- Queensland Treasury Corporation who partnered with CQ Health to develop and implement a business optimisation program.

1.3.4. Great Learning and Research

Great place to learn, research and shape the future of healthcare

Great Learning

The CQ Health Education and Research Unit delivered more than 650 programs across the health service in 2018-19 covering a large range of topics and locations.

CQ Health's mandatory training completion rate was 91 per cent on 25 May 2019.

Anaesthesia and Perioperative Care

State-wide Anaesthesia and Perioperative Care Clinical Network (SWAPNET) training is a simulated emergency scenario in the surgical theatre providing a great opportunity to improve team work, communication skills and identify improvements in the flow of emergency events. It was a collaboration presentation with Clinical Skills Development Service (CSDS), SWAPNET and CQ Health working together to improve patient safety.

Paediatric Education

Paediatric education is a specific target and includes:

- Sick child workshops
- Paediatric roadshows for rural nurses
- Regular simulator training in paediatric ward with collaboration between the Special Care Nursery and postnatal/birth suite.

- Optimus Prime - advanced training on preparing for retrievals in medical emergencies in paediatrics in a collaborative effort between Brisbane STORK team, Intensive Care Unit, Emergency Department and Paediatric Unit. The simulation-based training is now an ongoing course in our training calendar.
- The Paediatric Education Newsletter is a new initiative to get the word out for busy nurses with limited time to check emails but want to know what education is on offer to upskill them.
- Clinical nursing journal developed by the clinical facilitator and educator to improve monitoring of clinical competence in paediatric nurses.

Sepsis Education

Sepsis is a major cause of morbidity and mortality worldwide. In Queensland sepsis has increased from 13,087 episodes in 2013-14 to more than 21,000 episodes recorded in 2016-17 equating to 58 episodes each day. In 2016-17 more than 2000 of these patients died.

Rockhampton Hospital is part of the State sepsis collaborative which aims to reduce sepsis mortality and length of stay by reliably recognising and promptly treating sepsis. The Rockhampton Emergency Department is one of 16 participating in the collaborative from August 2018 to December 2019. Rockhampton Emergency Department was a pilot site for the paediatric sepsis pathway developed through Clinical Excellence Queensland in August 2018 and has since adopted the adult pathway.

As part of the collaborative, representatives of the CQ Health Sepsis project implemented evidence-based practices aimed at reducing harm to adults and children from sepsis.

Suicide Prevention training

Queensland Health data from 2015 showed that one in four people who died by suspected suicide had contact with a hospital and health service within seven days of their death. Research indicates that one in five people have contact with a primary health provider, such as a GP, within one week of their death.

The Suicide Risk Assessment and Management in the Emergency Department Course in delivered via e-learning and face to face and designed to enhance existing knowledge and skills of clinicians delivering care in an emergency department context, working with patients who are at risk of suicide by increasing awareness of personal reactions to suicidal people and their impact on practice, increasing participant capacity to develop a therapeutic alliance with a suicidal person and increasing knowledge and skills in suicidal risk assessment and management with the context of an emergency department.

Prevent Alcohol and Risk Related Trauma In Youth (P.A.R.T.Y) program

The P.A.R.T.Y. Program is presented in hospitals by clinicians caring for trauma patients. The RBWH P.A.R.T.Y. Program continues to receive funding from Department of Transport and Main Roads and AAMI which has enabled the expansion of the program to many sites including Rockhampton. It is a unique education experience aimed at changing behaviours and improving risk awareness in youth. It arms students with the necessary information required to make informed choices in relation to alcohol, drugs and risk-taking behaviour. Access by the students to the hospital and various departments enhances the messages and information

delivered. An injury survivor presents on the day to talk about the real impacts of trauma on life.

Expansion of Simulation Pocket Sites

CQ Health has a hub-and-spoke simulation concept and now has five Clinical Skills Development Service affiliated pocket sites in two more being developed. The Emerald simulation pocket site, a collaborative project between James Cook University, Queensland Ambulance Service and CQ Health, was opened in March 2019.

The Emerald facility includes a resuscitation room, area for three skill stations and computer access. The ambulances can drive right up to the door and it enables collaborative training between Queensland Ambulance Service, CQ Health and students.

An additional 16 simulation providers were trained in the first half of 2019.

CQU Post Graduate Program for Graduate Registered Nurses

In 2018 CQUniversity and education and research units from CQ Health, Cairns, Mackay, Wide Bay and Metro North health services implemented a new education course for graduate nurses on entry to the workforce. On completion of the program the graduates will be eligible for a Post Graduate Certificate in Nursing.

In the 2018 calendar year, 14 graduates participated in the program and in February 2019, 20 graduates enrolled. This program also supports experienced registered nurses to gain a higher level degree by providing an opportunity to recognise prior learning in the clinical context and provide an advanced standing into their enrolment into a master's program.

Rural Skills Workshop

This three-day program ensures staff in rural facilities have the knowledge and skills to deliver safe, evidence-based care to rural communities. It covers emergency maternity, infant resuscitation, mental health, triage, emergency management, plastering, assessment skills, retrieval processes and practical skills stations.

Books 2 Bedside

This training is delivered in collaboration with CQUniversity and was a Health Service Awards 2018 finalist in Improvement and Innovation Awards.

It enhances the skills and knowledge learnt at university and clinical placements, so the students can transition into the workplace as a graduate, more effectively and with improved confidence. It has delivered improved transition into the workplace particularly in areas such as: clinical communication; medication safety; hand hygiene; simulation training and clinical assessment.

Great Research

CQ Health strategic planning day for research was held in April 2019 and the strategy is currently being finalised. It will include the vision to deliver a dedicated research workforce, develop research resources and funding and effective partnerships that support translational research that respond to the health needs of Central Queenslanders.

Research and Evidence-Based Practice

The Education and Research Unit facilitates evidence-based nursing through a variety of sources. The Health Sciences Library provides resources and training to assist staff in locating evidence to support their clinical practice. Education and Research has established access for the organisation to Lippincott Procedures to assist with evidence-based, point-of-care information for clinicians.

The unit has a number of collaborative research projects with industry partners in progress and is developing an introduction to research course for nursing and allied health services with CQUniversity.

Research Ready Grant Program

The Research Ready Grant Program is a collaborative project involving CQ Health, CQUniversity and The University of Queensland. The program was one of the two finalists at the Faculty of Medicine excellence awards in the category of collaborator of the year in 2018.

The eight week workshop program culminates with the development of a research proposal. The team may choose to submit an application to the Research Ready Committee to apply for a research grant to operationalise the proposal.

$7000 grants are awarded to successful applicants who have developed a research proposal that meets assessment criteria.

Success of the program highlights the appetite for research among CQ Health staff. In 2018, its first year, there were 25 teams vying to be one of nine funded projects and that increased to 27 teams in 2019.

Human Research Ethics Committee

CQ Health's Human Research Ethics Committee operates in accordance with the *National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research* (2007), the Australian Code for the Responsible Conduct of Research and the CPMP/ ICH Note for Guidance on Good Clinical Practice to support research within CQ Health.

The committee reports annually to the National Health and Medical Research Council and remains a non-certified committee. The committee continues to meet monthly to review research proposals and was involved in considering the research proposals submitted by participants of the Research Ready Grant Program.

Two members of the research ethics committee were supported to attend the Australasian Ethics Network Conference when it was held in Townsville and members were also supported to complete HREC Essentials training provided by PRAXIS.

1.3.5. Sustainable Future

Securing the future of great healthcare with efficient, effective, affordable and sustainable services

2018-19 was a turnaround year financially and operationally for CQ Health.

Following a financial deficit in 2017-18, the health service did a major review of the sustainability of its operating model and, together with Queensland Treasury Corporation, implemented a far-reaching business optimisation program.

Over the course of 2018-19, and despite increased demand in virtually every service category, the health service lifted its performance, delivering more clinical activity to the people of Central Queensland than was contracted by the Department of Health. This was made possible by increased engagement and collaboration with clinicians and included the introduction of new extended care medical models at Gladstone and Capricorn Coast hospitals.

The CQ Health balance sheet was reviewed and strengthened – with updated asset and other valuations, close-out of several long-standing audit concerns, and correction of various prior year accounting entries; all of which had the potential to adversely impact performance in future years if not resolved.

The work was overseen by the CQ Health Board and completed in collaboration with Department of Health and internal and external auditors.

CQ Health delivered a small operating surplus and stronger financial foundations, preparatory to implementing a new financial and costing system in 2019-20.

CQ Health also completed important capital investment projects, including:

- a major refurbishment at the North Rockhampton Nursing Centre
- a new central sterilising department at Rockhampton Hospital, and
- a multi-level car park at Rockhampton Hospital.

Work also started on the $42 million Gladstone Hospital Emergency Department and outpatients upgrade, which will be complete in mid-2020.

In the year ahead, CQ Health will continue its focus on investing in the maintenance of its facilities, the replacement and introduction of new clinical equipment, and the opening of a six-bed cardiac care unit at Rockhampton Hospital, to treat patients closer to home.

Capital Projects

Rockhampton Hospital Car Park construction started on 11 December 2017 and was officially opened by Minister for Health and Minister for Ambulance Services Steven Miles on 20 March 2019.

The $25.5 million project delivered a four-level building containing 597 carpark spaces with capped pricing of $2 an hour or $10 a day for patients or visitors and $4 for staff. Extensive concessional rates are also available.

From March to June 30, the car park hosted 52,000 paid visitors, 21,000 staff visits, 5000 long-term concession passes and 3200 pension concession passes. The cost of pension concession in four months was $5983 and long-term concessions cost $49,870.

The Academic Centre at Rockhampton Hospital was completed on 31 May 2019 and opened on 7 July 2019. The $800,000 project was jointly funded by CQ Health Medical Trust and The University of Queensland. The space will bring together students, the community, academics and clinicians and sets the scene for the proposed 2022 full medical program.

North Rockhampton Nursing Centre underwent $8.5 million of upgrades with the upgraded Cec Pritchard Wing and new kitchen opened in June 2019.

The Cec Pritchard Wing was the oldest of three wings at the centre and its 40 residents enjoy the more modern and spacious design delivered by the $5.7 million program.

The new $2.7 million kitchen provides the capacity for the 120 centre residents to have a choice of meals.

Gladstone Emergency Department - The main construction works tender was awarded on 7 December 2018 to Woollam Constructions and work on the emergency department construction started on 14 January 2019.

Construction of the $42 million ED is expected to finish mid-2020. The project includes moving the department to the front entrance of the hospital, in a new 3000sq m building, a new main entrance and a linkway to the existing hospital and car park. It will have 36 treatment spaces, more than double the 15 spaces in the current emergency department.

When construction is finished and the department fully operational, the current emergency department will be redeveloped to provide an upgraded Specialist Outpatient Department.

1.4. Aboriginal and Torres Strait Islander health

Almost seven per cent of the CQ population identifies as Aboriginal and Torres Strait Islander people and the health gap is stark – a 12-year gap in life expectancy. Half will die before 58 years of age.

CQ Health's vision is to close the health gap for Aboriginal and Torres Strait Islander people living in Central Queensland by 2030. Success will be challenging, but a new team will play an important role in success.

During the reporting period CQ Health established an Aboriginal and Torres Strait Islander Health and Wellbeing Unit and appointed the inaugural director. The director will engage with Aboriginal and Torres Strait Islander communities and Elders, patients, families and carers, patients, and health delivery partners to:

- plan and deliver a closing the gap in health outcomes strategy for Central Queensland
- deliver a plan that meets the Statement of Action through a comprehensive Closing the Gap Health (and Wellbeing) Plan and Workforce Action Plan addressing Aboriginal and Torres Strait Islander health needs
- deliver an improved leadership and governance structure to support the health and wellbeing of patients, staff and services to meet the Closing the Gap in health outcomes targets in Destination 2030.

Following further and comprehensive consultation with all Traditional Owner Groups, Aboriginal and Torres Strait Islander people, CQ Health staff and other partners, a draft Closing the Gap in Health and Wellbeing for Aboriginal and Torres Strait Islanders in Central Queensland will be released in June 2020.

Initiatives that will deliver integration and collaboration with other service providers across Queensland and Commonwealth agencies to further health service delivery, scope, partnerships and place-based health initiatives include:

- Pathways to employment – grow your own. This involves a range of activities from: working with CQUniversity to establish specific education pathways; develop pathways in partnership with other service providers; establishing casual employment pools; recruit to vacant identified roles; and develop a training register based on a skills audit
- Community engagement and marketing to build internal and external engagement, develop an engagement and marketing strategy
- Pathways to better health care to deliver models of care that better align with culturally responsive health care
- Leadership and governance delivering strengthened Aboriginal and Torres Strait Islander leadership and guidance in the delivery of culturally appropriate health care in Central Queensland
- Culturally capable health services by placing the Aboriginal peoples and Torres Strait Islander peoples at the centre of the health service they need.

Closing the Gap performance

	2018-19	Change since last year
Childhood Immunisation [a]		
All children 1 year	94.8%	-0.6 p.p.
All children 2 years	92.9%	0.2 p.p.
All children 5 years	95.6%	0.2 p.p.
Discharge against medical advice [b]	1.5%	0.0 p.p.
Non-Aboriginal and Torres Strait Islander	1.3%	0.0 p.p.
Aboriginal and Torres Strait Islander	3.3%	-0.5 p.p.
Women who gave birth and attended 5 or more antenatal visits [b] [10]	95.1%	0.0 p.p.
Non-Aboriginal and Torres Strait Islander	96.5%	0.2 p.p.
Aboriginal and Torres Strait Islander	83.9%	0.0 p.p.
Completed general courses of oral health care [c]	18,850	-442
Non-Aboriginal and Torres Strait Islander	17,121	-304
Aboriginal and Torres Strait Islander	1,729	-138
Mothers who had > 5 antenatal visits, with first visit in the 1st trimester d [12]	56.4%	N/A
Non-Aboriginal and Torres Strait Islander	56.6%	N/A
Aboriginal and Torres Strait Islander	55.6%	N/A

[10] Data presented as Mar-19 FYTD.

[11] New data collection commenced in Dec-18. Preliminary data is available for the period Dec-18 to May-19.

[12] New data collection commenced in Dec-18. Preliminary data is available for the period Dec-18 to May-19. Lag of data due to trimester reporting. Data is only collected after the birth of the baby and is available for reporting two to three months after this event. It is a prerequisite that HHSs must also maintain their performance with respect to the performance standards under this QIP in terms of non-Indigenous mothers.

Source: [a] Communicable Diseases Unit, [b] Health Statistical Branch, [c] Oral Health Service, [d] Healthcare Purchasing Strategy Unit

1.5. Our community based and hospital based services

CQ Health is responsible for providing public hospital and health services including medical, surgical, emergency, obstetrics, paediatrics, specialist outpatient, mental health, critical care and clinical support services.

It also provides mental health services, oral health services, offender health services and aged care services, with facilities also providing community health services.

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

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

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

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

Outpatient clinics are located at:

- Boyne Valley
- Capella
- Gemfields
- Tieri.

Aged care facilities are located at:

- North Rockhampton Nursing Centre
- Eventide Nursing Home.

1.6. Targets and Challenges

CQ Health's targets are clearly identified in *Destination 2030: Great Care for Central Queenslanders* and include:

- 10,000 fewer lives lost to smoking-related disease
- 10,000 fewer patient journeys for Central Queenslanders
- Best patient experience in Queensland
- One of the best staff experience in Australia
- Digital revolution to connect heath across Central Queensland, improving safety and clinical outcomes
- Patients engaged in everything we do and a digital transformation providing patient access to health anytime, anywhere
- Close the gap in Aboriginal and Torres Strait Islander life

expectancy

- A centre for translational research expertise which improves care in Central Queensland
- Great partnerships delivering exceptional care, excellent learning and clinical research
- Major investment program to transform care, access, outcomes and experience
- Centre of learning excellence for rural medical, nursing, allied health and Aboriginal and Torres Strait Islander health staff.

Key challenges, and CQ Health's response to those challenges, include:

- **Failure to meet accredited or industry benchmark quality and safety standards** – continue to develop robust systems that measure, evaluate and implement improvements in quality and safety governance and performance
- **Asset and ICT infrastructure to meet Destination 2030 vision** – continue to develop a strategy for service-wide implementation of electronic medical records. Develop and benchmark project infrastructure delivery
- **Insufficient workforce resources to meet service delivery and business needs** – continue to design a Workforce Capability Development Framework and improve all aspects of the recruitment function
- **Failure to meet financial and business unit performance expectations** – continue to develop a medium term (five year) financial model to complement Destination 2030.

Chapter 2
Governance

2.1. Our people

2.1.1. Board membership

Cr Paul Bell AM (Board Chair)

Date of original appointment: 25 September 2015
Current term of office: 18 May 2017 - 17 May 2020

Mr Paul Bell AM was appointed as Chair of the Central Queensland Hospital and Health Service Board in May 2016. Paul has a long history of board leadership in the health, energy, rail, superannuation and community service sectors.

Paul has a strong belief in the public sector and its ability to deliver, given the right leadership and clear objectives.

Paul is Chair of the Central Highlands Healthcare Ltd Board and a director of the Central Highlands (Qld) Housing Company Ltd. He presently serves as a Councillor on his local council, a position he has held continuously for the past 34 years.

In 2005, Paul was awarded the Order of Australia, General Division. He has a Bachelor of Business Administration (BBus Admin. CQU) and is a Member of the Australian Institute of Company Directors.

Mr Matthew Cooke

Date of original appointment: 18 May 2019
Current term of office: 18 May 2019 - 31 March 2022

Mr Matthew Cooke is a proud Aboriginal and South Sea Islander man from the Lailai (Byellee) people in Gladstone, Central Queensland.

Matthew joins the Central Queensland Hospital and Health Board having a background in serving the Aboriginal and Torres Strait Islander Community Controlled Health Sector as both a Director and CEO over the past 10 years. Mr Cooke is currently the Chief Executive Officer for the Gladstone Region Aboriginal and Islander Community Controlled Health Service Limited t/a Nhulunda Health Services.

Matthew is actively involved in all aspects of Aboriginal and Torres Strait Islander affairs at national, state, regional and local levels. In 2007 he was named Young Leader in Aboriginal and Torres Strait Islander Health, in 2008 received the Deadly Vibe Young Leader Award and in 2011 received the Australian Institute of Management 2011 Young Manager of the Year Award – Gladstone.

Mr Cooke is also a member of the Australian Institute of Company Directors.

Professor Leone Hinton

Date of original appointment: 29 June 2012
Current term of office: 18 May 2019 – 17 May 2020

Professor Leone Hinton is a retired education and management consultant. Her previous employment was 30 years at CQUniversity as Dean of School, Nursing, Director, Corporate Strategy and Planning And Academic. Professor Hinton's expertise in this area was recognised when in 2011 and again in 2017 she was awarded the Australian Institute of Managers and Leaders, Central Queensland Professional Manager of the Year. Her interests are in organisational culture, governance, strategic planning and risk management.

Professor Hinton began her career as a registered nurse working at the Mater Children's and Rockhampton Hospitals before changing career paths to nursing training, education and research at the CQUniversity. Leone is a Fellow of the Australian Institute of Managers and Leaders and Fellow of the Australian Institute of Governance.

Professor Hinton has a Doctor of Professional Studies (Transdisciplinary) and has a Master of Education (Education Administration), Graduate Diploma of Education (Tertiary) and is a Justice of the Peace.

Ms Tina Zawila

Date of original appointment: 18 May 2019
Current term of office: 18 May 2021 - 31 March 2022

Ms Tina Zawila has more than 30 years' experience in the finance industry. She is a Chartered Accountant, financial planner and business advisor and director of a public accounting firm in Gladstone.

She is a non-Executive Director of Gladstone Airport Corporation, Chair of the Corporation's Finance and Audit Committee and a member of the Nominations, Remuneration and Human Resources Committee.

Ms Zawila also serves on local not-for-profit boards including Gladstone Area Group Apprentices and EQIP Gladstone.

Ms Zawila holds a Bachelor of Business (Accounting) with Distinction and Diploma of Financial Planning. She has completed the Australian Institute of Company Directors course and is a Fellow of the Institute of Managers and Leaders.

Mr Andrew Ireland

Date of original appointment: 18 May 2019
Current term of office: 18 May 2019 - 17 May 2021

Mr Andrew Ireland has forty years of senior management experience in strategic and operational management within local government, the VET sector, the tertiary education sector and private enterprise.

He has facilitated and operationalised change, provided strategic and operational management services and been responsible for financial management, corporate governance and stakeholder engagement.

Mr Ireland holds a Master of Business Administration, a Graduate Diploma in Management, a Bachelor of Business (Accounting) and a Bachelor of Education Studies. Mr Ireland is a Fellow, CPA Australia.

Dr Poya Sobhanian

Date of original appointment: 18 May 2016
Current term of office: 18 May 2017 – 17 May 2021

Affectionately known as Dr PJ by his patients, PJ is passionate about health services for all Australians. PJ is a University of Queensland trained dentist, who undertook his placement at the local hospitals of Rockhampton, Yeppoon and Emerald. He later helped serve publicly at the Gladstone Hospital. Subsequently PJ set up the Gladstone dental practice of Sunvalley Dental.

In addition to his small business background, PJ has extensive governance experience, including being past Chair of the Gladstone Regional Council's Commercial Services Committee and member of the internal audit Business Improvement Committee, as well, as a non-Executive Director at the Gladstone Area Water Board and member of that entity's Information Technology Optimisation Committee. PJ strongly believes in working together to best drive results for our community.

Dr Anna Vanderstaay

Date of original appointment: 18 May 2016
Current term of office: 18 May 2017 – 17 May 2021

Dr Anna Vanderstaay is a local GP and has worked in a number of rural and remote areas of Queensland. Born and raised in Rockhampton, Dr Vanderstaay has worked in a number of hospitals throughout the state, across a number of clinical specialties, and brings valuable health knowledge to the Board. She is also an active member of the local primary healthcare team.

Mrs Lisa Caffery

Date of original appointment: 18 May 2016
Current term of office: 18 May 2017 – 17 May 2021

Mrs Lisa Caffery is an experienced analytical and strategic professional in the specialist fields of social impact, community engagement and communications. Mrs Caffery is a self-employed consultant with leadership and governance experience across the private and public sectors.

She has held numerous advisory and strategy development roles in mining, local government, not-for-profit and regional development sectors. In January 2018, Mrs Caffery was awarded a Research Higher Degree Scholarship from Central Queensland University to undertake a Doctor of Philosophy (PhD). Mrs Caffery's research focus is in health, rural and remote communities and social impact.

Mrs Caffery holds a Bachelor of Arts (Journalism), a Master of Public Relations and is a graduate of the Australian Institute of Company Directors. Mrs Caffery resides in the rural town of Emerald in the Central Highlands and is committed to improving health services and outcomes for people living in regional areas.

Ms Leann Wilson

Date of original appointment: 18 May 2019
Current term of office: 18 May 2021 - 31 March 2022

Ms Leann Wilson is the Executive Director of Regional Economic Solutions (RES), which is a majority Indigenous owned business in partnership with the global engineering and project management company Ausenco. RES's focus is to identify opportunities to secure local businesses and employment into project supply chains and engage with stakeholders to support business government and Indigenous groups to create sustainable economic and social development outcomes.

Ms Wilson is a 2016 Reconciliation Award Winner (Qld) and has been a category finalist in the Telstra Business Woman of the Year. Ms Wilson joins the Board having extensive experience on boards including being Chair of the National Rural Women's Coalition, Deputy Chair on the National Aboriginal & Torres Strait Islander Healing Foundation, and board member of Australian Rural Leadership Foundation, Australian Red Cross Queensland Division and the Queensland Government Aboriginal and Torres Strait Island Business Innovation Reference Group. Ms Wilson is also a member of Directors Australia.

Immediate past members

Graeme Kanofski: 18 May 2013 to 17 May 2019

Frank Houlihan: 9 November 2012 to 17 May 2019

Elizabeth Baker: 20 May 2013 to 17 May 2019

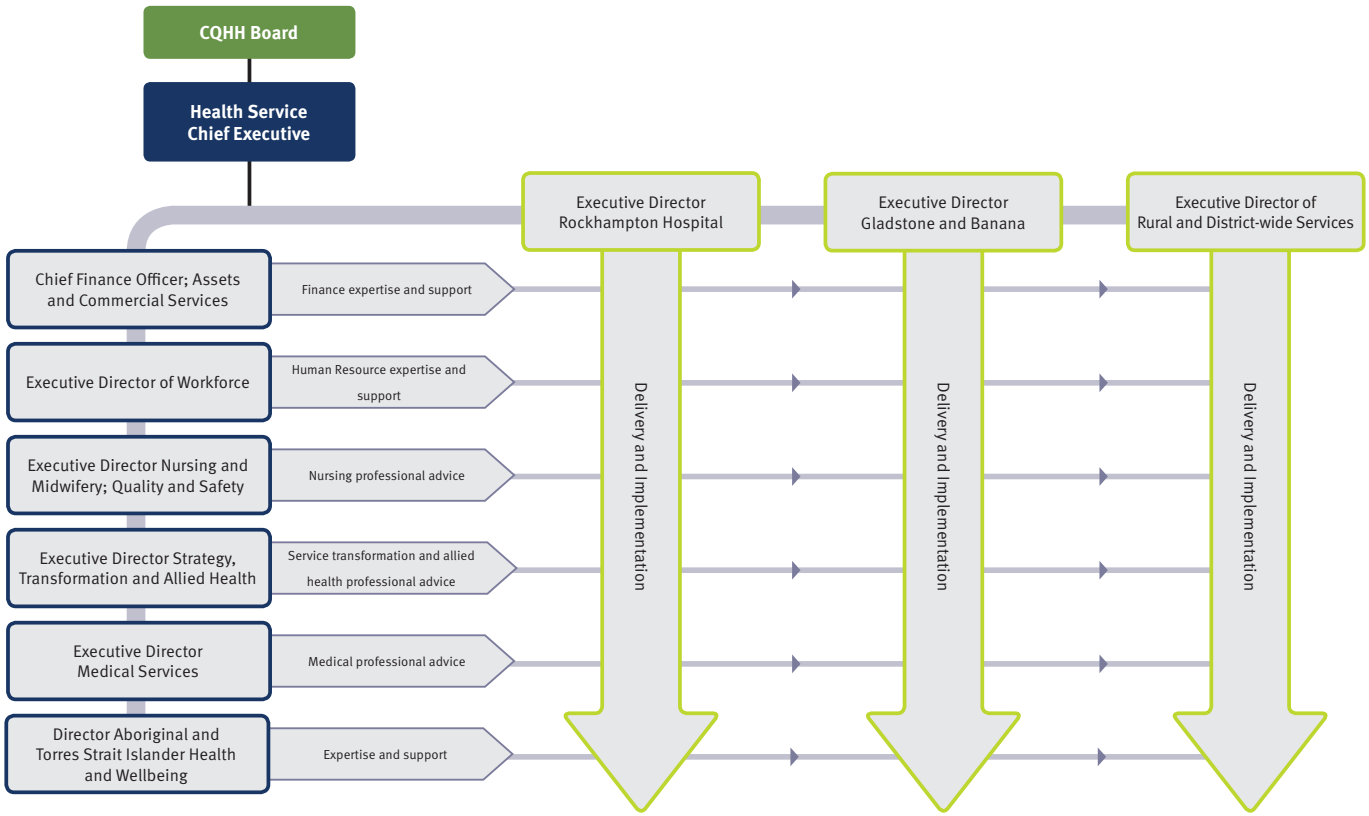
Karen Smith: 18 May 2014 to 17 May 2019

2.1.2. Government bodies (statutory bodies and other entities)

Central Queensland Hospital and Health Board						
Act or instrument	*Hospital and Health Boards Act 2011*					
Functions	The Central Queensland Hospital and Health Board controls the Central Queensland Hospital and Health Service					
Financial reporting	Transactions of the entity are accounted for in the financial statements					
Remuneration						
Position	Name	Meetings/ sessions attendance	Approved annual fee	Approved annual sub- committee fee per committee	Number of Committees	Actual fees received
Chair	Cr Paul Bell AM	11	$75,000	$4,000 (as member	4	$91,000
Deputy Chair	Mr Graeme Kanofski	7	$40,000	$4,000 (as Chair) $3,000 (as member)	1 1	$43,000
Member	Dr Leone Hinton	8	$40,000	$4,000 (as Chair) $3,000 (as member)	1 2	$48,000
Member	Mr Francis Houlihan	9	$40,000	$4,000 (as Chair) $3,000 (as member)	1 1	$41,000
Member	Ms Lisa Caffery	10	$40,000	$4,000 (as Chair) $3,000 (as member)	1 2	$51,000
Member	Ms Elizabeth Baker	7	$40,000	$4,000 (as Chair)	1	$41,000
Member	Dr Poya Sobhanian	11	$40,000	$4,000 (as Chair) $3,000 (as member)	1 2	$46,000
Member	Dr Anna Vanderstaay	11	$40,000	$4,000 (as Chair) $3,000 (as member)	1 2	$49,000
Member	Ms Karen Smith	8	$40,000	$3,000 (as member)	1	$38,000
Member	Mr Matthew Cooke	2	$40,000	$3,000 (as member)	2	$5.000
Member	Ms Leann Wilson	2	$40,000	$3,000 (as member)	2	$5,000
Member	Ms Tina Zawila	2	$40,000	$3,000 (as member)	2	$5,000
Member	Mr Andrew Ireland	2	$40,000	$3,000 (as member)	3	$5,000
No. scheduled meetings/ sessions	11 Board Meetings					
Total out of pocket expenses	$2,189.76					

2.1.3. Organisational structure and workforce profile

Executive structure



Executive management

Steve Williamson – Health Service Chief Executive

Steve has significant health leadership experience across hospital, community health, aged care, other health and care services, and in military hospitals. Steve moved from the UK in early 2017 to become Health Service Chief Executive for CQ Health which provides hospital and health services across a regional and rural area of over 110,000km to a population of over 220,000 Central Queenslanders.

During his first year, Steve led the development of *Destination 2030: Great Care for Central Queenslanders*, the hospital and health service's long-term strategic vision. This vision will deliver great care for Central Queenslanders, enabling improved health, closing the gap in Aboriginal and Torres Strait Islander health outcomes, supporting more care closer to home in Central Queensland, and shaping the future of health across the Central Queensland region.

Steve has also been a Chief Executive in a combined Hospital and Community Healthcare Foundation Trust in the NHS in England, as well as senior leadership roles in local government and in the UK's Courts Service. Steve moved to Central Queensland with his wife Jacqueline, their two children Josh and Daisy who are at school in Rockhampton, and their dog Toffee.

Steve is an Adjunct Professor at CQUniversity and plays A3 hockey for his local club.

James Kelaher – Chief Finance Officer; Assets and Commercial Services

James has held leadership and board roles in the private and public sectors encompassing health, health insurance, ICT, research and development.

James holds a bachelor's degree in Arts/Commerce, an MBA (with specialisations in strategy, international finance and operations management), and is a Fellow of the Australian Society of Certified Practising Accountants. He is a former Deputy Secretary in the Commonwealth Government and Deputy Managing Director of the Health Insurance Commission and has previously been the Chief Finance and Corporate Officer of the Metro North Hospital and Health Service, where he oversaw successive years of strong financial performance.

James recently joined CQ Health as its interim Chief Finance Officer also responsible for capital acquisitions, ICT and commercial services.

He is internationally accredited in project management (accredited PRINCE2/MSP practitioner and Gateway assessor) and is a member of the Australian Institute of Company Directors, the Risk Management Institute of Australia, the British Computing Society and the International Association of Privacy Professionals.

Dr Julieanne Graham – Executive Director of Medical Services

Dr Julieanne Graham has been with CQ Health since November 2016 and was appointed Executive Director of Medical Services in July 2018.

Dr Graham grew up in Clermont, Central Queensland, and now lives by the beach with her family in the beautiful Capricorn Coast region. She graduated from Medicine at University of Western Australia in 1998 and has Master of Public Health from the University of Queensland, Fellowships from the Royal College of General Practitioners, the Royal College of Medical Administrators and the Australasian College of Health Service Managers.

Over the last 20 years she has worked in both public and private practice, in front line clinical and senior management roles. These have included working as a GP independent contractor in multiple locations; a GP Owner and Director at Mayfair Medical Centre; a Senior Medical Officer at Mater Children's, at Family Planning Queensland and at the Inala Centre of Excellence in Indigenous Primary Health Care; the Director of Medical Services, Redland Hospital; the Deputy Director of Medical Services, Metro South; the Chief Medical Officer, Queensland Aboriginal and Islander Health Service; and the Director of Medical Services, Central Highlands. She is currently a supervisor for the RACGP training program in Capricorn Coast and Central Highlands, a supervisor and mentor for the RACMA candidate training program across the health service and sits as Faculty on the AFRACMA training program for Rural Generalists in Queensland. Dr Graham has recently completed training in forensic sexual assault examinations and is part of a small group of doctors in Central Queensland providing first response care to victims of sexual assault.

Dr Graham is passionate about patient care and reducing health inequalities for rural, regional Australians. She believes that creating a sustainable medical workforce in Central Queensland is the key foundation to reducing health inequalities in the bush. She is a strong advocate for

the Rural Generalist Program and has seen its success in sites such as Emerald and Biloela. Dr Graham would love to see an end to end medical program in Central Queensland and help train local students to be our next generation of doctors.

Susan Foyle – Executive Director Nursing and Midwifery; Quality and Safety

Sue is an experienced nurse and midwife of over 30 years. Sue's background is predominantly in midwifery, but also has intensive care and emergency nursing expertise.

Sue has extensive management and leadership experience in maternity services and in clinical governance and is passionate about ensuring there are systems in place to maintain and improve the reliability, safety and quality of health care delivered to Central Queenslanders.

Sue joined CQ Health in 2016 as the Director of Nursing and Midwifery for Rockhampton Hospital and Director of Maternity Services for Central Queensland. More recently Sue has been appointed to the Executive Director Nursing, Midwifery; Quality and Safety role.

Kerrie-Anne Frakes – Executive Director. Strategy, Transformation and Allied Health

Kerrie-Anne is the Executive Director Strategy, Transformation and Allied Health. Prior to this she was the Director, Clinical Support Services and Lead Allied Health Practitioner for CQ Health.

She has an extensive history in developing and implementing innovative models of care delivering transformational service changes and improved health outcomes for Central Queenslanders. The most notable include Capricorn Allied Health Partnership Interdisciplinary Student Clinic Model; Introduction of telehealth services to Central Queensland; and as the executive lead for Outpatient Services reduced the long waits to zero (across all specialities) and maintained these for over two years.

She has won state and national awards for innovative models of care and has an extensive publication history in chronic disease management and service delivery.

Kerrie-Anne first came to Central Queensland in 1999 as a Queensland Health Rural Scholarship Graduate in Podiatry as the first public podiatrist in the Central Queensland region. She has been the Director of Podiatry and State-wide Podiatry Chair.

She is passionate about regional and rural community capacity with a focus on workforce sustainability and care for patients closer to home.

Robert Forsythe – Acting Executive Director, Rural and District Wide Services

Robert has recently been appointed as Acting Executive Director Rural and District Wide Services (RDWS). The RDWS portfolio is responsible for delivering subacute, ambulatory and community health, mental health, oral health, offender health, aged care, public health, geriatric, rehabilitation and transition care services across the health service and is

responsible for managing the delivery of health care at Emerald Hospital and three MPHSs (Blackwater, Springsure and Woorabinda).

Robert is a long-term employee of CQ Health, having worked as Director of Pharmacy since 2006.

Robert's interest lies in the science of organisational improvement and he has completed several secondments over the past five years on service improvement projects. After completing accreditation as an Improvement Advisor with the Institute for Healthcare Improvement in 2017, Robert assists Clinical Excellence Queensland on the Statewide Sepsis Collaborative.

Originally from Belfast, UK, Robert worked in a variety of pharmacy jobs in the UK, Channel Islands, Germany and the middle east before settling in Queensland.

Sandy Munro – Executive Director, Gladstone and Banana

Sandy has an extensive background in the executive level in Queensland Health including roles as Executive Director of Nursing and Midwifery; Executive Lead for Quality and Safety; Nursing Director for Family Women and Children and Director of Nursing.

Sandy has worked previously in clinical roles across high dependency, intensive care, maternity and emergency and spent time in education and infection control prior to coming into management and Executive leadership roles.

Wendy Hoey – Executive Director, Rockhampton Business Unit

Wendy has worked for Queensland Health since 1995 after emigrating from Scotland.

Wendy's clinical background is nursing with a special interest in mental health nursing, having previously led national and state projects in least restrictive practice and consumer participation.

Wendy has represented the College of Mental Health Nursing on the Independent Hospital Pricing Authority in developing the mental health costing model and has a strong research portfolio with numerous publications relating to mental health nursing and general health outcomes for mental health consumers.

In 2013, Wendy broadened her focus to hospital administration, where she has been a consistent member of the Rockhampton Hospital Leadership Team taking on the role of Executive Director in 2016.

Wendy has worked with medical and other professional streams to improve clinician engagement in service planning and delivery. She is a strong advocate for patient safety and is very proud to have led the Rockhampton Hospital to significant improvements in patient and staff outcomes over the past two years.

Shareen McMillan – Executive Director, Workforce

Shareen is the Workforce Division Executive Director within CQ Health, leading a team of 43 who undertake key projects and activities, including capability and leadership development programs; cultural change including embedding values and staff recognition programs; workplace planning; organisational change; human resource governance; human resource systems including learning management; safety and wellbeing; recruitment services, as well as diversity and inclusion improvement strategies.

Shareen is a recent graduate of the Queensland Health Next Generation Program. Shareen's project *A diverse and inclusive CQ Health workplace* has been acknowledged for its importance and has been endorsed as one of the five key projects under the strategic objective Great People, Great Place to Work within the CQ Health *Destination 2030: Great Care for Central Queenslanders* future strategy.

Shareen has worked in various government agencies and has a wide range of expertise in organisational and cultural change management; training and development; strategic and operational planning and reporting; employee and stakeholder engagement, performance and project management.

Shareen holds a degree in communications, japanese language and tourism, receiving high distinction for her studies and a Japanese Language Award. Shareen has also completed a Graduate Diploma in Business Administration and Management with credit.

Sharni Tippett – Director, Aboriginal and Torres Strait Islander Health and Wellbeing

Sharni Tippett is a Barunggum/Garawa woman, qualified social worker and has been a long-time campaigner for Aboriginal and Torres Strait Islander community development and equity of access to systems and services to build healthy communities across Queensland and the Northern Territory.

As our first incumbent into the newly created Director, Aboriginal and Torres Strait Islander Health and Wellbeing position, she has begun the process of re-establishing the Hospital and Health Service's policy, staffing and investment planning for Aboriginal and Torres Strait Islander Health and Wellbeing. The recruitment and establishment of her office, included embarking on intensive engagement with Woorabinda partners, our staff, establishing Aboriginal and Torres Strait Islander leadership advisory committees and informing national standards.

Sharni is a member of the Executive Management Team and will be intrinsic to the development of the Board's Aboriginal and Torres Strait Islander Advisory Committee, building partnerships with Elders, Community Groups, Aboriginal and Torres Strait Islander community health organisations in the region and importantly providing guidance to the health service executive and Board on the changes that will be required to build a culturally responsive, capable and accessible health service.

In her previous roles, Sharni held the position of Manager, Remote and Statewide Engagement, working across the breadth of Queensland providing quality advice on policy development; Manager, Aboriginal and Torres Strait Islander Health Services, Metro North Hospital and Health Services and Social Worker for the Department of Human Services working

across Logan, Inala and South Brisbane.

As a skilled project manager, Sharni oversaw multiple complex programs with the former Department of Employment Workplace Relations in the Northern Territory at a time when Aboriginal peoples were impacted by the Northern Territory Intervention, delivering child care buildings and extensive cross-agency negotiations to establish self-governance for community. This involved engaging Traditional Owners in remote Western Arnhem, Daly River, Numbulwarr and eastern Darwin locations.

More doctors and nurses*

	2014-15	2015-16	2016-17	2017-18	2018-19	Number increase in staff
Medical staff [a]	237	257	287	313	328	15
Nursing staff [a]	1,176	1,212	1,268	1,338	1,385	47
Allied Health staff [a]	283	296	294	317	318	1

Greater diversity in our workforce*

	2014-15	2015-16	2016-17	2017-18	2018-19
Persons identifying as being Aboriginal and/or Torres Strait Islander [b]	77	66	78	92	98

Note: * Workforce is measured in MOHRI – Full-Time Equivalent (FTE). Data presented reflects the most recent pay cycle at year's end.

Source: [a] DSS Employee Analysis, b Queensland Health MOHRI, DSS Employee Analysis

Separation rate

One of CQ Health's strategic visions is to deliver great people and a great place to work. A measure of the service's ability to retain staff is the permanent separation rate. During 2018-19 that rate was 6.56 per cent.

2.1.4. Awards and recognition

CQ Health recognises and rewards its staff for the great care they deliver every day and the way in which they deliver that care.

Living the values of CQ Health is a key element in the rewards and recognition program. Displaying care, integrity, respect and commitment in every interaction and every commitment improve the workplace culture and patient experience.

July is CQ Health's staff recognition month in which the achievements during the previous financial year are celebrated. Those who reach a length of service milestone in the previous financial year – in five-year intervals starting at 10 years of service – celebrate with certificate presentation at a until or facility function. Most presentations are recognised with a photograph being published in staff newsletter The Drift.

Staff, team and unit achievements are also celebrated with nominations for awards usually in March or April of the financial year and winners announced at a gala staff function. The staff awards was reintroduced three years ago and creates strong interest and competition among staff.

2.1.5. Strategic workforce planning and performance

The health service is reviewing the endorsed five-year Strategic Workforce Plan and Strategy to ensure alignment with Destination 2030: Great People Great Place to Work objective.

The Workforce Planning Steering Group has been consulted and a gap analysis completed. The Department of Health's *Advancing health service delivery through workforce: A Strategy for Queensland 2017-2026* planning framework and focus area methodology has been used to ensure robust capture of all workforce components in planning:

1. Designing the workforce – Healthcare tasks, roles and teams are constructed in smart, safe and innovative ways. Workforce models harmonise with service models, digital innovation, workforce supply and the needs of a dispersed population.
2. Enabling the workforce – Innovative, streamlined work practices are supported by effective legislative, regulatory, policy and funding frameworks. Employment arrangements promote workforce quality, flexibility and sustainability. Contemporary workforce data systems enable evidence-based workforce planning.
3. Strengthening the workforce – Connections between stakeholders in healthcare, education, training and professional development are strengthened, optimising responsiveness to changing sector requirements. Educational pathways and clinical practice programs are streamline and enhanced.
4. Keeping connected – Strong relationships between health workforce stakeholders enable information sharing and the cultivation of a common understanding about priorities issues.

The Workforce Division Culture and Performance Team and the new CQ Health Strategy Transformation Allied Health Team will continue to work in collaboration to ensure outcomes of workforce priorities are realised.

The health service is also reviewing the *CQ Heath Medical Workforce Plan – Moving Towards 2020* Consultation Draft. This plan focussed on acute services across all facilities and highlighted the pending shortages of medical practitioners across all specialities projected by 2024 with reliance on agency and international medical graduates in rural and regional Queensland. To support this review, profiling of the current and future medical workforce has been completed.

2.1.6. Early retirement, redundancy and retrenchment

During the period, one employee received a redundancy package at a cost of $218,804.43. No early retirement or retrenchment packages were paid during this period.

2.2. Our committees

The Central Queensland Hospital and Health Board has met 11 times since July 2018 and meets monthly.

The Board has four committees – Executive Committee, Finance and Resource Committee, Safety and Quality Committee and Audit and Risk Committee. The composition of the Board's Committees was reconstituted

following the appointment of four new members to the Board following expiring terms of appointment.

Whilst committees are required to meet on a quarterly basis the Finance and Resource Committee has met monthly during 2018-19, the Safety and Quality Committee met seventeen times in preparation for a Coroner's matter, Office of the Health Ombudsman review of maternity services and organisation wide survey by the Australian Council on Healthcare Standards. The Executive Committee met five times to progress the strategic planning *Destination 2030: Great Health Care for Central Queenslanders.*

2.2.1. Executive Committee

The Executive Committee was chaired by Mr Graeme Kanofski until 17 May 2019 with Ms Lisa Caffery approved by the Board as the Chair from 31 May 2019.

The Executive Committee is responsible for supporting the Central Queensland Hospital and Health Board in its role of overseeing the strategic direction of CQ Health. The Committee's scope is to work with the Health Service Chief Executive to progress the strategic issues identified by the Board. The committee therefore works in close cooperation with the Health Service Chief Executive to strengthen the relationship between the Board and the Health Service Chief Executive and to ensure accountability in the delivery of services by the health service.

2.2.2. Finance and Resource Committee

The Finance and Resource Committee was chaired by Mr Frank Houlihan until 17 May 2019. Mr John Frazer, an independent advisor to the Board was approved by the Board as Finance and Resource Committee Chair from 31 May 2019. The Finance and Resource Committee is responsible for monitoring and assessing the financial management and reporting obligations of the health service. It oversees resource utilisation strategies including monitoring the service's cash flow and its financial and operating performance. The committee is also responsible for bringing the attention of the Board to any unusual financial practices. The Finance and Resource Committee works in close cooperation with the Health Service Chief Executive and Chief Finance Officer.

2.2.3. Safety and Quality

The Safety and Quality Committee was chaired by Professor Leone Hinton until 31 May 2019 with Prof Hinton seeing the organisation through the organisation wide survey conducted by the Australian Council on Health Care Standards. Prof Hinton stood down as the Chair of the Committee with existing member Dr Anna Vanderstaay being appointed as the Chair from 31 May 2019.

The Safety and Quality Committee is responsible for advising the Board on matters relating to the safety and quality of health services provided by the service, including the service's strategies to address the maintenance of high quality, safe and contemporary health services to patients. The committee works in close cooperation with the Health Service Chief Executive, Executive Director Nursing and Midwifery, Quality and Safety, and the Director Shared Services.

2.2.4. Audit and Risk Committee

Members of the Audit and Risk Committee as at June 2019 comprised:

- Chair: Dr Poya Sobhanian
- Members: Ms Lisa Caffery, Ms Tina Zawila and Mr Andrew Ireland
- Cr Paul Bell AM (ex-offico as Board Chair)

This membership was reconstituted as result of the appointment of four new members to the Board following expiring terms of appointment.

The membership of the Audit and Risk Committee up to an including 17 May 2019 was:

- Chair: Ms Elizabeth Baker
- Members: Dr Poya Sobhanian and Mr Frank Houlihan, Board Member
- Cr Paul Bell AM (ex-offico as Board Chair)

The Committee has standing rights of attendance for the following positions:

- Health Service Chief Executive
- Chief Finance Officer
- Executive Director Quality and Safety
- Internal Audit
- External Audit

Members of the Board are remunerated for their services to the committee.

The Audit and Risk Committee has observed the terms of its charter and had due regard to the Audit Committee Guidelines. The Audit and Risk Committee considered recommendations made by the Queensland Audit Office including performance audit recommendations.

The Audit and Risk Committee met six times during the 2018-19 period and followed an approved work plan reflecting the committee's charter. The role of the committee is to provide independent assurance and assistance to the Board in the areas of:

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

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

Financial statements

- Reviewing the appropriateness of the accounting policies adopted by the health service and ensure they are relevant to the health service and its specific circumstances.
- Reviewing the appropriateness of significant assumptions and critical judgements made by management, particularly around estimations which impact on reported amounts of assets, liabilities, income and expenses in the financial statements.
- Reviewing the financial statements for compliance with prescribed accounting and other requirements.

- Reviewing, with management and the external auditors, the results of the external audit and any significant issues identified.
- Exercising scepticism by questioning and seeking full and adequate explanations for any unusual transactions and their presentation in the financial statements.
- Analysing the financial performance and financial position and seek explanation for significant trends or variations from budget or forecasts.
- Ensuring that assurance with respect to the accuracy and completeness of the financial statements is given by management.
- Integrity oversight and misconduct prevention.
- Providing oversight, direction and guidance on the health service's integrity framework to ensure it is functioning appropriately.
- Overseeing the health service's Lobbyists Contact Register reporting and any significant integrity issues arising.
- Monitoring the effectiveness of the health service's public interest disclosure process.
- Ensuring the health service complies with relevant integrity legislation (e.g. *Crime and Misconduct Act 2001*, *Public Sector Ethics Act 1994*, *Public Interest Disclosure Act 2010*, *Integrity Act 2009*) and whole-of-government policies, principles and guidelines (including the *Code of Conduct for the Queensland Public Service*).
- Providing advice and recommendations on integrity issues to the Board and Executive Management, as necessary.
- Monitoring health service misconduct trends and prevention approaches and address any gaps in dealing with integrity issues in relation to misconduct (including fraud and corruption).
- Ensuring the health service complies with any Crime and Misconduct Commission requirements and recommendations to improve misconduct prevention and response.

Risk management

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

Internal control

- Reviewing, through the internal and external audit functions, the adequacy of the internal control structure and systems, including information technology security and control.
- Reviewing, through the internal and external audit functions, whether relevant policies and procedures are in place and up to date, including those for the management and exercise of delegations, and

whether they are complied with.

- Reviewing, through the Chief Finance Officer and the System Manager assurance certifications, whether the financial internal controls are operating efficiently, effectively and economically.

Performance management

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

Internal audit

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

External audit

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

Compliance

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

- Reviewing the findings of any examinations by regulatory agencies, and any auditor observations.

Reporting

The Audit and Risk Committee submits minutes to the Board outlining relevant matters that have been considered by it as well as the Committee's opinions, decisions and recommendations.

The Audit and Risk Committee circulates minutes of the committee meetings to the Board, committee members and standing invitees as appropriate.

The Audit and Risk Committee submits a summary of its activities for inclusion in the Health Service's Annual Report.

2.3. Our risk management

2.3.1. Internal audit

The Central Queensland, Sunshine Coast and Wide Bay hospital and health services have established a hub and spoke internal audit function to ensure effective, efficient and economical operation of the function. The function provides independent assurance and advice to the Board Audit and Risk Committee and executive management. It enhances the health service's corporate governance environment through an objective, systematic approach to evaluating internal controls and risk assessment.

The role, operating environment and reporting arrangements of the function are established in the Internal Audit Charter that has been approved by the Hospital and Health Board Chair. The Charter is consistent with the *Institute of Internal Auditors Professional Practices Framework* and the *Audit Committee Guidelines*.

The internal audit function is independent of management and the external auditors. The function has:

- discharged the responsibilities established in the Internal Audit Charter by executing the annual audit plan prepared as a result of risk assessments, materiality, contractual and statutory obligations, as well as through consultation with executive management
- provided reports on the results of audits undertaken to the Health Service Chief Executive and the Audit and Risk Committee
- monitored and reported on the status of the management's implementation of audit recommendations to the Audit and Risk Committee
- liaised with the Queensland Audit Office to ensure there was no duplication of audit effort
- supported management by providing advice on corporate governance and related issues including fraud and corruption prevention programs and risk management
- allocated audit resources to areas on a risk basis where the work of internal audit can be valuable in providing positive assurance or identifying opportunities for positive change.

The audit team are members of professional bodies including the Institute of Internal Auditors, CPA Australia and ISACA. The health services continue to support their ongoing professional development.

2.3.2. External scrutiny, Information systems and recordkeeping

External scrutiny

There are a number of reports which have involved the health sector conducted by the Queensland Audit Office.

For example:

- Access to the NDIS for people with impaired decision-making capability (Report 2: 2018-19)
- Managing transfers in pharmacy ownership (Report 4: 2018-19)
- Delivering coronial services (Report 6: 2018-19)
- Digitising hospitals (Report 10: 2018-19)
- Health: 2017-18 results of financial audits (Report 13: 2018-19)
- Managing consumer food safety in Queensland (Report 17: 2018-19)
- Delivering forensic services (Report 21: 2018-19)

During the reporting period CQ Health also underwent review by the OHO and Australian Council of Healthcare Standards.

Information systems and recordkeeping

There have been no changes to our functions, responsibilities or regulatory requirements to require changes to our recording-keeping systems, procedures and practices. The health service has a formal policy in place detailing the roles and responsibilities of staff for records management function and activities. Training for staff in the making and keeping of public records in all formats, including emails, is available online.

CQ Health is committed to transitioning from paper to digital records. Paper records required to be kept in accordance with the applicable destruction and retention scheduled are being captured and managed through the records management system. Public records are being retained as long as they are required, in accordance with general or core retention and disposal schedules. Over the course of the financial year, CQ Health followed the General Retention and Disposal Schedule for its record disposal program.

2.3.3. Queensland Public Service Ethics

CQ Health is committed to upholding the values and standards of conduct outlined in the Code of Conduct for the Queensland Public Service. The Code of Conduct applies to all employees, contractors and volunteers of the health service and espouses four core principles:

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

CQ Health follows the Code of Conduct for Queensland Public Service and the *Public Sector Ethics Act 1994* which are essential components of the mandatory training requirements for all staff.

Code of Conduct training incorporates the principles of the *Public Sector Ethics Act 1994* and was delivered on a regular basis for staff across the health service over the reporting period. It is a mandatory requirement for staff with compulsory refresher training to be completed every two years.

The Code of Conduct for Queensland Public Service, CQ Health procedures, polices and links to the Department of Health information and resources are available via the health service intranet site.

Code of Conduct training and staff orientation covers the appropriate requirements with a focus on:

- Operation of the *Public Sector Ethics Act 1994*
- Application of ethics principles and obligations to the public officials
- Rights and obligations of the officials in relation to contraventions of the approved code of conduct.

Regular reviews of all human resource policies are conducted in line with the schedule of renewal and documents are updated as required. Additional updates or rewrites are undertaken as necessary due to changing legislation. When required new documents are developed in line with legislation or industrial awards changes to ensure a full suite of governance documents are available to staff at all times. All documents are developed using the current CQ Health templates and style guides and are in line with content guidelines.

2.3.4. Confidential information

The *Hospital and Health Boards Act 2011* requires annual reports to state the nature and purpose of any confidential information disclosed in the public interest during the financial year. The chief executive did not authorise the disclosure of confidential information during the reporting period.

Chapter 3
Performance

3.1. Demand on services

Delivering more care within clinically recommended time

	2018-19	Change since last year
Babies born [a]	* 2,146	* 23
Oral health treatments [b 1]	218,644	-20,202
Emergency Department presentations [c]	128,237	3,891
Emergency Department 'Seen in time' [c]	103,373	651
Patient admissions (from ED) [c]	27,839	-460
Emergency surgeries [d 2]	2,742	-154
Outpatient occasions of service (specialist and non-specialist) [d 3]	270,594	18,249
Specialist outpatient first appointments delivered in time [e 4]	24,263	-1,691
Gastrointestinal endoscopies delivered [f]	3,359	199
Gastrointestinal endoscopies delivered in time [f]	3,199	726
Elective surgeries, from a waiting list, delivered [g]	5,927	202
Elective surgeries, from a waiting list, delivered in time [g]	5,808	148
Number of telehealth services [h]	13,996	2,806
Hospital in the Home admissions [d 5]	788	-104

[1] Oral Health treatments are identified as Weighted Occasions of Service.
[2] Emergency surgeries data is preliminary.
[3] Only includes Activity Based Funding (ABF) facilities.
[4] Specialist outpatient services are a subset of outpatient services, where the clinic is led by a specialist health practitioner.
[5] Hospital in the Home admissions data is preliminary.
* Perinatal data collection is based on calendar year 2018.
Source: [a] Perinatal Data Collection, [b] Oral Health Service, [c] Emergency Data Collection, [d] GenWAU, [e] Specialist Outpatient Data Collection, [f] Gastrointestinal Endoscopy Data Collection, [g] Elective Surgery Data Collection,
[h] Monthly Activity Collection.

Timely care

CQ Health is one of the top performers of the 16 Hospital and Health Services in Queensland Health, delivering great care on time and close to home.

At June 30, no CQ Health patient was waiting longer than recommended for surgery, an outpatient appointment, a scope procedure or an oral health appointment.

Results show more outpatient appointments were delivered outside Rockhampton and, coupled with a significant increase in Telehealth use, patients received care closer to home.

This was achieved against a backdrop and a significant increase in service delivery.

Elective and Emergency Surgery

Our staff delivered a total of 8669 surgeries to Central Queenslanders, and most of the additional procedures were delivered at Gladstone Hospital where the number of elective surgeries increased by more than 22 per cent and emergency surgeries by almost 13 per cent.

Emergency Department

CQ Health's emergency departments continued to be among the top performers in Queensland with almost 83.4 per cent of patients receiving treatment and being discharged within four hours.

Across the health service there was an increase of more than 3500 (2.8 per cent) presentations to our emergency departments when compared to the year before. The increased demand and data processing issues contributed to CQ Health failing to meet the target for Category 1 ED patients.

Gladstone Hospital emergency department accounted for more than 2600 of the additional presentations.

Outpatient

There was a significant increase in the number of outpatient occasions of service delivered across Central Queensland.

CQ Health delivered 18,249 additional outpatient occasions of service when compared with the year before taking the total to 270,594.

Endoscopy procedures

CQ Health maintained its focus on the delivery of endoscopy procedures to ensure timely diagnosis and early treatment delivering almost 200 additional gastrointestinal endoscopes achieving a total 3359. Of those, 3199 were delivered within the clinically recommended timeframe.

Oral Health

The CQ Heath oral health team delivered almost 219,000 oral health treatments during 2018-19 from its mobile and fixed sites across Central Queensland. More than 27,000 treatments were under the Child Benefit Dental Scheme.

The oral health service was affected by workforce issues across the health service which impacted on the ability of the service to deliver activity. The oral health service also experienced data reporting challenges. Corrective actions have been put in place.

It increased clinical visits to the Capricornia Correctional Centre, adult and school services at Woorabinda, clinical visits to Mt Morgan Dental Clinic, dental officer presence at the Capricorn Coast Dental Clinic and held some out-of-hours clinics to further reduce waiting lists.

The oral health staff banded together and donated a large amount of goods to the men's and women's shelters in Rockhampton and Gladstone, contributed to the Safer Dignity initiative for women and used fundraising to buy and donate goods to the Neville Bonner Hostel in Rockhampton.

The oral health team also plays a key role in encouraging patients to quit smoking and providing referrals to Quitline.

3.2. Service standards

Service standards - Performance 2018-19

Service Standards	Target	Actual
Effectiveness measures		
Percentage of patients attending emergency departments seen within recommended timeframes:		
Category 1 (within 2 minutes)	100%	98.1%
Category 2 (within 10 minutes)	80%	83.8%
Category 3 (within 30 minutes)	75%	82.1%
Category 4 (within 60 minutes)	70%	89.2%
Category 5 (within 120 minutes)	70%	98.4%
Percentage of emergency department attendances who depart within four hours of their arrival in the department	80%	83.4%
Percentage of elective surgery patients treated within clinically recommended times:		
Category 1 (30 days)	98%	97.9%
Category 2 (90 days)	95%	97.2%
Category 3 (365 days)	95%	99.0%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days	<2	0.4 [7]
Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit	>65%	72.6% [8]
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	<12%	7.1% [9]
Percentage of specialist outpatients waiting within clinically recommended times:		
Category 1 (30 days)	98%	99.4%
Category 2 (90 days)	95%	99.6%
Category 3 (365 days)	95%	99.9%
Percentage of specialist outpatients seen within clinically recommended times:		
Category 1 (30 days)	98%	93.8%
Category 2 (90 days)	95%	91.4%
Category 3 (365 days)	95%	96.8%
Median wait time for treatment in emergency departments (minutes)	..	10
Median wait time for elective surgery (days)	..	59
Efficiency Measure		
Average cost per weighted activity unit for Activity Based Funding facilities	$4,878	$4,791 [10]
Other Measures		
Number of elective surgery patients treated within clinically recommended times:		
Category 1 (30 days)	1,811	1,884
Category 2 (90 days)	2,015	2,047
Category 3 (365 days)	2,118	1,877
Number of Telehealth outpatient occasions of service events	10,266	13,996
Total weighted activity units (WAU's)		
Acute Inpatient	44,511	43,174 [11]
Outpatients	12,781	12,177
Sub-acute	6,110	3,970
Emergency	15,537	14,876
Department	5,201	3,840
Mental	2,907	2,544
Health		
Prevention and Primary Care		
Ambulatory mental health service contact duration (hours)	>38,352	38,708
Staffing	3,052	3,109

[7] SAB data presented is FYTD to Mar-19. Full year data expected mid-Aug-19.
[8] Community mental health follow up data presented is FYTD to May-19. Full year data expected mid-Aug-19.
[9] Readmission to acute Mental Health inpatient unit data presented is FYTD to Apr-19. Full year data expected mid-Sep-19.
[10] Cost per WAU data presented is FYTD to Mar-19. Full year data expected mid-Aug-19.
[11] Activity data presented is FYTD to May-19. Full year data expected mid-Aug-19.

3.3. Financial summary

CQ Health reported an operating surplus of $0.419 million for the 2018-19 financial year.

Our revenue from clinical activity increased, delivering corresponding increases in labour and non-labour costs.

There is a continuing challenge related to permanent recruitment to clinical positions which results in a significant impact by the premium costs associated with engaging medical locum and agency nursing staff.

In 2018-19 total net assets increased by $26 million which includes an increase of cash on hand of $3.7 million, the results of asset revaluation and the newly commissioned car park at Rockhampton hospital. The variance reflects the outcome of the building and land improvement revaluations resulting in a net increase of $18.67 million.

Key financial highlights are outlined in the table below including results for the previous financial year.

Anticipated maintenance is a common building maintenance strategy utilised by public and private sector industries. All Queensland Health entities comply with the Queensland Government Maintenance Management Framework which requires the reporting of anticipated maintenance.

Anticipated maintenance is maintenance that is necessary to prevent the deterioration of an asset or its function but which has not been carried out. Some anticipated maintenance activities can be postponed without immediately having a noticeable effect on the functionality of the building. All anticipated maintenance items are risk assessed to identify any potential impact on users and services and are closely managed to ensure all facilities are safe.

As of 30 June 2019, CQ Health had reported total anticipated maintenance of $19,425,026.

CQ Health has strategies in place to mitigate any risks associated with these items such as seeking assistance from the Priority Capital Program and increasing operational maintenance budgets.

Measures	2018-19 Actuals	2017-18 Actuals
	$'000s	$'000s
Income	622,624	579,084
Expenses	622,205	585,848
Operating Surplus (deficit)	419	(6,764)
Net land revaluation movement on land and buildings	12,561	(47,142)
Total comprehensive income	12,980	(53,906
Cash and cash equivalents	18,670	14,933
Total assets	424,304	398,324
Total liabilities	31,828	30,208
Total equity	424,304	398,324

Chapter 4
Financial Statements

4.1. Statement of comprehensive income for the year ended 30 June 2019

OPERATING RESULT	Notes	2019 $'000	2018 restated (Note 1.) $'000
Income from Continuing Operations			
User charges and fees	B1-1	**48,308**	42,466
Funding public health services	B1-2, G4	**547,730**	510,854
Grants and other contributions	B1-3	**23,117**	21,894
Other revenue	B1-4	**3,469**	3,870
		622,624	579,084
Total Income from Continuing Operations		**622,624**	579,084
Expenses from Continuing Operations			
Employee expenses	B2-1	**61,952**	54,684
Health service employee expenses	B2-2	**329,433**	306,726
Supplies and services	B2-3, G4	**192,460**	184,693
Other expenses	B2-4, G4	**12,388**	12,580
Depreciation	C4-1	**25,972**	27,165
Total Expenses from Continuing Operations		**622,205**	585,848
Operating Results from Continuing Operations		**419**	(6,764)
Other Comprehensive Income			
Items that will not be reclassified to Operating Result			
Increase/(decrease) in asset revaluation surplus	C6-2, G4	**12,561**	(47,142)
Total other comprehensive income for the year		**12,561**	(47,142)
Total comprehensive income for the year		**12,980**	(53,906)

Note 1. Certain amounts shown here do not correspond to the 2018 financial statements and reflect adjustments made, refer Note G4

4.2. Statement of financial position as at 30 June 2019

	Notes	2019 $'000	2018 restated (Note 1.) $'000	1 July 2017 (restated) $'000
Current Assets				
Cash and cash equivalents	C1	**18,670**	14,933	14,107
Receivables	C2-1, G4	**13,176**	11,822	17,611
Inventories	C3	**3,831**	4,015	3,804
Other		**593**	513	2,126
Total Current Assets		**36,270**	31,283	37,648
Non-Current Assets				
Property, plant and equipment	C4-1, G4	**419,862**	397,249	451,840
Total Non-Current Assets		**419,862**	397,249	451,840
Total Assets		**456,132**	428,532	489,488
Current Liabilities				
Payables	C5	**31,828**	30,208	27,820
Total Current Liabilities		**31,828**	30,208	27,820
Total Liabilities		**31,828**	30,208	27,820
Net Assets		**424,304**	398,324	461,668
Equity				
Contributed equity		**373,549**	360,548	369,986
Accumulated surplus/(deficit)	G4	**2,412**	1,994	8,758
Asset revaluation surplus	C6-2, G4	**48,343**	35,782	82,924
Total Equity		**424,304**	398,324	461,668

Note 1. Certain amounts shown here do not correspond to the 2018 financial statements and reflect adjustments made, refer Note G4

4.3. Statement of changes in equity for the year ended 30 June 2019

	Accumulated surplus $'000	Asset revaluation surplus $'000	Contributed equity $'000	Total equity $'000
Balance as at 1 July 2017	**9,650**	**82,924**	**369,986**	**462,560**
Adjustment on correction of error (Note G4)	(892)	-	-	(892)
As at 1 July 2017 (restated)	8,758	82,924	369,986	461,668
Operating Result				
Operating result from continuing operations	(4,429)	-	-	(4,429)
Net effect of correction of errors (Note G4)	(2,335)	-	-	(2,335)
Other Comprehensive Income				
Increase/(decrease) in asset revaluation surplus	-	(46,760)	-	(46,760)
Error land revaluation (Note G4)	-	(382)	-	(382)
Total Comprehensive Income for the Year	(6,764)	(47,142)	-	(53,906)
Transactions with Owners as Owners:				
Net assets received (transferred during year via machinery-of-Government change) (Note C6-1)	-	-	988	988
Equity injections - Minor capital works	-	-	16,741	16,741
Equity withdrawals - Depreciation funding	-	-	(27,167)	(27,167)
Net Transactions with Owners as Owners	-	-	(9,438)	(9,438)
Balance at 30 June 2018	**1,994**	**35,782**	**360,548**	**398,324**
Restated opening balance as at 1 July 2018	1,994	35,782	360,548	398,324
Operating Result				
Operating result from continuing operations	419	-	-	419
Other Comprehensive Income		-	-	-
Increase/(decrease) in asset revaluation surplus		12,561	-	12,561
Total Comprehensive Income for the Year	419	12,561	-	12,979
Transactions with Owners as Owners:				
Net assets received (transferred during year via machinery-of-Government change) (Note C6-1)	-	-	26,307	26,307
Equity injections - Minor capital works	-	-	12,665	12,665
Equity withdrawals - Depreciation funding	-	-	(25,971)	(25,971)
Net Transactions with Owners as Owners	-	-	13,001	13,001
Balance at 30 June 2019	**2,412**	**48,343**	**373,549**	**424,304**

4.4. Statement of cash flows for the year ended 30 June 2019

	Notes	2019 $'000	2018 $'000
Cash flows from operating activities			
Inflows:			
User charges and fees		**46,956**	42,052
Funding public health services		**521,508**	489,045
Grants and other contributions		**17,596**	17,146
GST input tax credits from ATO		**12,720**	13,523
GST collected from customers		**597**	498
Other receipts		**3,466**	3,837
Outflows:			
Employee expenses		**(61,793)**	(54,403)
Health service employee expenses		**(327,969)**	(305,783)
Supplies and services		**(192,239)**	(181,972)
GST paid to suppliers		**(12,669)**	(13,169)
GST remitted to ATO		**(588)**	(455)
Other		**(6,695)**	(6,374)
Net cash used in operating activities	C-F1	**890**	3,945
Cash flows from investing activities			
Inflows:			
Sales of property, plant and equipment		**48**	143
Outflows:			
Payments for property, plant and equipment		**(9,866)**	(20,003)
Net cash used in investing activities	C-F2	**(9,818)**	(19,860)
Cash flows from financing activities			
Inflows:			
Equity injections		**12,665**	16,741
Net cash provided by financing activities	C-F2	**12,665**	16,741
Net increase/(decrease) in cash and cash equivalents		**3,737**	826
Cash and cash equivalents at the beginning of the financial year		**14,933**	14,107
Cash and cash equivalents at the end of the financial year	C1	**18,670**	14,933

4.5. Notes to the statement of cash flows

CF-1 Reconciliation of surplus to net cash from operating activities

	2019 $'000	2018 restated (Note 1.) $'000
Operating surplus/(deficit)	**419**	(6,764)
Non-cash items included in operating result:		
Depreciation	**25,972**	27,165
Funding for depreciation	**(25,972)**	(27,165)
Net gain on disposal of non-current assets	**(8)**	(38)
Loss on disposal - (netted off account)	**125**	29
Loss on revaluation of land above asset reserve		520
Repairs and maintenance incorrectly classified as WIP	**-**	620
Changes in assets and liabilities:		
(Increase)/decrease in receivables	**(1,180)**	(34)
(Increase)/decrease in funding receivables	**(250)**	5,426
(Increase)/decrease in GST receivables	**51**	354
(Increase)/decrease in inventories	**184**	(211)
(Increase)/decrease in prepayments	**(80)**	1,613
Increase/(decrease) in accounts payable	**204**	628
Increase/(decrease) in accrued contract labour	**1,480**	943
Increase/(decrease) in revenue received in advance	**(222)**	539
Increase/(decrease) in accrued employee benefits	**158**	277
Increase/(decrease) in GST payable	**9**	43
Net cash used in operating activities	**890**	**3,945**

CF-2 Non-cash investing and financing activities

Assets and liabilities received or donated/transferred by the Hospital and Health Service to agencies outside of the Wholly-Owned Public-Sector Entities are recognised as revenues (refer Note B1-4) or expenses (refer to Note B2-4) as applicable.

Note 1. Certain amounts shown here do not correspond to the 2018 financial statements and reflect adjustments made, refer Note G4.

4.6. Notes to the financial statements

SECTION A

GENERAL INFORMATION

The Central Queensland Hospital and Health Service (CQHHS) was established on 1 July 2012 as a statutory body under the *Hospital and Health Boards Act 2011*. CQHHS is responsible for providing primary health, community and public health services in the area assigned under the *Hospital and Health Boards Regulation 2012*.

The 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 CQHHS is:

Rockhampton Hospital Campus
Canning Street
Rockhampton QLD 4700

STATEMENT OF COMPLIANCE

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

CQHHS is a not-for-profit statutory body and these general purpose financial statements are prepared on an accrual basis (except for the statement of cash flow which is prepared on a cash basis) in accordance with Australian Accounting Standards and Interpretations applicable to not-for-profit entities.

In addition, the financial statements comply with Queensland Treasury's Minimum Reporting Requirements for the year ending 30 June 2019, and other authoritative pronouncements.

New accounting standards applied for the first time in these financial statements are outlined in Note G5.

The financial statements have been prepared on the basis that the entity is a going concern and will continue in operation for the foreseeable future. CQHHS's primary source of income is via a Service Agreement with the Department of Health for the provision of public health services and the HHS's ability to continue viable operations is dependent on this funding. At the date of this report management has no reason to believe that this funding will not continue.

THE REPORTING ENTITY

The financial statements include the value of all revenues, expenses, assets, liabilities and equity of CQHHS.

MEASUREMENT

Historical cost is used as the measurement basis in this financial report except for the following:

- Land, buildings, which are measured at fair value;
- Inventories which are measured at the lower of cost and net realisable value.

Historical cost

Under historical cost, assets are recorded at the amount of cash or cash equivalents paid or the fair value of the consideration given to acquire assets at the time of their acquisition. Liabilities are recorded at the amount of proceeds received in exchange for the obligation or at the amounts of cash or cash equivalents expected to be paid to satisfy the liability in the normal course of business.

Fair value

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. Fair value is determined using one of the following three approaches:

- The market approach uses prices and other relevant information generated by market transactions involving identical or comparable (i.e. similar) assets, liabilities or a group of assets and liabilities, such as a business.
- The cost approach reflects the amount that would be required currently to replace the service capacity of an asset. This method includes the current replacement cost methodology.
- The income approach converts multiple future cash flows amounts to a single current (i.e. discounted) amount. When the income approach is used, the fair value measurement reflects current market expectations about those future amounts.

Where fair value is used, the fair value approach is disclosed.

Present value

Present value represents the present discounted value of the future net cash inflows that the item is expected to generate (in respect of assets) or the present discounted value of the future net cash outflows expected to settle (in respect of liabilities) in the normal course of business.

Net realisable value

Net realisable value represents the amount of cash or cash equivalents that could currently be obtained by selling an asset in an orderly disposal.

PRESENTATION MATTERS

Currency and rounding

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

Comparatives

The financial statements provide comparative information in respect to the previous period. In addition, CQHHS presents an additional statement of financial position at the beginning of the preceding period when there is a retrospective application of accounting policy, a retrospective restatement or a reclassification of items in the financial statements. An additional statement of financial position as at 1 July 2017 is presented in these financial statements due to a correction of an error retrospectively. See Note G4.

Current/non-current classification

Assets and liabilities are classified as either 'current' or 'non-current' in the statement of financial position and associated notes.

Assets are classified as 'current' where their carrying amount is expected to be realised within 12 months after the reporting date. Liabilities are classified as 'current' when they are due to be settled within 12 months after the reporting date, or where CQHHS does not have an unconditional right to defer settlement to beyond 12 months after the reporting date.

All other assets and liabilities are classified as non-current.

AUTHORISATION OF FINANCIAL STATEMENTS FOR ISSUE

The financial statements are authorised for issue by the Chairperson of CQHHS, the Health Service Chief Executive and the Chief Finance Officer at the date of signing the Management Certificate.

B1 REVENUE

Note B1-1: User charges and fees

	2019 $'000	2018 $'000
Pharmaceutical Benefits Scheme	**17,592**	15,426
Sales of services	**7,816**	4,198
Hospital fees	**22,900**	22,842
Total	**48,308**	42,466

Accounting policy – user charges and fees

User charges and fees are recognised as revenue when the performance obligation has been satisfied and can be measured reliably with a sufficient degree of certainty. This occurs when services provided to customers are completed, at which time invoices are raised. Accrued revenue is recognised if the revenue has been earned but not yet invoiced.

Note B1-2: Funding public health services

	2019 $'000	restated 2018 $'000
National Health Reform		
Activity based funding	**346,016**	321,925
Block funding	**89,057**	78,584
Teacher training funding	**10,936**	10,235
General purpose funding	**101,721**	100,110
Total	**547,730**	510,854

Accounting policy – funding public health services

Funding revenue is received in accordance with service agreements with the Department of Health Queensland (the Department). Larger hospitals are funded on an activity unit basis whereas funding for smaller hospitals is based on block funding and other funding models. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by CQHHS. 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. Activity based funding may include an accrual estimate to recognise the patient revenue for which funding has not yet been received at year end. The accrual estimate is determined by assessing the total dollar value of services performed in excess of the activity thresholds.

The service agreement between the Department and CQHHS specifies that the Department funds CQHHS's depreciation and amortisation charges via non-cash revenue. The Department retains the cash to fund future major capital replacements. This transaction is shown in the Statement of Changes in Equity as a non-appropriated equity withdrawal.

Note B1-3: Grants and other contributions

	2019 $'000	2018 $'000
Australian Government grants		
Nursing home grants	**9,610**	9,992
Specific purpose grants	**3,881**	3,387
Total Australian Government grants	**13,491**	13,379
Other grants		
Other grants	**4,338**	3,265
Services received below fair value		
Services received below fair value	**5,288**	5,250
Total	**23,117**	21,894

Accounting policy – grants and other contributions

Grants and other contributions that are non-reciprocal in nature are recognised as revenue in the year in which CQHHS receives the grant. Where grants are received that are reciprocal in nature, revenue is progressively recognised as it is earned in accordance with the terms of the funding arrangements.

Contributed physical assets are recognised at their fair value.

Accounting policy – services received below fair value

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

The Department provides services free of charge to CQHHS which include payroll, accounts payable, finance, taxation, procurement and information technology infrastructure services. The fair value of these services is estimated at $5.288 million for the 2018-19 financial year and is recognised in the Statement of Comprehensive Income.

Note B1-4: Other revenue

	2019 $'000	2018 $'000
Regulatory fees	**29**	26
Other recoveries	**2,965**	3,664
Other revenue	**475**	180
Total	**3,469**	3,870

Accounting policy – other revenue

Other revenue primarily reflects recoveries of payments for contracted staff from third parties such as universities and other government agencies. Other revenue is recognised based on either invoicing for related goods, services and/or the recognition of accrued revenue based on estimated volumes of goods or services delivered.

Note B2-1: Employee expenses

	2019 $'000	2018 $'000
Employee benefits		
Wages and salaries	**53,318**	46,421
Annual leave levy	**3,280**	2,832
Employer superannuation contributions	**3,829**	3,440
Long service leave levy	**1,093**	964
Termination benefits	**94**	706
Employee related expenses		
Workers compensation premium	**99**	84
Other employee related expenses	**239**	237
Total	**61,952**	54,684

	2019 No.	2018 No.
Full-Time Equivalent (FTE) Employees at 30 June	**141**	128

*FTEs are reflective of the minimum obligatory human resource information (MOHRI).

Note B2-2: Health service employee expenses

	2019 $'000	2018 $'000
Department of Health Queensland - health service employees	**329,433**	306,726
Total	**329,433**	306,726

	2019 No.	2018 No.
Full-Time Equivalent Health Service employees at 30 June	**2,968**	2,882

* FTEs are reflective of the minimum obligatory human resource information (MOHRI).

As CQHHS is not a prescribed employer, only certain employees can be contracted directly by CQHHS. Employee expenses represent the cost of engaging board members and employment of health executives including those engaged as a contractor, and senior or visiting medical officers who are employed directly by CQHHS.

On the other hand, the average minimum obligatory human resource information full time equivalent (MOHRI FTE) count does not include board members, executives engaged as a contractor, or employed under an award. CQHHS has engaged Health Service employees who are employed by the Department through service arrangements.

Accounting policy – employee benefits

Salaries and wages, sick leave, annual leave and long service leave levies and employer superannuation contributions are regarded as employee benefits.

CQHHS pays premiums to WorkCover Queensland in respect of its obligations for employee compensation.

Workers' compensation insurance is a consequence of employing employees. It is not an employee benefit and is recognised separately as an employee related expense.

Wages and salaries due but unpaid at reporting date, are recognised in the Statement of Financial Position at current salary rates. As CQHHS expects such liabilities to be wholly settled within 12 months of reporting date, the liabilities are recognised at undiscounted amounts.

Accounting policy – sick leave

As sick leave is non-vesting, an expense is recognised for this leave as it is taken.

Accounting policy - annual leave and long service leave

Under the Queensland Government's Annual Leave Central Scheme and Long Service Leave Scheme, a levy is charged to CQHHS to cover the cost of annual and long service leave for employees. The levies are expensed in the period in which they are payable. Amounts paid to employees for annual leave and long service leave are claimed from the scheme quarterly in arrears.

Accounting policy - 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 following completion of the employee's service each pay period. CQHHS's obligations are limited to those contributions paid to QSuper. The QSuper scheme has defined benefit and defined contribution categories. The liability for defined benefits is held on a whole-of-government basis and reported in those financial statements pursuant to *AASB 1049 Whole of Government and General Government Sector Financial Reporting*.

Board members and visiting medical officers are offered a choice of superannuation funds and CQHHS pays superannuation contributions into a complying superannuation fund. Contributions are expensed in the period in which they are paid or payable. CQHHS'S obligations are limited to those contributions paid to eligible superannuation fund.

Therefore, no liability is recognised for accruing superannuation benefits in the CQHHS financial statements.

Key management personnel remuneration benefits disclosures and related party transactions are detailed in Note G1 and G2 respectively.

Note B2-3: Supplies and services

	2019 $'000	Restated 2018 $'000
Consultants and contractors	**39,349**	37,925
Electricity and other energy	**6,232**	7,270
Patient travel	**29,489**	29,258
Other travel	**1,646**	1,529
Building services	**4,772**	3,401
Computer services	**2,128**	2,230
Motor vehicles	**432**	408
Communications	**6,053**	5,291
Repairs and maintenance	**6,298**	6,351
Minor works including plant and equipment	**2,906**	656
Operating lease rentals	**3,883**	3,714
Inventories consumed - held for distribution		
Drugs	**21,731**	20,380
Clinical supplies and services	**19,661**	18,229
Catering and domestic supplies	**6,521**	6,357
Outsourced service delivery		
Medical imaging	**13,924**	15,000
Medical	**1,915**	3,916
Other services	**3,053**	2,116
Pathology, blood and parts	**15,690**	14,013
Other	**6,777**	6,649
Total	**192,460**	184,693

Note B2-4: Other expenses

	2019 $'000	2018 $'000
External audit fees	**178**	229
Other audit fees	**71**	23
Insurance	**5,090**	4,856
Insurance premiums - other	**88**	135
Losses from disposal of non-current assets	**125**	29
Special payments - ex gratia payments	**9**	182
Other legal costs	**172**	206
Advertising	**201**	152
Grants distributed	**583**	413
Interpreter fees	**20**	38
Impairment losses on trade receivables	**188**	381
Services below fair value	**5,288**	5,250
Other expenses	**375**	166
Revaluation decrement on land	**-**	520
Total	**12,388**	12,580

Accounting policy – distinction between grants and procurement

For a transaction to be classified as supplies and services, the value of goods or services received by CQHHS must be of approximately equal value to the value of the consideration exchanged for those goods or services. Where this is not the substance of the arrangement, the transaction is classified as other grants in Note B1-3.

Accounting policy – operating lease rentals

Operating lease payments, being representative of benefits derived from the leased assets, are recognised as an expense in the period in which they are incurred. Incentives received upon entering into operating lease agreements are recognised as liabilities. Lease payments are allocated between rental expense and reduction of the liability.

Disclosure – operating leases

Operating lease agreements are entered into as a means of acquiring access to office accommodation and storage facilities. Lease terms extend over a period of 5 to 10 years. CQHHS has no option to purchase the leased item at the end of the lease term, however the lease provides for a right of renewal at which time the lease terms are renegotiated.

Operating lease rental expenses comprises the minimum lease payments payable under operating lease contracts. Lease payments are generally fixed, but with annual inflation escalation clauses upon which future year rentals are determined.

Accounting policy – revaluations

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

Accounting policy – other expenses

Audit fees

The external audit fee for 2019 is $178,500; (2018: $229,000).

Insurance

The Insurance Arrangements for Public Health Entities enables Hospital and Health Services to be named 'insured parties' under the Department of Health's policy. For the 2018-19 policy year, the premium was allocated to CQHHS according to the underlying risk of an individual insured party.

Special payments

Special payments represent ex gratia expenditure and other expenditure that CQHHS is not contractually or legally obligated to make to other parties. Special payments during 2018-19 include the following payments over $5,000:

- Reimbursement of medical costs totalling $8,049.

Grant distributed

CQHHS distributes two grants received from funding as per Service Level Agreements:

(a) The provision of aged care residential services, community care, and respite care at Theodore Multi-Purpose Health Service. The services are outsourced to the Theodore Council of the Ageing, and

(b) The provision of CQHHS research skills development. The services are outsourced to the Central Queensland University.

SECTION C NOTES ABOUT OUR FINANCIAL POSITION

C1 CASH AND CASH EQUIVALENTS

	2019 $'000	2018 $'000
Imprest accounts	**13**	4
Cash at bank	**16,347**	12,438
QTC cash funds	**2,310**	2,491
Total	**18,670**	14,933

Accounting policy – cash and cash equivalents

For the purposes of the Statement of Financial Position and the Statement of Cash Flows, cash assets include all cash and cheques receipted but not banked at 30 June 2019 as well as deposits at call with financial institutions.

CQHHS cash contributions primarily originate from Private Practice clinicians and external entities to provide for education, study and research in clinical areas. As at 30 June 2019 amounts of $2.31 million ($2.49 million in 2017-18) in general trust including $0.640 million ($0.551 million in 2017-18) for earnings in excess of the agreed amount under the Granted Practice retention arrangement.

C2 RECEIVABLES

Note C2-1: Receivables

	2019 $'000	Restated 2018 $'000
Trade debtors	**8,815**	7,893
Less: Loss allowance	**(266)**	(508)
	8,549	7,385
GST receivable	**1,080**	1,131
GST payable	**(62)**	(53)
	1,018	1,078
Funding public health services	**3,609**	3,359
Total	**13,176**	11,822

Accounting policy – receivables

At reporting date, lease receivables and trade receivables are recognised at amortised cost which approximates their fair value.

Receivables are recognised at the agreed transaction price. Receivables are generally settled within 30 days, while other receivables may take longer than 12 months. A large proportion of trade receivables arises on the date of discharge of patients, however, fees are submitted to the Health Funds to be recovered once claim processing has been finalised. This could delay the receivable by up to 60 days.

Disclosure – credit risk exposure of receivables

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. In terms of collectability, receivables will fall into one of the following categories:

Lease receivables

The credit risk on initial recognition for lease receivables was assessed as 0%. The credit risk or objective impairment for these lease contracts has been re-assessed at 30 June 2019 and the 0% credit risk rate has been maintained.

Trade receivables

CQHHS has assessed the credit risk to measure the expected credit losses on trade and other debtors. Loss rates are calculated separately for groupings of customers with similar loss patterns. CQHHS has identified five groupings for measuring expected credit losses based on the sale of services and the sale of goods reflecting the different customer profiles for these revenue streams.

Note C2-2 details the accounting policies for impairment of receivables, including the loss events giving rise to impairment and the movements in the allowance for impairment.

Note C2-2: Impairment of receivables

Disclosure – ageing of trade receivables

Customer Grouping	2019 Gross Receivables $'000	Loss Rate %	Expected Credit Losses $'000	Carrying Amount $'000
Third Party Insurance	59	18.3	(11)	48
Private Health Funds	7,055	0.10	(7)	7,048
Medicare Ineligible	1,370	17.86	(245)	1,125
Other	331	1	(3)	328
Government Agencies	3,609	0	-	3,609
Australian Taxation Office	1,018	0	-	1,018
Total outstanding	13,442	1.98%	(266)	13,176

Aging	Gross Receivables $'000	2018 Allowance for Impairment $'000	Carrying Amount $'000
Less than 30 days	9,287	(21)	9,266
30 to 60 days	1,112	(47)	1,065
60 to 90 days	604	(13)	591
Greater than 90 days	1,327	(427)	900
Total outstanding	12,330	(508)	11,822

Disclosure – movement in allowance for impairment for impaired trade receivables

	2019 $'000	2018 $'000
Balance at 1 July	508	434
Amounts written off during the year	(430)	(302)
Amounts recovered during the year	2	5
Increase/(decrease) in allowance recognised in operating result	186	371
Balance at 30 June	266	508

Accounting policy – impairment of trade receivables

The allowance for impairment reflects the occurrence of loss events or lifetime expected credit losses.

For lease receivables, a loss event occurs if the lessee is no longer able to meet the terms and conditions of the lease contract.

The loss allowance amount for lease receivables is based on

- a twelve-months expected credit loss if the credit risk has not increased significantly at the reporting date since initial recognition, or
- a lifetime expected credit loss if the risk has increased significantly since initial recognition.

For trade receivables loss events occur when Debtors do not pay in accordance with expected payment terms which may differ for debtor categories.

Australian Government agencies loss events rarely occur. No loss allowance is recorded for these receivables on the basis of materiality.

Refer to Note D1-2 for CQHHS's credit risk management policies.

Economic changes impacting the CQHHS debtors, and relevant industry data, will continue to form part of the documented risk analysis even though the associated risk factor has been set at 0%. The demand for services and collection of debts has not been significantly impacted by economic changes.

If no loss events have arisen in respect of a debtor or group of debtors, no allowance for impairment is made in respect of that debtor or group of debtors. If CQHHS determines that an amount owing by such a debtor does become uncollectible (after appropriate debt recovery actions have been taken), that amount is recognised in the impairment loss allowance 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.

The amount written off in the current year regarding receivables is $0.430 million (2018: $0.302 million).

C3 INVENTORIES

Note C3-1: Inventories

	2019 $'000	2018 $'000
Inventories held for distribution - at cost		
Clinical supplies	**2,524**	2,675
Catering and domestic	**44**	59
Pharmacy drugs	**1,255**	1,270
Other	**8**	11
Total	**3,831**	4,015

Accounting policy – inventories

Inventories (other than those held for distribution) are valued at the lower of cost and net realisable value.

Cost is assigned on a weighted-average basis and includes expenditure incurred in acquiring the inventories and bringing them to their existing condition, except for training costs which are expensed as incurred.

Material Imprest holdings are recognised at balance date through annual stocktake process at average weighted cost.

C4 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION

Note C4-1: Property, plant and equipment – balances and reconciliations of carrying amount

30 June 2019	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Gross	**16,881**	**805,049**	**59,764**	**963**	**882,657**
Less: Accumulated depreciation	**-**	**(429,821)**	**(32,974)**	**-**	**(462,795)**
Carrying amount at 30 June 2019	**16,881**	**375,228**	**26,790**	**963**	**419,862**
Represented by movements in carrying amount:					
Carrying amount at 1 July 2018	**16,621**	**338,782**	**25,207**	**16,639**	**397,249**
Transfers in from other Queensland Government entities	**260**	**25,969**	**78**	**-**	**26,307**
Acquisitions	**-**	**212**	**4,750**	**4,904**	**9,866**
Donated non-current assets received			**16**		**16**
Disposals	**-**	**-**	**(166)**	**-**	**(166)**
Transfers out to other Queensland Government entities	**-**	**-**	**-**	**-**	
Transfers between classes	**-**	**18,562**	**2,018**	**(20,580)**	**-**
Net revaluation increments/(decrements)	**-**	**12,562**	**-**	**-**	**12,562**
Depreciation expense	**-**	**(20,859)**	**(5,112)**	**-**	**25,972**
Carrying amount at 30 June 2019	**16,881**	**375,228**	**26,790**	**963**	**419,862**

30 June 2018 (restated)	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Gross	16,621	741,008	57,463	16,639	831,731
Less: Accumulated depreciation	-	(402,226)	(32,256)	-	(434,482)
Carrying amount at 30 June 2018	16,621	338,782	25,207	16,639	397,249
Represented by movements in carrying amount:					
Carrying amount at 1 July 2017	17,523	403,347	22,946	8,024	451,840
Transfers in from other Queensland Government entities	-	962	25	-	987
Acquisitions	-	434	7,049	11,900	19,383
Disposals	-	(2)	(132)	-	(134)
Transfer from WIP to repairs & maintenance	-	-	-	(620)	(620)
Transfers out to other Queensland Government entities	-	-	-	-	-
Transfers between classes	-	3,250	35	(2,665)	620
Net revaluation increments/(decrements)	(902)	(46,760)	-	-	(47,662)
Depreciation expense	-	(22,449)	(4,716)	-	(27,165)
Carrying amount at 30 June 2018	16,621	338,782	25,207	16,639	397,249

C4 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (continued)

Note C4-2: Accounting policies

Initial measurement

Recognition thresholds

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

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

Acquisition of assets

Plant and equipment is initially recorded at cost, determined as the value given as consideration plus costs incidental to the acquisition, including all other directly attributable costs incurred to bring the asset to the location or condition necessary to be ready for use. Items or components that form an integral part of an asset are recognised as a single (functional) asset.

Major health infrastructure projects are managed by the Department on behalf of CQHHS. These assets are assessed at fair value on practical completion by an independent valuer. They are then transferred from the Department to CQHHS via an equity adjustment at the valuation amount.

Where assets are received free of charge from another Queensland Government entity, the acquisition cost is recognised as the gross carrying amount in the books of the other agency immediately prior to the transfer together with any accumulated depreciation. Assets acquired at no cost or for nominal consideration, other than from another Queensland Government entity, are recognised at their fair value at the date of acquisition.

Componentisation of complex assets

Where assets comprise of separately identifiable components, subject to regular replacement, components are assigned useful lives distinct from the asset to which they relate and depreciated accordingly. CQHHS has determined all specialised health service buildings are complex in nature and warrant componentisation (separate useful lives assigned to component parts). These buildings comprise three components:

- Shell
- Fit out
- Services including plant integral to the asset

Subsequent expenditure

Expenditure relating to repairs and maintenance is only capitalised to an asset's carrying amount if it extends the service potential or useful life of the existing asset. Maintenance expenditure that merely restores the original service potential (lost through ordinary wear and tear) is expensed. Carrying amounts impacted by repairs and maintenance of a capital nature are considered when determining the value at cost or the fair value.

Depreciation

Key judgement: Buildings, plant and equipment are depreciated on a straight-line basis reflecting the even consumption of economic benefits over their useful life to CQHHS. Annual depreciation is based on fair values and CQHHS's assessments of the useful remaining life of individual assets. Land is not depreciated as it has an unlimited useful life.

Assets under construction (work-in-progress) are not depreciated until they reach service delivery capacity. Service delivery capacity relates to when construction is complete, and the asset is first put to use, or is installed ready for use, in accordance with its intended application.

Any expenditure that increases the originally assessed capacity or service potential of an asset is capitalised and the new depreciable amount is depreciated over the remaining useful life of the asset. The depreciable amount of improvements to leasehold land is allocated progressively over the shorter of the estimated useful lives of the improvements or the unexpired period of the lease. The unexpired period of leases includes any option period where exercise of the option is probable.

Key estimate: For each class of depreciable assets, the following ranges of depreciation rates were used:

Class	Depreciation rates (%)
Land improvements	1% - 5%
Building - shell	2% - 3%
Building - fit out	2% - 5%
Building - services	3% - 5%
Other building	2% - 10%
Plant and equipment	5% - 20%

Impairment of non-current assets

Key judgement: All non-current assets are assessed for indicators of impairment on an annual basis. This occurs through the stocktake process for plant and equipment assets and through the revaluation process for property assets. Where impairment is identified for plant and equipment assets, management determines the asset's recoverable amount (higher of value in use and fair value less costs to sell). Any amount by which the asset's carrying amount exceeds the recoverable amount is considered an impairment loss and recognised immediately in the Statement of Comprehensive Income.

C4 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (continued)

The valuation methodology for property includes an assessment as to whether the asset is impaired, i.e. the asset has experienced physical or technological obsolescence. Where obsolescence is identified, the comprehensive revaluation process incorporates the impact, ensuring that the asset is held at fair value, with any associated decrements realised in the Asset Revaluation Reserve or Statement of Comprehensive Income as required.

Subsequent measurement at fair value

Fair value is the price that would be received or paid for an asset at arm's length between willing market participants 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.

Key estimate and judgement:

Property assets are initially recognised at cost and subsequently valued by external valuers who use multiple inputs to derive fair value. The derivation of these inputs is subject to judgements and assumptions about the property's highest and best use.

Observable inputs are publicly available data that are relevant to the characteristics of the assets/ liabilities being valued, and include, but are not limited to, published sales data for land and residential dwellings. Unobservable inputs are used where observable inputs are not available and include data, assumptions and judgements that are not available publicly, but are relevant to the characteristics of the assets being valued. These include subjective adjustments made to observable data to take account of the specialised nature of health service buildings and on hospital site residential facilities, such as:

- historical and current construction contracts (and/or estimates of such costs), with consideration of locational factors in deriving appropriate unit rate costs;
- assessments of physical condition and any impairment; and
- remaining useful life, with consideration of the future service requirements of the facility.

All CQHHS assets measured at fair value 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:

Fair value level	Description	CQHHS valuations
1	Valuation is derived from unadjusted quoted market prices in an active market for identical assets	n/a*
2	Valuation is substantially derived from inputs that are observable, either directly or indirectly	Unrestricted land
3	Valuations is substantially derived from unobservable inputs	Reserved land Buildings

*None of CQHHS's property assets are eligible for categorisation into level 1 on the fair value hierarchy.

Plant and equipment are reported at their revalued amounts, being the fair value at the date of valuation, less any subsequent accumulated depreciation and impairment losses where applicable. Separately identified components of assets are measured on the same basis as the assets to which they relate.

Revaluation of property at fair value

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

Comprehensive revaluations are undertaken at least once every five years. However, if a particular asset class experiences significant and volatile changes in fair value, then that class is subject to specific appraisal in the reporting period, where practical, regardless of the timing of the last specific appraisal. 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. CQHHS uses indices to provide a valid estimation of fair values for the assets at reporting date. Materiality is considered in determining whether the differences between the carrying amount and the fair value of an asset is material (in which case revaluation is warranted).

Land

Land is measured at fair value each year using independent market valuations or indexation by the State Valuation Service (SVS), Department of Natural Resources, Mines and Energy.

In 2018-19, CQHHS's land was valued by SVS using independent market valuation or market indices. The effective date of valuation was 30 June 2019. Management has assessed the valuation provided by SVS as appropriate for CQHHS and accepted the result of the independent valuation.

The fair value of land was based on physical inspection and publicly available data on sales of similar land in nearby localities. SVS indicated that they used observable inputs from market transactions data and therefore these inputs fall into level 2 within the fair value hierarchy. The revaluation of land for 2019 resulted in no movement in the fair value currently recorded ($0.902m decrement in 2018).

Buildings

In 2018-19 CQHHS engaged AECOM as the independent valuers to undertake building revaluation in accordance with the fair value methodology. AECOM performed comprehensive valuation for partial retirements of existing assets, capital improvements to existing assets and valuations of new built assets. Indexation was applied to the remaining building portfolio previously valued in prior financial years. The effective date of the valuation was 30 June 2019.

C4 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (continued)

CQHHS values its buildings using the Current Replacement Cost valuation methodology. The valuation is provided for a replacement building of the same size, shape and functionality that meets current design standards, and is based on estimates of gross floor area, number of floors, building girth and height and existing lifts and staircases. The valuation methodology for the independent valuation uses historical and current construction contracts. The replacement cost of each building at the date of valuation is determined by considering location factors and comparing against current construction contracts.

The valuation methodology makes an adjustment to the replacement cost of the modern day equivalent building for any utility embodied in the modern substitute that is not present in the existing asset (e.g. mobility support) to give a gross replacement cost that is of comparable utility (the modern equivalent asset). The methodology makes further adjustment to total estimated life taking into consideration physical obsolescence impacting on the remaining useful life to arrive to the current replacement cost via straight line depreciation.

Indices used are also tested for reasonableness by applying the indices to a sample of assets, comparing the results to similar assets that have been valued by an independent professional valuer or quantity surveyor, and analysing the trend of changes in values over time. Through this process, which is undertaken annually, management assesses and confirms the relevance and suitability of indices provided based on CQHHS's own circumstances.

An index of 2.7% (3%: 2018) was recommended by AECOM to be applied to buildings not comprehensively revalued. The cumulative index is 5.7%. As the 3% index was not applied in 2018, the cumulative index is 5.7% and will be applied to the assets within the portfolio that were not comprehensively revalued in 2017-18 and 2018-19 financial year. The index of 2.7% will apply to the assets within the portfolio that have not been comprehensively revalued in the 2017-18 financial year only.

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

Note C4-3: Categorisation of assets and liabilities measured at fair value

	Level 2		Level 3		Total Carrying Amount	
	2019 $'000	2018 $'000	2019 $'000	2018 $'000	2019 $'000	2018 $'000
Land	**16,881**	16,621	**-**	-	**16,881**	16,621
Buildings		-	**375,228**	338,782	**375,228**	338,782
Total	**16,881**	16,621	**375,228**	338,782	**392,109**	355,403

C5 PAYABLES

	2019 $'000	2018 $'000
Trade creditors		
Department of Health Queensland	**1,565**	2,081
Other trade creditors	**16,037**	15,317
Accrued health service labour - Department of Health Queensland	**11,751**	10,271
Accrued employee benefits	**2,056**	1,898
Revenue received in advance	**419**	641
Total	**31,828**	30,208

Accounting policy – payables
Payables are unsecured and recognised upon receipt of the goods or services and are measured at the agreed purchase/contract price, gross of applicable trade and other discounts.

C6 EQUITY

Interpretation 1038 Contributions by Owners Made to Wholly-Owned Public-Sector Entities specifies the principles for recognising contributed equity by CQHHS. The following items are recognised as contributed equity by CQHHS during the reporting and comparative years:

- Cash equity contributions fund purchases of equipment, furniture and fittings associated with capital work projects managed by CQHHS. CQHHS received $26.3 million funding from the State as equity injections in 2019 (2018: $0.987 million). These outlays are paid by the Department of Health Queensland on behalf of the State.
- CQHHS received $25.971 million funding in 2019 (2018: $27.167 million) from the Department to account for the cost of depreciation. Funding for depreciation charges is via non-cash revenue. The Department retains the cash to fund future major capital replacements. As depreciation is a non-cash expenditure item, the Health Minister has approved a withdrawal of equity by the State for the same amount, resulting in a non-cash revenue amount and a corresponding non-cash equity withdrawal.

Note C6-1: Contributed equity - asset transfers

	2019 $'000	2018 $'000
Transfer in - practical completion of projects from the Department	**26,229**	962
Net transfer equipment between Hospital and Health Services	**78**	25
	26,307	987

The variance reflects the outcome of the building and land improvement revaluations. This has resulted in a net increment of $12.6 million. Non-reciprocal transfers of assets are recognised through equity when the Chief Finance Officers of both entities agree in writing to the transfer. Construction of major health infrastructure is managed and funded by the Department of Health. Upon practical completion of a project, assets are transferred from the Department to CQHHS. During this year a number of assets have been transferred under this arrangement.

Note C6-2: Asset revaluation surplus by class

	Land $'000	Buildings $'000	2019 Total $'000	2018 Total $'000
Balance 1 July		**35,782**	**35,782**	82,924
Revaluation increments/(decrements)		**12,561**	**12,561**	(47,142)
Balance 30 June	**-**	**48,343**	**48,343**	35,782

SECTION D NOTES ABOUT RISKS AND OTHER ACCOUNTING UNCERTAINTIES

D1 FINANCIAL RISK DISCLOSURES

Note D1-1: Financial instrument categories

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

Category	Notes	2019 $'000	2018 $'000
Financial assets			
Cash and cash equivalents	C1	**18,670**	14,933
Financial assets at amortised cost:			
Receivables	C2-1,G4	**13,176**	11,822
Total		**31,846**	26,755
Financial liabilities			
Payables	C5	**31,828**	30,208
Total		**31,828**	30,208

Note D1-2: Financial risk management

A financial instrument is defined as any contract that gives rise to both a financial asset of one entity and a financial liability or equity instrument of another entity. The identifiable financial instruments for CQHHS are cash, Queensland Treasury Corporation (QTC) investments, receivables and payables excluding prepayments and funds held in trust.

Financial risk management is implemented pursuant to Government and CQHHS policies. These policies focus on the unpredictability of financial markets and seek to minimise potential adverse effects on the financial performance of CQHHS.

CQHHS exposure to a variety of financial risks including how these risks are measured, is set out below:

Credit risk

Credit risk in relation to a financial instrument is the risk that a customer, bank or other counterparty will not meet its obligations in accordance with agreed terms. CQHHS has a credit management strategy in place which includes analysing ageing accounts receivable amounts and identifying cash inflows at risk.

CQHHS is exposed to credit risk in respect of its accounts receivables (Note C2-1). The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the accounts receivable, inclusive of any allowance for impairment.

Trade Debtor categories at risk

The trade debtors have been classified in the following five categories with Medicare ineligible patients and third-party insurance claims being the two categories with the highest credit risk.

1. Medicare ineligible patients with or without private health insurance and where Australia does not have a reciprocal health care agreement with the patient's country of origin.
2. Third party insurance claims for hospital charges pending legal action. The actual settlement of these claims can take many years. CQHHS may not be fully compensated for patients who seek compensation though motor vehicle and third-party insurance claims. The difference between treatment cost and the compensation amounts is written off.
3. Private Health Insurance.
4. Other debtors.
5. Government agencies

At 30 June 2019 the overall credit risk is low.

CQHHS credit risk strategy is to reduce the exposure to credit default by ensuring that CQHHS invests in secure assets considering legislative requirements and monitors all funds owed on a timely basis in accordance with expectations for each customer profile.

Liquidity risk

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

CQHHS is exposed to liquidity risk through its trading in the normal course of business and aims to reduce the exposure to liquidity risk by managing cash flows ensuring that sufficient funds are available to meet employee and supplier obligations at all times. An approved debt facility of $4.5 million under Whole-of-Government banking arrangements to manage any short-term cash shortfalls has been established. No funds had been withdrawn against this debt facility as at 30 June 2019.

Market risk

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

CQHHS is not permitted to trade in foreign currency and is not materially exposed to commodity price changes or other market prices. Interest rate risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market interest rates.

CQHHS does not recognise any financial assets or liabilities at fair value. Trade receivables and payables are recorded at the value of the original transaction less any allowances for impairment, which is assumed to approximate the fair value of the balance.

CQHHS has interest rate exposure on the 24-hour call deposits; however, there is no risk on its cash deposits as all interest earned on bank accounts that form part of the Whole-of-Government-Arrangements flow back into the Consolidated Fund (Note C1).

Changes in interest rate have a minimal effect on the operating result of CQHHS.

D2 CONTINGENCIES

(a) Litigation in progress

As at 30 June 2019, the following cases were filed in the courts naming the State of Queensland acting through CQHHS as defendant:

	2019 Number of cases	2018 Number of cases
Supreme Court	**4**	2
District Court	**4**	7
Magistrates Court	**-**	-
Tribunals, commissions and boards	**-**	-
	8	9

Disclosure – Litigation in progress

Insurance cover for CQHHS's exposure to litigation is underwritten by the Queensland Government Insurance Fund (QGIF) and WorkCover Queensland. For matters managed by QGIF, CQHHS's liability is limited to an excess of $20,000 per insurance event. As at 30 June 2019, CQHHS has 36 claims currently managed by QGIF (some of which may never be litigated or result in payments to claimants). At year end, the maximum exposure associated with these claims is $720,000.

During the financial year, 8 of the medical indemnity claims managed by QGIF were lodged with either the Supreme Court, District Court, or Magistrates Court. CQHHS legal advisers and management believe it would be misleading to estimate the final amounts payable (if any) in respect of the litigation before the courts at this time. As of 30 June 2019, there were no open claims before tribunals, commissions or boards that have been referred to QGIF for management or being managed by CQHHS.

Disclosure – Rockhampton car park

The Rockhampton Hospital Car Park has been operational since March 2019 and was transferred to CQHHS in May 2019. The Rockhampton Hospital Car Park was funded by both the Commonwealth and State Governments. CQHHS is in discussions with the Department of Health that would result in a component of any surplus car park revenue after taking into account operational expenses being returned to the Department of Health. As at 30 June 2019, such an arrangement has not yet been formally finalised and CQHHS has no certainty on the arrangement that will occur with the Department of Health or the estimated value of payment amounts. As a result, no liability has been recognised in the financial statements.

D3 COMMITMENTS

(a) Capital expenditure commitments

Commitments for capital expenditure at reporting date are exclusive of anticipated GST and are payable as follows:

	2019 $'000	2018 $'000
Property, Plant and Equipment		
No later than 1 year	**1,469**	325
Later than 1 year but no later than 5 years	**-**	-
Later than 5 years	**-**	-
Total	**1,469**	325

Disclosure – capital expenditure commitments

Material classes of capital expenditure commitments contracted for at reporting date but not recognised in the accounts as payable.

(b) Non-cancellable operating lease commitments as lessee

Commitments under operating leases at reporting date are exclusive of anticipated GST and are payable as follows:

	2019 $'000	2018 $'000
Operating Leases		
No later than 1 year	**1,800**	927
Later than 1 year but no later than 5 years	**175**	324
Later than 5 years	**-**	-
Total	**1,975**	1,251

Disclosure – non-cancellable operating lease commitments (lessee)

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

(c) Operating Leases as Lessor

Commitments for operating leases as lessor at reporting date are exclusive of anticipated GST and are receivable as follows:

	2019 $'000	2018 $'000
Property, Plant and Equipment		
No later than 1 year	**613**	964
Later than 1 year but no later than 5 years	**3,058**	3,058
Later than 5 years	**350**	962
Total	**4,021**	4,984

Disclosure – operating lease commitments (lessor)

Revenue received from operating leases is recognised as revenue progressively as the service period lapses each month.

CQHHS has 17 operating leases for the 2018-19 financial year with various parties on different terms and conditions for property and accommodation. The amount of $1.234 million has been received from leases held as a lessor in the 2018-19 financial year; $1.162 million for the 2017-18 financial year.

D4 CRITICAL ACCOUNTING JUDGEMENTS AND KEY SOURCES OF ESTIMATION UNCERTAINTY

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

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

- Activity based funding revenue – Note B1-2
- Property, plant and equipment – Note C4
- Service received below fair value, free of charge – Note B1-3 and Note B2-4

D5 FUTURE IMPACT OF ACCOUNTING STANDARDS NOT YET EFFECTIVE

Accounting standards issued but with future commencement dates

At the date of authorisation of the financial report, the expected impacts of new or amended Australian Accounting Standards issued, but with future commencement dates, are set out below:

AASB 16 Leases

AASB 16 Leases will first apply to the CQHHS 2019-20 Financial Statements. When applied, the standard supersedes AASB 117 *Leases*, AASB Interpretation 4 *Determining whether an Arrangement contains a Lease*, AASB Interpretation 115 *Operating Leases – Incentives* and AASB Interpretation 127 *Evaluating the Substance of Transactions Involving the Legal Form of a Lease.*

AASB 16 allows a cumulative approach rather than a full retrospective application to recognising existing operating leases. In accordance with Queensland Treasury's policy, CQHHS will apply the cumulative approach and will not restate comparative information. Instead, the cumulative effect will be recognised as an adjustment to the opening balance of accumulated surplus at the date of initial application. The adjustment represents the difference between the written down right-of -use asset amount and the NPV amount for the remaining lease payments.

Impact for lessees

Unlike AABS 117 Leases, AASB 16 introduces a single lease accounting model for lessees. For non-cancellable leases, lessees will be required to recognise a right-of-use asset (representing rights to use the underlying leased asset) and a liability (representing the obligation to make lease payments) for all leases with a term of more than 12 months, unless the underlying assets are of low value.

The right-of-use asset will be initially recognised at cost, consisting of the initial amount of the associated lease liability, plus any lease payments made to the lessor at or before the effective date, less any lease incentive received, the initial estimate of restoration costs and any initial direct costs incurred by the lessee. The right-of-use asset will give rise to a depreciation expense.

The lease liability will be initially recognised at an amount equal to the present value of the lease payments during the lease term that are not yet paid. Current operating lease rental payments will no longer be expensed in the Statement of Comprehensive Income. They will be apportioned between a reduction in the recognised lease liability and the implicit finance charge (the effective rate of interest) in the lease. The finance cost will also be recognised as an expense.

Outcome of review as lessee

CQHHS has completed its review of the impact of adoption of AASB 16 on the statement of financial position and statement of comprehensive income and has identified the following impacts which are outlined below:

CQHHS has been advised by Queensland Treasury and DHPW that, effective 1 July 2019 the internal-to-government non-cancellable leases such as Queensland Government Accommodation Office will be exempt from lease accounting under AASB 16. This is due to DHPW having substantive substitution rights over the non-specialised, commercial office accommodation assets used within these arrangements. From 2019-20 onward, costs for these commercial accommodation services will continue to be expensed as supplies and services expense, but no longer reported as non-cancellable operating lease commitments.

CQHHS also has several cancellable motor vehicle leases with QFleet that are not presently included as part of the operating lease commitments note as they do not constitute a lease under AASB 117 and Accounting Interpretation 4. Queensland Treasury has confirmed QFleet arrangements will continue to fall outside the requirements of AASB 16 for on-balance sheet accounting. From 2019-20 onwards, costs for these services will continue to be expensed as supplies and services expense when incurred.

D5 FUTURE IMPACT OF ACCOUNTING STANDARDS NOT YET EFFECTIVE (continued)

The opening balance of Retained Earnings in 2019-20 will not be adjusted for lease commitments for non-cancellable residential leases with a remaining lease period of less than 12 months at 30 June 2019. The commitment amount is $547,235.

In effect, 13 non-cancellable residential operating leases will be reported on the statement of financial position as a right-of-use asset and a lease liability under AASB 16.

CQHHS has quantified the transitional impact on the statement of financial position and statement of comprehensive income of all qualifying lease arrangements that will be recognised on-balance sheet under AASB 16, as follows.

- Statement of financial position impact on 1 July 2019:
  - $259,374 increase lease liabilities
  - $262,555 increase right of use assets
  - $3,729 increase in opening accumulated surplus
- Statement of comprehensive income impact expected for the 2019-20 financial year, as compared to 2018-19:
  - $202,538 increase in depreciation and amortisation expense
  - $2,887 increase interest expense
  - $202,538 decrease in supplies and service expense

Leases with below fair value terms and conditions

AASB 1058 Income of Not-for-Profit Entities applies where the leases have below market terms and conditions (peppercorn leases). Under the existing AASB 16 Leases and AASB 1058 Income of not-for-profit entities, leases with significantly below market terms and conditions principally to enable a not-for-profit entity to further its objectives (commonly referred to as 'peppercorn leases') are to be measured on initial recognition at fair value. In December 2018, the Australian Accounting Standard Board (AASB) issued AASB 2018-8 Amendments to Australian Accounting Standards – Right of-Use Assets of Not-for-Profit Entities to provide a temporary option for not-for-profit lessees to elect to measure all right-of-use assets as from concessionary leases at cost on initial recognition until the AASB issues further pronouncements on this matter.

Impact for Lessors

Lessor accounting under AASB 16 remains unchanged from AASB 117. For finance leases, the lessor recognises a receivable equal to the net investment in the lease. CQHHS does not have any finance leases. Lease receipts from operating leases are recognised as revenue progressively as the service period lapses each month.

AASB 15 Revenue from contracts with customers and AASB 1058 Income of Not-for profit Entities

The transition date for both AASB 15 and AASB 1058 is 1 July 2019. Consequently, these standards will first apply to CQHHS when preparing the financial statements for the 2019-20 financial year. CQHHS has reviewed the impact of AASB 15 and AASB 1058 on revenue. and identified that the impact on current revenue agreements on adoption of the new standards is expected to be minimal;

When effective, AASB 15 will replace the current accounting requirements applicable to revenue with a single, principle-based model. Except for a limited number of exceptions, including leases, the new revenue model in AASB 15 will apply to all contracts with customers as well as non-monetary exchanges.

The core principle of AASB 15 is that a contract with a customer needs to be:

- enforceable and sufficiently specific; with
- revenue recognised at transfer of control of goods/services, when performance obligations have been met, or when performance obligations are satisfied over time;
- to customers directly or indirectly to third party beneficiaries; and
- at the agreed transaction price.

AASB 1058 and AASB 1004 outline recognition principles for funding arrangements entered into by not-for-profit entities that fail to meet the criteria in AASB 15. The purpose of AASB 1058 is to align income transactions that are not contracts with customers, in accordance with their economic substance. AASB has also amended AASB 1004 Contributions as part of the release of new revenue standards.

From 1st July 2019, to defer recognition of grant income (unearned revenue), CQHHS will no longer be required to demonstrate that approximately equal value is given back directly to the grantor. CQHHS will instead need to demonstrate that the grant or funding agreement satisfy the 'enforceable agreement' and 'sufficiently specific performance obligations' criteria to be a reportable contract with a customer under AASB 15.

Transition approach for AASB 15 and AASB 1058

CQHHS will apply the modified retrospective approach, as mandated by the Department of Health whereby comparative figures do not need to be restated but an adjustment can be made to the opening balance of retained earnings. The modified retrospective approach applies to all contracts including completed contracts.

From 1st July 2019, to defer recognition of grant income (unearned revenue), CQHHS will no longer be required to demonstrate approximately equal value is given back to the grantor. Grants where value was given back to third party beneficiaries were marked as non-reciprocal under AASB 1004 and recognised as revenue when received. CQHHS will instead need to demonstrate that the grant or funding agreement satisfy the 'enforceable agreement' and 'sufficiently specific performance obligations' criteria to be a reportable contract with a customer under AASB 15.

D5 FUTURE IMPACT OF ACCOUNTING STANDARDS NOT YET EFFECTIVE (continued)

For the purpose of determining the transaction price and deferred revenue, CQHHS has assumed that the goods or services will be transferred to the customer / third party beneficiaries as promised in accordance with the existing contract and that the contract will not be cancelled, renewed or modified.

CQHHS has not identified agreements currently accounted for under AASB 1004 where income recognition can be deferred where there is a performance obligation or any other liability, nor any agreements that are classified as non-reciprocal grants. This means that no adjustment to the opening Balance of Retained earnings is expected.

The following sections summarise the assessment of current revenue contracts and agreements under the new accounting standards:

User Charges and Fees

CQHHS will recognise revenue under AASB 15 when the goods and services are transferred to customers at the transaction price. User charges include private health fund insurance claims for hospital fees or other insurance claims, WorkCover, subsidies received under the pharmaceutical benefit scheme (PBS), patient contributions and other sales of goods and services.

Funding Public Health Services

Activity based funding (ABF)

CQHHS receives funding for providing public health services procured by the Department of Health on a Weighted Average Unit (WAU) basis, which may vary depending on activity levels delivered and in accordance with agreed service level outputs. ABF funding revenue from the Department of Health represents 88% of CQHHS's total revenue. Where there is an activity shortfall or CQHHS has not met its specific funding commitments this would result in the return of funds to the Department of Health in accordance with the requirements of AASB 15.

Block funding

Block funding is received through an enforceable agreement and is presently recognised as revenue up-front under AASB 1004 as no specific performance obligations exists and service are provided to third party beneficiaries. From 1 July, block funding will be recognised under AASB 1058 because the performance obligations are not sufficiently specific.

Depreciation funding

CQHHS receives funding for the cost of depreciation in order to eradicate the impact of depreciation expenses on the bottom line. The Department retains the cash to fund future major capital replacements. Under AASB 1004, as depreciation is a non-cash expenditure item, the Health Minister has approved a withdrawal of equity for the same amount, resulting in a non-cash revenue amount and a corresponding non-cash equity withdrawal.

Grants and Other Contributions

CQHHS has reviewed its grants which are mostly comprised of Australian Government grants where the government is procuring health care, delivered by CQHHS through health initiatives and health programs, and grants received from professional not-for-profit member organisations to provide training opportunities to their members. These agreements have been identified as enforceable agreements that do not contain sufficiently specific performance obligations and therefore do not meet the criteria for deferral of revenue under AASB 15.

AASB 1058 applies where an enforceable agreement or component thereof of economic substance does not exist and the consideration to acquire an asset (including cash) is significantly less than fair value principally to enable an entity to further its objectives. Example are cash and other assets received from contributions, donations, bequests; volunteer services, the estimated value of services received free of charge or where there is no transfer of goods and services such as capital grants where CQHHS retains the output of the asset (constructed assets).

The fair value for volunteers is not measured, as the services would not have been purchased if they had not been donated.

Other revenue

This section of the Income Statement is subject to a number of accounting standards. Under AASB 1058, revenue in this section is recognised immediately where an enforceable agreement of economic substance does not exist; e.g. sponsorships without terms and conditions, fees and charges for recovering goods and services provided, including recoveries from employing health service employees to other organisations, or employees paying for meals and housing.

AASB 1058 Income of Not-for-Profit-Entities

The transition date for AASB 1058 is 1 July 2019. This standard will first apply to the CQHHS from its financial statements from 2019-2020. CQHHS has reviewed the impact of AASB 1058 and identified the following impacts.

AASB 1058 applies where the consideration to acquire an asset (including cash) is significantly less than fair value principally to enable an entity to further its objectives. Example are cash and other assets received from non-reciprocal grants, bequests, volunteer services, or where there is no transfer of goods and services such as capital grants and research results as CQHHS retains the output of the asset – constructed asset and intellectual property.

CQHHS will apply the partial retrospective approach available under AASB 1058. Under this transition approach, CQHHS will not need to restate comparative figures in its 2019-20 financial statements. Instead will recognise the cumulative effect of applying this standard as an adjustment to opening accumulated surplus at 1 July 2019.

Volunteer services will not be recognised, as they would not have been purchased had they not been donated.

Impact

This standard operates in conjunction with AASB 15 *Revenue from Contracts with Customers*. AASB 1058 will apply where AASB 15, and AASB 1004 do not apply. AASB 1004 *Contributions* will only be used for equity contributions and distributions, restructure of administrative arrangements and liabilities assumed by other entities. The main impact on adopting this standard is reflected above with the adoption of AASB 15 and in the following section about capital grants revenue.

CQHHS does not expect to make an adjustment to the opening accumulated surplus as revenue from non-reciprocal grants and donations is already recognised up-front in accordance with AASB 1058. CQHHS has one capital grant at year end from the University of Queensland which will be recognised upon practical completion of the Academic Centre (for shared use) at the Rockhampton Hospital.

D5 FUTURE IMPACT OF ACCOUNTING STANDARDS NOT YET EFFECTIVE (continued)

AASB 1059 Service Concession Arrangements

AASB 1059 will first apply to CQHHS financial statements in the 2020-21 financial year. This standard defines service concession arrangements and applies a new control concept to the recognition of service concession assets and related liabilities. CQHHS will be analysing the effects of this standard on CQHHS to report in the 2019-20 financial statements before the effective date of 1 July 2020.

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

D6 SUBSEQUENT EVENTS

There are no matters or circumstances that have arisen since 30 June 2019 that have significantly, or may significantly affect CQHHS's operations, the result of those operations, or the HHS's state of affairs in future financial years.

SECTION E NOTES ON OUR PERFORMANCE COMPARED TO BUDGET

E1 BUDGETARY REPORTING DISCLOSURES

This section discloses CQHHS's original published budgeted figures for 2018-19 compared to actual results, with explanations of major variances, in respect of CQHHS's Statement of Comprehensive Income, Statement of Financial Position and Statement of Cash Flows.

E1.1 BUDGET TO ACTUAL COMPARISON – STATEMENT OF COMPREHENSIVE INCOME

	Variance Notes	Original SDS Budget 2019 $'000	Actual 2019 $'000	Original SDS Budget V Actual Variance $'000	Variance % of original budget
OPERATING RESULT					
Income from Continuing Operations					
User charges and fees		47,370	**48,308**	938	2%
Funding public health services		544,761	**547,730**	2,969	1%
Grants and other contributions	1	14,660	**23,117**	8,457	58%
Other revenue		3,560	**3,469**	(91)	(3%)
Total Revenue		610,351	**622,624**	12,273	
Total Income from Continuing Operations		610,351	**622,624**	12,273	
Expenses from Continuing Operations					
Employee expenses	2	55,745	**61,952**	6,207	11%
Health service employee expenses		320,457	**329,433**	8,976	3%
Supplies and services		198,622	**192,460**	(6,162)	(3%)
Depreciation	3	33,652	**25,972**	(7,680)	(23%)
Revaluation decrement					
Other expenses	4	1,875	**12,388**	10,513	561%
Total Expenses from Continuing Operations		610,351	**622,205**	11,854	
Operating Results from Continuing Operations		-	**419**	419	
Other Comprehensive Income *Items that will not be reclassified subsequently to profit or loss*					
Increase/(decrease) in asset revaluation surplus		-	**12,561**	12,561	
Other comprehensive income for the year		-	**12,561**	12,561	
Total comprehensive income for the year		-	**12,980**	12,980	

Note:

Original Published Budget from the Service Delivery Statement (SDS) has been revised to improve transparency and analysis with comparatives by remapping particular budgeted transactions on the same basis as reported in actual financial statements. Reclassification for the Statement of Comprehensive Income has occurred for:

- User charges and fees in the original SDS have been dissected into user charges and funding public health services.
- Interest revenue has been rolled into other revenue as immaterial by size for individual reporting.
- Department of Health contract staff have moved from under supplies and services and is presented as a labour expense along with employee expenses.
- Grants and subsidies have been rolled into other expenses as immaterial by size for individual reporting.
- Losses on sale/revaluation of assets are rolled into other expenses as immaterial for actual reporting.
- Insurance expenses have been budgeted in the original SDS as supplies and services, however have been included in other expenses for actual reporting in accordance with Queensland Treasury's financial reporting requirements.
- Any account groups displayed on the SDS with a zero balance have not been included in the statement.

E1.1 BUDGET TO ACTUAL COMPARISON – STATEMENT OF COMPREHENSIVE INCOME (continued)

Materiality for notes commentary is based on the calculation of the line item's actual value percentage of the group total. If the percentage is greater than 5%, the line item variance from budget to actual is reviewed. A note is provided for where this percentage is 5% or greater for employee expenses, supplies and services, and depreciation and 10% or greater for others.

Explanation of Major Variances - Statement of Comprehensive Income

1.**Grants and contributions**: The budget variance is mainly due to the inclusion of the services below fair value for $5.288 million that was not included in the original budget.

2. Employee expenses: The increase relates to the conversion of external contract staff to permanent and addition of frontline staff to service growth in demand.

3. Depreciation: The decrease in depreciation against the budget relates to changes in the expected commissioning dates of some capital projects and a lower asset base due to assets revalued down in the 2017-18 financial year.

4. Other expenses: The budget variance is mainly due to the inclusion of the services below fair value for $5.288 million that was not included in the original budget and the allocation of the QGIF insurance premium of $5.1 million to other expenses.

E1.2 BUDGET TO ACTUAL COMPARISON – STATEMENT OF FINANCIAL POSITION

	Variance Notes	Original SDS Budget 2019 $'000	Actual 2019 $'000	Original SDS Budget V Actual Variance $'000	Variance % of original budget
Current Assets					
Cash and cash equivalents	5	14,589	**18,670**	4,081	28%
Receivables	6	18,560	**13,176**	(5,384)	(29%)
Inventories		3,859	**3,831**	(28)	(1%)
Other	7	2,235	**593**	(1,642)	(73%)
Total Current Assets		39,243	**36,270**	(2,973)	
Non-Current Assets					
Property, plant and equipment	8	489,704	**419,862**	(69,842)	(14%)
Total Non-Current Assets		489,704	**419,862**	(69,842)	
Total Assets		528,947	**456,132**	(72,815)	
Current Liabilities					
Payables		30,195	**31,828**	1,633	5%
Total Current Liabilities		30,195	**31,828**	1,633	
Total Liabilities		30,195	**31,828**	1,633	
Net Assets		498,752	**424,304**	(74,448)	
Equity					
Contributed equity	9	457,367	**373,549**	(83,818)	(18%)
Accumulated surplus/(deficit)	10	5,221	**2,412**	(2,809)	(54%)
Asset revaluation surplus	11	36,164	**48,343**	12,179	34%
Total Equity		498,752	**424,304**	(74,448)	

Note:

The Original Published Budget from the Service Delivery Statement (SDS) has been revised to improve transparency and analysis with comparatives by remapping particular budgeted transactions on the same basis as reported in actual financial statements (revised SDS Budget). Reclassification in relation to the Statement of Financial Position has occurred for:

- GST payable has been offset with GST receivable to align with the treatment required in the reporting of actual under Queensland Treasury's Financial Reporting Requirements.
- Accrued employee benefits and unearned revenue in original SDS have been aggregated into payables due to immateriality in size.
- Any account groups displayed on the SDS with a zero balance have not been included in the statement.
- Equity has been disaggregated into contributed equity, accumulated surplus/deficit and asset revaluation surplus for improved transparency.

Materiality for notes commentary is based on the calculation of the line item's actual value percentage of the group total. If the percentage is greater than 5%, the line item variance from budget to actual is reviewed. A note is provided for where this percentage is 5% or greater for Property, plant and equipment and 10% or greater for others.

Explanation of major variances - statement of financial position

Note 5. Cash and cash equivalents: The budget variance relates to increased funding for services and timing of payments to suppliers.

Note 6. Receivables: The decrease relates to the receipt of funding from the Department relating to prior year activity and prior year adjustments totalling $2.1 million. See note G4. The 2018-19 budget anticipated that the outstanding receivable balance at the 30 June would be in line with the 2017 financial statements that shows the receivables balance as $17.6m.

Note 7. Other: The decrease relates to prepaid expenditure. The 2018-19 budget anticipated other assets would be in line with the 2017 financial statements that shows the other current assets balance as $2.126m.

Note 8. Property, plant and equipment: The budget did not reflect the 2017-18 reduction in building valuations, because of the annual asset revaluation program. It was anticipated that some capital projects would be further progressed.

Note 9. Contributed equity: The budget did not consider the downward valuation of assets at 30 June 2018.

Note 10. Accumulated surplus/(deficit): The budget variance relates to prior year adjustments totalling $2.3 million. See note G4.

Note 11. Asset revaluation surplus: The variance reflects the revaluations that have occurred in the 2018-19 financial year.

E1.3 BUDGET TO ACTUAL COMPARISON – STATEMENT OF CASH FLOW

	Variance Notes	Original SDS Budget 2019 $'000	Actual 2019 $'000	Original SDS Budget V Actual Variance $'000	Variance % of original budget
Cash flows from operating activities					
Inflows:					
User charges and fees		47,397	**46,956**	(441)	(1%)
Funding public health services		545,066	**521,508**	(23,558)	(4%)
Grants and other contributions	12	14,660	**17,596**	2,936	20%
GST input tax credits from ATO	13	-	**12,720**	12,720	-%
GST collected from customers		-	**597**	597	-%
Other receipts	13	17,520	**3,466**	(14,054)	(80%)
Outflows:					
Employee expenses	14	(55,715)	**(61,793)**	(6,078)	11%
Health service employee expenses		(335,107)	**(327,969)**	7,138	(2%)
Supplies and services		(196,808)	**(192,239)**	4,569	(2%)
Grants and subsidies		-			
GST paid to suppliers		-	**(12,669)**	(12,669)	-%
GST remitted to ATO		-	**(588)**	(588)	-%
Other payments	15	(2,253)	**(6,695)**	(4,442)	197%
Net cash from/(used by) operating activities		34,760	**890**	(33,870)	
Cash flows from investing activities					
Inflows:					
Sales of property, plant and equipment		73	**48**	(25)	34%
Outflows:					
Payments for property, plant and equipment	16	(4,774)	**(9,866)**	(5,092)	107%
Net cash from/(used by) investing activities		(4,701)	**(9,818)**	(5,117)	
Cash flows from financing activities					
Inflows:					
Equity injections	17	4,774	**12,665**	7,891	165%
Outflows:					
Equity withdrawals	18	(33,652)		33,652	100%
Net cash from/(used by) financing activities		(28,878)	**12,665**	41,543	
Net increase/(decrease) in cash and cash equivalents		1,181	**3,737**	2,556	
Cash and cash equivalents at the beginning of the financial year		13,408	**14,933**	1,525	11%
Cash and cash equivalents at the end of the financial year		14,589	**18,670**	4,081	

Note:
Original Published Budget from the Service Delivery Statement (SDS) has been revised to improve transparency and analysis with comparatives by remapping particular budgeted transactions on the same basis as reported in actual financial statements (revised SDS Budget). Reclassification in relation to the statement of cash flows has occurred for:

- User charges in original SDS have been dissected into User charges and Funding public health services.
- Interest receipts have been rolled into other receipts as immaterial for actual reporting.

Materiality for notes commentary is based on the calculation of the line item's actual value percentage of the group total. If the percentage is greater than 5%, the line item variance from budget to actual is reviewed. A note is provided for where this percentage is 5% or greater for employee expenses, supplies and services, and property, plant and equipment and 10% or greater for others.

E1.3 BUDGET TO ACTUAL COMPARISON – STATEMENT OF CASH FLOW (continued)

Explanation of Major Variances - Statement of Cash Flows

Note 12. Grants & contributions: The budget was prepared based on known grants within the period, additional grant funding was obtained subsequent to the preparation of the budget.

Note 13. Other receipts: Budget line includes GST receipts based on the 2017-18 financial year, which was approximately $13 million.

Note 14. Employees expenses: The increase relates to the conversion of external contract staff to permanent and the addition of frontline staff to service growth in demand.

Note 15. Other payments: Relates to insurance payment (QGIF: $5.1 million) that was not classified to this budget line item.

Note 16. Payments to property, plant and equipment: The budget variance is due to the budget for capital acquisitions being held by the Department.

Note 17. Equity injections: Equity injections increased by $7.89 million because the capital budget is held by the Department who reimburse CQHHS for payments made in relation to capital works that are funded by the Department by the way of equity injections.

Note 18. Equity withdrawals: The original budget included the depreciation equity withdrawal as a cash flow item. This is a non-cash flow item.

SECTION F WHAT WE LOOK AFTER ON BEHALF OF THIRD PARTIES

F1 TRUST TRANSACTIONS AND BALANCES

CQHHS administers, but does not control, certain activities on behalf of the government. In doing so, it has responsibility for administering those activities (and related transactions and balances) efficiently and effectively. But does not have the discretion to deploy those resources for the achievement of CQHHS own objectives.

Accounting policies applicable to administered items are consistent with the equivalent policies for controlled items, unless stated otherwise.

The CQHHS acts in a custodial role in respect of these transactions and balances. As such, they are not recognised in the financial statements, but are disclosed below for information purposes. The activities of trust accounts are audited by the Queensland Audit Office (QAO) on an annual basis.

	2019 $'000	2018 $'000
Patient Trust receipts and payments		
Receipts		
Patient trust receipts	**4,588**	4,575
Total receipts	**4,588**	4,575
Payments		
Patient trust payments	**4,615**	4,668
Total payments	**4,615**	4,668
Increase/decrease in net patient trust assets	**(27)**	(93)
Patient trust assets opening balance	**951**	1,044
Patient trust assets closing balance	**924**	951
Patient trust assets		
Current assets		
Cash at bank and on hand	**551**	578
Patient trust and refundable deposits	**373**	373
Total	**924**	951

F2 GRANTED PRIVATE PRACTICE

Granted Private Practice permits Senior Medical Officers (SMOs) and Visiting Medical Officers (VMOs) employed in the public health system to treat individuals who elect to be treated as private patients. SMOs and VMOs receive a private practice allowance and assign practice revenue generated to the Hospital (assignment arrangement). Alternatively, SMOs and VMOs pay a facility charge and administration fee to the Hospital and retain an agreed proportion of the private practice revenue (retention arrangement) with the balance of revenue deposited into a trust account to fund research and education of clinical staff. In addition, all SMOs and VMOs engaged in private practice receive an incentive on top of their regular remuneration. Receipts and payments relating to both the granted private practice arrangements and right of private practice system during the financial year are as follows:

	2019 $'000	2018 $'000
Receipts		
Billings - (Senior Medical Officers and Visiting Medical Officers)	**4,178**	4,205
Total receipts	**4,178**	4,205
Payments		
Payments to Senior Medical Officers and Visiting Medical Officers	**12,236**	3,769
Hospital and Health Service recoverable administrative costs	**388**	359
Hospital and Health Service education/travel fund	**45**	75
Total payments	**12,670**	4,203
Closing balance of bank account under a trust fund arrangement not yet disbursed and not restricted cash	**11**	56

SECTION G OTHER INFORMATION

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES

As from 2016-17, the Minister for Health and Minister for Ambulance Services is identified as part of the CQHHS's key management personnel (KMP), consistent with additional guidance included in the revised version of *AASB 124 Related Party Disclosures*.

Ministerial remuneration entitlements are outlined in the Legislative Assembly of Queensland's Members' Remuneration Handbook. CQHHS does not bear any cost of remuneration of Ministers. The majority of Ministerial entitlements are paid by the Legislative Assembly, with the remaining entitlements being provided by Ministerial Services Branch within the Department of the Premier and Cabinet. As all Ministers are reported as KMP of the Queensland Government, aggregate remuneration expenses for all Ministers is disclosed in the Queensland General Government and Whole of Government Consolidated Financial Statements, which are published as part of Queensland Treasury's Report on State Finances.

The following details for non-Ministerial key management personnel reflect those positions that have authority and responsibility for planning, directing and controlling the activities of CQHHS during the current financial year:

Position	Incumbent	Contract Classification and Appointment Authority	Date of Initial Appointment	Date of Resignation or Cessation
Non-executive Board Chair Provide strategic leadership, guidance and effective oversight of management, operations and financial performance.	Cr Paul Bell AM	Hospital and Health Boards Act 2011 Section 25 (1)(a)	25 September 2015	-
Non-executive Deputy Board Chair Provide strategic leadership, guidance and effective oversight of management, operations and financial performance.	Mr Graeme Kanofski PSM	Hospital and Health Boards Act 2011 Section 25 (1)(b)	18 May 2013	17 May 2019
Non-executive Board Members Provide strategic leadership, guidance and effective oversight of management, operations and financial performance.	Professor Leone Hinton	Hospital and Health Boards Act 2011 Section 23 (1)	29 June 2012	-
	Mr Francis Houlihan	Hospital and Health Boards Act 2011 Section 23 (1)	9 November 2012	17 May 2019
	Ms Karen Smith	Hospital and Health Boards Act 2011 Section 23 (1)	18 May 2014	17 May 2019
	Ms Elizabeth Baker	Hospital and Health Boards Act 2011 Section 23 (1)	20 May 2013	17 May 2019
	Dr Poya Sobhanian	Hospital and Health Boards Act 2011 Section 23 (1)	18 May 2016	-
	Dr Anna Vanderstaay	Hospital and Health Boards Act 2011 Section 23 (1)	18 May 2016	-
	Ms Lisa Caffery	Hospital and Health Boards Act 2011 Section 23 (1)	18 May 2016	-
	Ms Tina Zawila	Hospital and Health Boards Act 2011 Section 23 (1)	17 May 2019	-
	Mr Matthew Cooke	Hospital and Health Boards Act 2011 Section 23 (1)	17 May 2019	-
	Mr Andrew Ireland	Hospital and Health Boards Act 2011 Section 23 (1)	17 May 2019	-
Health Service Chief Executive Responsible for the overall leadership and management of the CQHHS to ensure that CQHHS meets its strategic and operational objectives.	Mr Steve Williamson	S24/s70 Appointed by Board under Hospital and Health Board Act 2011 (Section 7 (3)).	9 January 2017	-
Chief Finance Officer, Assets, and Commercial Services Responsible for the management and oversight of the CQHHS finance framework including financial accounting, budget and performance management frameworks, assets and commercial services, information and technology, and corporate governance systems.	Mr Muku Ganesh	Contractor	16 August 2016	30 July 2018

Position	Incumbent	Contract Classification and Appointment Authority	Date of Initial Appointment	Date of Resignation or Cessation
Chief Finance Officer, Assets, and Commercial Services Responsible for the management and oversight of the CQHHS finance framework including financial accounting, budget and performance management frameworks, assets and commercial services, information and technology, and corporate governance systems.	Mr Muku Ganesh	HES 2 Appointed by CE under HHB Act 2011	31 July 2018	16 October 2018
Chief Finance Officer, Assets, and Commercial Services (acting) Responsible for the management and oversight of the CQHHS finance framework including financial accounting, budget and performance management frameworks, assets and commercial services, information and technology, and corporate governance systems.	Mr James Kelaher	Contractor	15 October 2018	-
Executive Director, Rockhampton Hospital Responsible for the leadership, management and coordination of the Rockhampton Hospital Business Unit.	Ms Wendy Hoey	HES 2 Appointed by CE under HHB Act 2011	20 June 2016	-
Executive Director Medical Services Central Queensland Responsible for the strategic and professional functions for CQHHS medical workforce, and clinical governance.	Dr Julieanne Graham	MMOI1 Appointed under Medical Officers (Queensland Health) Award – State 2015 and Medical Officer (Queensland Health) Certified Agreement (No. 4) 2015	16 July 2018	-
Executive Director Medical Services Central Queensland Responsible for the strategic and professional functions for CQHHS medical workforce, and clinical governance.	Dr Anette Turley	MMOI1 Appointed under Medical Officers (Queensland Health) Award – State 2015 and Medical Officer (Queensland Health) Certified Agreement (No. 4) 2015	16 November 2017	15 July 2018
Executive Director, Gladstone and Banana Responsible for the leadership, management and coordination of Gladstone and Banana Business Unit.	Ms Joanne Glover	HES 2 Appointed by CE under HHB Act 2011	29 August 2016	2 December 2018
Acting Executive Director, Gladstone and Banana Responsible for the leadership, management and coordination of Gladstone and Banana Business Unit.	Ms Sandralee Munro	NRG13 Appointed under Nurses and Midwives (Queensland Health) Award - State 2015 and Nurse and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018	13 November 2018	-
Acting Executive Director of Nursing Midwifery Quality and Safety Responsible for strategic and professional leadership of nursing workforce.	Ms Susan Foyle	NRG13 Appointed under Nurses and Midwives (Queensland Health) Award - State 2015 and Nurse and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018	10 September 2018	-
Executive Director of Nursing Midwifery Quality and Safety Responsible for strategic and professional leadership of nursing workforce.	Ms Sandralee Munro	NRG12 Appointed by CE under HHB Act 2011	20 July 2015	12 November 2018
Executive Director, Rural District Wide Services Responsible for the leadership, management and coordination of the Rural and District Wide Business Unit.	Mr Robert Forsythe	HES 2 Appointed by CE under HHB Act 2011	18 February 2019	-

Position	Incumbent	Contract Classification and Appointment Authority	Date of Initial Appointment	Date of Resignation or Cessation
Executive Director, Rural District Wide Services Responsible for the leadership, management and coordination of the Rural and District Wide Business Unit	Mr Kieran Kinsella	HES 2 Appointed by CE under HHB Act 2011	25 November 2016 (acting from 4 April 2016)	17 February 2019
Executive Director, Workforce Responsible for provision of leadership and oversight of human resource, occupational health and safety functions, and Indigenous training and development for the Health Service.	Ms Shareen McMillan	HES 2 Appointed by CE under HHB Act 2011	03 December 2018	-
Executive Director, Workforce Responsible for provision of leadership and oversight of human resource, occupational health and safety functions, and Indigenous training and development for the Health Service.	Mr Peter Patmore	HES 2 Appointed by CE under HHB Act 2011	5 September 2016	30 November 2018
Executive Director, Strategy, Transformation and Allied Health Responsible for leading development and implementation of a continuous service improvement approach across CQHHS.	Ms Kerrie-Anne Frakes	HP7 Appointed by CE under HHB Act 2011	22 January 2018	-
Director, Aboriginal & Torres Strait & Islander Health & Wellbeing Responsible for leading development and implementation of health programs and service improvement for the Aboriginal & Torres Strait and islander community across CQHHS.	Ms Sharni Tippett	DSO2-1 Appointed by CE under HHB Act 2011	11 December 2018	-

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Remuneration policy

Section 74(1) of the *Hospital and Health Boards Act 2011* provides that each person appointed as a Health Executive must enter into a contract of employment. The Health Service Chief Executive must enter into the contract of employment with the Chair of the Board for the Hospital and Health Service and a Health Executive employed by a Hospital and Health Service must enter into a contract of employment with the Health Service Chief Executive. The contract of employment must state the term of employment (no longer than 5 years per contract), the person's functions and any performance criteria as well as the person's classification level and remuneration entitlements.

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

- Short-term employee benefits which include: **Monetary benefits** – consisting of base salary, allowances and leave entitlements paid and provided for the entire year or for that part of the year during which the employee occupied the specified position. Amounts disclosed equal the amount expensed in the statement of comprehensive income. **Non-monetary benefits** – consisting of provision of reportable as well as exempt benefits together with fringe benefits tax applicable to the benefit. Benefits provided to individual employees working for a public and non-profit hospital under a salary package arrangement where the grossed-up value is equal or lower than $17,667 are not reported in this Note.
- 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.
- No performance bonuses were paid in the 2018-19 financial year (2018: $nil).

Board remuneration

Remuneration paid or owing to Board members during 2018-19 was as follows:

Board Member	Short-term employee expenses		Post employee expenses	Total Expenses
	Monetary expenses	Non-monetary expenses		
	$'000	$'000	$'000	$'000
Cr Paul Bell (AM) - Chair	91	-	8	**99**
Mr Graeme Kanofski - Deputy Chair	43	-	4	**47**
Professor Leone Hinton	48	-	5	**53**
Mr Francis Houlihan	41	-	4	**45**
Ms Elizabeth Baker	41	-	4	**45**
Dr Poya Sobhanian	46	-	4	**50**

Dr Anna Vanderstaay	49	-	5	**54**
Ms Lisa Caffery	51	-	4	**55**
Ms Karen Smith*	38	-	4	**42**
Ms Tina Zawila	5	-	1	**6**
Mr Matthew Cooke	5	-	1	**6**
Mr Andrew Ireland	5	-	1	**6**

* Board members who are employed by either CQHHS or the Department of Health are paid board fees when approved by government.

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Remuneration paid or owing to Board members during 2017-18 was as follows:

Board Member	Short-term employee expenses		Post employee expenses	Total Expenses
	Monetary expenses	Non-monetary expenses		
	$'000	$'000	$'000	$'000
Cr Paul Bell (AM) - Chair	94	-	9	**103**
Mr Graeme Kanofski - Deputy Chair	52	-	5	**57**
Professor Leone Hinton	46	-	4	**50**
Mr Francis Houlihan	49	-	5	**54**
Ms Elizabeth Baker	52	9	5	**66**
Dr Poya Sobhanian	48	-	5	**53**
Dr Anna Vanderstaay	46	-	4	**50**
Ms Lisa Caffery	52	9	5	**66**
Ms Karen Smith*	43	-	4	**47**

* Board members who are employed by either CQHHS or the Department of Health Queensland are paid Board fees when approved by government.

Other key management personnel remuneration

Remuneration paid or owing to employees who occupied key management roles, including while providing leave cover during 2018-19 was as follows:

2018-19

Position	Short-term employee expenses		Long term expenses	Post-employment expenses	Termination benefits	Total expenses
	Monetary expenses	Non-monetary expenses				
	$'000	$'000	$'000	$'000	$'000	$'000
Health Service Chief Executive	356	5	7	29	-	**397**
Chief Finance Officer, Assets and Commercial Services	431	10	1	4	-	**446**
Executive Director, Medical Service Central Queensland	457	8	9	37	-	**511**
Executive Director, Rockhampton Hospital	216	-	4	18	-	**238**
Executive Director, Gladstone and Banana	304	1	3	30	-	**338**
Executive Director, Nursing, Midwifery, Quality and Safety	303	-	5	24	-	**332**
Executive Director, Rural District Wide Services	188	-	4	18	-	**210**
Executive Director Workforce	182	72	3	17	-	**274**
Executive Director, Strategy, Transformation and Allied Health	171	-	3	18	-	**192**
Director, Aboriginal & Torres Strait Islander Health & Wellbeing	79	-	3	10	-	**92**

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Remuneration paid or owing to employees who occupied key management roles, including while providing leave cover during 2017-18 was as follows:

2017-18

Position	Short-term employee expenses		Long term expenses	Post-employment expenses	Termination benefits	Total expenses
	Monetary expenses	Non-monetary expenses				
	$'000	$'000	$'000	$'000	$'000	$'000
Health Service Chief Executive	367	6	7	33	-	**413**
Chief Finance Officer, Assets and Commercial Services	256	26	4	15	-	**301**
Executive Director, Medical Service Central Queensland	461	6	9	32	-	**508**
Executive Director, Rockhampton Hospital	199	-	4	19	-	**222**
Executive Director, Gladstone and Banana	196	1	4	19	-	**220**
Executive Director, Nursing, Midwifery, Quality and Safety	218	-	4	21	-	**243**
Executive Director, Rural District Wide Services	191	-	4	19	-	**214**
Executive Director Workforce	185	26	4	18	-	**233**
Director Operations and Innovation	158	-	3	18	-	**179**

G2 RELATED PARTY TRANSACTIONS

Transactions with people/entities related to key management personnel

There are no transactions with people/entities related to KMP.

Transactions with Queensland Government controlled entities

CQHHS is controlled by its ultimate parent entity, the State of Queensland. All State of Queensland controlled entities meet the definition of a related party in *AASB 124 Related Party Disclosures*.

Department of Health Queensland

Procurement of public hospital services

CQHHS receives funding in accordance with a service agreement with the Department. The Department receives its revenue from the Queensland Government (majority of funding) and the Commonwealth. CQHHS is funded for eligible services through block funding; activity-based funding or a combination of both. Activity based funding is based on an agreed number of activities per the service agreement and a state-wide price by which relevant activities are funded. Block funding is not based on levels of public care activity.

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

The signed service agreements are published on the Queensland Government website and publicly available.

In addition, the Department provides services free of charge to CQHSS which include payroll, accounts payable, finance, taxation, procurement and information technology infrastructure services. The fair value of these services is estimated at $5.288 million for the 2018-19 financial year and is recognised in the Statement of Comprehensive Income. The associated business expenses paid by Department on behalf of CQHHS for providing these services are recouped by the Department.

Health service employees

CQHHS is not a prescribed employer and 2,968 health service employees (MOHRI FTE) are employed by the Department and contracted to work for CQHHS.

Queensland Treasury Corporation

CQHHS has accounts with the Queensland Treasury Corporation for general and fiduciary trust monies.

Department of Housing and Public Works

CQHHS pays rent to the Department of Housing and Public Works for several properties used for employee accommodation, offices etc. In addition, the Department of Housing and Public Works provides vehicle fleet management services (QFleet) to CQHHS.

Transactions between Hospital and Health Services

Payments to and receipts from other Hospital and Health Services occur to facilitate the transfer of patients, drugs, staff and other incidentals.

Other

Grants are also received from other governments departments and related parties but they are no individually significant transactions.

G3 FEDERAL TAXATION CHARGES

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

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

G4 PRIOR PERIOD ERRORS AND ADJUSTMENTS

In preparation of the 2018-19 financial statements, CQHHS identified a number of prior year errors.

(a) An amount of $620,000 relating to repairs and maintenance was incorrectly recorded as capital work in progress. Restating this has increased the expenditure and decreased the non-current assets for the 2017-18 financial year.

(b) An amount of $902,449 was an error resulting from the non-application of a known land valuation decrement. Restating this has increased 2017-18 financial year expenditure by $520,318, being the amount over the available funds in the asset revaluation reserve, decreased the asset revaluation reserve by $382,131 and decreased the non-current assets (land) by $902,449.

(c) An amount of $1,194,561 was accrued in the 2017-18 financial year based on a projected over-delivery of 552 NWAU in activity that should have been known at the time was not going to be achievable. Restating this has decreased 2017-18 financial year revenue (Funding public health services) and receivables.

(d) An amount of $892,000 was erroneously accrued for grant funding in the 2016-17 financial year. Restating this has reduced the accumulated surplus balance, along with the receivables balance. This adjustment has been recorded against the opening 2017-18 retained earnings.

Comparative numbers reported in the 2017-18 financial statements, and at the beginning of the comparative financial year (1 July 2017) have been restated to correct these errors. The line items affected are as follows:

Note G4-1: Prior period adjustments

	2017			2018		
Financial statement Line items affected	***Published financial statements***	***Correction of error***	***Reinstated actual July 17***	***Published financial statements***	***Correction of error***	***Reinstated actual July 18***
	$'000	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*
Impact on equity (increase/(decrease) in equity						
Statement of financial position						
Receivables	18,503	(892)	17,611	13,909	(1,195)	11,822
Property, plant and equipment	-	-	-	398,771	(1,522)	397,249
Total assets	**18,503**	**(892)**	**17,611**	**412,680**	**(2,717)**	**409,071**
Accumulated surplus/(deficit)	9,650	(892)	8,758	5,221	(2,335)	1,994
Asset revaluation surplus	-	-	-	36,164	(382)	35,782
Total equity	**9,650**	**(892)**	**8,758**	**41,385**	**(2,717)**	**37,776**
Impact on statement of profit & loss and other comprehensive income (increase/(decrease) in profit						
Statement of comprehensive income						
Funding public health services				512,049	(1,195)	510,854
Supplies and services				184,073	(620)	184,693
Revaluation decrement				-	(520)	520
Total Profit & Loss				(4,429)	(2,335)	(6,764)
Other Comprehensive Income				(46,760)	(382)	(47,142)
Total Comprehensive Income for the year				(51,189)	(2,717)	(53,906)

G5 FIRST YEAR APPLICATION OF NEW ACCOUNTING STANDARDS OR CHANGE IN ACCOUNTING POLICY

Changes in accounting policies – AASB 9 Financial Instruments

CQHHS applied AASB 9 *Financial Instruments* and AASB 7 *Financial Instrument Disclosures* for the first time in 2018-19. Comparative information for the 2017-2018 has not been restated and continue to be reported under AASB 139 Financial Instruments: Recognition and Measurement. The nature and effect of the changes as a result of adoption of this new accounting standard are described below.

The main impacts of these standards on CQHHS are that they will change the requirements for the classification, measurement, impairment and disclosures associated with financial assets.

The transition provisions of AASB 9 allow an entity not to restate comparatives, as such CQHHS has elected not to restate comparatives in respect of the classification and measurement of financial instruments.

AASB 9 introduced new requirements for the classification and measurement of financial assets and financial liabilities, and associated impairment of financial assets.

Classification and measurement of financial assets and liabilities

All recognised financial assets that are within the scope of AASB 9 are required to be subsequently measured at amortised cost based on the CQHHS's business model for managing the financial assets and the contractual cash flow characteristics of the financial assets.

There has been no change to either the classification or valuation of the cash and cash equivalent items in Note C1.

All financial liabilities listed in Note C5 will continue to be measured at amortised cost.

CQHHS reviewed and assessed the existing financial assets and liabilities as at 1 July 2018 based on the facts and circumstances that existed at that date and concluded that the initial application of AASB 9 has had no material impact on financial assets with regards to the classification and measurement.

Trade receivables are classified and measured at amortised cost similar to the current classification of loans and receivables. However, new impairment requirements will result in a provision being applied to all receivables rather than only on those receivables that are credit impaired. Provisions for impairment on receivables are now to be based on an expected basis rather than an incurred basis.

CQHHS has adopted the simplified approach under AASB 9 and measure lifetime expected credit losses on all trade receivables and contract assets (arising from AASB 15) using a provision matrix approach as a practical expedient to measure the impairment provision. Applying this approach, CQHHS has estimated the opening provision for impairment and will not be adjusted.

CQHHS has assessed the impact of applying AASB 9 for the first time on the carrying receivables amount on 1 July 2018. Applying AASB 9 has resulted in a 2% increase of the carrying amount for receivables ($7.554 million); $7.385 million before considering the impact of AASB 9. The reason for this increase is due to an overstatement of the impairment loss allowance in prior financial years. The opening balance for retained earnings has not been adjusted as the difference is immaterial.

Impairment of financial assets

In relation to the impairment of financial assets, AASB 9 requires an expected credit loss model as opposed to an incurred credit loss model under AASB 139. The expected credit loss model requires CQHHS to account for expected credit losses and changes in those expected credit losses at each reporting date to reflect changes in credit risk since initial recognition of the financial assets. In other words, it is no longer necessary for a credit event to have occurred before credit losses are recognised.

Specifically, AASB 9 requires CQHHS to recognise a loss allowance for expected credit losses on:

(a) Lease receivables, and

(b) Trade receivables and contract assets

AASB 9 requires CQHHS to measure the loss allowance for a financial instrument at an amount equal to the lifetime expected credit losses (ECL) if the credit risk on that financial instrument has increased significantly since initial recognition, or if the financial instrument is a purchased or originated credit-impaired financial asset. However, if the credit risk on a financial instrument has not increased significantly since initial recognition (except for a purchased or originated credit-impaired financial asset), CQHHS is required to measure the loss allowance for that financial instrument at an amount equal to 12-months ECL for lease receivables. As per the Queensland Treasury guidance, CQHHS has adopted the lifetime ECL method for trade receivables

Accounting standards early adopted

No Australian Accounting Standards have been early adopted for 2018-19.

Accounting standards applied for the first time

Other than AASB 9 Financial Instruments, which is detailed above, no accounting standards that apply to CQHHS for the first time in 2018-19 have any material impact on the financial statements.

4.7. Management Certificate

Certificate of Central Queensland Hospital and Health Service

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

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

b) the statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of the Central Queensland Hospital and Health Service for the financial year ended 30 June 2019 and of the financial position of the Central Queensland Hospital and Health Service at the end of that year.

We acknowledge our responsibility under sections 8 and 15 of the *Financial and Performance Management Standard 2009* for the establishment and maintenance, in all material respects, of an appropriate and effective system of internal controls and risk management processes with respect to financial reporting throughout the reporting period.

Cr Paul Bell, AM
Chairperson Health Service
Date: 30 August 2019

Steve Williamson
Chief Executive
Date: 30 August 2019

James Kelaher
Acting Chief Finance Officer
Date: 30 August 2019

Queensland Audit Office
Better public services

INDEPENDENT AUDITOR'S REPORT

To the Board of Central Queensland Hospital and Health Service

Report on the audit of the financial report

Opinion

I have audited the accompanying financial report of Central Queensland Hospital and Health Service.

In my opinion, the financial report:

a) gives a true and fair view of the entity's financial position as at 30 June 2019, and its financial performance and cash flows for the year then ended

b) complies with the *Financial Accountability Act 2009*, the Financial and Performance Management Standard 2009 and Australian Accounting Standards.

The financial report comprises the statement of financial position as at 30 June 2019, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including summaries of significant accounting policies and other explanatory information, and the management certificate.

Basis for opinion

I conducted my audit in accordance with the *Auditor-General of Queensland Auditing Standards*, which incorporate the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report.

I am independent of the entity in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. I have also fulfilled my other ethical responsibilities in accordance with the Code and the *Auditor-General of Queensland Auditing Standards*.

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

Key audit matters

Key audit matters are those matters that, in my professional judgement, were of most significance in my audit of the financial report of the current period. I addressed these matters in the context of my audit of the financial report as a whole, and in forming my opinion thereon, and I do not provide a separate opinion on these matters.

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Specialised buildings valuation ($375.2m)

Refer to Note C4 in the financial report.

Key audit matter	How my audit addressed the key audit matter
Building Valuation Buildings were material to Central Queensland Hospital and Health Service at balance date and are measured at fair value using the current replacement cost method. A comprehensive valuation of buildings was undertaken by an independent valuation specialist in 2018 for 75% of the written down value of buildings at Central Queensland Hospital and Health Service. For 2019, Central Queensland Hospital and Health Service performed a revaluation of its buildings using relevant indices. The current replacement cost method comprises: • Gross replacement cost, less • Accumulated depreciation Central Queensland Hospital and Health Service derived the gross replacement cost of its buildings at balance date by applying indexation factors to the gross replacement costs determined at the previous balance date. Using indexation required: • Significant judgment in determining the indexation factors that reflected the estimated change, since the previous balance date, in the cost inputs used in developing the gross replacement. • Reviewing previous assumptions and judgements used in the determination of fair value in intervening years between the comprehensive valuation to ensure ongoing validity of assumptions and judgements used. The measurement of accumulated depreciation involved significant judgements for forecasting the remaining useful lives of building components. The significant judgements required for gross replacement and useful lives are also significant for calculating annual depreciation expense.	My procedures included, but were not limited: • Assessing the adequacy of management's review of the valuation process. • Reviewing the scope and instructions provided to the valuer. • Assessing the competence, capabilities and objectivity of the valuation specialist used to develop the models. • Obtaining an understanding of the methodology used and assessing its appropriateness with reference to common industry practices. • Evaluating the relevance and appropriateness of the indices used for changes in cost inputs: o By comparing to other relevant external indices; o Recalculating the application of the indices to asset balances; and • Evaluating useful life estimates for reasonableness by: o Reviewing management's annual assessment of useful lives; o Testing that no asset still in use has reached or exceeded its useful life; o Enquiring of management about their plans for assets that are nearing the end of their useful life; and o Reviewing assets with an inconsistent relationship between condition and remaining useful life. • Where changes in useful lives were identified, evaluating whether they were supported by appropriate evidence. • Reconciling the fair value of the buildings as determined by management to the underlying accounting records and disclosures in the financial statements

Responsibilities of the entity 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 the *Financial Accountability Act 2009*, the Financial and Performance Management Standard 2009 and Australian Accounting Standards, and for such internal control as the Board determines is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

The Board is also responsible for assessing the entity's ability to continue as a going concern, disclosing, as applicable, matters relating to going concern and using the going concern basis of accounting unless it is intended to abolish the entity or to otherwise cease operations.

Auditor's responsibilities for the audit of the financial report

My objectives are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for expressing an opinion on the effectiveness of the entity's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the entity.
- Conclude on the appropriateness of the entity's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. I base my conclusions on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

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I communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

From the matters communicated with the Board, I determine those matters that were of most significance in the audit of the financial report of the current period and are therefore the key audit matters. I describe these matters in my auditor's report unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, I determine that a matter should not be communicated in my report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

Report on other legal and regulatory requirements

In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2019:

a) I received all the information and explanations I required.

b) In my opinion, the prescribed requirements in relation to the establishment and keeping of accounts were complied with in all material respects.

C. G. Strickland

30 August 2019

C G Strickland
as delegate of the Auditor-General

Queensland Audit Office
Brisbane

Chapter 5
Glossary

Word	Definition
Accessible	Accessible healthcare is characterised by the ability of people to obtain appropriate healthcare at the right place and right time, irrespective of income, cultural background or geography.
Activity Based Funding (ABF)	A management tool with the potential to enhance public accountability and drive technical efficiency in the delivery of health services by: • capturing consistent and detailed information on hospital sector activity and accurately measuring the costs of delivery • creating an explicit relationship between funds allocated and services provided • strengthening management's focus on outputs, outcomes and quality • encouraging clinicians and managers to identify variations in costs and practices so they can be managed at a local level in the context of improving efficiency and effectiveness • providing mechanisms to reward good practice and support quality initiatives.
Acute	Having a short and relatively severe course.
Acute care	Care in which the clinical intent or treatment goal is to: • manage labour (obstetric) • cure illness or provide definitive treatment of injury • perform surgery • relieve symptoms of illness or injury (excluding palliative care) • reduce severity of an illness or injury • protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function • perform diagnostic or therapeutic procedures.
Admission	The process whereby a hospital accepts responsibility for a patient's care and/or treatment. It follows a clinical decision, based on specified criteria, that a patient requires same-day or overnight care or treatment, which can occur in hospital and/or in the patient's home (for hospital-in-the-home patients).
Allied Health staff	Professional staff who meet mandatory qualifications and regulatory requirements in the following areas: audiology; clinical measurement sciences; dietetics and nutrition; exercise physiology; leisure therapy; medical imaging; music therapy; nuclear medicine technology; occupational therapy; orthoptics; pharmacy; physiotherapy; podiatry; prosthetics and orthotics; psychology; radiation therapy; sonography; speech pathology and social work.
Benchmarking	Involves collecting performance information to undertake comparisons of performance with similar organisations.
Best practice	Cooperative way in which organisations and their employees undertake business activities in all key processes, and use benchmarking that can be expected to lead to sustainable world class positive outcomes.
Clinical governance	A framework by which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Clinical practice	Professional activity undertaken by health professionals to investigate patient symptoms and prevent and/or manage illness, together with associated professional activities for patient care.
Clinical workforce	Staff who are or who support health professionals working in clinical practice, have healthcare specific knowledge/ experience, and provide clinical services to patients, either directly and/or indirectly, through services that have a direct impact on clinical outcomes.
e-Health	Since 2007 Queensland Health has been working on an e-Health agenda that aims to create a single shared electronic medical record (eMR) which will be delivered through the use of information and communication technology. The vision of the e-Health Program is to enable a patient-centric focus to healthcare delivery across a networked model of care.
e-Learning	QH Online Training Environments. ELMO http://elmolearning.com.au/ and iLearn
e-plan	Computerised plan storage room.
Emergency department waiting time	Time elapsed for each patient from presentation to the emergency department to start of services by the treating clinician. It is calculated by deducting the date and time the patient presents from the date and time of the service event.
Full time equivalent (FTE)	Refers to full-time equivalent staff currently working in a position.
Health outcome	Change in the health of an individual, group of people or population attributable to an intervention or series of interventions.
Health reform	Response to the National Health and Hospitals Reform Commission Report (2009) that outlined recommendations for transforming the Australian health system, the National Health and Hospitals Network Agreement (NHHNA) signed by the Commonwealth and states and territories, other than Western Australia, in April 2010 and the National Health Reform Heads of Agreement (HoA) signed in February 2010 by the Commonwealth and all states and territories amending the NHHNA.

Word	Definition
Hospital	Healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.
Hospital and Health Board	The Hospital and Health Boards are made up of a mix of members with expert skills and knowledge relevant to managing a complex health care organisation.
Hospital and Health Service	Hospital and Health Service (HHS) are separate legal entities established by Queensland Government to deliver public hospital services.
Hospital in the home (HITH)	Provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation.
Incidence	Number of new cases of a condition occurring within a given population, over a certain period of time.
Indigenous health worker	An Aboriginal and/or Torres Strait Islander person who holds the specified qualification and works within a primary healthcare framework to improve health outcomes for Indigenous Australians.
Long wait	A 'long wait' elective surgery patient is one who has waited longer than the clinically recommended time for their surgery, according to the clinical urgency category assigned. That is, more than 30 days for a category 1 patient, more than 90 days for a category 2 patient and more than 365 days for a category 3 patient.
Medicare Local	Established by the Commonwealth to coordinate primary health care services across all providers in a geographic area. Works closely with HHSs to identify and address local health needs.
Medical practitioner	A person who is registered with the Medical Board of Australia to practice medicine in Australia, including general and specialist practitioners.
Nurse practitioner	A registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessing and managing clients using nursing knowledge and skills and may include, but is not limited to, direct referral of clients to other healthcare professionals, prescribing medications, and ordering diagnostic investigations.
Outpatient	Non-admitted health service provided or accessed by an individual at a hospital or health service facility.
Outpatient service	Examination, consultation, treatment or other service provided to non-admitted non-emergency patients in a speciality unit or under an organisational arrangement administered by a hospital.
Overnight stay patient	A patient who is admitted to, and separated from, the hospital on different dates (not same-day patients).
Patient flow	Optimal patient flow means the patient's journey through the hospital system, be it planned or unplanned, happens in the safest, most streamlined and timely way to deliver good patient care.
Performance indicator	A measure that provides an 'indication' of progress towards achieving the organisation's objectives. Usually has targets that define the level of performance expected against the performance indicator.
Private hospital	A private hospital or free-standing day hospital, and either a hospital owned by a for-profit company or a non-profit organisation and privately funded through payment for medical services by patients or insurers. Patients admitted to private hospitals are treated by a doctor of their choice.
Public patient	A public patient is one who elects to be treated as a public patient, so cannot choose the doctor who treats them, or is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.
Public hospital	Public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.
Registered nurse	An individual registered under national law to practice in the nursing profession as a nurse, other than as a student.
Statutory bodies / authorities	A non-departmental government body, established under an Act of Parliament. Statutory bodies can include corporations, regulatory authorities and advisory committees/councils.
Sustainable	A health system that provides infrastructure, such as workforce, facilities and equipment, and is innovative and responsive to emerging needs, for example, research and monitoring within available resources.
Telehealth	Delivery of health-related services and information via telecommunication technologies, including: • live, audio and/or video inter-active links for clinical consultations and educational purposes • store-and-forward Telehealth, including digital images, video, audio and clinical (stored) on a client computer, then transmitted securely (forwarded) to a clinic at another location where they are studied by relevant specialists • teleradiology for remote reporting and clinical advice for diagnostic images • Telehealth services and equipment to monitor people's health in their home.
The Viewer	The Viewer is a read-only web-based application that displays consolidated clinical information sourced from a number of existing Queensland Health enterprise clinical and administrative systems.
Triage category	Urgency of a patient's need for medical and nursing care.
Wayfinding	Signs, maps and other graphic or audible methods used to convey locations and directions.

Chapter 6
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/s	ARRs – section 7	Page iii
Accessibility	Table of contents Glossary	ARRs – section 9.1	Page iv Page 101
	Public availability	ARRs – section 9.2	Page i
	Interpreter service statement	Queensland Government Language Services Policy ARRs – section 9.3	Page i
	Copyright notice	*Copyright Act 1968* ARRs – section 9.4	Page i
	Information Licensing	QGEA – Information Licensing ARRs – section 9.5	Page i
General information	Introductory Information	ARRs – section 10.1	Pages 2-3
	Machinery of Government changes	ARRs – section 10.2, 31 and 32	n/a
	Agency role and main functions	ARRs – section 10.2	4,6
	Operating environment	ARRs – section 10.3	4,6
Non-financial performance	Government's objectives for the community	ARRs – section 11.1	Page 1
	Other whole-of-government plans / specific initiatives	ARRs – section 11.2	6
	Agency objectives and performance indicators	ARRs – section 11.3	55
	Agency service areas and service standards	ARRs – section 11.4	55
Financial performance	Summary of financial performance	ARRs – section 12.1	Page 56
Governance – management and structure	Organisational structure	ARRs – section 13.1	Page 38
	Executive management	ARRs – section 13.2	Pages 38-43
	Government bodies (statutory bodies and other entities)	ARRs – section 13.3	n/a
	Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* ARRs – section 13.4	Pages 50-51
	Queensland public service values	ARRs – section 13.5	6,50
Governance – risk management and accountability	Risk management	ARRs – section 14.1	49
	Audit committee	ARRs – section 14.2	Pages 46-49
	Internal audit	ARRs – section 14.3	Page 49
	External scrutiny	ARRs – section 14.4	Page 50
	Information systems and recordkeeping	ARRs – section 14.5	Page 50
Governance – human resources	Strategic workforce planning and performance	ARRs – section 15.1	Page 44
	Early retirement, redundancy and retrenchment	Directive No.04/18 Early Retirement, Redundancy and Retrenchment ARRs – section 15.2	Page 44
Open Data	Statement advising publication of information	ARRs – section 16	Page ii
	Consultancies	ARRs – section 33.1	https://data.qld.gov.au
	Overseas travel	ARRs – section 33.2	https://data.qld.gov.au
	Queensland Language Services Policy	ARRs – section 33.3	https://data.qld.gov.au
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 17.1	Page 96
	Independent Auditor's Report	FAA – section 62 FPMS – section 50 ARRs – section 17.2	Pages 97-100

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

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